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Competing Priorities: staff perspectives on supporting recovery

Abstract

Recovery has come to mean living a life beyond mental illness, and recovery orientation is policy in many countries. The aims of this study were to investigate what staff say they do to support recovery and to identify what they perceive as barriers and facilitators associated with providing recovery-oriented support. Data collection included ten focus groups with multidisciplinary clinicians (n=34) and team leaders (n=31), and individual interviews with clinicians (n=18), team leaders (n=6) and senior managers (n=8). The identified core category was Competing Priorities, with staff identifying conflicting system priorities that influence how recovery-oriented practice is implemented. Three sub-categories were: Health Process Priorities, Business Priorities, and Staff Role Perception. Efforts to transform services towards a recovery orientation require a whole-systems approach.

Declaration of interest

None.

Key words

Mental health service provision, Recovery orientation, Staff perspective, Competing priorities

Introduction

Mental health staff are encouraged to support the recovery of individuals living with severe mental illness (Department of Health, 2011; Department of health human services, 2003) by transforming services towards a recovery orientation (Bracken et al., 2012). Recovery is a unique, personal self-directed process of transformation, and discovery of a new self to overcome mental illness and reclaim control and responsibility for one's life decisions (Anthony, 1993). It is a journey of hope and empowerment, connectedness, identity, and meaning and purpose (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

The overarching aim of the recovery vision for services is to allow people opportunities and resources to lead meaningful and productive lives, and to redefine the long-term prognoses of people with severe and enduring mental illness (Henwood, Derejko, Couture, & Padgett, 2014). Attention is given to the recognition that there is more to a person than illness and primacy is given to each person in determining the stage and direction of their own individual recovery journey (Chen, Krupa, Lysaght, McCay, & Piat, 2013; Farkas, 2007). Further clarity on what constitutes recovery support and how recovery orientation might be operationalized in practice has been attempted. A framework based on an international review identified four practice domains: promoting citizenship, organizational commitment, supporting personally defined recovery, and working relationship (Le Boutillier C et al., 2011).

Despite research on the diffusion of innovations (Rogers, 2003), the growing discipline of implementation science (Tansella, 2009), and guidance on developing complex interventions (Craig, 2008), a translational gap remains between knowledge and routine implementation of recovery-oriented practice (Brown, Mahoney, Adams,

Felton, & Pareja, 2010; Salyers, Rollins, McGuire, & Gearhart, 2009; Tse, Siu, & Kan, 2013). Rose and colleagues advise that a multi-perspective evidence base is paramount in supporting adoption in practice (Rose, 2006). Clinician and manager perspectives are central to understanding how recovery support can be adopted in mental health care because they provide front-line services, and they are the vehicle bridging the gap between policy rhetoric and clinical practice (Hardiman, 2008). Current evidence indicates that research is early-stage (Piat & Lal, 2012) and a knowledge gap remains, with one of the biggest obstacles to implementation being the lack of a shared understanding of what recovery means in practice and how it can be best supported (Le Boutillier C et al., 2011; Salyers, Stull, Rollins, & Hopper, 2011). The aim of this study was to identify factors that help or hinder clinician and manager efforts to provide recovery support, by investigating what staff say they do to support recovery.

Method

Study design

Focus groups and individual semi-structured interviews were used to collect data. Grounded theory methodology was used to shape the research because staff perspectives on recovery support are relatively unexplored (Cresswell, 1998). Grounded theory draws on symbolic interactionism, whereby human beings create meanings of the world around them through interaction with others and through their own internal dialogue (Blumer, 1969; Strauss & Corbin, 1990). Blumer (1969) identified three basic assumptions behind symbolic interactionism: 1) "Human beings act towards things based on meaning that the things have for them". 2) "The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows". 3) "These meanings are handled in, and modified through an interpretive process and by the person dealing with the things they encounter" (Blumer, 1969, p2). Grounded theory therefore recognises the interrelationship

between meaning and behaviour and aims to develop a theory that explains the action in the social context under study.

Data collection

Ethical approval was obtained from Joint South London & Maudsley and the Institute of Psychiatry NRES (10/H0807/4) and East London NRES (11/LO/0083).

As part of the REFOCUS study (ISRCTN02507940), ten exploratory focus groups were conducted with clinicians (n=5) and team leaders (n=5), within five NHS Mental Health Trusts in England (South London and Maudsley NHS Foundation Trust, 2gether NHS Foundation Trust, Leicestershire Partnership NHS Trust, Devon Partnership NHS Trust and Tees Esk and Wear Valleys NHS Foundation Trust). Focus groups were used for early data collection to stimulate group interaction and discussion (Morgan DL, 1997). These were followed by thirty-two individual interviews with clinicians (n=18), team leaders (n=6), and senior managers (n=8). Sites were purposively chosen for diversity in geographical region of England, urban/rural balance and for perceived levels of success in implementing recovery-oriented practice.

Staff in community-based mental health teams providing a care co-ordinating function were included in the sampling frame if they had direct clinical contact with service users. Purposive sampling based on site (Trust, type of team e.g. early intervention, support and recovery etc.) and staff characteristics (core profession, grade, job role) was used to maximise the range of views. Participants were approached and recruited by local Mental Health Research Network Clinical Studies Officers (non-London sites) or by the lead author (London site) via the telephone, email or face-to-face.

