A case study exploring recovery-orientated mental health nursing practices in one NHS Foundation Trust

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DEDICATION

This thesis is dedicated to the memory of Francis Adzinku, who influenced, inspired and motivated countless people throughout his life. To me, a mentor and fellow doctoral student, Francis aspired to bring compassion into everything he did.

DECLARATION

“I certify that the work contained in this thesis, or any part of it, has not been accepted in substance for any previous degree awarded to me or any other person, and is not concurrently being submitted for any other degree other than that of Doctor of Philosophy which has been studied at the University of Greenwich, London, UK.

I also declare that the work contained in this thesis is the result of my own investigations, except where otherwise identified and acknowledged by references. I further declare that no aspects of the contents of this thesis are the outcome of any form of research misconduct.

I declare any personal, sensitive or confidential information/data has been removed or participants have been anonymised. I further declare that where any questionnaires, survey answers or other qualitative responses of participants are recorded/included in the appendices, all personal information has been removed or anonymised. Where University forms (such as those from the Research Ethics Committee) have been included in appendices, all handwritten/scanned signatures have been removed.”

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ABSTRACT

Aim: To explore how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services in one National Health Service Foundation Trust.

Methods: A qualitative instrumental case study methodology (Stake, 1995) was applied. Semi-structured interviews and focus groups were used to gather the views of participants. Thematic analysis was applied to arrange and interpret the data.

Findings: Recovery-orientated practices have been defined and explored within clinical and personal spheres. This study argues that such polar positions do not epistemologically align with mental health nursing. Instead, recovery-orientated nursing practices are seen as enabling processes along a continuum rather than divergence.

Barriers and enablers towards implementing recovery-orientated nursing practices are many and positioned within the Trust's micro, meso and macro system levels.

Participants argued that nursing executives often conflicted with opposing organisational priorities within mental health services, hindering them from directly influencing practice-based nurses towards implementing recovery-orientated nursing practices.

Opposed by practice-based nurses, policies and strategies were seen as how nursing executives can influence the implementation of recovery-orientated nursing practices. Visible leadership and role modelling were methods by which participants felt nursing executives could directly influence nursing practice and improve communication.

However, a strict hierarchical structure within the Trust hinders senior leaders from influencing recovery-orientated nursing practices in mental health services.

Conclusion: Regardless of the objectively identifiable policies, processes and procedures created within the Trust, if practice-based mental health nurses do not feel connected to their leaders or contribute to and value the policies they make, nursing executives may bear little to no influence on implementing recovery-orientated nursing practices.

GLOSSARY OF TERMINOLOGY

Throughout the text, many terms and concepts are introduced within the thesis. Definition and conceptualisation are provided whenever a new term is presented. A few terms are used early in the thesis that benefits the reader by being included within a brief glossary.

Terminology	Meaning
Personal recovery	**As a definition:** 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 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 (Anthony, 1993). **As a conceptual framework:** The recovery processes are identified as being most centrally relevant to research and clinical practice: connectedness, hope and optimism about the future, identity, meaning in life and empowerment, forming the acronym CHIME (Leamy et al., 2011)
Clinical recovery	Clinical recovery within mental health services places the clinician as the expert within an established healthcare infrastructure, concerned with the psychopathological assessment and pharmaceutical treatment of symptoms to stabilise the person's mental state while implementing risk-management interventions (Slade, 2009).
Recovery-orientated practices	This phrase refers to the practices of multi-disciplinary clinicians, meaning to provide interventions aligned to personal recovery and in contrast to clinical recovery.
Recovery-orientated (mental health) nursing practices	This refers to the specific practices of mental health nurses. As was explored within this case study, the recovery-orientated practices of mental health nurses sit on a continuum rather than neatly within the divergence of personal vs clinical recovery.
Service user	A term that identifies those who access and use mental health services. The terms service user, person, individual, patient and client are often used interchangeably within the literature and by participants within this study. Service user is the most used term in mental health policy and recovery literature.
Practice-based nurses	This term refers to participants who provide direct care to service users within the Trust. These nurses work in both inpatient and community settings.
Nursing executives	Nursing executives are the senior most nurses within the Trust. They are the system leaders for mental health nursing. They lead the development of nursing strategy and policy while holding clinical governance accountability for practice-based mental health nurses.

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INTRODUCTION

Introduction

In this introduction, the personal motivations of the researcher are discussed, and a walkthrough of the structure of the thesis is made. A summary of the background of recovery is presented, and a brief description of the case is provided. The study's aim and research questions are outlined, followed by an outline of the chosen methodology. Key findings are summarised, and the researcher's original contributions to existing knowledge are described.

Origins of the study

Through my exposure to practice and discussions with fellow nurses, there was an apparent dissonance between the expectations of mental health services and the expectations of mental health nurses and, consequently, service users. As with other graduate mental health nurses, I was taught about the paradigm of recovery throughout training at university and the fundamental values and processes required to fully support the individual's expectations.

Yet in practice, it appeared difficult for mental health nurses aligned with the paradigm of recovery to compete with the broader expectations of the service, such as the over-emphasis on medication and focus on the reduction of symptoms and risk levels, as well as the time spent updating monitoring systems – addressing the administrative targets the National Health Service (NHS) requires mental health nurses to satisfy daily.

With this new exposure, my interest moved away from a solution focus to one of exploration, for how can we attempt to fix a problem if we do not understand what the problem is? As such, I explored how the system conditions might influence mental health nurses to implement recovery-orientated practices. Thus, my research journey began.

Thesis structure

This thesis consists of seven individual chapters. Chapter One introduces recovery, a central concept underpinning contemporary mental health practice. Within this study, recovery is used as the process through which the person-centred practices of mental health nurses within an NHS Foundation Trust are explored. The concept of recovery is explored through differing published literature, including its sociohistorical development, definition and conceptualisation. A critical evaluation of the sociopolitical emergence of recovery through UK health policy within the broader neoliberal political agenda is undertaken. Finally, the relevance of recovery to mental health nursing is made through the increased power shift away from professionals to service users.

Chapter Two presents a critical review of the empirical literature exploring how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services. This literature review facilitated the identification of the knowledge gaps for this study to further explore.

Chapter Two outlines the aim and formation of the research questions of this study. The specific research processes for this study (research paradigms, methodology and methods) are discussed. Inductive Thematic Analysis (Braun & Clarke, 2006) is used within this case study. A critical appraisal of the analysis approach is made. The systematic process of coding the data and the formation of three themes are presented. Finally, ethics are discussed, and a table of trustworthiness is presented (Lincoln and Guba, 1985).

Chapter Three presents the findings of this case study. Predominantly descriptive, these are aggregated accounts of participants unless otherwise stated. No literature is used to critique the findings at this thesis stage to avoid dilution of the findings, reduce bias and allow participant views to be unfiltered.

Chapter Four provides a comprehensive discussion of the key findings (Chapter Four) within the contexts of the empirical literature (Chapter Two) and the sociohistorical and sociopolitical contexts of Chapter One. Finally, broader empirical literature published after this case study, between 2016 and 2022, is explored and referenced to ensure the discussion remains contemporary.

Chapter Five provides a final case summary. Scholarly contributions are discussed, outlining this study's limitations, implications and recommendations. Chapter Seven reflects the doctoral journey and feedback on the findings and recommendations from people with lived experience using services.

Background: the concept of recovery in England

Although the term recovery has become engrained in national policy (Department of Health (DH), 2011) as well as the professional standards for mental health nurses (Nursing and Midwifery Council (NMC), 2014), the concept of recovery in mental health did not come from policy-makers, professionals or academics. Instead, recovery emerged through the personal accounts of those with lived experiences of mental ill health (Deegan, 1988; Lovejoy, 1982; Repper & Perkins, 2003). As such, recovery is often defined as personal recovery, emphasising the individual's experience of mental illness. For example, Anthony (1993) defines personal 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 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."
>
> (Anthony, 1993: 15)

Some have viewed the application of the recovery as philosophy as problematic due to the uncertainty of its use and conceptualisation into practice. Leamy et al. (2011) sought to rectify this pitfall, undertaking a systematic review to develop a conceptual framework for personal recovery. As a result, the recovery processes were identified as most relevant to research and clinical practice. They are connectedness, hope and optimism about the future, identity, meaning in life and empowerment, forming the acronym CHIME (Leamy et al., 2011). However, the existence of clinical recovery (Slade, 2009) and a service-defined recovery (Le Boutillier et al., 2015a) has shown that dissonance remains between the perspectives of clinicians and the mental health service itself.

Today, empowerment, choice and personalisation are core tenets of the Care Act (2014). What is more, the Five Year Forward View (Mental Health Taskforce (MHT), 2016) emphasises that there remains a need to embed further the broad principles of recovery

into mental health services, where empowerment, choice and personalisation remain ways by which service users suffering from mental illness may experience better recovery-outcomes.

Empowerment, choice and personalisation appear to be here to stay. Not only does their emphasis continue to be fixed within national policy, but their core tenets have become embedded within the Care Act (2014). What is more, the Five Year Forward View for Mental Health (Mental Health Taskforce (MHT), 2016) emphasises that there remains a need to embed further the broad principles of recovery into mental health services, where empowerment, choice and personalisation remain ways by which service users suffering from mental illness may experience better recovery-outcomes.

Despite the personal-recovery focus within the Five Year Forward View for Mental Health (MHT, 2016) and, more recently, Commitment and Growth: advancing mental health nursing now and for the future (Health Education England, 2022), the NHS often uses the term recovery as something that is to be achieved, measured as an end goal for service users of mental health services, something that can be obtained following treatment or psychological intervention.

Background: a brief description of the case

NHS England is made up of many organisations. Some of these organisations are called NHS Trusts, aiming to provide care to the public. An NHS Trust may have several services responsible for delivering different specialist care, as well as various levels of organisational management that oversee the function of these services.

Within these services exists many different but overlapping systems of people, all contributing to the organisation's overall aim. Sometimes these systems of people can be bound by the service in which they work, such as the professionals within an A&E service, while in other circumstances, systems of people may cut through multiple organisational contexts, such as a particular professional group within an NHS Trust.

Mental health services are made up of various interrelated systems of professional groups. People within these professional groups may also be in places of management

and leadership at various levels of the NHS Trust. As such, a professional group within an NHS Trust will often cut through multiple contexts of the organisation. Although working within the same service, each of these professional groups has its roles & responsibilities, world-views and purposes, all of which contribute to the overall function of the service.

When trying to understand or explore an issue (Stake, 1995) within a particular service or indeed across an NHS Trust, the potential differences in the worldviews of professionals need to be acknowledged and managed. Exploring or addressing every system of the profession with a Trust can be extremely time-consuming. It was, therefore, essential to limit the focus of the study, outline the boundaries of the system being explored, and identify the various contexts the system may cut through.

In this case study, the professional group of mental health nursing within an NHS Foundation Trust has been selected to explore the context (i.e. system barriers and enablers) that may influence the implementation of recovery-orientated nursing practices. When bounded by their profession, mental health nurses are situated across multiple contexts of the NHS Trust.

As such, this study aims to explore not only the system conditions experienced by mental health nurses in practice but the system conditions experienced by those in senior managerial/leadership roles and the influence they might have on practice-based mental health nurses towards implementing recovery-orientated nursing practices.

Such conditions may be experienced exclusively by this one professional group, while others may represent the broader system, overlapping with the experiences of other professional and non-professional groups. Nevertheless, exploring one system within the complexity of the broader system provides deeply contextualised insight into the issue being studied.

Aim and questions

This study explored how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services in one NHS Foundation Trust.

Three issue questions underpinned the aim. These questions guided the exploration of this case through the experiences of the Trust's nurse leaders and practice-based mental health nurses:

1. How do mental health nurses conceptualise recovery-orientated nursing practices?
2. What are the barriers and enablers towards implementing recovery-orientated nursing practices?
3. How do nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices?

Research Methodology

This study adopted a qualitative instrumental case study approach (Stake, 1995). The methods employed within this case study were: semi-structured interviews and focus groups. Phase one used semi-structured interviews to explore the perceptions of the nursing executives. Phase two used focus groups to explore the perceptions of inpatient-based mental health nurses and semi-structured interviews with community-based mental health nurses. Thematic Analysis was applied to present and interpret the data.

Summary of key findings

This study explored how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services in one NHS Foundation Trust. The three questions guide the findings, helping ensure triangulation and contextualisation throughout. Below is presented a summary of findings for each of these issue questions.

How do mental health nurses conceptualise recovery-orientated nursing practices?

Participants described their experiences and observations and endeavoured to define recovery-orientated nursing practices within the context of mental health services. Both practice-based nurses and Nursing executives primarily conveyed their understandings of recovery within a continuum of interrelated yet contrasting concepts: an objectively measurable outcome and an individually defined process. As a result, differences in views of recovery amongst participants were often nuanced and overlapping rather than divergent.

When describing their role in implementing recovery-orientated nursing practices, participants saw themselves as potential enablers for a person's recovery. Rather than describing specific interventions or models of care, participants conceptualise recovery-orientated nursing practices as a set of enabling principles: seeing the person as an individual, setting short-term goals, and promoting choice through positive risk-taking. In addition, participants associated the idea of instilling hope as an additional component of the mental health nursing role in implementing recovery-orientated nursing practices.

Participants in this case study further add to the existing knowledge around the relevance of seeing the individual with a unique perspective of their recovery. Nevertheless, this highly-subjective version of recovery-orientated nursing practices remains abstract and needs clear form. Furthermore, the narrative surrounding recovery-orientated nursing practices weighs heavily on morality and ideology rather than considering applicability and reality within mental health services.

Unique to the participant group of senior nurse leaders, some saw the concept of recovery, in its abstract sense, as an established organisational philosophy underpinning all nursing practices. Recovery as a corporate philosophy was not regarded as a new concept but rather seen as the rephrasing or rebranding of historical and contemporary approaches to nursing care, the tenets of which were believed to have already been embedded within mental health nursing practices for some time.

With its multi-dimensional nature, determining the correct meaning of recovery within an interrelated and variable set of organisational, professional, socio-political and socio-

historical contexts may present a significant challenge for practice-based nurses and nursing executives within the Trust. As with any system change, careful consideration, and ongoing evaluation of implementation, is necessary for successful change to occur (Weiss, 1995) or certainly be tangibly observable.

What are the barriers and enablers towards implementing recovery-orientated nursing practices?

This case study has found there to be a multitude of reported barriers and enablers towards the implementation of recovery-orientated nursing practices. Most of these relate to various service processes and procedures (i.e. risk management, paperwork, admission and discharge) or how mental health nurses engage with others (i.e. patients, families and carers, and other professionals).

Practice-based nurses needed more power and control to overcome systemic challenges at the micro, meso and macro system levels (i.e. opposing professional paradigms, untenable service demands and social issues). In the way of barriers, many of the problems reported by participants could be inferred as engrained sociocultural issues rather than measurable or justifiable processes and procedures.

How do nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices?

Participants argued that nursing executives often conflicted with opposing organisational priorities within mental health services, hindering them from directly influencing practice-based nurses towards implementing recovery-orientated nursing practices. This thinking was underpinned by the idea that other service-level targets can create a culture that may impede nurses from implementing recovery-orientated nursing practices.

The nursing executive's commitment towards influencing the implementation of recovery-orientated nursing practices was said to be set out and embedded within the Trust's nursing strategy priorities. However, despite some nursing executives seeing recovery as a philosophy of practice already embedded Trust-wide, others regarded it as an ambition

rather than a current reality. Therefore, nursing executives highlighted an implementation gap from nursing strategy to policy and into practice.

Furthermore, nursing executives viewed policies and procedures as a means to influence the implementation of recovery-orientated nursing practices. However, practice-based nurses reported needing more connection with creating and operationalising policies. Moreover, a strict hierarchical structure hindered communication between those directly delivering care and those leading the Trust's strategic direction. Therefore, visible leadership through role-modelling at all levels is essential if nursing executives are to influence practice-based nurses towards implementing recovery-orientated nursing practices.

Original contribution

The award of a PhD requires an original contribution to existing knowledge (Quality Assurance Agency for Higher Education, 2014). This section highlights this doctoral research's original contribution to the current practice field.

The recovery philosophy

This study has contributed to the existing research on recovery-orientated nursing practices. Elements of personal, clinical, and service-defined recovery emerged and added further empirical context to the practice field.

Previous research on recovery has framed recovery in two opposing philosophical perspectives: personal and clinical recovery. Research into recovery is predominantly critical of the psychiatric medical model, instead aligning with the ideals of mental health services becoming more patient-led.

Moreover, a unique contribution underpinned by a sociohistorical and sociopolitical critique, this case study has found that these two seemingly opposing theoretical concepts do not entirely epistemologically align with mental health nursing practice. Instead, recovery-orientated nursing practices must be seen on a continuum rather than within rigid contrasting models. As such, a social constructivist framework was presented

to assist nurses in philosophically framing the meaning of recovery within mental health nursing practices.

Methodology

At the beginning of undertaking this study, a case study methodology still needed to be applied to explore recovery-orientated practices and recovery-orientated nursing practices. However, a case study has now been undertaken, exploring the implementation of recovery-orientated practices (Mhlanga, 2022). Nevertheless, how each case study is applied varies from project to project. For example, where Mhlanga (2022) looked at a broad perspective of multi-professional participants, her case study was defined by the structure of the Trust in which mental health services are provided. However, this case study bound itself by a particular professional group, mental health nurses, within and through an NHS Foundation Trust's micro, meso and macro system structure.

Unique in its approach, this case study explored the perspectives and relationships between practice-based mental health nurses (microsystem) and nursing executives (mesosystem). Although research has already explored the views of senior managers on implementing recovery-orientated practices (Mhlanga, 2022; Le Boutillier et al., 2015a), the interrelationship between practitioners and leaders within the NHS required exploration.

Moreover, how this case study explored the role of mental health nursing from board to the ward, underpinned and defined by its deep and complex sociohistorical and sociopolitical context, provides a unique contribution to how recovery-orientated nursing practices have been investigated and understood. Such context had yet to be explored within the existing research.

Existing knowledge

The literature review in Chapter Two shows that the particular system conditions underpinning practice-based mental health nurses towards implementing recovery-orientated nursing practices must be explored. In addition, there needed to be more

research exploring the experiences of senior nurses who may have created, influenced, and shaped such conditions. This study examined how practice-based mental health nurses and senior leaders experience implementing recovery-orientated nursing practices in one NHS Foundation Trust, addressing the dearth of information in the literature and offering an original contribution to existing knowledge.

Many of the issues discussed when exploring how mental health nurses conceptualise recovery-orientated nursing practices support the existing research critiqued in Chapter Two. Furthermore, rather than identifying specific interventions, participants saw recovery-orientated nursing practices as a set of enabling principles: seeing the person as an individual, setting short-term goals, and promoting choice through positive risk-taking. Moreover, promoting choice through positive risk-taking appears to be an original contribution to the existing knowledge, something aligned predominantly with mental health nurses, laden with moral, ethical and sociopolitical challenges.

Although many of the barriers and enablers identified through this study complement the findings within the existing research, how this study has explored and presented these at the various system levels (micro, meso and macro) seems original in its approach. In addition, the sociocultural, sociopolitical, sociohistorical, and socioenvironmental contextual framing of these findings is another original contribution.

Lastly, how this case study explored the interrelationships between practice-based mental health nurses (microsystem) and nursing executives (mesosystem) seems original in its approach. Although similar views have been reported in the empirical literature on recovery-orientated practices around competing priorities within NHS Trusts, this deeply interconnected and contextualised account, to our knowledge, has yet to be replicated elsewhere.

Identifying the strict hierarchical structure within the Trust, be it internally developed (mesosystem) or formed by the contributions of external factors (macrosystem), has provided new knowledge in understanding the crucial role of leadership in influencing recovery-orientated nursing practices within the Trust. Furthermore, the findings presented on the part of strategy and policy in influencing recovery-orientated nursing

practices and, indeed, nursing practice in its broadest sense is an original contribution of note.

CHAPTER ONE: THE EMERGENCE OF RECOVERY IN THEORY, POLICY AND MENTAL HEALTH NURSING PRACTICES

Introduction

This chapter introduces recovery, a central concept underpinning contemporary mental health practice. Within this study, recovery is used as the practice process through which mental health nursing within an NHS Foundation Trust is to be explored. In this chapter, recovery is explored through differing published literature, including its socio-historical development, definition and conceptualisation. A critical evaluation of the emergence of recovery through national health policy is undertaken within the broader neoliberal political agenda. Finally, in response to the increased shift of power away from professionals towards service users, the relevance of recovery to mental health nursing is made, highlighting the position of the role within the system-wide complexity of NHS services.

Recovery - a definition

The term recovery emerged in the 14th Century, meaning to return to health, from the Anglo-French recoverie and old French recovree - “remedy, cure, recovery” (Online Etymology Dictionary (OED), 2018). In line with its etymology, the word recovery is used in physical health care to refer to returning to or achieving good health after an episode of illness or treatment. Mental health care’s term recovery has a much more abstract definition. Although present in national policy and practice guidance, the idea of recovery in mental health did not come from policy-makers, professionals or academics. Recovery emerged through the personal accounts of those with lived experiences of mental illness (Deegan, 1988; Lovejoy, 1982; Repper and Perkins, 2003). Recovery is often defined as personal recovery, emphasising the individual’s experience of their mental illness. Anthony (1993) describes personal 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 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." (Anthony, 1993: 15)

Anthony's (1993) definition of personal recovery is well cited in mental health literature and appears within UK policy and professional standards for mental health nurses (Department of Health (DH), 2011 & 2006; Nursing and Midwifery Council (NMC), 2014).

Recovery - a socio-historical context

Although the term recovery in mental health emerged through the personal accounts of mental illness in the 1980s and 90s, earlier significant socio-historical milestones influenced its foundations. A combined drive of philosophers, clinicians, activists and service users calling for social change and greater equality for people with mental illness is frequently referred to in the literature as the recovery-movement (Davidson et al., 2010; Lawton-Smith & McCulloch, 2013). Where there is no linear or definitive starting point to explain the exact emergence of the recovery movement, some critical historical drivers have influenced the direction of mental health care and treatment within the UK towards a recovery orientation.

Perceval's influence – an early account of lived-experience

The service user drives in England can be traced back to the nineteenth century through John Thomas Perceval's written personal accounts of "mental illness" (Bateson, 1961). Percival, the tenth son of Prime Minister Spencer Perceval, documented his experience of mental illness, where he spent many years in lunatic asylums under the treatment of lunatic doctors. Percival's accounts and political-activist position place him at the forefront of the recovery movement in England, challenging the practice of psychiatric treatment and institutions, along with the restrictive policy and legislation of his time. In addition, Percival campaigned for more significant patient rights, increased care choices, and protection against wrongful confinement and medical treatment without consent (see Report from the Select Committee on Lunatics, 1860).

An example of Perceval's vision for mental health care is presented by Hunter and Macalpine (1962). They illustrate a letter from Perceval to Sir James Graham (written in

1845) as being somewhat prophetic, depicting the future developments of psychiatry in England over the 20th century:

> "I am of the opinion that one secret in the cure of lunatic patients will be discovered to be the art of allowing patients the faculty of expression, by gesture, utterance and exclamation, and to encourage with discretion the development of individual character, the spirit of independence and self-respect, the cure of many maniacs is impeded by repression, and cannot be effected but by giving liberty." (Hunter and Macalpine, 1962 pp: 395).

Although Perceval spent his life campaigning for the reform of lunacy laws and for better treatment of asylum inmates, such changes to legislation took decades and, in some cases, well over a century before it was effectively changed. For example, it wasn't until 1957 that the Percy Commission published the Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency. It was proposed that UK law be altered to reduce restrictive practices, offering people with mental illness the same rights as those receiving care for any other type of illness or disability (Percy Commission, 1957). Consequently, the introduction of the Mental Health Act in 1959 by the Ministry of Health removed the distinction between psychiatric and other hospitals, leading to the development of mental health care in the community.

Anti-psychiatry in the 60s and 70s

The term anti-psychiatry was introduced by Cooper in 1971, becoming a movement to challenge the psychiatric model through the context of a socio-political debate. The anti-psychiatry movement, in particular the views of Goffman, had a profound impact on psychiatric institutions and the propulsion of the recovery movement within the latter half of the 20th Century (Nasser, 1995). In his book, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates, Goffman (1961) presents his accounts of mental health asylums through a series of observational studies. Within these writings, Goffman coined the theory of total institution, defined as:

> "A place of residence and work where a large number of like-situated individuals, cut off from the broader society for an appreciable period of time, together lead an enclosed, formally administered round of life." (Goffman, 1961: xiii)

Goffman describes the asylums, under the medicalisation interpretation of mental illness, as places where people with a mental illness are stripped of their identity through social and physical abuse while being made to conform to the established infrastructure of the institution. That being said, Weinstein (1982) argues that Goffman focused too much on the negative and debilitating characteristics of mental hospitalisation without giving adequate attention to the therapeutic aspects it also provided. Nevertheless, Goffman's hard stance aligned with others such as Illich (1976), who is critical of the influence of medicine on everyday life, as well as the critiques of psychiatry in the 1960s and 1970s led by Szasz, Laing and Cooper, and later Foucault (see next paragraph). All aligned with a shared belief that the orthodox psychiatric model of mental illness was inadequate and cruel.

Laing, considered the father of anti-psychiatry in the UK, did not regard himself as an anti-psychiatrist (Nasser, 1995). Nevertheless, he argued that schizophrenia was the successful attempt of individuals to escape adapting to the social norms of the nuclear patriarchal family of a capitalist society (Laing and Cooper, 1969), where those who were medicalised as being mentally ill were done so because of their political disposition (Laing, 1967). Extending Laing's thinking, Cooper (1980) believed that abolishing psychiatry through transforming the socio-political landscape would remove the need for psychiatrists to police and oppress nonconformist societal disobedience. Moreover, the social-psychiatrist Szasz (1972) openly rejected the organic explanation for mental illness, debating that the mind is not part of the body, thus, cannot be diseased to require treatment or admission to an asylum. Such views were also exclaimed by Foucault (1971), who argued that madness was once seen and respected by society as another way of being but is now considered abnormal through the emergence of mental illness by psychiatry. Foucault's view echoed the thoughts of Goffman (1961), who claimed the impact of medically labelling people with a mental illness negatively affected individuals in societal identity. However, the current nature of commissioned healthcare dictates that without a diagnosis, people cannot access treatment, specialist mental health care and social funding (Joint Commissioning Panel for Mental Health, 2015).

The anti-psychiatry movement, subsequent advancement of social theory and improvements in psychiatric treatment, and the creation of the Mental Health Act (MH,

1959) led to deinstitutionalisation within the UK (MacSuibhne, 2009). Deinstitutionalisation drove the closure of all asylums, steering the development of community-based care (Lawton-Smith & McCulloch, 2013). The government's agenda for closing the asylums is underpinned by moral grounds rather than an overt financial impetus where the overall costs of adequate community services exceed the price of hospital admission (The Health Foundation & The Kings Fund, 2015). These developments provided the recovery movement with a more comprehensive socio-political foundation to assist with their endeavour for further equality and better care for those living with mental illness.

Recovery – a conceptualisation

Personal recovery

The concept of recovery has been and continues to be underpinned by first-person accounts of mental illness, a subjective phenomenon unique to the individual baring the fundamentals of hope, acceptance and the reclamation of a positive sense of self (Anthony, 1993; Deegan, 1988; Repper & Perkins, 2003; Lovejoy, 1982). Over the past decade, recovery (in this context) has become embedded within national healthcare policy (DH, 2011) and professional standards for nurses (NMC, 2014). Nevertheless, Deegan (1988) asserts that the concept of recovery does not refer to the health service's provision or practitioners' choice of treatment or interventions. Instead, it signifies a philosophical approach that values and emphasises the importance of promoting the lived experience of the person with a mental illness; their journey to accept or overcome the debilitating challenges they face (Deegan, 1988).

The relevance and practical application of recovery to mental health services and professional practice haven't gone without criticism. The values-based philosophy of recovery has been viewed as scientifically insignificant (Davidson & Roe, 2007), lacking a consensus of understanding (Hopper, 2008), which has proved problematic for empirical investigation and service operationalisation (Slade, 2009). Moreover, there is the belief that implementing recovery-orientated practices requires new services to become a reality (Davidson et al., 2006), placing further constraints on professionals and

already limited resources. Uncertainty around the implementation of recovery-orientated practices has inevitably arisen where recovery has been underpinned by a multitude of conceptualisations: from a set of processes and outcomes (Liberman & Kopelowicz, 2005) to the ideas of a vision or a life orientation (Silverstein & Bellack, 2008). Confusion around the applicability of recovery starts at the semantic level, let alone the conceptual. In other healthcare domains, the term recovery refers to returning to good health after an episode of illness through treatment or cure. It does not resemble the “unique process” described by Anthony (1993: 15). In 2011, Leamy et al. sought to rectify this pitfall by undertaking a systematic review to develop a conceptual framework for personal recovery, aiming to provide a conceptual basis for future recovery-orientated research and practice.

