Recovery-Oriented Reflective Practice Groups: Conceptual Framework and Group Structure

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ABSTRACT
The recovery-oriented reflective practice group (RORPG) is a staff-directed intervention aimed at achieving the recovery-focused transformation of mental health settings. This discussion paper aims to outline and reflect on the conceptual framework and group structure of recovery-oriented reflective practice groups. RORPGs build on conceptualizations of reflective practice, personal recovery, mental health nursing as a relational and reflective practice, and abductive reasoning. Dewey’s phases of reflection, together with an understanding of nursing practice as a dynamic process of care, provide a structure for group sessions in which abductive reasoning can be considered a core activity. This paper outlines a sound theoretical foundation and suggests that RORPGs might prove useful for providing a space for learning in practice, informed by both theoretical and practical knowledge.

Introduction
We understand a recovery-oriented practice to be person-centred, strengths-based, collaborative, and reflective, thereby enabling staff in psychiatric services to address the needs and rights of unique individuals in unique situations. The recovery-oriented reflective practice group (RORPG), as introduced in this paper, is a staff-directed intervention aimed at achieving recovery-focused transformation in mental health services. Expected outcomes involve staff becoming more reflective and recovery-oriented. Thus far, we have conducted two small-scale clinical evaluations, the results of which will be reported elsewhere. The purpose of this theoretical discussion paper is to outline and reflect on the conceptual framework and group structure of RORPGs.

Background
Reflective practice groups in nursing
Reflective practice groups, as a form of reflective practice, have been developed and evaluated in the context of mental health nursing (Dawber, 2013a, 2013b; Dawber & O’Brien, 2014; O’Neill, Johnson, & Mandela, 2019). They have been reported to promote self-awareness, clinical insight, and quality of care (Dawber, 2013b; Dawber & O’Brien, 2014) and to facilitate stress management and team building (Dawber, 2013b; O’Neill et al., 2019).

Dawber (2013a) described reflective practice groups as facilitated group supervision promoting reflection focusing on the interpersonal aspects of care delivery, allowing participants to share insights relevant to nursing practice in a supportive environment. Clinical supervision lacks an agreed-upon definition (Buus, Angel, Traynor, & Gonge, 2011; Cutcliffe, Sloan, & Bashaw, 2018), and best practices for clinical supervision in the context of mental health nursing remain unclear (Buus & Gonge, 2009). Arguably, clinical supervision should be clearly separated from managerial supervision, or management agendas might threaten possibilities of reflection on care (Cutcliffe et al., 2018). Peer group supervision has been suggested as an alternate form of supervision (Heron, 1999) and proposed as an accessible alternative to traditional clinical supervision in mental health nursing (Lakeman & Glasgow, 2009). A recent systematic review of clinical supervision evaluation studies in nursing (Cutcliffe et al., 2018) reported a small but emerging body of empirical work reporting positive effects of clinical supervision and a need for more quantitative or mixed-methods research. The review also highlighted the necessity of further qualitative evaluations of the effects and impacts of clinical supervision, although the existing literature reports “overwhelmingly positive” findings (Cutcliffe et al., 2018, p. 1360).

Recovery-oriented reflective practice groups
RORPGs are structured reflection-on-action with staff. They focus on what works, relationships, needs, and actions. They are about taking different perspectives and testing and evaluating actual changes. RORPGs are recovery-oriented because they promote recovery-oriented practice, but also because...
the conceptual framework and structure of groups align with recovery principles. Guiding principles of a recovery-orientation in mental health include self-direction, peer-support, empowerment, respect, responsibility, hope, and an understanding of recovery as holistic, nonlinear, strengths-based, individualized, and person-centered (Centre for Substance Abuse Treatment, 2007).

Service users experience greater improvement in personal recovery when involved in recovery-oriented care versus usual care (Thomas, Despeaux, Drapalski, & Bennett, 2018). Recovery-oriented practice training can promote recovery-oriented practice (Meadows et al., 2019). Barriers for recovery-oriented care include conflicting system priorities, indicating that efforts to transform services towards a recovery orientation require a whole-system approach (Le Boutillier, Slade et al., 2015).