Separate focus groups were conducted with team leaders and clinicians at each site to allow perspectives to be shared with others with similar managerial and clinical responsibilities. Each 90-minute focus group started by exploring staff perspectives on barriers and facilitators to providing recovery support. A conceptual framework of recovery-oriented practice was used in the early focus groups to organize the topic guide and generate discussion by providing examples of what recovery might mean in practice (Le Boutillier C et al., 2011). However, the discussion aimed to follow individual's interpretation of recovery-oriented practice, prompting the lack of a shared understanding of what recovery means in practice to emerge as an early finding. The many meanings of recovery-oriented practice quickly became apparent as an influence on what was actually being implemented. Barriers and facilitators to providing recovery support were also identified as an influence on how staff understood recovery as applied to their practice (one example is that participant understanding was frequently informed by system messages such as recovery equals service throughput). The aim to investigate what staff say they do to support recovery was subsequently added. The research became progressively focused and theoretical explanations were tested and revised with further data collection (Strauss & Corbin, 1990). Focus groups were led by authors CL or ML and moderated by authors ML or JW between May and August 2010, and were audio recorded and transcribed verbatim.

Focus group data analysis identified a methodological limitation, where participants had difficulty in eliciting individual accounts of recovery-oriented practice in a group context. Interviews (n=32) were therefore conducted to allow deeper probing to explore individual practice examples alongside barriers and facilitators to supporting recovery. Participants with a range of characteristics were sought to test out and refine the emerging theory (Strauss & Corbin, 1990). For example, clinicians and team leaders with greater work experience were actively recruited to examine

whether they were more likely to support recovery, and those who perceived themselves as successful in supporting recovery in practice were identified and recruited to explore the factors which enabled their success. Senior NHS managers were also recruited to examine the organizational factors identified as instrumental in shaping the meaning and success of supporting recovery. Recruitment continued until theoretical saturation was reached.

Interview participants were approached and recruited by authors CL or VB (London site), the 2gether research team (2gether site) or local MHRN Clinical Studies Officers (non-London sites) via the telephone, email or face-to-face. The interview schedule for clinicians and team leaders and a separate interview schedule for senior managers focused on using practice examples of recovery orientation to identify blocks and enablers to incorporating recovery into their routine clinical practice. Both interview schedules were revised iteratively to further explore emergent themes and deviant cases. For example, the category 'competing priorities for practice' emerged from focus group data, and was subsequently explored in interviews. Focus group participants were asked 'What are your priorities and goals for practice? Describe how, and to what extent you have been able to implement recovery-oriented practice; senior managers were interviewed and asked 'Can you describe how this organisation supports recovery? What do you see as the current organisational priorities?' Clinician and team leader individual interview participants were specifically asked if and how they prioritise recovery-oriented practice. Example clinician/team leader and senior manager individual interview schedules are included in supplementary data 2 and 3. Interviews were conducted across NHS sites, lasted around one hour, and were audio recorded and transcribed verbatim. Where requested, transcripts were returned to participants for comment and correction. Interviews were conducted by authors CL, ML or the 2gether research team between January 2011 and August 2012.

Data Analysis

Iterative inductive analysis of the data was undertaken in line with grounded theory methodology as developed by Strauss and Corbin (1990) (Strauss & Corbin, 1990). Data analysis occurred concurrently with data collection using NVivo QSR International qualitative analysis software (version 8). The lead author directed the analysis. The decision was made to analyse the data set as a whole, instead of according to participant characteristics (e.g. job role) to identify differences and similarities across respondent groups. Transcripts were read repeatedly to allow the researcher to become immersed in the data. Data analysis began with line by line open coding, and individual extracts were coded under one or several categories to fully capture their meaning. An initial coding frame was developed and axial coding was conducted to propose relationships among categories. As further data were collected, they were coded and categorised using the constant comparison, paradigm and conditional matrix analysis procedures. For example, participants' accounts were compared to identify provisional commonalities and differences; and the scope of study was determined by identifying relationships between micro (individual) and macro (organizational) conditions. Selective coding was undertaken whereby the emerging story line was described and categories that required further development were explored. Memos were kept to record initial impressions, analytic decisions, and the researcher's role in the process to demonstrate the theory was grounded in the data. For example, the lead researcher (CL) considered her own understanding of recovery, and previous experience of working in mental health services to enhance theoretical sensitivity. Multiple coding (authors ML and VL) was undertaken to reflect on and enhance the awareness of the coding approach.

Results

Participants

A total of 65 staff (clinicians and team leaders) participated in focus groups, and 32 staff (clinicians, team leaders and senior managers) in interviews. Their characteristics are shown in Table 1.

Insert Table 1 here

The mean age of staff was 45.2 years (range 24-61, s.d. = 8.5), and time working in mental health services ranged from 6 months to 35 years. The average number of years qualified was 18 years 6 months (range 30-396 months, s.d. = 123.0). Of the interview participants, six members of staff disclosed personal experience of mental illness, four disclosed experience of using mental health services and eighteen disclosed experience of supporting a family member or friend with mental illness. Data Supplement 1 details additional sample characteristics.

Core category and sub-categories

The developed theory is a result of the interrelationships between a central phenomenon or ‘core category’ and the sub-categories (Strauss & Corbin, 1990) identified as influencing staff implementation of recovery-oriented practice. Findings identified many implementation challenges alongside a difficulty of articulating examples of recovery-oriented practice. Despite the study focus on success stories, staff appeared to identify more barriers than facilitators to supporting recovery. An early finding was that barriers and facilitators identified by staff shaped their understanding of recovery as applied to practice. The core category to emerge from the data was Competing Priorities. Participants’ accounts of recovery-oriented practice appeared to be informed by priorities across different levels (for example, organizational level, staff level etc.) of the health system. One major challenge for participants was understanding recovery-oriented practice and the compromises that they feel have to be made when supporting recovery. Three sub-categories relating

to the competing priorities were identified: Health Process Priorities where clinical systems dictate the direction of practice; Business Priorities where financial concerns take primacy; and Staff Role Perception where the values and priorities of individual workers that support recovery shape their practice.