Their conceptual framework comprises three interlinked superordinate categories: “characteristics of the recovery journey; recovery processes; and recovery stages” (Leamy et al., 2011: 448). The recovery processes are identified as being most centrally relevant to research and clinical practice: connectedness, hope and optimism about the future, identity, meaning in life and empowerment, forming the acronym CHIME (Leamy et al. 2011). Figure 1 presents each process category and subtheme for more explicit conceptualisation. Although the robustness of their approach well serves the framework, Leamy et al. (2011) identify methodological limitations to their review. The analysis synthesised secondary data and did not directly explore the primary data; the emergent categories were only one way to group the findings, which subsequently changed after the authors undertook expert consultation; their separation of categories brings structure, but another study may not provide the same overall thematic arrangement. Leamy et al. (2011: 450) emphasise that the framework should not be viewed as definitive, for the philosophy of personal recovery is grounded in the subjective phenomenon, consisting of individual experience and meaning, rather than giving prominence to group-level aggregated data.

Figure 1. Recovery process

Recovery processes	Number (%) of 87 studies identifying the process
Category 1: Connectedness	75 (86)
Peer support and support groups	39 (45)
Relationships	33 (38)
Support from others	53 (61)
Being part of the community	35 (40)
Category 2: Hope and optimism about the future	69 (79)
Belief in possibility of recovery	30 (34)
Motivation to change	15 (17)
Hope-inspiring relationships	12 (14)
Positive thinking and valuing success	10 (11)
Having dreams and aspirations	7 (8)
Category 3: Identity	65 (75)
Dimensions of identity	8 (9)
Rebuilding/redefining positive sense of identity	57 (66)
Overcoming stigma	40 (46)
Category 4: Meaning in life	59 (66)
Meaning of mental illness experiences	30 (34)
Spirituality	6 (41)
Quality of life	57 (65)
Meaningful life and social roles	40 (46)
Meaningful life and social goals	15 (17)
Rebuilding life	19 (22)
Category 5: Empowerment	79 (91)
Personal responsibility	79 (91)
Control over life	78 (90)
Focusing upon strengths	14 (16)

Source: Leamy et al. (2011)

Notwithstanding its limitations, the conceptual framework has undergone validity and relevance testing. In their study of 48 mental health consumers, Bird et al. (2014) undertook a comparative inductive and deductive analysis of their data against the framework categories. The processes which give the acronym CHIME (Figure 1) remain relevant and are evident within the data. However, the inductive analysis led to three areas of difference: practical support, a greater emphasis on issues around diagnosis and medication, and scepticism surrounding recovery. Bird et al. (2014) propose that the conceptual framework for personal recovery is valid and relevant for clinical practice and

research. Practices that embed the philosophical values and conceptual processes of personal recovery can be evaluated as recovery-orientated (Slade, 2014). Nonetheless, given the individualistic nature of recovery, Bird et al. (2014) stress that there will always be the need to understand the specific population and context under investigation.

Clinical recovery

Following the historical drivers of the recovery movement in the 60s, 70s and 80s, developments in psychiatric treatment have moved away from their ancestry roots of institutionalisation towards that of person-centred care (Kitwood, 1993; Rogers, 1961). Person-centred care is recommended as best practice by the National Institute for Health and Care Excellence (NICE, 2011): “People who use mental health services should have the opportunity to make informed decisions about their care and treatment, in partnership with their health and social care practitioners” (NICE, 2011: 7). Person-centred care is also enshrined in law under regulation nine within the regulated activities of The Health and Social Care Act (HSCA, 2008) (HSCA Regulations, 2014).

Clinical recovery within mental health services places the clinician as the expert within an established healthcare infrastructure, concerned with the psychopathological assessment and pharmaceutical treatment of symptoms to stabilise the person’s mental state while implementing risk-management interventions (Slade, 2009). Recovery, in this sense, is measured by symptom remission, reduced levels of risk and relapse, where clinical tasks and interventions shape the delivery of recovery-based care (Le Boutillier et al., 2015b).

A clinical recovery emphasises a paternalistic meaning to the concept of recovery: implementing technocratic practices deemed by clinicians as beneficial to the service user based on a deficit medical intervention model. Paternalism is defined as:

> “the interference of a state or an individual with another person, against their will, and defended or motivated by a claim that the person interfered with will be better off or protected from harm.” (Dworkin, 2017)

Although deemed necessary under certain conditions where a person may lack the capacity to make informed decisions (Mental Capacity Act, 2005a) or pose a serious risk to themselves or the public (Mental Health Act, 1983), the underpinnings of a paternal

approach entirely oppose the philosophical values of personal recovery. Slade (2009) argues that having a primary focus on clinical recovery is incompatible with a primary focus on personal recovery, where an emphasis on clinical recovery will inevitably infringe upon the individual's domains of hope, meaning and symptoms.

Barber (2012) stresses that personal recovery from mental illness is compatible with newer medical treatment approaches, such as more recent generations of anti-psychotics and anti-depressants. Ralph and Corrigan (2005) assert that treatment is a vital component of an individual's recovery journey, where some people would not be able to function daily. However, Slade (2009) maintains that although at times integral to an individual's recovery, clinical recovery should be a subset of personal recovery, where its focus may be beneficial for some but can significantly hinder the healing of others.

A service-defined-recovery

Through national policy, the UK government has and continues to proclaim its commitment to align NHS mental health services in England towards a personal recovery orientation (DH, 2006; DH, 2011a; Mental Health Taskforce, 2016). Nevertheless, with the lack of operational guidance, recovery's conceptual confusion continues to prevail, where many NHS Trusts remain focused on measuring outcomes based on ideas of clinical recovery rather than endorsing the individualised processes and values of personal recovery (Slade et al., 2014; Rogers et al., 2007; Le Boutillier et al., 2015a).

What is more, literature has touched upon an underexplored concept of recovery underpinning today's mental health care systems; a service-defined-recovery, an idea owned by the organisation, measured by service throughput and accessibility, driven by financial and administrative goals, to reduce costs and shape practice (Le Boutillier et al., 2015a). A service-defined-recovery arose through a review of studies, where clinicians expressed concerns that recovery appears to be a corporate agenda; aimed at reaching targets to satisfy government and ultimately reduce costs for the organisation (Gilburt et al., 2013; Cleary et al. 20,13). The principles of such a concept align with critical fundamentals of what Seddon (2008) has labelled command-and-control thinking: a top-down functional design, reactive to political agenda for change, bearing a contractual

attitude towards staff and service users, where the role of management is to meet the organisation's measuring criteria of outputs, targets and standards, concerning budgets.

Such thinking is fuelled by extrinsic motivators, where the implementation of the values underpinning personal recovery will not be able to function in practice without the sharing of power and co-production between service users, practitioners and managers of mental health services (Tse and Whitley, 2014; Shepherd et al., 2010; Boardman and Shepherd, 2009; ImROC, 2017b). Furthermore, Ham (2014) argues that improvement in the NHS needs to be based on commitment rather than compliance, valuing leadership continuity with a distributed and collected approach to leadership across organisations, allowing skilled clinicians to work alongside managers. As such, a recovery strategy or policy created by senior managers alone and cascaded into operation will be ineffective in transforming services towards a personal recovery orientation.

Recovery – a broader political agenda

The emergence of recovery in UK Policy

The emergence of recovery in UK policy occurred during New Labour's NHS reform (see The NHS Plan - DH, 2000). However, the term recovery first appeared in UK national policy in 2001 through The Journey to Recovery – The Government's Vision for Mental Health Care (DH, 2001a). This policy emphasised the need for mental health services and for society to move away from the institutionalised and paternalistic thinking of mental illness towards one that focuses on recovery through the promotion of individuality and equal citizenship. As discussed in the previous sections of this chapter, the drive for the recovery orientation of mental health services came from social activists and people with lived experience of mental illness throughout the 80s and 90s. Yet, as McWade (2016) points out, recovery, in the context of the 2001 policy, was sold as the new vision of New Labour and did not resemble the guiding vision of personal recovery, notably referred to by Anthony (1993).

Unlike the recent No Health Without Health (DH, 2011) policy, where personal recovery was defined as a distinct concept from clinical recovery, no attempt was made to explain

or conceptualise recovery in 2001. The term recovery within the 2001 policy can be critically evaluated by looking at the preceding and proceeding text. At times, the recovery is intertwined with values that appear to resemble those of personal recovery: “mental health services that are planned and delivered around the needs and aspirations of service users” and “whatever they think is critical to their recovery” (DH, 2001a: 19 & 24).

The use of recovery as a metaphor to describe New Labour’s transformative vision for mental health services in crisis suggests that service users’ voices have finally been heard. However, the 2001 policy emphasises the necessity for service user dependence upon mental health services for recovery to become a reality: “The vast majority have real prospects of recovery – if they are supported by appropriate services, driven by the right values and attitudes” (DH, 2001a: 24). Yet the primary drive of the recovery-movement was to challenge the medicalisation of mental illness by critiquing the practices of psychiatry - the incarceration and forced treatment of individuals. As such, McWade (2016) argues that the emergence of recovery through The Journey to Recovery (DH, 2001a) and the subsequent 2007 review of the Mental Health Act (1983) has done more to solidify the position of psychiatry and further justify the need for restrictive practices than it has to address the concerns of those with lived experience of mental illness.

Recovery in the neoliberal agenda – empowerment, choice and personalisation

Although welcomed by activists of the recovery movement as a step towards making a recovery a reality (Repper & Perkins, 2009), some have critiqued New Labours’ use of the term recovery, emphasising its embeddedness within the broader economic and societal priorities of the UK Government’s neoliberal agenda of the early 2000s (see: Braslow, 2013; McWade, 2016; Recovery in the Bin, 2019). Neoliberalism is:

> “The belief that open, competitive, and unregulated markets, liberated from all forms of state interference, represent the optimal mechanism for economic development.” (Brenner & Theodor, 2002: 350)

Neoliberalism has also been used to describe social policies that reform citizenship as a project to pursue self-improvement through individual responsible risk-taking, with minimal interference from the state (Braslow, 2013). Such a view of citizenship is visible

within the 2001 mental health policy. Emphasis is placed upon a vision that “enables and empowers people with mental health difficulties to take their full place in society” (DH, 2001a: 24-25): recovery needs that are fulfilled by pursuing “an acceptable place to live, meaningful occupation, further education and training if necessary and access to – and information about – entitlements and benefits”.

The neoliberal approach adopted by New Labour builds on New Public Management (NPM) theory, which served as a source of inspiration for the reforms undertaken in the NHS during the 1980s (Simonet, 2015). NPM is an administrative approach that encompasses a range of defining features, such as delegating decision-making powers to managers, dividing large public organisations into smaller units, incorporating competition, prioritising efficiency, outcomes, and quality, emphasising individualism over collectivism, and identifying public service users as 'customers,' 'consumers,' or 'citizens' (Hannigan, 2002).

This neoliberal discourse is evident within broader New Labour health and social care policies driving the trends of individualisation (Callinicos, 2013), moving away from the paternalistic approach to care towards one of empowerment, choice and personalisation.

Empowerment first became prominent in The NHS Plan (DH, 2000). It can be defined as “helping people to discover and use their ability to gain mastery over their illness” (Funnell & Anderson, 2004: 201). Choice emerged through the NHS Plan (DH, 2000) and grew through The NHS Improvement Plan: Putting People at The Heart of Public Services (2004). Personalisation is most notably reflected in Our Health, Our Care, Our Say (DH, 2007) and, more recently, No Decision About Me, Without Me (DH, 2012a).

Personalisation (person-centred care) moved away from service-led decision-making towards one that further emphasised service user empowerment and choice. The argument for promoting choice is that it helps empower service users to decide what care they want and where they will receive it, further reducing the paternalistic approach to care and treatment. Furthermore, when people are free to make choices that others may consider wrong or unwise, the choice can significantly promote empowerment (Linhorst, 2006).

Moreover, empowerment through choice is central to personal recovery (Leamy et al., 2011). Personalisation recognises people as empowered individuals, acknowledging their strengths and social networks within planning care and treatment (Carr, 2010). In this sense, personalisation is aligned with the individualistic values underpinning personal recovery.

The introduction of service user empowerment and choice has also helped drive the economic agenda of service-to-service competition (The NHS Procurement, Patient Choice and Competition Regulations, 2013). A central tenet of personalisation is to reduce service user dependency upon the state-run NHS, where the neoliberal economic agenda, aiming to reduce the burden of demand and government spending, remains prominent. Moreover, empowerment, choice and personalisation in UK policy can be viewed as a more expansive manifestation of neoliberal citizenship underpinning the term recovery (Braslow, 2013), where people are rewarded for making the right decisions but can be punished for making the wrong decisions.

As McWade (2016: 16) points out, "the ideal of choice and its conflation with responsibility thus creates the very possibility for the removal of choice. Choice is contingent on conformity". Although society and government set the standards for conformity, in the neoliberal view of citizenship, it is the individual's responsibility to improve their circumstances. In contrast, the state and society bear little to no responsibility for the choices people (are allowed to) make. As such, neoliberal citizenship may do more to segregate and marginalise people with mental illness than it can to support their recovery.

McWade (2016) further argues that empowerment and choice for people with mental health issues present us with a paradox; service users are rarely able to make the necessary unwise decisions to provide empowerment. Moreover, despite the emergence of Positive and Proactive Care: Reducing the Need for Restrictive Interventions (DH, 2014) along with the 2015 review of the Code of Practice: Mental Health Act 1983 (DH, 2015a), many mental health services are not always safe, therapeutic or conducive to recovery (MHT, 2016).

McWade (2016) maintains that true power remains with psychiatrists and the state, where people who choose not to engage with (necessary) treatments and services, or those that

make risky decisions, can be quickly restricted and punished under the controls of the Mental Health Act (1983/2007). Perhaps the 2022 reforms to the Mental Health Act will either help shift services away from the use of restrictive practices towards practices that are more conducive to recovery or further feed the necessity for the NHS to operationalise recovery through the manifestation of a service-led approach.

Neorecovery – a theory, policy and practice shift

The grassroots visions of recovery are firmly rooted in the lived experience of people with severe and enduring mental health conditions, which has been discussed earlier in this chapter. However, Recovery in the Bin (2019), a group of mental health activists, argue that there has been a noticeable change in the focus of healthcare services and research over the past 20 years, a fundamental shift from catering to the needs of individuals with severe and long-term mental health conditions to catering to the needs of the broader population with mild, moderate, and time-limited conditions.

Recovery in the Bin (2019) argues that words such as independence, personal responsibility, and choice may sound empowering and self-actualising. However, these words have been distorted to fit the ideals of neoliberalism in the context of neorecovery.

They further propose the concept of neorecovery, a term encompassing recovery research, practice and policy embedded in neoliberalism ideals, psychological theories about attitude and behaviour change, and based on educational approaches. Recovery in the Bin (2019) states that neorecovery is not based on the social model of disability described by Anthony (1993).

Various personal recovery interventions rely on psychological theories about attitude and behaviour change, while others are based on educational approaches. Psychosocial interventions are recognised as a top priority by mental health nurses for enhancing care for patients, service users, and their families (Jones, 2023c; Jones, 2023d). Nevertheless, the lack of a psychosocial understanding of mental illness and disability within policy and service delivery further perpetuates the confusion of recovery in mental health nursing practice.

Mental health nursing – a future direction

This chapter has explored the concept of recovery from the influence of those with lived experience of mental illness to its emergence in UK national policy. Today recovery continues to be ingrained in national policy and mental health practice, where mental health nurses must practice the approach. Appendix 1.1 provides supplementary sociopolitical and sociohistorical context in the form of a history of mental health nursing, helping to understand how mental health nursing has developed over the past century.

A shift in power and control

The NHS Management Inquiry: Griffiths Report on NHS October 1983 saw a notable shift of power away from doctors and nurses towards general management through the theory of New Public management. Although Griffiths recommended that new general managers work with clinicians to shape service provision, the report was often wrongly interpreted as a means to exclude them from decisions altogether (Lewis, 2014).

Like the broader health service, mental health nursing has had to adapt to the socio-political changes of the late 20th Century following the closure of the asylums and move towards community-based care. Mental health nursing has also attempted to move away from its psychiatric routes towards more empowered and empowering practices (McCrae & Nolan, 2016). As Barker and Buchanan-Barker (2011: 338) maintain, “mental health nursing’ implies something more meaningful, more egalitarian, more health-promoting, and therefore more liberating than traditional psychiatric nursing”.

The historical power struggle between mental health nursing, psychiatry and general nursing remains a cornerstone of contention within the field of mental health nursing today (Brimblecombe, 2005; Nolan, 1993; Sands, 2009). Such influences have hindered mental health nursing from developing a coherent professional knowledge base (McCrae & Nolan, 2016; Chatterton, 2004). As Romme (2016) would argue, the foundations of professional identity are built on a shared purpose, defined by the professional’s knowledge and values, along with the associated interventions.

Like other healthcare professions, the professional identity of nursing has been under constant erosion over the past two decades. Since the emergence of the empowerment,

choice and personalisation agendas in the UK neoliberal policies of the early 2000s, power in the NHS has and is continuing to shift away from professionals towards patients and service users. Such a shift has created the need for flexibility in both working practices and the organisation of services, presenting increased challenges to the control and power of professionals over the direction of the NHS (Nancarrow & Borthwick, 2005).

A response to the service user movement

In 2006 the Chief Nursing Officer undertook a review of mental health nursing, aiming to answer the question of how can mental health nursing best contribute to the care of service users in the future (DH, 2006). One of the fundamental recommendations from this review was that mental health nursing should incorporate the broad principles of the Recovery Approach into every aspect of their practice. This means working towards aims that are meaningful to service users, being optimistic about change and promoting social inclusion for mental health [service] users and carers (DH, 2006).

The Nursing and Midwifery Council (NMC, 2014: 15) stipulates that registered mental health nurses must focus on "social inclusion, human rights and recovery, that is, a person's ability to live a self-directed life, with or without symptoms, that they believe is meaningful and satisfying." Furthermore, the NMC not only give mental health nurses responsibility for practising in a recovery orientation, they stipulate that "mental health nurses must contribute to the leadership, management and design of mental health services" (NMC, 2014: 17). As such, mental health nurses in the UK have a professional obligation not only to implement recovery-orientated practices but to develop and improve the services that support it.

Within NHS mental health services, mental health nursing is the largest professional workforce, where mental health nurses have, by far, the most face-to-face engagement with service users – both as inpatients and in the community. Mental health nurses in the NHS work within a complexity of contexts alongside many other professional and non-professional groups. Each group has their own (sometimes overlapping) sociohistorical and socio-political contexts that underpin its worldviews and how mental health care is delivered, be it recovery-orientated or not.

On paper, the mental health nursing profession has taken the opportunity to formally respond to the service user demands for recovery-orientated practices (DH, 2006; NMC, 2014). Mental health nurses are in a unique position not only to implement recovery-orientated practices but to shape the very nature of mental health services; in direct response to the day-to-day individual and collective needs of those that use them. However, more information is needed about the extent to which the concept of recovery has been implemented into the daily practices of mental health nurses in the NHS. Has the profession taken for granted an obligation to shift towards recovery, or can mental health nurses implement such practices without challenge?

The NHS as a system and hierarchy

Deming (2013) would view the NHS as a system of service where people form its fundamental components. He defines a system as: “an interconnected complex of functionally related components, divisions, teams, platforms, that work together to try to accomplish the system’s aim” (Deming, 2013: 151). As Deming (2013) notes, to function effectively, all systems need to work towards a common aim, the aim being central to the system and known by/communicated to everyone within; indeed, Deming (2015:151) proposes that “without an aim, there is no system”.

In the broader literature of systems, the term purpose is used in place of aim and is one of the essential concepts debated amongst systems thinkers (Ison, 2017; Seddon, 2008; Checkland, 1981; Deming, 2013; Arnold & Wade, 2015). Underpinned by two polarised traditions, the purpose of a system can either be externally attributed to a system (as purposive) or be derived through the multiple perceptions and actions of those within a system (as purposeful). For example, through the development of his Soft Systems Methodology, Checkland (1985) defines purposive and purposeful methods when he compares the traditions of hard systems thinking (purposive) with that of soft systems thinking (purposeful) (Table 1).

Table 1. Comparing Hard (purposive) and Soft (purposeful) Systems Thinking

Hard Systems Thinking Traditions	Soft Systems Thinking Traditions
Oriented to goal seeking.	Oriented to learning.
Assumes the world contains systems which can be engineered.	Assumes that the world is problematical but can be explored by using system models.
Assumes system models to be models of the world (ontologies).	Assumes system models to be intellectual constructs (epistemologies).
Talks about the language of problems and solutions.	Discussions about the language of issues and accommodations.
ADVANTAGES Allows the use of powerful techniques.	**ADVANTAGES** It is available to both problem owners and professional practitioners; it keeps in touch with the human content of problem situations.
DISADVANTAGES They may need professional practitioners. May lose touch with aspects beyond the logic of the problem situation.	**DISADVANTAGES** Does not produce final answers. Accepts that inquiry is never-ending.

Source: Checkland (1985: 765)

Influenced by the traditions of Deming (2000) and Taiichi (1988), Seddon (2008) argues that a system of service, such as the NHS, should be designed to meet a purpose as defined by its service users (that is, the expectations placed upon services by patients). However, expectations are set upon the NHS, not only from its service users but from national and local government, ostensibly representing the views of service users, commissioners, professional bodies, quality standards, evidence based-practice, carers and many more (See appendix 4.2 for a diagram of the NHS System).

Checkland (2000) emphasises obtaining multiple perspectives from those in the system which do the work and those who make decisions, aiming to accommodate a shared purpose (soft systems thinking). Arguably, such an approach may risk reinforcing what Seddon (2008) describes as a de facto purpose – centrally defined, concerned with output, targets and standards related to the budget. However, Checkland (2000: 55) highlights that the numerous changes and redesigns in the NHS have led services to

become increasingly less “appreciative settings for health professionals”, where decision-making and practice are often far removed from each other.

The flow of information between workers and managers is, or at least should be, two-fold – flow happens upstream and downstream. For example, the message of recovery-orientated nursing practices may be part of a strategic plan initiated at a senior manager level, where that information needs to reach mental health nurses downstream: i.e. through policies, practice guidelines, and meetings with staff (Deming, 2000). At the same time, how recovery-orientated nursing practices are being implemented also needs to be understood and communicated upstream: i.e. through outcome measures, IT systems, and direct feedback from nurses. The flow of information, both upstream and downstream, is also affected by issues external to the Trust (macrosystem), activities managers may be unable to influence.

To better understand the barriers and enablers influencing the implementation of recovery-orientated nursing practices, the discussion chapter (Chapter Five) frames the systems issues within the micro, meso and macro levels (Babbie, 2014) – see appendices 4.1 to 4.3. In so doing, systems thinking helps frame these issues within their sociocultural, sociopolitical, socioeconomic and sociohistorical contexts.

NHS management thinking

As the findings of this case study found, mental health nurses implementing recovery-orientated nursing practices report the existence of system-wide barriers that can only be influenced at the senior management level and beyond (Aston and Coffee, 2012; Cleary and Dowling, 2009; Cleary et al., 2013; McKenna et al., 2014a; Leamy, 2014). Furthermore, Dixon-Woods et al. (2013) found that more explicit organisational goals, along with distracting and overlapping priorities embedded in a systemic culture of compliance-orientated bureaucratic management, challenged the consistency of delivering and measuring high-quality care.

Checkland (2000) suggests that managing relationships between workers and decision-makers, based on the appreciation of varying perspectives, can aid in determining how situations will be seen at every system level. This perspective has been echoed by Ham

(2014), who proposes that improvement in the NHS should be based on commitment rather than compliance, valuing leadership continuity with a distributed and collected approach to leadership across the NHS, allowing for skilled clinicians to work alongside managers.

Resonating with these viewpoints, Seddon (2008) suggests that the decisions and actions of senior managers contribute to the formation of these issues at the macrosystem and microsystem levels – be they barriers or enablers. In a hierarchical organisational context, Seddon (2008) proposes that managers, more often than not, align with a command-and-control way of thinking as opposed to a systems thinking approach (see Table 2). Participants in this case study reported the idea of a command and control approach, where a systems thinking approach is one to be sought.

Table 2. Command and Control Thinking vs Systems Thinking

Command-and-control thinking		**Systems thinking**
Top-down, hierarchy	**Perspective**	Outside-in, system
Functional	**Design**	Demand, value and flow
Separated from work	**Design-making**	Integrated with work
Output, targets, standards: related to budget	**Measurement**	Capability, variation: related to the purpose
Contractual	**Attitude to customers**	What matters?
Contractual	**Attitude to suppliers**	Co-operative
Manage people and budgets.	**Role of management**	Act on the system
Control	**Ethos**	Learning
Reactive, projects	**Change**	Adaptive, integral
Extrinsic	**Motivation**	Intrinsic

Source: Seddon (2008: 70)

Conclusion

Empowerment, choice and personalisation appear to be here to stay. Not only does their emphasis continue to be fixed within national policy, but their core tenets have become embedded within the Care Act (2014). What's more, the Five Year Forward View for Mental Health (Mental Health Taskforce (MHT), 2016) emphasises that there remains a need to further embed the broad principles of recovery into mental health services, where empowerment, choice and personalisation remain ways by which service users suffering from mental illness may experience better recovery-outcomes.

With the increasing financial strains on public services, the neoliberal notion of economics and citizenship remain central tenets within the discourse of the NHS's response towards Implementing the Five Year Forward View for Mental Health (NHS, 2016). Despite the personal recovery focus within the Five Year Forward View for Mental Health (MHT, 2016), the NHS uses the term recovery as something that is to be achieved, measured as an end goal for service users of mental health services, something that can be obtained following treatment or psychological intervention.

Since New Labour's agenda for empowerment, choice and personalisation, power in the NHS has shifted away from professionals towards patients and service users. In response to these changes, the mental health nursing profession has adopted the principles of recovery as a paradigm to underpin their practices. As a result, mental health nurses have become professionally obliged to implement recovery-orientated practices and contribute to the leadership, management and design of mental health services.

NHS services are made up of many people, where other professional and non-professional groups will have their world-views, evidence-base and agendas, be it recovery or not. If mental health nursing is to implement recovery-orientated practices and contribute to the design of the services, the profession may have to contend with many challenges. Furthermore, hierarchy and conflicting purposes may prove hindering to the delivery of recovery-orientated mental health nursing practices.

To comprehend the evidence base that underpins the implementation of recovery-orientated nursing practices, the next chapter (Chapter Two) sets out to critically evaluate

the empirical literature exploring the question: How do mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services?

CHAPTER TWO: HOW MENTAL HEALTH NURSES EXPERIENCE THE IMPLEMENTATION OF RECOVERY-ORIENTATED NURSING PRACTICES IN MENTAL HEALTH SERVICES

Introduction

Chapter One provided a critical overview of the emergence of recovery within the UK and discussed the development of mental health nursing in response to an increasingly patient-led NHS. Bringing these chapter contexts together, this chapter critically reviews the empirical literature. In turn, determining the conceptual, theoretical, contextual and methodological gaps within the available evidence to answer this study's primary question: How do mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services?

The following sections screen, appraise, analyse and discuss the existing literature on mental health nursing and recovery within the organisational context of working-aged adult mental health services. In addition, a critique of the employed research strategies is provided. This review facilitated the identification of research and knowledge gaps this study aims to address.

Search parameters

The following databases were searched: Academic Search Premier; MEDLINE; PsycINFO; CINAHL Plus; Psychology and Behavioral Sciences Collection; PsycARTICLES; and Humanities International Complete. Search terms were informed by existing terminology presented in chapter one, developed through practice knowledge and refined through supervision. Initial test searches were undertaken to test and refine these terms as broad yet as specific as possible. The Boolean function was used to search the terms: "mental health" AND Nurs* AND Recovery. However, many other Western nations still refer to psychiatric nursing instead of mental health nursing. To ensure that records were not missed, the term "mental health" was replaced with Psych*, and the search was repeated.

The starting date of 2009 was selected to situate this review within contemporary European and UK mental health practice and policy (past ten years),[1] endorsing holistic, individualised and preventative care (Friedli, 2009) underpinned by and the promotion of recovery-orientated mental health services (DH, 2011a). The geographical locations were limited to UK & Ireland, Europe, Australia, New Zealand, and North America. The geographical parameters were inclusive of Western nations. Other than the UK, western countries have adopted the same recovery as defined by Anthony (1993). Due to this international assimilation, the selected geographical parameters allow international studies in this review to offer findings closely resembling that of the UK-based mental health nurse experience.