Thus far, we have evaluated recovery-oriented reflective practice groups at two supported housing units for people with psychiatric disabilities and one forensic psychiatric ward. In the supported housing setting, each staff member was offered a dozen 90-minute group sessions over the course of 24 weeks. Group members included rehabilitation assistants and unit managers. Groups were facilitated by the second author who is a registered nurse specializing in mental health. In the forensic setting, each staff member was offered seven 90-minute sessions over 7 weeks. These groups were facilitated by two registered nurses working at the clinic with support from the second author. Group members included nurses, nursing assistants, and the unit manager. Group sizes varied between five and ten members. Preliminary findings suggest that RORPGs can contribute to staff becoming more reflective, empowered, and recovery-oriented.

Conceptual framework and structure of group sessions

The conceptual framework of RORPGs pertains to an understanding of mental health as a relational, reflective practice addressing the needs, and rights of unique individuals in unique situations. Crucial concepts include reflective practice, abductive reasoning, personal recovery, and mental health nursing as a relational and reflective practice. In the following, we discuss these concepts in relation to the structure of group sessions. We propose that RORPGs promote a person-centered, individualized practice as they encourage staff to form trusting relationships and learn about service-users’ unique strengths, needs preferences, experiences, and backgrounds. They encourage staff to take a holistic approach and consider service-users’ entire life, including existential and social aspects. Groups look beyond the behavior of service-users and explore the rationale and meaning of behavior. Actions and approaches are considered that seek to create opportunities for staff to further get to know the service-user as a person. Groups are strengths-based as they challenge staff to reinterpret problem behavior in terms of resources. Also, by raising group members’ awareness of the impact of their actions and approaches on service-users’ recovery, they serve to inspire hope that recovery is possible. Actions and approaches are chosen that build on service-users’ capabilities and allow for growth and development. Groups are collaborative as they seek actions and approaches that empower service-users and respect their ability and right to make informed decisions about their own path to recovery. They consider the impact of relationships, or lack of relationships, on the situation at hand. Actions and approaches are chosen that allow staff to engage with service-users as partners, working together towards recovery. Finally, groups are reflective as they acknowledge that recovery is a nonlinear process. Members engage in a structured process of discovery during sessions, and actions and approaches are considered best guesses that need to be tested and evaluated in practice.

The structure and conceptual framework of RORPGs allow for the integration of elements of clinical supervision, peer supervision, and managerial supervision. Group members are primarily mental health staff engaged in interpersonal aspects of care. Facilitators need sufficient subject knowledge and facilitation skills to ensure that group members’ understanding of practice are challenged, and to aid in developing a new understanding. This might call for special training and support to enable existing staff to act as facilitators, or it might be necessary to bring in someone from outside to act as facilitator. As groups need to be able to initiate and follow up on changes to practice, they might also need to include unit managers. In adherence with recovery principles, we suggest that RORPGs might be further evolved into co-produced supervision by including experts by experience and/or service users as members.

Structured reflection-on-action

Reflective practice is regarded as the integration of theory and practice, a requisite for personal and professional development, and a strategy for fostering person-centred approaches to care (Goulet, Larue, & Alderson, 2016). The concept of reflective practice can be used to clarify the relationship between theory and practice. It was introduced by social scientist Donald A. Schön (1930–1997) in the context of how professionals think in action (Schön, 1983). Schön was heavily inspired by the ideas of educational reformer and pragmatist philosopher John Dewey (1859–1952). Schön (1983) argued that the devaluing of the professions is due to a single-minded emphasis on technical rationality that fails to appreciate that professional practice contains an element of artistry. Because situations in practice do not always correspond neatly to the categories of theory, professional practice is not the straightforward application of theory in a linear process (Schön, 1983). Being professional means having the ability to adapt practice to the situation at hand, especially in situations of "uncertainty, uniqueness and conflict" (Schön, 1987, p. xi). This is done by challenging one’s initial understanding of the situation, constructing a new understanding, and testing it—a process Schön called reflection-in-action (1983, p. 59) or “thinking what they are doing while they are doing it” (Schön, 1987, p. xi).
Dewey proposed that knowledge always concerns the relationship between actions and their consequences: We learn about the world through our actions, and gaining knowledge requires a process of knowledge creation (Dewey, 1929). As action and thought presuppose each other like practice and theory, action without reflection will not generate experience, and reflection needs to be based in action. Dewey described six phases of reflection: (1) identifying an experience, (2) the spontaneous interpretation of the experience, (3) naming the problem(s) or the question(s) that arises, (4) generating possible explanations, (5) ramifying explanations into hypotheses, and (6) experimenting and testing selected hypotheses (Rodgers, 2002). Building on these phases, we identify six corresponding constituents of RORPG sessions, each focusing on a specific question. We have chosen to label them “constituents” rather than phases in order to emphasize the dynamic and iterative nature of these sessions—all questions need to be addressed but not necessarily in any specific order:

1. What?
2. What is it about?
3. Why do we care?
4. How can we understand this?
5. What can we do?
6. Who does what?

We propose that recovery-oriented reflective practice groups, adhering to the structure outlined here, are engaged in a process of discovery and knowledge development known as abductive reasoning. The concept of abduction, first developed in the thinking of pragmatist philosopher Charles Sanders Peirce (1839–1914), has long attracted the interest of nursing scholars (Eriksson & Lindström, 1997; Råholm, 2010). Abduction is described as “a cerebral process, an intellectual act, a mental leap, that brings together things which one had never associated with one another: A cognitive logic of discovery.” (Reichertz, 2007, p. 220)

**What?**

The first constituent asks the question What? The focus of a session should ideally be a shared experience pertaining to interpersonal aspects of care. It might be the needs and wants of a specific service user, a behavior, a recurring type of situation on the unit, or anything service user-related that intrigues or frustrates staff members. While recovery-oriented practice might well entail the planning and execution of complex and highly structured nursing interventions, we suggest that a core activity of recovery-oriented reflective practice groups should be the problematizing of what Topor, Boe, and Larsen (2018) labeled “small things.” By highlighting, discussing, questioning, and providing a theoretical context for small things helpful in recovery, recovery-oriented reflective practice groups seek to bring these into the realm of professional practice.

**What is it about and why do we care?**

Abduction is generally considered a logical inference, reaching into the sphere of deep insight and new knowledge, that is intended to help make new discoveries in a logically and methodologically ordered way (Reichertz, 2007, p. 216). Thus, the next constituent asks the question What is it about? The group should take an inventory of how they perceive the shared experience based on their experiences and perceptions. If these understandings are valid and relevant or based on prejudices, myths and misconceptions are initially irrelevant as the purpose is to explore and create an awareness of how behaviors and situations are interpreted by group members. The third constituent takes another step on the path to discovery by inquiring Why do we care? The relevance of the shared experience for staff is explored in order to create an awareness. Is this a matter of concern for service users’ unmet needs, or is this mainly a problem from the staff’s point of view? Staff interested in understanding the perspectives of service users might strive to be flexible in order to meet the needs of individual service users, while staff emphasizing their own perspectives might prioritize solving the staff’s problems even at the expense of individual service users’ needs (Looi, Gabrielsson, Sävenstedt, & Zingmark, 2014).

**How can we understand this?**

Abductive reasoning requires a theoretical basis and sufficient knowledge of the field of inquiry (Råholm, 2010), and thus, How can we understand this? is the focus of the fourth constituent. A crucial component of RORPG sessions is to further problematize and apply different perspectives to the shared experience. Typically, a session would involve attempting to take the service user’s perspective on a situation, focusing on the service user’s needs rather than on the staff’s problems, or reinterpreting a service user’s problematic or challenging behavior in terms of strengths and resources.

Im and Meleis (1999) proposed that a nursing perspective should encompass a focus on health, caring, holism, the subjectivity of clients, a dialoged approach, and lived experiences. Meleis (2007) presented the following four characteristics that, when integrated, define the nursing perspective: the nature of nursing science as a human service; the practice aspects of nursing; caring relationships that nurses and service users develop; and a health and wellness perspective. RORPGs are based on an understanding of nursing that aligns with Thorne and Hayes’s (1997) description of nursing as a highly individualized, reflective, and contextual phenomenon. How nursing practice is characterized and understood is of vital importance for its further development as a profession and for building nursing knowledge. It has been argued that the emotional understanding of nursing, “to care for,” has been devalued in modern society and that the discipline of nursing itself contributes to this development in its striving for professional and academic status (Herdman, 2004). This rationalization of nursing would be evident in conceptualizations such as “evidence-based
nursing” and “the nursing process.” The emotional, caring aspect of nursing is proposed to have been made subordinate to the cognitive and instrumental aspects and the linkage between feeling and action to have been broken. There is also concern that a focus on safety and risk management fails to meet service users’ needs and hinders individualized, flexible, and recovery-oriented psychiatric care (Higgins et al., 2016; Morrissey, Doyle, & Higgins, 2018; Slomon, Jenkins, & Bungay, 2017). RORPGs are, therefore, informed by an understanding of nursing practice as a dynamic process of care focused on reflection, relationships, needs, and interventions (Looi, Sävenstedt, & Engström, 2016).