Core category: Competing Priorities

Although staff identified with the notion of recovery, supporting recovery was implemented in a number of ways and diverse translations were evident, based on competing priorities within and between the different layers of the health system. Health organizations incorporate the socio-political context, organizational structure, role and function of teams, role of staff, and relationship between staff and service users, which all combine to influence the success of services in supporting recovery. Discrepant priorities across these different levels of the health system led to a clash of paradigms and competing agendas in supporting recovery, with practice most often dictated by power within the system. Recovery support was identified as being professionalized where health system and organisational priorities take precedence.

> *The problem is [recovery's] at odds with the way the NHS is run basically, the way in which funding streams are decided, and everything else, it doesn't really fit. My understanding of the current ways in which we're being told to do things like four contacts a day, that we've got to have people within certain clusters… I think it takes our ability to function as independent clinicians out of the mix and it takes being able to treat clients as individuals and unique people out of the mix as well.* [5.6, occupational therapist]

Staff identified the need for a shared understanding of what recovery is and how it can be supported across the whole system. One team leader stated: "there needs to be consistency, it needs to be at all levels of the organization in terms of the recovery model".

Sub-category: Health Process Priorities

One of the sub-categories to emerge strongly in participants' accounts was Health Process Priorities. Participants suggested that recovery has been made to fit a health

infrastructure where its meaning is shaped by a traditional focus on hierarchy, clinical tasks, professional language, medicalization and psychiatric power.

> *…an organization like ours, which is predominantly medically oriented, has a history of clinical expertise so there has been this understanding of recovery as getting better. I think it's wider than that, a lot of people think it's wider than that but how that's actually illustrated in practice people struggle with because we still want to treat people and help them 'get better* [138, senior manager, occupational therapist]

Health processes were found to shape recovery-oriented practice and present barriers to recovery support. Where participants felt able to support recovery, the concept was translated to fit service structures, and was framed in clinical language and systems. In some instances, supporting recovery in a traditional health model was felt to compete with core medical tasks. For example, the relationship of recovery to the statutory clinical obligation of risk management was seen as a competing priority. Staff felt they would encourage recovery support through positive risk-taking if they were better supported by the organization.

> *People will always batten down the hatches and that's quite a natural thing to do. Because if you look at taking therapeutic risks and they do go wrong, I'm not sure that our Trust supports you as well as they should be supporting people.*[5.9, team leader, nurse]

The conflicting tension of delivering an individualised service in an institutional system caused concern.

> *We made quite a strong bid to set [an electronic system] up using recovery values to name and determine the fields so it could actually support recovery-based thinking and practice. Perhaps rather typically, we were told that it was an off-the-peg suite of forms and we had to work with it. And that tension as to whether you can personalise things and get them to serve the outcomes or whether you're taken hostage by them and you have to serve the system is a kind of pretty standard institutional tension really.*[4.8, psychiatrist]

Service structures that focus on diagnosis were also considered incongruent with providing individual recovery support.

> *I think there's something about working holistically as well, not just working with someone's diagnosis or someone's symptoms...I think the message that we give to them is really important. If we give them the message that they're ill, give them a diagnosis of schizophrenia, I think that's shockingly awful. I think it's about seeing beyond the diagnosis and beyond the symptoms and actually working with what else is important to that person.* [2.3, psychologist]

As too were service systems that focus on service priorities, for example, recording personal recovery plans that are the property of services and not people.

> *There's a dilemma that's represented by the concept of a 'personal recovery plan'. We've got this phrase, and there's a Trust objective that everyone should have a personal recovery plan. But it doesn't belong to the person, it actually belongs to the worker, and it's completed by the worker and yet it's called a personal recovery plan.*[4.8, psychiatrist]

Despite these factors, staff felt some service structures and health models can successfully support recovery. Workers of early intervention and assertive outreach teams reported more opportunities to support recovery, possibly due to defined practice models and lower caseloads. One nurse stated: "I do believe that to be able to deliver more effective recovery-led treatment packages, you need to have lowered caseloads so you can actually spend quality time with patients."

It was considered helpful that early intervention focus on early onset and assertive outreach focus on hard to reach cases. Conversely, recovery and support teams were identified as lacking a practice model.

> *I notice a difference at [early intervention service], they're very good to get in there early and try and maximise recovery. I also feel that assertive outreach, even though they have to be creative about the way they engage people, I think they're very good at it… And I think sometimes the people in [recovery and support teams] are not quite as focused on that or they get a bit lost in the middle.*[1212, psychiatrist]

Sub-category: Business Priorities

Another of the sub-categories to emerge strongly in participants' accounts was Business Priorities, where the financial concerns of the organization influence the meaning and implementation of recovery-oriented practice. It was suggested that the NHS business model is informed by competing government and commissioning priorities, and while policy provides overall directives to support recovery, there is a risk to organization survival if funding and contractual objectives (which often seem to conflict with promoting recovery) are not met. One senior manager stated: "Recovery is indeed an institutional strategic priority, but it isn't the only one..., and the

commissioners put numerous targets on us which very often are not about treating people as individuals."

Supporting recovery was predominantly viewed as an additional business objective that competes against a back-drop of meeting savings programmes, maintaining financial stability and meeting demands of increasing activity targets. The reality of managing and reorganizing services on a constantly contracting trajectory over the next few years was identified as a difficulty. Another senior manager reported: "One thing is survival basically...there are worries about sustainability of all services because of the financial situation."

Staff acknowledged the challenges facing organizations in the current financial climate. Some viewed saving money, rather than supporting recovery, as the 'overarching vision of the service at the moment,' where recovery support is shaped to promote organization survival. One team leader stated: "I feel recovery has been hijacked as an agenda to save money and get people squeezed quickly out the services before they're well enough."

