Implementing Recovery-Oriented Practice in Mental Health Services: A Qualitative Case Study

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Study Summary

Although the recovery philosophy has been adopted in mental health services in various Western countries including England, its implementation in practice has been described as "slow and patchy". Furthermore, there are suggestions in the literature that there is a lack of clarity around the implementation of recovery-oriented practice (ROP) and a dearth of research exploring the phenomenon. This study aimed to discover how recovery-oriented practice is implemented in an NHS Trust providing care for people experiencing mental health problems, in order to add to what is already known about the implementation of ROP to inform future practice

A qualitative case study approach was employed to investigate the implementation of ROP from strategic to grassroots level in two practice settings (Community Mental Health Team and Rehabilitation ward) within one NHS Trust providing mental health services in the South of England. Semi-structured interviews were conducted with 16 participants (senior managers, practitioners, service users) investigating their perceptions and experiences of ROP. Data were analysed using thematic analysis and further interpreted by situating it in the literature.

Main findings:

- Whilst there was a shared common understanding of the meaning of recovery and ROP in the organisation, there was a fundamental difference between practitioners and service users' conceptualisations with service users leaning more towards clinical recovery.
- At strategic level, strategies to facilitate implementation of ROP focused on changing the culture within the organisation through Implementing Recovery through Organisational Change (ImROC) recommended interventions such as: Recovery College, peer workers and use of the Recovery Star. At grassroots level, implementation was via the development of therapeutic relationships between service users and practitioners.
- Salient barriers to the implementation of ROP included: time taken completing paperwork resulting from performance measures used by commissioners in the community team, the shortage of resources and the tension between risk management and ROP in both settings.

Study contribution

This study addresses the gap in research on the implementation of ROP through an exploration of how ROP was being implemented in two practice settings in an NHS organisation providing mental health care. Methodologically, the qualitative case study approach adopted in the study allowed triangulation of data from participants ranging from grassroots level to strategic level. Furthermore, the approach taken with the sample consisting of service users, senior managers and practitioners from inpatient and community practice settings within the same organisation is not comparable with any other studies on ROP that have been conducted in England. This study therefore informs implementation efforts of similar organisations and makes recommendations for practice, commissioners and research.

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Statements and Declarations

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Abbreviation	Meaning
DH	Department of Health
ROP	Recovery-oriented practice
CMHT	Community Mental Health Team
Rehab Ward	Rehabilitation ward
PIS	Participant information sheet
ImROC	Implementing Recovery Through Organisational Change
CMHN	Community Mental Health Nurse
NHS	National Health Service
NSF	National Service Framework
MI	Mental Illness
TA	Thematic analysis
RC	Recovery College
OT	Occupational Therapist
CQC	Care Quality Commission
RITB	Recovery in The Bin
SOP	Standard Operating Procedure

Chapter 1: Introduction and Background

Introduction

Recovery has been the underpinning philosophy for mental health services in Western countries since the 1990s. In England, mental health policy and guidance since the early 2000s has indicated a shift to a recovery focus and the concept has also caught the attention of researchers. Several studies exploring various aspects of recovery have subsequently been published. However, the subject of how recovery-oriented practice (ROP) is implemented was identified as needing more investigation. The qualitative case study presented in this thesis therefore investigated how ROP was being implemented in two practice settings in an NHS organisation providing mental health care in the South of England. The aim was to discover how recovery-oriented practice is implemented in an NHS Trust providing care for people experiencing mental health problems, in order to add to what is already known about the implementation of ROP to inform future practice

. The study had the following objectives:

- To explore National Health Service (NHS) Trust senior managers', team leaders and practitioners' views on recovery-oriented practice and how it is implemented in their organisation.
- To elucidate service users' views and experiences of recovery-oriented practice.
- To investigate the strategies that have been put in place to facilitate recovery-oriented practice at different levels within the organisation.
- To identify any barriers and facilitators to the implementation of recovery-oriented practice at the different levels of the organisation.
- To clarify how recovery-oriented practice is evaluated in the Trust.

The study identified three themes namely: The meaning of recovery, The therapeutic relationship as the vehicle for ROP and Constraints to the implementation of ROP. Seven sub-themes falling within these three themes were identified as follows: Values, the lens through which practitioners view service users; The process of building the relationship; The nature of the relationship; Drivers for collaborative relationships; Limited resources; Risk management and Between a rock and a hard place.

Furthermore, it makes unique contributions in the field of recovery in mental health by providing a holistic exploration of how ROP was manifesting in two practice settings in an NHS organisation providing mental health care. This could inform similar organisations in their implementation efforts.

This introductory chapter provides the background for the thesis by outlining triggers for the study and giving an overview of recovery and recovery-oriented practice (ROP) which are the key concepts under investigation. Furthermore, the context for the implementation of ROP in England is established by highlighting key policy drivers for the adoption of recovery. Finally, an outline of the thesis is provided to give the reader an idea of what to expect in the rest of the thesis.

The triggers for this study

When I undertook my university based mental health nurse education from 2002 and 2005, I learnt the skills and knowledge required to be a safe and effective mental health nurse. After qualifying as a nurse, I worked on an acute inpatient adult ward then as a community mental health nurse (CMHN) in a Crisis Team. In both these roles, I encountered people with various mental health problems, and I viewed my role as being about helping them to "get better". This mainly involved working as part of a multi-disciplinary team led by a psychiatrist, focusing on the alleviation of their symptoms of mental illness using mainly medication. In instances where service users had other challenges such as social or financial needs, I would refer them to social work colleagues as these were viewed as being outside the remit of my role.

It was during my time as a CMHN in the Crisis Team in 2008 that I started hearing more about the recovery approach. I had heard the term mentioned before but did not know much about it. This term was something new to me even though it was being talked about and published about. However, as a busy practitioner, I did not really investigate it further. Practice remained the same and recovery was not discussed in my team.

In 2010, I started working in education as a Practice Educator at a University in England. My role included supporting students and mentors in practice and also teaching mental health nurses in the classroom. In my new role, I was tasked with teaching on the new recovery module. This immediately caught my attention as I knew this was something I was not very familiar with. I started reading about recovery to inform my teaching and that was when I developed a greater understanding of what it was about. Having read about the recovery approach, I found the ideas refreshing and felt practising with a recovery focus would have a positive impact on the experiences of people with mental health problems. I thought the philosophy had the potential to change both mental health services and society in general with regards to how mental illness and people with a diagnosis of a mental illness were viewed. I got excited thinking about how this was changing practice.

Fortunately, in my role I had the opportunity to work with practitioners and service users. This made it easier for me to keep up with developments in practice. As I had developed an interest in recovery, I would talk to my students and colleagues in practice about it. These conversations led me to realise that the practitioners I was talking to did not know much about the concept and seemed to not understand it. One practitioner stated that they were *"not bothered about all these fancy terms being used, my job is to help people"*. During another conversation with another practitioner, they informed that they were *"doing recovery"* using the Recovery Star. In addition to this, my students also informed me that what they were learning in class about recovery was not always reflected in practice. This made me wonder what organisations were doing to implement the recovery philosophy in their practice settings.

However, a talk given to my students by a service user was the impetus for the study. He revealed that he had been left with no statutory benefits whilst he was unwell because his care coordinator had told him that he would not help him to complete the application forms for his benefits because they were now "doing recovery" and that meant that the service user needed to do things for himself. The service user was very unwell, unable to concentrate or understand the forms so had ended up going without money for some time because he had not managed to complete the forms on his own.

Reflecting on this story and on my encounters with practitioners further ignited my interest in the adoption of recovery ideas in mental health services and that was the beginning of my research journey.

The history of psychiatry and the contested nature of mental Illness

In order to further set the scene for this study, it is necessary to clarify the context within which ROP in mental health services is implemented. To this end, a brief overview of the origins of psychiatry as a discipline, some of its critiques and the contested nature of mental illness will be given.

Psychiatry became an academic and clinical discipline in the mid-nineteenth century (Double, 2003). The goal of psychiatry was to identify an area of illness for mental disorders in the same way that had been done for physical illnesses (Morgan, 2014). Psychiatry is therefore underpinned by the bio-medical model and the underlying assumption is that mental disorders are caused by an underlying brain disease or anomaly in the anatomy or physiology of the brain (Slade, 2009). However, since the identification of neurological deficits associated with Alzheimer's disease in the early twentieth century, it has not been possible to identify physiological abnormalities underlying most disorders classified as mental illnesses. Illnesses such as schizophrenia, bipolar affective disorder, and depression were all classified and

diagnosed through observation of behaviour (Morgan, 2014). Furthermore, the treatments that were used for these conditions were often harsh without any understanding of how they cured the illness. This lack of evidence of physical causation and the use of value laden observations of what is considered "normal behaviour" left psychiatry as a discipline open to critique in the 60s and 70s including assertions that psychiatry functions as an agent of social control, judging what counts as normal behaviour (Morgan, 2014). Thinkers from different backgrounds challenged the assumptions made by psychiatry and some argued that the concept of mental illness was a "myth" (Szasz, 1972). The ontological status of mental illness is therefore questioned with others arguing that mental illness is socially constructed (Walker, 2006). To add on to this, in the 90s, the work of psychiatrists Marius Romme and Sandra Escher challenged the view that hearing voices was a meaningless expression of biological disorder. Their work showed that there were many people who heard voices who were not in contact with mental health services but instead learned how to live and cope with the voices through understanding the significance and meaning of the voices (Romme and Escher, 1993). This informed a different approach to voice hearing and gave rise to the Hearing Voices Networks now in many countries including England.

Apart from questioning the ontological status of mental illness, other critiques of psychiatric practice relate to the way in which people regarded as mentally ill are labelled, institutionalised and have their rights taken away (Goffman, 1973; Rosenhan, 1973). It was against this backdrop that ideas about recovery were born in the 60s and 70s with the rise of the service user/survivor movement. A further discussion on the background of recovery will follow.

However, to conclude this section, I reflect on my own positioning within the above debates. Categorisations by Repper and Perkins (2003) were useful in clearly articulating my beliefs. They categorised two distinct trends within the user movement, namely: a radical, antipsychiatry movement concerned with rejection of psychiatric services in favour of user-controlled and run alternatives and a reformist user movement, focusing on improving existing mental health services campaigning for more control and involvement within them. Examining my own beliefs about mental illness, I found that I am open to different ways of understanding mental illness. I believe that whilst there is value in diagnosis and treatment in some cases, it is also important to understand people's experiences and to value their contributions, respect their choices and view them as experts by experience. My beliefs are therefore aligned with the ideas of the latter service user movement which focuses on improving mental health services and the experiences of mental health service users.

Recovery: the background

The concept of recovery originated from the service user movement in the 1960s and 1970s as a response to service users' dissatisfaction with the way they were being treated and the views clinicians held about them which were mostly pessimistic (Slade, 2009; Pilgrim and McCranie, 2013; Roberts and Boardman, 2013). Although empirical studies that had been conducted over the years had challenged the assumption that mental illnesses such as schizophrenia were chronic with a deteriorating course (see Slade 2009 for examples of such studies), it was felt that professionals applied the chronic disease model to mental illness and focussed on biological treatments rather than on looking at the whole person including their strengths (Roberts and Boardman, 2013). Pilgrim and McCranie (2013) provided a succinct summary of the origins of recovery:

> *"Recovery does not rely on holding out for the magic bullet of medical therapy to eliminate mental health problems. It emerged as a messy response to some of that naïve optimism in the hope of medical science."* (Pilgrim and McCranie 2013, p. 2).

Over the last few decades, the concept of recovery as proposed by the service user movement has gained momentum and is widely published (for some early examples from the UK, see literature reviews by Bonney and Stickley (2008) and Stickley and Wright (2011)). The idea of recovery-oriented services was subsequently introduced and has been adopted in many countries with the United States of America (USA) cited as being the first country to have recovery in their policy before countries such as New Zealand, Australia and the UK followed suit (Pilgrim and McCranie, 2013).

Definitions and understanding of the meaning of recovery initially came from syntheses of the narratives of people with the lived experience of mental illness and their accounts illustrated what recovery looked and felt like from the inside (Slade, 2009). From a UK perspective, some seminal work by Repper and Perkins (2003) introduced the idea of recovery and social inclusion in mental health practice. Slade's (2009) work added to this as he further illuminated the difference between recovery in the traditional sense and recovery as proposed by the service user movement. Slade (2009) explored two conceptualisations of recovery, namely: clinical recovery and personal recovery. Clinical recovery was defined as the idea that emerged from the expertise of mental health practitioners which focuses on eliminating symptoms and helping the individual to get back their "normal" self with the following four features: "it is an outcome; it is observable; it is rated by the expert clinician, not the patient; the definition of recovery is invariant across individuals" (Slade, 2009, p.35). Personal recovery on the other hand, originated from the experiences of people with mental illness and emphasises hope, identity, meaning and personal responsibility rather than symptoms (Slade,

2009). According to Ramon et al. (2007), personal recovery is similar to, and often used interchangeably with social recovery which is about being able to live with minimal social disruption and being financially independent with stable accommodation. However, although the distinction is made between personal and clinical recovery, it has been proposed that the different conceptualisations of recovery are complementary of each other (Care Services Improvement Partnership et al., 2007). Slade (2009) further asserts that clinical recovery is subordinate to personal recovery and views the future of mental health as being about promoting personal recovery. He argued that this would change the values, practices and goals of mental health services which is a view I agree with based on my experience as a mental health nurse.

The different perspectives on the origins of recovery are summarised in Pilgrim and McCranie's (2013) categorisation of the meaning of recovery as shown below:

Figure 1: Meanings of recovery

(Pilgrim and McCranie 2013)

Although other perspectives on recovery are offered in the literature, these have similarities to Slade's (2009) conceptualisations of recovery. For example, Davidson and Roe (2007) refer to *"recovery from"* and *"recovery in"* mental illness. "Recovery from" mental illness is similar to clinical recovery as it is about absence of symptoms whilst and "recovery in" mental illness similar to personal recovery. Another perspective is from Liberman and Kopelowicz (2005) who proposed two ways of looking at recovery, namely: recovery as a process and recovery

as an outcome. They argued that recovery is an outcome of the process of recovering and highlighted pathways to recovery such as personal attributes, social environment, continuity, quality of treatment and subjective experience. This way of seeing recovery as being influenced by different factors concurs with the ideas put forward by Jacobson and Greenley (2001) who suggested that recovery was influenced by internal and external conditions as summarised below:

Table 1:Internal and External Conditions for recovery

Internal conditions for recovery	External Conditions for recovery
• Hope • Healing • Empowerment • Connection	• Implementation of the principles of human rights • Positive culture of healing • Recovery- oriented services

(Jacobson and Greenly, 2001)

These ideas were echoed in later work by Leamy et al. (2011) who proposed a conceptual framework of the processes of recovery which cited connectedness, hope and optimism about the future, identity, meaning in life and empowerment (CHIME) as the main processes of recovery.

Whilst the ideas around recovery as a process are useful as they give insight into the conditions that are required to facilitate the process, Liberman and Kopelowicz's (2005) idea of recovery as an outcome can also be useful for mental health service providers as it makes recovery something that can be operationalised, measured and validated (Liberman and Kopelowicz, 2005). Liberman et al. (2002) suggested the following criteria for measuring recovery as an outcome:

- Educational/work involvement
- Independent living
- Having social contact with friends
- Not being completely dependent on disability insurance

However, Pilgrim and McCranie (2013) argued that the criteria was a narrow view of success in recovery. I agree with this view as narrowing down recovery into a set of predetermined criteria takes away from the essence of recovery which is about individuals defining what recovery looks like for them based on their personal goals. However, the criteria do reflect a shift away from focusing solely on symptoms and provides an idea of some of the possible areas to look at guided by the individuals with mental illness.

Definitions of recovery

There is a plethora of definitions of recovery in the literature. However, for the purposes of this study, two examples of the most commonly used definitions for personal recovery will be given.

From a service user perspective, one of the most widely known definitions came from Deegan (1988) who stated that

> "*Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup again … The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution*" (p.15).

The other widely used definition is by a mental health service provider and researcher Anthony (1993) who defined recovery as:

> "*a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness…*" (p. 21)

It can be seen that although worded differently, both emphasise similar ideas around recovery being a process characterised by hope, having a sense of purpose in life and not being limited by mental illness. However, this study adopts Anthony's (1993) definition of recovery as it is the one used by the UK government in mental health policy (Department of Health (DH) 2009, 2011).

Recovery policy and guidance – the English context

This section provides a brief synopsis of the policies that have driven the adoption of recovery ideas by mental health services and will also highlight some key guidance and opinion papers relating to the implementation of ROP in England.

Recovery was first referred to in policy in 2001 in *"The Journey to Recovery. The Government's vision for mental health care"* (DH,2001; Ramon et al., 2009; Perkins and Slade, 2012). However, before this, thinking aligned with the recovery philosophy was evident in the National Service Framework (NSF) which was a ten-year modernisation programme for mental health introduced in 1999. It highlighted the impact of stigma and discrimination on

people with mental health problems, their ability to achieve their life goals and the importance of meaningful occupation, housing education and training in allowing people to achieve their aspirations. The National Institute for Mental Health in England (NIMHE) was established to support the implementation of the framework including the focus on social inclusion and identifying and implementing new ways of working for professionals. Social inclusion is a vital part of recovery (Repper and Perkins, 2003; Lloyd et al., 2008) which suggests that this focus on social inclusion paved the way for the adoption of recovery ideas albeit indirectly. As a continuation of their work, the NIMHE published a guiding statement on recovery in 2005 with information on best practice in recovery (NIMHE, 2005).

In addition to the above, Government strategies for mental health continued to evidence a shift from a biomedical focus to recovery principles starting with "New Horizons. A shared Vision for Mental Health" (DH, 2009) followed by "No Health Without Mental Health" (DH, 2011). Similar to the NSF, No Health Without Mental Health highlighted the importance of employment, good housing, relationships, people having control if their own lives and an overall better quality of life. Although the focus on recovery is not explicitly stated in more recent strategies and frameworks for mental health (Mental Health Taskforce 2016; NHS, 2019) the importance of supporting people with mental illness to be citizens with equal opportunities and the ability to live fulfilling lives in spite of mental illness continues to be highlighted. Furthermore, apart from mental health specific policy, health and social care policy in general has continued to move in a direction supportive of the recovery philosophy with emphasis being placed on patient involvement, the recognition of patients as experts by experience and individualised care.

In addition to policies and strategies, different initiatives were introduced for different professionals to encourage the adoption of recovery principles and to equip the workforce with the skills that would promote recovery (Hope, 2004; CSIP, 2005; College of Occupational Therapists 2006). For nurses, the Chief Nursing Officer's review of mental health nursing "From values to action" (DH, 2006) encouraged mental health nurses to adopt recovery principles as part of their practice.

Alongside these initiatives, various opinion papers and guidance on the principles and standards for recovery-oriented practice (ROP) were published to support the focus on recovery for example Shepherd et al. (2010). The Sainsbury Centre for Mental Health also published various guidance and position statements to aid organisations in their attempts to become recovery oriented (Shepherd et al., 2008 and Sainsbury Centre for Mental Health, 2009). In addition to this, a joint initiative between The Sainsbury Centre for Mental Health and the Mental Health Network of the NHS Confederation (Implementing Recovery through

Organisational Change (ImROC) was funded by the Department of Health in 2011 with the aim to help NHS organisations to become recovery oriented.

Criticisms of the adoption of the recovery philosophy by mental health services

Whilst the above evidence the desire to adopt recovery in mental health services, there has been some criticism of the adoption of recovery ideas in mental health policy. As previously described, the concept of recovery originated from people with personal experiences who were not happy with how they were being treated (Repper and Perkins, 2014). It is therefore not surprising that the adoption of recovery ideas by mental health services caused some concern and was met with some criticism. For example, a survivor critical theorist group called Recovery in The Bin (RITB) argues that the concept has been politicised and distorted to suit the neoliberal ideology which values individual responsibility and downplays community and solidarity (RITB, 2019). Repper and Perkins (2014) have also argued that the concept of recovery has mutated over time and is often distorted to fit into professional frameworks and practice. Furthermore, there are concerns relating to services abusing recovery (Slade et al., 2014). Examples of these abuses include: practitioners deciding which service users the recovery concept applies to, recovery being used to justify closure of services previously available to mental health service users and the use of compulsory treatment and detention to support recovery (Slade et al., 2014)

In addition to the above arguments, it has been proposed that genuine adoption of the recovery concept by mental health services requires a change in the balance of power between professionals and service users with professionals placing the same value on lived experience as they do professional expertise (Repper and Perkins, 2014). The same authors assert that this shift in power has not happened as professionals continue to maintain power through their claim to have special understanding and knowledge about mental illness. To further explore the factors influencing the power dynamic between service users and mental health professionals, ideas around power and how this is practiced in mental health services are discussed below.

Knowledge/Power

In her interpretation of Foucault's work, O'Farrell (2005) explains that power is not a thing or a capacity which can be owned by individuals or the state. Instead, power only exists when it is being exercised through interactions and relationships between individuals or groups. Furthermore, power and knowledge operate interchangeably as power produces different types of knowledge and the knowledge further re-enforces power (O'Farrell, 2005). As discussed in the section on the history of psychiatry, mental health professionals' claim to

knowledge about mental illness through the use of the bio-medical model was the way through which they managed to come into existence and to gain power and authority over those diagnosed as mentally ill. These ideas can be used to explain the power imbalance between mental health professionals and mental health service users where professionals are viewed as experts and service users as recipients of support from the experts.

Recovery approach – A threat to mental health professionals' claim to expertise and knowledge

Based on the ideas outlined above, it can be argued that in order for mental health professionals to maintain their position as experts, there is a need for them to monopolise knowledge about mental illness. This position is threatened by the recovery approach as it rejects the notion of illness and challenges the biomedical approach to mental health problems. According to the recovery approach, recovery can happen without intervention from mental health professionals and is independent of aetiological beliefs about illness as it is not about clinical symptoms but about finding meaning in life (Anthony, 1993). The recovery approach also involves placing responsibility back on the service user rather than on the mental health professional (Repper and Perkins, 2014). This entails a shift of power as the service user is regarded as the expert of their own experience and there is a move away from the logocentrism (the claim to be able to achieve unmediated knowledge) associated with the biomedical model. This means there is no single truth to explain illness or recovery which essentially shakes the foundations of mental health practice as it is built on the biomedical model and the assumption that mental illness has a biological cause.

It is therefore suggested that the adoption of the recovery approach in mental health care is a way of mental health services trying to remain in control through the distortion of recovery ideas (Repper and Perkins, 2014). These ideas relating to power will be further discussed later in this thesis I the context of the study's findings. The next section will explore what recover-oriented practice (ROP) means.

Exploring the concept of recovery-oriented practice (ROP)

In spite of the criticisms relating to the adoption of the recovery philosophy by mental health services, its adoption in England continues to be driven by professionals and policy (Perkins and Slade, 2012) and has facilitated the development of recovery-oriented services and recovery-oriented practice. This section will further set the scene for the study by clarifying the meaning of ROP.

Various ways of understanding ROP are proposed in the literature. It was also observed that different terms seem to be used interchangeably in the literature including recovery approach, recovery-orientation, ROP, recovery-oriented care and recovery services. Some authors

define ROP in relation to personal recovery. For example, according to Davidson et al. (2014) recovery-orientation relates to the different aspects of service delivery and practice that allow staff and services to promote personal recovery. On the other hand, Chester et al. (2016) referred to ROP as the work done by professionals to support personal and social recovery. The Victorian Government Department of Health in Australia (2011) further described ROP by proposing that it involves promoting self-determination and individualised care whilst emphasising hope, social inclusion goal setting and self-management. Furthermore, the review suggested that the recovery approach entailed moving away from the expert to recipient of care approach to a partnership approach. This is a useful description that goes beyond the definitions given above as it reflects the role of the service user in the process. This definition shows that recovery is not just about what services do to and for people, but it is about working in partnership. Overall, although there are variations in wording, a common theme is that ROP is about a shift from a focus on clinical recovery and traditional paternalistic ways of working with service users.

Frameworks for ROP

Different researchers have suggested frameworks for understanding ROP. For example, Farkas et al, (2005) proposed a framework for ROP which highlighted the importance of values. They identified four key values for recovery orientation from Anthony and Cohen, (1989) as summarised in the table below.

Table 2:Values for recovery orientation

Person orientation – the service focuses on individuals as having strengths, talents interests as well as limitations	**Person involvement** – the service focuses on people's right to full participation in all aspects of their recovery (planning, implementing and evaluating) the service that supports their recovery
Self- determination/choice – the service focuses on people's right to make individual decisions including the goals, outcomes, preferred moments to engage and disengage in services	**Growth potential** – the service focuses on the capacity of an individual to recover

(Anthony and Cohen,1989)

Similar values are cited by Davidson et al. (2009) who proposed person-centeredness, collaboration, empowerment and practitioners focusing on the service users' strengths as values underpinning ROP.

Similar values are seen in Slade's (2009) guidance on how to become recovery oriented. His paper *100 Ways to Promote Recovery* distinguished between traditional approaches and recovery approaches as shown below.

Table 3:Difference between traditional and recovery approaches

Traditional approach	Recovery approach
Values and power arrangements	
Apparently value free	Value-centred
Professional accountability	Personal responsibility
Control oriented	Oriented to choice
Power over people	Awakens people's power
Basic concepts	
Scientific	Humanistic
Pathography	Biography
Psychopathology	Distressing experience
Diagnosis	Personal meaning
Treatment	Growth and discovery
Staff and patients	Experts by training and experts by experience
Knowledge base	
Randomised controlled trials	Guiding narratives
Systematic reviews	Modelled on role models
Decontextualised	Within a social context
Working practices	
Description	Understanding
Focus on the disorder	Focus on the person
Illness based	Strengths based
Based on reducing adverse events	Based on hopes and dreams

Individual adapts to the programme	Provider adapts to the individual
Rewards passivity and compliance	Fosters empowerment
Expert care coordinators	Self-management
Goals of the service	
Anti-disease	Pro-health
Bringing under control	Self-control
Compliance	Choice
Return to normal	Transformation

(Slade, 2009)

Whilst these frameworks give us an understanding of values related to ROP, the work of Le Boutillier et al. (2011) summarises the different areas ROP focuses on. These researchers in recovery synthesised recovery guidance from different sources to make it easier to apply to practice. They presented a conceptual framework for ROP guidance with 16 dominant themes which they grouped into four practice domains as shown below:

Figure 2:Conceptual framework for recovery guidance

ROP Guidance Domains

Promoting citizenship
- Seeing beyond the service user
- Service user rights
- Social inclusion
- Meaningful occupation

Organisational commitment
- Workplace support structures
- Quality improvement
- Recovery vision
- Workforce planning
- Care pathway

Supporting personally defined recovery
- Individuality
- Informed choice
- Peer support
- Strengths focus
- Holistic approach

Working relationship
- Partnership
- Inspiring hope

(Le Boutillier et al., 2011)

This conceptual framework is useful for understanding the different aspects involved in ROP. However, to understand what the actual work of ROP is, insights are provided by Chester et al. (2016) who conducted a review of qualitative literature that articulated the work of ROP. The review identified three broad categories under which the work of ROP falls, namely: alleviating stigma, delivering effective recovery-supportive responses in the presence of complex health and social situations and managing challenges associated with the work of ROP. The work highlights the fact that ROP goes beyond what is done within services and requires work to be done within society and in communities to promote citizenship, challenging stigma and addressing barriers and challenges to recovery.

Study definition of ROP

For the purposes of this study, ROP refers to practice that promotes personal recovery and has the characteristics shown in Figure 3 below.

Figure 3:Characteristics of ROP

- encourages self-determination and self-management of mental health and wellbeing
- involves tailored, personalised and strengths-based care that is responsive to people's unique strengths, circumstances, needs and preferences
- supports people to define their goals, wishes and aspirations
- involves a holistic approach that addresses a range of factors that impact on people's wellbeing, such as housing, education and employment, and family and social relationships
- supports people's social inclusion, community participation and citizenship

Adapted from Victorian Government Department of Health (2011)

Challenges with implementation of ROP

Le Boutillier et al. (2011) highlighted that although the conceptual framework they proposed was useful and could potentially be used in the implementation of ROP, it would be challenging for services to implement the interventions for the four domains. Chester et al. (2016) also identified barriers to the work of ROP such as the context in which ROP is introduced. Different authors have suggested that implementation of ROP is a challenge and some have proposed reasons for challenges. For example, Pilgrim and McCranie (2013); Jacobson and Greenley (2001) and Armstrong and Steffen (2009) identified that the difficulties were due to the various conceptualisations of ROP and a lack of clarity around it. This view was also supported by studies that investigated staff understanding of ROP which indicated that it was not clear what constituted ROP and how it could be implemented (Gale and Lucette 2012; Aston and Coffey, 2012; Le Boutillier et al. 2015). This lack of clarity around ROP seems to be linked to the

subjective and idiosyncratic nature of the recovery process which makes it difficult to know how to facilitate it (Jacobson and Greenley, 2001; Armstrong and Steffen, 2009).

Interestingly, the findings above coincide with those of other studies that have looked at the implementation of interventions in mental health services. For example, van der Krieke et al's. (2015) study to identify and compare implementation barriers and facilitators for interventions for psychosis found that recovery interventions had more barriers than pharmacological interventions due to their complex nature and the requirement for additional resources. Furthermore, Bird et al. (2014) argued that successful implementation of interventions in mental health was complex as it was influenced by components occurring at multiple ecological levels of the healthcare system. Factors such as the political and economic context, individual patients' beliefs and behaviour, the organisation and individual practitioners were cited as influential.

This literature suggests the need for empirical studies on the implementation of ROP to give insights into what is happening on the ground to translate recovery policy into ROP. There is also an indication that there may be a translational gap between knowledge about recovery and implementation of ROP (Le Boutillier et al., 2011) therefore studies looking at how ROP is implemented could help to close this gap. The study presented in this thesis contributes towards what is known about how ROP is being implemented and goes some way into helping to narrow the identified gap.

Outline of Thesis

Having given the rationale for the study and established the background of recovery and ROP in this chapter, **Chapter 2** presents a scoping literature review focusing on empirical studies exploring the implementation of ROP in order to: get an understanding of the landscape in relation to research on the implementation of ROP, establish the nature of studies that have been conducted in the area and identify any gaps in research that my study could address. **Chapter 3** is the methodology and methods chapter which provides details regarding the philosophical underpinnings of the study and the methods employed to conduct it including permissions sought. **Chapter 4** presents the findings of the study, with the detailed exploration of the identified themes whilst **Chapter 5** is the discussion of the findings and situates them in existing literature. **Chapter 6** then articulates the contribution the study makes, outlines the implications of the study and makes recommendations for practice, commissioning and research. **Chapter 7** concludes the thesis with a reflection on my journey as a doctoral student conducting this research.

Chapter 2: Literature Review

Introduction

Following the introduction and rationale for the study given in the previous chapter, this chapter progresses the study by presenting a scoping literature review that was conducted to establish what was known about the implementation of ROP. Although I already had some initial research questions based on my experience and background reading as evidenced in the previous chapter, it was important for me to conduct the literature review prior to commencing the study to enhance my understanding of the topic under study, to identify the methods that had been used in previous studies, to avoid duplication and also to allow me to situate my study in the overall body of knowledge (Booth et al,. 2012; Aveyard, 2016).

Aims and objectives of the scoping literature review

Although I already had a review question in mind when I embarked on this task, to ensure that I had a focused question for the review I used PICo: population, phenomenon of interest and context (Cherry et al., 2014).

Population – Mental health practitioners, providers and service users

Phenomenon of **I**nterest – the implementation of recovery-oriented practice

Context – adult mental health services in the UK.

Initially, the question for the literature review was as follows:

How is recovery-oriented practice implemented by mental health practitioners in adult mental health services in the UK?

Although literature reviews on recovery focusing on the UK context had been conducted before (Stickley and Wright, 2011), they were published in 2011 and were looking at the evidence base for recovery in the UK. This scoping review sought to add to the evidence base by focusing specifically on implementation of ROP and including more recent research studies on the topic of ROP.

An initial scoping search was conducted with the above question in mind. This was a quick search to give me an idea of the volume of studies investigating the topic, to help me to refine the literature review question and to develop the search strategy (Dundar and Fleeman, 2014). The scoping search revealed that there were limited studies on the implementation of ROP that had been carried out in the UK and that it would be useful to get an understanding of the international picture. The review question was therefore modified to:

How is recovery-oriented practice implemented by providers and mental health practitioners in adult mental health services?

The scoping search also suggested that to address the above question fully and to gain a more in-depth understanding of the phenomenon of interest, it would be necessary to explore the following objectives:

1. What are mental health providers', practitioners' and service users' experiences and perceptions of the implementation of recovery-oriented practice?
2. What are the barriers and facilitators to the implementation of recovery-oriented practice?

Approach taken to conduct the literature Review

Having established the review question, it was important to also decide about the type of literature review that would help to meet the objectives of the review. Various approaches are proposed in the literature (Grant and Booth, 2009; Dickson et al., 2014; Aveyard et al., 2016; Coughlan and Cronin, 2017). However, decisions about the type of review to be conducted need to be informed by the nature of the questions being asked and the intended outcomes of the review. As argued by Arksey and O'Malley (2005), there is no perfect review type and researchers need to use tools offered by different literature review methods appropriately. With this in mind, it was decided that as this review was of an exploratory and descriptive nature, it would be appropriate to conduct it as a scoping review. This type of review assesses potential scope and size of available research literature and aims to identify the nature and extent of research evidence on a topic (Grant and Booth, 2009). Scoping reviews have the added advantage that they are versatile and provide the opportunity to be flexible (Aveyard et al. 2016). Although some authors have suggested that scoping reviews are poorly defined and vary in the rigour with which they are conducted (Davis et al., 2009; Colquhoun et al., 2014), Arksey and O'Malley (2005) provided a methodological framework for conducting them which can enhance their transparency and rigour. Several reasons for conducting a scoping review are cited in the literature (Arksey and O'Malley, 2005; Munn et al., 2018). However, the reasons of relevance to this review relate to the fact that it is for a doctorate study therefore the review serves to: map the range, nature and extent of research activity in implementation of ROP, determine the feasibility of conducting a full empirical study, identify gaps in the current research, to develop methodological ideas for the empirical study and to justify further research studies (Arksey and O'Malley, 2005; Anderson et al., 2008 and Munn et al.,2018).

The framework for conducting scoping reviews proposed by Arksey and O'Malley (2005) and clarification by Levac et al. (2010) informed this review (see Figure 4). Although scoping reviews do not formally appraise the quality of included studies, Levac et al. (2010) proposed that the need for quality assessment should be considered to enhance the usefulness of scoping study findings. Furthermore, Munn et al. (2018) stated that even though critical appraisal is not mandatory in scoping reviews, reviewers may assess the risk of bias. A decision was therefore made to modify the framework by Arksey and O'Malley (2005) by including a critical appraisal step to further enhance rigour.

Scoping review framework

Figure 4: Methodological framework for conducting a scoping review

1. Identify the research question
2. Identify the relevant studies
3. Select the studies
4. Chart the data
5. Collate, summarise and report the results
6. *Optional stage: consultation exercise (not done in this study).

(Arksey and O'Malley 2005, p.22)

Stage 1: Identifying the research question

This stage has been outlined above.

Stage 2: Identifying the relevant studies

This stage involved the development of a search strategy. This is a very important stage as it determines the output of the literature review (Schirmer, 2018). The stage involved deciding where the review articles would be sourced and how the search would be conducted. For this review, various sources were used namely: electronic databases, reference lists of published papers, recommendations from researchers in the area, namely Mike Slade (a professor in recovery) and Jed Boardman (a social psychiatrist who contributed to the published position statements and frameworks on implementing recovery by the Sainsbury Centre for Mental Health). Previous experience of having conducted a literature review helped in making decisions about relevant databases to search and breaking down the review question using the PICo helped to identify keywords that were used for the searches. Although using the keywords still made the search broad and had the disadvantage of yielding large numbers of articles, it helped to reduce the likelihood of missing out on relevant papers. Furthermore, it was felt that having broad results at the start would allow the researcher to be more familiar

with the literature and the search could be narrowed down following this initial stage (Arksey and O'Malley,2005). A pragmatic approach was therefore taken during this process to balance the sensitivity and specificity of the search (Dundar and Fleeman ,2014). The aim was for the search to be sensitive enough to capture relevant studies whilst also specific enough to not result in unrelated studies being retrieved (Aveyard, et al.2016). Furthermore, assistance was sought from the subject librarian to help to refine the search. This helped with the appropriate use of truncation and he also suggested the use of synonyms to widen the search as shown in the search terms used for the CINAHL and PsychINFO searches (see Table 4 below). The search was not linear and required various iterations before the final search.

See Table 4 below with details of databases searched and search terms used.

Databases searched and search terms used

Table 4:Databases searched and search terms used

Database	Search Terms used
BNI	recovery AND implementation AND mental health services
MEDLINE	recovery AND implementation AND mental health
CINAHL	Recovery approach OR recovery concept OR recovery model OR recovery orient* AND mental health or psychiatr* or mental disorders or mental illness AND implement*
PsycINFO	Implement* AND recovery model OR recovery-oriented practice OR recovery focus AND mental health
Cochrane	A title, abstract and keyword search using the phrase - Implementation of recovery in mental health
OATD	Recovery AND mental health
Scopus	Recovery AND oriented AND practice
Google Scholar (search engine)	Implementation of recovery in mental health

Stage 3: Select the studies

This stage involved selecting the studies to be included in the review. Arksey and O'Malley (2005) advocate the use of inclusion and exclusion criteria to promote consistency in making decisions about studies to be included. The criteria were informed by familiarity with the literature, examination of the review question and objectives and clarification of the purpose

of the review which helped to make decisions about the nature of the studies needed to achieve them. For example, it was noted that whilst there is a lot of published literature on recovery from different countries, not all of it focuses on the implementation of ROP. The question being addressed in this study required research focussing on implementation so such studies would not be fit for purpose. The inclusion and exclusion criteria are outlined below.

Study inclusion and exclusion Criteria

Inclusion Criteria

Participants

- Studies involving mental health service providers such as National Health Service (NHS) Trusts or the equivalent in other countries.
- Studies involving managers and practitioners working within adult mental health services including nurses, psychologists, social workers, psychiatrists. This is because of the generic working within mental health which means all the different professions work together and take on roles such as care co-ordinator in community mental health teams.
- Studies involving adult mental health service users.

Phenomenon of interest

Studies included in the review had to be investigating the following phenomena:

- Mental health service providers, managers, service users or practitioners' views and experiences of implementing recovery-oriented practice.
- The barriers and facilitators to recovery-oriented practice.

Context

- Studies from Western countries where the recovery approach is well established in policy. These would allow an exploration of how ROP was being translated into practice.
- Studies carried out in community and inpatient adult services. This was also to enhance applicability and relevance of findings as these were the contexts the empirical study being informed by the review focused on.

Types of study

- Primary research studies including quantitative, qualitative or mixed methods studies. The rationale for including only primary research studies was that the main purpose of

conducting the review prior to commencing my research study was to get a clearer picture of the landscape with regards to the empirical studies on the implementation of ROP. This would in turn help to identify a gap in the empirical literature to inform the direction to be taken by my research study.

Exclusion criteria

- Studies conducted in countries with systems and culture fundamentally different from the UK were excluded because the cultural context is relevant as it affects applicability of findings.
- Countries in the early stages of developing recovery policy and guidelines were excluded as ROP would not be well established.
- Studies conducted in specialist services such as forensic, older adults or children's services were excluded as the focus of the study is adult mental health services which is a different context from specialist services. Applicability of findings could be compromised due to nuances specific to specialist services.
- Studies in languages other than English were excluded due to costs associated with translation.
- Studies published before 2009 were excluded as some of the key policy documents (Shepherd et al., 2008) and guidelines (Slade, 2009) suggesting how ROP could be implemented in the UK were published from 2008 onwards. The study is therefore interested in exploring the landscape of ROP after the publication of these documents as the expectation is that ROP would have started gaining momentum in the UK.