Inclusion and exclusion

The reviewed studies had to fit the following inclusion criteria:

1. Specifically, identify the cohort of their study to be only or primarily made up of mental health nurses working in mental health services.
2. The studies had to explore mental health nurses' perceptions towards recovery explicitly.
3. The mental health nursing cohort had to work with working-aged adults (18-65 years) in a non-forensic setting.

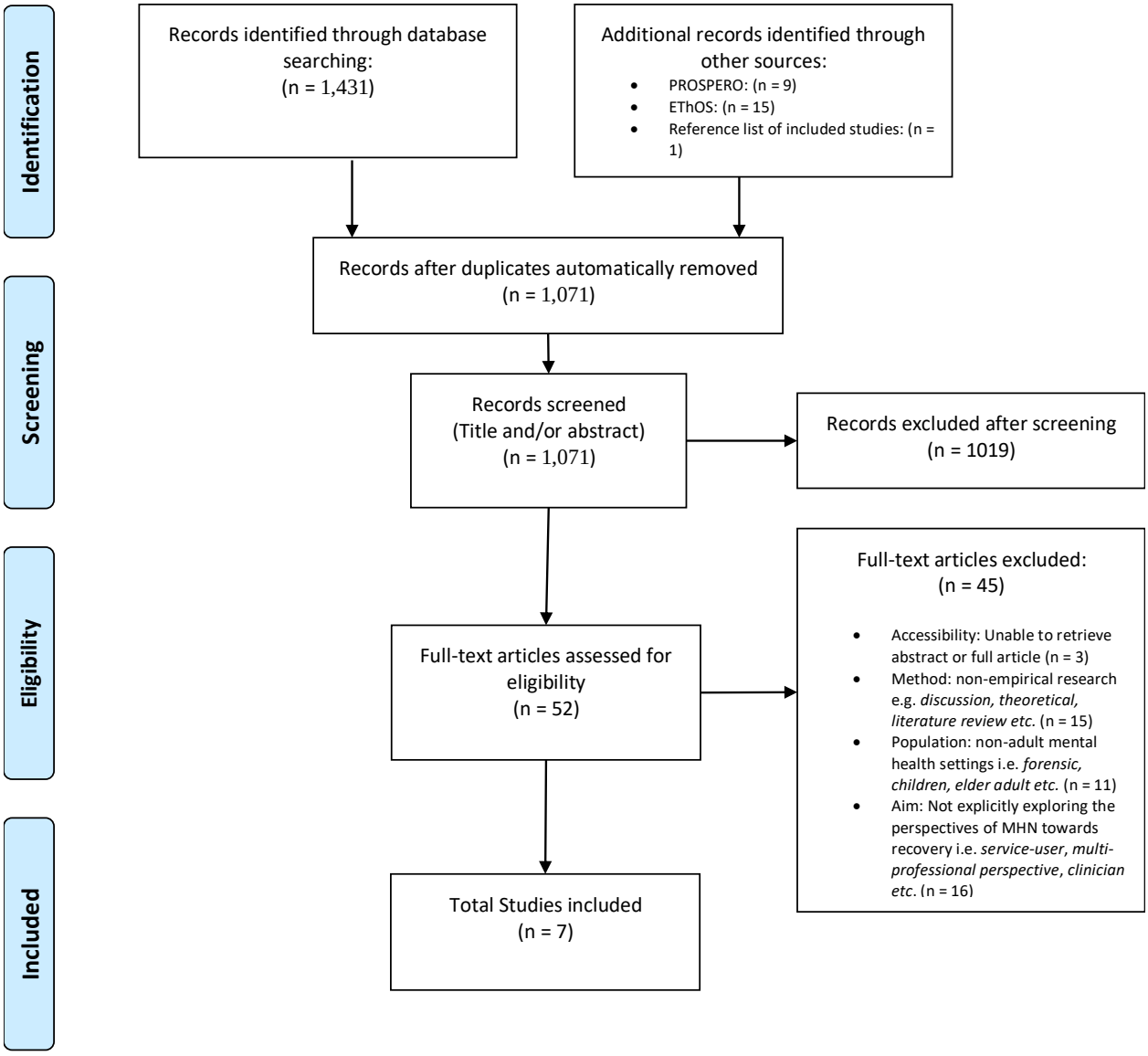
Screening

A combined total of 1,430 records were identified through database searching using the two search strategies. Through other sources (PROSPERO, EThOS and reference lists), 25 papers were found. Once duplicates were automatically removed, 1,070 records remained. All 1,070 records were screened: viewing the title and abstract. One thousand and nineteen records were excluded, while 51 were set aside for further eligibility

[1] Later papers identified and discussed in the discussion (Chapter Five)

assessment. After carefully reading the abstracts and entire articles, 45 were excluded, and seven studies were selected for review (see Figure 2). The Research Papers Matrix (Appendix: 3.1) provides an overview of the seven critically reviewed studies.

Figure 2. Study Inclusion Flow Diagram



Adapted From: Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of internal medicine*, *151*(4), 264-269.

Quality evaluation

The hierarchy of evidence is used as an indicator to rank the relevance and importance of research. As Aveyard & Sharp (2013) explain, there are various forms of the hierarchy of evidence, where the selection of the most appropriate is determined by what you are asking of the research. When choosing the effectiveness of treatments, the traditional hierarchy of evidence is most often used (Sackett et al., 1997). Such a hierarchy ranks randomised control trials at the top, with anecdotal opinion at the bottom. However, such a hierarchy is not suited to situations that aim to understand people's views and experiences of interventions and services (Aveyard & Sharp, 2013). In such cases, a hierarchy such as Noyes (2010) is better suited, ranking well-conducted qualitative studies higher than quantitative studies. As this literature review is interested in understanding the experiences of mental health nurses within mental health services, Noyes (2010) has been used to rank the studies from 1-6 (1 being the top, 6 being the bottom).

Useful as the hierarchy of evidence may be to determine the scope and relevance of research on a particular issue, more is needed to assess individual studies' quality. To help with quality measurement, the four qualitative studies were evaluated using the Critical Appraisal Skills Programme Qualitative Checklist (CASP, 2013). In addition, the three mixed-methods studies were assessed using the Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (NIH, 2014). The number of standards determined each study's quality rating of good, fair and poor met (good > 80%, fair = 50-80%, poor < 50%). Table 3 outlines the study quality scoring and rank within the hierarchy of evidence.

Table 3. Quality Scoring of Studies

Authors	Country	Mental Health Service Setting	Number of Nurse Participants	Study Methodology/Methods	Study Quality (CASP, 2013; NIH, 2014)	Hierarchy of Evidence (Noyes, 2010)
Gale and Marshal-Lucette (2012)	UK	Community	n=23	Mixed method (two-part study): a descriptive questionnaire used to identify nurse perspectives	Good	4
Aston and Coffey (2012)	UK	In-patient	n=5	Qualitative: Focus Group	Good	3
Cleary et al. (2013)	Australia	In-patient	n=21	Qualitative: Semi-structured interviews	Good	3
Cleary and Dowling (2009)	Ireland	In-patient and Community	n=92 (71% of total participants)	Mixed Method: Closed descriptive questionnaire. Two open questions	Good	4

Jacob et al. (2015)	Australia	Community	n=9	Qualitative: Semi-structured interviews	Good	3
McKenna et al. (2014)	Australia	In-patient	n=46	Qualitative: Focus Groups (five)	Good	3
Gaffey et al. (2016)	Ireland	In-patient and Community	n=136 (77.3% of total participants)	Mixed Method: Closed descriptive questionnaire. Two open questions	Good	4

A critical overview of selected studies

Studies in this review examined data from mental health nurses (n = 332) through qualitative (n = 4) and mixed method (n = 3) approaches. Service settings included inpatient (n = 3), community (n = 2) and both (n = 2). The research took place in the UK (n = 2), Ireland (n = 2) and Australia (n = 3). Most studies (n = 5) exclusively analysed the experiences of mental health nurses. In contrast, the other two, predominantly made up of mental health nurses, explored the knowledge and experiences of mental health professionals. The following subsections provide a brief critical overview of each of these studies.

Qualitative studies

Cleary et al. (2013) used face-to-face interviews, guided by a semi-structured questionnaire, to explore mental health nurses' understandings of recovery, how recovery-orientated practices are implemented and what barriers and enablers mental health nurses face when implementing recovery during and immediately after relapse. A qualitative approach was suitable to address the aim of this study. Their sample group was made explicit, and data saturation was sought and reached. Although Cleary et al. (2013) did not use an existing validated instrument to underpin their questionnaire, the questions were designed through their literature review and sought face validity.

Using focus groups, Aston & Coffey (2012) explored the perspectives of service users and mental health nurses regarding recovery and how it fits within mental health services. Although a qualitative approach was appropriate for the research aim, just one focus group was used to gather the experiences of inpatient mental health nurses (n = 5). One focus group is insufficient in providing data saturation. To acquire saturation, 3-4 focus groups should be conducted with each interest group (Kruger and Casey, 2015) - i.e. 3-4 with mental health nurses and 3-4 with service users. Despite this limitation, the data analysis was rigorous and explicit, and the data gathered met the aim of the research. That being said, the findings can only be deemed applicable to the cohort within their study, where there is minimal opportunity for any generality beyond its particular contexts.

Jacob et al. (2015) used a phenomenology methodology to explore service users, carers and mental health nurses' lived experiences of recovery. Although the primary focus of phenomenology is to describe the shared everyday experiences amongst a group of individuals (Creswell, 2013), this study explicitly presented the experiences of each participant group, allowing for the specific views of mental health nurses to be known. As a result, data saturation was reached, and the analysis process was made explicit. As phenomenological studies are challenging to replicate and highly subjective by nature, they are at risk of researcher bias (Manen, 1990; Creswell, 2013). A weakness of this study is that the authors (who are members of a school of nursing) have not declared or adequately considered the relationship between them and their participants. Without knowing this relationship, there is always the possibility that researcher bias has affected

the formation of research questions, sample recruitment and choice of location for this study (CASP, 2013).

Using focus groups (n = 5), McKenna et al. (2014) sought to determine the extent to which elements of existing nursing practice resemble the domains of recovery-orientated care and to provide a baseline understanding of practice in preparation for transformation to recovery-orientated services, as reflected in policy directives. The overall research strategy for this study was rigorous, from articulating the aim to presenting the findings. Although some authors are registered nurses, they report no conflict of interest. Nevertheless, any strategies used to help mitigate potential researcher bias could have been made explicit. The data collection and analysis were designed around the concept of recovery in the context of Australian national policy (DH, 2011b). By adopting such a predetermined concept of recovery, McKenna et al. (2014) report that the questions within the focus groups were leading and needed to facilitate an open-ended discussion among participants. Although highly applicable to the contexts of their study (inpatient mental health services in one region of Australia), the findings can only be considered generalisable within them.

Cross-sectional studies

To explore the perceptions of community mental health nurses, Gale and Marshall-Lucette (2012) used a self-efficiency questionnaire to establish the extent to which community mental health nurses are confident in their knowledge and skills that are required when applying the recovery model in their daily practice. Although a response rate of 85% is noted, the total population may be considered small (n = 31). That being said, the people represented the entire cohort of community mental health nurses in the service where this study occurred. As such, the findings can be considered highly representative of this population. In addition, the authors measured the exposure status of participants: length of service experience (in years). The outcome measuring tool was also validated.

Finally, consideration was made to the relationship between the outcome measures and the exposure level. Gale and Marshall-Lucette (2012) stated that there was no significant

difference between the exposure levels and demographics of participants with the outcomes of their questionnaire ($p > 0.05$). However, with a small sample size, the cohort of participants predominately made up of women (83%) and the majority of participants having less than two-year's of experience in community mental health (82.6%), the findings may not be considered generalisable to the broader population of community mental health nurses.

Clearly and Dowling (2009) set out to examine the knowledge and attitudes of mental health professionals to the concept of recovery in one mental health service. A sample size of 100 mental health nurses was selected from 264, with a further 53 from other professional disciplines. The total participation rate was 85%. Mental health nurses comprised 71% of the total responses ($n = 92$), while medical staff, psychologists, social workers and occupational therapists made up the remaining 29%. The exposure status was clearly defined and measured. A questionnaire of the validated Recovery Knowledge Inventory (RKI) (Bedregal et al. 2006) was used to measure participants' knowledge of recovery. The statistical analysis estimated the relationships between the exposures and outcomes of the questionnaire.

However, the range of non-nurses was made up of various professional groups, where particular disciplines whose roles have a greater emphasis on recovery (i.e. psychology and occupational therapy) could have skewed the mean of the non-nurse group. Clearly and Dowling (2009) has identified that a limitation of their study is the lack of non-nurse participants, making statistical comparisons between each discipline unachievable. Consequently, findings are not generalisable beyond the context of this service.

Review findings

This chapter undertook a critical review of the empirical literature exploring how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services. Braun and Clarke's (2006) approach to thematic analysis guided the analysis of the findings of this review. NVivo 11.2.2 qualitative data analysis software (QSR International, 2016) has assisted with the analysis process. To further quality assure the formulation of the themes, in-person thematic mapping was undertaken with

the first supervisor (using an in-person classroom-based whiteboard). This helped with considering the codes' semantic, conceptual and contextual meanings and themes. This process helped to refine the themes.

While analysing the literature for this review, themes were developed through inductive coding. In the initial stages, the themes and code names were influenced by existing concepts related to recovery. For instance, the first version of this chapter had Theme 1, named ‘paternalistic-hope’, underpinned by six codes (hope, optimism, empowerment, paternalism, medication, and return to pre-illness state). The first three codes were merged into a broader personal recovery code, and the latter three were grouped under clinical recovery. However, after rewriting and refining the review, the structure of the findings was firmly based on the inductive nature of the codes, as identified through the reviewed papers. Existing concepts and theories related to recovery and mental health nursing were instead embedded in the discussion section.

The literature review settled on three final themes: A conceptual dissonance, facilitative collaboration and competing contextual conditions. Each of the seven studies covers the content of each theme. These themes point to the existence of dissonance in the beliefs, values and practices of mental health nurses towards implementing recovery-orientated practices. The findings also allude to external challenges outside of practice settings; contextual conditions reported to influence how the philosophy of recovery is adopted and implemented service-wide.

Theme 1: A conceptual dissonance

The term hope is centrally engrained within the philosophy of recovery – belief in the possibility of living a meaningful life beyond the limitations caused by mental illness (Anthony, 1993). As outlined in Chapter One, recovery-orientated practices require the instilling of hope and optimism about the future, fundamentally underpinned by the following conditions:

> “The belief in the possibility of recovery, feeling motivated to change, with the support of hope-inspiring relationships, through positive thinking and valuing success, while having dreams and aspirations for the future.” (Edited: Leamy et al., 2011: 448)

The term hope was raised within the discourse of six of the seven reviewed studies, where participants in one study did not mention the term (Jacob et al., 2015). Although the term hope was raised within the six studies, it needs to be clarified if mental health nurses hold a shared conceptual understanding of hope or its applicability to implementing recovery-orientated practices. Nevertheless, mental health nurses articulated ways in which hope is and can be implemented into their practices to promote recovery.

McKenna et al. (2014 pp: 528) found that the process of inspiring hope for the person is supported through narrative discussion and respect for the person's unique circumstances. Gale and Marshal-Lucette (2012) report that if a person is to gain a positive vision of the future, nurses must have a sense of hope and optimism in implementing care and therapeutic engagement. The results of their self-efficacy questionnaire, exploring mental health nurses' perspectives of recovery-orientated practices, highlight that participants were confident or somewhat confident in their ability to instil hope in others (Gale and Marshal-Lucette, 2012). Contrary to these findings, Cleary and Dowling's (2009) study, where mental health nurses undertook an adapted Recovery Knowledge Inventory questionnaire (Bedregal et al., 2006), found that some participants undervalued the importance of hope and were unsure of how to help develop realistic expectations with service users.

Aston and Coffey (2012) found that some mental health nurses depicted a clinically-orientated paternalistic meaning of recovery: implementing technocratic practices that nurses viewed as being beneficial to service users, based on a model of medical intervention (see Chapter One – clinical recovery). Aston and Coffey's (2012) findings are echoed by Cleary et al. (2013), where one group of mental health nurses viewed: medication adherence, reduction of symptoms, improved mental state, and the reduction and management of risk as the fundamentals of nursing practice. However, other mental health nurses in this study saw 'positive attitudes, person-centred care, hope, education about mental illness medication side-effects, and the acknowledgement of individual recovery pathways' as necessary components for avoiding relapse and future admission (Cleary et al., 2013 pp: 211). Similar findings were present in Jacob et al.'s. (2015) study, where mental health nurses demonstrated a divergence in views: some saw recovery as

returning to a pre-illness state; others described it as the process of ascertaining optimum levels of potential to achieve goals, with or without a diagnosed mental illness.

Within the reviewed studies, mental health nurses hold divergent views about the use and applicable implementation of recovery in practice. Some mental health nurses view recovery as something done to service users determined by professionals for their benefit (Aston & Coffey, 2012; Cleary et al., 2013), while others emphasise that recovery-orientated practices should primarily focus on understanding and promoting the views and individual needs of service users (Jacob et al., 2015), not solely focusing on the objective management of risks and reduction of symptoms (McKenna et al., 2014). To meet the individual needs of service users, mental health nurses should try to foster the essence of hope and optimism to facilitate empowerment and promote personalised recovery pathways (Gale & Marshall-Lucette, 2012; Cleary & Dowling, 2009).

Theme 2: Facilitative collaboration

Mental health nurses have been described as 'facilitators who join the person to support the journey' (Jacob et al., 2015 pp: 12). This implies that mental health nurses working towards implementing recovery-orientated practices should bear a facilitative approach, promoting hope, empowerment and independence. A facilitator is defined as:

> One who contributes structure and process to interactions, so groups can function effectively and make high-quality decisions. A helper and enabler whose goal is to support others as they pursue their objectives. (Bens, 2012, pp.).

This idea is echoed by Aston and Coffey (2012), whose study found that engagement with staff was described as an essential ingredient and possible predictor of future pursuit along a recovery pathway. However, highlighting that there is limited time and a lack of resources to promote an effective and engaging facilitative approach in all aspects of practice, participants in McKenna et al. (2014 pp: 531) study report: "We do our best with the resources we've got, with the knowledge we have, to empower [the person] enough to get them going through the next step…".

Aston and Coffey's (2012) findings suggest that in environments where facilitative and therapeutic relationships are most successful, there is an emphasis on collaborative

working, a contribution from both the nurse and the service user. This was echoed by Cleary and Dowling (2009), who highlighted holistic collaboration as being imperative to empowering the service user, 'putting clients' needs first before their own and 'working with clients as opposed to directing them towards institutional goals' (Cleary and Dowling, 2009 pp: 543).

Cleary et al. (2013) found that care planning, determining goals, and discharge planning were ways mental health nurses collaborate daily with service users. Similarly, McKenna et al. (2014) reported collaborative care planning as central to promoting hope. Nevertheless, Aston and Coffey (2012) found that there is still a need to work more collaboratively in the planning of care, engagement with service users and the use of language.

Nurses in inpatient settings have expressed that some service users should not have collaborative planning of care imposed upon them, where one must respect the potential acuteness of their mental illness (McKenna et al., 2014). As a pragmatic solution towards implementing recovery-orientated practices in such circumstances, these participants suggest that the mental health nurse could take an advocacy role, making the service user's concerns heard at a cross-disciplinary level, an approach that may still facilitate collaboration and foster empowerment, despite the acuteness of their illness.

Cleary and Dowling (2009 pp: 544) propose combining core counselling skills, sharing knowledge and fostering collaborative partnerships as the 'vehicle to recovery'. It may be imperative for nurses to behove a sense of a 'facilitative collaboration' when nurturing the therapeutic relationship towards recovery, in turn, enabling the promotion of empowerment, building a rapport and instilling optimism about the future through hope-inspiring relationships (Gale & Marshall-Lucette, 2012; McKenna et al., 2014). However, where there may be discord among the views of the service users and mental health nurses about the meaning of recovery, it may be difficult for collaboration to be fully endorsed by all (Jacob et al., 2015).

Three reviewed studies highlight the importance of mental health nurses engaging in interdisciplinary collaboration while being aware of other disciplines' roles to facilitate the implementation of recovery-orientated practices. For example, McKenna et al. (2014)

found that mental health nurses work collaboratively with other professionals. However, due to time pressures, they were regularly referring service users to other professionals to meet their holistic needs rather than attending to them (i.e. occupational therapists for addressing activities of daily living or psychologists for implementing psychological interventions). Collaborative interdisciplinary working was further presented as something that may help nurses identify and manage their professional values and practices towards a more recovery-orientated approach (Cleary et al., 2013).

Theme 3: Competing contextual conditions

The reviewed studies shed light on broader contributing factors beyond the direct influence of mental health nurses, competing for contextual conditions that may bear influence over a successful implementation of recovery-orientated practices.

Five of the seven studies suggest that education and training influence the implementation of recovery-orientated practices. For example, in circumstances where hope was not universally valued amongst mental health nurses (Cleary & Dowling, 2009), such nurses identified a gap in their education around recovery, which may impact mental health nurses' ability to develop realistic expectations and instil hope-inspiring practices.

In concurrence with these findings, Jacob et al. (2015) found that mental health nurses trained in recovery concepts were better equipped to view the significance of recovery than those who had not received any formal training. Such findings have been echoed by Gale and Marshal-Lucette (2012), who found a direct correlation between the confidence and knowledge of community mental health nurses and the shortfalls in education and training received around recovery-orientated practices. However, what exactly constitutes recovery concepts within the training, or who provided the training, is unclear.

As such, it was felt that more education is needed to promote a recovery philosophy across both inpatient and community mental health settings (Gale & Marshall-Lucette, 2012; Cleary et al., 2013). Gale and Marshall-Lucette (2012) conclude that there needs to be more educational support available to mental health nurses in the form of continued professional development for this to be a reality.

It was suggested that mental health nurses who work in rigid task-orientated services report added frustrations and increased time pressures, which impinge on the delivery of holistic recovery-orientated care (Aston & Coffee, 2012; McKenna et al., 2014).

Aston and Coffee (2012) concluded that constant observations and the diversity of the service users made it challenging to implement recovery-orientated practices in the current inpatient environment. Cleary & Dowling (2009) made a specific note of the dissonance nurses report between policies and a culture of implementing recovery-orientated practices, where one policy may set out to support the service user and the mental health nurse to take positive risks, while another may stimulate a restrictive risk management approach. McKenna et al. (2014) highlight that a risk-averse culture, along with high acuity pressures in practice, were viewed by mental health nurses as competing priorities that impact the successful implementation of recovery-orientated nursing practices.

Cleary et al. (2013) found that despite recovery being the aim of services, mental health nurses believe that the claim of recovery by employers is 'just a rhetoric', lacking adequate resources and policy direction to fulfil a truly integrated programme. From their findings, McKenna et al. (2014: 531) suggest that:

> Regardless of how the national policy of recovery-orientated care may be applied in the near future, mental health nurses are challenged more by the structure of the health service than the comprehension of recovery-orientated care as a new paradigm of mental health service delivery.

As the empirical literature suggests, if services are to become recovery-orientated, they need to focus on individual outcomes for the person experiencing mental illness rather than on meeting organisational performance outcomes (Aston & Coffee, 2012). Mental health nurses will not be able to implement recovery-orientated practices if the competing contextual conditions within and beyond services do not enable them to do so. Cultivating the right conditions will require extensive commitment at all levels; recovery cannot be an add-on to existing services (Cleary & Dowling, 2009); it requires some administrative changes to coordinate recovery system-wide (Cleary et al., 2013).

Discussion of findings

This review set out to critically analyse the existing literature exploring how mental health nurses perceive the implementation of recovery-orientated practices in mental health services. The analysis and synthesis of the seven reviewed studies pointed to dissonance in mental health nurses' beliefs, values and traditions towards implementing recovery-orientated practices within mental health services. Although there was evidence to suggest that many but not all mental health nurses have a good knowledge of the processes and principles of recovery, there still exists a notable discrepancy around its conceptualisation and use in nursing practice.

The section on hope-inspiring relationships highlighted that some mental health nurses hold a paternalistic clinically-orientated view of recovery. Such ideas have been articulated in the broader literature, where the paternalistic perspective of staff in acute in-patient mental health services has been found to affiliate with statements such as promoting and restoring the health of the patient, providing exemplary care and assuming responsibility for the service user's recovery (Pelto-Piri et al., 2013). Through a paternalistic lens, recovery is made to a service user, determined by the professionals' perceptions of the benefit of that service user (Aston and Coffey, 2012; Cleary et al., 2013). Even where service users are happy for mental health nurses to lead on their care, practices that are not person-centred and without collaboration are non-conducive to recovery. Some service users may lack the capacity to make decisions or pose a risk to themselves or others. In such circumstances, it was suggested that mental health nurses take an advocacy role, making the service user's concerns heard at a cross-disciplinary level, an approach that may still facilitate collaboration and foster empowerment, despite the acuteness of their illness.

Furthermore, mental health nurses believe care should focus more on the service user's needs (Jacob et al., 2015), not only on managing risks and reducing symptoms (McKenna et al., 2014). This allows mental health nurses to foster the essence of hope and optimism to facilitate empowerment and promote individualised recovery pathways (Gale & Marshall-Lucette, 2012; Cleary & Dowling, 2009). These findings align with the conclusions of a systematic review synthesising multi-professional staff's understanding

of recovery-orientated mental health practice. As a result, there has been a shift from a clinical recovery to a personal recovery, but it is not yet complete (Le Boutillier et al., 2015a).

Mental health nurses have been described as ‘facilitators who join the person to support the [recovery] journey’ (Jacob et al., 2015 pp: 12). The notion of facilitation is not new to the discourse of mental health nursing. Peplau (1952) first noted that interpersonal skills were vital in forming therapeutic relationships between mental health nurses and service users. For many years, mental health nurses have adopted a six-category intervention analysis (Heron, 1976) as a holistic approach towards interpersonal communication (Ashmore, 1999).

Heron (1976) proposes two polarised overarching approaches to communication: facilitative and authoritative, each containing three secondary categories: cathartic, catalytic, supportive (facilitative) and prescriptive, informative, and confronting (authoritative). A facilitative approach emphasises power toward the person with lived experience of their mental illness; the nurse promotes and values that experience through active listening and an empathic commitment to support their thoughts and feelings. An authoritative approach centres on the nurse as a source of information, challenging the service user’s thinking while prescribing advice and guidance for how the person is to behave. Although undertaking a pure facilitative role would appear to fit with the nurse’s position in the individual’s recovery journey, all six categories in Heron's framework have equal relevance (Sloan & Watson, 2001).

Beyond the use of any formal communication method, Barker suggests that it is fundamental to the role of the mental health nurse to facilitate the “provision of the necessary conditions for the promotion of growth and development” (Barker, 1989 pp: 138) using whatever resources available (Barker and Buchanan-Barker, 2011). Through this process, mental health nurses can intentionally acquire an insight into a person’s life, better understand their individual story and appreciate their experience of mental illness (Barker, 1996).

This literature review found that in environments where facilitative and therapeutic relationships are most successful, there is an emphasis on collaborative working, a

contribution from both the nurse and the service user. Mental health nurses viewed collaboration as imperative to empowerment and central to supporting hope; care planning, determining goals, and discharge planning were ways to collaborate daily with service users. Nevertheless, a more significant shift towards working more collaboratively in the planning of care, engagement with service users and the use of language is still needed. The Care Quality Commission (CQC) (2016) reports that those who have used NHS mental health services identified needing more professionalised care underpinned by collaboration and shared decision-making.

Interdisciplinary collaboration was seen as essential for supporting the holistic needs of service users. It may help nurses address their professional values and practice skills towards a more recovery-orientated approach. It is important to note that nurse-to-person and interdisciplinary collaboration can be impeded by determents of power such as knowledge, information and expertise (McCloughen et al., 2011), where there may be competing practice paradigms amongst multi-professional clinicians. Acknowledging the dominance and limitations of a paternalistic medicalised model of mental health illness can promote the diversity of alternative practice methods, which may better suit the needs of individuals (Kidd et al., 2015; Slade, 2009).

This literature review uncovered suggestions of external influencers outside of the nurses to person relationship; contextual conditions are reported to influence how recovery-orientated practices are adopted and implemented service-wide. There was a clear suggestion that a lack of training and education around the concept of recovery negatively impacts mental health nurse's knowledge and understanding of the approach, reducing their ability and confidence in implementing recovery-orientated practices (Gale & Marshall-Lucette, 2012; Cleary et al., 2013; Cleary & Dowling, 2009; Jacob et al., 2015; Gaffey et al., 2016).

Those who were trained or educated in recovery were better equipped to describe the philosophy of the approach. Nevertheless, it was noted that there is insufficient educational support available to mental health nurses in the form of continued professional development (CPD) around recovery. An independent review of mental health nursing (Butterworth & Shaw, 2017) reports a lack of CPD opportunities for

graduate mental health nurses in the NHS, with options continuously decreasing yearly. With any future training and education needs, it is recommended that opportunities to which both the mental health nurse and the service users can contribute should be promoted and encouraged (Aston & Coffee, 2012; Butterworth & Shaw, 2017; Department of Health and Social Care, 2022).