It was suggested that services tailor recovery-oriented practice to meet commissioning demands such as employment outcomes.

> *I'm not sure whether our idea of recovery is the same as our senior managers' idea of recovery… we get questionnaires all the time 'how many people have you got on your caseload that are in work, how many people have you got that you got jobs for?*[5.1, nurse]

Commissioning structures (such as mental health clusters, care pathways) were also considered incongruent with supporting recovery. Funding systems were viewed as prescriptive and lacking individual choice and a person-centred approach, with organizational priorities taking precedence.

> *There's a real tension that we are going down a route of care pathways and provision of care that's quite restricted. So people will get an assessment within a period of time, then they'll have interventions and there'll be an expectation of discharge, along a pathway.* [138, senior manager, occupational therapist]

Participants identified that performance and compliance targets (such as caseload size, seven day follow-up) compete with recovery. Services are measured on increased activity and contact time targets, referral demands and not on service user experience. When asked to identify priorities for practice, one team leader stated: "If you dont meet the targets then I'm usually chasing people, so for me it's more focused on making sure we meet performance targets, feeding the beast as it were."

The idea that recovery is supported and people are empowered to become more independent was considered incongruent with measuring how many times that person had been seen, or having to achieve a certain target to see that person. Staff appeared disappointed that the focus is on efficiency and productivity and not on quality of care, and identified that their work prioritised tick box exercises. The mental health assessment was seen as an additional tick box target, which according to one worker "becomes the priority rather than clients' needs". Recovery was viewed by many participants as an outcome, for example where service end points are assessed by staff and based on professional judgement on when a person is ready for discharge. In some instances recovery is measured in terms of service throughput or 'moving-on'. Some staff identified how service throughput is at odds with successful recovery support. One team leader reported: "It's this using the recovery model to say, 'well, you know they're not motivated enough, or they're not taking responsibility or they're not taking ownership, and therefore we're stepping out because we're a recovery-based service."

Sub-category: Staff Role Perception

The category Staff Role Perception encompasses how staff understand their work roles and how staff prioritise work tasks. Despite reported frustrations, a few workers identified an ability to support recovery outside organizational priorities and described ways of balancing statutory demands and fulfilling service user priorities. A social

worker stated: "I was working til half six last night with someone and I'm a 9 to 5 worker but I sometimes work at eight in the morning, sometimes work at half six if it suits the client."

A readiness to test the boundaries and break the rules emerged as an important factor for some.

> *I say to my team I really don't give a toss about those figures, if I know you are going out and you are knocking on employers doors...thinking well who will take up, that is a good use of your time and I will stand up and be counted against when they look at our numbers, that's what I think.* [1.14, team leader, nurse]

Other participants felt they must comply within service parameters. One nurse described: "I've got to function within that, otherwise I'm gonna lose my job and I can't afford to lose my job. I've got to function within the parameters set out by the bosses."

Staff who felt they were able to support recovery within the organizational parameters prioritised person-centred and strengths-based practice and identified these approaches as paramount to their success.

> *'It's having that vision in mind all the time, so when you see somebody you're trying to build on their strengths and the sort of things that are working rather than thinking about things that get in the way of their recovery… trying to all the time play to their best strengths.'* [139, senior manager, psychiatrist]

While some staff illustrated their role in supporting recovery as having specialist knowledge, others recognised interactional elements and identified the need to understand that service users are people, where the most interesting quality is not their illness, and where service users are not viewed as fundamentally different to themselves. Participants who prioritised the working relationship and who shared a bit of themselves with service users recognised the value for service users to also see staff as people. One team leader stated: "You need that core value in a person, to work a certain way and to believe. I guess a humanist approach...we're all human and we're all people, and its people first kind of thing."

The understanding of those staff that identified an ability to support recovery outside organizational priorities was often influenced by personal values and professional maturity where traditional values and power relations are challenged. The differences in practice could not be accounted for by distinction of years of experience, or profession. There appeared to be greater relation to who you are; personality traits, professional confidence, and different conceptualisations that individual staff have of their sense of self and job role. A nurse explained: "I think it's shaped by a few things, I don't think it's particularly profession based. I think it depends on you as an individual. I think some basic attitudes and values are there or they're not."

Staff attitude was also considered paramount. Another nurse reported: I don't believe in dictating because it's not my life. I believe in enabling people to do it for themselves, because at the end of the day it's their lives and they have to function within it."

Job value was also often presented as an influence on recovery-orientation, for example, whether employment was considered a job or a vocation. Some staff focused on the esteem of their professional role, prioritising duty of care and professional identity, while others promoted empowerment and spoke of enabling service users to lead the lives they choose to lead.

> *I think some people have very narrow ideas about what their job is and isn't about, a very narrow range of duties or tasks. The way I view it is that each person I'm working with, it's up for negotiation as to what the work will be.*[123, nurse]

Discussion

This study aimed to investigate staff perspectives on supporting recovery in order to better understand how staff support recovery in their practice, alongside the associated barriers and facilitators to providing recovery-oriented practice in mental health services. This grounded theory study identified a core category, of Competing

Priorities, where staff struggle to make sense of recovery-oriented practice in the face of conflicting demands, informed by different priorities of different health system levels. Three sub-categories outlining the competing priorities were identified: Health Process Priorities, Business Priorities and Staff Role Perception.

Reflecting on the three core assumptions of symbolic interactionism that guided this study, the findings suggest that: 1) staff participants have their own personal perspective of recovery-oriented practice (i.e. staff role perception), 2) the notion of recovery as applied to practice is influenced and directly shaped through priorities of the health system, most notably from commissioners and senior managers (i.e. business priorities), and 3) recovery-oriented practice continues to be modified through experience and the environment within which staff work (i.e. health process priorities) (Blumer, 1969).