Deciding on the inclusion and exclusion criteria was useful in reducing the number of irrelevant studies for the review. Firstly, for the database searches, it allowed the use of limits. Although the available limits varied according to database, broadly the following limits were applied: geographical area, language and year of publication. The use of the "Linked full text only" limit was avoided as it carried the risk of losing relevant studies which may not have been available in full text on the databases but available in journals that could be accessed using other means (Coughlan and Cronin, 2017). Following the application of limits, the titles and abstracts of the remaining papers were screened with the inclusion and exclusion criteria in mind to identify relevant studies. Studies that appeared relevant were downloaded and saved in folders on the databases. A folder was also created to save them in my documents on the computer. The next step involved reading through the full text articles to make a final decision regarding inclusion in the study. Following this process, 23 papers were identified for inclusion in the review. See Appendix 1.

Stage 4: Chart the data

This involved developing a data extraction form to extract relevant information from each study. When developing the form, it was important that information which would enhance knowledge and understanding of the scope and nature of the studies was included. Summarising the studies in this way also allowed easier comparison and sorting of studies according to themes (Arksey and O'Malley, 2005). See Appendix 1.

Twenty-two research papers and one thesis meeting the inclusion criteria were included. Studies were conducted in the following countries: England (nine studies), Ireland (one study), USA (three studies), Australia (five studies), Canada (four studies) and Denmark (one study). The studies used different research approaches. Eleven of the included studies adopted a qualitative approach, six used the survey approach, two were quasi-experiments, two were case studies, one was a randomised control trial (RCT) and one used mixed methods.

During the process of reading through the studies and extracting the data described above, a critical appraisal of the studies was also conducted using Cronin et al's. (2015) guidelines for conducting a critical appraisal (see Figure 5). It is important to emphasise that a critical appraisal was conducted rather than a critique of the studies. Coughlan and Cronin (2017) distinguish between the two and describe a critique of a study as an assessment of the steps in the research process undertaken by the researcher in their study, comparing them to the expected standard. This usually involves the use of checklists or tools. Critical appraisal on the other hand involves the identification of the main strengths and limitations of a study with a view to making a judgement about the study. This was felt to be more appropriate for this study as the aim was to have a broad sense of the issues and strengths of the existing research to inform the interpretation of the findings (Munn et al. 2018).

Figure 5:Guidelines for Critically Appraising a Research Study

• Verify if the study is relevant to the review • Review the study in detail and verify its robustness (purpose of study, methodology, how steps of the research process were followed) • Identify strengths and limitations • Recommendations for future studies in this field • Overall evaluation of the study (how you rate the study's robustness and its contribution to the topic being studied)

Adapted from Cronin et al. (2015)

Stage 5. Collate, summarise and report the results

This was the final stage of the review and involved different activities. Firstly, all the study summaries were collated and presented in a table (see Appendix 1). The next step was

challenging as it was necessary to find a coherent way of presenting the findings of the review from studies that had a range of designs (qualitative, quantitative, mixed methods) and different ways of presenting their findings. However, as stated by Arksey and O'Malley (2005), scoping reviews do not aim to aggregate findings from different studies. Instead, there is a need to identify an analytic or thematic construction to guide the narrative presentation of the literature. Furthermore, Wakefield (2014) proposes that identifying themes in literature reviews is useful as it helps with the presentation and discussion of the review findings. To this end, the creation of the data extraction table helped with this process as it allowed for the studies to be read thoroughly, and to be summarised in a way that made summarising them easier. As in the example by Arksey and O'Malley (2005), studies were initially organised according to geographical region and then subsequently organised according to the aspect of ROP their findings focused on. This iterative process facilitated the identification of themes which formed the basis of the narrative account of the scoping review findings. For this study, four themes were identified as follows: Training as a way of promoting ROP, Barriers and facilitators to implementation of ROP, The relationship between risk management and ROP and the impact of ROP on service user experience and outcomes.

The next step, stage five therefore involved providing a detailed discussion of the themes as shown below. Studies addressing the same theme were grouped together and some studies that address more than one theme will appear under more than one theme.

Literature Review Themes

Theme 1: Training as a way of promoting recovery-oriented practice

This theme relates to training and its value as a way of promoting ROP. Six of the studies included in the review explored the impact of recovery training on the implementation of ROP. Two of the studies included were conducted in the USA (Peebles et al., 2009 and Salyers et al., 2009), two were conducted in England (Gilburt et al., 2013 and Leamy et al., 2014), one in Denmark (Waldemar et al., 2018) and one in Australia (Marshall et al., 2009). Two studies (Waldemar et al., 2018 and Marshall et al., 2009) explored service user experiences of support following staff training in recovery and the other studies focused on practitioners' experiences and perspectives. Each study will be summarised in turn and a discussion of the findings presented below.

Gilburt et al. (2013) conducted a mixed methods quasi experiment study to evaluate the implementation of ROP through training. Their study was conducted in three regions of London between 2008 and 2009. Twenty-two multi-disciplinary teams (MDTs) from the non-crisis service were recruited to the study. These included Early Intervention Teams, Community Mental Health Teams, inpatient rehabilitation wards, continuing care teams. Recovery training

was offered to staff in two regions (intervention) and one region did not get the training (the control). A baseline care plan audit was conducted before training had started and then three months after the training to evaluate any changes from before and after the training. They also compared these care plans to the control region care plans. Further data was collected from interviews with team leaders from the intervention regions.

The findings of the care plan audit showed that the content of the care plans in the intervention group had changed. It was found that attributed responsibility for the actions on the care plan had changed with the intervention group having more shared responsibility for actions in the care plan and more responsibility attributed to the service user compared to the control group. The findings were supported by findings from interviews with team leaders which highlighted changes in staff approaches to care, with more holistic approaches to care, a focus on improvement rather than maintenance and an increase in the use of recovery terminology. Interestingly, over half of the team leaders interviewed for this study felt that the training had had minimum or no impact and in some cases had reinforced the idea that recovery was something they were already doing. The researchers therefore suggested that training alone is not sufficient to create widespread and sustained change. Drawing on evidence from a systematic review on the processes of change, they stated that training had been found to be effective for transferring knowledge but not for increasing motivation. They concluded that implementing ROP fully would require a multi-faceted approach. These findings however need to be interpreted with caution as the study had a few limitations. These include the fact that there may have been confounding factors such as the exposure of participants in the control group to previous recovery training which was not controlled for. There was also no blinding so bias could have been introduced. Furthermore, the care plan audit tool was not sensitive to different stages of change so may not have detected the full impact of the training. Despite this, the study provides useful insights into training practices in relation to ROP and the use of the mixed method design allowed exploration of experiences of staff which may be generalisable to similar organisations.

Interestingly, the findings from the care plan audit by Gilburt et al. (2013) concur with the findings from an earlier study conducted in Australia by Marshall et al. (2009) which examined consumer experience of recovery focused support practices and their valuing of these following staff training in Collaborative Recovery Model (CRM). Ninety-two service users from metropolitan, rural mental health organizations in Eastern Australia participated in the study by completing questionnaires developed by the researchers. Results suggested that consumers identified significant changes to service delivery following staff training with regards to the frequency with which they took responsibly for recovery. They also reported that there was more collaboration with professionals for homework activities. However, the

overall ratings of clinicians' helpfulness in assisting recovery were not different between the staff who had received training and those that had not.

Although the researchers cited limitations to their study such as its quantitative nature which meant that there were no qualitative data to elaborate on findings and the fact that the data collection tool needed psychometric testing, the similarity of some of the findings of the study to Gilburt et al's. (2013) study is interesting and adds strength to the findings of both studies. This suggests that training alone may result in changes to attributed responsibility for recovery but may not be sufficient as the only intervention for implementing ROP.

To add on to these findings, a study conducted in the USA by Peebles et al. (2009) which examined the effectiveness and or impact of a curriculum based on recovery principles for mental health providers was also reviewed. The researchers evaluated the educational curriculum's impact on recovery-based knowledge and recovery-consistent attitudes of service providers using survey methods. They also compared the knowledge and attitudes of those who had received the training to those of providers at a neighbouring institution who had not received the training. The study results indicated that training had been successful in promoting enhanced knowledge of recovery and partially successful in encouraging practitioners to adopt recovery promoting attitudes. It was also observed that attitude change was mainly following workshops where consumers and practitioners shared experiences. However, based on their findings Peebles et al. (2009) also concluded that knowledge gain and attitude shift from training do not necessarily translate to lasting changes in practice. They suggested that research in skill development mastery and transfer was needed.

This study by Peebles et al. (2009) was not without its limitations. They highlighted the possibility of social desirability bias due to the self-reported nature of the attitudinal measure used and impact of natural events on study outcomes as confounding factors could not be controlled for. However, the study still illuminated a different dimension to training and its impact on ROP as it suggested that the nature of the training may affect its impact.

The importance of the nature of training on its effectiveness is also highlighted in a study conducted in England by Leamy et al. (2014). As part of an evaluation of a bigger randomised controlled trial, Leamy et al. (2014), conducted a qualitative study to investigate trainer and staff perspectives on the barriers and facilitators to the implementation of a complex intervention (REFOCUS) designed to help staff to support recovery in service users with a diagnosis of psychosis in the community. The study was conducted in 14 community teams based in two NHS Trusts (one located in a rural and one in an urban area in the UK). The researchers conducted 28 interviews with staff, three interviews with trainers, focus groups with teams that had been in the intervention groups and analysed trainer reports. Although

other results were reported in this study, training effectiveness was also explored. The researchers found that training effectiveness was influenced by engagement strategies used, delivery style and modelling recovery principles. Validating existing skills prior to training in order not to undermine efforts already being made was found to be important. The researchers found that use of role plays and pilot experiences of using recovery-oriented interventions with service users helped to translate practitioner intent to implement to actual implementation behaviour. They found that recovery training which aims to promote ROP through knowledge acquisition and values-based training was less effective and less popular with the participants.

Despite some of its limitations such as: possible recall bias due to participants having to report on a 12-month period, sampling bias due to the use of a purposive sample of practitioners who self-reported use of the intervention and the possible impact of changes such as staff turnover, this study expands on and reinforces the findings in the Pebbles et al. (2009). It is a bigger study, conducted in various teams in different organisations and this strengthens the generalisability of the findings. The use of the qualitative approach allowed a more in-depth exploration of the participants views and experiences whilst the use of different data sources allowed triangulation of data which gives more confidence in the findings of the study as it enhanced the validity of the study.

Further illumination into the effectiveness of training as an intervention for implementing ROP is provided by Salyers et al. (2009). They assessed the extent to which mental health providers would implement a recovery intervention (Illness management and recovery (IMR) following training and investigated barriers and facilitators to translation of training into practice. They used a survey approach and recruited 89 care providers from Indiana, USA who had attended the IMR training into the study. Results showed that a quarter of those trained did not use IMR and that some did not use it consistently. Participants cited the training, materials for the intervention, support from co-workers and supervisors and institutional practices as facilitators for implementation. Barriers identified were lack of consumer motivation and administrative /agency issues such as systems not geared for IMR. The researchers concluded that training and availability of toolkits alone is not sufficient for successful implementation of IMR. They suggested that attention needs to be paid to organisational structures, and that support from leadership is needed. The importance of staff motivation in successful implementation of recovery interventions following training was also highlighted.

Although the study had some limitations such as a low response rate and possible bias due to self-selection of the sample, it still enhances our understanding of the factors at play in relation to translation of recovery training into practice. It adds to what was found in the

previously discussed studies by bringing our attention to the role of the consumer, staff motivation and organisational structures in the implementation of ROP.

Further barriers to the translation of recovery training into practice were also revealed in the study conducted in an inpatient facility in Denmark by Waldemar et al. (2018). They conducted a study to explore how efforts to implement a recovery-oriented approach were reflected in inpatient experiences of patients. They conducted a qualitative study in two mental health wards in the capital of Denmark. Fourteen patients were interviewed and the findings suggested that their experiences did not fully reflect important dimensions of ROP. Although the patients felt safe and accepted on the ward, they felt that their treatment centred on medication and that they had limited choice and influence on their treatment. They also reported lacking information about their treatment and feeling like they were being observed by staff with limited opportunity for interaction as they were mostly in their office. Researchers also concluded that training and education are not sufficient for implementation of ROP. They suggested that merely adding to already existing practice results in ROP having to fit into pre-existing practice. They suggested that barriers to ROP within organisations should be identified and tackled and recommend prioritising mental health services at a political level by supplying resources needed to facilitate and sustain ROP.

This study adds to what we know about the translation of recovery training and knowledge into practice as it brings in the service user experience and how that reflects the adoption of a recovery-oriented approach. Whilst it had limitations such as possible recall bias and the fact that it was conducted in inpatient settings in Denmark with a small sample size, it complements the study by Salyers et al. (2009) which used a quantitative approach and had practitioner participants. The use of interviews allowed exploration which brought issues for consideration in the implementation of ROP to the fore.

Summary of theme

The studies have illuminated the challenges associated with using training as an intervention to facilitate the implementation of ROP in different mental health contexts. The results indicate that training is positively evaluated and useful for enhancing knowledge and understanding of the recovery philosophy. However, this knowledge does not always result in lasting changes in attitudes and practice. The nature of the training, practitioner attitudes, service user motivation and wider organisational and systemic influences all play a role in success of translation of ROP training into practice. Furthermore, findings from some of the studies suggested that the involvement of service users in training had the potential to enhance the effectiveness of training. Confidence in the credibility of the findings above is enhanced by the fact that all studies were conducted in different countries and utilised different research

methods and yet common themes emerged. Although individual studies had limitations as highlighted in their summaries, bringing them all together helped to enhance the validity of their findings as it allowed triangulation of findings from a wide range of participants from different settings. It is worth noting that these studies were published over the period 2009 to 2018. This suggest that it is still imperative to investigate how knowledge from training can become everyday practice and what needs to be in place to facilitate the translation of knowledge from training to actual ROP. Finally, it can be concluded that when implementing ROP, training should only be one of the interventions to facilitate implementation whilst attention is also paid to other wider organisational and individual practitioner and service user related factors to ensure sustained transformation of practice is achieved.

Theme 2: Barriers and facilitators to implementation of recovery-oriented practice

One of the common themes in all studies included in this review related to barriers and facilitators to the implementation of ROP in general. For some of the studies, although the main aim was not specifically to identify barriers and facilitators, they were mentioned by participants. The studies that will be summarised here include three studies conducted in Australia (Nugent et al., 2017; Hungerford and Fox, 2014; Hungerford and Kench, 2013), three studies from Canada (Piat et al., 2010; Piat and Lal, 2012; Khoury and Rodriguez del Barrio, 2015), one study conducted in the USA (Clossey and Rheinheimer, 2014), two studies conducted in England (Le Boutillier et al., 2015 and a thesis by Murphy,2012), one study conducted in Ireland (Cusack et al.2017). Some of the findings from previously mentioned studies (Gilburt et al., 2013 and Leamy et al., 2014) relating to barriers and facilitators to implementation of ROP will also be summarised.

In Canada, Piat et al. (2010) conducted a qualitative study in three geographical areas to investigate decision makers' perspectives on the transformation of mental health services to recovery-oriented systems of care. Ten participants (policy makers, senior administrators in large psychiatric facilities, senior administrators in regional planning organisations) from three geographical areas were interviewed. The study found that decision makers believed that implementation of recovery was more suited to community settings. They highlighted negative attitudes of inpatient staff and the focus on security as barriers to implementation of ROP. Decision makers viewed their role as establishing overall service implementation and allocating funds and felt that providers were best placed to implement recovery values into services. In terms of facilitators, they suggested the need to foster new professionalism with staff who had training in ROP and education. They also highlighted the importance of service

user involvement and suggested the creation of recovery standards and outcome measures to enhance accountability on the part of providers.

A further study also conducted in Canada by Piat and Lal (2012) complemented the 2010 study by exploring the experiences and perspectives of service providers on recovery-oriented reform in Canada as well as barriers faced in implementing ROP. They conducted focus groups with sixty-eight service providers from three Canadian states. Their sample consisted of multi-disciplinary team staff including social workers, occupational therapists and psychologists. Results of the study suggested that some providers had a positive attitude ROP reform. These providers felt that ROP was a better way of delivering services as it allowed attention to be paid to wider determinants of health and led to a shift from paternalistic and prescriptive practice to egalitarian collaborative way of working. However, others experienced scepticism towards it and felt it did not contribute anything new that they were not already doing. Others felt recovery was a "fad" and a" buzz-word". Providers also highlighted challenges with implementation. They felt that uncertainty about the concept could be a barrier. Furthermore, some participants felt that practice contexts could influence the implementation of ROP. Services such as crisis teams were highlighted as presenting a challenge. Other barriers expressed by participants were the burden of paperwork because of the bureaucratisation of recovery tools, limited leadership support, stigma and social exclusion when dealing with external agencies such as housing. Researchers recommended the need for formal training to improve knowledge and attitudes.

These two studies from Canada highlighted the differences in opinion and expectations between providers and decision makers with regards to responsibility for implementation of ROP. Decision makers felt their role was a facilitative one, with their responsibility being mainly to allocate funds whilst providers saw their role as being more involved than this. Providers expected more support from decision makers in terms of ensuring systems that support recovery were in place. Whilst providers viewed barriers to implementation as being outside their control (issues such as bureaucratisation, stigma from external agencies), decision makers felt providers' attitudes were a main barrier.

Although the study by Piat et al. (2010) had a small sample size, the use of semi-structured interviews allowed an in-depth exploration of the decision makers' perspectives and the fact that participants were from different organisations across different geographical areas enhanced generalisability of the findings. On the other hand, the Piat and Lal (2012) study had a bigger sample size and used a qualitative approach which allowed exploration of participants' views. However, the use of focus groups may have led to some participants not expressing their opinions. Despite these limitations, the studies contribute to our

understanding of some of the factors that influence successful implementation of ROP and bring attention to the need to ensure there is clarity of roles played by decision makers and providers. These studies were conducted at the start of the implementation efforts so need to be interpreted with that context in mind.

Interestingly, difference in perspectives between different levels were also found in a study conducted in Australia by Hungerford and Kench (2013). Their study which was part of a bigger case study investigating challenges in the effective implementation of ROP analysed health professionals, practitioners and managers' perceptions of ROP. They had 12 participants for their study and data were collected using four focus groups and one interview. Results from this study indicated that practitioners felt that they were already practicing in a recovery-oriented way and felt unsupported by managers who they felt were using a top-down approach to implementation. As found in the study by Piat and Lal (2012), practitioners cited barriers such as lack of resources and volume of documentation. In addition to this, participants were concerned about professional accountability in relation to risk. Furthermore, some practitioners also felt that consumer characteristics such as chronic mental illness made it difficult for them to articulate goals which was a barrier to implementation of recovery interventions. The researchers observed that there was an adversarial relationship between practitioners and managers which was a barrier to implementation of ROP. They recommended education, training and professional support for health professionals relating to risk and accountability.

Whilst the studies above mainly focused on provider and practitioner perspectives, as part of a bigger case study investigating challenges with the implementation of ROP, Hungerford and Fox (2014) explored consumers' experiences of the implementation of recovery-oriented services. They conducted focus groups and three interviews with nine consumers. Consumers in this study highlighted challenges such as their fear of change. Some participants felt that they were happy with where they were and were afraid of what recovery could mean for them. They also felt that professionals were struggling to implement ROP and were taking a hands-off approach. Views were also expressed that there was no clarity regarding responsibilities. Furthermore, some participants felt that the biomedical model was a barrier due to its incongruence with the recovery philosophy. However, participants in the study also suggested facilitators of implementation of ROP. These included: education for professionals and consumers which would be delivered by consumers, peer support in the form of consumer consultants, collaborative working between hospitals and community services for continuity and listening to service users.

Given the findings from the studies investigating the impact of training on ROP, it is interesting that these two Australian studies both highlight the importance of training as a facilitator of the implementation of ROP. This further reinforces the importance of knowledge on recovery as a steppingstone to ROP. However, it is important to bear in mind as highlighted previously that other factors influence the success of the translation of the training into practice. The results of the Australian studies need to be interpreted with caution as the sample sizes used were small and whilst some useful insights were provided, the case study approach taken limits the generalisability of their findings.

To add on to the above findings, other study exploring barriers and facilitators to implementation of ROP from the perspectives of professional groups were reviewed. One such study was conducted in Canada by Khoury and Rodriguez del Barrio (2015) who focussed on social workers' perspectives. The researchers conducted semi-structured interviews with seven social workers, three managers and one clinical coordinator from 2 health care agencies in Quebec.

Barriers highlighted by participants in the study related to the tension between ROP and a system that requires outcome measures based on statistics to ensure efficiency. Researchers found that participants' focus was on meeting the targets for these measures as they were tied to budget renewal. Participants felt that this focus on outcomes paradoxically supported clinical recovery rather than personal recovery. They also felt that their professional autonomy was constrained by the focus on outcomes such as number of service users seen or number of service users discharged rather than outcomes that reflect social work values.

Participants felt that social work values and practice were well aligned with ROP. They found that the nature of social work to use diverse approaches and psychosocial interventions when supporting service users was at odds with managerial calls for standardisation of care. Participants felt that the biomedical model was dominant and at times meant social workers had to adopt practices that were not part of their social work training. The researchers concluded that recovery being named in policy does not necessarily transfer the focus of care from the biomedical model to the social models that align with recovery. They also highlighted that the meaning and practice of ROP is shaped by macro and meso-level factors and that structural and organisational support of ROP is needed for successful implementation.

A later study conducted in Australia by Nugent et al. (2017) focused on Australian occupational therapists' (OTs) experiences of developing and sustaining recovery-orientation in mental health practice. The researchers employed a qualitative design for their study and interviewed twelve occupational therapists. The participants highlighted the importance of having a clear understanding of ROP. They suggested this could be done by seeking out knowledge through

reading and training. As found in the Khoury and Rodriguez del Barrio (2015) study, participants described the fit between ROP and their profession's philosophy. Principles such as person centredness, taking a holistic approach and supporting engagement are all important aspects of the OT approach which were cited as congruent with recovery principles. Another similarity with the findings from the Khoury and Rodriguez del Barrio (2015) study was that despite the fit between the OT philosophy and ROP, participants encountered challenges. The participants cited the dominance of the medical model and its focus on deficits whilst valuing professionals as powerful as a barrier. Also like the Canadian study, structural barriers such as outcome measures which were not congruent with recovery were cited. Mental health legislation for example was felt to lead to restrictive practices. Time limitations due to heavy caseloads were also identified as a barrier. Human aspects acting as barriers were negative co-worker attitudes towards recovery and lack of hope. Facilitators suggested were support from senior management and having people with lived experience as part of the workforce. Adoption of key performance indicators that are recovery-oriented and providing training and education to facilitate system change was recommended.

The two studies above serve to highlight the role professionalism in the implementation of ROP. They show that the professional philosophies for mental health professionals like OTs and social workers are aligned with recovery principles and that there are barriers within the system making it a challenge for the professionals to implement ROP. Even though the studies had small sample sizes and were conducted in different countries, their findings could inform implementation efforts in other settings as the use of qualitative approaches allowed them to obtain rich accounts of the professionals' experiences which could be applicable in other settings.

As shown in the studies described above, organisational factors play an important role in the implementation of ROP. This is further expanded on by a study conducted in the USA by Clossey and Rheinheimer, (2014). They conducted a survey to explore the impact of mental health organisational culture on consumer perceptions of agency support for their recovery. Questionnaires were completed by consumers, administrators and direct service staff from twelve mental health agencies in Pennsylvania. Findings indicated that consumers from agencies with more constructive cultures had scored higher perceptions of agency support for recovery. Constructive culture was described as one characterised by low stress, low levels of burn-out, greater engagement of clients, cooperation and support from colleagues which are all characteristics congruent with recovery support. Interestingly, organisations' consistency with the recovery model was insufficient to result in higher scores on the measure for perceptions of recovery support. The researchers concluded that agency culture impacted consumer perception of support for recovery and recommended that organisational culture

should be targeted when implementing ROP. The sample for this study was small and it was conducted in Pennsylvania so findings may not be generalisable.

Further findings relating to organisational culture in relation to the implementation of ROP were presented by Cusack et al. (2017). Even though their study sought to understand mental health nurses' role and the skills that facilitate ROP, their findings were broader than skills and provided insights into various other factors relating to ROP. They employed a mixed methods approach which included a survey, focus groups and written submissions. The findings from the study indicated that nurses had different understandings of recovery and some believed it to be about focussing on the individual, their strengths, beliefs and needs whilst others associated it with symptom remission. As found in other studies, findings indicated that staff needed opportunities for more training and education around recovery. The medical model was cited as a barrier to the adoption of a recovery approach. It was suggested that there was a need for the recovery ethos to permeate all levels of the organisation with organisational culture and structures that support recovery-oriented practice. Furthermore, skills such as listening, ability to conduct recovery focused assessments and risk assessments and fostering of hope were identified as facilitative ROP.

Looking at the English context, the qualitative evaluation from the Gilburt et al. (2013) study produced similar findings to some of those summarised above in relation to barriers and facilitators to the implementation of ROP. Some of the barriers found related to ROP being viewed as conflicting with the roles of the service such as discharging people from services, detention and risk management. As found in the Piat and Lal (2012) study, some participants viewed recovery as a Trust initiative which would soon be de-prioritised like other Trust initiatives they had experienced in the past.

In addition to the barriers, participants also identified practical elements that could facilitate ROP. Interventions such as medication, symptom management, psychological therapies, social inclusion interventions and practical elements promoted recovery. As proposed in the Piat et al., (2010), Nugent et al., (2017) and Khoury and Rodriguez del Barrio (2015) studies, participants also advocated the use of recovery measures for implementation of ROP as they felt that this would show that ROP was a priority for the Trust and would provide an evidence base for the approach.   Participants also highlighted the need for more resources as they regarded them as vital in implementing ROP.

The study by Leamy et al (2014) also reported barriers and facilitators to the implementation of ROP and added to the findings from the Gilburt et al. (2013). Their findings highlighted the importance of organisational readiness for change with factors such as organisational commitment (communication, resource availability, commissioning priorities, existing

structures), organisational change (timing of the intervention, job threats, increase in task demand) and staff readiness (attitudes, intervention knowledge, willingness to apply knowledge to practice and perceived fit with existing values) being influential in successful implementation of the intervention to support ROP.

To further elaborate on the English context with regards to implementation of ROP, another English study by Le Boutillier et al. (2015) was reviewed. They investigated what staff say they do to support recovery and to also identified perceived barriers and facilitators to ROP. Their study used a qualitative approach (grounded theory). Data collection was done using ten focus groups with 65 participants from multidisciplinary teams. Interviews were also conducted with 18 clinicians, six team leaders and eight senior managers. Participants were recruited from five NHS Trusts in different regions of England using purposive sampling.

The main finding and overarching theme from this study was that there were competing priorities impacting the implementation of ROP. Some challenges identified were around health processes priorities. Clinical language and systems such as risk management practice were seen as barriers. Like some of the previously summarised studies (Khoury and Rodriguez del Barrio, 2015; Nugent et al., 2017), the focus of systems on the institution rather than the individual and structures that focus on diagnosis and the medical model were identified as barriers. As was found in the Canadian and Australian studies, business priorities such as targets driven by commissioners were found to not always be aligned with ROP but were prioritised due to their influence on funding. Participants expressed that there was conflict between government priorities and commissioning priorities as government policy was recovery oriented but commissioning targets not always aligned with this policy. Like Khoury and Rodriguez del Barrio (2015), funding structures were found to compromise individual choice as they were prescriptive. In addition to this, financial concerns were identified as taking priority and there was suspicion that recovery was being used as a smokescreen for saving money.

Other barriers and facilitators identified in the study were associated with individual practitioners. Staff role perception was found to influence ROP. This related to how staff understood their role and prioritised their work. Here it was found that some staff were able to still practice in a recovery-oriented way and found a way to balance organisational priorities with service user demands. This was found to be influenced by personal values and professional maturity. The importance of person-centred care, strengths-based practice, specialist knowledge and the establishment of a working relationship with the service user were regarded as paramount in ROP. Other influencing factors were staff attitudes and the value they placed on their role. Overall, the researchers concluded that whilst mental health

staff are encouraged to implement ROP, their ability to do so was affected by the need to manage competing organisational and financial requirements.

The three English studies (Gilburt et al., 2013; Leamy et al.,2014 and Le Boutillier et al. 2015) provided useful insights into the English context in relation to barriers and facilitators to the implementation of ROP. A lot of the barriers and facilitators identified were like those found in research studies conducted in Australia (Nugent et al.2017) and Canada (Khoury and Rodriguez del Barrio 2015). Although limitations such as small sample sizes and context specificity of the studies were highlighted, having the studies from different countries with participants from diverse backgrounds revealing similar findings gives some confidence in them. Additionally, the study by Leamy et al. (2014) had 97 participants from five different NHS Trusts which enhanced the generalisability of the findings.

Although a small study, a decision was made to include the thesis by Murphy (2012) as it explored how ROP was being implemented using theory. This provided a different lens for looking at ROP which was felt would add to the review. As part of a doctorate study, Murphy, (2012) investigated the kind of discourses practitioners and service users were drawing on during the adoption of ROP for a newly introduced Support and Recovery Team in London. Data was collected through two service user focus groups, one staff focus group, documentary analysis (Recovery Star notes and care plans). The team had introduced more recovery-oriented ways of working by adopting use of the Recovery Star (McKeith et al. 2010) and the introduction of recovery groups. The data from focus groups was analysed using a Foucauldian discourse analysis. Murphy (2012) had based his investigation on Positioning Theory which argues that roles and "positions" people adopt impact their opportunities for particular action and in turn their experiences. He suggested that discourse influences the positions people take up. His study therefore explored the social mechanisms at play during the implementation of ROP through language. He proposed that staff and service users were drawing from both the medical and personal recovery discourse.

Murphy (2012) found that the personal recovery discourse was used more by staff than service users. He argued that there was a tension between the two discourses with the recovery discourse struggling to become established. He suggested that the medical discourse positioned the service user as the patient whilst positioning the service or the staff as doing things to people to make them better. Murphy (2012) also argued that the patient subject position led to the meaningfulness of service user experiences being disregarded and ignored factors such as abuse, discrimination or disadvantage which allow a social understanding of mental illness. Clinical recovery was argued to position service users as dependent on services and not having responsibility. This in turn limited opportunities for positive risk taking

and self-management. The personal recovery discourse was used much more by staff and positioned service users as equals and involved in their care. He proposed that when using the personal recovery discourse, service users adopted the subject position of being empowered to prioritise their own goals.

According to Murphy, (2012), the two discourses led to different meanings and possibilities available to service users. For example, the discourse of chronicity and helplessness led to less hope and blocked the opportunity for change and the adoption of ROP. He argued that for ROP to be implemented, the personal recovery discourse needed to be the widely shared discourse between service users and practitioners. He also suggests that services needed to be more aware of the problematic aspects of the medical discourse with regards to how it can position people socially.

As evidenced by the findings, this thesis identified how discourse used in practice settings can be a barrier or facilitator in the implementation of ROP. Although it is a small study conducted in one practice setting, it highlights the need for future research to investigate the impact of discourse on implementation of ROP.

Summary of theme

The various studies included in this section all identified barriers and facilitators to ROP. The studies used different approaches but the majority used qualitative methods which allowed exploration of participants' views and experiences in relation to implementation of ROP. Although studies were conducted in different countries and settings, they complemented each other and gave a better understanding of some of the issues encountered by organisations and practitioners on their journey to ROP. Barriers such as conflicting priorities between policy and organisational priorities, the dominance of the medical model, bureaucratisation in mental health services, lack of clarity on the meaning of ROP and how to implement it, organisational culture and the lack of resources are some of the major ones cited were identified across studies from different countries suggesting that these are common barriers which need to be addressed to successfully implement ROP. Facilitators identified by the studies were: education and training for staff and service users to enhance understanding of recovery, use of outcome measures that relate to ROP, aligning organisational priorities with ROP, staff having the right skills and attitudes and the employment of people with lived experience of mental illness.

Theme 3: The relationship between risk management and ROP

Another theme that was identified in the review was risk management and its seeming incompatibility with ROP. Although the theme of risk is common among almost all studies

included in this review, for the purposes of a more in-depth exploration, three studies that mainly investigated the relationship between risk and ROP will be summarised. Two of the studies were conducted in England (Tickle et al., 2014 and Holley et al., 2016) and one in Australia (Crowe and Deane 2018).

The study conducted by Tickle et al. (2014) explored the views of clinical psychologists on concepts of risk and recovery in the context of mental health services using an exploratory, social constructionist grounded theory methodology. Semi-structured interviews were held with 11 clinical psychologists working within adult mental health services in two NHS Trusts in England. Data from the interviews were analysed using a grounded theory approach. The findings suggested that participants felt that quality and quantity of resources influenced their level of risk taking. Stakeholders like the NHS Trust, non-NHS agencies, carers and service users were identified as having an influence on practice. The NHS Trusts' influence was mainly to do with its role in resource provision, how it deals with incidents, service development and policy development. Non-NHS agencies that work in partnership with the services were identified as influencing risk management as they sometimes have their own policies and cultures relating to risk. Carers and service users were highlighted as important stakeholders in terms of the support they offer and that which they may need. In addition to the influence of stakeholders, the research found that there were narrow conceptualisations of risk with the focus being on harm rather than broader issues such as stigma, iatrogenic effects, social exclusion and effects of psychiatric treatment. Findings indicated that there was a focus on fear of blame and harm but neglect of the potential benefits of positive risk taking such as recovery and learning from mistakes which affected the ability to implement ROP. Participants in the study encountered professional conflicts and dilemmas in their practice as they wanted to support service users, to promote independence and to increase service user responsibility but were at the same time aware of their professional accountability. Participants suggested that there was no clear understanding of the meaning of recovery and training was needed.

The researchers concluded that in a culture where concerns about risk are dominant, recovery may be marginalised. They suggested the need for a culture that promotes learning from incidents rather than blame. They proposed that institutions need to create learning environments that promote staff development and offer guidelines for ROP. The researchers felt that broadening conceptualisations of risk and sharing responsibility for risk between service users, carers and MDT could potentially promote positive risk taking.

The findings from the Tickle et al. (2014) study were supported by a later study also conducted in England by Holley et al. (2016). This study included various mental health professionals and service users. The researchers explored mental health workers and service users'

understanding of recovery-oriented care (ROC) in the context of risk management practice (RMP) and identified how risk management practice impacts upon the implementation of ROC. They employed a qualitative approach using grounded theory methods. A sample of eight practitioner and service user dyads from five community mental health teams across three London Boroughs was recruited. In-depth interviews were conducted with the mental health workers and service users. Furthermore, vignettes were also used to explore the participants' perceptions and experiences of RMP and ROC.

Findings from staff interviews showed that when discussing hypothetical situations, staff suggested that they would be encouraging service users to take more responsibility and control and they would be using a positive risk-taking approach. However, when referring to real life situations, like the participants in the Tickle et al. (2014) study, mental health workers found it challenging to practice in a recovery-oriented way whilst also managing risk as they found ROC and RMP to be conflicting components of their role. As found in the study by Tickle et al. (2014), this study found that professional accountability impacted RMP and ROC. The study found that in some cases, risk management decisions were made as team and so if the team was risk averse, then this resulted in less positive risk taking which in turn impacted ROC. In real life situations, mental health workers retained responsibility for managing the service user's exposure to risk and this meant that the extent to which service users took responsibility for recovery was reduced. The analysis also found that both service users and mental health workers placed emphasis on alleviation of symptoms as they felt this would enable the service user to move forward. This limited understanding of the concept of recovery and was found to lead to a focus on compliance with medication. Holley et al. (2016) also highlighted the service user perspective which revealed some interesting findings. Some service users in the study found it difficult to carry the risk usually carried by their workers as they feared they would fail or relapse. Fear on the part of the service users was also identified in the Australian study by Hungerford and Fox (2014) where fear was cited as a barrier to ROP. This suggests the importance of service users being willing and ready to take responsibility for their own risk management for recovery-oriented care to be possible.

The authors highlighted that challenges in implementing ROC might be related to the lack of guidance on how to address RMP within a ROC strategy. As suggested in the study by Tickle et al. (2014), Holley et al. (2016) also asserted that a less risk averse culture was needed to implement ROC. These findings are strengthened by the fact that although small, the studies were conducted in different NHS Trusts and whilst the Tickle et al. (2014) study participants were all female psychologists, participants in the Holley et al. (2016) study were from a wider range of professions making the overall sample more representative. The use of a grounded

theory qualitative approach also had the advantage of producing rich data from in depth exploration.

Crowe and Deane (2018) approached the investigation into the relationship between risk and risk management on ROP from a slightly different angle. They investigated the relationship between clinicians and managers' risk aversion and the implementation of a recovery intervention (the Collaborative Recovery model (CRM)). They conducted a cross sectional survey across five states of Australia and used questionnaires to measure risk aversion and commitment to CRM. Their findings indicated that clinicians with high risk aversion scores had positive attitudes towards goal setting. They also found that managers had less risk aversion than clinicians. The study concluded that implementation of CRM was influenced by training, commitment to CRM principles and goal setting attitudes. They also deduced that long term exposure to concepts of CRM may contribute to reduction in risk aversion and maintain positive attitudes towards recovery tools. Positive risk taking seemed to be associated with experience and confidence.

Although at face-value, the study by Crowe et al. (2018) appears to suggest that more risk averse practitioners were recovery-oriented practitioners, this needs to be interpreted with caution as the results were in relation to a particular aspect of CRM which was the goal setting. The researchers suggested that this result may have been more an indication of the fact that the use of recovery tools may reduce uncertainty and anxiety in risk averse practitioners. Another interesting finding from the study which suggests that managers are less risk averse seems to contradict findings from the Tickle et al. (2014) and Holley et al. (2016) studies where risk aversion seemed to be attributed to lack of support from leaders. However, the researchers suggested that the lower risk aversion in managers could be because they do not have direct face-to-face contact with service users with as much regularity as practitioners. Despite these differences, overall, these studies suggest that risk has a significant impact on ROP and therefore needs to be considered when implementing ROP.

Summary of theme

Even though only three studies looking specifically at risk and its relationship with ROP have been reviewed in this section, the issue of risk management has been raised as a barrier to ROP in several other studies. This suggests that it is a key factor that needs to be considered when implementing ROP. Although the three studies reviewed in this section reported somewhat differing findings with the survey producing different results from the two qualitative studies, it can be seen from the manager, service user and practitioners' views that striking a balance between ROP and risk management is a challenge and requires collaborative working between all stakeholders to share responsibility for risk. The qualitative studies (Tickle et al.,

2014; Holley et al.,2016) showed the importance of organisations adopting a positive risk-taking culture with broadened conceptualisations of risk to implement ROP. A focus on learning from incidents rather than apportioning blame and having guidelines on to support staff to manage risk within a ROP context was suggested. The quantitative study (Crowe and Dean 2018) showed that there were differences between practitioner and manager risk aversion and that exposure to ROP tools reduced risk aversion. However, these were tentative findings as there were alternative explanations for the findings. Overall, the three studies included had various limitations therefore more studies investigating the relationship between risk and ROP need to be conducted to further inform practice in relation to risk management in a ROP context.

Theme 4: The impact of recovery-oriented practice on service user experience and outcomes

Some of the studies exploring the implementation of ROP reported results on the impact of implementation on service user outcomes and experience of care. Four studies included in this review reported on this theme. Three of the studies were conducted in the UK (Leamy et al. 2016; Slade et al. 2015; Wallace et al. 2016) and one was a Canadian study (Kidd et al. 2011).