The diversity of people's needs and the acuity of inpatient wards were viewed as conditions that impact the successful implementation of recovery-orientated practices (McKenna et al., 2014; Aston & Coffee, 2012). Mental health nurses report dissonance between a recovery-orientated culture and local policy; one may set out to support and empower service users and professionals to take positive risks, while another promotes a risk-averse approach to practice (Cleary & Dowling, 2009; McKenna et al., 2014).

Positive risk-taking is a collaborative process (DH, 2008) and has been identified as a fundamental skill that mental health nurses should be confident and competent at implementing; 'being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk' (DH, 2009 pp: 11). A study exploring the barriers and facilitators towards implementing recovery in practice (Le Boutillier et al., 2015b), highlights that mental health professionals viewed the statutory clinical obligation of risk management as a competing priority; staff would further embrace positive risk taking if their organisation better supported them to do so.

Some mental health nurses saw the claim of recovery by employers as a 'rhetoric', lacking policy direction and adequate resources. Despite the national strategic drive, complex challenges remain to successfully transform mental health services towards a recovery orientation (Slade et al., 2017a). With mental health nurses perceiving recovery in multiple ways, a conceptual consensus at all levels of mental health nursing must be achieved: 'no stakeholder's interests are served if incompatible and unmeetable expectations are placed on staff to support all three types of recovery fully' (personal, clinical and service-defined-recovery) (Le Boutillier et al., 2015a pp: 13). Furthermore, the challenge of recovery focused leadership at every level and culture of recovery, remains a significant hurdle yet to be overcome (Slade et al., 2017b: 14).

The studies in this review highlight that if mental health services are to influence the implementation of recovery-orientated mental health nursing practices, decision-makers need to be focused on promoting individual outcomes for service users rather than focusing primarily on meeting organisational performance outcomes (Aston and Coffee, 2012). This requires extensive commitment at all levels; it cannot be an add-on to existing services (Cleary & Dowling, 2009) and requires some administrative changes to coordinate recovery system-wide (Cleary et al., 2013).

Limitations of the existing research base

Using the hierarchy of evidence (Noyes, 2010), the studies critiqued in this review are well-conducted qualitative studies (rank 3 of 6) and well-designed research and customer surveys (rank 4 of 6). Ranks 1 and 2 are systematic reviews of qualitative research and mixed-method approaches. As individual studies, the reviewed research was deemed relevant, and the findings can be considered significant. Nevertheless, given their design and scope, none of the studies can claim generality. Furthermore, only two of the studies in this review were undertaken in the UK, where only 8.4% of the total participants across all seven studies were UK-based mental health nurses (n = 28/332).

What is more, these two studies had further sampling limitations. Aston and Coffey (2012) explored only one focus group of inpatient mental health nurses (n = 5), while Gale and Marshal-Lucette (2012) focused on a single cohort of community-based mental health nurses in one mental health service (n = 23). The size and limited scope of these studies make generalisation and transferability of findings to similar UK services a challenge.

With the limited number of studies (total = 7, UK = 2), there remains a need to explore and evaluate mental health nurses' experiences towards implementing recovery-orientated nursing practices in mental health services. Moreover, the lack of exploration of mental health nursing within the UK calls for an in-depth exploration of nurses implementing recovery-orientated practices within the specific sociocultural, sociopolitical and sociohistorical contexts in which they practice.

Conclusion

This critical literature review explored how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services. The study of the existing literature sheds light on areas within mental health nursing and recovery that require further exploration and evaluation. For example, there remains an inconsistency around the nurse's conceptualisation of recovery in practice. This point is aligned with the need for further assessment of education and training around recovery for the concept to be fully understood and applied by mental health nurses in practice.

It is still being determined whether the specific contexts of mental health services bear any influence over mental health nurses' understanding of recovery or ability to practice collaboratively with service users. The contextual conditions influencing the implementation of recovery-orientated nursing practices within mental health services still need to be explored in the literature. Across the broader literature of recovery (not only specific to mental health nursing), there also remains to be a deficiency within the evidence exploring, reducing and removing such barriers within an organisational context (Slade et al., 2017b). Although there remains a need for more information, the research explored in this review has begun investigating the experiences of practice-based mental health nurses towards implementing recovery-orientated practices. However, current research has only examined the experiences of mental health nurses at the micro-level of NHS mental health services, where the full extent of mental health nursing spreads beyond the contexts of clinical practice.

In mental health services, mental health nurses are in leadership and management roles that spread across multiple organisational contexts (Clearly et al., 2017). Nurses in such positions of power help to shape the contextual conditions that underpin the practices of mental health nurses within clinical settings. Moreover, there needs to be more evidence within research exploring the experiences of senior mental health nurse leaders and how (if at all) they influence practice-based mental health nurses towards implementing recovery-orientated practices.

To fully comprehend the contextual conditions that impede or enable practice-based mental health nurses, it is vital to explore the experiences and understandings of senior

mental health nurse leaders. Such an exploration can help provide a deeply contextualised knowledge of the meso-level conditions influencing practice-based mental health nurses towards implementing recovery-orientated practices.

As has been informed by this literature review, the aim of this study is to explore how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services. The following questions emerged from this literature to guide the primary investigation of this research study and explore some of the empirical gaps in the literature:

1. How do mental health nurses conceptualise recovery-orientated nursing practices?

2. What are the barriers and enablers towards implementing recovery-orientated nursing practices?

3. How do nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices?

CHAPTER THREE: METHODOLOGY

Introduction

Having explored the literature around mental health nursing and recovery contexts in Chapters One and Two, the unaddressed challenges of mental health nurses implementing recovery-orientated nursing practices are systemic. There needs to be more evidence exploring and understanding such issues within the context of NHS mental health services. Where there is a need for more information about the experiences of practice-based mental health nurses, even less is known about the experiences of mental health nurses in positions beyond the practice setting. Mental health nurses in senior management and leadership positions influence nursing practice from and through various levels of NHS Trusts. This chapter outlines the specific research processes for this study (research paradigms, methodology and methods). The chapter is broken into three primary sections: research paradigms, methodology, methods of data collection, method of analysis, and ethics.

Research Paradigms

A paradigm is a set of philosophical assumptions about the world (Creswell, 2013), views that believers accept as being true or sure to happen without unquestionable proof. Paradigms are constructions of human beings, distinguished by differing beliefs and values, a set of viewpoints that ultimately cannot be proved or disproved (Guba and Lincoln, 2005).

A common debate amongst researchers is one of dualism between the pure-ontological basis of objectivism: believing that only a singular external reality exists beyond ourselves (Creswell, 2013) and subjectivism: views that our mental activity is the only unquestionable fact of our experience (Richardson & Bowden, 1983). This dualism is explicit in the methods of a study, where quantitative studies are undertaken in an objectivist manner (i.e. questionnaires, surveys and statistics). In contrast, qualitative studies are predominantly subjectivist by nature (i.e. focus groups, interviews and observations). Philosophical assumptions underpinning any study should be made

explicit. Such views are expressed through the ontological (the nature of reality), epistemological (how knowledge is known), methodological (the procedures of research) and axiological (nature of values) dimensions of the research process (Guba & Lincoln, 1994; Denzin & Lincoln, 2011; Creswell, 2013).

Positivism and Postpositivism (critical realism)

In mid-nineteenth century France, Comte (1798 – 1857) conceived the idea that knowledge passes in succession through three different theoretical stages: theology or fictitious state (phenomena are explained through mythical beings such as gods), metaphysical state (these fictional ideas are replaced by more abstract but still imaginary entities such as essences and causes) and the positive state (through reasoning and observation, the mind endeavours to discover the invariable laws of phenomena) (Callinicos, 2007). Thus, Comte was the founder of positivism:

> A philosophical doctrine that appeared to offer a solid epistemological foundation for those sciences willing and capable of adhering to the rigours of the scientific method. (Caldwell, 2010: 4)

Durkheim (1858 – 1917), considered the founder of social science, formulated social positivism as a foundation of social inquiry (Calhoun, 2012). Durkheim encouraged objectivism, focusing on the functionality of society and the method of comparison between one social fact against another (Callinicos, 2007). All positivists believe in an external world, a single objective reality removed from the researcher's worldviews (Hudson and Ozanne, 1988), where real events can be observed empirically and explained through logical analysis (Leong, 2008). Pure positivism situates itself within the natural sciences, such as mathematics, physics, chemistry and biology, where cause and effect can be observed and measured.

On the other hand, post-positivism accepts that the researcher's worldview can influence what is being observed (Robinson, 2013). Unlike positivists, post-positivists are critical realists; they believe that cause and effect are not absolute; instead, it is a probability which may or may not occur (Creswell, 2013). Like positivism, Postpositivism pursues

objectivity using many approaches (series of logical steps) and tools of data collection and quantitative analysis (Phillips and Burbules, 2000).

Post-positivism's ontology is critical realism, where a single reality exists outside of ourselves but may not be reached or understood due to the lack of absolutes (Creswell, 2013). Thus, epistemologically, a postpositivist believes only in the approximation of reality, constructed through empirical investigation and statistical analysis. Methodologies focus on objectivity by applying deductive methods while controlling the researcher's biases. Although post-positivism is mainly seen in quantitative studies, various principles of its assumptions can and have been used in qualitative research, such as the systematic approaches to analysing and comparing data in case studies (Yin 2003).

Social Constructivism (or interpretivism)

In their book The Social Construction of Reality, Berger and Luckmann (1966) introduced social constructivism to social science: a treatise in the sociology of knowledge. Social constructivism is a paradigm based on interpretivism, where the emphasis is placed on the construction of knowledge through the personal interactions of and between individuals or groups (Weaver & Olson, 2006). Constructivism focuses on the individual's knowledge relative to their experiences and interpretations. Thus, the explanation of reality is multiple. A social constructivist researcher relies on the participant's views of a given situation as much as possible: the subjective knowledge formed through social interaction within the context of the historical and cultural norms behind the individual or group's life (Creswell, 2013).

The ontological assumption of social constructivism accepts that multiple realities are subjectively constructed through our lived experiences and interactions with others (Creswell, 2013). These constructions are not set in stone or viewed as absolute truth; they can alter as they become better informed and sophisticated (Guba & Lincoln, 1994). Epistemologically, knowledge is known through a transactional process between the researcher and participants. Reality is co-constructed and shaped by the experiences of individuals and develops as the research process proceeds (Guba & Lincoln, 1994; Stake, 1995). Methodologically, emphasis is placed on inductive approaches, generating

theories from the data rather than beginning with a theory or hypothesis (Creswell, 2013). A solid social constructivist philosophical stance suggests that the natural world has little or nothing to do with the construction of scientific knowledge (Collins, 1981).

Social Constructivism as applied to this study

As outlined in Chapter One , contemporary mental health nursing is underpinned by historical and cultural norms unique to the profession. As mental health nurses are situated across many organisational contexts (i.e. care settings, management and leadership, and policy), their experiences and interpretations of influencing and implementing recovery-orientated practices are multiple and possibly varying.

The social constructivism paradigm was well suited for this study. Social constructivism allows the researcher to explore the experiences of mental health nurses within their unique and multiple contexts, applying qualitative research methods to gather and interpret data. The researcher analyses the collective experiences of participants to provide subjective co-constructed knowledge about participants' experiences of the particular issue being investigated. Such an inductive approach allows for the emergence of new ideas, generating theories or concepts from the data rather than starting with or being guided by an existing theory or hypothesis. Table 4 presents social constructivism as applied to this study.

Table 4. Social Constructivism – The Underpinning Paradigm of this Study

Assumption	The philosophical question	Characteristics of the assumption	As applied to this study
Ontology	What is the nature of reality, its form, and what can be known about that reality?	Our lived experiences and interactions with others construct multiple realities.	This study adopted a qualitative approach - seeking to explore the perspectives of mental health nurses and senior nurse leaders and to understand the conditions that may influence the implementation of recovery-oriented practices in the context of an NHS Trust.
Epistemology	What is the nature of the relationship between the researcher and that being researched? How are claims of knowledge justified?	The interactions between the researcher and the participants, shaped by individual experiences, co-construct reality.	This study explored the experiences of senior nurse leaders and practice-based mental health nurses towards implementing recovery-orientated practices. Knowledge is known through the participants' collective subjective perspectives through the researcher's interpretation.
Axiology	What is the role of values?	Values are honoured and negotiated between and among individuals.	The researcher's axiology has been explicitly outlined - a mental health nurse working in NHS mental health services. The potential influence of insider-researcher bias was managed through reflective and preventative measures. The individual and collective values underpinning the data are evident throughout the analysis.
Methodology	What process can the researcher take to discover what they believe can be known?	The inductive method of emergent ideas (through consensus). Uses qualitative methods to gather and interpret data.	A qualitative case study methodology was chosen for this study. Qualitative methods were used (semi-structured interviews and focus groups). Inductive thematic analysis was applied to analyse this data. Multiple data sources provide triangulation of findings.

Influenced by: Guba & Lincoln (1994) and Creswell (2013)

Axiology

Denzin and Lincoln (2011) situate axiology in the first phase of the research process: The Researcher as a Multi-Cultural Subject. Creswell (2013) identifies phase 1 of Denzin and Lincoln's (2011) research process as frequently overlooked by many researchers. Yet, it is the phase where the researcher considers what they bring to the study. For this section of the chapter, I outline myself, my values and how I view myself and others, along with the considerations underpinning my insider-researcher position.

My self, values and how I view myself and the other

My nursing role and my interpretation of knowledge, values and ethics are the foundation of how I approach any form of research. In my view, having a clear intention towards the values and ethics behind any decision one makes, along with the consideration of the effect this has upon others, is vital in any process of exploration or action. An oft-quoted African Proverb has personally resonated with me:

> If you want to walk fast, go alone. If you want to walk far, go together. African Proverb.

I am ambitious to understand and improve how things work in the real world to benefit others. I believe this goal can only be achieved through cooperation and the construction of shared knowledge. Therefore, my view of myself towards the other is one of cooperation and facilitation, "marked by a willingness and ability to work with others" (Merriam-Webster, 2017c) to "help bring about" change (Merriam-Webster, 2017d).

Insider-Researcher

For qualitative studies to be credible, the researcher must clarify their role within the study (Unluer, 2012). In the general sense of the term, an insider researcher chooses to study a group they are a part of, while an outsider researcher is not part of the group being studied (Breen, 2007). The basis of work-based research is that it is undertaken within the researcher's place of work (Costley et al., 2010). An insider researcher is uniquely positioned to study an issue in depth using their professional knowledge and experience, placing them in a prime position to explore and change a practice situation (National

Institute for Health Research, 2016; Costley et al., 2010). The politics within the institution under study are generally known to the insider researcher, where they discern what works rather than only recognising the formal hierarchy (Unluer, 2012), something that would take an outsider a long time to acquire (Smyth and Holian, 2008).

Where there are clear advantages of being an insider researcher, a risk of bias comes when one is more familiar with the study area and holds prior knowledge of the case. Unluer (2012) argues that over-familiarity can lead to a loss of objectivity. Reliability and validity, particularly in insider research, are complex and open to debate and scrutiny while dependent on ontological and epistemological assumptions (Rooney, 2005).

Nevertheless, there are ways that the insider researcher can guard against bias: careful attention to participant feedback, initial evaluation of data, and a transparent and reflective sense of self. When critically reflecting on her accounts of conducting a case study in her organisation, Unluer (2012: 1) concluded that "to conduct valid research, a researcher must overcome some of the disadvantages with the help of several preventions." Unluer (2012) identified six key disadvantages insider researchers face. The six key disadvantages and preventative means for overcoming these in my study are presented in the table below (Table 5).

Table 5. Overcoming Potential Disadvantages of Insider Research

Disadvantage	How does this affect me in my research?	How to overcome this disadvantage?
Role duality (mental health nurse/student researcher)	To colleagues in the Trust, I am a mental health nurse, and to the university, I am a student researcher. When studying in my Trust, I bring my student researcher role to the organisation where I practice.	This study has gone through ethics and has been approved. I can pragmatically approach my data gathering in an immersed yet, somewhat removed manner. I was not coming forth in my usual MHN role but as a student researcher.
Overlooking certain routine behaviours	Where I will have experiential knowledge of some areas under study, I	Applying a rigorous case study methodology allows the focus of the study to remain bounded. As such, when gathering the data, I will be

	may misperceive critical perspectives or events as normal behaviours.	sensitive to the participant's responses towards the intended aim of the study. I am regularly engaging in supervision with university supervisors, who highlight issues of rigour and bias. Having a variety of focus group participants from areas of practice I have little or no experience with will present new behaviours or thinking that I would otherwise not have preconceived as routine.
Making assumptions about the meanings of events and not seeking clarification	I may hold preconceived assumptions based on my practice experience, thus increasing bias potential. For example, when first embarking on this study, I held the belief that all mental health nursing practices should be personal recovery-orientated.	Completing a reflective diary during all stages of the research process, particularly data collection can help identify issues of bias. I engage in regular supervision with university supervisors, who highlight issues of rigour and bias. I am ensuring that I apply data triangulation and seek clarification of meanings and events expressed by participants. Through my clinical skills, I have a depth of experience with exploring issues beyond the surface of simple comments. These skills are transferable and will help to avoid slipping into assumption-making.
Assuming they know participants' views and issues	It may cause problems of bias if I research close colleagues.	When sampling the practising MHN cohort for this study, I have excluded those with whom I have a close working relationship. An exploration of existing literature, theory and research designs preceded this study. When undertaking data analysis, I am sensitive to my experiential knowledge and understanding of the more comprehensive academic work. The data-gathering tools use open-ended semi-structured questions. As such, participants are open to responding to what I may assume are their issues and problems. All data is recorded and transcribed verbatim. Then, supervisors read through a cross-section of this and identify potential assumptions.
The participants may tend to assume you	Although this may also be considered a strength, if participants think I know	When sampling the practising MHN cohort for this study, I have excluded those with whom I have a close working relationship. I actively and

already know what they know	what they know, there is a risk that their perspectives must be fully articulated and adequately explained.	consciously engage with participants in a way that shows I do not already know their experiences. Through reflection when conducting the interviews, I could see that I requested participants to expand on abbreviations and discipline-specific terminology. Thus, ensuring the data could be understood and not assumed.
Closeness to the situation hinders the researcher from seeing all dimensions of the bigger picture while collecting the data.	Given my experience of the case, there is a risk that I may not see the bigger picture.	Again, open-ended questions allow participants to express their perspectives, which may offer different dimensions to the inquiry. The rigorous adoption of a methodology helped keep the focus of the study bound. It also encouraged adequate attention to the complexity and multiple contexts. Use a reflective diary, reflecting upon participants, stakeholders and lived-experience group feedback. Triangulation (Stake, 1995) was undertaken to ensure the quality of analysis and evaluation. I engage in regular supervision with university supervisors, who highlight issues of rigour and bias.

Influenced by: Unluer (2012)

Methodology - case study research

This section presents the methodology, methods, and ethical considerations underpinning this study. Firstly, the rationale for choosing qualitative research and the selection of case study research is made. Then, informed by crucial literature and principle methodologists, case study research is defined, and its challenges and limitations are outlined. Next, the research questions are presented and formulated through case study research principles, and the case study approach is applied. The methods of data gathering are then discussed. The final sub-section of this chapter examines this study's ethical considerations.

Aim and questions

As was explored through Chapter Two, the overarching aim of this study is to explore how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services. The formation of the research questions that underpin the aim is discussed later in this chapter. To note at this stage, the research questions are:

4. How do mental health nurses conceptualise recovery-orientated nursing practices?

5. What are the barriers and enablers towards implementing recovery-orientated nursing practices?

6. How do nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices?

A qualitative case study approach

Quantitative studies are undertaken in an objectivist manner, while qualitative studies are predominantly subjectivist by nature. Methodologies focusing on objectivity use quantitative research methods by applying deductive approaches to study the natural world while controlling the biases of the researcher (i.e. questionnaires, surveys and statistics). On the other hand, methodologies focusing on subjectivity use qualitative research methods, placing a primary emphasis on inductive approaches, where knowledge is known through a transactional process between the researcher and participants (i.e. semi-structured interviews, focus groups and observations). Quantitative methods are best suited to answer the what and when questions of research, while qualitative approaches are best used to answer the how and why questions.

A qualitative case study approach was adopted for this study due to the need for more information surrounding the issue of mental health nursing and recovery within the context of the NHS. Where little is known on a particular subject, a qualitative approach allows for the construction of new knowledge, asking the why and how questions of research and exploring people's experiences of a real-life and context-rich issue. A case study

emphasises an in-depth description and analysis of such issues. They are best used in situations where little is known about a complex issue that requires holistic exploration of multiple contexts, such as the exploration of a particular issue within an organisation. The following section presents the defining features, challenges and limitations of case study research, selecting the methodological approach most appropriate for this study.

Defining features, challenges and limitations

Case studies are the preferred strategy when how or why questions are posed (Yin, 2009). A case study methodology can be defined as an intensive holistic description and analysis (Merriam, 1998) of a contemporary phenomenon within a real-life context (Yin, 2009), identified through a complex yet specific bounded system (Stake, 1995). Hyett et al. (2014) propose that case studies can come under criticism when researchers do not adequately understand or apply the critical principles of case study methodology to their specific research issue. Creswell (2013) argues that the biggest challenge facing case study researchers is identifying the case: clearly outlining the focus, design and boundaries. Yazan (2015) suggests that the primary reason is the varying epistemological assumptions underpinning each critical author's approach. He identifies the epistemological commitments of Yin (2009) as positivism, Merriam (1998) as constructivism and Stake (1995) as constructivism and existentialism. Yazan points to the importance of understanding the varying contributions of each author, where consideration of this must be made explicit in one's worldview, research strategy and case study design.

As this study explores participants' individual and collective experiences of recovery-orientated practices through a social constructivist lens, Stake's constructivist and existentialist worldview is most appropriate for this study. Stake (1995) identifies two forms of qualitative case study designs: intrinsic and instrumental. Intrinsic case studies focus on understanding the uniqueness of a particular case – such as evaluating an organisational programme or exploring the experience of a single person through their recovery journey. On the other hand, instrumental case studies begin with identifying an issue of interest and selecting a single bounded case to illustrate and explore the issue through people's experiences. This study adopted Stake's (1995) instrumental case study

approach. An instrumental case study approach was chosen due to Stake's (1995) social constructivist epistemological perspective, focus on issues concerning context, and flexible research design.

An Instrumental Case Study

Stake (1995) defines a case as:

> "The case is a specific, complex functioning thing. …in social science and human services, is likely to be purposive… The case is an integrated system. The parts do not have to work well, and the purposes may be irrational, but it is a system. Thus, people and programmes are prospective cases." Stake (1995: 2)

Stake (1995) emphasises a case to be a complex integrated system where particular importance is placed upon the holistic exploration of an issue. To understand the issue of the case significantly, Stake (1995: 16) identifies a need for the researcher to "appreciate the uniqueness and complexity of the case, its embeddedness and interaction with its contexts".

Instrumental case study research is interested in studying issues holistically – understanding a particular issue through exploring relationships between the people within the case, their historical and political context, and their environment (Yazan, 2015; Stake, 1995). This methodological position is further illustrated through the Merriam-Webster (2018) definition of a case study:

> "An intensive analysis of an individual unit (such as a person or a community) stressing developmental factors concerning environment"

The case study design

As discussed, this study has adopted Stake's instrumental case study methodology (1995). An instrumental case study approach was chosen due to Stake's (1995) flexible design and social constructivist epistemology. Hyett et al. (2014) and Yazan (2015) propose that case studies come under criticism when researchers do not adequately understand or apply the fundamental principles of the chosen methodology. Creswell (2013) argues that the biggest challenge of qualitative case studies is the design and identification of the case: clearly outlining the focus, the scope and the boundaries.

Underpinned by the work of Stake (1995), Creswell (2013) summarises five defining steps of case study design. The five steps have been paraphrased below and are applied to this study.

1. The identification of the case - context, focus and boundaries

Context – the organisational setting of the case

This case study occurred in an NHS Foundation Trust located in London. The Trust offers primary, secondary, and tertiary mental health and physical health care to individuals of all ages, mainly in three London Boroughs. The services are provided to a population size of over 860,000 individuals, with diverse backgrounds. For instance, approximately 56% of people in one Borough identified themselves as belonging to the "White" ethnic group (2021 census), making the population ethnically diverse.

The mental health services within the Trust are divided into four domains: working-aged adults; children and adolescents; older people; and forensic & prisons. The working-age adult domain is broken into three directorates, reflecting three Borough localities. These non-specialist services are split into acute inpatient and community mental health services comprising multi-professional teams. These services act as the primary setting for this case study.

The secondary setting is the nursing executive. The nursing executive is the name given to a group of senior nurses who hold managerial and leadership positions at various structural levels of the Trust. The managerial and leadership positions range from the board-level director of nursing to the service managers and heads of nursing across the four mental health service domains. See Appendix 4.1, 4.2 and 4.3 for an illustrated overview of the macro, meso and micro organisational contexts.

Richie et al. (2016) state that qualitative studies are frequently confined to a particular geographic, community, or organisational area. They explain that this approach is advantageous as it enables the researcher to comprehensively understand the context in which the study is being conducted. The locations selected are typically relevant to the

subject matter being investigated, such as the location of a specific organisation or service.

The organisation's context is highly conducive to conducting a case study on mental health nurses' perspectives on recovery. It is an exemplary organisational setting that stands out due to its unique shape, size, and population served. The Trust's structure and layout play a significant role in determining how nurses provide care and add to the depth of the case. The size of the Trust is also crucial as it affects how nurses interact with patients and their colleagues, including from policymakers to grassroots nurses. Additionally, the diversity of the population served adds depth to the study, potentially providing valuable insights into nurses' unique challenges in their practice. Overall, the Trust's characteristics make it an ideal setting for conducting a case study on mental health nurses' views of recovery.

Focus

Stake (1995: 16) argues that case study researchers need to "sharpen the focus" of the case to minimise their "interest in the situation and circumstance". As such, Stake (1995:16) recommends that case studies use issue questions to "force attention to complexity and conceptuality". When we look at Stake's (1995) instrumental case study approach, the emphasis is on an issue of interest. The researcher selects a bounded case to illustrate this issue within its real-world contexts.

Within the literature, there needs to be more information exploring the experiences of mental health nurses and their implementation of recovery-orientated nursing practices in mental health services. The existing research has touched upon conditions outside the direct influence of practice-based mental health nurses and conditions that may hinder the successful implementation of recovery-orientated nursing practices. Mental health nurses are situated in and through multiple organisational contexts. In senior managerial and leadership roles, mental health nurses may be best positioned to influence the meso-level conditions that underpin practice. However, more is needed to know about the role of mental health nurses beyond the micro-level context.

The existing empirical literature explored in Chapter Two would suggest that the specific experiences of senior mental health nurses towards implementing recovery-orientated nursing practices have yet to be explored.

Boundaries

The organisation's structure does not always bind case studies; instead, they may be bound by less concrete parameters, such as exploring relationships or decision-making processes (Stake, 1995). Instrumental case studies seek to explore issues that cut through multiple contexts. Therefore, clearly defining and bounding a case is essential but can be difficult to articulate (Creswell, 2013).

Exploring the issue of the case at the meso-level of an NHS foundation Trust, this case is bound by the practice-based mental health nurses working within inpatient and community teams of working aged adult mental health services, as well as the Trust's nursing executives within the context of the Trust's nursing executive. Where the issue explored in this case overlaps multiple organisational contexts, the boundaries of the case cannot be neatly arranged and defined by existing structures. Appendices 4.2 and 4.3 provide diagrammatical overviews of the meso and micro contexts of the NHS Trust where this study is placed.

2. Research questions - the intent of the case should be made clear

Case studies are exploratory and descriptive. They cannot produce answers to research questions that are considered generalisable. Instead, research questions seek to provide answers that give insight into a particular issue within a specific setting through individual perspectives. Creswell (2013) explains that questions in qualitative research should be open-ended and exploratory, restating the aim of the study in more specific terms; questions that evolve, develop and refine as you go through the various research processes. Epistemologically and methodologically, the answers can never be viewed as final or definitive; findings will always be bound to the case and influenced by interpretation.

Stake's (1995) case study approach refers to research questions as issue questions. Issue questions help break down the research's aim into subtopics for investigation (Creswell, 2013). Stake (1995) recommends that case studies have a small number of crucial issue questions to help with conceptual structure and focus. Issue questions are the questions the research intends to answer. The aim of this study is to explore how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services, seeking to answer the issue questions:

1. How do mental health nurses conceptualise recovery-orientated nursing practices?

2. What are the barriers and enablers towards implementing recovery-orientated nursing practices?

3. How do nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices?

Topical information questions are then formulated to guide the data-gathering process. They help the researcher to acquire and structure the information needed to answer the issue questions within the specific and unique contexts of the case (Stake, 1995). Table 6 outlines this study's issue and topical information questions with their corresponding data sources.