Many factors contribute to the success of implementing a complex intervention like recovery support in mental health services (Bird, 2014), including conceptual clarity. This is echoed in the findings of Piat & Lal (2012), where the challenge of conceptual uncertainty was identified as a core influence on the success of implementing recovery-oriented practice in Canada (Piat & Lal, 2012). Competing priorities (informed through social interaction with commissioners, senior managers, team leaders, colleagues, and service users) shape staff understandings of recovery-oriented practice and influence the success of implementation.

The strong emphasis on health processes alters recovery-oriented practice. Health organizations function in a context where the recovery support is modified to fit a health infrastructure organized around diagnosis, symptoms and risk. While support for recovery is evident in contractual arrangements, it is one objective among many, and services define the concept flexibly to meet other commissioning demands and

targets. For example, successful recovery support has been operationalized in terms of discharge, reduced hospital admissions, improved clinical outcome scores, and return to employment (Slade, 2014).

The precedence given to business priorities also impacts on practice, because financing influences clinical decisions that affect value and quality of care (Slade, 2014). The business model seeks to improve value for money, typically through paying services by results which are measured as activity targets or predefined health outcomes (Department of Health, 2012b; Department of health human services, 2003), rather than as personalised service user outcomes or experience of care. Rather than expecting service users to fit around service priorities, the need for services to be more responsive to people who use services has been identified (Department of Health, 2012a; Piat & Lal, 2012). Future quality indicators which will connect payment to recovery and to service users' experiences are being developed (Department of Health., 2011). Supporting recovery needs to be understood as a cross-cutting strategic priority, rather than one goal amongst many. Cost-effectiveness data will be central to this strategy, allowing incorporation of recovery-oriented practice into business priorities. International initiatives to promote recovery-orientation in mental health organizations are gaining recognition, such as ImROC in UK (Repper, 2013), Partners in Recovery in Australia (Australian Government Department of Health and Ageing, 2012) and Recovery to Practice in USA (www.samhsa.gov/recoverytopractice/).

Whitley and colleagues identified four staff influences when supporting the success of implementing a specific recovery intervention in the United States; leadership, innovative organizational culture, effective training, and committed staff (Whitley, Gingerich, Lutz, & Mueser, 2009). Gilburt and colleagues identified organizational hierarchy as a barrier to recovery support, the power of the system viewed as

conflicting with service user aims (Gilburt, Slade, Bird, Oduola, & Craig, 2013). There is concern that recovery is translated to support service cuts or to exclude those individuals in most need of support (Dickerson, 2006) where individuals are labelled as either recovered or not recovery-ready. Equally, some organizations have stipulated a time frame in which one should recover. For some recovery has simply become a new term for rehabilitation. Because the call for recovery-oriented services is happening alongside the current financial climate, there is concern that recovery could be co-opted as a concept and left without content (G. Roberts, Hollins, S., 2007).

Parallels can be drawn with service user perspectives on supporting recovery. For example, the recovery concept, initially a service user defined phenomena, is itself made up of multiple and often contested meanings (Leamy et al., 2011). Service users report that recovery has become 'hijacked', where they too have competing expectations placed on them (Mental Health 'Recovery' study working group, 2009). People with lived experience have also reported a feeling of lack of individualisation, a focus on organizational goals rather than hopes and dreams for their own view of a meaningful life, and a difficulty of working in partnership (Braslow, 2013). Although previous work identified the need for practitioners to support individuals to be partners in their own care (Le Boutillier C et al., 2011), our findings identified little reference to either the expectations of people using services, or to using 'lived experience' as a recovery resource. There is a need to develop new approaches to increasing partnership between people working in and using mental health services (Farkas, 2007; G. Roberts & Boardman, 2014)

Implications for policy and practice

The findings of the study are clinically important, relevant to current health priorities, and influence the mental health system at both policy and practice levels. While

mental health staff are encouraged to transform their practice towards a recovery orientation, they reported the need to manage competing organisational and financial imperatives, which compromised their ability to support recovery. The findings point to the need for organizational alignment around a shared focus on recovery support, including how recovery support is conceptualised in practice. Staff understanding of recovery-orientated practice is a significant factor influencing the success of implementation.

Strengths and limitations of the study

The study followed the systematic research methodology and procedures of grounded theory (Strauss & Corbin, 1990). Use of a pre-defined recovery practice framework in early focus groups may have influenced the descriptions of recovery-oriented practice provided by participants, although efforts were made to encourage individual's own conceptualisations. Although the total number of staff approached was not recorded, data collection and analysis continued until theoretical saturation was reached where the accounts of 97 members of staff (with diverse job roles) were explored, making the scope large for a qualitative study. Participants were recruited using purposive and theoretical sampling strategies. Nursing staff made up the majority of the sample as they were considered the majority of the workforce. While researcher reflexivity was present throughout, researcher interpretation is evident. The pros and cons of having worked in a role similar to that under study, and sharing a staff perspective, were explored in reflective diaries. The findings are specific to the study context, that is five NHS mental health Trusts, from 2010-2012. This study also focused on mental health service community care provision and did not address staff understanding of recovery as applied to in-patient care.

Overall, there is a discrepancy between the organizational endorsement and expressed intent to promote recovery-oriented practice on the one hand, and the

capacity of services and practitioners to operationalize the concept in day-to-day work on the other. Addressing this dissonance will involve the development of professional expectations around recovery-orientation as a primary focus for staff. Concrete examples of what recovery means in practice will help, and existing clinical skills in managing competing priorities need protection. However, only when a shared understanding and unified approach exists across all levels of the mental health system will the vision of recovery-orientation be closer to being fully implemented.