Leamy et al. (2016) and investigated the relationship between recovery orientation of mental health teams and personal recovery. They conducted a cross sectional survey between 2010 and 2012 in CMHTs of six NHS Trusts from different regions in England. Participants included: 120 patients, 22 team leaders, 109 clinicians and were recruited using purposive sampling. Teams included Assertive Outreach Teams, Early Intervention Teams, Support and Recovery Teams and generic CMHTs. Parallel versions of the Recovery Self-Assessment (RSA) tool were used by clinicians, team leaders and patients to rate the recovery orientation of their team. In addition to the RSA measure, patients also used the Questionnaire about the Process of Recovery (QPR). Regression analyses revealed various associations. The study showed that there was an association between recovery orientation of teams and personal recovery. In their discussion, the researchers suggested that routine measurement of recovery orientation could help in the implementation of ROP.

A similar finding was reported in Canada in an earlier study conducted by Kidd et al. (2011). They investigated the relationship between recovery-orientation of service providers and client outcome using the survey approach. Sixty-seven Assertive Community Treatment Teams (ACT) in Ontario were recruited. Two hundred and forty-two family/support members, 1400 service users and 518 staff completed RSA tools to measure the recovery-orientation of

teams. A toolkit for measuring psychosocial rehabilitation outcomes was also used. An association between recovery orientation of teams and service user recovery was found. The study found modest results suggesting that services that implement ROP have better client outcomes. Results indicated an association between high client RSA scores and outcomes such as best practice employment, rights and respect. Modest results suggested an association between high RSA scores for team leaders and fewer annual hospital days for clients. The generalisability of the study may be questionable as it was conducted in one Canadian province and in an ACT team. Nevertheless, the fact that similar findings were reported in an English study which included diverse teams gives confidence in the findings.

Another study with modest findings in relation to impact or ROP on service user outcomes is the Slade et al. (2015) study. This was conducted as part of the REFOCUS project and was a multi-site cluster randomised controlled trial (RCT) to assess whether implementing an intervention that promotes ROP affected staff rated and patient rated outcomes in the care of patients with psychosis. The study was conducted in two NHS Trusts (SLaM and 2gether NHS Trusts) between 2011 and 2012. Twenty-seven MDTs were allocated to the REFOCUS group which received training in the REFOCUS intervention (intervention group) and the usual treatment alone group (control group). Baseline data was collected from patients and staff before allocation of teams and then one year after allocation. The primary outcome was recovery and was assessed using the Questionnaire about the Process of Recovery (QPR). Other secondary outcomes were also assessed and these included hope, quality of life, empowerment, well-being and met and unmet needs. Validated scales were used to measure all outcomes.

Unlike the Leamy et al. (2016) study, the results showed that there was no significant difference in recovery between the patients in the REFOCUS group and those getting treatment as usual. However, there were some positive results relating to secondary outcomes where it was found that those in the intervention group had improved functioning. Although there was no statistical significance in most of the findings, the study suggests that patients receiving care from high participation REFOCUS teams had higher scores on the interpersonal sub-scale than those from low participation REFOCUS teams. Care costs were reduced for patients in the REFOCUS group and scores for recovery promotion behaviour were found to be higher for high-participation teams than for those in low-participation teams. These results are modest but suggest that ROP may lead to improved outcomes and reduced cost.

More insights were introduced in a qualitative study conducted by Wallace et al. (2016) to investigate the impact of recovery-oriented care on service user experience. Whilst Slade et al. (2015) carried out an RCT and compared the intervention and control group, Wallace et al.

(2016) only recruited participants from the intervention group using purposive and convenience sampling. Twenty-four interviews and two focus groups were conducted. The findings from the interviews indicated that whilst some service users found aspects of the recovery intervention positive in that they helped staff to get to know them, to appear genuinely interested in them and helped to build mutual trust and respect, others felt that some of the questions were intrusive. This highlighted the importance of adopting an individualised approach to ROP. Service users also reported that discussing their strengths made them more aware of them and in some instances, they planned how to use their strengths. Goal striving was seen by some SU as beneficial as they felt it gave them something to work towards, a sense of purpose and a sense of achievement. Participants felt that findings from discussions around goals and strengths would be useful if used to inform the care plan.

When reporting about the overall impact of the intervention, service users described feeling empowered and had greater self-awareness as they were able to focus on a range of areas not previously focused on. Participants also reported an increase in hope and optimism.

Summary of theme

As shown above, some of the studies reporting on the impact of ROP on service user outcomes present conflicting findings. The challenge is that the conflicting results are from studies that used quantitative methods so the reasons for the differences in findings were not explored. However, the studies have some limitations which could have impacted the results. These included: recruitment challenges which could have impacted the power of the study, the suitability of the QPR as a primary outcome measure, the control group had been exposed to recovery (Slade et al. 2015). Limitations of the Leamy et al. (2016) study also related to the validity and reliability of the tools used to collect data as the validity of QPR for people with illnesses other than psychosis not known and the RSA measure was developed in the USA and its cross-cultural validity is not known. Looking at all the findings presented in the studies representing this theme, it can be tentatively suggested that ROP was associated with positive service user experiences. However, the concerns about the validity of the findings mean that further studies to investigate the relationship between ROP and service user outcomes are needed.

Reflection on the literature reviewing process

When I started the literature review, I was under the impression that it would not be too difficult as I had conducted literature reviews in my other studies and as part of the taught component of the doctoral study. Prior to the formal literature review for the thesis, I had done a lot of reading around recovery which I had enjoyed. This helped me to have a clear idea about what I needed to focus my literature review on. However, even though I had a review question and

search strategy, I was overwhelmed by the sheer volume of the studies on recovery. Support from the subject librarian and discussions with my supervisors helped me to realise that this exercise was not about including all studies on recovery and ROP and that part of my growth involved me being able to sift through the studies and having clarity about what I wanted to include in my review. Attending the literature reviewing session that was facilitated for doctorate students via the Cardiff University Doctoral Academy helped me to have a better understanding of the role of a literature review in a thesis which gave me further clarity around the purpose of what I was doing. Wide reading around types of reviews helped to identify a suitable framework to use for my review and using the framework for scoping reviews helped me to structure the review and gave me confidence in the rigour of my review.

Limitations

The review may not have included all literature on the implementation of ROP as the search was not exhaustive and was carried out by one reviewer. Furthermore, the review did not synthesise or aggregate findings. However, it was not the objective of the review to present all studies on the topic nor to aggregate findings. The aim was to give an overview of the research in the area based on studies that met the inclusion criteria in order to inform further studies. Another limitation is the potential bias that was introduced during the selection of studies, data extraction and reporting of findings as I was the only reviewer. To mitigate for this, I adopted a transparent approach throughout the process and made attempts to be as objective as possible by reflecting on decisions I was making. Furthermore, the use of the framework by Arksey and O'Malley (2005) allowed me to have a transparent reporting strategy which allows the reader to identify potential bias.

Conclusion

This literature review has shown that health care organisations in Western countries are actively making efforts to implement ROP. The studies have included different professional groups, providers and service users and revealed that ROP is generally viewed as a positive change which will help to improve the experiences of people with mental health problems. Studies looking at the perspectives of both service users and practitioners tentatively suggest that ROP results in positive outcomes for people with mental illness. In addition to this, findings from the studies into how ROP is implemented have indicated that the use of training and education can be beneficial in terms of increasing knowledge and understanding about ROP. However, it is not sufficient for attitude change and translation of knowledge into practice as there are various barriers that impede implementation. The review has shown that organisational culture, organisational priorities and the dominating discourse within the organisation all need to be aligned with the recovery philosophy to contribute toward

successful implementation of ROP. Furthermore, the need for positive risk taking and support from leadership in relation to risk management have also been pointed out as necessary for successful implementation. A variety of facilitators were suggested including the employment of people with lived experience. Moreover, some skills and attributes on the part of mental health practitioners were also highlighted.

Considering all the above, the review gives an overview of the landscape in relation to empirical studies on the implementation of ROP. Of note was the dearth of current research in this area. Although some of the studies from the UK were published in 2014 and later dates, the actual research was conducted in 2011 or earlier in some cases. Furthermore, most of the English studies appear to be mainly around the REFOCUS project and only a few were conducted by researchers outside the REFOCUS group. In addition to this, most of the English studies looking at implementation efforts were mixed methods studies and RCTs covering more than one organisation and evaluating specific ROP interventions. However, findings from this review suggest that to get a full understanding of how recovery is being implemented within an organisation, it would be necessary to use an approach that allows one to look at the different levels within the organisation and takes context into consideration. There is therefore a dearth in research using a case study approach to allow an in depth understanding of ROP implementation efforts not specific to an intervention. To add on to this, over the years, the focus on ROP has increased in the UK and there is also greater awareness of the concept. It is therefore imperative for more up-to-date research investigating progress with the implementation of ROP to be conducted to inform and improve practice. To contribute towards narrowing the gaps mentioned above, the study presented in this thesis is a case study that investigated how an NHS organisation was implementing ROP. The next chapter will provide the philosophical underpinnings of the study and give a detailed account of how the study was conducted.

CHAPTER 3: Methodology and Methods

Introduction

Previous chapters provided the background and rationale for the study. This chapter progresses the thesis by elucidating the philosophical underpinnings of the study, the approach taken and the methods used to conduct it. Firstly, the beliefs about reality and knowledge that provided the foundation of the study are articulated to clarify the lens through which it was conducted and to evidence the suitability of the case study approach taken. A description of the study setting and study participants including the recruitment criteria is then provided to establish the context in which the study was conducted. Furthermore, ethical issues that were considered and the permissions sought prior to commencement of the study are highlighted to give assurance in this regard. Importantly, all methods employed at each step of the research process are detailed whilst adopting a reflexive approach throughout to promote transparency and allow the reader to discern the validity of the findings (Bryman, 2012). The chapter ends with a step-by-step account of how analysis of data was conducted and introduces the themes which will be presented in the findings chapter.

Philosophical Underpinnings of the Study.

Epistemological and ontological position.

As stated by Ormston et al. (2014), the study of the social world raises many philosophical questions. Some of them relate to the nature of reality and what there is to know about the word (ontology) whilst others relate to how we know what we know, how knowledge is best acquired, and what is truth (epistemology) (Ormston et al., 2014; Crotty,1998). I therefore needed to explore these philosophical questions as part of my growth as a researcher. This exploration helped to unearth the assumptions underpinning the study which were indeed rooted in my philosophical positions in relation to ontology and epistemology. Upon reflection, I found that my background and experience influenced the decisions I had made about the topic I studied including the type of questions I asked, how I asked them and how I interpreted the findings (Gray, 2014).

In examining my ontological position, some of the key ontological questions I had to ask myself were whether I viewed reality as objective "out there", existing independent of people's conceptions and interpretations (realism) or if I believed it was subjective, meaning there are multiple, context specific or shared realities (idealism) (Crotty, 1998; Ormston et al., 2014). Although these are the two main overarching schools of thought in relation to ontology, there are other nuanced perspectives which fall between them and that is where my ontological position sits. I believe that there is a reality out there but also believe that we only know it

through our minds, our beliefs, and socially constructed meanings (Crotty, 1998). This position has been termed subtle realism or critical realism (Ormston et al., 2014; Sullivan and Forrester, 2019). I believe this position was influenced by various factors including: my background and experience of having been born and bought up in Africa then moving to the UK at age 19, my gender as a female, my profession as a mental health nurse, my experience as an academic and my experience of working in various settings in the NHS. My Christian faith leads me to believe that there is a world and a reality that exists out there. However, my life experience and my exposure to different contexts have shown me the role of culture in interpreting that reality. Furthermore, working in mental health nursing has shown me the power of the mind in interpreting reality. For example, when working with individuals experiencing psychosis (also sometimes referred to in lay man's terms as having" lost touch with reality"), it is important for me as a nurse to be aware that my reality may differ from that of other people. Having this position allows me to be able to show empathy and understanding so that I can provide person centred support. With this background, it is not surprising that in designing this research, the questions asked and methods used focused on allowing me to elucidate participants' subjective views and experiences of reality.

To further position this study philosophically, I also examined the epistemology that influenced this study – my belief about what is truth and how we know it. I found that my ontological position played a vital role as my beliefs about the mediated nature of reality naturally aligned with a constructionist epistemology. This is the view that knowledge and meaningful reality or truth is based on human practices being constructed as they interact with each other and with the world they are interpreting (Hennink et al. 2020; Crotty, 1998). Supporting this position is my belief that when we study the social world, we need to acknowledge human agency and seek understanding through the interpretation of participants' different views about the world (interpretivism) (Crotty, 1998; Ritchie et al. 2014). A further discovery was that these assumptions were in keeping with the ethos of the subject I chose to study (the recovery philosophy in mental health) which rejects the idea that there is one way to be recovered and challenges the dominance of the medical model as the only way to know or understand about mental illness. In this study, I was therefore interested in exploring different subjective views on recovery and how ROP was being implemented from the perspectives of people with the lived experience of supporting recovery and those on the receiving end of that support. I was therefore seeking idiographic knowledge which values subjectivity and seeks to understand the individual rather than nomothetic knowledge which seeks to establish laws and to generalise (Crotty, 1998).

Establishing my ontological and epistemological position helped me to understand why I had chosen the methodology adopted for the study. It is important to mention that although this

process has been outlined in stages, it happened simultaneously, organically, and subconsciously for me. It was only upon reflection that I was able to unpick and provide this clear picture of the philosophical backdrop for the study. Furthermore, it is important to highlight that although my philosophical position influenced the study, the choice of methodology had also been influenced by the types of questions I was asking. The importance of ensuring the approach taken to research aligns with the questions being asked is highlighted in the literature and researchers are warned against focussing solely on aligning choice of research approach with epistemological and ontological positions (Ormston et al. 2014; Sullivan and Forrester, 2019).

For this study, the qualitative case study design was chosen. This approach was well aligned with both my philosophical position and the type of questions I was asking. Ensuring the right choice of methodology was important as the methodology helps to translate ontological and epistemological principles into the blueprint for the research (Sarantakos, 2005). Jackson (2013) makes a distinction between methodology and methods describing methodology as the overall design that is employed to conduct the research whilst methods are the techniques used to collect and analyse data. The sections below will therefore outline both the methodology and the methods employed in this study in order to enhance its trustworthiness (Korstjens and Moser, 2018).

The case study's aim and objectives :

This case study investigated how ROP was being implemented in two practice settings in an NHS organisation providing mental health care in the South of England. The aim was to discover how recovery-oriented practice is implemented in an NHS Trust providing care for people experiencing mental health problems, in order to add to what is already known about the implementation of ROP to inform future practice.

. The study had the following objectives:

- To explore National Health Service (NHS) Trust senior managers', team leaders and practitioners' views on recovery-oriented practice and how it is implemented in their organisation.
- To elucidate service users' views and experiences of recovery-oriented practice.
- To investigate the strategies that have been put in place to facilitate recovery-oriented practice at different levels within the organisation.
- To identify any barriers and facilitators to the implementation of recovery-oriented practice at the different levels of the organisation.
- To clarify how recovery-oriented practice is evaluated in the Trust.

Qualitative Case Study

Qualitative research is an umbrella term for approaches underpinned by the interpretive approach. It allows the researcher to explore people's experiences using a specific set of research methods (Green and Thorogood, 2018; Hennink et al. 2020). This approach was deemed suitable as it would provide a set of methods that would allow exploration of the subjective, constructed, and diverse views of my study participants (Sarantakos, 2005). In addition to this, background reading and the literature review had revealed that ROP was a complex, contemporary phenomenon and that little was known about its implementation. Based on knowledge gained from undertaking research methods modules as part of the taught component of the doctoral programme, this seemed to fit with the kind of research that would be suited to a case study approach. According to Yin (1994, 2018), case studies are useful in the following situations: where the main research questions are "how" or "why" questions, where the researcher has little or no control over behavioural events and where the focus of study is a contemporary (as opposed to entirely historical) phenomenon. Based on these criteria, the case study methodology was explored as a potential approach for this study.

There are several definitions of case study in the literature (Merriam 1988; Yin, 1994; Stake, 1995; Simons, 2009; Thomas, 2021). Yin (1994) defined a case study as

> *"an empirical method that investigates a contemporary phenomenon (the "case") in depth and within its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident"* (Yin, 1994 p. 13).

Simons (2009) also offered a well-rounded and clear definition as she defined the case study as:

> "*an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a 'real life' context. It is research-based, inclusive of different methods and is evidence-led. The primary purpose is to generate in-depth understanding of a specific topic (as in a thesis), programme, policy, institution or system to generate knowledge and/or inform policy development, professional practice and civil or community action*" (p.21).

This definition goes further to encompass the purpose and uses of case study, giving more clarity and understanding. However, even though there are slight variations in the definitions, there is a consensus that the main function of case studies is to explore an event or phenomenon in depth and in its natural context (Crowe et al., 2011).

Further consideration of this approach showed that it had several advantages that made it suitable for this study. One of them was its flexibility and suitability for approaches from different epistemological positions (Crowe et al. 2011; Thomas, 2011). However, despite having all these advantages, the case study approach is not without its criticisms. Most of these are as a result of them being compared to Randomised Controlled Trials (RCTs). It has been argued that these criticisms of qualitative case studies based on comparisons with RCTs fail to recognise their value which would be best understood from an interpretivist or social constructionist viewpoint of other authors (Stake, 1995; Merriam, 2009). According to Stake (1995), qualitative case studies draw from naturalistic, holistic, phenomenological, ethnographic and biographic research methods. In comparison with other qualitative approaches such as phenomenology and grounded theory, they have the advantage of being more flexible as they use a palette of methods with the study designed to suit the case and study question (Hyett et al., 2014). The focus is on the case rather than the methods of enquiry used and it allows for the complexity of the phenomenon being studied to be captured (Stake, 1995). There is therefore flexibility in relation to the nature of data collection in comparison to approaches such as ethnography that tend to focus on specific aspects such as culture and emphasise details of observational data. Whilst other qualitative research approaches are useful for approaching specific questions, for this study the level of flexibility offered by the case study approach was found to be advantageous especially because little was known about the phenomenon being studied. Furthermore, for this study, context was very important so the ability to study a bounded system offered by the case study approach was appropriate. Nevertheless, the importance of ensuring that case studies are conducted in a rigorous manner in order for them to be recognised as valuable is highlighted in the literature (Yin, 2014).   He asserted that for this to be possible, there was a need for clear research designs that were rigorous throughout the research process. This case study will therefore aim to ensure rigour and transparency throughout the process. Moreover, the approach's suitability for answering the "how" and "why" questions being posed in this study will be highlighted. It is also worth noting that concerns raised in the literature about generalisability of case study findings do not apply to this study as the aim was not to generalise but to particularise. Particularisation is about getting an in-depth understanding of a phenomenon using a single setting to add to knowledge on a specific topic (Simons, 2009). This is in keeping with this study as it was exploring the implementation of ROP in the context of the organisation being studied by adopting the idiographic approach. As explained by Thomas (2021), the premise of the case study approach is the assumption that studying the subject from different angles will help the research to get closer to the how and why.

Although various authors have proposed different designs for case studies, Baxter, and Jack (2010) highlighted that the key approaches to case study were proposed by Robert Stake (Stake, 1995) and Robert Yin (Yin, 2003 and 2006). Although their approaches have some similarities, as highlighted above, Stake (1995) adopts a more relativist and interpretive approach (acknowledging multiple realities and multiple meanings, with findings that are observer dependent) whilst Yin's approach leans more towards a realist ontology and positivist epistemology (the belief that that it is possible to carry out independent, objective and value free social research much like in the natural sciences) (Baxter and Jack, 2010; Yin, 2018). Whilst Stake's approach was more aligned with my philosophical position, some ideas from Yin were adopted for this study as he advocates the use of clear research designs to ensure case studies are structured and transparent (Yin, 2014). On the other hand, Thomas (2011) provides a clear explanation of the case study approach therefore ideas from Yin (2014) and Thomas (2011) were instrumental in guiding my thinking during the planning stages of the study. Moreover, Thomas (2021) provided a framework which I used retrospectively to clearly articulate the factors I considered during the planning stages of the study. These have been summarised below.

Step 1 – Identifying the subject of the study

This step was about clarifying the case to be studied. For this study, based on the literature review and the questions generated for the study, a decision was made that the case would be an NHS Trust providing mental health services in the South of England. The selection of the case was based on "local knowledge" (Thomas, 2021). This means the selections was based on the researcher's knowledge and experience. In selecting this case, I knew this would be an appropriate selection for the study as I was aware that the Trust was implementing ROP based on my role as a University Link Lecturer in the Trust. In addition to this, two practice settings within the Trust were selected for the study. This was based on local knowledge which suggested that the two areas presented the most obvious opportunities for ROP. The descriptions of the services on the Trust intranet also explicitly stated that they were providing ROP.

Step 2. The object of the study

This next step involved establishing the object of the study (the topic of interest) being explored (Thomas, 2021). It was established during the initial stages of the study and following the literature review that the study would explore how ROP was being experienced and implemented in an organisation providing mental health care. The objectives of the study were therefore set around this.

Step 3. The purpose of the study

This step required me to clarify why the study was being conducted. It was clear from the literature review that this study needed to provide insights to help our understanding of how ROP is implemented in mental health services with a view to inform practice, future research and policy. Various ways of classifying case studies based on their purpose have been proposed as summarised below (Yin, 2003 and Stake, 1995).

Table 5:Types of case study

Yin (2003)	Stake (1995)
Descriptive – used to describe an intervention/phenomenon in the real-life context in which it occurred **Explanatory** – used when answering questions that seek to explain presumed causal links in real life interventions that are too complex for survey of experiments **Exploratory** – used to explore situations where the intervention being studied has no clear single set of outcomes **Multiple case study -** allows the researcher to compare differences within and between cases	**Intrinsic** – used when the intent is to better understand the case. Undertaken to learn about a unique phenomenon. **Instrumental** – uses a particular case to gain a broader appreciation of an issue or phenomenon. **Collective** - allows the researcher to compare differences within and between cases. involves studying multiple cases simultaneously or sequentially to generate a still broader appreciation of a particular issue.

(Yin, 2003 and Stake,1995)

Based on the above descriptions, this case study can be classed as an instrumental case study using Stake's (1995) classification as its purpose was to get more insights into the phenomenon as described above. It is also a collective/multiple case study (Stake, 1995 and Yin, 2003 respectively) as two practice contexts were investigated to get a broader understanding or the implementation of ROP.

Step 4. Clarifying the approach of the study

This involved deciding whether the study would be testing theories from the literature around implementation of ROP or formulating ideas around implementation of ROP from the insights gained in the study. The latter was found to be more appropriate as the phenomenon being studied required further exploration due to paucity of research in the subject. Therefore, an inductive approach that allowed exploration and generation of ideas was taken.

Step 5. Deciding the methods to use for the case study.

This involved making decisions around data collection and analysis methods. Semi-structured interviews were chosen as the data collection methods. It was felt that this would allow a structured approach to data collection guided by literature whilst also remaining open to new insights being illuminated by participants. A decision was also made to be record all interviews and to transcribe data verbatim in order to enhance the authenticity of the transcripts and not to lose the participants' voices. When it came to the analysis approach, it was decided that a thematic analysis would be conducted for the interview data and a documentary analysis for the care plans. The data collection and analysis processes followed will be described in more detail later in this chapter.

Step 6. Deciding the process.

This stage involved deciding about the type of case study in relation to the number of cases, timing of the case study. Based on the phenomenon being studied and the knowledge I had in mental health practice as a mental health nurse, the decision made was that although the study would have a single case (one NHS organisation), two units (one working age adult community mental health team and one rehabilitation ward) from the organisation would be included in the study – meaning there would be embedded units (Yin, 2018). These two settings were chosen because they provided opportunities to practice ROP and their service descriptions explicitly stated that they were providing ROP. Furthermore, the two settings provided an opportunity for comparison between two different practice settings which would give more insights into any issues pertaining to any context and provide a more in-depth understanding due to the opportunity to triangulate data from different participants in the different units.

Ethics

Having thought about the plan for the study, before embarking on the research it was important to establish that the study was ethical and to seek ethical approval from all the relevant bodies. This step was very important as historically, there have been instances of harmful and unethical research (Gelling, 2010; King, 2019; Costley and Fulton, 2019). A major milestone

in the development of research ethics was the Helsinki Declaration in 1964 which has been updated a few times since then (King, 2019). This provides principles which should underpin research involving human subjects including social research. As a researcher, I am therefore accountable for upholding the principles and for how I conduct myself morally. Below is a summary of some of the considerations made in this study with regards to the ethical principles that underpin research and details of the process of acquiring ethical approval.

Beneficence

This principle relates to doing good and is about ensuring the research is for the benefit of other people (Costley and Fulton, 2019). This research will inform practice and help to make changes that will improve the experience of service users, staff, and carers. As a researcher, I made sure the research was designed well and that I got the right training through undertaking research modules and attending Doctoral Academy research workshops which allowed me to be able to conduct the study in a competent manner so that it is credible and fit for purpose.

Respect and autonomy

This principle is about people's right to make autonomous and informed decisions (King, 2019). It was therefore important to ensure participants got detailed information about the study and that participation in the study was voluntary and not coerced. The Participant Information Sheets (PIS) and consent forms (see appendices 8,9,10,11,12,13) gave detailed information about the study and the option to withdraw at any time. As it was recognised that some potential participants could be vulnerable individuals, gatekeepers were in place to ensure they were supported to make informed decisions. Furthermore, apart from the signed consent forms, at the start of each interview, I made sure that I checked with each participant that they were happy to participate and informed them of their right to withdraw or stop the interview at any time. Please also see the recruitment procedure adopted for the study outlined later in this chapter for more details.

Principle of justice

This entailed making sure that people were treated fairly throughout the research. As a researcher, I had to ensure that no-one was disadvantaged due to participation or non-participation in the study. This was a consideration I had to make throughout the research process. For example, during recruitment I made efforts to ensure that all potential participants got the opportunity to be invited to take part in the study (see appendix 5, for the flyer). During data analysis I had to ensure I was impartial, considered all participants' views and presented an account that was as representative of all participants as possible. This is evidenced in the quotations used in the findings chapter.

Non-maleficence

This principle relates to ensuring that any risk of harm is avoided or minimised (Costley and Fulton, 2019). As part of the preparation for this research, I had to think about the potential harm the research could cause and find ways of eliminating or reducing the risk. I had to think about the nature of the questions I was asking and whether they were sensitive or had the potential to cause distress. Although this seemed to not be the case as no sensitive questions were being asked, I still ensured that participants were aware of where to get help or express concerns if needed (see PIS in appendices 8,9 and 10). I also had to consider the potential for unintended harm through for example, a breach of confidentiality or failure to maintain anonymity. Anonymity and confidentiality are important issues   in research ethics. As this was a case study, it was particularly important for me to be careful as some of the information given about the organisation or individuals within it could lead to easy identification. I therefore had to strike a balance between giving enough information to describe the case in a way that established the context and ensuring that the risk of giving information that would lead to easy identification information was kept low (Simons, 2009). Some measures taken were the use of pseudonyms throughout, and in some cases the exact job titles were not stated explicitly where there was a risk that this would lead to easy identification. To ensure confidentiality was maintained, the General Data Protection Regulation 2018 was adhered to together with Cardiff University Guidelines on how to manage and store research data. Participants were also made aware of how the data would be stored, who it would be shared with and what it would be used for (see PIS).

Apart from the general principles outlined above, as a nurse I was also guided by my professional values which are articulated in the Nursing and Midwifery Council (NMC)Code (NMC, 2018). My professional values are aligned with the research ethics and emphasise my responsibility to promote people's dignity, autonomy, confidentiality and ensuring I cause no harm. I have a responsibility as a registered nurse to uphold the reputation of my profession and to always act with honesty and integrity. These values were also underpinned by Christian values which place importance on doing good, showing kindness and respect amongst other things. All in all, these values represent the micro-ethical principles that underpinned the ethical sensitivity that was practiced throughout the study (Costley and Fulton, 2019). However, there were also the procedural ethics which related to gaining permissions or ethical approval to conduct the study (Guillemin and Gillam, 2004). The process will be summarised below.

Ethical Approval

The ethics application procedures for this study took approximately eleven months to complete. This was because several steps had to be followed including refining the research proposal and evidencing the ethical integrity of the study to different review panels. Firstly, a Research Passport was obtained from Cardiff University (see Appendix 4). Following this, a proposal and a request for approval was submitted to the School of Healthcare Sciences Research Ethics Committee (REC). School REC approval was granted in July 2016 (see Appendix 2). Cardiff University sponsorship was also granted prior to the commencement of the study. With the permissions from the University REC, an agreement in principle on condition of NHS ethics approval was obtained from the Trust's Research and Development (R&D) department. An application was then made to the NHS REC via the Integrated Research Application System (IRAS). This process took some time but was helpful as it made me consider all potential ethical issues and helped me to refine the design of my study as the form asked very specific questions. As the study mainly involved interviewing participants and was non-invasive, the application was made to the Health Research Authority (HRA) Proportionate Review Panel. Approval was granted by the HRA on 27th February 2017, REC reference: 16/LO/1889 (see Appendix 3). Following receipt of confirmation of approval, this was sent to the Trust R&D department to be granted permission to access the Trust sites to conduct the research. The letter of access was granted on 12th June 2017 and a nominated manager from the Trust to support me with access and navigation of the Trust was identified. With all this in place, I had the permissions to start the study. The processes subsequently followed in conducting the study will be outlined later in this chapter.

The Case

The Trust

It is a large NHS Trust covering a wide geographical area in the south of England. The organisation provides community and mental health services across all ages. It employs over 6 000 staff who range from doctors, nurses, support workers and other allied health care professionals such as physiotherapists, psychologists, occupational therapists and so on. The Trust has a capacity of around 400 inpatient mental health beds has 260 clinical teams working from 150 sites. Over 135 000 people per year are treated in the Trust.

The Community Mental Health Team (CMHT)

The selected CMHT is one of the community mental health teams providing support to working age adults (18 – 65 years) experiencing mental health problems in the Trust and covers one of the geographical areas in the Trust's catchment. It is led by a team manager, a deputy team manager, and a consultant psychiatrist. The team has about 50 staff members from

various professional backgrounds including mental health nurses, occupational therapists, and social workers. These professionals take on the role of care coordinator for service users on the Care Programme Approach (CPA) – each with an average caseload of 20- 30 service users. There are also a few support workers who work alongside the care coordinators in the team. The team is described as aiming to provide a "holistic needs led service" and uses the Recovery Star as a guide to ensure support is provided for a wide range of needs including housing, employment and meaningful activity and social inclusion. The CMHT has links with local General Practitioners (GPs) as this is where some of their referrals come from and they also work closely with other community teams and the inpatient wards.

The rehabilitation ward

The rehabilitation ward is a 20-bed mixed sex ward that describes its provision as "rehabilitation and recovery-orientated service for people who experience a serious and enduring mental illness". The service is part of the adult mental health pathway catering for people aged between 18 and 65 years old. As part of this pathway, the ward has close links with the CMHTs, other inpatient wards such as the acute wards, social care and third sector organisations. The ward is led by the matron, the consultant psychiatrist, and the ward manager. The team has about 38 staff from various professional backgrounds with most staff being from a mental health nursing background. However, the ward also has occupational therapists, doctors and other non-registered staff working in support worker roles. Various evidence-based treatments and interventions are offered on the ward including medication and various groups.

Participant Inclusion and Exclusion Criteria

Before recruiting participants into the study, I needed to have clarity around the inclusion and exclusion criteria to ensure only participants who were able to help to address the research questions would be involved and also to have a structured and objective approach to recruitment. The inclusion and exclusion criteria were as follows:

Inclusion criteria for service user participants

- Working age adults between the age of 18 - 65
- English speaker
- Currently in receipt of care from the NHS Trust being studied.
- Diagnosis of a serious mental illness
- Able to give informed consent
- Identified by their care co-ordinators/named nurses as being in receipt of recovery-oriented support.

Inclusion criteria for managers

- Agenda for change band 7 and upwards
- Leading the teams included in the study

Inclusion criteria for practitioners

- Registered professional giving direct care to service users (Bands 5-6)
- Working within the community mental health team or the rehabilitation ward that have been identified as units for the case study.

Inclusion criteria for senior managers

- Band 8b and above
- Working at strategic level within the mental health directorate of the trust
- Involved in monitoring and influencing the standards of care strategically.

Exclusion criteria for service user participants

- Not in receipt of care from the Trust
- Below the age of 18 years of age or over the age of 65 years
- Not able to give informed consent

Exclusion criteria for senior Managers

- Not working within the adult mental health directorate
- No involvement with the vision for the Trust with regards to the mental health provision for working age adults.

Exclusion criteria for practitioners

- Not involved in direct care.
- Not a registered professional
- Not involved in decision making regarding the care of people with mental illness.
- Not working within the adult community mental health team or the rehabilitation ward identified as the units for the study.

Exclusion criteria for Managers

- Not working in the two settings under study

Sampling and Recruitment of Participants

Polit and Beck (2017) describe sampling as the process of selecting or searching for participants who provide rich data for the research being conducted. In qualitative research, sampling is deliberate and there are various sampling strategies to choose from so it is

important for me as a researcher to articulate the choices made and provide rationale for them in order to enhance the trustworthiness of my study (Moser and Korstjens (2018). Recruitment to this study was via a combination of purposive and snowball sampling. Purposive sampling was necessary to ensure that only those who met the inclusion criteria and hence were able to contribute to answering the research question were approached (Green and Thorogood, 2018). Furthermore, purposive sampling allowed the selection of a sample that would give diverse perspectives (Hennink et al., 2020). For example, I had a mixture of mental health professionals, service users and managers in the sample to prevent bias from hearing the views of one group. On the other hand, snowball sampling involved participants suggesting others they thought would be appropriate participants. However, as advised by Hennink et al., (2020), all participants were still screened for eligibility to the study. More detailed descriptions of recruitment of participants are given below.

Firstly, after all the permissions required to conduct the study had been obtained, a director who had been suggested by the Trust Research and Development department as the appropriate first contact for senior manager recruitment was contacted via e-mail. Participant information sheets (PIS) and consent forms were sent to him via e-mails as well. He was happy to participate in the study and suggested other strategic level individuals in the Trust who were involved in implementing ROP and would be appropriate to interview for the study. One of them was approached via e-mail and agreed to participate. Following this, to recruit practitioner participants, the managers of the two teams were approached and given information about the study to make them aware and to request their support. According to Gelling (2010), it is important to do this as they act as gatekeepers who can control access to participants. However, I had to be careful that potential participants did not feel coerced to take part in the study due to the involvement of managers (Hennink et al., 2020) so I requested for copies of the PIS, consent forms and posters advertising the study shared with the managers to be displayed in the staff room and on the ward for staff to see and contact me if interested in participating.

The process of recruiting practitioners and managers was surprisingly straight forward. This was mainly because of the snowball effect as managers and other participants suggested people who would be appropriate to talk to. I was humbled by how willing staff were to participate in my study and how supportive the managers were as they allowed staff to talk to me in between their duties during working hours. This required me to be flexible- working around their availability. For the rehabilitation ward, this flexibility included attending the ward during the night as one of the participants was working night shifts.

For service user recruitment, due to the nature of some mental illnesses and the impact they have on capacity, it was important to ensure the right process for recruitment was followed in order not to compromise the ethical integrity of the study. A decision was made to have named nurses, care coordinators and responsible clinicians as gatekeepers to ensure only those service users who were able to give informed consent were approached for the study. Service user participant recruitment was therefore via suggestions from their respective care coordinators (for CMHT service user participants) and responsible clinician (rehab ward service user participants). The consultant psychiatrists and care coordinators were given service user participant information sheets, consent forms to share with the service users who they felt were able to give informed consent. Initially, the plan was that the service users would contact me, but the reality was that they gave consent for me to contact them to their care coordinator or consultant psychiatrist who in turn shared their contact details with me. See Appendix 6 for template of letter sent to service users. Even though in some cases consent had been given via gatekeepers, I still ensured that I went through the PIS and checked for informed consent prior to any interviews. As stated by Fulton and Costley (2019) this should not be viewed as an extra step but as an integral part of the research process. This way of recruiting could potentially have introduced selection bias as gatekeepers could have selected the participants they thought would give favourable responses (Hennink et al. 2020). However, the benefits of having a gatekeeper were deemed to outweigh this risk of bias.

Reflecting on my positional stance during the recruitment phase, I concluded that my role as a university link lecturer and my identity as a mental health nurse made me an insider and could have made access to participants easier for me (Fulton and Costley, 2019). I experienced a friendly and welcoming attitude towards my research and I noticed that practitioner participants made an effort and were willing to talk to me openly suggesting there was an element of trust. However, there were also other participants I had never met before who were equally as willing to participate. It is therefore possible that the study topic was of interest among the practitioners. I also reflected on the possibility of some participants feeling coerced to take part as they knew me. However, I felt that the PIS and consent forms made it clear that participation was voluntary and that a choice not to participate would have no detrimental impact on the individuals. The same applied to service users as the gatekeepers made it clear that choosing not to take part would not affect their care (see PIS in Appendix 9).

Participants

A total of 16 participants were recruited to the study. However, as stated by Vasileio et al. (2018), choosing a sample size in qualitative research is a debated topic and an area that

lacks clarity. This is evidenced by the consensus reached by qualitative research experts in the Baker and Edwards (2012) paper which concluded that sample size depends on various factors including epistemological, methodological and practical issues. Interestingly, some qualitative researchers argue that sample size is determined by data saturation (a point where no new data is arising during the data collection process) (Polit and Beck 2017) and others have proposed statistical calculations for sample size (Fugard and Potts 2015). However, further insights into the question of sampling in qualitative studies come from recent publications as the issue of sample size in qualitative research has become topical (Sim et al. 2018; Braun and Clarke, 2016). Due to the philosophical underpinnings of this study, my position is in agreement with Sim et al. (2018) and Braun and Clarke (2016) who identified philosophical and methodological issues related to the methods that have been proposed for use in determining and justifying sample size in qualitative research. I am therefore of the position that the underlying assumptions related to determining sample size align with a realist ontology and contradict my ontological position (subtle realism), my theoretical approach (interpretivism) which both mean my beliefs are that there are multiple realities which are influenced by our interpretations. Furthermore, I agree with Braun and Clarke (2021) who questioned the idea of saturation. I believe that saturation can never be reached as my interpretation of the data is dynamic, iterative and nuanced, as are my participants' interpretations of their experiences. With all this in mind, what was important to me when making decisions about the sample was to ensure that the sample was able to help me to get some insights into the phenomenon I was investigating. To this end, the question I was asking meant that it was important that the sample included participants from the different levels in the organisation and also service users. A decision was made to have equal numbers of participants from the two practice settings to ensure that there was equal representation of views and reduce the potential bias of findings leaning towards one setting. The biggest number of participants were practitioners as it was felt that they were responsible for delivering ROP so whilst all participants' input was valuable, they would bring insights into how ROP was being implemented. Overall, this heterogenous sample of 16 participants was felt to be sufficient for this study as the aim was to get in depth accounts from the participants. Moreover, consideration of the fact that there was one researcher and also the word limit for the thesis made this number more practical and fit for purpose.

The tables below give details of participants whilst maintaining anonymity (pseudonyms were used). This information is important for the reader to be able to assess the transferability of the findings (Korstjens and Moser. 2018).