Table 6. Research Questions & Data Sources

Issue Questions	Topical Information Questions	
	Senior Nurse Leaders (senior nurses at the meso-level of NHS Trust – members of the nursing executive)	**Mental Health Nurses** (practising in working-aged adult mental health inpatient and community settings)
How do mental health nurses conceptualise recovery-orientated nursing practices?	How well do you feel recovery-orientated mental health nursing practice is delivered, and why? How do you measure recovery-orientated nursing in practice?	How would you define your role within your service? What does recovery mean to you, and what does recovery look like in practice?

	What competing priorities may influence the implementation of recovery-orientated nursing practices?	What is the purpose of your service? How are people referred to your service? What determines a person's suitability for admission? Who decides if a person is suitable for admission or not? Once a person is admitted to your service, how are care and treatment plans formulated? How do you decide if a person is ready to be discharged from your service? Where do people tend to get discharged to? What enables you to implement recovery-orientated practices at the point of assessment, during care and treatment, and at the point of discharge? What barriers do you face towards implementing recovery-orientated practices at the point of assessment, during care and treatment, and at the point of discharge?
What are the barriers and enablers towards implementing recovery-	What is your role within the Trust's Nursing Executive?	How do you feel senior nurse leaders enable you to

orientated nursing practices?	What are your primary responsibilities? How is this role situated within the wider Trust management structure? How do you influence the implementation of recovery-orientated nursing practices? How do you contribute to forming nursing practice policy within the Trust? What specific Trust policies guide recovery-orientated mental health nursing practices? Are any obstacles impeding your ability to influence recovery-orientated nursing practice? If so, what do you feel these are?	implement recovery-orientated practices? To what extent do you feel able to shape nursing practice within your service? To what extent do you feel the priorities of senior nurse leaders are the same as yours? How do you contribute to the formation of a Trust policy? Are any policies that support or hinder you in implementing recovery-orientated practices? How and why?
How do nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices?	Are other obstacles impeding your ability to influence recovery-orientated nursing practices? If so, what do you feel these are? What could you or the Trust do differently to influence the implementation of recovery-orientated nursing practices further?	What could senior nurse leaders do differently to influence you towards implementing recovery-orientated practices? In your service, do you feel you face any other barriers to implementing recovery-orientated practices? What could be done differently to remove or reduce these barriers?

3. The hallmark of a good case study is apparent through an in-depth understanding

It is imperative that an in-depth understanding of the issue within the specifics of the unique case is made apparent. To ensure this occurs, case study research principles require researchers to provide a detailed description of the case and a logical and accurate assertion of its meaning (Stake, 1995). Case studies are interpretive and will never provide an undertested consensus of what is occurring (Stake, 1995). Although most often seen in quantitative research, validity is essential in case study research (Creswell, 2013; Stake, 1995; Yin, 2003). Stake (1995) stresses that case studies require researchers to minimise misinterpretation and misunderstanding through the validation process of triangulation.

As recommended by Stake (1995), this study has applied data source triangulation (using multiple sources of information to provide different experiences and meanings of the same issue – nurse leaders & mental health nurses), methodological triangulation (applying different methods of data gathering within the same case – semi-structured interviews & focus groups) and investigator triangulation (having another researcher view the data and analysis to offer their interpretations – input from supervisors). Stake (1995) states that only essential data and claims must be deliberately triangulated. He identifies importance as the critical information used to emphasise the understanding of the case or information that may or may not hold conflicting meanings. Table 7 summarises the data situation and the necessity for triangulation.

Table 7. Case Study Triangulation

Data Situation	Need for Triangulation
Uncontestable data…	Need little effort toward confirmation.
Dubious and contested description…	Need confirmation
Data are critical to an assertion…	Need extra effort towards confirmation
Critical interpretations…	Need extra effort towards confirmation
Author's persuasions, so identified…	Need little effort toward confirmation.

Source: Stake (1995) pp: 112

4. The approach towards the analysis of the case study will differ

When it comes to data analysis, Stake (1995; 77) outlines that “each researcher needs, through experience and reflection, to find the forms of analysis that work for him or her”. As such, researchers can have great flexibility in their approach. This study used thematic analysis to identify themes within and across the dataset. See the thematic analysis section of this chapter for a comprehensive overview of this approach to analysis.

5. A closing conclusion

Once the data of the case has been analysed and the researcher’s interpretations of the findings have been triangulated, the final part of a case study is to write a closing conclusion, or what Stake (1995: 121) calls “writing the report”. The report summarises the entire case study, reporting on the various stages of the research process. Stake emphasises the importance of writing for the reader to help readers better understand the case and the researcher’s interpretations of it. Within this thesis, the report is outlined in the discussion Chapter Five.

Methods

Stake (1995) recommends that people are sources of information, where the researcher is not bound to any particular analysis approach. This section presents the key sources of data used in this study. Each section briefly describes the sampling method and recruitment strategy applied. The data collection followed a two-phase process: interviews with nursing executives (1), focus groups with inpatient-based nurses and interviews with community-based nurses (2). The following sections are presented in the format of these consecutive phases. Figure 3 provides an illustrated overview of this study.

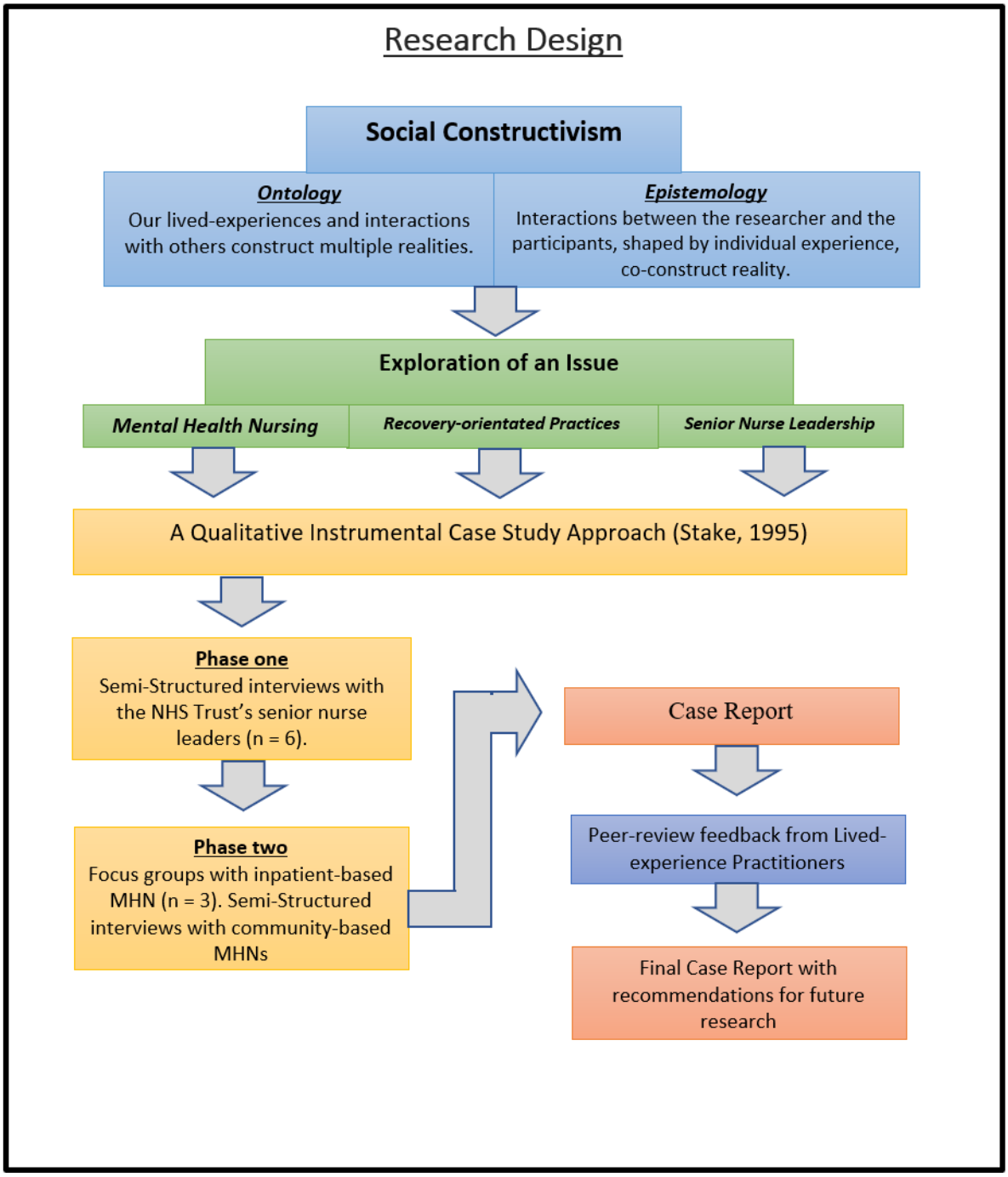


Figure 3. Research Design

Phase one: Interviews – Nursing Executives

This section presents the nursing executives' selection and recruitment, data collection process and data analysis method. In total, six interviews were conducted with this group.

In addition, data has been gathered through semi-structured interviews; conducted by the researcher.

Sampling, selection and recruitment

Initially, a purposeful sampling method was applied, identifying and selecting nursing executive members who may be suitable for interview. Purposeful sampling ensures that the right participants are recruited to answer the questions in line with the focus of the study (Stake, 1995). The purposeful sampling identified the most senior participant within the Trust. Through interviewing this individual, the initial participant identified the nursing executive members to fit the following inclusion criteria:

- Participants must be members of the Trust nursing executive.
- Participants were registered nurses who provided nursing leadership to mental health nurses within the Trust.
- Have the title of director of nursing; associate (or deputy) director of nursing; head of nursing, or a role similar to head of nursing based on their influence over mental health nurses within the Trust.

All relevant senior nursing executives who had the most influence over mental health nursing strategy and operation within the organisation were selected for interview. all eligible nursing executives participated in the study. As such, a whole population sample was achieved for phase one, strengthening the reliability of the data.

Six participants were recruited through email communication. At the time of the interview, the nursing executive participants sat in the roles of Director of Nursing (n = 1), Associate Director (n = 2), Head of Nursing (n = 3), Consultant Lead Nurse (n = 1) and Service Manager (n = 1). Some participants had dual roles, and others had been in other roles within a year before this study.

An email invitation from the researcher outlined the proposed study and its purpose. Participants were asked whether they wished to be interviewed face-to-face or over the telephone. All participants requested face-to-face interviews. The six interviews were arranged for a time of the participants choosing. The interviews were all conducted in

quiet areas within the Trust, such as their office or private meeting room. All selected participants at the point of recruitment agreed to engage in this inquiry. Signed consent was sought and received from all participants.

Data collection

Semi-structured interviews were undertaken with the nursing executive participants. The advantages of semi-structured interviews are multiple: they provide researchers with a comprehensive view of the issue under study; it's easier to engage participants in a 1-1 setting rather than in a group – where people are usually more comfortable and open in their discussion; they facilitate spontaneous responses from participants, while social cues can also be taken advantage of (Opdenakker, 2006).

However, there are also disadvantages to using semi-structured interviews: they can feel intense, requiring strong concentration from both participants and researcher, where researchers have to be continuously reflexive throughout; there is a risk of bias if the researcher takes the role of expert, particularly as an insider researcher (see Table 5. For how this was mitigated against); unstructured protocol can lead to irrelevant discussion; if not recorded, researchers may forget essential responses. In addition, transcribing recordings is a highly time-consuming exercise (Opdenakker, 2006).

To overcome some of the disadvantages of this method, an indicative topic guide was used to guide the researcher towards gathering the interview data (Appendix 4.4). The guide included topic questions that were collaboratively created between the researcher and the supervisors to help gather the information to answer the study's issue questions. All of the interviews were recorded using a digital recording device. Recorded data were transcribed verbatim in preparation for thematic analysis.

Data analysis

Thematic analysis (Braun & Clarke, 2006; Braun & Clarke, 2012; Clarke & Braun, 2013) was used for this qualitative dataset (see the latter section in this chapter for an overview of thematic analysis).

Phase two: Focus Groups and Interviews – mental health nurses

The next phase of the study was to undertake focus groups with registered mental health nurses working in inpatient settings and semi-structured interviews with community-based mental health nurses.

Sampling and selection

The examination of the literature in Chapter Two indicates that it is still uncertain how the particular conditions of mental health services impact mental health nurses understanding and application of recovery-orientated practices. Furthermore, in the wider body of recovery literature, there is a lack of evidence concerning the identification, minimisation, and elimination of operational barriers within the service and organisational contexts.

Phase two involved selecting participants through criterion sampling, enabling a comprehensive exploration and understanding of the study's aim (Ritchie et al., 2016) and addressing the knowledge gaps identified within the literature. Moser & Korstjens (2017) define criterion sampling as a sampling method in which the researcher selects participants who share a common experience (in this case, the implementation of recovery-oriented practices) but differ in their characteristics and individual experiences (such as their role and area of practice).

As the sample population of this study was reasonably homogeneous by way of all being registered mental health nurses, this study set out to acknowledge the relevant internal diversity of the case (Ritchie et al., 2016). Specifically, a mix of participants from both community and inpatient mental health services were invited to participate, while also being representative of the three directorates comprising the Trust's mental health services.

A further strategy that further enhances the quality of qualitative research sampling and selection is the concept of saturation. In their evaluation of saturation methods and methodologies, Saunders et al. (2018) critically present a range of approaches to saturation in qualitative data, the selection of which is determined as best suited to the research methodology and analysis process.

Two approaches that are, in combination, most relevant to this study are data saturation (at the point of data collection) and inductive thematic saturation (at the point of analysis). According to Grady (1998), data saturation occurs when new data no longer provides new information and instead repeats the information already gathered. For instance, during interviews, when the researcher starts hearing the same comments repeatedly, they have likely reached the point of data saturation. At this stage, the researcher should stop data collection and start analysing the data they have already collected. When using inductive thematic saturation, the point at which no new codes or themes are identified and new theoretical insights can no longer be gained from the data is the point at which adequate data has been captured (Saunders et al., 2018).

As is outlined later in this chapter, Thematic Analysis (Braun & Clarke, 2006) was used in this case study, an approach that promotes the familiarisation of the data (i.e. through transcribing, reflexion and reflection) and coding (i.e. organising the data into coherent concepts relevant to the studies aim) as an iterative process that can enable both data saturation and thematic saturation simultaneously. However, when analysing large quantities of qualitative data as was the case in this study, determining what constitutes towards saturation can be a daunting task.

According to Malterud et al. (2016), information power is another concept that can help determine an adequate sampling for qualitative studies in the context of saturation. The idea is that the more information participants provide that is relevant to the study, the fewer participants are needed. As such, the focus of the coding and determinants of saturation aligned with the study's aim and research questions, the specificity of the sample, and the analysis strategy.

As the data was being analysed, all new information, relevant to the questions and specificity of participants (i.e. inpatient and community) became standalone codes. As more data was gathered and analysed the more refined the codes became, from 75 down to 17 (see pages 105-109). By the time the coding had been completed for the entire dataset, there were no standalone codes representative of a single participant. Thus providing confidence that the codes and themes in this study held the information power to argue that both data and inductive thematic saturation had been met.

Recruitment

Both inpatient and community participants were recruited through email invitations. The email comprised an outline of the proposed study, its purpose and inclusion/exclusion criteria, i.e. qualified RMN, limited to an area of work. A link was attached to the email, leading to a secure electronic registration portal. Participants were asked to provide personally identifiable information so they could be contacted and categorisable information (i.e. length of practice, place of work, time spent working in the organisation). All participants were given written and verbal information about the research, provided with opportunities to ask questions and signed a consent form (appendix 4.8) before taking part.

Focus Groups:

The three focus groups consisting of registered mental health nurses working in acute inpatient settings were undertaken. The recommended size of a focus group is generally 6-8 people (Office for Health Improvement and Disparities, 2020). Nevertheless, when the purpose of a study is to understand a complex issue where the participants are experienced and potentially passionate about the topic, Krueger and Casey (2014) identify that smaller focus groups (4-6 participants) are better suited.

As well as being easier to recruit for, smaller focus groups allow the individual participants more time to share their views, providing richer in-depth information. That said, mini-focus groups limit the range of experiences due to their small numbers. Stake (1995) prefers using methods that provide the opportunity for in-depth understanding. As such, smaller focus groups have been used for this study. Each focus group had four participants. The total number of participants across the three focus groups was (n = 12). Focus groups were transcribed by a professional transcribing company, for which a confidentiality agreement was written up and signed. No personal data beyond what participants may have shared within the focus groups were provided to the transcribers.

Semi-structured Interviews:

Initially, this case study intended to facilitate focus groups for inpatient and community-based mental health nurses. However, it was impossible to hold focus groups with these participants due to community-based participants working across multiple sites and varying schedules. Instead, to ensure the experiences of this group were captured, semi-structured interviews were carried out. The total number of participants recruited for semi-structured interviews was (n = 8). Semi-structured interviews with community-based nurses were transcribed by a professional transcribing company, for which a confidentiality agreement was written up and signed. No personal data beyond what participants may have shared within the focus groups were provided to the transcribers.

Table 8. Participants for Focus Groups and Semi-Structured Interviews

Practice Setting	**Data Collection Method**	**Number of Participants**
Mental health nurses working in acute-inpatient adult mental health services of Directorate 1	Focus Group	N = 4
Mental health nurses working in acute-inpatient adult mental health services of Directorate 2	Focus Group	N = 4
Mental health nurses working in acute-inpatient adult mental health services of directorate 3	Focus Group	N = 4
Mental health nurses working in the community adult mental health services of Directorate 1	Semi-structured Interviews	N = 2
Mental health nurses working in the community adult mental health services of Directorate 2	Semi-structured Interviews	N = 3
Mental health nurses working in the community adult mental health services of directorate 3	Semi-structured Interviews	N = 3

Total Participants: N = 20

Focus groups – advantages and disadvantages

Focus groups and semi-structured interviews were the applied data collection techniques for this group of participants. The semi-structured interviews' strengths and weaknesses were explored in this chapter's nursing executive section. Table 9 outlines the specific strengths and weaknesses of using focus groups as a qualitative data collection technique. As with the nursing executives, a topic guide was used to guide the structure of the interviews and focus groups (see Appendix 4.5).

Table 9. Advantages and Disadvantages of the use of Focus Groups

Advantages	Disadvantages
It provides an opportunity to gather data from specifically identified groups. Facilitates discussion of precise topics of interest to the researcher. A flexible technique that meets the traditional techniques of interviews and observations in the middle. It can save researchers time and resources. Smaller focus groups can provide in-depth information about an issue.	However, participants may not openly discuss their opinions. Risk of disagreements between participants. Risk of dominating or irrelevant views. Potential for group bias. The researcher must remain the group moderator rather than become the topic expert. Less controlled than interviews and less revealing than observations.

Sources: Morgan (1996); Krueger & Casey (2014)

Data analysis

Like the nursing executive interviews, inductive thematic analysis was applied to investigate the dataset’s content (see next section for an overview of thematic analysis).

Thematic Analysis

Braun & Clarke (2012: 57) define Thematic Analysis (TA) as:

> "…a method for systematically identifying, organising, and offering insight into patterns of meaning (themes) across a dataset. Through focusing on meaning across a dataset, TA allows the researcher to see and make sense of collective or shared meanings and experiences."

The focus of TA is not to explore individual interpretation but rather to identify and articulate a consensus of ideas across several individuals relating to a particular question. Before being articulated as defined above, TA was a technique or method used by researchers. Yet, its use was only sometimes identified or popularised amongst other qualitative analysis forms (Braun & Clarke, 2006). TA differs from other forms of qualitative analysis that look for patterns across a data set, such as interpretative phenomenological analysis (Smith et al., 2009) and grounded theory (Corbin & Strauss, 2008).

The critical difference between TA and other established forms of qualitative analysis is that TA is not aligned with any pre-existing theoretical framework (Braun & Clarke, 2012), facilitating the inductive approach of a social-constructivist epistemology. In its flexibility, TA covers a broad spectrum of philosophical assumptions and theoretical perspectives. Its systematic process allows the researcher to grasp a foundation in qualitative data analysis quickly. Researchers must be aware of the strengths and limitations of TA before adopting it as the suitable method of analysis for their study (see Table 10).

Table 10. Strengths and limitations of Thematic Analysis

	Strengths	**Limitations**
Flexibility	It claims to be a relatively easy and quick method to learn and do. Allows for a wide range of analytic options. Does not sit in any one theoretical or philosophical camp.	Requires doing TA to better understand its use. The potential range of things that can be said about the data is vast.

		Researchers may need help deciding what aspects of their data to focus on.
Accessibility	Accessible to researchers with little or no experience of qualitative research. Results are generally accessible to the educated general public. Robust analysis to use with multiple researchers.	Lacks the kudos of more established interpretive, analytical methodologies. Multiple researchers' interpretations can reduce reliability.
Epistemological Nature	It can be used across a range of epistemologies and research questions. Method of data analysis that supports both a deductive and inductive approach. The research question and the underpinning theoretical assumptions drive it. Values and assumptions are managed through reflexivity.	Disadvantages depend on poorly conducted analysis or inappropriate research questions. Potential for bias – if values and existing assumptions are not made clear.
Interpretive Power	Codes emerge through the data. Data extracts support the interpretation of themes. Mapping allows for transparency in the process of forming codes and themes. Reliable analysis for studies that go beyond individual experience.	It does not allow the researcher to make claims about language use or functionality of talk. Only interpretative reliability is used within an existing conceptual framework. Researchers cannot retain a sense of continuity and

	Can usefully summarise critical features of a large body of data. Can highlight similarities and differences across the data set. Can generate surprising insights.	contradiction through any individual account, which may otherwise be revealing.
Instrumental Case Study Approach	The issue questions and the people's experiences within the case drive it. It provides a thick description and holistic approach, using the entire dataset. Encourages the inclusion of context.	Without using a conceptual framework, the reliability of findings may become an issue.

(Influenced by: Braun & Clarke, 2012; Stake, 1995)

The applied method of analysis

This analysis pulls on three primary references underpinning TA: Braun and Clark (2006; 2012) and Clarke and Braun (2013). Firstly, Braun & Clarke's 2006 article is their seminal paper outlining their systematic approach towards TA. It is the most cited of their work and is referred to as the source of their analysis method. Braun & Clarke (2012) is a book chapter presenting an overview of TA: why to use it and how to follow it. It outlines applying a deductive or inductive approach towards analysis and a combination of both.

Finally, Clark and Braun's (2013) article discusses overcoming challenges and developing strategies for effective learning of TA, underpinned by a qualitative survey on students' experiences of qualitative and TA teaching. A combination of these references provides a strong base for learning the process of TA, overcoming challenges and undertaking a systematic inductive analysis of the data.

Maintaining Participant Anonymity

Maintaining anonymity was a vital part of the ethical approval process for this study (University of Greenwich, 2021). There is a potential for participants to recognise each

other or be recognised by colleagues, but a minimal likelihood of being recognised outside of the Trust. Systematic steps have been taken to ensure anonymity issues are considered throughout every phase of the analysis process.

To maintain anonymity, all participants were given a pseudonym. Using a stereo handheld audio recording device allowed this to be possible for focus group members too (helping note the location of participants within the room). With this form of recording, participants could be identified and their data withdrawn if they so choose to do so. In addition, disclosures of personal information expressed by participants have been carefully omitted in data extracts. Where something has been removed, the reason is explained in brackets.

The Analysis Framework

A social constructivist paradigm underpins this study. Aligned with the epistemological assumptions of social constructivism, an inductive approach was applied (Braun & Clarke, 2012). Inductive in that the participants' experiences have formed the content of the findings, and the coding of their stories was not up suppressed using an existing theoretical framework. Although aspects of the code's names encompass existing concepts relating to mental health nursing and recovery, the language of the participants was used to name the codes, capturing individual and collective subjective experiences.

The process of Thematic Analysis

Clarke and Braun (2013) explain that TA is an iterative process, where the six stages of TA are not necessarily completed in a linear or chronological order. Braun & Clarke (2012) highlight that as coding progresses, codes are likely to develop, where recoding of earlier-coded data may be necessary. Codes may need modification to capture both the semantic or the latent level of meaning across the data set. For clarity, the following sections have been presented chronologically through the six phases of TA: 1) familiarisation with the data; 2) coding; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes; 6) writing up (Braun & Clarke, 2006).

Phase 1 - Familiarisation with the data

Phase 1 of TA is to familiarise yourself with the data. This involved transcribing the recorded interviews and reading over the transcriptions several times. Initial ideas and thoughts about the data were noted through the familiarising phase. Reflexivity was used throughout. Thoughts such as ‘That comment is exciting’ or ‘Does that align with my theoretical proposition?’ were noted and reflected upon to recognise, observe and reduce potential bias.

Phase 2 - Coding

Approach and Peer-Review

Initially, the dataset was split into nursing executives and practice-based nurses’ – coding was undertaken separately for each participant group. The intention was to have two findings chapters distinct from one another, aligned to the two participant groups. However, as the findings chapters were being written, there was a clear conceptual cross-over and repetition. Therefore, it was decided that the entire dataset should be treated to emphasise interconnectivity, as aligned with the case study methodology.

It has been suggested that NVivo software can increase the robustness of qualitative research by creating a body of evidence supporting the proposed thematic patterns (Bergin, 2011; Furtmueller et al., 2015). Therefore, NVivo 11 and 12 were used to manage and organise the entire dataset. As the research progressed, further focus on content was undertaken, ensuring the analysed data aligned with the research questions.

One supervisor sought peer review to view the coding process's soundness. One supervisor, experienced in the process of TA, reviewed the data extracts in full and provided discussion and detailed notes about the methodological approach and how they interpret the content. Such feedback was used further to solidify the analysis and presentation of this data.

The Coding Process

As previously discussed, coding was initially undertaken with nursing executives, seeing practice-based nurses as a secondary group.

Initial coding of nursing executives

Each nursing executive interview was coded individually, and a list of emerging codes was made. Colours (yellow, indigo and blue) were assigned as pseudonyms (changed later as the analysis developed). The list of initial codes was used throughout the analysis of the interviews, where new emerging codes were added to the coding list. For example, the coding of Yellow, which was the first interview to be analysed, revealed 44 initial codes. From the 44 initial codes identified from Yellow, 32 of these were found in Indigo, with 22 new initial codes emerging. Through the coding of Blue, nine new initial codes emerged, with 44 of the same initial codes found in Yellow and/or Indigo.

When listing all 75 initial codes, it was clear that there were both conceptual (mental abstract or theoretical meaning) and semantic (the meaning in language or logic) relationships between several codes. For example, **the purpose of the system is not clear,** has semantic and conceptual significance to **the purpose from top to bottom is not clear** as well as **the message is lost in translation**. The data underpinning these three initial codes emphasise systemic issues around the clarity of ideas from senior management to practice-based mental health nurses. Therefore, the merged code **the mental health nursing system lacks a clear purpose from top to bottom** was used to encompass these related initial codes.

The initial codes were revisited and modified after each interview was analysed, merging similar codes and recoding earlier data. Table 11 shows how the 75 initial codes were merged into 26 codes.