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Table 1: Staff participants (n=97)

n (%)	**Focus groups** *n=65*	**Interviews** *n=32*
Job role		
Clinician	34 (52.3)	18 (56.3)
Team leader	31 (47.7)	6 (18.8)
Senior manager	0 (0.0)	8 (25.0)
NHS Trust		
South London and Maudsley NHS Foundation Trust	13 (20.0)	16 (50.0)
2gether NHS Foundation Trust	14 (21.5)	10 (31.3)
Leicestershire Partnership NHS Trust	12 (18.5)	2 (6.3)
Tees, Esk and Wear Valleys NHS Foundation Trust	13 (20.0)	4 (12.5)
Devon Partnership NHS Trust	13 (20.0)	0 (0.0)
Team		
Assertive Outreach	15 (23.1)	1 (3.1)
Early Intervention	12 (18.5)	4 (12.5)
Forensic	0 (0.0)	0 (0.0)
Support and Recovery	32 (49.2)	18 (56.3)
Rehabilitation	2 (3.1)	0 (0.0)
Supported housing	2 (3.1)	0 (0.0)
Management	0 (0.0)	7 (21.9)
Works across teams	2 (3.1)	1 (3.1)
Profession		
Psychiatrist	2 (3.1)	2 (6.3)
Nurse	40 (61.5)	17 (53.1)
Social worker	7 (10.8)	2 (6.3)
Occupational Therapist	9 (13.8)	5 (15.6)
Psychologist	1 (1.5)	2 (6.3)
Associate practitioner	0 (0.0)	1 (3.1)
Vocational Specialist	1 (1.5)	1 (3.1)
Support time and Recovery worker	2 (3.1)	1 (3.1)
Support worker	2 (3.1)	0 (0.0)
Exercise and health practitioner	1 (1.5)	0 (0.0)
Manager (no clinical background)	1 (1.5)	1 (3.1)

Supplementary data 1:
Full staff participant characteristics (n=97)

Mean (SD)	Focus Groups n=65	Interviews n=32
Age (years)	45.43 (8.116)	44.58 (9.344)
Time since Qualified (months)		228.52 (121.139)
Time in Mental Health Services (months)	207.78 (105.496)	209.81 (120.736)
Time in post (months)	50.58 (46.785)	66.84 (66.735)
n (%)		
Gender		
Male	26 (40.6)	13 (40.6)
Female	38 (58.5)	19 (59.4)
Missing	1 (1.5)	0 (0.0)
Ethnicity		
White British	50 (76.9)	28 (87.5)
White Irish	2 (3.1)	1 (3.1)
White Other	1 (1.5)	2 (6.3)
Black/Black British-African	5 (7.7)	1 (3.1)
Black/Black British-Caribbean	2 (3.1)	0 (0.0)
Black Other	3 (4.6)	0 (0.0)
Asian/Asian British-Other	1 (1.5)	0 (0.0)
Missing	1 (1.5)	0 (0.0)
NHS Trust		
South London and Maudsley NHS Foundation Trust	13 (20.0)	16 (50.0)
2gether NHS Foundation Trust	14 (21.5)	10 (31.3)
Leicestershire Partnership NHS Trust	12 (18.5)	2 (6.3)
Tees, Esk and Wear Valleys NHS Foundation Trust	13 (20.0)	4 (12.5)
Devon Partnership NHS Trust	13 (20.0)	0 (0.0)
Job Role		
Clinician	34 (52.3)	18 (56.3)
Team Leader	31 (47.7)	6 (18.8)
Senior Manager	0 (0.0)	8 (25.0)
Team		
Assertive Outreach	15 (23.1)	1 (3.1)
Early Intervention	12 (18.5)	4 (12.5)
Forensic	0 (0.0)	0 (0.0)
Support and Recovery	32 (49.2)	18 (56.3)
Rehabilitation	2 (3.1)	0 (0.0)
Supported housing	2 (3.1)	0 (0.0)
Management	0 (0.0)	7 (21.9)
Works across teams	2 (3.1)	1 (3.1)

Profession		
Psychiatrist	2 (3.1)	2 (6.3)
Nurse	40 (61.5)	17 (53.1)
Social worker	7 (10.8)	2 (6.3)
Occupational Therapist	9 (13.8)	5 (15.6)
Psychologist	1 (1.5)	2 (6.3)
Associate practitioner	0 (0.0)	1 (3.1)
Vocational Specialist	1 (1.5)	1 (3.1)
Support time and Recovery worker	2 (3.1)	1 (3.1)
Support worker	2 (3.1)	0 (0.0)
Exercise and health practitioner	1 (1.5)	0 (0.0)
Manager (no clinical background)	1 (1.5)	1 (3.1)
Highest Qualification*		
National Vocational Qualification 4	0 (0.0)	1 (3.1)
Higher National Diploma	0 (0.0)	4 (12.5)
Bachelors	0 (0.0)	13 (40.6)
Masters	0 (0.0)	10 (31.3)
PhD	0 (0.0)	2 (6.3)
Missing	65 (100)	2 (6.3)
Grade**		
Band 2	1 (1.5)	0 (0.0)
Band 3	2 (3.1)	2 (6.3)
Band 4	0 (0.0)	1 (3.1)
Band 5	6 (9.2)	1 (3.1)
Band 6	17 (26.2)	12 (37.5)
Band 7	2 (3.1)	5 (15.6)
Band 8a	0 (0.0)	2 (6.3)
Band 8b	1 (1.5)	3 (9.4)
Band 8c	0 (0.0)	1 (3.1)
Band 8d	0 (0.0)	1 (3.1)
Consultant	2 (3.1)	2 (6.3)
Professor	0 (0.0)	1 (3.1)
Social Services	2 (3.1)	0 (0.0)
Student	1 (1.5)	0 (0.0)
Missing	31 (47.7)	1 (3.1)

Note * Highest qualificaton: National Vocational Qualification 4 and Higher National Diploma qualifications are equivalent to diploma, foundation degree, nursing qualification.
Note ** Grade: Agenda for Change NHS pay scale - Bands 2-4 typically represent support staff, bands 5-6 typically represent qualified clinical staff, band 7 typically represents of team leader staff and bands 8a-8d typically represent senior manager staff. Staff grades are decided locally by each NHS Foundation Trust

Supplementary data 2

Clinician and Team Leader individual interview schedule

The interview schedule will focus on learning from success by using practice examples of recovery orientation to identify blocks and enablers to implementation as well as gathering participants' views on incorporating recovery in to their routine clinical practice. The interview will last up to one hour with an additional fifteen minutes to complete consent and respondent demographic data.