Table 6:Practitioners and Senior Managers

Pseudonym	Role	Base	Length of time in MH services	Length of interview in minutes
Nancy	Senior manager	SMT	Over 20 years	49
Ronnie	Director	SMT	Over 25 years	60
Monica	Consultant Psychiatrist	Rehabilitation ward	Over 30 years	60
John	Consultant Psychiatrist	CMHT	About 10 years	90
Mabel	RMN	Rehab ward	Over 10 years	90
Theo	OT	Rehab ward	Just under 10 years	43
Rachel	RMN	Rehab ward	Over 10 years	31
Dawn	RMN	Rehab ward	40 years	79
Kate	OT	CMHT	About 10 years	37
Ruth	CPN	CMHT	About 10 years	54
Jane	SW	CMHT	Over 10 years	56
Bob	RMN	CMHT	35 years	95

Table 7:Service user participants

Pseudonym	Base	Gender	Length of contact with MH services	Length of interview in minutes

Tim	CMHT	Male	33 years	43
Jerry	CMHT	Male	20 years	34
Jade	Rehab ward	Female	over 10 years	24
Ken	Rehab ward	Male	6 years	15

Data collection methods and tools

Data collection was via individual semi-structured interviews lasting up to 90 minutes (see actual duration of individual interviews above). According to King et al. (2019), interviewing is the most commonly used method of data collection in qualitative research. Furthermore, Simons (2009) cites it as one of the most used methods of data collection in case study research and one that has the advantage of allowing the researcher to go into greater depth and allows participants to tell their stories. This method was chosen as it fitted well with my philosophical position as described earlier and suited the research question and objectives. Initially, the plan had been to complement the interviews with documentary analysis with a review of the care plans of the service user participants. However, this was not possible as three of the four service user participants did not give consent for me to access their care plans and the care coordinator of the one that consented did not give access despite several reminders. The challenges faced in trying to obtain care plans revealed to me the importance of seeking consent for different aspects of research separately. I was glad I had not assumed by participating in the study, service users were giving implicit consent allowing me to access their care plans or care record. I did however wonder why those who were not willing to give consent for this aspect were reluctant to do so. I was not able to ask as I did not want them to feel like their decision was being questioned or that they were being coerced. More importantly, I was concerned that missing the care plans would compromise the rigour of the case study. However, upon discussion with my supervisors we all agreed that the 16 interviews with participants from different levels and different settings would still allow triangulation of data and offer rich insights into the implementation of ROP in the contexts being researched.

To assist with data collection, separate semi-structured interview guides were created for the different participant groups to aid the interviews (see Appendices 14, 15 and 16). According to King et al. (2019), flexibility is important in qualitative interviewing. Therefore, semi-structured interviews were chosen as a data collection method as they allowed flexibility and exploration of participants' views whilst also helping to stay focused on the questions that

would help to meet the research objectives which was helpful for me as a novice researcher (Braun and Clarke, 2013). It is important that the interview guides are fit for purpose and King et al. (2019) cite three sources from which topics for the interview guide can be drawn. Two of these sources were used in this study. Firstly, my background reading and the literature review with ideas from Farkas (2005), Slade (2013), Sainsbury Centre for Mental Health (2009) being instrumental as they suggested ways in which ROP was to be implemented. Secondly, my personal experience as a mental health nurse and stories shared by others (service users and student nurses). The third source cited by King et al. (2019) is preliminary work on the topic by the researcher. This was not done in this instance. Finally, to ensure richness of data collected, when putting together the questions I ensured there was a variety of questions to elicit different kinds of information (King et al.,2019). These were questions to do with experience, perceptions, opinions/values and knowledge (see appendices 14.15 and 16).

Interviews

When making the decision about where the interviews would be conducted, I needed to ensure interviews were conducted in an environment where participants felt comfortable (physically and psychologically) (King et al., 2019). Participants were therefore given a choice to be interviewed in their homes (CMHT service users only), in one of the rooms on Trust premises or at my workplace. However, all participants chose to be interviewed on Trust premises. For practitioners, this allowed them to save on travel time and travel expenses and for service users it provided a familiar environment. I had been granted access to quiet offices in the outpatients' department and on the wards for data collection purposes so this worked well as rooms the rooms allowed uninterrupted time and privacy during interviews. Interestingly, although attending the interview on the hospital site seemed straightforward, a conversation with one of the CMHT service user participants showed me that it was not. He shared with me that his medication made him drowsy and tired, and that he normally struggled to wake up in the mornings. He therefore had ensured he took his medication earlier than usual the night before our interview so that he would be able to get up on time for our appointment. This sacrifice on his part really humbled me and reminded me of my role as a researcher to ensure his voice was heard as it demonstrated the sacrifices participants were making to give their input. This experience also made me determined to complete this study and kept me going when the doctorate journey got tough.

During the interviews, a recording device was used to record all interviews for transcription later. As noted by King et al. (2019), being recorded can make some people uncomfortable. Being aware of this, I took steps to make participants feel safe by creating a relaxed friendly atmosphere in the interview room, ensuring there were no tables between me and the

participants and using phatic talk before the interviews. This was something one of the service user participants commented on as he told me towards the end of our interview that the way I had greeted him with a smile had made him feel comfortable to talk to me. This suggested to me that although the lack of anonymity during face-to-face interviews is cited as a disadvantage as it could lead to socially desirable responses or a choice not to participate (Braun and Clarke, 2013), it can be outweighed by the benefits of establishing a rapport with participants which allows them to open up during the interview leading to rich data. Keeping participants informed of what I was doing and why also helped. For example, I had a notebook for jotting down any important points or reminders for myself and this was explained to the participants. Having a notebook allowed me to reflect on my experiences and learn from them. Costley and Fulton (2019) posit that this practice of reflection is important in research and others have proposed that reflexivity enhances trustworthiness in qualitative research (Korstjens and Moser, 2018).

This stage of data collection was the most interesting for me and I found myself immersed in the stories the participants were telling. This part of the process came naturally to me because it was very similar to what I did in my role as a mental health nurse and a lecturer. These roles enhanced my communication skills and my ability to listen with curiosity. The downside of this was that sometimes I got carried away and the interviews went off on a tangent, so I had to remember to return the participants to the research topic. However, this flexibility which allows participants to tell their own stories is also cited as one of the advantages of semi-structured face-to-face interviews as it allows unanticipated insights to be gained (Braun and Clarke, 2013). The interview schedules were helpful in bringing back the focus and ensuring important questions were addressed. Another observation I made earlier on was that my role as an insider (mental health nurse with experience working in both inpatient and community settings and also as a link lecturer supporting students and mentors in similar settings) whilst advantageous in that it helped me to understand the context and potentially ask the right questions (Costley and Fulton, 2019) it also put me at risk of bringing my own interpretations and biases which could potentially compromise the quality of data collected. I therefore made a conscious effort to listen to the participants and to use the interview guide rather than asking leading questions based on my assumptions. Moreover, another observation which led to my growth as a researcher was that after the first interview, I listened to the recording and found myself with questions I could not answer because I had not sought further information or clarification from the participant as I was keen to move on to the next question. This showed that although enjoyable, interviewing can be challenging as it involves multi-tasking – taking notes, listening, processing and probing so it requires one to be skilled to ensure relevant, rich data is gathered (Braun and Clarke, 2013). Having made this observation, I made a mental

note to improve my interviewing skills and made sure I followed-up and asked questions for clarification in subsequent interviews. Adjusting the interview guide or asking probing questions not on the interview guide is common and encouraged in qualitative interviewing (Braun and Clarke 2013; King et al. 2019).

Reflecting on my experience of conducting interviews, I found that I learnt the importance of being flexible and not making assumptions. For example, I had assumed in designing the interview guide that words such as values and recovery would be understood by all participants. However, I discovered during interviews that these words needed clarifying for some participants. I also found that I had to re-word some of the questions when talking to service users as it became clear that terms like recovery and ROP for example were jargon. For example, the question "*Thinking about how you are supported whilst receiving care, in your opinion, what is recovery-oriented practice?"* had to be re-phrased to **"***Could you tell me about an experience of care that you felt was positive and promoted your recovery?"* as service users seemed to find it easier to give examples when the question was rephrased in this way. I also learnt that I had to take into consideration that participants' understanding of recovery would be different from what I was defining as recovery, and I had to be careful not to impose my understanding of recovery on the participants. Further flexibility was required in relation to time. It became apparent that some service users found it difficult to concentrate for long periods and needed the interviews to end quickly. I therefore had to respect their autonomy and terminate the interviews when they needed me to do that. I learnt that it was not about my agenda and I had to put their needs first.

Overall, I found that during the interviewing stage, having adopted an interpretivist philosophy allowed the flexibility and curiosity to understand from the perspectives of the participants. I was open to learning about the different interpretations due to my belief that there is not a single truth or a single reality and that we gain knowledge and understanding by exploring the different views and experiences people have. I therefore embraced the fact that after the 16 interviews, I had rich data from a diverse "sample" from which I could gain useful insights on the implementation of ROP.

Transcription

Following the interviews, it was necessary to transcribe them to convert the recordings into textual data. According to Hennink et al. (2020), this is an important step in preparing data for analysis and needs to be informed by the purpose of the analysis that will be conducted. For this study, the analysis aimed to develop themes from what was said by participants therefore the transcripts needed to fucus on what was said or the spoken words. This is called verbatim or orthographic transcription (Braun and Clarke, 2013) and is different from other forms of

transcription that record paralinguistic aspects (what was said and how it was said). This transcription style is more suited to linguistic or conversational analysis where the focus is on how people talk (Hennink et al. 2020) which was not required in this study. However, even though verbatim transcription seems straight forward, it became apparent when listening to the recording of the first interview that there were other nuances to be considered such as pauses, speech fillers and incomplete sentences as they held different meanings which could inform the analysis. It was also interesting transcribing one of the service user interviews as he used profanities. All these are examples of what Braun and Clarke (2013) referred to as the messiness of spoken natural language. It was important that this messiness was reflected in the transcripts as changing what was said would add another layer of interpretation and would not be representative of the participant's own voice (Hennink et al., 2020). To ensure such nuances were captured and utilised in interpreting the findings, I listened to recordings again and wrote summaries of each interview with comments that took into consideration for example where frustration was evident in the recording.

Initially, the plan was to complete transcription during the data collection phase of the research. This decision was made because literature suggests that this approach is advantageous as it initiates the inductive process of data collection through the identification of issues to be further explored in subsequent interviews (Hennink et al., 2020). This meant that after every interview, time needed to be aside to complete the transcription. For this study, this was successful for the first two interviews but became difficult to keep up with due to the time-consuming nature of transcribing. Working full-time also meant that I was juggling different commitments and could not always spare 4-5 hours after each interview. However, I ensured I listened to all recordings after each interview, made notes and reflected on anything that could be done differently in the next interview. Although transcription was not completed immediately after the interviews for the rest of the interviews, I transcribed nine of the interviews but due to time constraints and to reduce the time burden of transcription, seven of the interviews were transcribed by a professional transcribing service. A reputable service with experience of transcribing for many research projects and awareness of data protection requirements, anonymity and confidentiality was used. All transcripts were checked for accuracy and completeness by reading through them whilst listening to the recordings. Furthermore, to ensure data protection regulations were followed, all recordings were stored on a password protected computer which only I had access to and deleted from the recording devices following each interview. Pseudonyms were used on all transcripts which were also saved on a password protected computer.

Data analysis

According to Spencer et al. (2014), although analysis is an inherent and ongoing part of qualitative research that begins at the start of the process when ideas about what to study are formed, there is also a formal analysis stage of the research process where the researcher is consciously conducting the analysis. Transcribing audio recordings of the interviews described above was part of the preparation for formal analysis (Braun and Clarke, 2013). This next section of the chapter builds on this and outlines the formal analysis process that followed transcription. Being clear and transparent about the processes followed helps others to be able to assess the value of the findings as they will be able to see how the researcher got to them (Spencer et al. 2014).

As with all the stages in the research process, the approach that was taken for analysis was influenced by the type of research questions and by the philosophical underpinnings of the study. An interpretive epistemology and a desire to find out about how ROP was being implemented led to a decision to choose a data analysis method that allowed description and interpretation. This was found to be appropriate as the descriptive analysis would help to know more about implementation of ROP and the interpretive analysis would give a deeper understanding of the why and how (Braun and Clarke, 2013). Thematic analysis (TA) was found to be one such approach as it is a substantive approach to analysis (Spencer et al. 2014). This type of approach means the focus is on what the text says and uses the data to get insights into the participants' world (Spencer et al. 2014). This approach was also aligned with orthographic transcription which had been conducted for all interviews as it emphasised what was said.

TA is one of the methods based on a constant comparative approach to data. As highlighted by Thomas (2021), the constant comparative method is one of the ways case study data can be analysed. He also pointed out that although there are many variations of the method, the essence is the same and as he put it:

> *"There may be many bells and whistles that are added to the constant comparative method, but, however elaborate, it will always be defined by the simple principle of going through data again and again (this is the constant bit), comparing each element – phrase, sentence or paragraph – with all of the other elements (this is the comparative bit)"* (p.225).

However, whilst the above quote captures the essence of what the method is about, it is simplistic, and authors have since developed ideas that add depth to the process (Braun and Clarke, 2006). These ideas were useful in informing the analysis conducted for this study.

Further clarification of the type of thematic analysis adopted will therefore be given to illuminate the thinking behind what was done and to promote transparency. Being transparent in this way and having a structure is encouraged by authors such as Braun and Clarke (2006) who found that although widely used, TA was poorly demarcated and not well understood. They undertook an in-depth study into TA including its history and proposed a way of understanding it including a structure which could be followed (Braun and Clarke, 2006). However, it is worth noting that TA has been criticised for lacking substance, being too simple, for not having limited interpretive power and being mostly descriptive. These criticisms have been argued to be unfounded and misguided as TA can be interpretive and sophisticated depending on the focus of the analysis and the ability of the researcher (Braun and Clarke, 2006; 2019; 2020). Furthermore, as qualitative researchers, Braun and Clarke have continued to think and reflect on their learning and have added new insights to their method of TA which they have now named in reflexive TA. This new name reflects the fact that the researcher's role in knowledge production is central to their approach (Braun and Clarke, 2019). This aligns with my philosophical position and places importance on me as the researcher being cognisant of my assumptions and how they influence the analysis and interpretation of data. To add on to this, although guidance from Braun and Clarke (2006) was used, "analytic sensibility" was applied throughout the analytic process. Braun and Clarke (2013) emphasise the importance of this and highlight how good qualitative analysis is not a product of following the rules or prescribed recipes for analysis. They argue instead that applying analytic sensibility - *"the skill of reading and interpreting data through the particular theoretical lens of your chosen method"* (Braun and Clarke 2013, p. 201) is what produces good qualitative analysis. Quality reflexive TA is therefore about the researcher's reflexive and thoughtful engagement with their data and with the analytic process rather than following procedures or accurately coding (Braun and Clarke, 2019). This reflexive engagement with the data will be demonstrated in the account of the application of Braun and Clarke's (2006) six step guide to analysis below.

Familiarisation with the data

This is considered the first step of analysis and it started before the formal analysis, during the data collection phase. It involved familiarising myself with the data by listening to the recorded interviews, transcribing, and reflecting on individual interviews. This process helped me to start noticing things of interest earlier on in the research process such as differences between responses given by participants from different practice settings or different professional groups. Summaries of individual interviews reflecting my thoughts were made during this stage. However, Braun and Clarke (2013) warn that these things we notice straight away are usually a reflection of what we bring to the data and should not be used as the main or sole basis of the analysis. This was the case in my study as I found that the ideas that stood out

initially related to ideas I had come across whilst doing the literature review or the reading. I also noticed that I was bringing some judgements based on my experience and background as a mental health nurse and the fact that I knew some of the participants in a professional capacity (see example summary in Box 1 below).

Box 1: Reflecting on Dawn's interview

This was one of the most interesting interviews I conducted. I have known Dawn for a number of years in my capacity as link lecturer so I was hoping this would not affect our interview. Dawn is a very experienced nurse who has worked in various settings. This interview was very insightful and really helped me to see some of the things that shape nurse' practice. Dawn's responses showed that she has a very humanistic approach and can see the person behind the illness. She disclosed that she had a close family member who had a mental illness, and this appears to have really influenced her approach to patient care. Empathy and compassion permeated all responses. Dawn was able to put herself in the patients' shoes and to imagine what it must feel like for them. Dawn also disclosed a life changing illness that had helped her to see what it must be like to experience a life changing event. She related this to her patients' experiences, and it helped her to be compassionate. Key themes from this interview relating to the impact of mental illness were loss. Loss of identity, family, sense of purpose, future, place in society. Another theme was stigma which was then connected to the loss. She identified the role of services in recovery as being about empowering people to be able to lead fulfilling lives by having positive risk-taking approaches and positive optimistic attitudes on the part of staff. The importance of identifying patients' strengths and helping them to look forward to a future, being valued, feeling like they are of use, have a role in life. She highlighted the barriers to ROP a being pessimistic attitudes, focus on risk management, focus on service needs rather than individual patients' needs, restrictive practice and paternalistic approaches. Qualities such as being bold and able to speak up on the part of nurses were identified as being important to be an advocate

However, as I immersed myself in the data by listening and re-reading the transcripts, I started to develop themes. This immersion is important as it helps one to see more in the data (Braun and Clarke, 2013) and ensures the analysis is grounded and supported by the data (Spencer et al., 2014).

Initial coding

The second step in Braun and Clarke's (2006) guide to analysis is the development of codes. This was initially challenging as I was unsure about what a code was as it felt very much like an abstract concept. There are various definitions of codes in qualitative research literature (Saldana, 2009; Spencer et al., 2014; Braun and Clarke, 2013). However, Hennink et al. (2020) define codes as *"issues, topics or concepts that are present in data"* p. 218. Braun and Clarke (2013) further define coding as *"a process of identifying aspects of the data that relate to your research question"* p. 206. Coding serves two purposes, namely: capturing the emic perspective on the research questions and secondly, as part of data management by breaking it into smaller meaningful parts for analysis (Hennink et al., 2020). Both these purposes were pursued in this study.

Although it is argued that it is not possible to adopt a purely inductive coding process due to our own influence on the interpretation of the data (Braun and Clarke 2021), I made attempts to adopt an inductive approach to coding. This meant that although I had the research questions in mind whilst reading through the transcripts, I highlighted the parts in the data that would be relevant in answering the questions and labelled them according to the data rather than using pre-determined codes (Spencer et al. 2014). This approach has the advantage that it allows the participants' voices rather than the researcher's priorities to be heard (Hennink et al. 2020). This process of coding was time consuming as it involved reading the transcripts, making sense of what was said, reflecting and developing codes to capture the issue. An alternative would have been to use a deductive strategy where I would have predetermined codes based on my professional experience, the interview topic guide or literature which I would fit the data into. However, this strategy carries the risk of missing new insights the participants bring and defeats the purpose of qualitative research (Hennink et al. 2020). It is worth highlighting that even with the steps taken to ensure it was the participants' voices being captured, as a researcher I still had a lot of influence as I made the decisions about what to highlight and also the codes developed. Nonetheless, to further ensure the codes were as representative of the participants' voices as possible, in addition to the strategies outlined earlier in this section, mostly semantic coding was used. This meant that the codes were data derived rather than researcher derived codes (Braun and Clarke, 2013). In generating the codes, I therefore summarised what the participants said rather than putting my own interpretations as codes. See Table 8 below which shows examples of semantic codes and inductive approach taken to coding for Rachel, a rehab ward practitioner.

Table 8:Example of semantic codes

Data extract	Initial code
Rachel: …sometimes we have a lot of patients who remain on section 3 for quite a long time and that in the way... I suppose that's a barrier	Sections 3 of the MHA is a barrier
Rachel: …some people have a way of talking to patients that's a bit disrespectful and I find it is not encouraging it is more you do this at this certain time and have you had a wash you can't go out until you have had a wash and how many cigarettes are you taking out with you …	Disrespectful staff attitudes towards patients Inflexible rules Taking away patient autonomy - Restrictive practice

The first transcripts to be coded were a mixture across the rehabilitation ward staff and patients and the CMHT participants. After coding 5 transcripts, a pattern of coding was noticed, and I had a set of codes which were common. This made coding subsequent transcripts quicker as it became easier to notice and name the codes in the data. There were some differences noted across the different participant groups – so to capture these differences, new codes were developed in order not to lose any valuable insights from the participants. Although there are software packages for qualitative data analysis, these do not develop codes for the researcher. A decision was made not to use software and the coding was therefore an active process I conducted using the convert text to table function in Microsoft office word to create a table with columns for the codes. Doing this helped me to be closer to my data as I was constantly actively engaging with it. This also facilitated my reflection on how I was maintaining anonymity and realised that the rehabilitation ward manager would be easily identifiable if I labelled her as such as there was only one rehabilitation ward and one ward manager. A decision was therefore made to include the two managers' analysis with practitioners in order not to compromise their anonymity and confidentiality. Taking such steps is advised in case study research as there is a risk of participants or cases being identified (Simons, 2019).
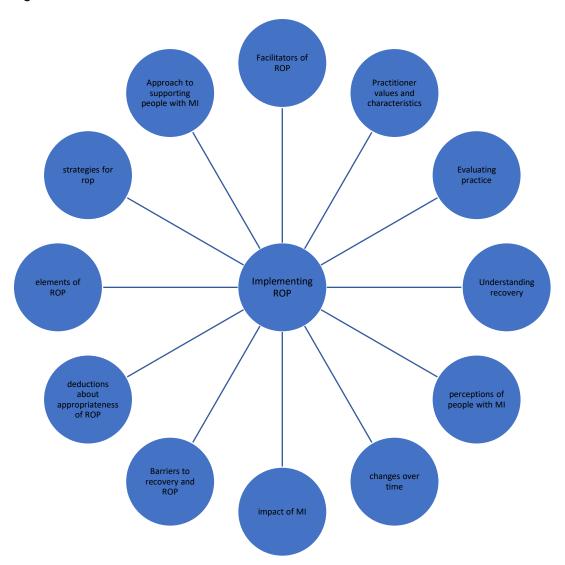
Searching for themes

After coding all the transcripts, all the codes were reviewed to identify and group together similar codes. Initially, this was done separately for each transcript, starting with the rehabilitation ward participants, then the CMHT and senior managers. Candidate themes were developed as shown in the example below. However, looking across the data from the different settings and participants, I noticed that there were some similar candidate themes.

Table 9:Example candidate themes

Data extract	Codes	Candidate themes
Mabel: Erm, not a lot of emphasis, I don't think, is being put on recovery and I think it's probably because people don't really understand what recovery is and [ward name] for a long time, it still is a little bit more of a long stay ward than a rehabilitation ward and we've got patients who have been on the ward for, some people, for about eight years on the ward, which makes it more of a long stay ward than a rehabilitation ward…	recovery is not emphasised Lack of understanding of meaning of recovery The ward is not fulfilling the purpose it is supposed to serve	Barriers to the implementation of ROP
Mabel: I guess one of the most important things is building a rapport or a relationship with the person to understand what works for them	Importance of building a relationship. Respecting individuality and individual preferences	Approach to supporting people with mental illness

After reviewing the candidate themes for each transcript according to setting and participant group, twelve candidate themes which captured the essential meaning of the data and allowed comparing and contrasting between participant groups and setting were developed. These are represented in the diagram below.

Figure 6:Initial candidate themes

Reviewing themes

After identification of candidate themes for all transcripts, all the extracts and codes from the same candidate themes were grouped together according to setting and participant group (see Appendix 17 showing extracts from CMHT practitioners for the candidate theme "Barriers to ROP) to make comparisons and to identify any differences and similarities as part of the more

in-depth analysis. These groupings were further reviewed to capture the essence of the candidate themes and to also identify how the candidate themes related to each other to further refine the themes. This process took some time as it was vital not to lose important information and to ensure the candidate themes that would help to achieve the research objectives were kept.

Initial review of themes

Table 10:Initial review of themes

Theme	Candidate theme
The evolution of mental health care	Changes in MH practice over time
The meaning of recovery and ROP– staff and patient perspectives.	Understanding of recovery Impact of MI Deductions on the appropriateness of ROP
What needs to be in place for ROP to be implemented	Practitioner values and characteristics Approach to supporting people with MI Facilitators of ROP Perception of people with MI
What they do to promote recovery	Elements of ROP Strategies for implementing ROP Evaluating ROP
Barriers and challenges to the implementation of ROP	Barriers to recovery and implementation of ROP

Defining and naming themes

Braun and Clarke (2006, 2013) encourage ongoing analysis to refine the themes, to name them and to generate clear definitions of each theme. This iterative process was conducted for this study, and it involved going back to look at the research question and the objectives

of the study, assessing which themes would best tell the story of how ROP was being implemented in the CMHT, the rehab ward and the Trust. This process was challenging as I kept on asking myself if I had chosen the right codes and the right themes. However, I had to remind myself that inter-rater reliability was more of a concern in quantitative studies and that for my qualitative study, what was more important was to ensure I was transparent about how I arrived at the themes and that the story the analysis told was as representative of what the participants said as possible (Spencer et al., 2014). At this stage, an initial finding report with the themes shown in the table above was written and shared with my supervisors. They came back with questions, and we had a further discussion during supervision which resulted in me re-visiting the themes and refining them further. For example, one of the questions related to the role of the relationship in implementing ROP. It was apparent in my initial write-up that the relationship played a central role and yet I had not included it as a theme. Therefore, further reading of the initial analysis including the data extracts and codes led to the development of a thematic map (see Appendix 18) which was a visual representation what the data was telling me were the important factors in implementation of ROP and their relationships (Freeman and Sullivan, 2019). Based on this iterative process of reviewing the data, the research objectives, and the themes, three overarching themes and seven sub-themes were identified. Sub-themes are essentially "themes within a theme" (Braun and Clarke, 2006 p. 22). These helped me to breakdown and structure the two and complex themes I had in a way that allowed me to tell a coherent story based on the data (Freeman and Sullivan, 2019). Brief summaries of the scope and content of each theme were written as a way of testing whether identified themes at this stage were refined and clear (Braun and Clarke, 2006). Furthermore, in naming the themes, I ensured that theme names were concise and would give the readers an idea of what the theme was about (Braun and Clarke, 2006). See Table 11 below showing themes and their descriptions.

Themes and theme summaries

Table 11:Themes and theme summaries

Theme and sub-theme	Description of scope and content
1. The meaning of recovery and ROP	Provides a foundation for the rest of the analysis by giving an overview of participants' understanding and interpretation of recovery and ROP based on their experiences and perceptions.

2. The therapeutic relationship as the vehicle for ROP • *Values, the lens through which practitioners view service users* • *The process of building the relationship* • *The nature of the relationship* • *Drivers for collaborative relationships*	Establishes the therapeutic relationship as the channel through which ROP is implemented at the micro level and explores factors that influence the relationship.
3. Constraints to the implementation of ROP • *Limited resources* • *Risk management* • *Between a rock and a hard place*	Describes what participants viewed as the challenges or hindrances to the implementation of ROP.

Producing the report

The final stage in Braun and Clarke's (2006) guide to thematic analysis involved writing up my themes, including choosing extracts that would best tell the story from the data set. As stated by Spencer et al. (2014), analysis is never fully complete until the report is written and finalised. I found this to be true as I continued to reflect on the themes and to make comparisons between what I had found in the CMHT, rehab ward and across the different participants. All these reflections informed how I told the story of the participants in the final write up of the findings. In addition to this, decisions around which data extracts would be included in the write-up were made. The chosen extracts had to bring the themes to life, evidencing that the themes were indeed data derived. Fortunately finding them was made easier by the fact that during the coding and development of the initial candidate themes, extracts had been included and these were organised according to participants, their role and setting. Furthermore, going through the transcripts in the way that I had done during earlier stages had indeed given me intimate knowledge of my data.

Reflection and summary on analysis

In summary, using the six-step guide from Braun and Clarke (2006) helped to structure my analysis and to be more transparent about the steps I followed, and the decisions I made at each stage. However, as stated at the beginning of the analysis section, analytic sensibility was practiced throughout and at each stage I made decisions according to what I thought would help to achieve the research objectives (Braun et al., 2017). Furthermore, I took into consideration Braun and Clarke's (2019) reflections on the evolution of their ideas on TA to ensure any ideas that could improve the quality of the analysis were incorporated. Firstly, my philosophical assumptions, the qualitative paradigm informing the case study and how they

align with reflexive TA were made clear. Reflections on my role as the researcher and the acknowledgement of the subjective nature of the process undertaken despite attempts made to remain as grounded in the data as possible were also clarified throughout. Finally, the practice demonstrated at each stage of the analysis reflected the ethos of reflexive TA which is about me as a researcher being cognisant of my role in the production of knowledge. The report of the analysis is presented in the next chapter. It reflects the participants' voices, mediated by my philosophical assumptions, my knowledge and experience and my analytic skills.

Conclusion

This chapter has presented a detailed account of the philosophical underpinnings of the study, the cases being studied, the participants and the methods followed to collect and analyse data. The details of the data analysis including rationale for choice of method and the steps followed to arrive at themes have been provided. The chapter has set the scene for the next chapter by introducing the findings from the study. The next chapter will therefore provide a detailed report on the findings, exploring the themes and situating them in the interview data.

Chapter 4: Findings

Introduction

The previous chapter introduced the three themes that were identified during analyses of the data from the rehabilitation ward, CMHT and senior managers namely: The meaning of recovery, The therapeutic relationship as the vehicle for ROP and Constraints to the implementation of ROP. Seven sub-themes were presented as: Values, the lens through which practitioners view service users; The process of building the relationship; The nature of the relationship; Drivers for collaborative relationships; Limited resources; Risk management and Between a rock and a hard place. This chapter further expands on the previous chapter by presenting a synthesis of the findings under the identified themes. As pointed out in the previous chapter, the analysis process was influenced by the lens through which I was looking at the data. Therefore, to promote transparency, direct quotations have been used throughout to provide evidence from the data to support the assertions made in the findings.

Theme 1: The meaning of recovery

A decision to explore participants' understanding of recovery was made following suggestions in the literature that recovery was not well understood and had multiple meanings. It therefore became apparent that to set the scene and to ensure clarity, it was vital to establish participants' perceptions and understanding of recovery before exploring how it was experienced and implemented in practice. This theme therefore gives an overview of participants' understanding and interpretation of recovery based on their experiences.

Data from the interviews with service users, practitioners, managers and senior managers confirmed that there were various conceptualisations of the term recovery. Practitioners, managers and senior managers pointed out the fact that recovery meant different things to different people:

> Monica (rehab ward practitioner): *"Well I've got my definition but then every person involved with mental health services has their own definition and every single patient has got their own definition."*

Theo on the other hand highlighted the wide range of things recovery refers to, revealing her understanding of the different facets to recovery:

> Theo (rehab ward practitioner): *"I think for different people it will be about having relationships back with family and friends for other people it'll be about their symptoms for other people it will be about not being in hospital for other people it'll be kinda their confidence self-esteem having control over their own lives I think it's completely*

individual so it's hard to say that one factor that's kinda the same for everyone because its dependent on the person."

Community mental health team practitioners and senior managers also held similar views and pointed out the importance of recognising that recovery does not mean the same thing for everyone:

John (community practitioner): "*Erm… I think there's my view of what I would consider recovery to be if it was applied to me personally, then there's a kind of recognition that other people might not agree."*

However, despite these variations in the definitions of recovery, there was a general consensus that recovery was not about the absence of symptoms. Participants acknowledged that it was sometimes not always possible to get rid of the symptoms entirely due to the complex nature of factors that contribute to the development of mental illness:

Ruth (community practitioner): "*… it's not really about the cure, it's… People go "oh, well I need to be cured". Well, I can't take away what you've been through in life; I can't change what you've been though in life."*

Practitioners and senior managers however pointed out that what was important in recovery was the patients' quality of life and their ability to fulfil the roles they regard as important to them:

Nancy (Senior manager): "*…I think recovery is what an individual considers themselves to be in when they live the life they want and the quality that they want and that will vary enormously from what I want, what you want, what somebody else wants can be extremely different… I guess it is about feeling like you have the quality of life you want, you are able to fulfil your role in life whether as a parent, partner, friends whatever that you are able to fulfil your role and that you are able to pursue the things that you want to personally."*

Practitioners highlighted indicators of quality of life that ranged from internal factors such as, being happy, having a positive outlook and external factors such as housing, relationships with friends and family, having things to look forward to, having a job and having the same opportunities as everyone else. They also described some characteristics of a patient in recovery. These characteristics mainly related to autonomy, having control over one's life and having the ability to choose:

Mabel (rehab practitioner): *"[…] someone who is doing what they want to do; someone who has the freedom to make choices. Someone who's not afraid to make mistakes; people do make mistakes."*

These responses from practitioners showed that there was a shift in the meaning of recovery from clinical recovery to personal recovery in this practice context. Interestingly however, although service user participants also had varying definitions of what recovery meant to them, they all seemed to associate it with symptom remission. This was evident in Ken's response when he expressed that he would never recover due to the poor prognosis associated with a diagnosis of schizophrenia:

Ken (rehab service user*) "[…] well not really someone told me you can't be cured from schizophrenia"*

The importance of the alleviation of symptoms was also expressed by Jerry (community service user) when he was talking about the meaning of recovery to him:

"[…] mainly it's about being stable being stable not going into hospital". Ken (rehab service user) echoed these sentiments: *"([…] I think it's about just feeling better and taking my medication…: not feeling depressed.*"

Furthermore, some service users associated recovery with going back to their premorbid state:

Nelly (rehab service user) *"…so it is getting back to how I was, being myself"*.

This reinforces the observation that service users placed importance on clinical recovery. It appeared from the conversations with service users that symptoms of mental illness caused them distress hence the importance placed on being free from them. Tim (community service user) described his experience and what recovery for him would mean:

"[…] anxiety is the worst thing with these kinds of illnesses, 'cos you get this dreadful feeling that you can't shake off very easily… But I think recovery means freedom from most of that. There's still a bit going on, but… Not the end of it, but the manageability of it."

Listening to the accounts of given by service users in relation to the suffering and bondage caused by symptoms of mental illness, it is understandable that they regard symptom management as an important part of recovery. Service users talked about experiencing loss, social isolation and stigma due to mental illness:

Jerry (community service user) *"…it's been a long journey I've lost family have lost everything they see you as different family I mean family your dad and everything they look at you as an embarrassment"*

Tim spoke about feeling like an outcast and how he was missing out on things that would be considered normal life. He expressed feeling like a victim of the illness:

Tim (community service user) *"The way I feel is, I feel like I've kind of been dumped out of society, almost. Everybody else is doing all these great things, you know, and I'm stuck in this flat or house, you know… Erm, even though I said I am kind of enjoying my life at the moment, but yeah, it's important to know that you're still part of the world, you know, even though you're not working or you don't have your own family or… Yeah, sometimes I wonder: why on earth did I end up in a place like this? You know? The position that I'm in. I just don't know. It's weird. How come everybody else has got this, that, and… You know? It's really quite upsetting at times."*

These responses clearly highlighted the negative impact of mental illness on the individuals. In addition to this, they showed how mental illness had changed the trajectories of their lives and how helpless service users felt having to adjust their life goals to cope and move on with their lives. There was some evidence that although practitioners considered the ability to set new goals and "live with the illness" as recovery, for service users it appeared to be a position they considered as a compromise as they had no other choice. Their responses in some cases reflected their perceived loss of control, low expectations of themselves and pessimism resulting from their experiences of mental illness as evidenced by Tim and Jerry when talking about why they were unable to work:

Jerry (community service user): *"[…] then when you get ill, they take your licence because you can't drive because of the medication and then you are in [name of mental health hospital]"*

Tim (community service user): *"I think I might antagonise people if I worked in a full-time job, because I wouldn't; be able to perform to the level I'd like to be, because I know what I'm… As I say, I know what my limitations are. And with this type of illness, you live with it; you don't get rid of it, you just live with it."*

Given the impact service users associated with symptoms of mental illness it is not surprising that stabilising them was viewed as vital in order to achieve other aspects of recovery such as relationships with family, having somewhere to live and such things. Interestingly, although practitioners suggested that recovery was not necessarily about absence of symptoms, there

was evidence that they placed a lot of importance on the role of medication in recovery. Particularly doctors seemed to view managing the medication aspect of care as an important aspect of their role:

> Monica (rehab practitioner) *"[…] I would like them to have the mental state it doesn't have to be completely perfect but it should be one that they can live with and doesn't cause them distress and doesn't put them at risk so I so I try to optimise the mental health and mental state through whatever treatment we've got on offer so I kind of think as a doctor that's my core responsibility".*

Practitioners' responses also highlighted the time taken focusing on stabilising symptoms using medication as suggested by Dawn:

> Dawn (rehab practitioner*) "[…] I was sort of saying that people when people come into hospital sometimes I think the focus is very much on medication and on that type of treatment and how to get the right balance sometimes a lot of time is spent trying to find the right formula"*

John also emphasised with the importance of getting the balance with medication right, highlighting the effort that was put into trying to ensure symptoms were managed whilst also prioritising the service users' quality of life:

> John (community practitioner): "*So it's not necessarily, um, not necessarily getting rid of all symptoms all the time, especially if to do that, you might have to leave somebody feeling like they've been crippled by side effects from all of the medication that they're on."*

Although there seemed to be a consensus that recovery was about having the quality of life one desired, there seemed to be a lack of clarity about practitioners' role in relation to promoting recovery. There were suggestions that the confusion sometimes led to the neglect of patients as expressed by Mabel (rehabilitation ward practitioner):

> *"… I think it's probably because people don't really understand what recovery is".*

There seems to be some confusion about what it means to give the patients more control which at times then leads to neglect of the patients in some cases as highlighted by Mabel*:*

" […] There is a tendency to go the other way as well, so from being really really controlling to almost not doing anything at all, […] That we've said: well, no, let the patients take control. You can't go and do everything for them. To a point where people have said "well, we're not

doing anything at all for them" and then we are just self-neglecting… We are neglecting them, rather and I'm finding that quite difficult."

This theme has provided a backdrop against which the exploration of how ROP is implemented can take place as it has illuminated the participants' understanding and conceptualisation of recovery. In the context of this study, it can be argued that although participants had various definitions of recovery, there was a consensus among practitioners that recovery was not necessarily about absence of symptoms but was about having a good quality of life where one could practice autonomy. On the other hand, service users pointed out how mental illness had taken away their citizenship and mainly associated recovery with alleviation of symptoms and easing of suffering caused by distressing symptoms. The recognition of the importance of managing symptoms as part of ROP was highlighted.

Theme 2: The therapeutic relationship as the vehicle for ROP

When participants talked about their experiences, the central role played by the nature of the relationship between service users and practitioners and the various factors that feed into this relationship became apparent. This overarching theme therefore explores how ROP was implemented and experienced through the therapeutic relationship. Three sub-themes (Values – the lens through which practitioners view service users, The process of building the relationship and The nature of the relationship) break the theme down into its different components to elicit a more in-depth exploration.

Sub-theme 1: Values – the lens through which practitioners view service users

Of note in the responses from participants was the evidence that there were fundamental values impacting the nature of the relationships between practitioners and service users. It was apparent that the practitioners' values influenced their perception of people with mental illness and in turn shaped how they related with service users. Values such as treating people with respect and dignity and the idea that one should treat others as one would like to be treated were commonly held maxims across the different practice settings:

> Rachel (rehab practitioner): *"[…] the main thing that I believe is to treat other people like I how I would like to be treated myself umm I always try to be as honest as I can be with people but without being blatantly rude"*

> Ruth (Community practitioner): *"… I mean, the same as you would expect to be treated yourself, so with respect, with dignity, erm, and with where they want to be in society in mind …treat others as you expect to be treated yourself."*

Theo also stated: *"treating people with respect and kind of how you would want to be treated so that continually thinking about how you work with people if it was a family member having similar treatment would you be okay with it"*

Practitioner responses also evidenced a link between individual values and professional values:

"*My values are very much about wanting to enable people to have self-determination and control over their own lives and I think part of that is about making sure that people have the right information and certainly within social care – which is what I do."* (Jane, CMHT practitioner)

The responses showed that empathy played a central role, allowing practitioners to adopt a humanistic approach in their practice. This demonstration of empathy and genuine concern was also highlighted by service users when talking about their positive experiences of care as exemplified by Tim's response:

"*Most psychiatrists talk about "how are you?" And you know, "are there any side effects of the tablets?" And you think: oh, I've heard all this before, you know. But I remember one of them said "[Name], are you suffering?" And I said "No, doctor". And he was ever so pleased; you could tell he was pleased. He was worried that he wasn't helping me enough…"* Tim (community service user).