While nursing and recovery perspectives are at the forefront in RORPGs, we propose a pluralistic approach where these perspectives are allowed to be complemented and/or challenged by other perspectives. To gain a fuller understanding of service users’ needs, other perspectives might prove necessary and helpful, e.g. psychological, medical, and pedagogical.

What can we do and who does what?

The result of abduction is an uncertain possibility that needs to be tested through inductive and deductive reasoning (Råholm, 2010), a new order that solves the practical problems that arise from surprising facts and is justified by its usefulness (Reichertz, 2007, p. 222). The fifth constituent asks the question What can we do? The group should seek to identify and articulate the existence of or the need for trusting relationships, possible needs of service users or lack of knowledge of service users’ needs, and potential actions and approaches that would address service users’ needs. A review of the literature on staff understanding of recovery identified three different conceptualizations of recovery-oriented practice: clinical recovery, personal recovery, and service-defined recovery (Le Boutillier, Chevalier et al., 2015). RORPGs adhere to an understanding of mental health recovery as a transformative experience that is a “deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles” (Anthony, 1993, p. 527).

Recovery is about accepting and overcoming the challenge of disability and recovering a new sense of self and purpose (Deegan, 1988). Recovery processes include connectedness, hope, identity, meaning, and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Recovery means that the individual must begin and complete a highly individualistic journey of healing and improvement to overcome the consequences of a mental illness (Topor, Borg, Di Girolamo, & Davidson, 2011).

In the process of exploring ways for staff to support recovery, it is important to ask, “What are we already doing that works?” Often, the necessary knowledge already resides within the group—a key function of the group is to facilitate learning from those experiences. RORPGs are about identifying, creating, and valuing possibilities and growth. The sixth constituent simply asks What does what? A group session should not end without deciding on specific actions that should be taken by specific staff members in a set time frame. The actions chosen should correspond to the overall recovery orientation in that they should be person-centred, strengths-based, collaborative, and reflective. To further facilitate learning, these actions also need to be evaluated at an upcoming group session. In accordance with pragmatic epistemology (Kim & Sjöström, 2006), the “truth” of explanations derived in RORPG sessions are determined by their usefulness, i.e. to what extent actions taken as a result of sessions serve to support recovery in service users.

The case of the manipulative service user as an example

A typical behavior that might be discussed in an RORPG session would be a service user not being truthful with staff, e.g. concealing sharp objects or substances, over- or understating suicidal intention (What?). In our experience, a common explanation for this kind of behavior, especially in regard to service users who self-harm or abuse drugs or alcohol, would be that the service user is manipulative (What is this about?). This can cause feelings of frustration in staff as they might feel that service users are not acting in their own best interests or because they fear being tricked or manipulated (Why do we care?). In a theoretical context where recovery-oriented nursing practice is understood as person-centred, strengths-based, collaborative, and reflective, the labeling of service users as “manipulative” is readily identified as false and counterproductive (How can we understand this?). For example, mental health nursing research suggests that not telling the truth might be understood as a survival strategy that service users adopt based on their experiences of staff not listening to and trusting them (Looi, Engström, & Sävenstedt, 2015). Options for future courses of action might include staff not talking about the service user as being manipulative, not assuming that the service user is lying, not being judgmental, actively striving to understand the situation from the service user’s perspective, and engaging the service user in a discussion of how the behavior has been perceived and how staff can better support the service user’s recovery in the future (What can we do?). To clarify the range of possibilities, discussions would also include more-controversial steps, such as always assuming that the service user is telling the truth or letting the service user make decisions about treatment options. The session might conclude with participants deciding that designated staff should actively seek to connect with the service user on his/her terms and strive for the development of mutual, trusting relationships in which the service user might feel safe to share his or her experience (Who does what?). As a result of RORPG sessions, participants might come to realize that they repeatedly miss opportunities to develop trusting relationships and, thus, have no real understanding of a service user’s need due to his or her being labeled as “manipulative.”

Conclusion

The RORPG is an intervention with the potential to facilitate the recovery-focused transformation of mental health
services. More research is needed to establish the mechanisms and impact of RORPGs. Conceptualizations of reflective practice, personal recovery, mental health nursing, and abductive reasoning provide a sound theoretical foundation and suggest that RORPGs might prove useful in providing a space for learning informed by both theoretical and practical knowledge. Mental health nurses can play an important role in initiating and facilitating RORPGs.

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