Research objectives

These semi-structured interviews explore the experiences of staff on implementing recovery orientated practice. There are four key research objectives: to explore,

- the understanding of recovery
- the experience of implementing recovery orientated practice
- the barriers and facilitators to implementing recovery orientated practice
- the impact of implementing recovery orientated practice

1. INTRODUCTION AND CONSENT

Aim: To introduce the research, clarify the content of the interview, explain confidentiality and gain consent.

- Introduce self, REFOCUS
- Introduce research
- Participation is voluntary and respondent can withdraw at any time either before, during or after the interview
- Explain confidentiality assurances (confidential unless participant reports unsafe practice against code of conduct)
- Recording (to gain accurate record of discussion, allow interviewer to focus on what respondent is saying, only research team will hear it)
- Length (about an hour with breaks if needed)
- Nature of discussion (conversational in style with specific topics to be addressed, following up information given in survey)
- Place of interview (need for private space to conduct the interview)
- Reporting and data storage (no-one identified in final report, data stored securely under Data Protection legislation – can only be used for purpose collected by law, e.g. transcripts kept in locked cabinets, not shared with anyone outside research team.
- Address any questions
- Gain written consent

2. CURRENT CIRCUMSTANCES – SOCIODEMOGRAPHICS FORM

Aim: To gain background information about the respondent, to explore their staff role and to identify key characteristics of staff that are more likely to implement recovery.

- gender (male, female)
- age (years)
- education level
- *personality characteristics*
- team model of practice (seven team models of practice: assertive outreach, continuing care, early intervention, forensic, support and recovery, rehabilitation, other)
- work role
- core profession (support time and recovery worker, nurse, psychiatrist, occupational therapist, psychologist, social worker, vocational specialist)
- grade
- length of time since qualification
- length of time in current post (years and months)

- length of work experience in mental health services (years and months)
- experience of mental illness (yes, no)
- use of mental health services (yes, no)
- experience of supporting a family member/friend with mental illness (yes, no)

3. STAFF PERCEPTIONS OF RECOVERY *[20 mins]*
START RECORDING

Aim: To identify how staff frame their practice, without directing the conversation to recovery. To identify if staff frame practice in terms of recovery, without the prompt (people may work in a recovery-oriented way without referring to recovery)

What is it that you hope to achieve in your practice with clients? What are your priorities and goals for practice? *What is important?*

Aim: To identify how staff understand and define recovery, their views on recovery, whether or not the definition/understanding/view changes during a career trajectory/over time, meaning-in-use, message from whom/source of information, role perception, personal world view

I'd like to ask you to describe an example where you have supported a person's recovery

Prompts:

- *What happened and how*
- *What was it about [this example] that supported [that person's] recovery?*
- *What was it that enabled recovery? practice (tasks) or reasoning (approach) or both*
- *Was it easy to support [that person's] recovery or did anything get in the way? What helped you to support that person's recovery?*
- *Explore why participant chose to focus on sharing that particular example*
- *Have you always worked in this way? Or has the introduction of recovery meant that you have changed the way you practice?*
- *In what ways has your working practice changed in order to support recovery?*

4a. BARRIERS AND FACILITATORS TO IMPLEMENTING RECOVERY – INDIVIDUAL PRACTICE *[20 mins]*

Aim: To explore what level of implementation participant has experienced, circumstances surrounding implementation, understandings of how and why it happened, as well as how it made the participant feel, explore experiences of successful/unsuccessful implementation.

Describe how, and to what extent *you* have been able to implement recovery orientated practice

Describe how, and to what extent *you* have been able to implement the REFOCUS recovery intervention. Who is involved? What was successfully implemented? What problems were encountered? What lessons can be learnt?

Prompts:

- *individual values*
- *knowledge about personal recovery*
- *skills in coaching and the three working practices (understanding individual values, strengths, goal striving)*

- *behavioural intent (plan to use coaching and implement the three working practices)*
- *behaviour (more use of coaching and the three working practices)*

What is it that enables YOU to support recovery?

4b. BARRIERS AND FACILITATORS TO IMPLEMENTING RECOVERY – TEAM PRACTICE *[20 mins]*

Aim: To explore what level of implementation respondent has experienced, circumstances surrounding implementation, understandings of how and why it happened, as well as how it made the respondent feel, explore experiences of successful/unsuccessful implementation.

Describe how, and to what extent *your team* has implemented recovery orientated practice

Describe how, and to what extent the REFOCUS recovery intervention is being implemented by *your team*. Who is involved? What was successfully implemented? What problems were encountered? What lessons can be learnt?

Prompts:

- *team values*
- *knowledge about personal recovery*
- *skills in coaching and the three working practices (understanding individual values, strengths, goal striving)*
- *behavioural intent (plan to use coaching and implement the three working practices)*
- *behaviour (more use of coaching and the three working practices)*

Prompts:

- *Describe an example where your team has supported a person's recovery*
- *What happened and how?*
- *What was it about [this example] that supported [that person's] recovery?*
- *Was it easy to support [that person's] recovery or did anything get in the way? What helped the team to support that person's recovery?*
- *Explore why respondent chose to focus on sharing that particular example*

What is it that enables YOUR TEAM to support recovery?