Whilst practitioners talked about their individual values, senior managers also referred to the organisational values and how they shaped the approach taken by practitioners. Senior managers suggested that organisational values shaped the care delivered as they were implicit in all the processes of care through things such as Standard Operating Procedures, policy, guidance. Although practitioners did not explicitly talk about the organisational values and their influence on their practice, it was apparent that there was a common understanding that service users' safety was a priority and that they were to be involved in their care, treated with respect and with a caring attitude. This came across in all the interviews suggesting that it was something engrained in day-to-day practice and part of the organisation's culture.

In addition to this, there was a suggestion by practitioners that values did not exist in isolation and that the practice context also had an impact on how practitioners related with service users. Practitioners suggested that the ward environment was more restrictive and could hamper their ability to show respect to patients. Some community practitioners cited that as the reason for their choice to work in the community as stated by Ruth:

> Ruth (community practitioner): "*I prefer to work in an environment where you're going into people's homes; you treat them with that level of respect; you treat them as you'd expect to be treated yourself and I've just always worked better in that regard… it's not that people don't; treat people with respect in the wards, but I think because people, are so unwell, because they're out of their own environment and in a ward setting, you do treat people differently and that's why I've never wanted to work on the ward*"

Responses by some of the rehabilitation ward practitioners regarding how some staff related with service users on the ward seemed to support the idea that the ward environment could lead to more paternalistic approaches.

Further to this, some subtle differences were also noted between community practitioners and ward practitioners. For example, community practitioners mostly referred to their service users as clients whilst ward-based participants referred to them as patients. This stood out as I was analysing the data as the word client is often associated with being a customer or an individual paying for a service which is a position that comes with certain assumptions about how an individual should be treated. This suggests that although similar values are held by practitioners in different settings, there may be fundamental differences in how service users are viewed when in the community and when on the ward which could potentially influence the nature of the relationship.

Based on observations made during interviews with service users, it could be argued that the mental state of the service users plays a role in the nature of their relationship with practitioners. It was observed that compared to community service users who took part in this study, rehabilitation service users seemed to be experiencing more severe symptoms resulting in them lacking motivation, struggling to concentrate and finding it difficult to articulate themselves well. This could mean that to a certain extent, the nature of the relationship rehabilitation ward staff had with their service users needed to be different as they took on the role of a helper taking the lead as that was what was required due to the severity of the symptoms. Rehabilitation ward service users talked about valuing practitioners doing things with them and helping them – suggesting a level of reliance on staff.

Sub-theme 2: The process of building the relationship.

Apart from the observation that practitioner values and context of practice seemed to influence the nature of the relationship between practitioners and service users, it was apparent in the data that practitioners followed a systematic approach in building relationships facilitative of recovery. There was evidence that this was done using different interpersonal skills such as the use of good communication skills. Listening was highlighted as an important skill as

evidenced by Theo (rehabilitation ward practitioner) when talking about her practice and how she engaged service users:

> *"kinda listen to people that whole kind of active listening and really trying to understand someone and where they're coming from."*

Practitioners also talked about how taking time to get to know the service user helped them to be effective in discussions about goals for recovery. They pointed out how spending time allowed them to encourage service users and empower them to fulfil their potential. Service users' responses also supported this:

> Ken (rehabilitation ward service user) *"…when the nurses talk to me and put my mind on other things or go with me for a walk that makes me feel quite optimistic…"*

There was evidence that service users viewed interactions with staff as an essential part of what practitioners should do to provide appropriate support:

> Jerry (community service user): *"[…]another thing I don't agree with is when we used to have one ward rounds and then all the doctor does is go by notes he's never come to my house once they rely on (care coordinator's name)'s notes …yes doctors and GPs rely on other people's notes they really should come out of the office and come down and have a cup of tea with the patients Or walk to the shop with them and see how they they react or come to the flat not just going by notes notes notes…"*

Furthermore, when talking about good experiences of care, service users also cited talking to staff as stated by Ken, a rehabilitation ward service user:

> *"[…] well when the nurses talk to me that's really nice all of them are very very friendly and very helpful but some of them they will say good things about you that make you feel good about yourself".*

There was also a suggestion that staff spending time with the service users helped to maintain stability in the community. Jerry (community service user) attributed his ability to remain stable in the community to the time spent with his care coordinator:

> *"[…] I have not been sectioned I have not been sectioned since I've had [care coordinator's name] I swear that man will come round to your house at 5:30 and stay there until 8:30 at night that man is a different CPN I've never had a CPN like him never never in my life."*

Responses from practitioners suggested that spending time with service users was a deliberate and well thought out strategy to help to build therapeutic relationships:

> Theo (rehabilitation ward practitioner): *So to begin with there was a lot of me actually spending time with her when she was on a different ward to get to know her and to build a rapport to figure out what she liked and didn't like umm...what her hobbies, interests were who she was as a person …"*

This in turn promoted relationships where there was understanding, genuine concern and mutual respect as demonstrated in the account given by Jerry (community service user) when talking about his experiences of care:

> Jerry: "*I had respect for her. I've had respect for that woman ever since she took me out many times and we never had a problem it's not like nowadays with all this agency staff they don't know about patients and don't know about certain things about patients to be able to care for them in the way that they are supposed to."*

This suggests that getting to know the service users was of vital importance and taking the time to do so was appreciated by them:

Another strategy for building the relationships highlighted by practitioners was the use of self-disclosure:

> Ruth (community practitioner): "*I give something of myself. I mean, different people, different things. I've never had a problem with clients knowing something about me. …I think that makes it easier for them to feel able to open up to me, because if I'm not prepared to give anything of myself, then it's very hard to expect them to tell me everything about them and I think it's everything within reason."*

Self-disclosure was viewed by practitioners as a way of promoting reciprocity and allowing connection on a human level. However, this had to be done carefully to maintain professionalism as pointed out by Theo:

> "*[…] being able to be open and honest with people about experiences obviously whilst maintaining your professional boundaries but being able to kind of give that support to someone just being able to interact on a human level."* Theo (rehabilitation ward practitioner).

In addition to the use of self-disclosure to build recovery facilitating relationships, practitioners also pointed out the importance of establishing mutual trust within the relationship. Practitioners suggested that to be recovery-focused, there needed to be respect for the service

users' preferences and also trust. An example given by Bob (community mental health practitioner) showed how progressing from supervised medication to self-administration required the practitioner to trust the service user. Bob suggested that this trust had to be mutual with both client trusting clinician and the clinicians trusting the clients:

> Bob: "*… and, I suppose to a certain extent, we mentioned earlier about trust and people… You know, trust in us, it's about doing it the other way. You know, trust in them as well. I still have no idea, the four days that we don't see him, whether he's taken his medication or not.*"

However, it was not always easy to trust the service users and to hand over responsibility especially where there were differences in opinion:

> Monica (rehabilitation ward practitioner): *"[…]to me being recovery focused is it difficult sometimes because you have to give up some responsibility you have to sort of think well I think recovery is this but what we are doing is what the patient thinks recovery is and we've got to try and reach a compromise so you have to kind of hand over some responsibility which is quite tricky sometimes and you have to accept that somebody else's view of getting better may be very different from your own view of getting better and that can be quite difficult but it is about accepting because that's what the evidence tells us which tells us that when people get what they feel is important that they will have a better quality of life."*

Practitioners sharing these experiences shows how ROP has required a shift in the nature of the relationship between practitioners and service users. This is particularly in relation to the power balance. Participants' responses showed that the recognition of service users' position as experts by experience had to be deliberate on the practitioners' part as the natural inclination seemed to be that practitioners knew what was best for the service users.

Sub-theme 3: Nature of the relationship

It was apparent from the responses given by participants that the nature of the relationship between service users and practitioners was a facilitative and supportive one. Practitioners adopted a solution focused approach and worked in stages with service users in order to achieve the service user's bigger goals. Practitioners evidenced that they involved service users in their care prioritised the service users' preferences. As part of their role, practitioners encouraged service users and supported them to overcome obstacles in order to achieve their goals:

Kate (community practitioner): *"[…] work's really important to her, so what could we work on together to make that a more realistic achievement? So, we did things looking at kind of being able to establish a routine and then doing some voluntary work and those sort of…, so it was not saying… Not sort of disheartening her, I guess; not saying, you know, working would be a ridiculous goal to have and that's not… 'Cos it wasn't ridiculous; I would never say that to someone and I would never think that for someone; it's not achievable right now, but that's what you really want to do, so how do we take steps to get there?"*

Mabel (rehabilitation ward practitioner): *"I could give an example of someone who is… who really loves horses. She's got OCD and it's quite crippling for her and there are a lot of things that she can't do but she's identified that she has a love for horses and we are looking at supporting her to go and do some voluntary work, working with horses…"*

Responses evidenced that practitioners had to have a positive and optimistic outlook coupled with believing in the potential of the service users they were supporting in order to keep the service users' dreams alive. Participants used words like "we" which suggested that a partnership approach was being adopted.

Service user participants valued the supportive nature of their relationships with the practitioners but also seemed to get some reassurance from knowing that certain things they struggled with could be done for them. For example, in Jerry's (community service user) case:

"[…] it's like when I get a letter and I don't understand it [name] will come around and make phone calls or I bring it here for [name of care coordinator]."

Although practitioners viewed their role in the service user's lives as being about supporting them to be able to achieve their goals and ultimately, to be independent of services, it seemed there were various other drivers at play. Conversations with senior managers revealed that the desire to empower service users to be independent of services may not have been based purely on services users' interests. There was a suggestion that this way of working was necessary as there was a shortage of services for people with mental illness due to budget cuts. It was also highlighted that services could not sustain the level of demand, thereby necessitating the need for service users to be able to manage on their own:

Nancy (senior manager)*: "I think to an extent we have suffered hugely in terms of resources which meant that people have had to sometimes take more control whilst in the past we used to have day centres where people used to go to for years and we do not have those facilities now"*

In this context, the importance of establishing empowering relationships that would enable service users to be independent of services was emphasised:

> Nancy (senior manager): "*…ultimately the right way to care for people is to help them to care for themselves and to build the network and support that they need of varying kinds because because we cannot be there for them forever…in order to make people resilient for the long term they need to learn how to do those things for themselves and they need to fail sometimes and sometimes they need to fail with the medication as well which is really hard to accept but that is their right to do so.*"

Sub theme 4: Drivers for collaborative relationships

To add on to the above, further drivers for collaborative relationships were identified. Conversations with senior managers highlighted the fact that the shift to more collaborative relationships between practitioners and service users was widespread and went beyond their organisation. Drivers on a national level that were cited included the availability of information due to advances in technology and users of services having access to information. It was pointed out how the expectations of people accessing healthcare services had been changing over the years particularly, the expectation to be involved in their care. There is also now a requirement by monitoring organisations such as the Care Quality Commission (CQC) that there is evidence of collaborative relationships between staff and service users and where paternalist practices are observed, organisations are expected to address such practices. As evidenced by senior manager Ronnie when talking about actions they had to implement following a CQC visit:

> Ronnie (senior manager): "*…if you saw the change in what we do it was largely moving away from paternalistic restrictive practice to collaborative patient centred practice which is recovery.*"

This requirement had prompted measures to be put in place from a strategic level to ensure promotion of collaborative relationships where service users were valued as active participants in service planning and delivery. At Trust level, efforts were being made to shift the culture to that of coproduction. Some of the interventions cited included the Trust engaging the organisation called Implementing Recovery Through Organisational Change (ImROC) in order to support them to introduce a Peer Support Worker programme and also Recovery College which are both well-known strategies for promoting a culture of co-production and partnership working:

> Ronnie (senior manager): "*…So Recovery College is an education-based approach helping the individual to live the life despite the ongoing experience of all past*

> *experience of mental health difficulties and it is based coproduction so that's a key tool in trying to change things this is culture shift as well so it is a shift for a lot of us to think in this way."*

Overall, the senior managers expressed a desire to ensure a culture of partnership working and coproduction was embedded in their organisation. It is therefore not surprising that throughout the interviews with staff, it was apparent that there was an emphasis on promoting collaborative relationships with the main goal being to respect and support goals based on the service users' preferences and priorities.

Theme 3: Constraints to the implementation of recovery-oriented practice (ROP).

Another theme identified in the data was about perceived barriers to the implementation of ROP. Although staff highlighted the importance of the relationship in the implementation of ROP, it was apparent in the data that there needed to be structures and processes in place to support the development and maintenance of recovery promoting relationships. This theme therefore highlights the areas practitioner participants felt were hindrances – making it a challenge for them to work in a recovery-oriented way. Three sub-themes, all relating to systemic constraints were identified and will be explored below.

Sub-theme 1: Limited resources

Whilst interviews with senior managers suggested that the implementation of ROP was viewed to some extent as a way of reducing the strain on resources caused by high demand for mental health care, participants suggested that ROP required more resources. The lack of resources was one of the most commonly cited barriers to ROP cited by participants. Staff responses suggest that in their experience, there had not been enough resources provided in order to allow them to work in the way they would view as ROP. There were some differences between the nature of resources mentioned by the community practitioners and those by rehab ward practitioners. For example, rehabilitation ward practitioners mostly cited the lack of facilities to support service users to develop, maintain or improve their daily living skills. As Mabel, a practitioner from the rehabilitation ward pointed out:

> *"…but we are very limited in terms of resources and what we can provide for the patients. For example, our kitchen isn't our ideal kitchen, it's like a gallery kitchen; it's really tiny and we can only get one person in there to do cooking at a time."*

On the other hand, community staff mainly highlighted staffing issues as a barrier. Practitioners suggested that there was a high demand for support in the community leading to services not being able to meet the demand. As stated by John (community practitioner):

> *"So we have a lot of patients who are all being managed under the care programme approach and the caseload of our care coordinators has really become too high."*

Ruth (community practitioner) echoed this observation and alluded to the strain the demand was causing:

> Ruth: "…*but it's the state of the services as they are at the moment, unfortunately…There are so many people in need and only so many workers and you have to kind of spread yourself, so that you can provide to the many.*"

Staff suggested that these problems were being caused by cuts in the NHS in general and that the issue of demand exceeding capacity was more widespread:

> Kate (community practitioner): "*The reduction in resources has had a significant impact. I think it makes it more and more difficult, because I think that workers are more and more stretched. I guess, I'm talking about reduction in NHS budgets overall, so I think that everyone's more stretched and I think that means the time that people have got to devote to the work that they're doing, the service users, is compromised.*"

It was suggested that the shortage of staff was leading to the quality of care being compromised as staff had less time to spend with service users. Community service user responses also indicated that they too were recognising and feeling the impact of the shortage of resources as evidenced by Tim, a community service user:

> "[…] *you don't sit down with someone and talk about your experiences. It's all done with pills, really. You know, I had to spend probably about £250 on fees to Mind… But [name of worker] comes around to my house maybe once every couple of months, … And I think services are a bit stretched.*"

Community practitioners expressed how the need to keep up with the demand for services was compromising the quality of care and contributing to a revolving door:

> Ruth (community practitioner): "… *it's providing the maximum amount in the minimum time to get people moving forwards, so kind of in, on feet, out; in, on feet, out… And literally just propped up on feet prior to going out…so you do then have to look at: well where are clients on my caseload and can they be discharged? Which is hard, because some of them probably could do with a bit longer but don't get that and have to be discharged sooner, which I think can set some up for relapse when perhaps that might not necessarily have been the case had they had a lot longer with us.*"

Service users' experiences reflected some of the problems highlighted by staff. They found that practitioners focused mainly on routine questions relating to medication and there was an absence of a more holistic approach that would encompass other aspects of the service users' lives in order to support recovery:

> Tim (community service user): *"[…] there's not been any assessment of my life as a whole to actually, erm… The assessments that have taken place are always the same. You know, "how are you? Are you feeling alright? Are you still taking the tablets...?" You know. That. But what they could do... they could analyse all the things you're doing in your life at the moment and then work out what extra things could be added on to fulfil your dreams or desires on a day-to-day level."*

These responses suggest that for community practitioners, there was a disparity between their ideal practice and their real practice due to the constraints staffing shortages presented.

Senior managers also indicated that they recognised the challenges the shortage of resources presented. Unfortunately, some of the strategies employed to address the shortage of staff seemed to present unintended consequences. In particular, the employment of agency staff which was felt to not be ideal as it hindered continuity of care and was not conducive for the building of therapeutic relationships:

> Ruth (community practitioner): *I think in our team, again, with the staffing numbers, because that's then meant that we've had a lot of locums and the locums have only been working for set periods of time, which has meant clients have had stop/start, stop/start, getting to know different care coordinators and I think that's hindered the recovery process for them because they don't have that continuation with somebody."*

> John (community practitioner): *"Well, it's partly an external pressure; partly internal, erm, that makes it hard to take a recovery focus is over-reliance on locums, both medical and in other professions as well. Er, because of, say if we rely too much on locum care coordinators, then erm, you, if you only get to know your care coordinator for two months and then they disappear and you have a new one, you're constantly just in that process of getting to understand each other."*

Service user responses also showed the negative impact of having agency staff and the negative impression service users had based on their experience with agency staff. Jerry (community service user) summed up his opinion on agency staff:

"[…]some staff some staff are full of shit especially the agency staff all agency staff want to do is clock up hours they don't want to get involved when you've got normal staff you get to know them you know…".

His assertions suggested that there was suspicion around the motives and priorities of agency staff and that there was belief that they did not care about the service users. This lack of trust would in turn lead to challenges in building a therapeutic relationship facilitative of recovery.

Interestingly, all these observations were made in the community. Rehabilitation ward participants did not raise these challenges suggesting that these issues were context specific to the community setting. This may be indicative of the impact of the shift of most of the mental health service provision into the community.

Sub-theme 2: Risk management

On the other hand, risk management was cited as a barrier in both the community and inpatient interviews with practitioners and senior managers. Interestingly, service users did not really delve into risk and its impact on their recovery. However, community team and rehabilitation ward practitioners identified different factors in their practice contexts that made risk management whilst promoting ROP a challenge.

Community practitioners attributed the focus on risk management to shortage of staff. There was a suggestion that the shortage of staff made crisis management the focus and priority in their day-to-day work:

Jane (community practitioner): "*The work here is very crisis management-driven… so I think all the things that don't seem like an immediate priority; keeping people safe, you know, they're just kind of lost.*"

Furthermore, practitioners expressed an element of being helpless in the situation as the shortage in resources led them to focus on risk management which was not their preference as they would have preferred to spend more time working on recovery goals:

Kate (community practitioner): " *I think sometimes that means that people will focus more on risk and things like that rather than giving as much time to someone as they'd like to, to be able to do a really good recovery-oriented piece of work I think it's not that people don't want to do that or don't value it or see it as important; I think that they feel very compromised in what they can achieve within the time that they've got.*"

Whilst community practitioners attributed the focus on risk to shortage of staff and increased demand on services, rehabilitation ward practitioners suggested that there were inherent

anxieties around risk and its management on the part of the practitioners in general. Participants suggested that achieving the right balance between managing risk and promoting recovery was a challenge as stated by Monica (rehabilitation ward practitioner):

"Risk and having to balance risk with people reaching their kind of goals so that's always an issue".

Rehabilitation ward practitioners also indicated that they were aware of the negative impact of risk aversion on recovery as evidenced by Dawn (rehabilitation ward practitioner):

 "[…] if you are too risk averse then people won't learn people won't be able to move on they won't have a chance to be independent again".

Theo (rehabilitation ward practitioner) echoed these sentiments: *"[…]: that kind of oh we shouldn't be doing this or letting that person do that's just in case and not really thinking about how we could we support them to do it or support them to understand any consequences or support them to do it rather than just thinking well.. let's not do that just in case".*

However, although there was this recognition of the importance of taking risks in order to support recovery, participants showed that feeling responsible and accountable for the service user's well-being contributed to practitioners having reservations about taking risks and instead, being more cautious and restrictive in their practice:

Monica (rehabilitation ward practitioner) *"[…] I am concerned that if that person is not in some way constrained by something like a community treatment order for example and I am worried that they could relapse and not only would they be a risk to themselves but a risk to other people[…] if I let them hurt anybody else because not only would that be a tragedy for them or somebody else it would also compromise them and it would mean that they would be engaged with things like the criminal justice system for example when I could have stopped that happening so I don't want patients to get into trouble if I feel like I've got a way of preventing it from happening and that is a real issue sometimes"*

These concerns about things going wrong were to some extent explained by Dawn who pointed out that there was a belief that decision makers or responsible clinicians in the care of service users would face negative consequences if things went wrong:

"*[…] I know ultimately they do have responsibility and I dare say on the ward as well because if anything goes wrong they are on the chopping block.*" (Dawn rehabilitation ward practitioner)

These responses suggest a fear on the part of practitioners which seems to be a result of beliefs/perceptions that service users are prone to being harmed or harming others.

Responses from senior managers suggested that they were aware of practitioners being wary of risk, and that this was a culture that needed to be changed:

Ronnie (senior manager): "*…when we talk about risk so because of risk we become entirely paternalistic …but what staff feel they say "I'm not going to do this because I am going to end up in a Coroner's Court and they will blame me" that's what people say so part of my job is to change that culture.*"

However, apart from individual practitioners' anxieties about risk, there seemed to also be concerns about risk in the organisation. For example, responses from rehabilitation ward practitioners suggested that there had been instances where blanket rules had been applied as part of risk management. Practitioners expressed frustration as they felt that some rules were not appropriate for their service and nature of their service user group and as a result became a barrier to ROP:

Theo (rehabilitation ward practitioner): "*One of the barriers sometimes is the risk stuff that comes down from the acute wards things having to change because of incidents on the acute wards and us having to comply with that*".

An example given was the removal of all wardrobe doors after an incident on the acute wards. This was felt to be inappropriate for the rehabilitation ward.

The decision making around blanket rules was perceived as being against the ethos of recovery leading some practitioners to feel that ROP was being paid lip-service by senior managers as suggested by Mabel when talking about the inflexible blanket rules they had to implement:

"*So it's some of those things that we are not allowed to sit and discuss with our patients and risk assess with them and come up with a risk management plan that's collaborative. It's not. But then they talk about "yeah, we do collaborative working"*". (Mabel, rehabilitation ward practitioner)

The concerns suggest that risk management can be viewed as a double-edged sword because although it is necessary to manage risk to ensure the safety of mental health service

users, the need to do so is also leading to a risk averse culture which reduces opportunities for growth.

Sub-theme 3: Between a rock and a hard place

Although community practitioners did not talk about blanket rules being a barrier, they referred to the burden of paperwork and how this was hindering ROP. It is worth noting that whilst rehabilitation ward practitioners mentioned paperwork causing them to spend more time in the office, the issue of paperwork seemed mostly dominant in the community practice context.

Community practitioners expressed frustration that the amount of paperwork they needed to complete shifted the focus from ROP. They highlighted how the amount of paperwork was out of their control as it was part of the assurance processes required to fulfil contractual agreements with commissioners:

> John (community practitioner): "*The paperwork burden has become too high as well and part of that is the demands of our commissioners, who want to see that we're generating activity; that they get a sense that they're getting sort of their value for money. And that detracts from recovery-focussed work.*"

More experienced practitioners suggested that the volume of paperwork had been increasing over time. Bob (community practitioner) mentioned this in his interview:

> "*You know, the more admin-type things that we have to do. Erm, you know, I suppose impacts on our time, so I suppose you could see that as a barrier…. I suppose it just feels that it just becomes more and more frequent with the time…*"

This requirement to produce paperwork as evidence of work being done with service users seemed to have the unintended consequence of detracting from the quality of work being done. Practitioners expressed that the paperwork was viewed more as a burden as it was perceived as not value adding in relation to the care received by the patients and only fulfilled service priorities:

> John (community practitioner): "*… the more you drive people to keep doing lots and lots of paperwork, the more… the paperwork is intrinsically very impersonal… I don't mind the idea of people doing paperwork if the paperwork serves the patient's interests; it's where the paperwork serves only the interests of bureaucrats, erm… Or duplicating paperwork*"

Practitioners expressed being conflicted as they had to go against what they considered their main priority in order to fulfil the organisation's priorities. There was a suggestion that staff found this frustrating:

> Jane (community practitioner): "*It's the things that get audited are the things that are the priority but the priority for the clinicians is… I think it genuinely is, on the whole, the wellbeing of the people on their caseload but that's not necessarily what they get to spend their time on.*"

Practitioners indicated that the attachment of funding to paperwork was putting pressure on managers to prioritise production of required paperwork in the timescales assigned. Practitioners highlighted how this pressure to meet deadlines led to unintended consequences such as gaming of the system in order to fulfil contractual requirements. This was particularly the case with completion of the Recovery Star (an outcome tool which measures changes in ten areas of recovery) which could have been of benefit to the service users but was not being used effectively due to targets attached to its use. Practitioners indicated that in the community, in some cases the Recovery Star was completed as a tick-box exercise to meet targets:

> John: "*It's difficult, 'cos I think the problem is, because it's become part of what we're commissioned to do, our team managers are in this rather invidious position where they, on the one hand, we want to try and encourage people, to think about the Recovery Star as a way of structuring a discussion with the patient about what they actually want to achieve out of their time being helped by the team, but at the same time, they are also having to kind of crack the whip and they say "look, we have to get this proportion of Recovery Stars done, or else we'll lose a big chunk of our funding". And the more you do of the latter, the harder it is to emphasise the former, then everyone starts to perceive it as more yet another kind of administrative burden.*"

The central role of contracts between the Trust and the commissioners in determining the priorities of the Trust in terms of care delivery and assurance processes was made apparent in the interviews with senior managers who also confirmed that the use of the Recovery Star had been driven by the contract with the commissioners. However, whilst practitioners seemed to view the Recovery Star as a burden, senior managers considered it a good tool which they felt allowed collaborative working with the patient:

> Ronnie: "*The recovery star is a really good patient facing tool it is really good for working with the patient to look at what they want to do.*"

Senior managers were also of the impression that the Recovery Star was facilitating service user involvement in care planning:

> Nancy: "*We use the Recovery Star now in terms of informing the care plan and the care plan is written from the patients' perspective with the patient*."

However, interviews with some practitioners suggested that this was not always the case as they ended up being completed by practitioners on their own in order to meet the targets. This revelation validated some of the arguments made by senior managers regarding some of the performance measures that were used to assess the performance of the services and the challenges these presented:

> Nancy (senior manager): "*Our performance is judged on really crude measures like that and also we ourselves we collect information about you know have they got a care plan in place has it been reviewed in the last six months has the patient had been involved does the patient have a copy and as long as we say yes to that we say yes that's great quality but we haven't asked that patient what the experience of that process was so all of those things can be in place but we don't know to what extent they were involved to what extent the conversation that took place you know.*"

Nancy (senior manager) further highlighted the shortcomings of using paperwork to judge the quality of the service, pointing out how the quality of paperwork was not a true reflection of the service user experience:

> "*you can look at a set of beautifully written notes, care plan done, thorough risk assessment progress notes done but it doesn't tell you anything about the therapeutic relationship that that patient has with their worker doesn't tell you how the patient feels they have improved in the last year it doesn't tell you whether they feel listened you know there is such a lot those numbers don't tell us so I think we have to be really careful about measuring.*"

The reservations about paperwork were also expressed by service users who felt that notes were not reliable as they were completed as a paperwork exercise. As stated by Jerry (community service user):

> "*[…] I have noticed in hospital come end of the shift everyone is quickly writing in the notes … 'that's Tom done, that's John done' do you understand? you can't go by notes you can't go by notes*"

Evidence to reinforce Nancy and Jerry's arguments about the caution that needs to be practiced when dealing with paperwork was noted during analysis as an observation was made that whilst practitioners and senior managers talked about the use of the Recovery Star for care planning, the service users did not mention them. In fact, both community service users said they had not seen their care plans and they appeared to not have much interest in them. Tim however, expressed reservations about the usefulness of care plans as he did not feel they were facilitative of recovery:

> Tim (community service user): "*Yeah, not a 'care plan'. Care plans are medical. To make sure you're still taking the tablets, you know? But a life plan, to see how your life can be improved to maybe be level with people who've never had mental illness. You know? I've always been… Not envious, but looking at people in jobs, you know, wandering around doing things and thinking I've been deprived of that. I've got no career, you know? I've got no family of my own, because probably my mental health took me off in a different direction, so… But no, I think if they put something in place called a 'life plan assessment' to assess your strengths and weaknesses and work with you to lead a better quality of life.*"

This suggests that care plans need to be more holistic, looking beyond the mental health needs to encompass different areas of an individual's life including their aspirations in order to be recovery focused.

In summary, participants evidence that the need to provide assurances and meet targets set by commissioners through completion of paperwork was resulting in unintended consequences such as taking time away from practitioners which could have been used for value adding recovery-focused work. Instead, the situation was promoting gaming of the system in order to meet targets. On the part of service users, apart from being deprived of the time they needed to form therapeutic relationships with their workers, there was a risk of inaccurate reports and subsequently inappropriate care being given due to overreliance on paperwork.

Summary of Chapter

The findings from this study highlight the varying conceptualisations of recovery and suggest that service users prioritise different things for their recovery. It was apparent that whilst practitioners emphasised that recovery was not necessarily about the absence of symptoms of mental illness and subscribed to the personal recovery rather than the clinical recovery school of thought, service users placed importance on alleviation of symptoms as part of recovery. Service users in both practice contexts highlighted the suffering and distress caused

by symptoms of mental illness, suggesting the importance of interventions aimed at symptom reduction and management as an integral part of implementing ROP.

Furthermore, the findings indicated that in both practice contexts, the therapeutic relationship was central to the implementation of ROP. Participants revealed their values which impacted how they viewed service users and in turn related with them. Practitioner participants described different approaches to building recovery facilitative relationships including taking time to get to know the service user and use of self-disclosure. They also described the nature of the relationships and these were mainly supportive and facilitative where practitioners were positive in their approach, working with service users to support them to achieve their goals. The prioritisation of service user goals was highlighted and there was evidence that practitioners needed to have an optimistic outlook and problem-solving approach in order to find ways to support with overcoming the challenges threatening achievement of goals. These values appeared to be reinforced by their professional values. At organisational level, there were structures put in place to promote recovery supportive relationships. These included organisational values which shaped care delivery through Standard Operating Procedures (SOPs), policies, guidelines. There were also structures put in place to shape the organisational culture into a culture of co-production which promotes relationships where there is a power balance between service users and practitioners rather than paternalistic practices. Recovery College and a Peer Support Worker programme were examples given by senior managers although not mentioned in detail by practitioners. Overall, these findings led to the conclusion that the development of recovery promoting relationships was based on individual practitioner characteristics and values coupled with structures within the organisation that helped to influence practice. This highlighted the importance of congruence between organisational expectations of recovery facilitative relationships and practitioner values and practices.

On the other hand, although the findings showed the organisation and practitioners were invested in ROP, the ideal situation was different from the reality. Participants revealed that there were various constraints within the system which were viewed as barriers to the implementation of ROP. Constraints identified by participants differed in the two practice contexts. Whilst the rehabilitation ward participants identified constraints relating to facilities, in the community constraints were mainly problems relating to capacity and demand. These issues were identified as impeding the development of the therapeutic relationships conducive for a recovery focused approach. There were issues identified around the unintended consequences resulting from important processes such as risk management in both practice contexts. However, in the community this also extended to administrative duties resulting from the need to provide assurances to commissioners. It was apparent that whilst these activities

were important and necessary, other problems within the system such as staffing were making it difficult for practitioners to keep up with the demand on their time. Such pressure was affecting how these activities were viewed- mainly as burdensome and non-value adding in relation to the quality of the service user experience. Participants also pointed out the importance of ensuring outcome measures were meaningful and provided a picture of the service user experience. Although there was a recognition of all these factors, there was a sense of helplessness on the part of practitioner participants as contractual requirements with commissioners had to be met. This applied to both senior managers and frontline staff. These findings show the central role played by commissioners in determining what is prioritised by providers of mental health services and how these priorities can be barriers or facilitators of ROP.

The facilitators and the constraints to the implementation of ROP identified by practitioners were reflected in the service users' accounts of their experience. Community service users specifically were able to describe some of the elements in the system which hampered their recovery. However, although there were some insights given by rehabilitation ward service users, these were limited as the service users found it difficult to concentrate during interviews. This led to the observation that the way recovery support is provided is context specific and that there needed to be some differences in practice on the rehabilitation ward due to the differences in presentation between inpatient service users and those in the community.

Conclusion

This chapter has presented the findings of the study through the exploration of the key themes identified in the data. The next chapter will present a discussion of the findings in relation to literature in order to situate them in existing literature and theory.

Chapter 5: Discussion

Introduction

The previous chapter presented a detailed account of the findings of the study synthesised into three overarching themes namely: The meaning of recovery, The therapeutic relationship as a vehicle for ROP and Constraints to the implementation of ROP. In this chapter, the themes will be discussed in relation to the literature in order to situate the study in the existing knowledge about ROP and to further interpret the findings. Furthermore, there will be a theoretical discussion to support the interpretation of some of the findings using Foucault's ideas about power and knowledge, previously introduced in the introductory chapter of the thesis.

The meaning of recovery and ROP

Exploring the meaning of recovery and ROP helped to contextualise the study and to establish an understanding of the participants' conceptualisation of the terms. This was particularly important as the literature review had evidenced that there was a lack of clarity when it came to the meaning of recovery in mental health and that staff understanding of the concept would influence implementation (Le Boutillier et al., 2015). Unsurprisingly, this study's findings are in keeping with some of the common conceptualisations of recovery in the literature, namely personal recovery and clinical recovery (Slade, 2009). Moreover, CMHT practitioner responses also evidenced the existence of service defined recovery. This conceptualisation of recovery was proposed by Le Boutillier et al. (2015). Based on their research findings, they explained that this was the translation of recovery into practice based on organisational priorities. Although this was not explicitly articulated by participants, it was apparent that organisational priorities influenced how ROP was being implemented in practice. For example, the focus on targets in relation to the use of the Recovery Star as revealed in the previous chapter.

Notably, there were differences between service user and practitioner conceptualisation of recovery in this study. Interestingly, although recovery literature asserts that ideas about personal recovery originated from service users (Pilgrim and McCranie, 2013; Slade, 2009), the service user participants in both community and rehabilitation ward settings in this study mainly alluded to clinical recovery when describing what recovery meant to them. Whilst they referred to aspects of their social lives such as relationships with family and friends, they also articulated their need to be free from the distressing effects of symptoms of mental illness. This supports findings from a systematic review that was conducted to understand how people

with severe and enduring mental illness experienced recovery where returning to or desiring normality was a theme (Stuart et al., 2017).

On the other hand, practitioners and senior managers' definitions of recovery reflected the personal recovery lens. Their definitions echoed the widely quoted Anthony (1993) definition of recovery suggesting that they had been exposed to recovery training or literature. This finding is reflective of the evidence on the adoption of recovery principle in mental health policy and practice in England (DH, 2011). Interestingly, differences in conceptualisations of recovery between service users and practitioners have been highlighted in other studies (Simpson et al.,2016; McCabe et al, 2018; Murphy, 2012) and possible explanations for this have been offered. For example, McCabe et al. (2018) proposed that the reason service users had a clinical recovery focus was that they got enculturated into the ideals of the medical model in practice and their views reflected staff views which were projected onto them. Moreover, Murphy's (2012) study also identified that different discourses in relation to recovery were being used by staff and service users and cited this as a barrier to the implementation of ROP. He suggested that it would be helpful for practitioners and service users to use the same discourse. Although generalisability of the findings from the study may be questioned (for example the McCabe et al. (2018) study was a qualitative study conducted in a forensic mental health setting) their findings still suggest that the differences in conceptualisation of recovery between service users and practitioners is common and may be an area that requires attention in future research.

Further observations in relation to the meaning of recovery were that whilst practitioners seemed to describe personal recovery when articulating their understanding of recovery, when describing their practice and what they did to support service users, they focused on aspects that would be considered as falling under the remit of clinical recovery. Both community and rehabilitation ward practitioners emphasised the importance of "getting the medication right". This seemed particularly the case for the consultant psychiatrists who viewed an important aspect of their role as being about treating symptoms to reduce the distress and risk associated with symptoms of mental illness. Whilst it can be argued that these findings were reflective of the fact that ROP was being implemented in a system where the medical model was still dominant and mental "illness" was still viewed from a biological lens, these findings may also be supporting the suggestions in the literature that personal and clinical recovery are not mutually exclusive (Slade, 2009; Davidson et al., 2009). Moreover, findings bring into consideration Khan and Tracy's (2021) suggestion that separating the meaning of recovery according to the lens through which it is viewed may not be helpful.

Practitioners' concern with medication if taken at face value seems to validate suggestions that have been made in the literature about the shift to recovery policy not having resulted in changes in practice and that practice in England continues to focus on cure, care, and containment (the "3 Cs") (Perkins and Slade ,2012). However, this would not be an accurate assumption as examination of the responses given by participants in both settings in the study evidenced a shift from prescriptive and paternalistic practice with more collaboration between service users and practitioners. For example, the evidence from the rehabilitation ward that focus was being placed on service user goals where traditionally, more paternalistic approaches were taken due to the chronic nature of the mental illnesses experienced by service users in such settings. Practitioners in the CMHT and senior managers also evidenced similar principles relating to ROP being about working together to achieve service users' goals – doing with rather than doing to.

However, a point of caution was noted as it was observed that whilst senior manager and practitioner views on recovery were aligned with personal recovery, one of the senior managers expressed a view that the adoption of a recovery philosophy was a necessity and a solution to health services capacity and demand problems. Concerns about this way of thinking have been expressed in the literature (Slade et al., 2014; RITB 2019) where it has been suggested that recovery was being "abused" and used as a smokescreen for cutting services for people with mental health problems. This way of thinking could also lead to service defined recovery which focuses on organisational priorities rather than the service user recovery priorities (Le Boutillier et al., 2015).

An alternative interpretation of the findings relating to the different conceptualisations of recovery can be further explored in the context of Foucault's ideas about power and knowledge, previously referred to in relation to the power balance between service users and mental health practitioners (Repper and Perkins, 2003; 2014). The findings suggest that professionals seem to know more about personal recovery ideas than service users and that practice appears to still place importance on medication and treatment of symptoms of mental illness. There is also the seeming emergence of service defined recovery. This can be argued to affirm the argument that the concept of recovery has mutated over time and is often distorted to fit into professional frameworks and practice (Repper and Perkins, 2014). The same authors suggested that the shift in power required for ROP has not happened and professionals continue to maintain power through their claim to have special understanding and knowledge. This can be seen in this study's findings where professionals appear to be the experts in relation to both clinical and personal recovery due to service users seemingly not being aware of ideas regarding the meaning of recovery from the survivor movement perspective. This seeming monopolisation of knowledge can be argued to not be conducive for the

implementation of ROP as this requires is a balance in power between professionals and service users where service users are in control of their care and are viewed as experts by experience.

Whilst the above argument is important, the findings in this study also suggested a genuine aspiration on the part of the mental health professionals to implement ROP as a way of supporting people to become more autonomous and independent of services for their own benefit and not a malicious intent to take away support or a conscious effort to maintain power. This was evidenced by the fact that senior manager accounts of ROP and what they encouraged practitioners to do seemed to be focused on the service users' needs and priorities, an important aspect of ROP. However, it is important for the potential threat to the power balance between service users and practitioners due to knowledge about the recovery philosophy being monopolised by professionals that has been highlighted to be addressed.