Table 11. Code List for Interviews - Indigo, Yellow and Blue

Code 1 – Ticking boxes by focusing on records and tasks vs prioritising patient outcomes Check your priorities – ticking boxes or helping patients Focusing on records and tasks rather than supporting patient outcomes	**Code 2 –** If we set the right goals, indirect priorities can be complementary to recovery and competing priorities are dealt with If we set the right goals, the competing priorities are dealt with Indirect priorities – complimentary to a recovery orientation
Code 3 – The environment and wider systems can impact our work, we can impact on er systems and the environment The environment and wider system impacts on what we do We impact on the environment and wider system	**Code 4 –** As the largest workforce, nurses need to be empowered to make decisions and be at the forefront of service and policy delivery Nurses need to be at the forefront to deliver services and policy They (nurses) must be the people to be empowered Clinicians must decide how to move forward Largest clinical workforce
Code 5 – The mental health nursing system lacks a clear purpose from top to bottom The purpose of the system is not clear The purpose from top to bottom is not clear The message is lost in translation Clinical leaders must not dilute the message We all want the same things Are we engaging the right people?	**Code 6 –** The person is the how of recovery, it is real life, not just practice The person is the how of 'our' practice (the what can be measured, the how is personal) A clinical recovery vs a personal recovery lens Recovery is being human, it is real life, not just practice
Code 7 – Strategy pulls everything together by engaging all the right people Strategy pulls everything together Interface with senior management Interface with the person and staff is key to promote good practice	**Code 8 –** responsible for influencing, inspiring and supporting nursing so that care is delivered really well in practice A clear job description Delivering nursing care really well Support and inspire workers Influencing the direction of nursing

	Responsible for all nursing activities Looking at what is happening practically A conduit between the executive and the directorate
Code 9 – too many structures to satisfy, some aid good practice while others create issues Too many structures to satisfy Some structures can aid good practice, but some can create other issues Different services have different barriers to recovery-orientated practice	**Code 10 –** we are measuring lots of things we think we want to achieve, but are we asking the right questions? What we say we do and what we are aspiring to achieve Measuring what we think we want to achieve Measuring lots and lots of things Are we asking the right questions?
Code 11 – despite unprecedented pressures, issues of finance must not overshadow the purpose of the system Issues of finance must not overshadow the purpose of the system Unprecedented pressures	**Code 12 –** the specialist professional role of mental health nursing may not be understood Do we understand the specialist knowledge of nurses? Lacking professional recognition from leaders We struggle to evidence what nurses do really well
Code 13 - The golden thread is not there, yet – thinking needs to change The thinking of nurses must change for the purpose to be understood to its fullest The golden thread is not there, yet Shifting the attitude away from containment	**Code 14 –** Thinking of recovery as a system wide paradigm creates an environment for how we do things Creating an environment for how we do things Recovery orientation as a system-wide paradigm, not an approach or model
Code 15 – it takes a whole-team approach with multi-professional clinical leadership at all levels It takes a whole-team approach Strong clinical leadership is essential	**Code 16 –** Training and education around recovery Training and education around recovery Not necessarily big training needs

Code 17 – policy can liberate and enable recovery-orientated nursing practice. Policy can be liberating enablers for recovery-orientated nursing It's about having a conversation with the patient	**Code 18 –** Policies are created reactively, being proactive is difficult It is difficult to predict Incidents and complaints underpin policy initiatives Policies are identified through need
Code 19 – Policy can guide workforce planning but does not capture practice, good practice is shared differently Good practice is shared, but policy does not capture practice Nursing policy can identify training needs and guide workforce planning	**Code 20 –** Policy is expert led and embedded into governance it is tested, improved and approved Organisational policy is embedded into governance Policy formation is expert lead through an outside and inside perspective Test it out and get lots of feedback Trust policy underpins the processes of our service
Code 21 – Supervision & reflection Supervision and reflection Do I feel I have made a difference today? What keeps people in the job?	**Code 22 -** subjective data helps build the picture but is difficult to measure Subjective data helps build the picture Measuring unique experience is difficult
Code 23 – lived-experience is essential for getting the system right Experienced based co-design Lived-experience is essential for getting it right	**Code 24 –** It is information giving as ideas are forced top-down Its information giving as opposed to reflecting and learning to improve practice. Ideas are forced top-down
Code 25 – Operation overshadows strategy with competing roles and expectations Competing roles and expectations Operational duties overshadow strategic planning	**Code 26 –** Technologies need to be designed for practitioners to help facilitate recovery Current technologies hinder person centred care Technologies could enhance practice Technologies and reporting systems need to work for us

Coding of the combined dataset (nursing executives and practice-based nurses)

Originally the analysis of the interviews with the nursing executives was undertaken separately to the interviews and focus groups of practice-based nurses. However, on writing two separate findings chapters, it became clear that there was cross-over between the two datasets. As such, the two datasets were merged and the coding process revisited. NVivo 12 was used to manage the data and the codes, which were refined into fifteen core codes, as presented in the next section (see Figure 5).

Phase 3, 4 & 5 – Searching for, constructing and naming the themes

Phase 3 of TA involves searching for themes. Themes are formed by organising codes into related clusters, presenting an overarching coherent and meaningful pattern in the data relevant to the research question (Clarke and Braun, 2013). An important emphasis made by Braun & Clarke (2012) is that themes do not just emerge from the codes or data. Instead, themes are actively generated and constructed by the researcher in order to present a particular narrative.

Braun & Clarke (2006; 2012) recommend that phase 3 finishes with a thematic table, diagram or map. A thematic map shows readers how the researcher came to generate themes through the coded data. Presenting a thematic map at this stage provides transparency of the analysis process. In the thematic map below (Figure 4), the themes are within the rectangular boxes and the codes are presented within ovals.

Refinement of the themes as originally set out in Table 11 was undertaken following peer review from supervisors. The themes were renamed to ensure the content and narrative between each section were clear (see Chapter Four).

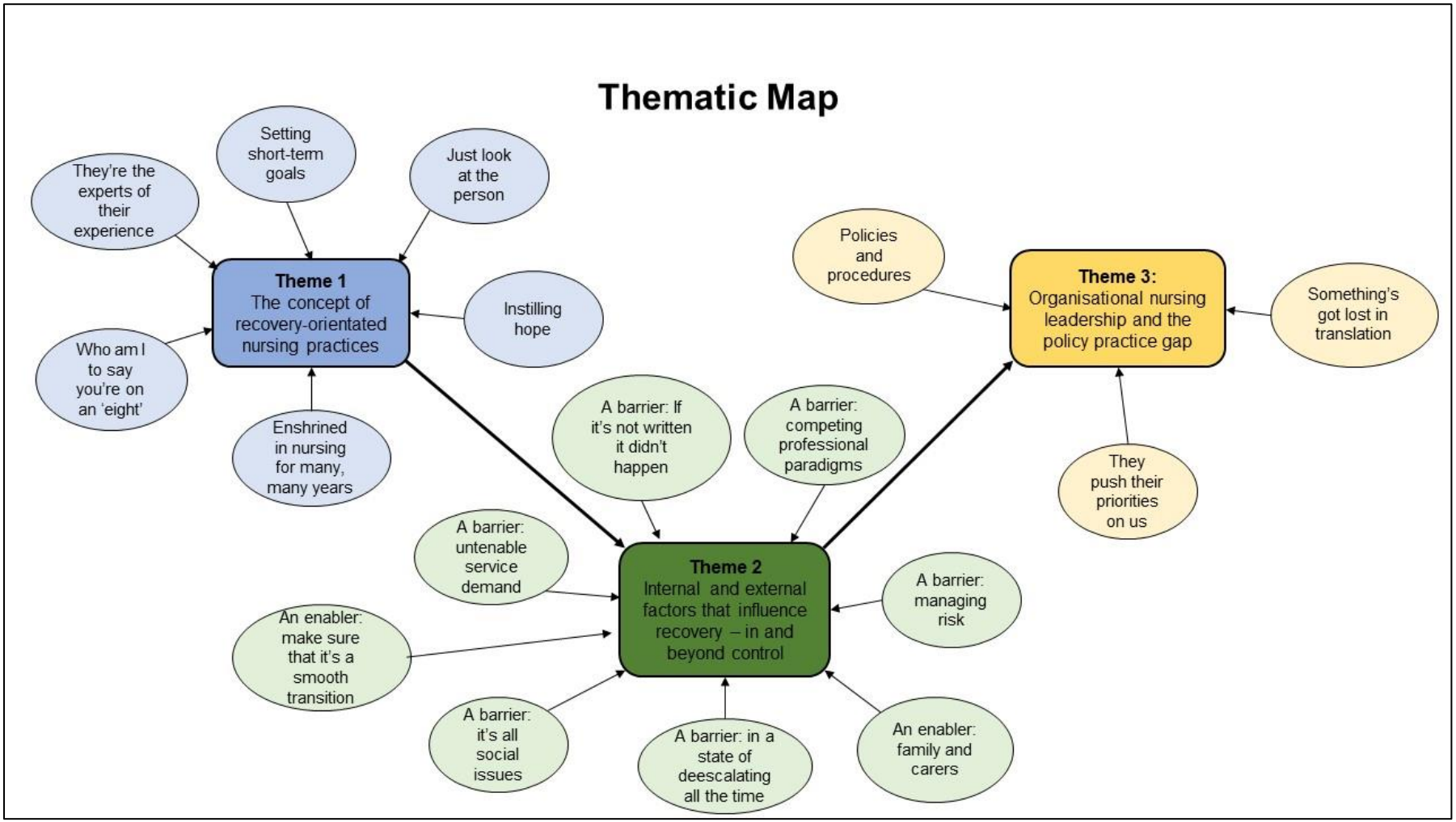


Figure 4. Thematic map – themes and codes

Phase 6: producing the report

The report pulls together the findings under each theme. A clear narrative is formed and helps the reader to understand the data through the analysis of the researcher. The report writing stage was complex and time consuming. With excess of over one hundred thousand words of data and multiple quotes aligned to each code, making a choice on what data to present is challenging. As such, the best quotes to illustrate an aggregate issue were chosen (Braun & Clarke, 2006). Careful consideration for opposing perspectives was made and is explicit within the findings chapter (See Chapter Four).

Ethical Considerations

This study sought the approval of the University Research Ethics Committee (UREC) and NHS R&D management. There were no research procedures undertaken in this study that warranted NHS ethical approval. However, intrusive methods (interviews and focus groups) were carried out. These were undertaken only with NHS staff. Although NHS ethics approval was not required, University Ethics Approval (UREC) was sought and provided a means to outline and reflect on the areas pertinent to the intrusive procedures of this study. As such, specific steps were undertaken to address the potential issues that may arise. These issues were: maintaining confidentiality and anonymity, informed consent and participants' right to withdraw from this study, managing disagreements or upsets, and the researcher's nursing role within the Trust.

Maintaining confidentiality and anonymity

Any data files containing study participants' names and contact details were stored on a password-protected computer, and access restricted to the researcher and the supervisors. Audio files, participant contact details and anonymised transcripts were saved separately and password protected. Paper copies of transcripts were kept in a locked cabinet. Only the researcher and supervisors have had access to the recordings and transcripts. Participants were reminded of the confidential nature of the study. This has been highlighted on the written consent forms (appendix 4.8) that participants were asked to sign before participating in the study.

All raw data has been de-identified, and pseudonyms have been used. Information produced for a report or published in academic journals will be done so that it does not identify participants, their current place of employment (ward/directorate) or any specific details arising. Anonymity within the Trust staff group may be challenging due to the small pool of selected participants participating in the interview process. Nevertheless, the data was managed so that participants will not be identified outside the Trust. Participants of the interviews were informed of this in the information sheet, so they know the potential for their identification within the Trust staff cohort.

Informed consent and participants' rights to withdraw from the study

Participation was entirely voluntary, and this is outlined in the information sheets (appendix 4.6 & 4.7). Written consent was obtained for the interviews and focus groups. Participants were able to consider their participation and choose whether to opt in. It was made clear to participants in the information sheets that they are free to withdraw from this study without giving any reason and without their professional and legal rights being affected. Participants had the right to remove themselves from the study. Participants had the right to refuse to answer any of the questions.

Managing disagreements or upsets

Within the focus groups, there was the potential for disagreement and upsets regarding ideas (Morgan, 1996; Krueger and Casey, 2014). This could have escalated to a heated debate which will have to be de-escalated. There was complete information in the recruitment information sheet that informed participants of the expected professional and ethical standards and expectations. Participants signed that they had read this agreement before the focus group commenced. If tensions within the focus group escalated beyond these agreed standards, the focus group would have been stopped immediately. However such issues did not occur.

If necessary, concerns would have been escalated to the local collaborator. Any conflicting situations would have been reported to the R&D manager and the university supervisors. Participants were be guided to the Trust counselling/listening ear services

and HR if they required further support following the focus groups. The researcher would have undertaken a debrief with participants following stressful discussions and potential upsets. If the researcher experienced issues through the interviews and focus group discussions, they would have discussed this with their supervisors, NHS Trust collaborator and university counselling services as required.

The researcher's nursing role within the Trust

This area was discussed in detail in the Axiology section of this chapter (see page 76). As a member of staff within the Trust, the potential ethical considerations must be made clear. Inevitably the researcher knew of the selected participants being interviewed. Nevertheless, this was in a formal capacity, where minimal interaction has occurred between the researcher and these participants.

Furthermore, there was the potential that mental health nurse participants would be current working colleagues of the researcher, practising across multiple sites other than the rehab unit where the researcher is based. As such, any current (at the time of the study) close-working colleagues were excluded from this study. Reflective accounts and regular supervisor input and support were maintained to mitigate the influence of potential insider biases.

Patient and Public Involvement (PPI)

Although this study does not evaluate the specific practices or interventions of mental health nursing or explore the service user's experiences, lived experiences remain an essential element of both NHS services and recovery (Capobianco et al., 2023). Peer support remains a valuable and supporting element for service users' recovery (Perkins et al., 2018). Moreover, the co-production of people with lived experience of mental illness with people working in NHS mental health services has been a long-standing driver for the successful implementation of recovery with mental health organisations (Slade et al., 2017a).

As such, this study set out to engage a group of lived-experience practitioners employed by the Trust to reflect upon the case report and contribute their thoughts to the direction

of future research. As the involvement of the lived-experience group was not within the original NHS research and development proposal, a minor amendment request had to be put forward. The request was made in January 2018 and formally approved by the NHS Trust in June 2018.

The Trust where this study takes place employs lived-experience practitioners to support service users' recovery within practice while contributing to the direction of mental health services. A case report was completed and shared with all Trust lived-experience practitioners (April 2023). Initially intended to be a peer-review focus group, feedback was instead requested via a questionnaire, strengthening anonymity and improving access to an already stretched workforce. Moreover, this group was also asked to contribute their opinions on future research direction. Although no primary data will be recorded from the group, a focus group summary formed part of the reflective process (see Chapter Seven).

When reflecting on this research design, one thing that could have been done differently would be to involve the lived-experience practitioners at earlier stages of the project. Such a recommendation for future research was made within the thesis conclusion (Chapter Six).

Trustworthiness

To advance the quality of quantitative research, Lincoln and Guba (1985) introduced and refined the four elements of trustworthiness: credibility, transferability, dependability, and confirmability. Trustworthiness criteria are pragmatic choices for researchers concerned about the acceptability and usefulness of their research for a variety of stakeholders (Nowell et al., 2017). In essence, the table of trustworthiness (Table 12) brings all the key quality assurance elements of the research study, as previously discussed within this chapter, into one coherent section.

Table 12. Research table of trustworthiness

Components of trustworthiness	What this means	How was this achieved
Credibility	Credibility shows the researcher's confidence that the data accurately represent the phenomenon. In case study research, this is called validation through triangulation (Stake, 1995).	**The researcher:** Utilised the role of Trust Sponsor (NHS Ethics process) to understand the Trust better and identify the most appropriate participants to answer the aim of the question. Using a purposive sampling method that identified initial key individuals as participants, followed by snowball sampling to identify stakeholders inaccessible in the purposive process. Utilised strengths of insider researcher to understand the complex and overlapping contexts of the case, identifying a broad yet specific participant sample. Obtained in-depth data through qualitative methods (interviews and focus groups), which provided context-rich information. Fully cognisant of case study triangulation (see Table 7.). Any assertions made were tested through the perspectives of multiple participants. Sense-checked the relevance and accuracy of the critical assertions with the Trust sponsor (post-Covid pandemic – April 2023).

Transferability	Transferability means how the researcher can show that the study may be applied to similar situations and people. As case study research is context-rich, findings are not generalisable but may be relevant to other environments or systems with similar contexts (Stake, 1995).	**The researcher:** Provided detailed description of the case within its multiple contexts: from the role of mental health nursing, the emergence of recovery, and a clear definition of the NHS Trust where the research occurred (both written and diagrammatical). Used an interview schedule to ensure all participants answered the same topic questions, helping to keep the discussion focused and relevant to the phenomenon being explored. Used social and systems theory to position the findings of the case within its sociopolitical, sociocultural and historical contexts, providing a deep description; helping readers to determine transferability further. Critiqued the findings against the existing empirical literature (identifying relevance), as well as the sociohistorical and sociopolitical contexts of the case, grounding the study within the knowledge space of recovery-orientated mental health nursing practices.
Confirmability	Confirmability means how the researcher can show the analysis process in detail and the rationale for decisions made about how the data is interpreted. Where Stake (1995) does not identify a prescriptive method of analysis, he does encourage researchers to reflect, triangulate and be sceptical	**The researcher:** Used a reflexive and reflective approach to data gathering and analysis, navigating the process with supervisors to check codes, refine themes and audit the data analysis by sharing raw data extracts and comparing findings. Used NVivo 12 to code the data, ensuring all relevant quotes were available in one space when

	about first impressions and simple meanings.	analysing and refining codes and themes. Used an internationally recognised qualitative analysis in the form of Thematic Analysis, fully recognising the strengths and limitations of the approach. Using reflexivity, emphasised that the case is complex and not definitive. The truth of the findings will be specific to the participants and contexts of the case. Selected the most appropriate quotes within the analysis process to support assertions. However, simultaneously ensured all competing perspectives or perspectives with differing contexts were also presented. Described the analysis process in detail to give high confirmability. Including outlining the iterative process of adapting to new information as the study progressed (i.e. having two datasets become one).
Dependability	Dependability is one of the four criteria for rigour and trustworthiness in qualitative research (Janice, 2022). Dependability is how other researchers might reasonably expect to achieve similar findings if replicated.	**The researcher:** Tested codes, refined themes, and examined the analysis with supervisors by sharing raw data extracts and comparing interpretations. Further strengthened reliability by using a conceptual framework to help interpret and describe the findings of the case (i.e. social constructivism, case study research and systems thinking/theory). Sampled participants from multiple service and system contexts and combined different methods

		(interviews and focus groups), aiding triangulation and dependability. Participant name, role, area of practice and method applied information is provided throughout quotations in findings. Provided a transparent step-by-step process of how the methodology was undertaken, including the potential biases of the researcher, the theoretical frameworks used and the research methods applied. Grounded the findings within the sociopolitical and sociohistorical writings of recovery and mental health nursing. Positioned the findings within the subject matter empirical literature.

Conclusion

This chapter outlined the specific research processes for this study (research paradigms, methodology and methods). The chapter was broken into three primary sections: research paradigms, methodology, methods of data collection, method of analysis, and ethics. The next chapter presents the findings of this case study, exploring the question: How do practice-based mental health nurses and nursing executives experience implementing recovery-orientated nursing practices in one NHS Foundation Trust?

CHAPTER FOUR: MENTAL HEALTH NURSING AND THE IMPLEMENTATION OF RECOVERY-ORIENTATED NURSING PRACTICES

Introduction

Chapter Four presents the analysis and findings of both the nursing executives and the community-based nurse interviews, as well as the inpatient-based nurse focus groups. As explained in the methodology chapter, aligned to the epistemological assumptions of social constructivism, an inductive approach was applied to the thematic analysis (Braun and Clarke, 2006; 2012).

The views and experiences of participants are described throughout this findings chapter. Specific caution was taken to ensure participants' experiences were not suppressed through the author's use of existing theoretical and conceptual frameworks (i.e. as explored in Chapter Two) or overshadowed by researcher bias. Although presented as primarily descriptive throughout this chapter, in-depth critique is provided in Chapter Five (discussion).

Codes were identified by analysing the entire dataset of the three focus groups, eight interviews with practice-based nurses, and six interviews with nursing executives, leading to three overarching themes. Participant name, role, area of practice and method applied information is provided in Table 13 and throughout the quotations in the text. Names have been pseudonymised for anonymity purposes.

Table 13. Participant reference table

Code	Participant Name	Role	Area of Practice	Method applied
CN1	Lydia	Charge Nurse	Acute Inpatient	Focus Group
CN2	Olu	Charge Nurse	Acute Inpatient	Focus Group
CN3	Ibrahim	Charge Nurse	Acute Inpatient	Focus Group
CN4	Agnieszka	Charge Nurse	Acute Inpatient	Focus Group
CN5	Annette	Charge Nurse	Acute Inpatient	Focus Group
SN1	Janis	Staff Nurse	Acute Inpatient	Focus Group
SN2	Reginald	Staff Nurse	Acute Inpatient	Focus Group
SN3	Rebecca	Staff Nurse	Acute Inpatient	Focus Group
SN4	Fredrick	Staff Nurse	Acute Inpatient	Focus Group
SN5	Ashley	Staff Nurse	Acute Inpatient	Focus Group
SN6	Sara	Staff Nurse	Acute Inpatient	Focus Group
SN7	Martine	Staff Nurse	Acute Inpatient	Focus Group
CPN1	Laura	Community Mental Health Nurse	Early Intervention Psychosis	semi-structured interview
CPN2	Rowena	Community Mental Health Nurse	Crisis Home Treatment	semi-structured interview
CPN3	Gary	Community Mental Health Nurse	Mental Health Recovery	semi-structured interview
CPN4	Marcia	Community Mental Health Nurse	Early Intervention Psychosis	semi-structured interview
CPN5	Rosemarie	Community Mental Health Nurse	Low-Intensity Psycho-Social Support	semi-structured interview
CNM1	Marcus	Community Nurse Team Manager	Mental Health Recovery	semi-structured interview
CNM2	Kyle	Community Nurse Team Manager	Intensive Psychosis	semi-structured interview
CNM3	Mitchell	Community Nurse Team Manager	Crisis Home Treatment	semi-structured interview
NE1	Anthony	Nurse Executive	Trust-Wide	semi-structured interview
NE2	Katie	Nurse Executive	Directorate level	semi-structured interview
NE3	Mandeep	Nurse Executive	Trust-Wide	semi-structured interview
NE4	Andy	Nurse Executive	Directorate level	semi-structured interview
NE5	Sian	Nurse Executive	Directorate level	semi-structured interview
NE6	Yaw	Nurse Executive	Directorate level	semi-structured interview

Theme 1: The concept of recovery-orientated nursing practices

Setting short-term goals

Exploring the meaning of recovery with mental health nurses emerged the concept of 'crisis'. Mental health nurses explained crisis as a state of mental distress wherein the person[2] may require hospital admission or community support for care and treatment. Being in a crisis was seen as a distinct stage of unwellness preceding the occurrence of recovery – a seemingly binary progression from one state of being to another:

> I feel that recovery is basically the person coming out of their crisis; they've come to us in a crisis, no matter how little or small we might think it is, but it's not; it's very big in their lives, so once a crisis has ended, they then go into recovery, and we have to support them through the crisis and then recovery. [Martine - Staff Nurse, Inpatient; focus group]

Mental health nurses reported that a crisis could occur when someone is either incapacitated[3] to make informed decisions or has made unwise decisions[4], leading to or contributing to mental distress. The notion of noncompliance with treatment, namely medication, was seen as the primary 'unwise decision' leading to someone entering a stage of crisis and necessitating hospital admission:

> When they're in an inpatient setting means they're in that crisis stage, literally, we're able to actually support them wherein they are not able to like say, comply with their medications effectively, and they have some sort of risk that's involved in that. [Sara - Staff Nurse, Inpatient; focus group]

Recovery, as described by several participants, was viewed as a stage proceeding the person's crisis. In this context, getting objectively better (asymptomatic) and engaging with services, were the key indicators used by some participants to determine when someone is no longer in crisis and now 'in recovery':

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[2] The person – refers to someone with lived experience of mental illness, a service user, a patient or a client.

[3] A person lacks capacity concerning a matter if at the material time he is unable to decide for himself concerning the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (MCA, 2005)

[4] A person is not to be treated as unable to make a decision merely because he makes an unwise decision. (MCA, 2005; Section 1(4))

> Yeah, probably means to me for the individual being at least 50% better than how he was, or she was on admission, you know, with… you know, a little bit of insights on what is being done for him to be 100%. So the moment the person starts to be more involved in their treatment or his care then that's probably is recovery is progressed, yeah. [Ashley - Staff Nurse, Inpatient; focus group]

The idea of recovery as an objectively measurable outcome with the ambition of "getting 100% better" [Andy – Nurse Executive; semi-structured interview] was disputed by other participants The relevance of 'recovering' to a pre-crisis state was acknowledged as being necessary for some but inappropriate for others; namely people with long-term severe mental illness (SMI).

These differences in views amongst participants were often nuanced and overlapping, rather than divergent. One participant provided some clarity around the meaning of recovery from a mental health service perspective while reinforcing the idea that recovery is, for some, not about becoming 'normal':

> I guess services would tend to define recovery as people returning to a normal social role, so are they more productive? Are they back at work? Are they asymptomatic, for example? Whereas for the person it's really about, well, where they see themselves in terms of their progress and their quality of life. So, recovery is about flipping it on its head really and saying, well, you know, where are you with all of this and what do you think we need to support you with? [Marcia – Community Mental Health Nurse; semi-structured interview]

It was argued that recovery as defined by mental health services is an objective outcome, measured by the person's progression from 'being in crisis' towards 'being well'. Opposing this stance, as explored in the next section, is the idea that recovery is something to be defined by the person; their perception of progress and quality of life.

They're the experts in their experience

Instead of recovery being an objectively measurable outcome and the result of something done to the person, as determined by a mental health nurse, it was argued that defining a 'personal recovery' demands a more concerted approach:

> Because we always say, and it may sound like a sound bite but and how they feel. We don't know what it, well most of us don't know what it feels like to have a mental illness, to have experienced psychosis and stuff, so you really have to listen to your clients. [Laura – Community Mental Health Nurse; semi-structured interview]

This view places the person as ‘the expert’ of their recovery rather than the mental health nurse. Such a position not only shifts the power dynamics between the caregiver (mental health nurse) and the care receiver (the person) but adds further uncertainty to the meaning and applicability of recovery in practice. Recovery, as an individually defined concept, was acknowledged by participants as being wide open to debate and interpretation, with various ‘personal’ meanings of recovery, that may or may not be conducive to one another:

> So I think, you know, and I think that's, that's why I think the recovery, the idea of recovery is quite interesting isn't it because actually, because actually it's going to mean something different for everybody, some patients' relatives will have that expectation that the patient's going to go back to how they were before. [Mandeep – Nurse Executive; semi-structured interview]

As highlighted in the quote above, recovery is not only defined by the person, mental health nurses and mental health services. The person’s family and loved ones will also have their conceptualisation and aligned beliefs of what recovery should look like. With its multi-dimensional nature, determining the ‘correct’ meaning of recovery, in this context, may present s significant challenge.

Within a myriad of potentially competing perspectives and expectations, one participant argued that nurses should focus on supporting the individual needs of the person. In this sense, empowerment and shared responsibility were seen as a conduit enabling recovery to be more owned by the person rather than mental health nurses, services, families and loved ones.

> I think always it’s about any model, and particularly my understanding of the recovery-based model, is about keeping that focus on individualised care; but of the empowerment and the responsibility of the person receiving the care, they’re part in it. [Sian – Nurse Executive; semi-structured interview]

Several other participants drew out the idea of individualised care: “it’s really about that person defining recovery and it’s a very individual process” [Marcia – Community Mental Health Nurse; semi-structured interview]. The added suggestion that recovery is a process rather than a distinctly identifiable outcome or intervention was echoed across the dataset: “Recovery for me is a process, it is, definitely not the start or the end of a

treatment or a, a, well the care that is being delivered". [Kyle – Community Team Manager; semi-structured interview]

Despite recovery being referred to by several mental health nurses as a process without a clear beginning or an end and a clear outcome, this was not universally depicted by all. One participant suggested that the process is still indicative of striving towards being objectively well, pessimistically viewing recovery as something possible when the person has the 'right support' in place:

> An ongoing thing and you'll have blips which is to be expected but as long as you can pick yourself up and move forward with the appropriate support, then I think it's feasible to be maintained to some extent. [Laura – Community Mental Health Nurse; semi-structured interview]

Another participant argued that recovery as a process continues beyond the person's engagement with and support from mental health services. Their argument reaffirmed the idea that promoting empowerment and shared responsibility is vital for enabling the individualised and personal nature of recovery:

> And the recovery process, we do not see it all the way through though, we enable a client, or a patient to take control of their own illness, and see the final stages of their recovery, independently from our services. [Kyle – Community Team Manager; semi-structured interview]

Just look at the person

The previous section outlined two interrelated yet contrasting concepts of recovery: an objectively measurable outcome vs an individually defined process. Participants' understandings often held components of both perspectives when attempting to explain the meaning of recovery. For example, participant Laura emphasised the need for an individually defined recovery ("they're the experts of their experience"), while also suggesting that recovery, as an outcome, is achievable "with the appropriate support" from mental health services. Participants' understandings of recovery can be seen more on a continuum rather than being aligned to either 'contrasting' concepts.

Several participants strongly aligned their views with the idea of recovery as an individually defined process, often rejecting the suggestion that recovery is an objectively

measurable outcome. In such circumstances, participants viewed the mental health nurse's role as an enabler of a person's recovery[5].