Are there any [other] factors that influence whether or not you or your team are able to support a person's recovery?

End of interview. Thank respondent and close interview.

Supplementary data 3

Senior manager individual interview schedule

The interview will focus on gaining senior manager perspectives on recovery, and explore how the concept is supported at the organisational level. The interview will continue to identify blocks and enablers to implementation by gathering reflections on incorporating recovery in to routine clinical practice. The interview will last up to one hour with an additional fifteen minutes to complete consent and respondent demographic data.

Research objectives

These exploratory interviews will focus on the experiences of senior managers on supporting recovery in practice. There are three key research objectives: to explore,

- the understanding of recovery
- the experience of supporting recovery at the organisational level
- the barriers and facilitators to implementing recovery orientated practice

1. INTRODUCTION AND CONSENT

Aim: To introduce the research, clarify the content of the interview, explain confidentiality and gain consent.

- Introduce self and research
- Cue participants into
  - why they have been selected to be interviewed,
  - what the interview will entail (Inform participants that the interview will ask questions on both what happens in the organisation, and what their views are),
  - what I would like to get out of it.

- Participation is voluntary and participant can withdraw at any time either before, during or after the interview
- Explain confidentiality assurances (confidential unless participant reports unsafe practice against code of conduct)
- Recording (to gain accurate record of discussion, allow interviewer to focus on what respondent is saying, only research team will hear it)
- Length (about an hour with breaks if needed)
- Nature of discussion (conversational in style with specific topics to be addressed)
- Place of interview (need for private space to conduct the interview)
- Reporting and data storage (no-one identified in final report, data stored securely under Data Protection legislation – can only be used for purpose collected by law, e.g. transcripts kept in locked cabinets, not shared with anyone outside research team.
- Address any questions
- Request written consent

2. CURRENT CIRCUMSTANCES – SOCIODEMOGRAPHICS FORM

Aim: To gain background information about the respondent, to explore their staff role and to identify key characteristics of staff that are more likely to implement recovery.

- gender
- age
- education level
- team model of practice
- work role
- core profession
- grade
- length of time since qualification
- length of time in current post
- length of work experience in mental health services

- experience of mental illness
- use of mental health services
- experience of supporting a family member/friend with mental illness

INTERVIEW TOPICS AND PROMPTS

[START RECORDING]

Section 1: Understanding and supporting recovery *[10mins]*
Aim:
To identify senior managers' understanding and perspectives on recovery

TOPIC: UNDERSTANDING AND SUPPORTING RECOVERY

Main question:

- Recovery can be interpreted and understood in many ways, how would you describe it?

Prompts:

- How do you understand recovery?
- In your opinion, how is recovery best supported in practice?
  [Explore detail on recovery knowledge, attitudes, values and principles]

- Can you describe how SLaM *[or other NHS org you have worked for]* supports recovery?
- Does the organisation have any recovery initiatives?
- What is the organisation doing to reinforce recovery values and principles in practice? *[Is there anything to reinforce recovery in day-to-day practice?]*

- How do you view your role and the purpose of your job within the organisation?
- What pressures do you face in your work?
- How does recovery fit with your everyday work? *[Is it central to your role?]*
- Is recovery something that you are able to support in your role?
- Are you able to give an example?

Section 2: Barriers and facilitators to supporting recovery *[50 mins]*
Aims:
To identify organisational priorities and any impact on supporting recovery
To explore existing service design structures that support recovery
To explore experiences of successful/unsuccessful implementation

TOPIC: ORGANISATIONAL PRIORITIES

Main question:

- How would you describe the core business of this organisation?

Prompts:

- What is SLaM's central vision/mission?
- What do you see as the current organisational priorities?
  [cost effectiveness [back to work], efficiency savings, innovation, throughput [discharge], contacts, patient activity [caseload size] risk] [Is recovery a priority?]
- What are the fundamental targets that need to be delivered?

[other than contact time, HoNoS, CPA]

- What are the risks to the organisation if targets are not met?
- How central is recovery to organisational priorities?
- Are there any targets around recovery? CQUIN?
- Is recovery additional and offered when all other targets have been met?
- How does recovery fit with the organisational priorities?
- Can you give me (any other) examples of how recovery is supported by the organisation?
- How are organisational priorities informed? What drives the decisions?
- What is it that drives and maintains current practice?
  [Influence of commissioning structures and funding priorities]

TOPIC: SERVICE DESIGN/REDESIGN

Main questions:

- Has the introduction of care pathways and/or clinical academic groups enhanced recovery support?

- In your opinion, do any practice models support recovery more than others, e.g. EIS Vs R&S?

Prompts:

- What is it about the model that facilitates recovery e.g. underlying capacity of staff – staff-SU ratio?
- In your opinion, what (other) existing service design structures support recovery?
- Have you found any challenges in supporting recovery in an established health system?
  [Recovery becomes framed in clinical language and clinical systems e.g. risk, crisis, discharge]

- How do you view the role of the workforce in supporting recovery? Is it their primary role to deliver on organisational targets/priorities?
- How can the workforce be adapted to support recovery?
- How do you ensure staff know it's their job to support recovery?
- Is the workforce recruited to support recovery? If so, how?

TOPIC: GAP BETWEEN SYSTEM AND SERVICE USER PRIORITIES

Main question:

- How does the organisation put the priorities of the service user first?

Prompts:

- In your opinion, are there any tensions between your understanding of recovery and the reality of what happens in practice?

End of interview. Thank respondent and close interview

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