The therapeutic relationship as the vehicle for ROP

The accounts given by practitioners relating to the work they did with service users to support their recovery evidenced that the relationship with the service user was the cornerstone of ROP. The importance of the relationship was echoed in service user accounts of the support that they found helpful to their recovery. This study supports findings from other studies looking into recovery in mental health settings which have also highlighted the importance of the relationship in the implementation of ROP (Bird et al., 2011; Le Boutillier et al., 2015; O'Keefe et al., 2018; Hannigan et al., 2018; Chester et al., 2016; Stickley and Wright, 2011). This finding is not surprising and serves to reinforce theories and literature that highlights the centrality of relationships and interpersonal skills in mental health practice in general with examples such as the seminal work on interpersonal relations by Hildegard Peplau in 1952 and the theory of client centred therapy (Rogers, 1951). Carl Rogers was an advocate for the humanistic approach which promotes autonomy and views human beings as self-determining. The humanistic approach also places importance on the idiographic approach (seeing the individual) rather than nomothetic (grouping people together). Peplau (1952) on the other hand viewed nursing as a collaborative, mutual and interpersonal process. These assumptions are aligned with recovery philosophy and the study found that both practitioners and service users talked about the importance of spending time and getting to know each other. The participants' accounts showed that this allowed the implementation of tenets of recovery such as collaborative goal setting as practitioners were able to identify the service users' strengths, interests and aspirations and find ways to support them to achieve them. Practitioner participants in this study also evidenced how they promoted autonomy and choice by working with service users to identify and achieve their personally defined goals rather than focusing solely on clinical goals. This practice reflects guidance for health professionals on how to

implement ROP proposed by Slade (2013) where it was suggested that it was important to have both recovery and treatment goals when supporting recovery. Recovery goals are strengths based and focus on what the service user wants to do- their dreams and aspirations whilst treatment goals are based on societal expectations and professional obligations including things such as risk management, treatment of symptoms. The findings in this study show that this was indeed the case. This study also shows that although there was a suggestion from some of the community practitioners that an inpatient context was more restrictive and promoted a more paternalistic approach, rehabilitation ward practitioners made efforts to foster collaborative, autonomy promoting relationships. This evidences that both inpatient and community settings presented opportunities for such relationships to be established.

Strategic level interventions to promote recovery

In addition to individual practitioners' practice, the findings from the senior managers' interviews in this study evidence that there were some external drivers that helped to steer practice in the direction of more egalitarian relationships between practitioners and service users. Senior managers brought a different perspective as their roles involved implementing interventions at strategic level which were meant to direct practice to ensure the organisation was meeting the expectations of different stakeholders. Examples of broader, external factors highlighted as having necessitated the move to collaborative relationships were policy guidance and regulatory bodies such as the Care Quality Commission (CQC) who expect organisations providing mental health care to evidence collaborative relationships between services and service users. These developments and expectations saw the implementation of interventions to facilitate a shift in the culture of the organisation. These included engaging guidance from Implementing Recovery through Organisational Change (ImROC) which is an organisation that supports mental health service providers to implement ROP, the employment of peer workers and the establishment of Recovery Colleges (both interventions that promote a culture of partnership working and valuing contributions from service users as experts by experience). This thinking is in keeping with literature on recovery which highlights the importance of creating environments that are conducive for practitioners to be able to practice with compassion in hope inspiring relationships (Spandler and Stickley, 2011). It also suggests the organisation was making some progress in addressing the challenges highlighted in the position paper by Sainsbury Centre for Mental Health where Recovery Colleges were cited as a way of organisations becoming more recovery-oriented (Sainsbury Centre 2009).

Furthermore, tools such as the Recovery Star were implemented to facilitate the implementation of ROP in the organisation. Interestingly, whilst senior managers pointed out these evidence-based interventions for the implementation of ROP, there was no significant

mention of some of them (for example peer support workers and the Recovery College) by service users and practitioners bringing into question the level of uptake and the impact they were making to practice. Moreover, although the Recovery Star was mentioned by practitioners, in the CMHT it was in the context of it increasing the burden of paperwork, making it a barrier to ROP. Therefore, with regards to some of the interventions that were implemented at strategic level by the organisation to facilitate ROP, their impact seemed not as apparent in the accounts given by practitioners. However, a possible explanation for service users and practitioners not talking about the Recovery College and peer workers could be the fact that the Trust was still in the infant stages of their implementation therefore they may not have been fully embedded and widely known about in all practice areas. Another observation was that some of the impact of interventions to promote ROP could have been implicit- for example, the fact that practitioners were familiar with recovery philosophy could have been emanating from the interventions aimed at embedding a culture facilitative of ROP. Upon reflection, I found that this was something I could have explored further during the interviews with practitioners and service users to get a clearer picture regarding the usefulness and impact of these interventions from their perspectives. Nevertheless, this finding still highlighted the importance of communication between senior managers and frontline staff to ensure appropriate strategies to support adoption of tools or interventions to promote ROP are used. For example, the use of templates such as those provided by Shepherd et al. (2010) to support organisations to plan and track their progress with implementation of ROP facilitative interventions.

Nature of the relationship

Whilst at the strategic level the organisation was implementing interventions to promote the development of a culture facilitative of collaborative working between service users and staff, literature suggests that caution needs to be practiced when implementing ROP in order not to set service users up to fail. The systematic review by Chester et al. (2016) which explored the elements of ROP, highlighted that it was essential to be flexible and to recognise the non-linearity associated with experiences of mental illness. In recovery literature, analogies such as "the service user in the driving seat of their care" are used. These arguments are usually linked with suggestions that the service users should be directing their care. Whilst this is true, findings from this study suggest that there are times when practitioners need to be more directive as evidenced by some of the accounts of recovery supportive encounters with staff given by service users. Both community and rehabilitation ward service users described relationships with practitioners where they were being helped and having things done for them at times as positive recovery supportive experiences. The danger of not recognising instances where practitioners needed to be more directive were highlighted by a rehab ward practitioner

and associated with the risk of neglecting service users. These findings relating to the need for flexibility and responsiveness with regards to the level of responsibility given to the service user within the relationship echo those from the study by O'Keeffe et al. (2018) where some service user participants described needing more structure and support. The study highlighted how the move to a recovery approach had left some service users feeling unsupported (O'Keefe et al.2018). As Slade (2013) stated "It is unhelpful to put expectations on a person who is still early in their recovery journey (what a professional might call acutely unwell) which they cannot even begin to meet." This study therefore re-enforces the importance of the notion of "practitioners on tap and not on top" (Repper and Perkins, 2003). As exemplified by a CMHT service user in this study who appreciated not having set appointments with his care coordinator preferring instead to be equipped with knowledge about where to get help when needed. The challenge relating to changing the nature of day-to-day interactions between practitioners and service users was also highlighted in the position paper by the Sainsbury Centre for Mental Health as a key challenge (Sainsbury Centre for Mental Health, 2009). This study showed some of these challenges as the inclusion of both community and rehabilitation ward service users in this study helped to shine a light on the need for different approaches to be used based on the individuals involved. The rehabilitation ward service users in this study were observed as presenting differently, with evidence of debilitating symptoms compared to the CMHT service users suggesting the importance of flexibility and the ability to adapt on the part of the practitioners.

The Role of Values

Another suggestion from the findings was that practitioners' values influenced the nature of the relationships between them and service users. The importance of values in mental health practice is well documented (Fulford, 2004; Woodbridge and Fulford, 2004; DH, 2006). As has been established in the literature on values, the concept is complex as it relates to various things including ethics, quality of life and aesthetics. Values also vary with time and place and differ from person to person (Woodbridge and Fulford, 2004). This study found that there were commonly held values regarding right and wrong (moral values) in relation to how to treat others. A commonly held maxim was "treat others as you would like to be treated". Practitioners also recognised that mental illness could be experienced by anyone and that people with mental illness should be treated like anyone else. The importance of this value was highlighted by Slade (2013) in his publication *100 Ways to Support Recovery* where he supported the assertion by Anthony (1993) that "People with severe mental illnesses are people". This view stood out in practitioner interviews with empathy for service users evident. This is one of the three core conditions cited by Rogers (1952) as essential in the relationship between a client and therapist for psychological change to occur. Although the core conditions

were related to therapy, it can be argued that they are applicable to recovery as recovery involves a shift in how the service user views themselves in relation to their mental illness (Deegan, 1993). Adoption of humanistic approaches is cited as important in ROP and is viewed as a way of alleviating stigma (Chester et al. 2016). Furthermore, this approach mirrors the recovery values of person centredness, collaboration and empowerment (Davidson et al. 2009). The importance of this approach was also exemplified by accounts given by service users relating to ordinary human experiences they shared such as sitting down for a cup of tea with a care coordinator, having chats or being shown genuine care and concern as a human being rather than a "patient". Further support for these ideas is found in literature where it has been suggested that being seen as an ordinary, complex individual with problems can alleviate the distress caused by objectification of diagnostic labelling (Larsen and Terkelsen, 2014) and that service users have the need to be seen as social, sexual, psychological, spiritual and physical beings with societal value (O'Keeffe et al. 2018).

Further to the influence practitioner values have on the nature of the relationships with service users, this study also found that practitioner values in relation to their work were also influenced by their professional values. As alluded to earlier, the importance of values is well published in professional literature with nurses (they form the bulk of the mental health workforce) expected in their code of practice to "Prioritise People" which includes treating them with kindness respect compassion and dignity, listening to people and responding to their preferences and concerns, encouraging and empowering people to be involved in decisions about their care (NMC, 2018). The OT participants also highlighted that OT values were synonymous with recovery principles whilst a social worker participant described her values as promoting self-determination as that is a big part of the social worker's role. Similarly, consultant psychiatrists who participated in the study seemed to have values aligned with recovery. These findings may possibly be attributed to the work done to ensure recovery principles were embedded in the mental health workforce (Care Services Improvement Partnership (CSIP) et al. 2007). The role professional bodies and professional training courses play in the implementation of ROP through the fostering of professional values that are congruent with ROP is highlighted in the literature (Shera and Ramon, 2013). Furthermore, the importance of professional values of the different professions working in mental health being aligned is also highlighted as having different values could cause clashes and result in challenges with implementation of ROP (Khoury and Rodriguez del Barrio, 2015).

Promoting citizenship and challenging stigma
An observation made from the findings in relation to facilitators of ROP was that practitioners and senior managers mainly focused on internal factors (things that could be done within the organisation) and not on external factors (outside the organisation and outside mental health

services). This needs to be explored further as CMHT service user participants highlighted the stigma and exclusion they experienced due to mental illness. This issue is of stigma being a barrier to recovery is discussed in literature (Shera et al., 2002; Ramon et al., 2009; Shera and Ramon, 2013; Sainsbury Centre for Mental Health, 2009) and guidance on ROP cites promoting citizenship and challenging stigma in the community as important aspects of ROP work (Chester et al., 2016; Le Boutillier et al., 2011). In addition to this, seminal literature on recovery suggests that recovery may not be possible without this work as there are many environmental barriers that make it difficult for people with mental illness to recover (Deegan, 1992). Sayce (2000) also emphasised the importance of breaking down societal barriers to the participation and inclusion of people with mental illness as citizens and advocated the adoption of the social model of disability which recognises that barriers to participation are in society rather than the disabled individual. The need for attention to be paid to this aspect of ROP is also highlighted by service users in this study who disclosed the challenges they faced in some areas of their lives such as relationships and employment. A CMHT service user in this study suggested the need for a "life plan" rather than a care plan – when he was explaining that he needed a plan which would also focus on his activities outside healthcare. This service user's experience reinforces the importance of mental health services working with communities to change attitudes towards people with mental illness through things like anti-stigma campaigns as proposed by the Sainsbury Centre for Mental Health (2009). This is supported by a recent study by O'Keeffe et al. (2018) who also recommended that providers needed to confront stigma to normalise mental illness and to enhance social inclusion.

The subject of stigma and discrimination is associated with some of the criticisms relating to the adoption of ROP. It has been argued that the recovery approach as adopted by services ignores the wider determinants of mental health whilst placing responsibility for recovery on the individual (Stuart et al., 2017; Price Robertson et al., 2016). It has been proposed that a more useful approach would be to look at recovery from an ecological lens and an alternative approach for recovery that views it from a relational perspective which acknowledges the interdependent and inseparable relationship between people and the environment they are in proposed (Price-Robertson et al., 2016). These ideas concur with earlier suggestions by Onken et al. (2007) who also highlighted the important role of society in creating an environment facilitative of recovery and Bauer et al. (2019) who articulate the need to address social and environmental aspects of recovery to support people as citizens in their communities. Further research into how these environments can be created could be beneficial for progressing the implementation of ROP to ensure attention is paid to factors in the society that could impede recovery.

Constraints to the implementation of ROP

Whilst the findings of the study highlighted the ways in which recovery principles were being implemented in practice, it became apparent that some of the practices that the practitioners had described as recovery promoting were aspirational rather than the reality due to constraints in the system. This realisation is not unique to this study as previous and more recent studies have also discovered similar findings (Hannigan et al., 2018; Le Boutillier et al., 2015; Simpson et al., 2016; Solomon et al., 2021). Furthermore, a literature review conducted by Waldemar et al. (2016) to investigate the adoption of ROP in inpatient units also revealed that there were various constraints impacting the implementation of ROP, similar to those found in this study. Interestingly, the three main barriers (shortage of resources, risk management and the challenge of paperwork and targets) which were highlighted in the sub-themes to the theme "Constraints to the implementation of ROP" impact the relationship between staff and service users which was identified as central to the implementation of ROP at grassroots level. However, the extent to which the two practice settings were affected by the different constraints appeared to differ with the CMHT seeming to be more affected by the burden of paperwork and targets. This may be reflective of some of the issues cited in literature with respect to the economic challenges resulting in budget cuts and inadequate funding for mental health community care (Ramon et al., 2009; Shepherd et al., 2010).

Inadequate resources

The findings from this study contradicted the suggestion by Shepherd et al. (2010) that service changes they proposed for implementation of ROP were cost neutral. Findings also challenged the assumption that adopting a recovery focus is a way of saving on resources. In fact, the evidence from this study suggested a need for an increase in resources in both inpatient and community settings and a need to find ways of working smarter by ensuring all work practices are aligned with and contribute to ROP. This study suggested that for rehabilitation services, investment in facilities that allow service users to be supported with regaining skills they would need to live independently in the community was needed. This supports findings in the literature review by Waldemar et al. (2016) where physical structures of the inpatient environment were found to not always be fit for purpose making it a challenge to implement ROP. On the other hand, it was apparent that for the CMHT an investment in staff to meet the demand for services was required in order not to compromise the capacity of practitioners to build therapeutic relationships with service users. CMHT practitioners pointed out how the staff shortages were leading to increased caseloads, reduced time to devote to service users and a focus on crisis management rather than recovery work. Similar barriers were found in other studies (Nugent et al., 2017; Gilburt et al., 2013). Interestingly, although these issues did not seem as problematic on the rehabilitation ward, they were highlighted by

Waldemar et al. (2016) as constraints in the implementation of ROP in inpatient units. However, the differing findings may be due to the differences in practice contexts as the studies in the literature review included acute inpatient units with high acuity compared to the rehabilitation ward. Nevertheless, the experiences of the CMHT practitioners support assertions by Spandler and Stickley (2011) who highlighted the role of the socioeconomic context on the implementation of policy. The same authors proposed that it would be challenging for practitioners to develop compassionate relationships necessary for recovery in environments with heavy workloads and inadequate resources (Spander and Stickley, 2011). Furthermore, the need for investment in resources to support service users in the community is historical as evidenced in previous studies (Simpson, 2005; Burns et al., 2007). Traditionally, mental health services have received less funding than other health services that focus on physical health. However, in recent years, the need for parity of esteem between mental health and physical health has been highlighted (Royal College of Psychiatrists, 2013; DH, 2014) with the need for more funding for mental health recognised as reflected in more recent policy such as The Five Year Forward View for Mental Health (Mental Health Taskforce, 2016) and The NHS Long-Term Plan (NHS, 2019). However, whilst these are promising developments, there is still a need for commissioners and service providers to ensure congruence of priorities with ROP.

Between a rock and a hard place

Closely linked to the resource issues in the CMHT was the paperwork or administrative work linked to their roles. This issue although mentioned by a couple of rehabilitation ward practitioners seemed more problematic in the community team. Practitioners highlighted the tension between spending time with service users and completing the paperwork required to evidence achievement of targets set by commissioners. This finding illuminated the influence commissioners have over what was prioritised by mental health service providers as participants pointed out how managers focused on ensuring targets set by commissioners were achieved. Furthermore, it was evidenced that even though there was a desire and intention to implement ROP at all levels within the organisation, there were factors that were not within the control of practitioners and senior managers which necessitated prioritisation of organisational obligations that were not always directly service user driven. These findings support those from other studies (both local to the UK and international) which found the burden of paperwork to be a hindrance to the implementation of ROP (Simpson et al, 2016; Leamy et al., 2014; Hannigan et al., 2018; Le Boutillier et al., 2015; Hungerford and Kench, 2013; Piat and Lal,2012; Khoury and Rodriguez del Barrio, 2015). In addition to this, the findings highlighted that some of the targets and key performance indicators set by commissioners were not valid measures of the service user experience and senior managers

in the study felt that there was too much reliance on counting. This challenge relating to appropriate measures for commissioners was discussed by Shepherd et al. (2010) who found that some commissioners were interested in using simple metrics to score the recovery-orientation of services. They advised against this, arguing that such measures could be misleading and get in the way of innovation. This is evidenced in this study where the use of the Recovery Star (McKeith et al., 2010) as a measure of performance and its completion as an incentive tied to funding resulted in gaming of the system. Furthermore, it had the unintended consequence of taking practitioners' time, reducing the opportunities for building therapeutic relationships, making it a perverse incentive (an incentive that results in unintended and undesirable outcomes for those introducing the incentive) (Boyle, 2011). This scenario supports an assertion by Boyle, (2011) who argued that any payment system where payment is based on activity or meeting targets could result in perverse incentives. He suggested that such systems cause the focus to shift from service users to managers. Boyle (2011) also argued that once money is attached to activity or meeting targets, staff would always find ways to manipulate the system so that it works in their favour (gaming). Apart from the issues with gaming, the Recovery Star itself has been criticised for being "a redundant, unhelpful, and blunt tool for narrowly judging how someone should be expected to 'recover'" (RITB, 2019), and its usefulness as a recovery outcome measure is debated (Killaspy et al. 2012). However, there are also suggestions that when completed collaboratively, it facilitates the development of a therapeutic relationship and allows service users to be active participants in their recovery (Tickle et al., 2013). This therefore suggests that practitioners completing the Recovery Star on their own as a paperwork exercise diminishes the chances of any benefits of using the Recovery Star and instead takes them away from the service users.

This example of the Recovery Star serves to underscore the importance of commissioners ensuring that performance measures are more meaningful and give a more detailed picture of the patient experience in relation to their recovery rather than relying on numerical values such as number of completed care plans or Recovery Stars. Overall, the findings in this study suggest that identifying and using performance measures aligned with and facilitative of ROP remains a challenge.

Risk

Further exploration of barriers to the implementation of ROP identified that although senior managers were advocating for the move away from paternalist approaches to adopting a positive risk-taking culture, the operationalisation of this in practice seemed to be a challenge. Whilst practitioners highlighted the importance of recognising the service users' experience and working collaboratively with them, they divulged their struggles with giving up some responsibility to the service users in their day-to-day practice. These struggles seemed to be

mainly linked to the contentious issue of risk management. For example, the rehabilitation ward psychiatrist viewed managing risk as a core aspect of the role and an important responsibility. Despite the awareness of the need for positive risk taking, participants evidenced a risk averse culture and a practitioner suggested the organisation had a reactive approach to risk sometimes leading to the application of blanket rules rather than more individual/local risk assessments. Whilst senior managers suggested that they encouraged positive risk taking, this seemed to not filter down to practice. This finding supports other studies that have found the tension between risk management and ROP (Cleary and Dowling, 2009; Tickle et al., 2014; Crowe and Deane, 2018, Holley et al., 2016). Waldemar et al. (2016) also highlighted how staff became risk averse due to the professional responsibility for patients' safety and well-being placed on them. The mental health system continues to have structures supported by legislation and policy whose main aim is to manage risk such as the Mental Health Act and the Care Programme Approach and this has been cited as a barrier to ROP (Nugent et al, 2017). It has also been proposed in the literature that whilst working within these coercive frameworks, organisations and consequently practitioners are steered towards risk aversion (Spandler and Stickley, 2011). Furthermore, Waldemar et al's. (2016) literature review highlighted that in such situations, practitioners were faced with an ethical challenge as the coercive frameworks meant that they struggled to offer choice or work collaboratively with service users. Moreover, some of the structures seem to be based on an inherent belief that people with mental illness are a danger to themselves or others and that someone needs to assume responsibility for them with role titles such as Responsible Clinician given to psychiatrists. This is contradictory to the values practitioners described in this study such as regarding people with mental illness in the same way as they would view anyone else. This finding calls attention to the need to ensure positive risk taking is not something that is just paid lip service but is implemented in the mental health system as a whole. Additionally, the findings in this study support previous studies that have suggested the need for further investigation into the barriers to service user involvement in risk assessment and management in order to facilitate better understanding and allow the identification of strategies to tackle these barriers and foster a culture of positive, collaborative risk assessment and management between service users and practitioners (Simpson et al., 2016).

Observations from the findings relating to barriers

Exploration of these barriers revealed the juxtaposition between practitioners' aspirations and the reality with regards to ROP. This could be argued to have the potential to lead to moral distress in practitioners. Moral distress is a concept that was identified by Jameton (1984) cited in Lamiani et al. (2017) who proposed that the condition arises when one knows the right thing to do but institutional constraints make it nearly impossible to do it. Three causes of

moral distress are identified in the literature. These are: poor quality and futile care, unsuccessful advocacy and raising unrealistic hope (Schluter et al., 2008). It could be seen in the study that elements of two of these causes of moral distress (poor quality and futile care, unsuccessful advocacy) were present. Firstly, although the care described by practitioners was not described as poor care, it was apparent that they felt that they could provide better quality care and were facing the constraints mentioned above (lack of resources, paperwork). However, they were going above and beyond to try and provide the quality they could be satisfied with as highlighted by a CPN Ruth:

> *"It's, well… what do you need as a whole and how can I make that happen for you. As I once had described by a manager, "we only have to give a gold service here, not a platinum" and I don't agree with that. You know, if I can give a platinum service, I'll give it, because that's what I would hope for myself; I would hope that if the situation was reversed, that somebody would be prepared to do that for me."*

Practitioners also attributed the revolving door nature of some service users to the fact that they were discharged too early with inadequate support for sustained stability. This could cause of moral distress in staff if they perceived the support they provided as futile. In addition to this, some of the paradoxes that exist in the system could be a trigger for moral distress. It is important that barriers relating to the implementation of ROP at grassroots level are addressed as moral distress has been found to have a negative impact on the health and well-being of staff (Schluter et al.,2008). Although the evidence for any negative impact on care is unclear, moral distress is also associated with reduced job satisfaction and can lead to staff leaving their jobs which could have an indirect impact on care through the exacerbation of staff shortages.

Conclusion

Through the exploration of how one organisation providing mental health care is implementing ROP, this study has shown that some progress is being made with measures being put in place at all levels to facilitate implementation of ROP. Drawing on existing literature, the discussion showed some commonalities between this study's findings and existing literature on ROP. The discussion explored the existence of shared common values and an understanding of the recovery philosophy amongst practitioners and senior managers and supported previous literature that has highlighted the need to ensure there was a common discourse between practitioners and service users to progress implementation of ROP. Moreover, the discussion reinforced previous literature on ROP that advocates for a multi-faceted approach to ROP incorporating both clinical and personal recovery ideas whilst also looking at recovery from an ecological lens, acknowledging the role of society as a potential

barrier or facilitator. Furthermore, different ways though which ROP was being implemented at different levels within the organisation were revealed with the study strengthening literature that locates the therapeutic relationship between practitioners and service users at the centre of ROP. However, challenges impacting the development and sustenance of recovery promoting relationships in practice were also discussed, reflecting some of the concerns also expressed in other studies. Further observations in relation to the promotion of citizenship and challenging of stigma were made. Finally, the discussion asserted that the conditions created by the constraints to ROP were conducive to the development of moral distress in staff and suggested the need for attention to be paid to this possible issue.

Having discussed the findings and situated them in existing literature, the next chapter outlines the study's contributions and articulates the implications of the study's findings for practice, research and policy. Recommendations are also made as appropriate.

Chapter 6: Contributions, Implications and Recommendations

Introduction

This study adds to what is known about implementing ROP through an exploration of the perceptions and experiences of service users, senior managers and staff in an NHS organisation providing mental health services. A scoping literature review showed that there was a dearth in research exploring the implementation of ROP in mental health practice. A qualitative case study approach was adopted to allow an in depth, context specific exploration of the phenomenon. Semi-structured interviews were conducted with 16 participants (senior managers, managers, practitioners, and service users) in two practice settings (CMHT and rehabilitation ward) to gather a wide range of views from the different levels within the organisation. A thematic analysis of the data produced three overarching themes and seven sub-themes which were detailed in the previous two chapters. Whilst some of the study's findings are similar to previous studies on ROP, the study brings some new insights and makes unique contributions towards the implementation of ROP. This chapter therefore builds on the previous discussions by outlining the contributions this study makes to existing knowledge, the implications of the findings and the recommendations for research, commissioning and practice. Lastly, a discussion of the limitations of the study is conducted before concluding the chapter.

The study objectives

- To explore National Health Service (NHS) Trust senior managers', team leaders and practitioners' views on ROP and how it is implemented in their organisation.
- To elucidate service users' views and experiences of ROP.
- To investigate the strategies that have been put in place to facilitate ROP at different levels within the organisation.
- To identify any barriers and facilitators to the implementation of ROP at the different levels of the organisation.
- To clarify how ROP is evaluated in the Trust.

The unique contribution this study makes.

This study makes unique contributions in the field of recovery in mental health by providing a holistic exploration of how ROP was manifesting in two settings in an NHS organisation providing mental health care. Methodologically, the qualitative case study approach adopted in the study allowed triangulation of data from participants ranging from grassroots level to strategic level. Furthermore, the approach taken with the sample consisting of service users, senior managers and practitioners from inpatient and community practice settings within the

same organisation is not comparable with any other studies on ROP that have been conducted in England. Whilst studies on ROP have been conducted previously, these focused on: assessing the impact of training (Gilburt et al., 2013 and Leamy et al., 2014); the relationship between ROP and risk (Tickle et al., 2014 and Holley et al., 2016); investigating what staff did to promote recovery (Le Boutillier et al., 2015); the impact of recovery-oriented care on service user experience (Wallace et al., 2016);the relationship between ROP and personal recovery (Leamy et al., 2016) and the impact of a ROP promoting intervention on staff and service user rated outcomes for psychosis (Slade et al., 2015). Furthermore, studies on ROP conducted in England were mostly part of the REFOCUS project conducted by the same group of researchers (Slade et al., 2008). This study therefore also adds variety to the repository of literature on the implementation of ROP in England and provides insights into the facilitators and challenges to the implementation of ROP as experienced in one NHS organisation. This is important as the literature review identified that there was a dearth in studies on the implementation experiences of organisations providing ROP. This study contributes towards closing that gap and could inform implementation efforts of similar organisations.

In addition to the above, this study's original contribution to knowledge is that as practice moves towards a personal recovery focus, it is important not to lose the positive aspects of the medical model. The study shows that whilst the medical model has its shortcomings and has been widely criticised for being reductionist, paternalistic and for placing too much focus on the diagnosis rather than the person, the distress and experiences of exclusion caused by the symptoms of mental illness are barriers to recovery. The importance of clinical recovery and addressing symptoms of mental illness whilst promoting personal recovery is highlighted. The study therefore reinforces the idea that clinical and personal recovery should be seen as complementary of each other with equal importance placed on both depending on the service user's experience and priorities. To this end, ROP should involve adopting a multi-faceted approach, informed by the different conceptualisations of recovery, viewing recovery from different lenses including an ecological lens which would allow identification and tackling of barriers to recovery.

Following on from the above, a further contribution this study makes relates to a gap that was identified in practice in relation to promoting citizenship. It was observed that even though service users' accounts of their experiences reflected the stigma they suffered due to mental illness and tackling stigma and promoting citizenship are cited as a part of ROP work (Sainsbury Centre for Mental Health 2009;Chester et al., 2016, Le Boutillier et al., 2011), most efforts by the organisation and practitioners focused on implementing interventions within the organisation and it seemed little attention was paid to tackling barriers such as stigma outside the organisation. An explanation for this could be the shortage of resources which was

identified in the study, making it difficult for practitioners to do citizenship promoting work due to time constraints particularly in the CMHT. Nevertheless, this study highlights the need for organisations providing mental health care to explore how they can support staff to look outwards, identifying and tackling barriers to citizenship in their local communities as part of their endeavour to implement ROP.

Finally, the study brings attention to the unintended consequences associated with using completion of recovery tools such as the Recovery Star as incentives in the implementation of ROP. It adds weight to studies that have highlighted the need for meaningful measures for recovery and ROP (Williams et al. 2012). Importantly, it shows that commissioners are in a powerful position to influence service providers' priorities and could be a driving force in the implementation of ROP rather than a barrier as evidenced by John, a CMHT participant:

> "*The paperwork burden has become too high as well and part of that is the demands of our commissioners, who want to see that we're generating activity; that they get a sense that they're getting sort of their value for money. And that detracts from recovery-focussed work.*"

Implications and recommendations

Implications for practice

The findings in this study suggest that as mental health service providers implement ROP, there is a need for them to ensure service users are aware of personal recovery ideas. It seemed from the findings that only staff had been exposed to personal recovery ideas whilst service users mainly viewed recovery from a clinical recovery perspective. Having a limited view of recovery is associated with self-stigma, an inferior self-perception and a belief that one is damaged for life which results from the idea that one has an incurable illness (Shera and Ramon, 2013). Having knowledge about the different conceptualisations of recovery is therefore important as it could help to foster hope in service users, knowing that it is possible to live a fulfilling life in spite of having a mental illness which is essential for recovery (Repper and Perkins, 2003). Furthermore, it could help to address the power imbalance that can be created between service users and practitioners due to a perceived lack of knowledge on the part of service users. Including service users in training on recovery, providing information about recovery ideas in written form or through discussions are some of the imperative interventions organisations must include in their implementation efforts in order to expose service users to different conceptualisations of recovery and ensure they are equipped with knowledge. Such an approach could help to address some of the concerns relating to the adoption of ROP highlighted in earlier chapters and facilitate successful implementation of ROP.

Another implication for practice relates to the time commitment associated with building recovery promoting therapeutic relationships. The findings show that organisations providing mental health care need to ensure that they are committed to creating an environment that is conducive for this by making efforts to tackle barriers to service users and practitioners forming therapeutic relationships. As highlighted by Spandler and Stickley (2011), compassionate, hope inspiring relationships between service users and practitioners are influenced by the nature and context of the practice environment with things such as big caseloads, inadequate supervision and scarcity of resources being detrimental to such relationships. There is therefore a need for investment in resources and infrastructure to support and maintain hope inspiring relationships as part of the implementation of ROP in mental health services. This will also reduce the chances of moral distress burn-out in staff.

Implications for commissioners

The role of commissioners in supporting the translation of policy into practice was shown to be vital. Firstly, it was shown that what was prioritised and measured by commissioners became a priority for the service providers. Therefore, to promote implementation of ROP, it is important that commissioning priorities reflect a recovery orientation. Linked with this is the importance of ensuring the methods used to assess and measure achievement of targets are facilitative of ROP. Overreliance on counting and the use of completion of tools as incentives was shown to result in gaming and perverse incentives. The need to develop more meaningful ways of evaluating and measuring ROP was highlighted. The use of qualitative data which could give a more detailed reflection of the service users' experiences is indicated as quantitative measures have the potential to become tick-box exercises, limited in scope and depth. Using information from service user feedback and having people with lived experience working in services in roles that allow them to work with service users and gather authentic feedback could be helpful in evaluating the quality of the service and progress with implementation of ROP. Finally, prioritisation of allocation of resources also needs to reflect a recovery orientation. The study has shown the need for more resources which contrasts previous suggestions by Shepherd et al. (2010) that implementing service changes relating to the framework for implementing ROP by Sainsbury Centre (2009) would be cost neutral. For example, changing the nature of day-to-day interactions and the quality of the experience requires staff to spend time with the service user, building a therapeutic relationship. This is challenging with big caseloads and a shortage of staff. It is therefore essential that such resources are prioritised in the budgets and contracts reflect the need for providers to evidence this.

Implications for research

As this study has highlighted some of the barriers to the implementation of ROP, it would be useful for future studies to investigate strategies to overcome them. Firstly, it has been shown that finding meaningful and effective measures for assessing and evaluating ROP for use by commissioners and practice remains a challenge, it would therefore be useful for further research to investigate this as it could help to identify appropriate and effective ways of evaluating ROP and facilitate further developments in the implementation of ROP.

Secondly, the tension between risk management and ROP continues to be highlighted. This shows that there is a need to investigate how risk can be managed collaboratively and in a way that is aligned with recovery principles such as strength-based approaches and shared decision making. Investigating barriers to the use of these approaches could inform the implementation of ROP as organisations would be able to anticipate and put measures in place to overcome the barriers.

Thirdly, it would be useful for future research to explore the implementation of ROP from commissioners' point of view as this study has shown the important role they could play in the implementation of ROP. Future case studies including commissioners, service provider and service user participants could give a well-rounded view of the implementation of ROP and any associated challenges and facilitators.

Finally, further research investigating mental health service providers' experiences of tackling stigma and promoting citizenship as part of the implementation of ROP would be useful as this was an area that was identified as needing further attention. Interestingly, a recently published systematic review by Piat et al. (2021) strengthens this recommendation as it highlighted the need for further studies investigating factors outside the organisation which influence implementation of ROP.

Limitations

When the study was conducted, the organisation was in the infant stages of implementing some of the well-known ROP innovations such as the Recovery College and peer support worker scheme which could mean their impact may have not yet been realised. However, it was still useful to know about the different strategies the organisation was putting in place to implement ROP as it provided an understanding of the various innovations being adopted. The study also identified areas where caution might need to be practiced in implementing these innovations and in so doing informs future practice.

Another limitation in the study is that a review of the care plans of the service user participants was not conducted as part of the data collection as had been originally planned. This was

because consent for access to their care plans was not granted. However, whilst the care plans could have further corroborated what was being said by practitioners, talking to the service users also served the same purpose and therefore the study still gives a well- rounded view of how ROP was being implemented and experienced.

Furthermore, it could be argued that inclusion of carers and commissioners could have given a more holistic picture of how ROP was being implemented. However, these insights came from having conducted the study and evidence the contribution the study makes to future research rather than being a limitation as such. As evidenced in the previous sections, this study still provided new insights and a holistic picture in the context of the organisation that was being studied.

Finally, some may view the methodological approach taken as a limitation. However, whilst qualitative studies are criticised for lacking generalisability, Korstjens and Moser (2018) argue that quality criteria such as generalisability that are used for quantitative studies are not suitable for qualitative research. Therefore, instead of aiming for generalisability, the study aimed for transferability. This is the extent to which the findings of the study can be transferred to other contexts (Korstjens and Moser, 2018). Providing a description of the context, the NHS Trust, the two practice settings and the participants as I did in the methodology chapter allows readers to assess transferability. Furthermore, the NHS organisation the study was conducted in is a typical mental health service provider with practices that will be similar to other NHS organisations. The findings therefore bring useful insights which can help other organisations to examine and improve their practices in relation to the implementation of ROP. Moreover, conducting a case study had the advantage that it allowed an in-depth, context specific exploration of the phenomena (Simons, 2009). As highlighted by Simons (1996),

> *"The tension between the study of the unique and the need to generalise is necessary to reveal both the unique and the universal and the unity of that understanding"* p. 239.

As part of reflexivity, Stake's (1995) critique checklist for case study reports was used to self-assess the quality of the case study presented in this thesis (see Appendix 19).

Conclusion

This chapter has provided details on the unique contributions the research study makes to the subject of recovery and ROP. The implications of the study's findings for practice, commissioning and research have also been outlined together with recommendations for the future. Finally, the chapter provided a critique of the study and identified limitations for

consideration when interpretating the findings. The next chapter will conclude the thesis with a reflection on my journey as a doctoral student conducting this study.

Chapter 7: Personal Reflection

Reflection and reflexivity have been practiced throughout the research as the two exercises are integral to research (Fook, 2019). Reflexivity on my part as the researcher was important as it allowed me to look at myself and examine any assumptions and how these influenced the research. On the other hand, reflecting on my experiences helped me to learn from them and to adapt and improve my practice as a researcher. Moving forward, reflecting on my learning from the experience as a doctoral student and researcher will continue to inform my future practice as I continue to gain insights and to learn from the experience. Although reflexivity and reflection were practised throughout the research as evidenced in previous chapters, this chapter provides a rounded reflection on my journey as a professional doctorate student, looking at my development as a researcher, a professional and an individual.

Embarking on the professional doctorate programme was both exciting and daunting as I was aware it would be a lot of hard work. Since completing my A 'Levels and commencing my nursing course, I have studied on different programmes and courses so being a student was a familiar experience. The first two years of the doctorate programme involved completing eight taught modules. This provided a gentle introduction to doctorate level study, research philosophy and ethics which all proved invaluable for the research stage of the programme. The taught sessions allowed me to build relationships with other doctorate students who were novice researchers like me and these relationships provided opportunities to share ideas and encouragement when challenges arose during the research stage of the programme.

As a researcher, the lived experience of successfully planning and conducting a research study from the beginning to the end has increased my confidence. Being able to take an experience shared by a service user and turn it into a research question seeking more understanding and knowledge to improve practice has made me feel empowered. Having conversations with participants and being in a position to ensure their voices were heard through this work has been inspiring. Being on this journey gave me the confidence to join other researchers on a peer mentoring project which we got published. Finally, I was also invited to become a Recovery Research Network Collective member with some renowned recovery researchers in England which was an honour. This experience has therefore opened doors for me to continue on my journey as a researcher in this area. Moving forward, I plan to present my thesis findings at the next Recovery Research Network conference and to publish them in the Journal of Psychiatric and Mental Health Nursing.

In addition to developing research skills, going through the research process has also increased my level of self-awareness. Examining my values, beliefs, experiences and assumptions and how these shape my world view was an eye opener. It has made me more

conscious of the fact that my interpretations are subjective and influenced by various factors. This has made me more open to others' perspectives, a better leader and team-player.

As an academic, doctorate study has equipped me with the ability to be analytical and critical. These are lifelong transferrable skills I have used as an academic – teaching on the nursing programme and more recently as a Governance Performance Lead in the NHS. In my previous role as a nursing lecturer, embarking on the doctorate programme helped my development as I was given the role of course coordinator and lead for an MSc Dissertation module. In this role, I used my knowledge to teach and support students who were undertaking their MSc dissertations. Upon leaving my academic role in 2020 to work in the NHS as Governance Lead, I found that my background knowledge from studying recovery and ROP helped me immensely as I used insights and skills gained from my research experience to inform investigations, quality improvement projects and my report writing.

As a mental health nurse, my awareness of the barriers to ROP in day-to-day practice has been enhanced. My study findings have made me more critical of interventions that are implemented in practice, questioning how value adding they are to the service user experience and recovery. The importance of listening to service users and carers in order to learn from their experiences is something I now place a lot of value in and ensure that I use every opportunity I can in my role to provide a platform for them to share their experiences. What Tim, a CMHT service user said will always stay with me and influence my practice:

> "[…] Care plans are medical. To make sure you're still taking the tablets, you know? But a life plan, to see how your life can be improved to maybe be level with people who've never had mental illness. You know? I've always been… Not envious, but looking at people in jobs, you know, wandering around doing things and thinking I've been deprived of that. I've got no career, you know. I've got no family of my own, because probably my mental health took me off in a different direction, so… But no, I think if they put something in place called a 'life plan assessment' to assess your strengths and weaknesses and work with you to lead a better quality of life."

Fortunately, I am in a privileged position as Governance Lead to work with practice areas in my Trust to strive to achieve ROP and to ensure people like Tim do not feel like they have been dumped out of society. To date, using the knowledge and experience gained on recovery whilst undertaking this study, I have taken on the role of Chair in the Staff Network for staff with lived experience in the Trust I work for. I plan to continue to apply the insights gained in this and future studies to play a part in driving ROP forward.