Seeing persons as unique and individual people beyond diagnosis and symptoms was argued to be core to implementing recovery-orientated nursing practices and a premise for initiating the enabling role of the mental health nurse. Viewing the person as an individual with a past, present and future were believed to be fundamental in assisting nurses to become enablers of recovery:

> So in order to improve recovery you need to understand… Who the person is. …who the person, exactly, the person. Not the condition, 'You're just EUPD'[6], or, 'You're just somebody that is depressed', or, 'You are somebody that's schizophrenic', just look at the person, look at their past, their careers. What's going on for you right now? Why is that impairing you to have a good quality of life? [Rosemarie – Community Mental Health Nurse; semi-structured interview]

Assessment, a core tenet of nursing practice, was where recovery-orientated nursing practices begin. Enabling the person to articulate 'their goals', was regarded as a means to capture recovery as an individually defined process:

> I guess when we do the initial assessment we try and find out what their goals would be, what they've done in the past, where they can see themselves in the future and then once we start working with them it's about maybe setting short-term goals. [Gary – Community Mental Health Nurse; semi-structured interview]

A particular emphasis was placed on setting short-term goals, rather than aiming for longer-term outcomes. By setting short-term goals, participants believed the person and nurses could identify and address critical needs while enabling the process of recovery to continue beyond the support of mental health services:

> I think hopefully most people realise that actually, we're not, it's not always possible to get someone back to exactly where they were before, but actually, it's trying to find the place where they can get back to, to get on with their life that's the best place than they have

[5] supporting relevant persons to make, or participate in making, decisions relating to the care or treatment to the maximum extent possible (HSCA, 2008, Regulations 2014; Section 9 (d))

[6] EUPD: *Emotionally Unstable Personality Disorder*

> been, that's probably, that's probably quite critical. [Mandeep – Nurse Executive; semi-structured interview]

Within the context of 'unwise decisions', there is a high possibility that such individualised goals will not always align with nurses' views or fit within the scope of mental health services. Exploring this potential arose the concept of positive risk-taking:

> I think it is about, you know, positive risk-taking, it is about you know, taking into account capacity, allowing people to make unwise decisions. [Marcus – Community Team Manager; semi-structured interview]

As outlined in the first section of this chapter, noncompliance with treatment, namely medication, was seen as an 'unwise decision', that could lead to a crisis and the need for a mental health service intervention. A person setting a goal to stop taking their prescribed medication may pose a moral or ethical dilemma for nurses. Nevertheless, a participant explained how nurses and mental health services have the tools to enable such a choice to be taken. Nurses have the scope to offer interventions other than medication to enable the person to achieve or pursue their individualised recovery:

> So, if clients say to me, 'I'm just going to stop taking medication,' I would say, 'Well, that's against our advice to do so, but ultimately it's your choice,' but we would put other things in place by increasing contacts, speaking to family members and stuff like that just so that we, yeah, keep a closer eye on things, because we've taken a treatment away. [Marcia – Community Mental Health Nurse; semi-structured interview]

Instilling hope

Tentatively, without apparent meaning or application, mental health nurses practising in the inpatient setting implied the idea of 'hope' as being associated with recovery-orientated nursing practices: "Introducing hope to them isn't it?" [Fredrick - Staff Nurse, Inpatient; focus group]; "Yeah, just, yeah, giving them hope" [Ashley - Staff Nurse, Inpatient; focus group]. Providing additional meaning and context to the term, community-based mental health nurses argued that instilling 'hope' was central to the implementation of recovery-orientated nursing practices:

> For me, I believe recovery is not a cure, but it's someone giving hope to somebody, because when someone doesn't believe they're going to recover, it's going to be hindering their movement, their performance, their cure, their process of gaining their day-to-day activities. [Rowena – Community Mental Health Nurse; semi-structured interview]

The perceived 'enabling principles': seeing the person as an individual, setting short-term goals, and promoting choice through positive risk-taking, were reported by mental health nurses as being central to the implementation of recovery-orientated nursing practices. Once aligned towards these 'enabling principles', it was argued that nurses must set out to instil hope in the person:

> Then, with those principles in mind, you as a nurse have to sell the idea of 'it is possible', and that's your role, to sell and convince that it is possible for you to get better and it is how you do that. [Katie – Nurse Executive; semi-structured interview]

Regarded as fundamental to the implementation of recovery-orientated nursing practices, when aligned with the 'enabling principles', 'instilling hope' was not seen as an arduous task requiring specialist training:

> That instilling hope and guidance, I don't think they are massive skills, I don't see them as big training needs; we ask the question what do you want out of your care and treatment, how can I help you, where would you like to see yourself in 2 hours' time, two days, two years, whatever? [Anthony – Nurse Executive; semi-structured interview]

Who am I to say you're on an 'eight'

Mental health services and the mental health nurses who practice within them must evidence the impact of their care. Outcomes are key indicators used to measure the efficacy of interventions and treatment. If recovery means something different to each person and is the process of achieving personal goals rather than a clinical outcome, how do you measure recovery-orientated nursing practices?

One participant argued that recovery-orientated nursing practices can be evaluated using HoNOS (Health of the Nation Outcomes Scales)[7], a measure of the health and social functioning of people with severe mental illness:

> That's what HoNOS does, that's what a recovery principle is: how can I get this person to function at a level where its 1. They are getting better, they don't have to wait to get better fully before they move on, they look at it as a whole process as long as they are safe, they

7 Health of the Nation Outcome Scales (HoNOS): https://mentalhealthpartnerships.com/resource/health-of-the-nation-outcome-scales-honos/

> have somewhere to live and they have some support and they are willing to work with you [Katie – Nurse Executive; semi-structured interview].

Conversely, other participants disagreed with the appropriateness of using measuring tools to assess recovery-orientated nursing practices. There was an evident ethical and moral conflict amongst those who disagreed:

> Who am I to say you're on an eight and not a two? For me that was completely conflictive, and some models in recovery for me are very… [Rosemarie – Community Mental Health Nurse; semi-structured interview].

The concerns around quantifying progress and success were expanded to include other measuring tools such as the Recovery Star (Triangle Consulting Social Enterprise, 2021), often used in the context of rehabilitation and recovery services. The key argument from this participant was that not all persons will see recovery as a progression towards further independence. The realisation and acceptance of their new limitations, brought on by mental illness, may instead be their individually defined recovery process:

> I think sometimes we have like, even when we use the Recovery Star I felt a little bit uncomfortable about some aspects of it because it felt like we were quantifying success on one scale. Whereas you know, success for some people is living in more supported accommodation, and not going back to work, you know, that is success, that is their quality of life. [Marcus – Community Team Manager; semi-structured interview]

Although argued as not able to measure recovery as an individually defined process, outcome measures were seen as something that can be beneficial for some, enabling the person to see how their mood and symptoms have changed over some time:

> I say it measures recovery? No. I would say it more measures how someone is feeling, how the past week has been" [Laura – Community Mental Health Nurse; semi-structured interview]; If you can show, you know 'this is what you were then, this is what you are like now', it really hits home [Laura – Community Mental Health Nurse; semi-structured interview].

To promote job satisfaction and a sense of worth, it was pointed out that nurses need to see and be able to articulate the effects of their care and support. Observing changes in the person's presentations or seeing them reach their achievements or aspirations, were ways in which outcome measures may play a role in informing the implementation of recovery-orientated nursing practices:

> I mean actually getting paid at the end of the day is really important, but actually it's really important to see things happening with patients and carers that you think 'actually I feel proud of that', or 'actually I think that's really positive' or 'I think that's really something that drives me forward' and actually that's, that's really, that's really important. [Mandeep – Nurse Executive; semi-structured interview]; definitely, definitely informs recovery, because it helps the professional" [Laura – Community Mental Health Nurse; semi-structured interview].

Enshrined in nursing for many, many years

Unique to the participant group of nursing executives, some saw recovery, in its abstract sense, as an established organisational philosophy underpinning all nursing practices:

> We have this philosophy around what we're doing in the directorate and everything we do is based on those ideas about person-centred care so. [Andy – Nurse Executive; semi-structured interview]

Recovery, as a philosophy was also not regarded as a 'new concept', but rather seen as the rephrasing or rebranding of historic and contemporary nursing approaches; the tenets of which were believed to have already been embedded within mental health nursing practices:

> I think it's, you know, it's something that's not new, something that's been, I think it's been something that's part of nursing, it's just that we've been framing it as recovery more recently, but I think it's something that's been enshrined in nursing for many, many years. [Mandeep – Nurse Executive; semi-structured interview]

It was claimed that a recovery philosophy underpinned the Trust's primary aims and objectives. Organisational support for the implementation of the 'enabling principles' was said to be set out within the Trust's strategic priorities:

> So when I think about recovery-orientated nursing, its actually the bread and butter of what we are trying to achieve, so look at our quality priorities, and we have our patient promise, we have our four must dos, we have our personalised care planning, we have our outcomes. [Anthony – Nurse Executive; semi-structured interview]

Conversely, another nurse executive leader argued that the 'enabling principles' are often impeded by competing for organisational priorities within mental health services. They aligned to the idea that other service-level targets can create a culture that hinders the implementation of recovery-orientated nursing practices :

> So the Trust says that I need to look at their wellbeing, I need to look at their risk assessment and all that ties in with mental state. If I've done all that, ticked all those boxes I have finished, now you are working for the Trust, you are not working for the patient, you need to change your paradigm, you need to change your focus to one that you are here for the patient. [Katie – Nurse Executive; semi-structured interview]

Despite some nursing executives seeing recovery as a philosophy of practice already embedded Trust-wide, it was regarded by others as an ambition rather than a current reality. In this instance, nurse leaders highlighted the existence of a potential implementation gap from strategy into practice:

> But, I'm not naive, it's how we are aspiring to do things. So, what is the gap between what we are aspiring to do and between what we say we are doing, and actually how people translate that into practice? [Anthony – Nurse Executive; semi-structured interview]

Theme 2: Internal and external factors that influence recovery – in and beyond control

There was a broad consensus amongst practice-based nurses that organisational targets are often non-conducive to implementing recovery-orientated nursing practices: "a lot of targets and I think it's all about target-orientated practice right now than recovery-orientated practice" [Olu - Charge Nurse, Inpatient; focus group]. Some of these perceived issues are situated and influenced at the micro (practice) and meso (organisational) levels. Others are beyond the control of nurses, or the organisation, positioned within macro system level and seemingly constrained by opposing sociopolitical priorities.

Participants predominantly use the interviews and focus groups as a means to air their frustrations within their places of work. As such, the reporting of barriers towards influencing recovery-orientated nursing practices was more prominent than enablers. The subsections below start with the two enablers described by participants, followed by seven perceived barriers.

An enabler: family and carers

Nurses described holding prejudice against the persons who may present with issues considered to be 'behavioural', rather than a symptom of a diagnosable mental illness. In such circumstances, nurses may implement non-conducive practices to the person's recovery. Families and carers were therefore seen as a vital resource in helping nurses to better understand the person as an individual and provide care that is tailored to their specific needs:

> Because I'm seeing some patients now who to be honest they don't have any psychotic symptoms at all, they are just very abrasive, very angry, very rude, and confrontational, and you just think, it's behaviour, but the family will tell you this is the mental illness, that when that… when they're well they're the sweetest people you can find. [Annette - Charge Nurse, Inpatient; focus group]

The persons may be unwilling or unable to provide information, at the point of assessment, that would help nurses understand their individual needs and circumstances. In these instances, nurses identified the importance of involving families and carers to enable the implementation of recovery-orientated nursing practices :

> We recognise that, you know, the role of carers and loved ones in terms of recovery and relapse rates and the role… the key role that they play in terms of influencing the outcome of somebody's recovery. [Marcia – Community Mental Health Nurse; semi-structured interview]

> Sometimes we've never met this person ever, and then we see them when they're very unwell, but the family or even like support staff, if they're in supported housing, can tell you. [Martine - Staff Nurse, Inpatient; focus group]

Nurses reiterated the importance of involving families and carers during the care and treatment process through to discharge. Nurses reported to involve families and carers, alongside relevant mental health services, during the discharge planning process:

> Before they get discharged it's like an MDT process, where you'll get the families involved, we get the home treatment team involved, we get carers and all these people coming together and they know we're going to be discharging them. [Sara - Staff Nurse, Inpatient; focus group]

Nurses' engagement with families and carers reportedly helped to identify and address some of the social needs of the persons that could have otherwise been overlooked.

Offering guidance to families and carers on how to support their loved ones at home, was believed to promote recovery beyond hospital:

> we try to liaise with the relatives, and come, you know, we do hold a lot of meeting, counselling, and advise from there, if they can live with them, so we've discharged to them, to their, to look after them, and they'll check on them to see how that is going, and make sure that we still support them while they are still with the relative or whoever our… [Ashley - Staff Nurse, Inpatient; focus group]

In the cases where the persons received community service input, continued family and carer involvement beyond hospital was seen to enhance relationships between professionals, the persons and those closest to them at home:

> I find that working with people, helping them to understand and also trying to get knowledge from them, you know, saying we need you to help us, you're really valuable and making people feel informed and part of the process, has really, really helped. And we've had quite a bit of feedback on the work we've done with carers and it's all been really positive, I'm very, very proud of that. Very proud. [Marcus – Community Team Manager; semi-structured interview]

An enabler: make sure that it's a smooth transition

The discharge planning process was considered important for a the person's successful transition from hospital into the community. It was noted that discharge planning encourages nurses and others to think about the short-term continuity of care once a person leaves the wards:

> Just making sure that they're ready to go on the day, making sure that they've got somewhere to go, they've got housing, and then follow-up for 48 hours, and then seven-day follow-up, and who's going to be seeing them in the community, just to make sure that it's a smooth transition into the community. [Rebecca - Staff Nurse, Inpatient; focus group]

A lack of engagement from care coordinators was reported to be an often-occurring issue in the inpatient setting; delaying people's discharge from hospital and becoming a barrier to the successful implementation of recovery-orientated nursing practices: "some CCOs don't turn up and then nothing is ever done because the CCOs are not coming for the ward rounds" [Agnieszka - Charge Nurse, Inpatient; focus group].

On the contrary, poor communication and engagement within and from inpatient mental health services with community services was identified as one of the reasons the persons may not receive the required community support:

> And sometimes another thing is you ring the ward and say "oh I'm coming to assess the guy at 3", you turn up at 3 o'clock, "oh they've gone on leave, they're not coming back for two days", "but I rang to say that I was coming", "oh it wasn't handed over to us". So communication can be…[Laura – Community Mental Health Nurse; semi-structured interview]

Although nurses saw bed management as a potential barrier to implementing recovery-orientated nursing practices, it was noted that bed-management 'huddles'[8] did at times enhance communication between services and support the discharge process. It was felt that speaking with people face-to-face helped overcome some of service barriers and address unnecessary delays in discharge:

> Yeah, quicker, whereas before it was just email ping-pong, but now we've actually got people sitting there, and you can actually, even sometimes it doesn't need to be in the meeting, maybe after when you come out you can just say you've just got these few bits and pieces, can you just clarify them for us, and that they normally do. [Annette - Charge Nurse, Inpatient; focus group]

Although these perceived barriers may affect those who have an existing care coordinator when in hospital, nurses reported an excessive delay in the allocation of care coordinators for the persons newly placed under CPA:

> I think when you refer a patient for care coordination you need to probably get a response maybe between one week or something like that, instead they tell you, you have to chase them up and then they tell you, oh it's going to take about four weeks before the patient could be allocated. [Ibrahim - Charge Nurse, Inpatient; focus group]

The delay in allocating new care coordinators was a consensus among participants, attributing the issue to a seemingly extensive waiting list: "We get a lot of referrals, at the moment we get around 50 people waiting allocation for care coordination" [Rosemarie – Community Mental Health Nurse; semi-structured interview].

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[8] Huddles were explained as management meetings, focusing primarily on overcoming operational barriers to discharge.

Primary care mental health services act as the gatekeepers to the broader community mental health services, screening referrals before sending them on to the relevant teams. Although ostensibly simplifying the structure of the referral process (one point of access), this extra layer of screening, followed by the secondary screening from the relevant mental health teams, with possible re-referral if deemed unsuitable, seemingly contributed to an unnecessary wait in the allocation of a care coordinator:

> Allocation of care coordination, which tends to take maybe like three weeks, four weeks before they allocate a care coordinator from various teams in the community [Ibrahim - Charge Nurse, Inpatient; focus group]; Referrals take weeks, so the time we discharge a patient, thinking, okay, he'll have a community team to help them, they can say this person is not suitable for our service. [Agnieszka - Charge Nurse, Inpatient; focus group]

A seeming knock-on effect of the delayed referral process and increased pressures on inpatient services meant that participants were seeing an increase in the number of what they deemed as 'inappropriate referrals':

> And sometimes it feels as if because we're quite an efficient service the wards refer everything to us, especially when they want to discharge a client, it's like "refer it to early intervention, they will take it, they will come and see the client immediately". [Laura – Community Mental Health Nurse; semi-structured interview]

> Because of the, you know, the pressures on services at the moment and like you said, the time-limited constraints, we find people are often referred to us that don't really have clear rehab goals. [Marcus – Community Team Manager; semi-structured interview]

Care coordinators who were actively involved, were seen as enablers towards the implementation of recovery-orientated nursing practices, supporting people's transition from hospital into the community: "because they've been allocated a care coordinator, they help them a lot, they feel much better" [Lydia - Charge Nurse, Inpatient; focus group]. Nevertheless, even when people are discharged from the hospital with a care coordinator in place, they can still relapse, end up in crisis and return to the hospital:

> And we find that sometimes before patients are brought back from the community, after relapse, I think sometimes they've gone too far and you wonder this person had a care coordinator, and has relapsed this much, why, you know? [Annette - Charge Nurse, Inpatient; focus group]

Nurses explained how only some patients will be deemed appropriate for aftercare support or be suitable for the allocation of a care coordinator. In these instances, nurses

highlighted other enablers for implementing recovery-orientated nursing practices. Social engagement was viewed as an essential aspect of people's recovery. Community activities, voluntary work and mental health charities were seen as enablers of social engagement, supporting recovery outside of mental health services, helping to reduce the occurrence of relapse:

> Sometimes we refer them to Mind, to attend some groups with Mind, because some of them are just isolated and wish then to bring them back to the ward, yeah, so and some people even could prevent relapse, you know, so if you get them into like social groups in the community, this could prevent relapse. [Ibrahim - Charge Nurse, Inpatient; focus group]

It was felt that much of the support provided by formal community mental health services could, and should, be provided by Primary Care services (i.e. GP). However, mental health nurses explained how GP practices are not supporting the administration of depots (medication via injection). It was reported that there are the service users who would not require the support of mental health services if the appropriate primary care provisions were in place:

> The Depot thing is the main thing because the amount of clients that we could probably discharge to the Depot clinic or that we will discharge to the Depot clinic but really it's just so they can have their injection, it's not because they need to see a mental health nurse or a mental health person. [Gary – Community Mental Health Nurse; semi-structured interview]

A barrier: managing risk

Nurses believed that 'the culture' within the Trust was often too risk-averse when identifying people's admission suitability; admitting people who, in their view, were not posing substantial risks to themselves or others. A risk-averse culture was viewed as a barrier towards implementing recovery-orientated nursing practices; believing people's mental health needs could be hindered by admission to an acute inpatient setting rather than supported:

> I mean sometimes I do find like the home treatment team, or the liaison team tell us, "I've got this patient, he needs admission," and you listen to them and you think that that's not a rationale for admission, that's not suitable, but who wants to take that risk, nobody wants to take that risk [Annette - Charge Nurse, Inpatient; focus group]

Empathising with a situation where a person may threaten harm to themselves, nurses felt that they would more than likely admit a 'risky' person, even if doubting their suitability for a hospital stay. In this context, the influencing factor of language (terminology of risk) may dominate empirical evidence:

> And this client, when you've got repeated admissions, from this client, they know the right things to say, they know the right words to use, and at the end of the day if I'm going to be very honest, once the client comes to me and say, "I want to kill myself right now", I would do that, even though I know that I'll be scared of saying, look, let me refer you to Home Treatment Team, because I don't know what's going to happen next, next minute. [Olu - Charge Nurse, Inpatient; focus group]

The perceived ability to influence admission and the perceived rationale for admission (difference in opinions) appeared to influence the delivery of recovery-orientated nursing practices. It was stated that risk-averse practices can negatively impact how nurses view service users. The service users perceived to be unsuitably admitted under the precedence of a risk-averse decision appeared to be attributed with a level of blame for their role in the process:

> They will say all the right thing to make them admitted, and once they get admitted everything they actually said is not being observed, at all, and we're thinking why is this person here, you know, it's like they just come on the ward, they just want to be there. [Lydia - Charge Nurse, Inpatient; focus group]

Meso-level organisational demands were also seen as barriers to implementing recovery-orientated nursing practices at the point of discharge. Nurses reported experiencing pressure to move people out of the hospital: "gatekeepers, the bed managers they just think that client is ready for discharge, discharge, and that's the honest truth" [Olu - Charge Nurse, Inpatient; focus group]. It was felt that people were often discharged with unmet needs, needs that cannot be met within the boundaries of community mental health services, leading to relapse and readmission:

> I feel like the senior managers sometimes make things worse for clients because they've got this "all beds you need to go, all beds you need to go, all beds you need to go", that affects recovery because a client might be an inpatient, on an inpatient admission and before you know it they're discharging, you're like "what?" And two weeks later they're back in hospital because "we're clearing the beds, we're clearing the beds, we need a bed, this person needs to go, this person needs to go". [Laura – Community Mental Health Nurse; semi-structured interview]

It was noted that the ultimate decision to discharge the persons remained with the consultant psychiatrist and MDT. Nevertheless, bed management's presence and perceived drive inevitably influenced clinical decision-making. This highlighted a possible four-way conflict between the person, admission team, home treatment team and inpatient nursing team:

> I think so, because I think they influence, I'm not saying they discharge, but they do have an influence because obviously if you are the service manager and you need the bed and you are telling the consultants that you need the bed and what to do? In my view I think you are interfering really, because the consultant needs to make that decision independently, without you saying… [Lydia - Charge Nurse, Inpatient; focus group]

A barrier: it's all social issues

An everyday discourse amongst nurses was around the influence of socioenvironmental factors on people's mental health, seemingly a macro-level issue beyond the control of mental health nurses. Nurses argued that most admissions to inpatient settings were underpinned by more complex social needs rather than the care and treatment of a mental illness. Such a shift was seen to jeopardise the established crisis-orientated paradigm of inpatient services:

> I'm seeing, to be honest, about 60, 70% of my patients are not crisis patients anymore, if not more. It's all social issues. So gone are the days when we'd call it acute… if I could stand up now and kick the patients off my ward, I'm telling you, about 65% of them would be off today, because they're not crisis patients, they're social issues, patients. [Annette - Charge Nurse, Inpatient; focus group]

The way services are designed, in line with priorities set out by commissioners, was seen as another constraint on recovery-orientated nursing practices. Participants believed it was within their control to address some social issues. However, participants reported an inability, due to capacity issues, to respond to the needs of the persons that sit outside the boundaries of commissioned services:

> The first thing that springs to mind is CCG priorities and the way services are commissioned. Because quite often we are a bit tied down with what we can offer because it is what commissioners are paying for. Like we don't have the capacity to, we don't have the freedom to manage things. [Sian – Nurse Executive; semi-structured interview]

It was highlighted that nurses often struggled to evidence the impact socioenvironmental factors can have on people's mental health. This statement rings true to the challenges nurses face when defining and evidencing the highly-individualised nature of recovery-orientated nursing practices. It was argued that focusing solely on access to mental health services, while addressing the person's 'functional skills' limits the implementation of recovery-orientated nursing practices:

> It is kind of evidence-based things, so you know an example would be, engrained in our culture are things like people need to be kept access [to services], they are focusing on their daily living skills, nobody ends up in a place like this [mental health services] just because they have a psychotic breakdown. There is always something else there like housing or whatever is going on at the time. [Yaw – Nurse Executive; semi-structured interview]

Substance misuse, dysfunctional families, poor social networks, inadequate housing and access to public funds were seen as challenges to recovery, beyond the direct control of mental health nurses. When people's social needs remain unaddressed, it was felt that the implementation of recovery-orientated nursing practices was often impeded. With nurses unable to implement 'holistic' recovery-orientated nursing practices, the persons can leave the hospital with unmet complex social needs. Once their clinical symptoms and risk levels had reduced, they had been discharged back to the unchanged social environments that contributed to their crisis:

> Most of our clients are coming with alcohol problems or substance misuse problems [Rowena – Community Mental Health Nurse; semi-structured interview]; Because when they are in the community, they still go in the same crisis, you know, their friends, and their, you know, their relatives that they have, so the same, somebody might smoke cannabis and it, you know, disturbs the person. [Ashley - Staff Nurse, Inpatient; focus group]

Again, as a macro-level issue, having access to appropriate housing was considered a fundamental need that could significantly enable or impede someone's recovery beyond the hospital. It was believed that the length of time it takes to acquire appropriate accommodation often resulted in a delay in people's discharge from the hospital, contributing to relapse when people are already at the point to move on:

> I think most important thing is the housing, if that can be, if that can be more organised, efficiently, that would be one of the… that will, you know, solve most of the problems of our patients…[Ashley - Staff Nurse, Inpatient; focus group]; you're looking for housing, supported housing, high, medium, low, and that takes a lot of time which means that the

> person is on the ward for a lot longer, which could then mean that they might be in recovery but then they could start to decline again because of how long they've been on the ward. [Martine - Staff Nurse, Inpatient; focus group]

A barrier: in a state of deescalating all the time

At the micro-level, the presentation of acutely unwell service users was seen to be a barrier towards the implementation of recovery-orientated nursing practices; where the higher demands of some can hinder the care of others:

> So you will find that the more vocal ones are taking about almost all the staff that are attending to the one patient, and then the other patient that's acutely unwell, because they're not making noise, or they're quiet, they tend to be forgotten, because they're not causing any trouble. [Reginald - Staff Nurse, Inpatient; focus group]

When the persons are acutely unwell, nurses report prioritising de-escalation to maintain safety within the service. Nurses felt that they can sometimes be "in a state of deescalating all the time" [Annette - Charge Nurse, Inpatient; focus group], taking nurses away from other activities and tasks, focusing on safety and risk management:

> If the ward's unsettled then you're running from the paperwork that you're meant to be doing to go and deal with someone who is just being aggressive, and then you've got to deal with that, possibly give them PRN, just as an ongoing priority. [Martine - Staff Nurse, Inpatient; focus group]

Within their control, nurses believed it paramount to have "protected engagement time" [Rebecca - Staff Nurse, Inpatient; focus group] with the persons during every shift. Prioritising protected engagement time was seen to put nurses in a position to provide preventative support to disturbed persons to "minimise the risk of aggression" [Lydia - Charge Nurse, Inpatient; focus group].

It was felt that 'therapeutic observations', used to monitor risk and presentation, can allow nurses to formally prioritise and focus on the person engagement, where nurses are less likely to be disturbed by other service demands, focusing instead on implementing recovery-orientated nursing practices:

> I know the one that enables to do our proper work is the observation one, which I know is quite good because now we are doing it, it's admittedly it doesn't have to be set time, 15 minutes, it doesn't have to be… but it could be in-between ten, so you know? [Olu - Charge Nurse, Inpatient; focus group]

The care of the persons within an environment that restricts people's liberties through detention under the Mental Health Act (1983), was seen to be another time constraint and influence for increased distress of service users:

> So on a ward of 20 patients, you find that 15 of them have escorted leave, 30 minutes, an hour to get… and then you have to do this because if you don't they'll keep knocking, and they'll keep knocking. [Annette - Charge Nurse, Inpatient; focus group]

Within their control, yet seemingly acting as bystanders (blaming meso-level constraints), nurses believed services needed to support more planned outings, where nurses take groups of service users off the unit to engage in meaningful community activities. Reminiscing experiences of a previous practice setting, it was believed that such interventions reduce other constraints on nurses, freeing up time to enable the implementation of recovery-orientated nursing practices:

> But it does work in other units, and then the patients come back, and they're a lot more cheerful, it reduces the challenging behaviour down on the ward, and the ward is much more settled, and you can get stuff done, and the patients you can deal with the backlash because there's less patients to be dealing with [Martine - Staff Nurse, Inpatient; focus group]

A barrier: untenable service demand

A macro-level challenge, there were reports of increasing demands placed upon mental health services: "8 years ago you will have probably 200 referrals from A&E at any given month, now it's nearly touching at 400 a month so it's kind of doubled in terms of demand…" [Mitchell – Community Team Manager; semi-structured interview]. A lack of adequate staffing to meet these increasing demands was highlighted as a barrier to the implementation of recovery-orientated nursing practices:

> Staffing, or sometimes you have got two [assessors] a shift, we have got four assessments, you are rushing yourself to do a good assessment because the time is limited, you cannot run away from that. [Rowena – Community Mental Health Nurse; semi-structured interview]

Inadequate staffing, as a barrier to implementing recovery-orientated nursing practices, was also seen to be indicative of the size of the team caseload. The higher the caseload, the less recovery-orientated nurses felt able to practice, impacting upon individualised and person-centred outcomes:

> So we will prioritise medication, diagnosis, but that very rarely matters to people, what matters is that they have what most of us want, decent housing, good relationships, enough money, quality of life and those are the things that we work on. [Marcus – Community Team Manager; semi-structured interview]

Regardless of the quality of the assessment and subsequent care planning, nurses testified that when caseloads exceeded what was thought to be manageable, work pressures increased. Nurses were no longer implementing recovery-orientated nursing practices:

> You do a good care plan but you sometimes might not be able to fulfil that because the pressure is just far too much, and got huge caseloads, and then we need to kind of move people quite quick. [Rosemarie – Community Mental Health Nurse; semi-structured interview]

Citing their use of agency to cover staff shortages, nurses explained how the challenge is not only about the total number of nurses available on each shift, but has more to do with the specific skills, knowledge and experience required to support the implementation of individualised recovery-orientated nursing practices:

> There's something about having the right, having the right people, it's the right people in the right place with the right skills delivering the right care which is really quite critical isn't it. [Mandeep – Nurse Executive; semi-structured interview]; Sometimes it's difficult for agency staff to be, you know, to know the patient for just one day [Ashley - Staff Nurse, Inpatient; focus group].