On a personal level, completing the research is part of my self-actualisation. This has been a challenging process trying to juggle full-time job, family life and doctorate study. I learnt a lot about myself during the process including the fact that I am resilient as I continued with the course despite life changing experiences I endured whilst studying. The sense of duty I had towards my participants who had spared time and made sacrifices to participate in my study kept me going as I felt it was my responsibility to ensure in my own small way their voices were heard through my thesis and any subsequent publications. Finally, the experience has humbled me as it has shown me how much more learning there is to do as I continue my journey towards becoming a seasoned researcher.

Conclusion

In concluding this thesis, I am reminded of how the research journey started with a service user sharing his experience of ROP. Reflecting on his story and the findings of the study, I am convinced that ROP is about supporting people who experience mental illness with their priorities and goals so that they can live lives that are fulfilling and meaningful to them. Looking back at the aim and objectives of this study, I am satisfied that the study has achieved them. It has answered the question: *"How is recovery-oriented practice implemented in an NHS Trust providing care for people experiencing mental health problems?"*. In so doing, it has revealed insights to help our understanding of how ROP is implemented. These insights include: the different conceptualisations of recovery and the importance of incorporating these different ways of viewing recovery into ROP, the various strategies employed to implement ROP such as the use of the Recovery Star, the introduction of Recovery College and peer workers. Importantly, it has been shown that the therapeutic relationship plays a central role in implementing ROP at practitioner-service user level. In addition to this, the study highlights barriers to the implementation of ROP such as: the unintended consequences of using recovery tools as incentives and as tools for evaluating ROP, the tension between risk management and ROP and the shortage of resources that are facilitative of ROP. Moreover, the influence commissioners have over what is prioritised by providers of mental health services and the important role they could play in promoting the implementation of ROP is illuminated. Finally, this thesis has evidenced that whilst there is some progress with the implementation of ROP in mental health services, like recovery itself, the implementation of ROP is a journey. The need to promote citizenship and challenge stigma as part of implementation of ROP is articulated and recommendations for future research that could further propel the implementation of ROP are made.

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Appendices

Appendix 1: Data extraction sheet with study summaries

Title and Author	Aim	Methodology and Methods	Setting and sample	Findings	Conclusion/ recommendations	Critical appraisal
Salyers et al. (2009) Barriers and facilitators in implementing Illness Management and Recovery (IMR) for consumers with severe mental illness: trainee perspectives.	To assess the extent to which MH providers who had attended IMR training were implementing the programme and to identify the barriers and facilitators related to implementation.	Survey and content analysis of open-ended questions	Indiana, USA 89 care providers who had attended IMR training.	Barriers: lack of consumer motivation, consumer non-attendance, systems not geared towards IMR. Facilitators for implementation: the training, materials for the intervention, support from co-workers and supervisors and institutional practices	Training and toolkits do not function in a vacuum. There is a need for structural elements and staff motivation to support implementation.	The use of self-reported data, potential self-selection bias of sample. The response rate was low.
Peebles et al. (2009) Immersing practitioners in the Recovery Model: An educational programme evaluation	To evaluate the effectiveness and or impact of educational interventions for an academic audience which offer training based on a traditional medical model of care that the recovery model seeks to transform.	Quasi-experimental design - Survey using Recovery Knowledge and Attitude questionnaires. - -Comparison between practitioners who had received educational	Georgia, USA Psychiatry residents, psychologists, psychiatrists, psychology postdocs Pre-intervention – 35 responses. Post-intervention – 42 responses.	Training was successful in promoting enhanced knowledge of recovery and recovery key principles, partially successful in encouraging practitioners to adopt recovery supporting attitudes. Attitude change observed following workshop where practitioners and consumers shared experiences.	Knowledge gain and attitude shifts do not equal lasting changes to practice. Research in skill development mastery and transfer is needed	Attitudinal measures were self-report scales susceptible to social desirability bias, lack of control as quasi-experiment meant possible sampling bias, other natural events could have affected the study outcomes.

			programme and those who had not.	Control – 34 participants (Psychiatry residents, psychiatrists, psychology postdocs).			
Gilburt et al. (2013) Promoting ROP in MH Services, A quasi experimental mixed method study.	To evaluate the implementation of ROP through training across a system of mental health services.	Quasi experiment mixed method study. Semi structured interviews, Care plan audi.t		3 London Boroughs, UK. 22 MDTs (community and rehabilitation teams). Care plans of 700 patients. 16 team leaders interviewed.	Training had a positive impact with changes in the content of the care plan and attributed responsibility for action points in care plan changed for the intervention group. Resources are key in the implementation of ROP, with staff being a vital resource. Key qualities of staff were experience, motivation energy, commitment.	Lack of conceptual clarity is a barrier to implementation. Conceptual frameworks that focus on values, characteristic processes and stages of recovery and dimensions of recovery rather than actions may be useful in integrating ideological and practical elements to provide understanding of recovery. Organisational culture and climate are key to implementation of recovery models.	Strengths – use of mixed methods Limitation – Not RCT so not able to control for confounding factors Potential bias as no blinding Care plan audit was not sensitive to different stages of change so not able to detect the full impact of training.

					Training is useful as a way of knowledge transfer however training alone is unlikely to be sufficient to spread and sustain change. The use of measures is important in supporting and evaluating implementation. Organisational transformation requires ROP to be embedded in the core identity and role of mental health service providers.	
Leamy et al. (2014) Implementing a complex intervention to support personal recovery.: A qualitative study nested within a cluster RCT. REFOCUS Project	To investigate staff and trainee perspectives on the implementation of a complex recovery intervention designed to enable staff to increase recovery support to service users with a diagnosis of psychosis.	Qualitative study Face-to-face interviews with staff, team leaders from intervention group. 28 Interviews with trainers.	2 NHS Trusts in the UK 14 community based mental health teams Trainers, mental health care staff, trainer reports.	Barriers and facilitators to implementing the interventions related to: 1. Organisational readiness for change • (Trust readiness i.e., commitment and change), • team readiness i.e., effective leadership, recovery practice at baseline, team	Important to target the transition from practitioner intent to implement to actual implementation behaviour. Organisational commitment is central to implementation. Staff evaluate organisational	Strengths – data triangulation increases validity. Limitations: purposive sample for interviews and focus groups with self-reported use of the intervention as inclusion criteria. Possible recall bias as participants had to recall

		4 Focus groups with intervention teams Analysis of 28 trainer reports		• stability and composition • individual readiness i.e., attitudes towards the trial and intervention, perceived fit with own values knowledge and willingness to apply to practice) 2. Training effectiveness (engagement strategies, delivery style, modelling recovery principles).	commitment based on resource allocation, key performance indicators, outcome measures.	events over the past 12 months. Possible confounding factors such as staff turnover, changes in policy could have impacted the implementation.
Marshall et al. (2009) Mental Health consumers perceptions of receiving recovery-focused services.	To examine consumers' experience of recovery-focused support practices and their valuing of the activities.	Self-report questionnaire completed by consumers.	Australia Convenience sample of consumers from various mental health services in eastern Australian states.	Consumers receiving support from staff trained in a recovery-focused intervention identified significant changes relating to frequency with which they were encouraged to take responsibility for recovery, the level of collaboration with their workers and the amount of completed homework tasks. However, they did not rate their workers as more helpful in supporting recovery – consumers suggested that staff were supportive of their recovery regardless of whether they had received training.	Consumers are able to perceive recovery focused service changes.	The questionnaire used was not tested for reliability and validity.

| Waldemar et al. (2018)

Recovery orientation in mental health inpatient settings: Inpatient experiences. | To explore how efforts to implement ROP were reflected in inpatients' experiences of care. | Semi-structured interviews with inpatients. | Denmark

2 mental health wards in the capital region of Denmark. | Themes were: being accepted and protected; having company yet longing for dialogue; in the dark, confused, and uninformed; being observed and assessed; limited choice and influence; treatment centred on medicine. Overall, the patients' experience did not reflect recovery principles. | Educating health professionals and supplementing practice are not sufficient to implement ROP as traditional approaches continue to dominate settings.

Adding ROP to pre-existing structures transforms the concept and delivery of ROP into pre-existing ideas about mental health treatment. It is important to identify and address barriers to ROP in the organisation.

Implementation efforts need to bridge the gap between the notion of providing ROP and the reality of clinical practice.

ROP needs to be prioritised at political level as resources needed to sustain ROP need to be supplied. | Strength – use of semi-structured interview guide, exploratory approach taken.

Limitation - Participants reported memory problems due to medication – possible recall bias. |

Tickle et al. (2014) Can we risk recovery? A grounded theory of clinical psychologists' perceptions of risk and recovery-oriented mental health services.	To offer a preliminary insight into clinical psychologists' perceptions of risk and recovery approaches in mental health.	Grounded theory. Semi-structured interviews with clinical psychologists.	UK 2 NHS Trusts inpatient and community services.	There seemed to be limited strategic incorporation of recovery principles in MH practice by participants due to uncertainty about the meaning and practicalities of recovery, risk related anxiety and preoccupations with risk avoidance. The existing culture of mental health services was seen as emphasising the need to avoid risks which was seen as limiting innovation in the implementation of ROP.	Narrow conceptualisations of risk as related to harm and danger were contributing to a sense of needing to be risk averse. Sharing decision making and responsibility among stakeholders can reduce anxiety about risk and increase positive risk taking which can promote recovery. There is a need for learning environments that promote individual professional development and guidelines for ROP.	All participants were female and clinical psychologists.
Holley et al. (2016) The impact of risk management upon the implementation of recovery-oriented care in community mental health services: a qualitative investigation.	To explore how risk management practice impacts the implementation of recovery-oriented care.	Grounded theory. Semi structured interviews with 8 mental health worker and service user dyads.	UK, London. 5 CMHTs across 3 London Boroughs Mental Health Trusts.	4 themes: recovery-oriented care and positive risk taking, competing frameworks of practice (recovery-oriented care and risk management practice), a hybrid of risk and recovery, real life recovery-oriented care in the context of risk management practice.	A lack of strategic guidance at policy level and a lack of guidance and support at practice level may result in resistance to implementing ROP in	Purposive sample

| | | | | | the context of risk management practice.

Mental health workers aspirations for implementing ROP were contaminated by responsibility felt for managing and reducing service user exposure to risk. | |
|---|---|---|---|---|---|---|
| Crowe and Deane (2018)

Characteristics of mental health recovery model implementation and managers' and clinicians' risk aversion. | To investigate the relationship between clinicians' and managers' risk aversion and a range of variables related to the implementation of collaborative recovery model (CRM). | Cross sectional survey using questionnaire. | 5 states in Australia.

Clinicians and managers from NGO supporting people with mental illness. | Positive attitudes toward the use of goal planning tools in the context of ROP were associated with less risk aversion among clinicians.

Training, commitment to CRM principles, positive goal setting attitudes were significant predictors of CRM implementation. Less risk eversion significantly predicted higher self-reported consumers in clinicians.

Managers were found to experience less risk aversion than clinicians and the implementation of CRM principles was associated with lower risk aversion implementation of CRM with | Clinicians' risk aversion impacts upon their implementation of the CRM, with managers less risk averse than clinicians. | Research conducted in single organisation

The measures used had little psychometric data which limits their validity and reliability.

Response bias such as social desirability possible as self-reported. |

Kidd and George (2011) Recovery-oriented service provision and clinical outcomes in Assertive Community Treatment (ACT).	To examine the relationship between recovery-orientation of service provision for people with SMI and outcomes in ACT.	Survey. Recovery Self-Assessment (RSA) tool used to collect data.	67 ACT Teams in Ontario, Canada. Client, family, staff and managers were in the sample.	Modest results showing that RO service provision was associated with better client outcome in ACT. ACT team leader results showed significant negative association with annual hospital admission days, legal involvement and positive association with school involvement. Provider ratings showed significant positive associations with change in employment status in year 1 clients Client ratings showed positive association with clients in best practice employment settings	Study provides tentative evidence that MH services that incorporate recovery values and practices have better client outcomes. Evidence of the relationship between ROP and outcomes was inconsistent across stakeholders. Ongoing work to implement ROP and better articulate the relationship between ROP and clinical/functional outcomes is needed.	Reporting bias due to RSA being self-reported measure. Limited to ACT context in Ontario which could impact generalisability.
Slade et al. (2015) Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): a multisite cluster randomised controlled trial.	To assess whether implementing REFOCUS (an intervention to promote ROP) affected staff rated and patient rated outcomes in comparison to routine care for patients with psychosis.	Cluster RCT. Used Questionnaire about Processes of Recovery (QPR), Recovery Knowledge Inventory (RKI) Mental Illness Clinicians Attitudes (MICA)	2 NHS Trusts in the UK (England) Staff and patient participants from various AMHTs.	No significant effect of the REFOCUS intervention on recovery compared with treatment as usual. Most secondary outcomes did not differ except improved functioning Scores for self-reported recovery promotion behaviour were higher for high participation team staff and patients in these team also had higher QPR scores on the interpersonal subscale.	The organisational practice domain needs attention so that support of recovery is viewed as core business rather than an additional task for mental health services.	Bias in self-reported engagement with training due to social desirability. Existing practice in control group might have been recovery promoting as staff previously exposed to recovery training. QPR not been previously used as a primary outcome measure so

		For outcomes: the CANSAS-P and CANSAS-Staff, HoNOS, MANSA, Hope Index and such tools.		REFOCUS was associated with reduced costs of care but the difference was not significant.		may not have been responsive enough to capture change. There was no pilot study. Recruitment challenges meant smaller sample size which could have impacted the power of the study.
Wallace et al. (2016) Service user experiences of REFOCUS: a process evaluation of a pro-recovery complex intervention.	To investigate service user experiences of receiving the REFOCUS intervention to provide ecologically valid evidence for the impact of RO care on the experience of service user.	Qualitative study Interviews and focus groups.	CMHTs in 2 NHS Trusts in the UK. Service user participants.	The intervention facilitated a mutually open and collaborative relationship between staff and service users when successfully implemented. The intervention led to enhanced awareness of the SU strengths and values, a more positive self-image and increase in hope and empowerment. Some individuals struggled to notice any changes and could not describe any new tasks or conversations making the implementation of the intervention questionable.	Rigid formulaic implementation was not helpful. Recovery-focused tools should be integrated into care planning. Organisational transformation needs to balance technical skills with interpersonal qualities to promote recovery.	Strength – qualitative study allowed in-depth exploration Limitations - Possible recall bias as looking over a 12-month period. Researchers were known to be researching recovery so there may have been social desirability bias. Participant's selection based on self or staff reports of exposure to the REFOCUS intervention – may not be

						representative of other service users.
Leamy et al. (2016) Recovery practice in community mental health teams: national survey.	To investigate difference in team leader, clinician and SU perspectives on recovery orientation of CMHTs in England.	Cross sectional survey. RSA and QPR questionnaires.	6 NHS Trust CMHTs in the UK Team leader, clinicians and service user participants.	RSA scores varied by team – Early Intervention Psychosis had higher scores. Differences by team may have been due to the differing clinical populations. There was an association between SU perception of recovery orientation and their own recovery RSA scores associated with QPR scores for service user. Some NHS trusts scored higher on the RSA than others. NHS Trust accounted for variance in RSA No association between clinician and team leader recovery orientation score and personal experience of mental illness. Team leader RSA was higher that clinician and service user RSA scores. Possibly due to social desirability, overoptimistic or inaccurate appraisal of practice and different thresholds for ROP.	The study showed a cross sectional association between the recovery orientation of a team and the recovery experience of a service user.	Strengths – NHS Trusts from 5 regions of England Limitations – clinician sample via convenience sample may have led to selection bias. Some professional groups underrepresented. Small sample size of clinicians and team leaders without lived experience could account for the lack of association of lived experience and recovery orientation scores.. Only SU judged by clinician as well enough to participate were included so they may not be representative. Validity of QPR for people with illnesses

						other than psychosis not known. RSA measure was developed in the USA and its cross-cultural validity is not known.
Hungerford and Kench (2013) The perceptions of health professionals of the implementation of recovery-oriented health services: a case study analysis.	To consider how to overcome challenges in the implementation of recovery-oriented care, using insights gained from health managers and practitioners who have been involved in the process of implementation.	Descriptive single case embedded case study. Interviews and focus groups.	Australia 12 mental health practitioners.	Two themes capturing participants' perceptions were identified. These were: **Change management:** there was a common understanding of the meaning of recovery. Lack of clarity around how to implement ROP. Adversarial relationship between staff and management. Staff felt that a top-down approach to implementation had been adopted and felt unsupported by managers when dealing with patients who were too ill to set their own goals. Lack of clarity around managing risk whilst promoting autonomy. Managers felt staff had pessimistic attitudes towards patients.	Questions about the content of the education and training provided, and about the ongoing support provided to practitioners who work within a Recovery-oriented framework were raised. Proposed solutions include consultation, collaboration and consensus building with stakeholders to facilitate implementation and education, training and support for staff to work in a recovery-oriented way.	Small sample No medical practitioners or acute bed-based nurses participated so the sample was not wholly representative of the mental health workforce and acute care settings.

				Work practices: Challenges related to resource shortages in terms of staffing and insufficient organisational and community-based resources to support the realisation of recovery goals. The amount of paperwork associated with implementation of recovery-oriented care was too much for staff. Managers felt the above concerns were a symptom of the general anxiety staff had about the change.		
Hungerford and Fox (2014) Consumer's perceptions of recovery-oriented mental health services: An Australian case-study analysis.	To identify the nature of the challenges associated with the implementation of recovery-oriented services from a consumer perspective and to develop recommendations to address these challenges.	Case study (part of a bigger case study exploring challenges in the effective implementation of ROP) Focus groups Interviews IPA for analysis	South-eastern Australia. 9 Service user participants.	Most participants' understanding of recovery was consistent with the literature. Challenges to implementation related to consumers' fear of change. Professional struggle to translate recovery knowledge into practice – taking a hands-off approach rather than working with consumers and other stakeholders. Lack of clarity around responsibilities.	Consumers and health professionals lack clarity about responsibilities in recovery-oriented care. Ongoing targeted education facilitated by consumers to support recovery-oriented care should be offered to professionals.	Small sample size Case study design may mean findings not generalisable.

| Nugent et al. (2017)

Developing and Sustaining Recovery-Orientation in Mental Health Practice: Experiences of Occupational Therapists (OTs). | To explore OT's experience of developing and sustaining recovery orientation in mental health practice. | Qualitative study with a grounded theory approach.

Semi-structured in-depth interviews. | Australia.

12 OTs as participants. | ROP described as a journey, ongoing active process of seeking out knowledge, finding fit between ROP and their professional identity, holding hope, developing confidence.

Human and systemic aspects of the workplace influence the process

Barriers – key performance indicators (KPIs) not recovery oriented but clinically driven, legislation such as MHA leading to restrictive practice, time limitations, caseload size, negative co-worker attitudes towards recovery, medical orientation, lack of hope

Facilitators – leaders supporting ROP, involvement of people with lived experience, | Recommend recovery oriented KPIs.

Inclusion of peer workers.

Context specific troubleshooting.

OT leadership to facilitate implementation of ROP.

Training and education to facilitate system change. | Sample not representative of all OTs as from New South Wales and Victoria in Australia.

Only OTs who self-reported as practicing ROP were included. Views of those unable or unwilling to implement ROP could have been useful. |
|---|---|---|---|---|---|---|
| Piat et al. (2010)

The transformation of mental health services to a recovery-orientated system of care: Canadian decision maker perspectives | To explore the role and influence of organizational decision makers in the transformation to a recovery-oriented system of care | Qualitative study.

Semi structured interviews. | 3 Geographical areas in Canada.

10 Decision makers (policy makers, involved in regional planning, senor admin in large | How decision makers viewed the implementation of recovery was summarised in the following themes:

The need to agree on a definition of recovery. | Frontline providers play a vital role in translating recovery theory into practice. | Small purposive sample.

Study conducted at the start of the implementation of ROP. |

				psychiatric facilities).	Community settings were viewed as the easier setting to implement recovery.		
					They described their role as establishing overall service orientations and allocating funds, and found service providers as best positioned to incorporate recovery values into services		
					Negative attitudes of inpatient staff and the focus on security identified as barriers to implementation of ROP.		
					Fostering a new professionalism grounded in recovery values and practices, user involvement in planning and implementation, creating standards and outcome measures identified as facilitators.		
Piat and Lal (2012) Service Providers' Experiences and Perspectives on Recovery-oriented Mental Health System Reform.	To explore the experiences and perspectives of service providers on recovery-oriented reform and barriers face in implementing ROP.	Qualitative study. Focus groups.	3 Canadian States 68 service provider participants.	3 themes: Some participants expressed positive attitudes towards recovery-oriented reform and felt it was better way of delivering services which allowed attention to be paid to wider determinants of health and a shift from paternalist relationships to egalitarian /collaborative relationships.	Recommendations: training for providers to improve knowledge and attitudes. Practice policies to be consistent with recovery philosophy, support by leaders, research on application of ROP in certain contexts, active	Strengths – random sample selection, participants from diverse settings and different levels, relatively large sample. Limitations – focus group may result in participants not expressing their thoughts, sample not representative of all	

| | | | | Some participants expressed scepticism towards recovery-oriented reform and felt it did not contribute anything new, was a buzz word, questioned the use of the term recovery because of its association with cure.

Participants highlighted challenges associated with implementing recovery-oriented practice including conceptual uncertainty, challenges in some practice context e.g. Crisis, bureaucratisation of ROP – burden of paperwork, limited leadership support, dealing with stigma when working with other agencies such as housing. | engagement of consumers. | providers, data was collected during initial stages of implementation of ROP. |
|---|---|---|---|---|---|---|
| Khoury and Rodriguez del Barrio (2015)

Recovery-Oriented Mental Health Practice: A Social Work Perspective. | To explore the concept of recovery-oriented social work practice in mental health as understood and practiced by social workers. | Qualitative research.

Interviews.

Document analysis. | Canada.

11 Social Worker (SW) participants. | 2 themes: Work organisation, which refers to the systemic barriers to recovery-oriented practice, social work values and practice.

Work organisation challenges: organisational structures and systems that focus on outcome measures not aligned with recovery, focus on targets, flexibility of professional autonomy limited due to statistic and performance outcome measures, | Results oriented management practice focused on outcomes/targets may be at odds with ROP. Reconciliation of the competing demands for a recovery focus and a technocratic 'outcome' focus is a challenge for social workers. | Limited sample size. |

				predominance of the medical model, standardisation of care and of interventions, meaning and expression of ROP shaped by macro, meso, and micro factors such as emphasis on outcomes, long standing norms in psychiatry shape SW belief and discourse		
Clossey and Rheinheimer (2014) Exploring the Effect of Organizational Culture on Consumer Perceptions of Agency Support for Mental Health Recovery.	To explore the impact of mental health agency culture consumers' perceptions of agency support for their recovery	Survey Questionnaires	Pennsylvania, USA 12 Agencies, 188 consumers, 90 staff, 11 administrators.	Organisations with more constructive cultures had had consumers who indicated higher perceptions of agency support with recovery. Consistency with recovery model was insufficient to result in higher consumer perceptions of agency support for their recovery. Constructive culture means low stress, greater engagement of clients, more functionality, greater professional discretion, sense of support and cooperation from colleagues. Elements of constructive culture mirror elements of recovery support.	Organisational culture should be targeted when implementing ROP. A constructive culture is needed to implement ROP.	Small sample. Possible selection bias due to staff selection. Setting was rural Pennsylvania so may not be generalisable.

Le Boutillier et al. (2015)	To investigate what staff say they do to support recovery and to also identify perceived barriers and facilitators to recovery-oriented practice.	Qualitative study Grounded theory methodology.	5 NHS Trusts in different regions of England. 10 focus groups with 65 participants from MDTs, interviews with: 18 clinicians, 6 team leaders, 8 senior managers.	One core category (Competing priorities) and 3 sub-categories relating to influences on how recovery is implemented were identified. Health Process Priorities: challenges related to clinical language and systems such as risk management practice, the focus of systems on the institution rather than the individual, structures that focus on diagnosis and the medical model. Business Priorities: targets driven by commissioners not always being recovery focused, targets tied to funding make them a priority, conflict between government priorities and commissioning priorities as government policy is recovery oriented but commissioning targets are not always aligned with this policy, funding structures such as care clusters which are prescriptive, financial concerns suggestion that recovery had been high jacked as an agenda to save money. Staff Role Perception: some staff were able to still practice in a recovery-oriented, balancing	Successful implementation of ROP is influenced by staff understanding of ROP which is shaped by social interaction with commissioners, senior leaders, team leaders colleagues and service users. Mental health staff ability to implement ROP is affected by the need to manage competing organisational and financial requirements.	Strength - 97 staff from diverse roles participated (majority were nurses) Limitations - Findings are specific to the study context, use of a pre-defined ROP framework could have influenced participants' descriptions of ROP., insider position of some of the researchers could have influenced interpretation.

				organisational priorities with service user demands (influenced by personal values and professional maturity), some staff reported being able to practice in a recovery-oriented way within the organisational parameters, person centred care and strengths based practice was highlighted as important, specialist knowledge and establishing a working relationship with the service user, staff attitudes, the value they placed on their role viewed as influential in implementing ROP.		
Murphy (2012)

Recovery-orientation in Mental Health Services. What kinds of discourses are service users and staff drawing on during the adoption of recovery-oriented practices? A Foucauldian Discourse Analysis | To explore the positioning of service users and how recovery was being constructed during the implementation of ROP in a Community Support Team. | Foucauldian Discourse Analysis

Focus groups, interviews and documentary analysis | Community Support and Recovery Team in London England

9 service users, 5 staff, service user care plans, Recover Stars | Staff and service users were drawing from both the medical and personal recovery discourse.

The personal recovery discourse was used more by staff than service users.

There was a tension between the two discourses with the recovery discourse struggling to become established.

The medical discourse positioned the service user as the patient whilst positioning the service or the staff as doing things to people to make | Services needed to be more aware of the problematic aspects of the medical discourse with regards to how it can position people socially.

For ROP to be implemented, the personal recovery discourse needed to be the widely shared discourse between | Possible selection bias for both staff and service user sample as participating staff could have been those interested in recovery. Findings might not represent the general population.

The availability of a subject position provided by a discourse does not explain why some people |

| | | | | them better. The patient subject position caused the meaningfulness of service user experiences to be disregarded and did not allow a social understanding of mental illness by ignoring factors such as abuse, discrimination or disadvantage.

Clinical recovery positioned service users as dependent on services and not having responsibility. This in turn limited opportunities for positive risk taking and self-management.

Personal recovery discourse was used much more by staff and positioned service users as equals and involved in their care.

When using the personal recovery discourse, service users adopted the subject position of being empowered to prioritise their own goals.

The two discourses led to different meanings and possibilities available to service users. The discourse of chronicity and helplessness led to less hope and blocked the opportunity for change and the adoption of ROP. | service users and practitioners | get attached to that position. |

| Cusack et al. (2017)

The professional psychiatric/mental health nurse: skills, competencies and supports required to adopt recovery-oriented policy in practice. | To explore mental health nurses' role and to identify skills required for recovery-oriented policy and practice. | Mixed method approach

Survey, 22 focus groups and 28 written submissions. | Multiple health services in Ireland

1249 psychiatric/mental health nurses. | Survey: Specific areas that were addressed most in care planning for service users included medication management, type of support systems and coping mechanisms available, the person's hopes, wishes, fears and anxieties.

Inhibitors of ROP- Medicalised format of documentation within mental health service, biomedical focus of care planning, side effects of medication.

Facilitators: Supportive family relationships, community/peer support services environment where care is delivered –

Most used interventions: Goal setting, conversing.

Factors that facilitate the development of the role were knowledge, personal motivation and skills.

Factors that inhibit development of the role are: the medical model and organisational culture

Focus group: three major factors they perceived would assist them in working in a recovery-oriented way | The use of the symptoms focused approach in mental health care can be a barrier to the implementation of ROP.

Education and training in ROP across all disciplines is required to ensure consistency in care planning and delivery.

Organizational, service, professional and operational policies and guidelines need to reflect the principles and values of a recovery approach. | Descriptive study which may not be generalisable, however participants were from many different settings so the findings may be applicable to various settings. |

				- a need to increase opportunities for recovery education and training. - an organisational culture and structures to support a recovery-orientated approach. - ensuring recovery involves working as a member of an MDT with a focus on establishing collaborative partnerships with key community and peer support agencies. Skills, competencies - caring, interpersonal and recovery-oriented communication skills, competencies in recovery-focused assessment skills, particularly risk assessment/safety management and skill development Evidence-based practice - fostering support for service user outcome measurement and research.		

Appendix 2: School Ethics

School of Healthcare Sciences
Ysgol y Gwyddorau Gofal Iechyd
Head of School and Dean, Pennaeth yr Ysgol a Deon
Professor, Yr Athro Heather Waterman

Cardiff University

Eastgate House
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35 – 43 Newport Road
Cardiff
CF24 0AB

Tel +44 (0)29 20 688559

Email
...............HCAREEthic
s@cf.ac.uk

Prifysgol Caerdydd

06 July 2016

Fortune Mhlanga

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Caerdydd
CF24 0AB

Ffon: +44 (0)29 20
688559

E-bost
...............HCAREEthics@c
f.ac.uk

Dear Ms Mhlanga

Overall I am happy to confirm that I have reviewed the proposed study in line with your request and have included track changes on the PASE Form and the Participant information sheets. The consent forms have no comments. Your study appears well thought through, is easy to understand and appears to have current clinical relevance.

I am happy to discuss my comments with you if helpful but they are very minor.

Good luck with your IRAS application and in undertaking the study.

Kind regards

Dear Mrs Mhlanga

Letter of HRA Approval

Study title:	**The Implementation of Recovery-oriented Practice in Mental Health Services. A nested case study.**
IRAS project ID:	**202218**
Protocol number:	**1540-16**
REC reference:	**16/LO/1889**
Sponsor	**Cardiff University**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Appendix 4: Research passport

Student Occupational Health, Counselling, Health and Wellbeing
Student Support and Wellbeing Division
Iechyd Galwedigaethol i Fyfyrwyr, Cynghori Iechyd a Lles
Adran Cymorth a Lles Myfyrwyr

CARDIFF
UNIVERSITY

PRIFYSGOL
CAERDYDD

RESEARCH PASSPORT

TO: Dr Ben Hannigan

Cc   Fortune Mhlanga

NAME: Fortune Mhlanga

DEPARTMENT: School of Health Sciences
SCREEN DATE: 10/04/2017

1.   Fit   ☑

2.   Fit with adjustments   ☐

3.   Awaiting further information from GP/Consultant   ☐

4.   Referred to Occupational Health Consultant Physician   ☐

The implementation of recovery-oriented practice in mental health services: A qualitative case study

Are you a registered practitioner working within the community mental health team or the rehabilitation ward?

You are invited to participate in a study exploring how recovery-oriented practice is being implemented in mental health services for working age adults. You could contribute to this study by talking about how you work with people experiencing mental health problems who are under your care to promote their recovery.

What will this involve?

- You will be asked to participate in an interview with the researcher lasting between 45 and 90 minutes. This interview will focus on your experience of providing care and support for the service users you work with.
- You will be asked to identify service users / a service user you work with whose recovery you have supported who you feel could also participate in the study.

For more information, please contact the researcher:

Fortune Mhlanga

Tel: 07939872263

e-mail: mhlangaft@cardiff.ac.uk

Appendix 6: Service user invite template

Dear XXX,

I hope this letter finds you well.

My name is Fortune. I am a doctorate student at Cardiff University. I was given your contact details by XXX as you have indicated that you are happy to be contacted in relation to research.

I am writing to invite you to participate in a study I am conducting as part of my doctorate study. The study aims to investigate how mental health services support people who experience mental health problems with their recovery. I believe you may be able to provide some insights into this study.

Please see the participant information form included with this letter for more details. If you have any questions, you can contact me via e-mail: MhlangaFT@cardiff.ac.uk

I look forward to hearing from you.

Regards,

Fortune Mhlanga

Doctorate Student

Cardiff University

The Implementation of Recovery-oriented Practice in Mental Health Services: A qualitative case study

Reply slip

Please contact me about this study.

Name:

Telephone number:

e-mail address:

Or alternatively, you can contact the researcher using the following details:

Fortune Mhlanga

Tel:

e-mail: mhlangaft@cardiff.ac.uk

The Implementation of Recovery-oriented Practice in Mental Health Services: A qualitative case study

Managers Participant Information Sheet

Introduction

I would like to invite you to take part in a research study I am conducting. I will be exploring how a healthcare organisation is implementing recovery-oriented practice. This information sheet contains more information about the study and how you can be involved. Please feel free to discuss this information with others if you wish. It will take you about 10 minutes to read through the information.

What is the research about?

This research aims to explore how recovery-oriented practice is implemented in organisations providing care to people with mental health problems. Recovery is a concept that arose from mental health service users who were unhappy with the way their care was being given. The concept has gained momentum and has now been adopted in most of the Western world including the United Kingdom. Recovery in mental health means different things to different people. However, there is a consensus that it is about having hope, being in control and leading a fulfilling life in spite of symptoms of mental illness. Organisations providing mental health care in the UK are expected to be adopting the recovery approach. However, literature suggests that it is not always clear how to implement recovery in mental health services. This research aims to add to what is known about how recovery is implemented in mental health services by exploring the views and experiences of practitioners, managers and service users in a mental health organisation in relation to recovery-oriented practice.

Why is this research being undertaken?

This research is being undertaken in order to add to what is known about how to implement the recovery approach in mental health services. This is because although UK policy advocates the adoption of the recovery approach in mental health services, the implementation has been slow and patchy. Implementing a recovery approach requires a change from the traditional way in which care has been delivered. It entails a shift from focussing on symptom reduction to helping people to live their lives with or without symptoms of mental illness. Promoting personal recovery has the potential to help to reduce negative experiences such as social exclusion, loss of control of one's life and hopelessness suffered by people with serious mental illness. It is therefore important that we know how to implement the recovery approach in order to improve the experience of people with mental health problems. This study will help to promote the recovery approach by contributing to what is known about barriers and facilitators to the implementation of recovery and by finding out how organisations can become more recovery focussed.

Why have I been chosen?

You are being invited to take part in this study because you are currently a manager within an NHS organisation providing care to people with mental health problems and have a role as a recovery lead or have a leading role within a team that delivers care to people of working age experiencing mental health problems. Sharing about your vision and experiences of influencing how care is delivered within your organisation will help to elicit the philosophy of care being adopted by the Trust and how this is filtered down to those providing direct care. This will help to explore factors that facilitate or hinder the implementation of recovery-oriented practice from a management perspective as you will be able to share the Trusts' vision in relation to mental healthcare and recovery and how managers turn it into a reality. By sharing your views, you will add to what is known about how organisations can implement recovery – oriented practice at management level.

Do I have to take part?

Participation in this study is voluntary and your decision to participate or not does not impact your role or employment in any way.

What will participation involve?

If you choose to take part in the study, you will need to contact the researcher using the contact details below or the reply slip and envelope provided. The researcher will then contact you to make an appointment to conduct an interview with you which will last no more than 90 minutes. You can choose where you would prefer to have the interview. This can either be at the researcher's place of work or at your own place of work. The researcher will ask you to complete a consent form before the start of the interview. This will also be an opportunity for you to ask any questions you might have regarding participation in the study. The researcher will record the interview.

What are the benefits for me if I participate?

There are no direct or immediate benefits for you from the study. However, your participation will help to inform mental health service providers about how to improve care and enhance the experiences of people with mental health problems receiving care from healthcare organisations. Barriers and facilitators to the implementation of recovery-oriented practice will be identified. This will help organisations to plan and put in place measures to reduce the barriers and support staff to be in a position to practice in a recovery-oriented way.

Are there any risks associated with participation?

There are no risks associated with your participation. If you feel that some questions are sensitive or personal during the interview, you can choose not to answer them.

What will happen if I do not want to continue with the study?

You can opt out of the study anytime you choose to. However, as your data will be getting anonymised when it gets stored, if you opt out after the data has been anonymised, your interview data will still be used in the study as it will be difficult to identify it for removal. However, you will not be contacted by the researcher for any further information.

How will my information be kept confidential?

Firstly, all data will be anonymised in order to protect participants' identities. Data will be stored in accordance with the requirements of the Data Protection Act and Cardiff University's information governance guidance. This means all data will be stored in a locked cupboard, only accessible to the researcher. Any electronic copies of data will be kept on a password protected work computer and will only be accessible to the researcher. Furthermore, any documents with identifiable information will be stored in a locked cupboard separate from the interview data. Everything you share with the researcher will be kept confidential unless there are concerns about your safety or that of others. In such a case, the researcher would let you know about the concerns and the matter would be dealt with by the appropriate authorities.

What will happen to the results of the study?

The study will be submitted as part of a Doctor of Advanced Healthcare Practice thesis. Findings will also be presented at conferences and submitted for publication in academic journals. A summary of the report will be given to the participating NHS Trust and to all participants who would like a copy.

What if I have concerns about the study?

You can discuss any concerns relating to the study with the researcher. However, if you are still unhappy, and wish to complain formally, you can follow the NHS complaints procedure via xxx Trust.

What do I do next?

You may wish to discuss this information with your colleagues and others. Please feel free to do so. You can also contact the researcher for clarification or further information before making a decision.

However, if you have read and understood the information and wish to participate, please contact the researcher using the contact details below. Alternatively, you can complete and send the reply slip provided to the researcher. The researcher will then contact you to agree a mutually convenient time to go through the consent forms and the interview.

If you have decided that you do not wish to participate in this study, you do not need to do anything else.

Thank you for taking time to read through this information.

Fortune Mhlanga

Cardiff University Research Student

Contact details:

e-mail – MhlangaFT@cardiff.ac.uk

The Implementation of Recovery-oriented Practice in Mental Health Services: A qualitative case study

Service User Participant Information Sheet

Introduction

I would like to invite you to take part in a research study I am conducting. I will be exploring how a healthcare organisation is implementing recovery-oriented practice. This information sheet contains more information about the study and how you can be involved. Please feel free to discuss this information with others if you wish. It will take you about 10 minutes to read through the information.

What is the research about?

This research aims to explore how recovery-oriented practice is implemented in organisations providing care to people with mental health problems. Recovery is a concept that arose in the United States from mental health service users who were unhappy with the way their care was being given. The concept has gained momentum and has now been adopted in most of the Western world including the United Kingdom. Recovery in mental health means different things to different people. However, there is a consensus that it is about having hope, being in control of one's life and leading a fulfilling life in spite of symptoms of mental illness. Organisations providing mental health care in the UK are expected to be adopting the recovery approach. However, literature suggests that it is not always clear how to implement this approach in mental health services. This research aims to add to what is known about how recovery can be implemented in mental health services by exploring the views and experiences of practitioners, managers and service users in a mental health organisation in relation to recovery-oriented practice.

Why is this research being undertaken?

This research is being undertaken in order to add to what is known about how to implement the recovery approach in mental health services. This is because although UK policy advocates the adoption of the recovery approach in mental health services, the implementation has been slow and patchy. Implementing a recovery approach requires a change from the traditional way in which care has been delivered. It entails a shift from symptom reduction to helping people to live their lives with or without symptoms of mental illness. Promoting personal recovery has the potential to help to reduce negative experiences such as social exclusion, loss of control of one's life and hopelessness suffered by people with serious mental illness. It is therefore important that we know how to implement the recovery approach in order to improve the experience of people with mental health problems. This study will help to promote the recovery approach by contributing to what is known about barriers and facilitators to the implementation of recovery and by finding out how organisations can become more recovery focussed.

Why have I been chosen?

You are being invited to take part in this study because you are currently receiving care from the NHS organisation where this research study is being undertaken. Your care coordinator/named worker has identified you as someone who will be able to contribute to this research. Sharing about your experience of care as a service user will help to elicit how care is being delivered by the team and how your recovery is being promoted by those supporting you. This will give some insight into the aspects of your care that you consider as helpful to your recovery and those which hinder your recovery. Your name will only be passed on to me (the researcher) if you are interested in taking part in the research study.

Do I have to take part?

Participation in this study is voluntary and your decision to participate or not does not affect your care in any way.

What will participation involve?

If you choose to take part in the study, you will need to contact the researcher using the contact details below or the reply slip and envelope provided. The researcher will then contact you to make an appointment to conduct an interview with you which will last no more than 90 minutes. If you are currently an inpatient, the interview will be carried out in a quiet room on the ward. If you are receiving care in the community, the interview will either be carried out in the outpatient department offices at the hospital or at your home depending on your preference. Prior to the start of the interview, the researcher will ask you to complete a consent form. This will also be an opportunity for you to ask any questions you might have regarding participation in the study. The researcher will record the interview. In addition to this, the researcher will be asking for permission to access your clinical notes in order to get more information about your care.

What are the benefits for me if I participate?

There are no direct or immediate benefits for you from the study. However, your participation will help to inform mental health service providers about how to improve care and enhance the experiences of people with mental health problems receiving care from healthcare organisations.

Are there any risks associated with participation?

There are no risks associated with your participation. If you feel that some questions are sensitive or personal during the interview, you can choose not to answer them.

What will happen if I do not want to continue with the study?

You can opt out of the study anytime you choose to. However, as your data will be getting anonymised when it gets stored, if you opt out after the data has been anonymised, your interview data will still be used in the study as it will be difficult to identify it for removal. However, you will not be contacted by the researcher for any further information.

How will my information be kept confidential?

Firstly, all data will be anonymised in order to protect participants' identities. Data will be stored in accordance with the requirements of the Data Protection Act and Cardiff University's information governance guidance. This means all data will be stored in a locked cupboard, only accessible to the researcher. Any electronic copies of data will be kept on a password protected work computer and will only be accessible to the researcher. Furthermore, any documents with identifiable information will be stored in a locked cupboard separate from the interview data. Everything you share with the researcher will be kept confidential unless there are concerns about your safety or that of others. In such a case, the researcher would let you know if they needed to discuss the concerns with the team involved in your care and the matter will be dealt with by appropriate authorities.

What will happen to the results of the study?

The study will be submitted as part of a Doctor in Advanced Healthcare Practice thesis. Findings will also be presented at conferences and submitted for publication in academic journals. A summary of the report will be given to the participating NHS Trust and to all participants who would like a copy.

What if I have concerns about the study?

You can discuss any concerns relating to the study with the researcher. However, if you are still unhappy, and wish to complain formally, you can follow the NHS complaints procedure via xxx Trust. You can also contact the Patient Advise and Liaison Support service (PALs) provided by the Trust for support and advice.

What do I do next?

You may wish to discuss this information with your care co-ordinator, carers, family or friends. Please feel free to do so. You can also contact the researcher for clarification or further information before making a decision.

However, if you have read and understood the information and wish to participate, please contact the researcher using the contact details below. Alternatively, you can complete and send the reply slip provided to the researcher. The researcher will then contact you to agree a mutually convenient time to go through the consent forms and the interview.

If you have decided that you do not wish to participate in this study, you do not need to do anything else.

Thank you for taking time to read through this information.

Fortune Mhlanga

Cardiff University Research Student

Contact details:

e-mail – MhlangaFT@cardiff.ac.uk

The Implementation of Recovery-oriented Practice in Mental Health Services: A qualitative case study

Practitioner Participant Information Sheet

Introduction

I would like to invite you to take part in a research study I am conducting. I will be exploring how a healthcare organisation is implementing recovery-oriented practice. This information sheet contains more information about the study and how you can be involved. Please feel free to discuss this information with others if you wish. It will take you about 10 minutes to read through the information.

What is the research about?

This research aims to explore how recovery-oriented practice is implemented in organisations providing care to people with mental health problems. Recovery is a concept that arose from mental health service users who were unhappy with the way their care was being given. The concept has gained momentum and has now been adopted in most of the Western world including the United Kingdom. Recovery in mental health means different things to different people. However, there is a consensus that it is about having hope, being in control and leading a fulfilling life in spite of symptoms of mental illness. Organisations providing mental health care in the UK are expected to be adopting the recovery approach. However, literature suggests that it is not always clear how to implement this approach in mental health services. This research aims to add to what is known about how recovery is implemented in mental health services by exploring the views and experiences of practitioners, managers and service users in a mental health organisation in relation to recovery-oriented practice.

Why is this research being undertaken?

This research is being undertaken in order to add to what is known about how to implement the recovery approach in mental health services. This is because although UK policy advocates the adoption of the recovery approach in mental health services, the implementation has been slow and patchy. Implementing a recovery approach requires a change from the traditional way in which care has been delivered. It entails a shift from symptom reduction to helping people to live their lives with or without symptoms of mental illness. Promoting personal recovery has the potential to help to reduce negative experiences such as social exclusion, loss of control of one's life and hopelessness suffered by people with serious mental illness. It is therefore important that we know how to implement the recovery approach in order to improve the experience of people with mental health problems. This study will help to promote the recovery approach by contributing to what is known about barriers and facilitators to the implementation of recovery and by finding out how organisations can become more recovery focussed.

Why have I been chosen?

You are being invited to take part in this study because you are currently. a mental health professional providing care to people with mental health problems within an organisation providing mental health services. Sharing about your experiences of working with people with mental health problems towards their recovery will help to elicit how care is being delivered to mental health service users and any challenges you may face in trying to provide this care. You will also be able to add to what is known about barriers and facilitators of recovery-oriented practice from a mental health practitioner's view.

Do I have to take part?

Participation in this study is voluntary and your decision to participate or not does not impact your role or employment in any way.

What will participation involve?

If you choose to take part in the study, you will need to contact the researcher using the contact details below or the reply slip and envelope provided. The researcher will then contact you to make an appointment to conduct an interview with you which will last no more than 90 minutes. You can choose where you would prefer to conduct the interview. This can either be at the researcher's place of work or at your own place of work. The researcher will ask you to complete a consent form before the start of the interview. This will also be an opportunity for you to ask any questions you might have regarding participation in the study. The researcher will record the interview. In addition to this, the researcher will be asking you to identify a service user or service users you are working with who you think would be suitable to give a service user perspective of recovery-oriented care. Your assistance with this will also be voluntary. In the event that you are in a position to identify any service user participants, you will be asked to forward an information pack about the research to them.

What are the benefits for me if I participate?

There are no direct or immediate benefits for you from the study. However, your participation will help to inform mental health service providers about how to improve care and enhance the experiences of people with mental health problems receiving care from healthcare organisations. Barriers and facilitators to the implementation of recovery-oriented practice will be identified. This will help organisations to plan and put in place measures to reduce the barriers and support staff to be in a position to promote recovery, thereby improving the staff and service user experience.

Are there any risks associated with participation?

There are no risks associated with your participation. If you feel that some questions are sensitive or personal during the interview, you can choose not to answer them.

What will happen if I do not want to continue with the study?

You can opt out of the study anytime you choose to. However, as your data will be getting anonymised when it gets stored, if you opt out after the data has been anonymised, your interview data will still be used in the study as it will be difficult to identify it for removal. However, you will not be contacted by the researcher for any further information.

How will my information be kept confidential?

Firstly, all data will be anonymised in order to protect participants' identities. Data will be stored in accordance with the requirements of the Data Protection Act and Cardiff University's information governance guidance. This means all data will be stored in a locked cupboard, only accessible to the researcher. Any electronic copies of data will be kept on a password protected work computer and will only be accessible to the researcher. Furthermore, any documents with identifiable information will be stored in a locked cupboard separate from the interview data. Everything you share with the researcher will be kept confidential unless there are concerns about your safety or that of others. In such a case, the researcher would let you know about the concerns and the matter would be dealt with by the appropriate authorities.

What will happen to the results of the study?

The study will be submitted as part of a Doctor of Advanced Healthcare Practice thesis. Findings will also be presented at conferences and submitted for publication in academic journals. A summary of the report will be given to the participating NHS Trust and to all participants who would like a copy.

What if I have concerns about the study?

You can discuss any concerns relating to the study with the researcher. However, if you are still unhappy, and wish to complain formally, you can follow the NHS complaints procedure via xxx Trust.

What do I do next?

You may wish to discuss this information with your colleagues and others. Please feel free to do so. You can also contact the researcher for clarification or further information before making a decision.

However, if you have read and understood the information and wish to participate, please contact the researcher using the contact details below. Alternatively, you can complete and send the reply slip provided to the researcher. The researcher will then contact you to agree a mutually convenient time to go through the consent forms and to conduct the interview.

If you have decided that you do not wish to participate in this study, you do not need to do anything else.

Thank you for taking time to read through this information.

Fortune Mhlanga

Cardiff University Research Student

Contact details:

e-mail – MhlangaFT@cardiff.ac.uk

Consent Form for Managers

**Study: The Implementation of Recovery-Oriented Practice in Mental Health Services.
A qualitative case study.**

Name of Participant: **...**

Name of Researcher**...**

Please initial box

I confirm that I have read and understand the information sheet (V2 Participant Information Sheet for Managers) for the above study.
I have had the opportunity to consider the information and ask questions and I have had these answered satisfactorily.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any effect on my employment.

☐

I understand that the interview will be recorded on a digital recording device.
I give permission for this.

☐

I understand that direct quotations from the interview will be used in the research report, publications and presentations arising from the study. I understand that the quotations will be anonymous with no person, or NHS Trust identifiable.

☐

I agree to take part in the above study.

☐

Name of participant   Date   Signature

_____   _____   _____

Name of researcher   Date   Signature

When completed: 1 for participant, 1 for researcher

Consent Form for Practitioners

**Study: The Implementation of Recovery-Oriented Practice in Mental Health Services.
A qualitative case study**

Name of Participant: ....

Name of Researcher...

Please initial box

I confirm that I have read and understand the information sheet for the above study (V2 Participant Information Sheet for Practitioners).
I have had the opportunity to consider the information and ask questions and I have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any effect on my employment.

I understand that the interview will be recorded on a digital recording device.
I give permission for this.

I understand that direct quotations from the interview will be used in the research report, publications and presentations arising from the study. I understand that the quotations will be anonymous with no person, or NHS Trust identifiable.

I agree to take part in the above study.

Name of participant   Date   Signature

Name of researcher   Date   Signature

When completed: 1 for participant, 1 for researcher

Consent Form for Service User Participants

**Study: The Implementation of Recovery-Oriented Practice in Mental Health Services.
A qualitative case study**

Name of Participant: **...**

Name of Researcher**...**

Please initial box

I confirm that I have read and understand the information sheet for the above study
(Participant Information Sheet for Service User Participants).

☐

I have had the opportunity to consider the information and ask questions and I have had
these answered satisfactorily.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time
without giving any reason, without any effect on my care.

☐

I understand that the interview will be recorded on a digital recording device.
I give permission for this.

☐

I understand that the researcher will access my clinical records as part of the data collection
process. I give my permission for this.

☐

I understand that direct quotations from the interview will be used in the research
report, publications and presentations arising from the study. I understand that the
quotations will be anonymous with no person, or NHS Trust identifiable.

☐

I agree to take part in the above study.

☐

Name of participant   Date   Signature

Name of researcher   Date   Signature

When completed: 1 for participant, 1 for researcher

Semi-Structured Interview Guide for Service User Participants

1. **Please tell me about your journey in mental health services.**

   Prompts:

   How long have you been using services?

   What has been your experience of care?

2. **Please tell me about what recovery means to you.**

   What does recovery mean to you?

   What is most important to you with regards to your recovery?

   What needs to happen for you to consider yourself recovered?

3. **Thinking about how you are supported whilst receiving care, in your opinion, what is recovery-oriented practice?**

   Prompt:

   Could you tell me about an experience of care that you felt was positive and promoted your recovery?

   How did the team working with you approach your care?

   What were the priorities with regards to your care and how were they decided?

   What made this experience recovery oriented in your view?

   Was there anything about you or something you did that made the experience positive?

4. **In your personal experience, has there been any change in how you have been supported over the years?**

   Prompt:

   Please tell me about these changes if any.

   What do you think has led to the changes?

5. **Please tell me about your current experience of care.**

   Prompt:

   Are there any aspects of the support you are receiving that make you feel hopeful and optimistic for the future?

   Who is in control of the direction in which your care is taking?

   How were the goals for your care plan decided?

   How are your relationships with others including friends, family promoted?

   Are you involved in any activities outside mental health services?

   What aspects of your care do you find helpful in achieving your goals for your future or your recovery? (This can be to do with the organisational structures, the qualities of your worker or any resources that have been put in place to support recovery.)

6. **Please tell about any barriers or potential barriers to the achievement of your future goals or your recovery.**

   Prompt:

   What characteristics or challenges does your illness present that could hinder recovery?

   Are there any approaches taken by mental health practitioners that are unhelpful?

   Please tell me about any structures, systems or attitudes on the part of service providers that could be a hindrance.

7. **Based on your experience as a service user, what are your views with regards to the recovery approach being adopted in mental health services?**

Is there anything else you would like to tell me about how services can ensure successful implementation of recovery-oriented practice?

We have reached the end of the interview. Thank you for your participation and for your time.

Semi-Structured Interview Schedule for Practitioners

1. **Please tell me about your values as a practitioner.**

   Prompts:

   What are your beliefs with regards to how people with mental illness should be treated and supported?

   What is most important to you when you are working with service users?

2. **In terms of mental health, what does recovery mean to you?**

   Prompts:

   What do you regard as important for someone to be considered as "recovered" or "in recovery"?

   Is there a way of measuring recovery?

3. **What is your understanding of recovery-oriented practice?**

   Prompts:

   Please could you tell me about a service user whose recovery you feel you supported well.

   What did you do to support this person?

   What made you think you had supported them well? What was the outcome?

   Please tell me about your individual qualities that you feel facilitated the individual's recovery.

4. **In your experience, what changes have been made to practice with regards to the way practitioners work with service users since the introduction of recovery in policy and practice?**

   Prompts:

   What areas does your multi-disciplinary team providing care focus on with regards to supporting individuals in your care?

   How are treatment goals decided upon?

Who is in charge of the direction the service user's care takes?

5. **What structures within your organisation/ service do you find helpful and facilitative of recovery-oriented practice?**

   Prompts:

   Have you had any training?

   Have any tools or resources been made available to you to enhance recovery orientation in your practice?

6. **From your experience, please tell me about any factors that you feel could be barriers or potential barriers to recovery-oriented practice?**

   Prompts:

   Are there any structures, systems or ways of doing things that make it difficult to be recovery oriented?

   On a personal level, are there any characteristics or beliefs practitioners could have that could be an impediment to recovery-oriented practice?

   Do you feel well equipped and supported to practice in a recovery-oriented way?

   Are there any service user characteristics that could present a challenge?

7. **How do you get feedback about how well you are supporting the personal recovery of the service user you work with?**

   Prompts:

   Is it discussed in supervision?

   Is it part of your performance appraisal with your manager?

   Do service users have the opportunity to give verbal or written feedback using formal tools or informally?

   Are there measured outcomes that give an indication of how well you have supported someone?

8. **From your experience as practitioner, is there anything that you feel could be done to ensure successful implementation of recovery-oriented practice?**

9. **From your experience as practitioner, what are your views about the appropriateness of the recovery approach in mental health practice?**

Is there anything else you would like to tell me about the implementation of recovery-oriented practice from a practitioner's perspective?

We have reached the end of the interview. Thank you for your participation and for your time.

Appendix 16: Semi-structured interview guide for manager participants

Semi-Structured Interview Guide for Manager Participants

1. **Please tell me about the values of your organisation.**
   Prompt:
   What are the priorities of the service with regards to the support people under the care of the service receive and how this support is delivered?

2. **Could you describe how the organisational values are communicated and embedded in the organisation?**

Prompt:
Are the values reflected in the operational policies or mission statements?
Are the values considered during recruitment to ensure candidate with the right values join the team?
Are they communicated as part of staff induction?

3. **Please tell me about your understanding of recovery for people with mental illness.**

   Prompt:

   What is considered as "recovery" in the service users being supported by your service?

4. **Please tell me about your understanding of recovery -oriented practice.**
   Prompt:
   How has your organisation implemented recovery-oriented practice?
   What structures have been put in place to promote recovery-oriented practice?
   Have any additional resources been allocated to support implementation of recovery-oriented practice?
   Are there any new roles or training for staff relating to recovery-oriented practice?
   Do you follow any guidance with regards to how to implement recovery-oriented practice?
   Overall, do you think there has been a change in the way the service provided by your team is delivered since the introduction of recovery in national policy and guidance for mental health services?

5. **In your experience, what would you say are some of the barriers to the implementation of recovery-oriented practice?**

6. **In your experience, what would you say are the facilitators of recovery-oriented practice?**

7. **Do you evaluate your performance with regards to the implementation of recovery-oriented practice?**

    Prompt:
   If yes:
   What mechanisms / tools do you use to gather feedback?

Which aspects do you measure to get an indication of how ell recovery has been implemented?

What do your evaluations indicate in terms of how well recovery-oriented practice has been implemented so far?

Are there any challenges associated with evaluation of recovery-oriented practice? If no:

What are the reasons why you do not evaluate implementation of recovery-oriented practice?

Are there plans to do this in the future?

8. **From your experience in practice, what are your views about the appropriateness of the recovery approach in mental health practice?**

Is there anything else you would like to share with me with regards to the implementation of recovery-oriented practice within your organisation?

We have reached the end of the interview. Thank you for your participation and for your time.

Appendix 17: Example data extracts for candidate theme – CMHT practitioners

Yellow- quotes from participants

Green – Fortune's interpretations

Barriers to implementation of ROP

Ruth	Bob	Jane	John	Kate
but it's the state of the services as they are at the moment, unfortunately. We just have… There are so many people in need and only so many workers and you have to kind of spread yourself, so that you can provide to the many. Limited resources As a service, I think we are trying to move people through. I mean, we are told to start talking to clients about discharge almost at the point they come through to us, so they've always got discharge in mind, which I	What's 'doing my job'? You know? I sometimes think that what I do and consider to do my job and some of the things that I do, you know, that there's probably some of my managers that would totally disagree and be saying that I shouldn't be doing that and I need to be doing more of this and making sure all this is up to date and that's up to date and… Erm… You know? Which is… That side of it is obviously also part of my job, but you know, I suppose… Blurred line regarding the role expectations – managers may	certainly within social care – which is what I do – it's… my kind of worry is that… Social care kind of gets lost within this organisation a little bit. Quite a lot. There's been this kind of medicalisation of social work Concerns that social care is forgotten about – medicalisation of social care You know, we've got this very generic model within adult mental health, you know, whether you're a CPN or a social worker or an occupational therapist, you're doing the care coordinated job. Apart from some very slight differences around medication and depot medication, they are all effectively doing the same job and so there's been this real kind of merging of professional identity and professional values and I think that's been to the detriment of the social care staff	So we have a lot of patients who are all being managed under the care programme approach and the caseload of our care coordinators has really become too high and… The paperwork burden has become too high as well and part of that is the demands of our commissioners, who want to see that we're generating activity; that they get a sense that they're getting sort of their value for money. And that detracts from recovery-focussed work because it means that there is… There's too much pressure to simply just get through seeing all of your patients enough times to feel confident that you know what's happening with them; that you know what their risk assessments are and	… The reduction in resources has had a significant impact. I think it makes it more and more difficult, because I think that workers are more and more stretched. I guess, I'm talking about reduction in NHS budgets overall, so I think that everyone's more stretched and I think that means the time that people have got to devote to the work that they're doing, the service users, is compromised and I think sometimes that

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don't know is always helpful, because sometimes I think that puts a barrier up between the self and the client, particularly working with personality disorders, because people often feel that they are rejected anyway and feel that people don't care and that they can't trust people, so if you're automatically talking about discharge form the onset, you know, sometimes the attitude can be: oh, what's even the point

Service priorities are to move people on quickly

Barrier to therapeutic relationship

it's providing the maximum amount in the minimum time to get people moving forwards, so kind of: in, on feet, out; in, on feet, out… And literally just propped up on feet prior to going out,

have different view of what is important

Managers place importance in paperwork

Yeah, but I mean there's always been paperwork but obviously there's a lot more of it now and it's not just the paperwork, because it's all electronic and it's all to do with stats and a lot of it can be repetitive. Erm… You know?

Job now involves more paperwork and electronic administration work than before

Focus on statistics

, not especially, no. I mean, whether if I specifically brought it up, I suppose it would, but erm, you know, it might come up in the sense that the audit's out for recovery stars and we've got

and the detriment of the social needs of the service users.

Generic worker model is at the detriment of the social worker role resulting in neglect of social needs of service users

, like doing a social care assessment face to face with the person; asking them the questions; giving them the opportunity to think about their needs in a really holistic way often doesn't happen. Often, I hear "oh, don't worry; I'm going to do the face to face assessment tomorrow. I saw them a few weeks ago…" You know; people aren't doing this work properly. They're not valuing the way the Care Act is structured or… And I think it's because they don't know it. I think there's a lack of training.

Practitioners do not value the Care Act because they do not know it because of lack of training.

Social workers working in mental health teams are de-skilled because of generic working

a lot of the social workers that we've had have only ever been care coordinators in a

then trying to keep up to date with all of the resulting mountain of paperwork and erm, I think that the risk there – and most of our care coordinators, especially our most experienced ones are very good at avoiding this

Commissioners demands dictating the need to generate data to prove activity taking away time from patient's

Patients with negative symptoms getting lost in the system as those patients who are acutely unwell take priority due to limited resources

Well, it's party an external pressure; partly internal, erm, that makes it hard to take a recovery focus is over-reliance on locums, both medial and in other professions as well. Er, because of, say if we rely too much on locum care coordinators, then erm, you, if you only get to know

means that people will focus more on risk and things like that rather than giving as much time to someone as they'd like to, to be able to do a really good recovery-oriented piece of work think it's the people don't; want to do that or don't value it or see it as important; I think that they feel very compromised in what they can achieve within the time that they've got.

Reduction in resources is a barrier to ROP

Cuts to budgets increasing workload on workers and making it difficult for them to have time to spend with patients

Focus is on risk because workers are under

because when I'm having supervision, it's "well, what are you doing with this client? How long before discharge?" and that seems to be the priority in terms of: when can we discharge this person, so that you can take on somebody else, which is leading to us spreading ourselves thin, having high caseloads

Supervision focuses on discharging people

Limited resources

Limited resources

Pressure on resources

I don't think it's done in a mean way. You know, people do this job because they care, but we are just, we're very short staffed and we have a lot of referrals come through, erm, the assessment team can only

to get to from 80 or 90 whatever percent it is up to 100% or we're going to be losing money. Erm… You know, 'do you need any extra admin time to get them done?' So in that sense, but not in…

ROP not discussed unless in the context of completing the recovery star for audit purposes

time, probably. Erm… Yeah. But then, you know, I suppose if you broke that down, again, it's like some of the… You know, the more admin-type things that we have to do. Erm, you know, I suppose impacts on our time, so I suppose you could see that as a barrier,…. I suppose it just feels that it just becomes more and more frequent with the time… Spending… Between getting a lot of it

mental health team, so they… You know, they almost never had an identity, a working active identity as a social worker in the first place and there's a… We integrated CPA and care coordination, care management years ago. Back in about 2002, 2003, so it's been like this for a really really long time and I think, when I remember back to that, there was a sense that the social workers had to 'do' health as good as their nurse colleagues to be valued in the same way, so I think social work has really embraced all the really good things about mental healthcare and recovery included and erm, relapse prevention, crisis management, you know, all of those kind of, you know, things like… Psychoeducation, all those things that are kind of your bread and butter work as a care coordinator

Social workers working in mental health teams are de-skilled because of generic working

Social workers have embraced the duties/skills/knowledge that would

your care coordinator for two moths and then they disappear and you have a new one, you're constantly just in that process of getting to understand each other and I think it happens with everyone being a bit overworked,

Use of locum is a barrier to ROP

Use of locum practitioners prevents continuity of care

and it's really hard to find ways to let people take on a caseload that lets them exercise their own professional skills to the greatest extent they can and even to a level that, erm, we've got a… Our care coordinators are all social workers, nurses and OTs and often it feels like it's quite hard to focus for example, OT skills on someone who needs to do a piece of work with an OT because everyone's just got the caseload of who needed to be allocated at the moment, that they had a space on their caseload; that's profoundly unhelpful

pressure and have to prioritise

Workers want to practice ROP but

, I think… I think it's the financial resulting in the time, resulting in the need to prioritise discussions around risk and risk management rather than always… yeah… That's my feeling.

Financial and time constraints leading to prioritisation of risk and risk management

work with people for a very short period of time before they need to come through to treatment and obviously at the point people are coming through to our team, they're in crisis. ==You know, they are at a high level of need, so you do then have to look at: well where are clients on my caseload and can they be discharged?== Which ==is hard, because some of them probably could do with a bit longer but don't get that and have to be discharged sooner, which I think can set some up for relapse when perhaps that== ==might n==ot necessarily have been the case had they had a lot longer with us

Pressure on resources

Dilemma for practitioners

done seems to be getting shorter and shorter

Lack of time due to the admin work is a barrier

There is a lot of paperwork to be done in a short space of time

When I worked n the assertive outreach teams, obviously a much smaller team, more cohesive, more supportive of each other, erm…, I think also recently, it's like there's so many staff changes. You know, you've got people leaving, being off sick. You know, there's lots of agency workers around at the moment, which…

Being in a smaller more cohesive team allowed practitioners to support each other

traditionally have been considered nursing to the detriment of social work skills

Worry that service users are not empowered to manage their lives in the best way because they do not know what they are entitled to because staff lack knowledge and understanding.

You know, how do we follow social care processes within a team? So if nurses don't understand it and they ask their social work colleagues, they don't necessarily understand it any better, so… So I worry – just going back to values – I worry that people aren't enabled or kind of empowered to kind of manage their lives in the best way that they can because they don't understand what they're entitled to, because no one else understands that because working with them and if you can translate legislation into kind of positive action for them

There was without a doubt and nurses are continually saying… whenever I do training on social care and the social care processes and how you get your direct payment or, you know, placement or whatever it is that you think somebody needs, all I hear is: "this is really annoying; I shouldn't be having to

Patients are just allocated without consideration of the best professional to meet their needs so professionals not always able to put their expertise to good use.

Not being able to practice in area of expertise can drain motivation and de-skill

Changes in the team leading to loss of morale and making it difficult to work in RO way

; if you're trained to have a particular professional portfolio, but what you're doing is what generic care coordination work is, it's going to sap your motivation and eventually, it'll drain your ability to then do those highly specialised pieces of work with people and… And so keeping up… I think we've come through a fairly rough patch.

if the team's feeling stressed and not feeling high morale, then it's harder to then keep that kind of continuous curiosity about what someone else wants to do with themselves with

… I think sometimes when managers get in their head: we need to do this; this needs to happen, and… They're not always giving people a chance to put their case across and to argue differently. And then you end up with service users coming back through and back through and then you get this kind of constant moaning situation; "oh, they're back through again", "well yes, but how do we put this into place? Initially, we might have been able to prevent that". Managers focus on service priorities Revolving door due to early discharge of patients	Instability of team caused by use of agency staff and sickness absence You know, and without I suppose having to read various research papers and then trying to work it out for yourself or… you know, going and getting a book or whatever. Knowledge and information on recovery is not easily available to staff	do this work; I'm not a social worker; when do I get the time to send therapeutic time with my clients?" And the social workers are saying "oh, I've forgotten how to do any of the social acre because I spend all my time resolving medication crises or… you know, doing all the other kind of…." The work here is very crisis management-driven. Practitioners feel that they are being asked to do things outside their role which take them away from their patients The work in the team is mostly managing crises because of the large geographical area the team covers , then we had assertive outreach team and early interventions, all crisis teams and all of these things have combined to make these big mega-teams and they're really difficult to manage and so I think all the things that don't seem like an immediate priority; keeping people safe, you know, they're just kind of lost. The main priority is keeping people safe and anything that is not urgent is not the focus	keeping a recovery focus, because again, the more you drive people to keep doing lots and lots of paperwork, the more… the paperwork is intrinsically very impersonal; you become focussed on doing it in that particular way, so it takes you away from kind of taking a slightly more holistic view of what's going on. Not being able to practice in area of expertise can drain motivation and de-skill Changes in the team leading to loss of morale and making it difficult to work in RO way Focus on paperwork makes the work impersonal and takes away from recovery focus ; the disconnect is trying to – as I said in my answer to the previous question – it's trying to make that work in the face of constant erosion of funding, staff turnover, the difficulty of being able to live in this part of the UK on a kind of band five	

following pressure from managers to discharge them

I think in our team, again, with the staffing numbers, because that's then meant that we've had a lot of locums and the locums have only been working for set periods of time, which has meant clients have had stop/start, stop/start, getting to know different care coordinators and I think that's hindered the recovery process for them because they don't have that continuation with somebody and it's almost, when you've got a new person in, that's almost starting from fresh and I think that's then meant it's not been the most productive use for our team

Staff shortages leading to use of locum nurses and lack of continuity in the care of

But in terms of… It's really hard to maintain social care values in a very very medical model.

The medical model is dominant making it difficult to maintain social care values

I think the priorities are very clearly: things that get audited. So… Erm, 'is the risk assessment updated within the last 12 months?' I can't remember all of them. 'Have you had a CPA within the last 12 months?' You know? 'Is your recovery star up to date?

Priority is on things that get audited

It's the things that get audited are the things that are the priority but the priority for the clinicians is… I think it genuinely is, on the whole, the wellbeing of the people on their caseload but that's not necessarily what they get to spend their time on.

or six salary. All those practical obstacles and although the Trust's… We've talked about what to do about this; is there ways of trying to help with recruiting and retaining staff and making sure there's enough staff in the right places to be able to do all of this properly,

Reduction in funding causes a disconnect between what the senior Trust people want and the reality

A major challenge with recruitment and retention of staff

So it's easy to generate ideas but it's much harder to implement them, especially again, with all of the pressures that the wider NHS is under at the moment and I think that that's the real challenge.

Work pressures make it difficult to implement ideas

in terms of just trying to find ways of releasing people's time a little bit and cutting down the extent of the

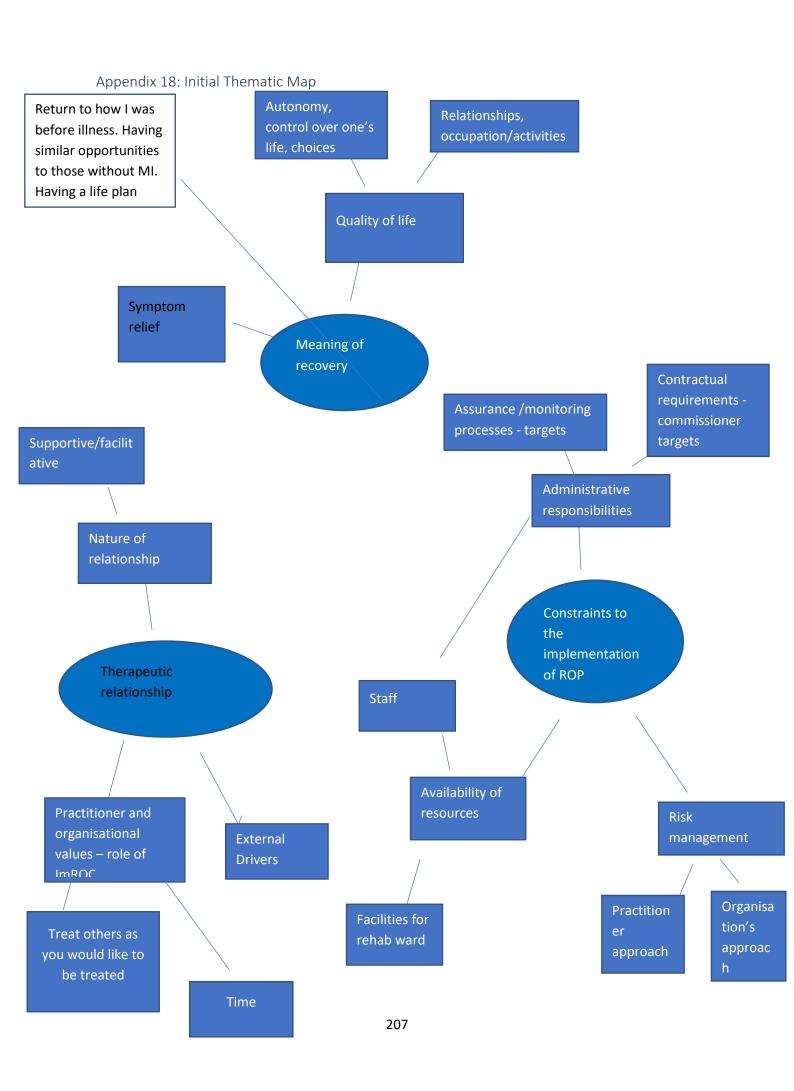|				
clients and delays in their recovery but I guess the organisation have to be a little bit more black and white with things, because we are a business, I suppose. You know? If you want to come down to it, we are a business and we have to offer to the many; we can't… You know, as my manager says: it's a gold standard across, as opposed to a platinum standard for the few, whereas I will always try and find a way of providing as much as I possibly can to as many as I possibly can, to the point of running myself thin at times the Trust is a business so Sometimes there is a need to balance the ideal and the reality due to high demand and limited resources so although there is a desire to		Practitioners' priority is the well being of their clients but they have to spend time on other thigs that are regarded as priorities because so much of your time has to be spent, you know, in front of your computer, feeding in the information and… So when your manager's hovering on your shoulder, they're not saying: "ae you really happy with the quality of the work you're able to do with someone?" They're saying "I've got a list of 20 people that haven't had a recovery star. How many are you doing today?" It's… Those are the kind of things that drive people out of care coordination. Those are the priorities; it's whatever's getting audited at the time. A lot of time has to spent on paperwork The focus is on audited things rather than the quality of wok with patients.	bureaucracy… I don't mind the idea of people doing paperwork if the paperwork serves the patient's interests; it's where the paperwork serves only the interests of bureaucrats, erm… Or duplicating paperwork as well. Paperwork is only helpful if it serves the patients' interests not when it I only for bureaucratic purposes	

do the best, sometimes they have to do what they can and what is possible if you don't have the full skill mix and I think there needs to be nurses within a management team to have a full understanding of different disciplines and I know we are all classed as generic workers, but there are certain things that nurses can do that others can't do an certain things that others can do that nurses can't do and unless you've got a management team that fully understands and appreciates all of that, I think that does have a hinderance to the recovery process and the understanding of… However… 'Cos we do all work slightly differently		You know, if it's that kind of detail of their social care that you're not asking because you're going in and you're looking at mental state all the time… You're looking at mental state and risk. You're not asking the questions about their social care, which impact massively on people's quality of life and massively on carers. Focus is on mental state and risk without paying attention to social care which impacts quality of life of SU and carers ? But the people have got caseloads of 30+ and there's only so much you can expect them to do and if you're working for health and your managers are health and your managers are pushing your health targets, it's completely obvious why social care kind of slips. Large caseloads impacting people's ability to do everything that is required so they focus on what managers prioritise		

Full skill mix needed in management to represent different professional groups Although classed as generic workers, different professional groups have different skills		Health manager focus on health targets so SC is neglected. I think that the will is there and when you talk to people individually about the work they're doing, that's what they want to be doing; they want to be doing the recovery-focused work, but they're feeling constrained because I've got to do… You know, a face assessment, a recovery star, a care plan, a risk assessment, erm… I've got to set up social care services, I've Practitioners want to be doing ROP but are constrained by the demands of paperwork ? The pressure is phenomenal and I think … Practitioners working in the community are under intense pressure		

		I think something else that we struggle with is, is over the years, the lack of… The reduction in funding for day services. So for instance, we used to have a day service [that used to be called] [name] and what it did really really well at was engaging and containing people with an emotionally unstable personality disorder. It seemed to be really popular. You know, it was very creative; it was very service user-led, it was very supportive, it was very appropriate and that group of people who we really really struggled to support in these teams take up a massive amount of time… I was talking to [name] about this last night, actually and we said "God, do you remember Renaissance?" All these people that are really taking up a lot of time now, they just used to go; we didn't used to have these problems with them and I think, in a way, kind of one of the downsides of the recovery model is this suggestion that people should be integrated into standard kind of everyday community services, which is great for a whole load of people but for another load of people, it's really not and for the people who need an environment where their mental health needs are understood and accepted, maybe with a greater degree of tolerance or being		

able to spend time around people that they can relate to, those services just have disappeared and Renaissance is a really good example of that. Um, so…

Closure of day services is contributing to the increased caseloads as support offered by day services is no longer available

The ideas that people should be integrated into their communities does not work for all SU as some need to be with other people with MI who understand and accept them and whose experiences they can relate to

But I think that we need to make sure that we still have a range of services that suit a range of people, so… It's just going back to that example about Renaissance, really. It was brilliant. It was really really well attended. Everybody just thought it was the best thing ever and we were utterly utterly shocked when it closed.

		Need for services in the community for people with MI so ROP should not lead to closure of day centre for people with MI		

Appendix 18: Initial Thematic Map

Return to how I was before illness. Having similar opportunities to those without MI. Having a life plan

Autonomy, control over one's life, choices

Relationships, occupation/activities

Quality of life

Symptom relief

Meaning of recovery

Assurance /monitoring processes - targets

Contractual requirements - commissioner targets

Administrative responsibilities

Supportive/facilitative

Nature of relationship

Constraints to the implementation of ROP

Therapeutic relationship

Staff

Practitioner and organisational values – role of ImROC

External Drivers

Availability of resources

Risk management

Treat others as you would like to be treated

Facilities for rehab ward

Practitioner approach

Organisation's approach

Time

Appendix 19: Critique Checklist for a Case Study Report

Criteria	Self-assessment
Is this report easy to read?	Yes. The report is well written, well structured and follows a logical sequence making it easy to follow.
Does it fit together, each sentence contributing to the whole?	Yes.
Does this report have a conceptual structure (i.e. themes or issues)?	Yes. This is apparent from the introductory chapters and throughout the study.
Are its issues developed in a serious and scholarly way?	Yes. The report also shows evidence of engagement with a wide range of literature as evidenced by the references.
Is the case adequately defined?	Yes. See methodology and methods chapter.
Is there a sense of story to the presentation?	Yes. The report presents a story of the implementation of ROP in two settings in an NHS organisation.
Is the reader provided some vicarious experience?	Yes. The transparency practiced throughout and the reflexive approach adopted by the researcher provides vicarious experiences. The story told in the findings also provides a vicarious experience. The context is described well in the methodology chapter.
Have quotations been used effectively?	Yes, quotations have been used to support the findings.
Are headings, figures, artefacts, appendices, indexes effectively used?	Yes
Was it edited well, then again with a last-minute polish?	Yes
Has the writer made sound assertions, neither over- or under-interpreting?	Yes. A balanced report of the study is given.

Has adequate attention been paid to various contexts?	Yes, the study included participants from different practice contexts and roles. It also included service users.
Were sufficient raw data presented?	Yes, the findings chapter presents raw data.
Were data sources well chosen and in sufficient number?	Yes, this was done through heterogeneity of the sample. Including participants with different roles and positions and service users produced rich data. A discussion on the sample size is in the methodology and methods chapter.
Do observations and interpretations appear to have been triangulated?	Yes, data from all participants triangulated and presented in the form of a thematic analysis report.
Is the role and point of view of the researcher nicely apparent?	Yes, the researcher's position and assertions are made apparent throughout the report. This was done through reflection, reflexivity and communication of my views.
Is the nature of the intended audience apparent?	Yes, this study aims to inform practice and research on the implementation of ROP. This is made clear from the introductory chapters and throughout the thesis.
Is empathy shown for all sides?	Yes, a balanced report of findings based on responses from all participants was presented.
Are personal intentions examined?	Yes, reflexivity was practiced throughout the study.
Does it appear individuals were put at risk?	No. See methodology and methods chapter for steps taken to ensure study was safe and ethical.

(Stake, 1995)