The value of having consistency within teams and nurses who know the service user was noted as an enabler for implementing recovery-orientated nursing practices at the micro-level. Taking time and regularity to develop, the therapeutic relationship between nurses and the persons was seen to be a necessity for implementing recovery-orientated nursing practices:

> If you've a relationship with someone's poor or non-existent you're probably not going to go very far at all, in actual fact, there's a good chance you're not going to go anywhere, so it's that, that's the one critical thing in terms of nursing is, for me, is actually how do you make that connection with somebody and what is it about that. [Mandeep – Nurse Executive; semi-structured interview]

Workload pressures were noted at all nursing levels of the Trust. Tasks such as workforce management (i.e. "recruitment, sickness management, managing the safe staffing – reporting on safe staffing") took leaders "away from where care is being delivered, so you

are inevitably influencing that care less." [Yaw – Nurse Executive; semi-structured interview]. Due to increased workloads and insufficient staffing, nurses were burnt out, resulting in sickness and further pressure on services:

> Yeah, we're stretched everywhere now, it's stretched, it's too much and a lot of sickness, staff being burnt out and, yeah, calling out sick, and the rota then agency will come in, tell them the story again, yeah. [Ashley - Staff Nurse, Inpatient; focus group]; It's all about resources, if one goes off sick, it affects everything… [Rowena – Community Mental Health Nurse; semi-structured interview]

There were deep concerns over the reduction of 'therapy staff', in particular psychologists; viewed as being able to help identify and address people's psychological needs. Nurses highlighted that the majority of "patients need psychological therapy" [Reginald - Staff Nurse, Inpatient; focus group] but were not having this need met during their admission:

> I think I more or less agree, that's my bug bear, the lack of therapeutic engagement, lack of psychological therapy, that is person-centred though, and you walk into a ward you expect to find that, and that's the last thing you see, when oh no, there is a psychologist, and you're already getting discharged at this point. [Fredrick - Staff Nurse, Inpatient; focus group]

Nurses were asked if they could address the shortfall in psychological interventions. Several nurses believed that this was not practical within their current roles, outlining the impact implementing formal therapeutic interventions would have on an already stretched workforce:

> Yeah, or if we had more staff to it, but again therapy is different, you then have to say to your colleague, oh sorry, I cannot be around for an hour or two, I need to deal with this, which is really not practical in the ward, yeah. [Reginald - Staff Nurse, Inpatient; focus group]

Some nurses believed the Trust would not support them to gather the required skills and knowledge to enable them to address the psychological needs of the persons formally: "…training and the resources, DBT, CBT or any baseline, you can't, [the Trust] won't do it" [Fredrick - Staff Nurse, Inpatient; focus group]. Conversely, other nurses stated that they did receive formal training to equip them to meet the psychological needs of the persons:

> Colleagues have been trained in family intervention and they're also trained in CBT so you don't necessarily have to be a psychologist, well we don't have enough psychologists for only the psychologists to undertake these interventions, so you are invested in and you feel

> valued and if you feel valued then you're going to pass it on to your clients. [Laura – Community Mental Health Nurse; semi-structured interview]

There was an apparent culture within clinical teams, as well as at the meso-level of the Trust, where the work of nurses is measured against the completion of measurable tasks. The tasks of the shift and meeting service expectations were seen to take precedence over the delivery of individualised recovery-orientated nursing practices, emphasising nurses loss of control to direct their practice autonomously:

> And there's a thing, like because of the way they [managers] want us to work, like what create… let everything just happen that first, like she might be having therapeutic conversations with clients, my view might be like oh she's so lazy, she just wants to talk to the clients, when she's meant to be doing this, according to policy seven o'clock and eight o'clock. [Olu - Charge Nurse, Inpatient; focus group]

A barrier: competing professional paradigms

Within their practice, nurses reported barriers towards implementing recovery-orientated nursing practices underpinned by competing professional practice paradigms. Influenced and directed by the dominance of psychiatry, participants believed that many mental health nurses are over-reliant on the use of pharmacological interventions, in treating and reducing the symptoms of mental illness:

> What we are just doing is medication management, managing our clients' core symptoms, and just discharging, so sometimes the consultants don't even know the client. [Olu - Charge Nurse, Inpatient; focus group]

As a standalone intervention, pharmacological treatments were regarded as non-conducive to recovery. The possible implications for service users' physical wellbeing were noted: "We talk about recovery but actually that's a really stark thing, we give people medications that increase their chances of cardiometabolic risks" [Mandeep – Nurse Executive; semi-structured interview]. Focusing purely on medication management was seen to impede the creation of therapeutic relationships between nurses and the persons:

> So people were going round and inspecting medication or people were bringing it in and showing the boxes, which I can see the value you know when you're looking at concordance and medication management but, it has to be part of something else, otherwise, it feels like a 'we don't Trust you'. [Marcus – Community Team Manager; semi-structured interview]

It was also believed that recovery determined by the reduction of symptoms through medication concordance was an inadequate way to measure and promote the person's recovery beyond the hospital:

> I don't think if we're talking about true recovery that's recovery enough, because it's just like we're getting them to a level and get, push them to the community, get back to the same condition and come back. [Sara - Staff Nurse, Inpatient; focus group]

With psychiatrists making the majority of critical clinical decisions, particularly in the acute inpatient setting, the so-called 'medical model' was seen to be the predominant paradigm underpinning nursing practice. In this context, the measure of recovery readiness is from a biological perspective rather than a biopsychosocial perspective. Although seemingly a micro-level issue, this is another example of nurses losing power and control. Participants argued that without a shift towards more holistic thinking, moving away from a medicalised model of care, the implementation of recovery-orientated nursing practices will continue to be challenged:

> We see that from a doctor's perspective, because they are not on the day-to-day floor with these clients, they just think do these things, medicate them, refer them. Clients can never attain full optimum functioning if there are certain things, you know, look at the hierarchy of… this food, this shelter, this clothing, you know, if the physiological needs are not being met, they can never attain recovery. [Olu - Charge Nurse, Inpatient; focus group]

Despite feeling 'trapped' by domineering practice paradigms, mental health nurses believed that their ability to form unique therapeutic relationships, underpinned by their 24-hour engagement with the persons (within the hospital), empowered them to have particular knowledge to influence certain clinical decisions (i.e. appropriate treatment pathways and suitability for discharge):

> I think when people know the patient, I think history of patients, I find that is helpful, because when people know the patient, I think some of the nurses they know what works for the patients [Janis - Staff Nurse, Inpatient; focus group]

Notwithstanding participants' general criticality of nursing practice being heavily influenced and aligned towards a medicalised model of recovery, the perspectives of 'therapists' were also seen as a potential competing practice paradigm. An occasional tension between nurses and therapists, who may follow a rigid psychological intervention model, was regarded as a competing priority:

> They work in a very kind of… can, not all of them, because not everybody works the same but, it can be a competing priority if I'm caring for somebody and the therapist is quite a purist, there can be a tension in the between the work I am doing against the work they are doing. [Sian – Nurse Executive; semi-structured interview]

A barrier: if it's not written it didn't happen

Nurses reported the existence of a Trust culture that has created an excessive and unmanageable demand for the completion of "paperwork" [Janis; Ashley; Agnieszka] to "provide data" [Yaw – Nurse Executive; semi-structured interview] to meet a multitude of organisational "targets" [Anthony – Nurse Executive; semi-structured interview]:

> So our priorities are about ticking the boxes, not necessarily about patient care. Controversial, but I think it is true. I think it is important to look at what the Trust wants, what the nurses wants and what the patient wants, and marry the three. [Katie – Nurse Executive; semi-structured interview]

Participants viewed such a challenge as one of the most significant barriers to implementing recovery-orientated nursing practices. It was believed that the over-emphasis on paperwork created the well-versed notion of 'if it's not written down it didn't happen':

> I just find that the amount of paperwork is just ridiculous, because 'if it's not written it didn't happen', so as a nurse that's for me that's a barrier, and for my team recovery, because every time the focus is on, oh document it, or if you didn't write it, so you're constantly focusing on paperwork. [Janis - Staff Nurse, Inpatient; focus group]

Participants were asked about the type of paperwork they see competing with their nursing roles or acting as barriers towards implementing recovery-orientated nursing practices. Nurses identified completing referrals, documentation of notes (Focus Groups: 1,2&3), incident reports (Focus Group: 2), pre-leave checks, updating monitoring spreadsheets (Focus Group: 3) and environmental risk assessments (Marcus – Community Team Manager; semi-structured interview) as being gratuitously time-consuming:

> You do the pre-leave checks, so you'll have a nurse doing pre-leave checks after community meeting, you have to document on paper, document on RiO and now we have to do our daily staffing, which is another spreadsheet, so we're having to write the level of obs, how many staff, are we fully staffed because they've [senior managers] changed the format. [Agnieszka - Charge Nurse, Inpatient; focus group]

Senior nurse executives acknowledged the multitude of operational targets and quality indicators affecting service-level managers[9]. Targets that lead to the creation of 'tick-box paperwork' were noted:

> So, I think we are trying to do lots and lots of things, we are trying to measure lots and lots of things which are sometimes perceived as targets or transactional stuff; we've got the ifox, you've got the CQUINS, you've got quality indicators, you've got all the must dos that managers are chasing people for, all these poor middle managers are going greyer by the day. [Anthony – Nurse Executive; semi-structured interview]

Not only was time spent on completing administrative tasks viewed as a barrier, some nurses felt that the format and function of computer systems added further challenges of inefficiency:

> We had to do a ligature risk assessment which took two of us almost 9 hours, trying to upload photographs, take the photographs, working through the IT stuff. [Marcus – Community Team Manager; semi-structured interview]; An incident takes like 30 minutes to fill out [Fredrick - Staff Nurse, Inpatient; focus group]; because it freezes and you have to do it again, it should be an easy system to do it [Reginald - Staff Nurse, Inpatient; focus group].

The nursing executives expressed the disproportionate amount of time nurses spent documenting and uploading data. Concerns were predominantly around the data-gathering methods, rather than the relevance of the data itself:

> It's not that I don't think the data is useful, I just think the way in which it is collected and collated should be much more focused to avoiding clinicians having to spend a lot of time doing that [Yaw – Nurse Executive; semi-structured interview].

Nurses conveyed that a rigid shift structure, partially induced by bed managers and other professionals within the team, can take nurses away from service user engagement, focusing instead on tasks such as medication administration and handovers. This imposed structure is another indicator of loss of control for nurses in practice:

> we are too much, as a team, focused on rules and regulations, so that the policy rules, what I say rules, I'd say 7am, I forgot the right words to use, 7am handover, 9am medication, 11

[9] Managers who directly oversee the operation of mental health services

> o'clock bed management meeting, and as a nurse how can you even spend time with your client when you've got so much duties to do. [Olu - Charge Nurse, Inpatient; focus group]

Rigidity in the structure of services was seen as a barrier towards implementing recovery-orientated nursing practices. This was explained in the context of a uniform approach towards 'episodic care'[10], where some service users may instead require support over an extended period:

> I understand, you know, the difference in the move towards episodic care, but sometimes the rigidity of the service that we provide works against person-centred care. Because a person-centred approach doesn't necessarily fit in with a rigid six sessions, or two years, or one year, and that isn't what we provide within rehab anyway. [Marcus – Community Team Manager; semi-structured interview]

Theme 3: Organisational nursing leadership and the policy practice gap

They push their priorities on us

A consensus across the cohort of practices-based nurses pointed to a divergence between what they saw as their priorities and those of the nursing executive. Participants believed that the nursing executive prioritised numerically measurable targets over treating the person as an individual, the latter central to the concept of recovery and ostensibly the priority of practice-based nurses:

> No, I don't. I don't think they're the same as ours. I think they look more at targets than individuals. I think they're target-focused, so it's numbers, whereas for me it's an individual thing. It's the individual experience and I think that's where it's different because I think when you're target-focused you can lose sight of what is important because it's like "oh my God, we need to hit this, we need to do this, we need to do that". [Laura – Community Mental Health Nurse; semi-structured interview]

[10] Mandated period of time engagement with service users (i.e. maximum 6 weeks)

This divergence in priorities was highlighted as having a direct influence over the function of services and nursing practices. The targets were not noted as negatively influencing the implementation of recovery-orientated nursing practices. How the targets were embedded and construed within services, was seen to overshadow their intended purpose:

> You've done it because it's gone green on 48 hour follow-up but what did that mean for the person, when you see the person back in 4 months' time with another self-harm, not that we can stop it, but when you look back, yes, the only thing we, we saw you when you were discharged after 2 days, then we had nothing after that. [Mitchell – Community Team Manager; semi-structured interview]

Further concerns around the applicability of targets within mental health services were seen to be intertwined with the risk-averse culture noted earlier in this chapter. Practice-based nurses appreciated the potentially 'good intentions' behind setting targets. However, it was felt that the majority of targets were in place solely to make it seem like good practice was occurring within services, where senior nurses were seen to be "more interested in how you manage risk rather than your philosophy of mental health" [Marcia – Community Mental Health Nurse; semi-structured interview]:

> Well maybe, okay, maybe I'm being harsh, maybe to a certain extent, maybe some of them were nurses, they want us to help patients, to treat them, and they discharge and everything is okay, but I feel that they want to mitigate risk, to manage risk, to make sure that things are done, so on paper it looks like the hospital is doing fantastic, so 100% everything is achieved, I think that's how they are, they look on targets. [Agnieszka - Charge Nurse, Inpatient; focus group]

Another competing priority noted by practice-based nurses was the apparent emphasis the nursing executive placed upon managing the Trust's finances. Although the core ambition to provide exemplary service user care was not seen as missing from the nursing executives, it was felt that the level of attention placed upon 'finances' overshadowed their ability to influence the implementation of recovery-orientated nursing practices:

> See, I will always think that my priority is the patient and it's not that I don't think that's their priority but I just think they've got financial... They have to weigh it up with the financial so they make decisions based more on the financial side of things rather than the patients' needs if that makes sense. [Gary – Community Mental Health Nurse; semi-structured interview]

> No, it's the same, I think we all are working to the same goal, but the priorities are different, I don't have to worry about finances, my role is to worry about the patient and looking after them, their role is slightly different, they need to have beds, so me I worry about the 17 patients in the ward, anyone else I think most of us are the same, it's not our problem of providing a bed, it's to ensure the safety and care and treatment of the patients we have in front of us, so that's where we differ. [Reginald - Staff Nurse, Inpatient; focus group]

Although the argument put forward by managers may be that prioritising budgets is for the greater good of the Trust, this position was disputed. The potential negative impact of prioritising the management of finances over service user care and the implementation of recovery-orientated nursing practices was also noted by the nursing executives. One participant strongly opposed the idea of nursing executives making their financial priorities an issue for those delivering care. It was thought that putting such pressures on practice-based nurses would restrict their ability to implement recovery-orientated nursing practices, in fear of overspending:

> So, to your question, what do we need? Nothing, we just need more senior staff who understand that engagement is the response, not finance. And telling staff; oh, all the number of bank staff you've booked and all that, I don't think, let them book whoever they ned to book. Let the ward manager explain it, but I don't expect the ward manager to go and discuss all this with the ward staff, let the ward staff get on with it. [Katie – Nurse Executive; semi-structured interview]

Intertwined with the issue of target-setting, was the perception that the nursing executive prioritises promoting the image of the Trust to external commissioners, more than they strive to promote recovery-orientated nursing practices :

> I don't think we have the same goals to be honest, I may be harsh about that, but we see that becoming this time, it's that, and let's get ready for CQC, is everything done, let's make sure that everything is good, but here ultimately we want to look after patients, we want to make sure that they're well, yeah. [Agnieszka - Charge Nurse, Inpatient; focus group]

Participants of the nursing executive echoed this view. There was an apparent divergence between the priority to build the reputation of the Trust and the endeavour to implement recovery-orientated nursing practices. It was felt that both priorities should work hand-in-hand, rather than competing with each other:

> But something's are, I suppose more about the Trusts reputation, which is of course important, but sometimes it feels like that is more important than the care we deliver. They should be both intertwined… [Yaw – Nurse Executive; semi-structured interview]

There was a sense that nurses believed external commissioners placed pressure upon the nursing executive to evidence that set standards were being met. However, some targets were viewed as arbitrary and unaligned with the core purpose of recovery-orientated nursing practices (i.e. number of contacts made, rather than personal outcomes):

> It's like there is no kind of, because from a management point of view, so we talk about leadership and managerial point, you know the managers need to prove to commissioners that we 'see a certain amount of people'. [Rosemarie – Community Mental Health Nurse; semi-structured interview]

It was explained that initiatives from commissioners can promote the implementation of recovery-orientated nursing practices. The issue was not with the initiatives themselves, but how commissioners, seemingly pressured Trust leaders, attempted to measure and 'guarantee' their implementation in practice. An approach that was seen as restrictive and unintentionally hindering the implementation of recovery-orientated nursing practices:

> "Reducing restrictive practices like seclusion and restraint" and "using education development as part of people's recovery": But doing it in a very rigid set way in which the commissioners thinks it must be done is less helpful, and that's the issue to me. It isn't about, it's much more micromanagement rather than being strategic management saying that this is what we should be aiming for and we will check that you get there, it's more like we want you to get this, this, this and this. [Yaw – Nurse Executive; semi-structured interview]

Where the priorities of practice-based nurses and the nursing executive were varied and at times unaligned with one another, Trust values were regarded as essential for influencing the implementation of recovery-orientated nursing practices. It was believed that the values should be the same at all levels of the Trust, helping staff to articulate and work towards the same goals:

> So it does help, that well our Trust has the same values as we do and we have the same values as the Trust, and the managers have the same values, everybody has similar values throughout the hierarchy basically, definitely helps. [Kyle – Community Team Manager; semi-structured interview]; Fundamentally if you've got that right, I think the only challenge we face is the demand and supply I think is the challenge we face, how do they manage the demand with what we have and how do we prioritise, you know. [Mitchell – Community Team Manager; semi-structured interview]

Delivering good quality care and positive outcomes for the persons was generally accepted as the core goal of both practice-based nurses and the nursing executive.

Although believing this to be the case, the issue lay with the perceived competing ways these goals are being implemented, measured and promoted. It was acknowledged that this issue would continue to prevail all the while the Trust's quality goals remained unclear:

> We are all in it for the same thing! But we haven't articulated our quality goals, which are exactly the same as what you are talking about in recovery-orientated, down to practice. If you get that right, all the transactional stuff that gets in the way and makes people busy or stressed, is just done. [Anthony – Nurse Executive; semi-structured interview]

Something's got lost in translation

One apparent method for influencing the implementation of recovery-orientated nursing practices was incident reporting and complaints. Nursing executives described playing a central role in reviewing and responding to these processes as they arise:

> I can make sure that we're delivering the best recovery based models because you know when we have incidents and complaints I'm in, I often lead on those investigations and complaints. [Andy – Nurse Executive; semi-structured interview]

Although these processes were seen as conduits to promote the implementation of recovery-orientated nursing practices, practice-based nurses needed to align with this thinking. How nursing executives approach investigations of incidents and responses to complaints, was observed to have either a positive or negative impact on practice-based nurses. Applying a learning approach was seen as more conducive to improving practice, compared to an approach viewed as punitive:

> The way the senior managers deal with complaints and investigations, influences decisions, or confidence of staff, a lot more in how they deal with clients, that if it doesn't come down, if there's an investigation, if it's not a… if it doesn't follow the approach of trying to find guilt, or responsibility for something, if it's more about learning from the event, and the managers' demonstrate this learning approach staff feel more confident that if something goes wrong it's about learning from the process. [Kyle – Community Team Manager; semi-structured interview]

It was felt that the incident reporting process was, in some cases, the only time some senior nurses engaged with practice-based nurses. A reactive response to an issue, missing the means to engage with practice-based nurses proactively:

> I think it became very clear to me how many people became interested when this incident occurred. But was I having regular dialogue with these people? Generally no, I wasn't. [Marcia – Community Mental Health Nurse; semi-structured interview]

A member of the nursing executive echoed this thinking. Reacting to incidents and complaints was seen to be the easiest way to identify an issue, responding to concerns with actions. Being proactive in understanding and addressing impending issues facing practice-based nurses, was noted as a challenge for the nursing executive:

> The easiest way is to have an incident or a complaint, respond to that and then develop an action to that. Out of that action you may realise that a policy needs to be made around this, that's the easiest way. The most difficult way is to sit down and think about nursing practice and predict which direction things are going to go and then start planning for that direction, looking at what the issues are going to be. That's the difficult part. [Katie – Nurse Executive; semi-structured interview]

Practice-based nurses reported a disconnect between them and members of the nursing executive. A strict hierarchical structure was seen to hinder communication between those directly delivering care and those leading the strategic direction of the Trust:

> Yeah, you don't feel connected to the top, but people going up the layers feel connected to the layer above them. But obviously working at a practitioner level you don't feel like, you know, there's a… it seems like there's a hierarchical process of support that you don't get to jump, you don't get to skip levels, you know, kind of it works in a very structured way. [Marcia – Community Mental Health Nurse; semi-structured interview]

The nursing executive acknowledged the communication gap between them and practice-based nurses. It was felt that the strategic message is often lost in translation as it filters down through multiple layers of 'the hierarchy' and into practice. A disjoint between strategy and its implementation was viewed as being marred by measurements and targets detached from the original purpose or vision:

> I'll get to a certain point, I'll go to a band 6 or a band 7 meeting and something's got lost in translation; and its: you must do this on RIO, you must tick here, yeah? Whereas actually the message is, we want to be able to ensure that every patient has a personalised care plan that is up to date with a great risk assessment and were checking what outcomes are being delivered, if we need more support and if we are going right or wrong. [Anthony – Nurse Executive; semi-structured interview]

It was felt that the strategic message was more likely to reach clinical practice if you had good 'clinical leadership' at all levels of the hierarchy. With good clinical leadership it was

believed that the core message of recovery-orientated nursing practices would be more likely to translate into practice:

> Yeah, and to me that is clinical leadership at every level, and it's communicating that message, I know it gets diluted [NEC 1]; So yes, it's where we've got a strong nurse leader it filters down [Kyle – Community Team Manager; semi-structured interview].

The idea of 'visible leadership' was also regarded as a means for the nursing executive to directly influence the implementation of recovery-orientated nursing practices. Visible leadership was described as being seen working alongside junior colleagues to deliver day-to-day care:

> But I do also try to be quite visible in terms of my leadership, so I try to make sure that I am seen working with frontline staff or directly working with patients, for at least part of every working week. [Yaw – Nurse Executive; semi-structured interview]; Do some nursing care and do those things so people could actually see me actually doing these things and delivering the care, and I think that's much more powerful than me just talking about it, so… [Andy – Nurse Executive; semi-structured interview]

Another participant termed this approach to visible leadership as 'role modelling'. They further expanded upon the scope of visible leadership in the context of the nursing executive. Nursing engagements such as nursing conferences and creating communication channels were noted as other forms of visible leadership. Being present, articulate and accountable at all levels of the Trust was viewed as crucial to the repertoire of a visible leader:

> I think it's about role modelling, I think it's about having strong structures in terms of like nursing conferences, I think it's about having strong structures in terms of things like Nursing Council, think it's having a Nursing Executive that is, that's accountable, that's vocal, that's interested, that's engaged. I think it's about having clear lines of communication, it's about giving people the opportunity to say what they think matters to them. [Mandeep – Nurse Executive; semi-structured interview].

Another means of engagement, to influence the implementation of recovery-orientated nursing practices, was through direct clinical supervision, or by line managing those who "provide supervision to other people" [Yaw – Nurse Executive; semi-structured interview]. Clinical supervision was seen to be a place where nurses explore the meanings of their relationships with the persons, while critically reflecting on the care provided in practice:

> So, in clinical supervision, that's very much a thinking about how relationships are working and thinking about how people are feeling about the journey of the work that they are doing and helping people to think about… [Sian – Nurse Executive; semi-structured interview]

Practice-based nurses could have explicitly given details on the purpose and scope of clinical supervision within recovery-orientated nursing practices or concerning the nursing executive. Supervision was only highlighted as a means by which practice-based nurses were able to raise concerns with a senior colleague on a one-to-one basis, addressing issues locally and within their teams:

> The only way I think we can contribute into that, is obviously through your supervision, whatever you discuss in the supervision that you're not happy with, or maybe something that you need to… that needs to be discussed, then if you are happy for your supervisor to now discuss it in the comment, or business meeting, from the business meeting manager would be aware about it, and it's going to be a team thing, you know. [Lydia - Charge Nurse, Inpatient; focus group]

Developing individuals and tangibly valuing the voice of practice-based nurses was seen as essential in ensuring the strategic drive for the implementation of recovery-orientated nursing practices is achieved:

> So that they develop their staff has a major influence, the staff feel valued, feel that they are part of the, if they raise issues they are lessons to… it's, yeah, major impact. [Kyle – Community Team Manager; semi-structured interview]

Without feeling valued and supported by the nursing executive, practice-based nurses believed their openness and willingness to follow the direction of senior colleagues would be hindered. Such a situation was said to influence the morale of staff and consequently how nursing practices are delivered:

> So if you're able to do that and people feel supported, then the service will improve, because I find that when that is gone, the loyalty goes, that's it [Rosemarie – Community Mental Health Nurse; semi-structured interview]; Right, because if I don't want to be here and I'm here I'm not going to give you my best, I'm just there because I'm... [Lydia - Charge Nurse, Inpatient; focus group].

Based on the experiences of one participant, it was believed that a lack of visible leadership and engagement has eroded the Trust between those strategizing care and those delivering. Even if the nursing executive sincerely aims to develop and support their staff, practice-based nurses may be unwilling to accept it:

> So even if they were to come and have a conversation with me, I wouldn't believe it. Even if they were to say "oh I'm here to develop you, duh, duh, duh, duh", I'd just be like "yeah, you're just telling me that because you're trying to motivate me, I don't believe anything that you say". [Laura – Community Mental Health Nurse; semi-structured interview]

Policies and procedures

Participants argued that Trust policies influenced the drive for increased administrative nursing responsibilities. It was believed that prioritising interactions with the persons through "therapeutic time, that's against Trust policy because we are not documenting things" [Janis - Staff Nurse, Inpatient; focus group]. However, when asked which policies influenced these issues, participants could not identify specific documents. Nevertheless, an apparent service culture to prioritise administrative tasks persisted:

> I'm not aware of a particular policy that I can actually quote off my head, however, I do know that the expectations for me to be documenting things is happening, which at times I don't find that helpful. [Janis - Staff Nurse, Inpatient; focus group]

Policies were primarily viewed by practice-based nurses as guidelines of procedural processes, having little impact on how nurses implement recovery-orientated nursing practices. It was understood that there is a level of discretion and flexibility in how policies are used, where the application of clinical expertise was seen as the true enabler towards implementing recovery-orientated nursing practices:

> I don't feel a tangible connection to policies, procedures and senior nurses around recovery-orientated nursing practices [Marcia – Community Mental Health Nurse; semi-structured interview]; But I think a policy is a guideline, it's something that you have to still use your own discretion, your clinical judgement within, based on [Annette - Charge Nurse, Inpatient; focus group]; I think at sometimes, in some situations, if you follow the policy to a T, actually it would not have a good outcome, you have to be able to use your own kind of professional judgement I think sometimes. [Gary – Community Mental Health Nurse; semi-structured interview]

Participants reported no specific recovery policy within the Trust: "I could not find anything" [Anthony – Nurse Executive; semi-structured interview]. The necessity for having a recovery policy was disputed. Nursing executives aligned with practice-based nurses, where the enablers of recovery-orientated nursing practices were seen to be influenced by the practical application of nursing interventions. Policies were regarded only as guides that can help shape the frameworks and boundaries of care:

> They [nurses] need something there to keep them safe, they need some boundaries and some frameworks. But if they do a proper risk assessment, and have got a really got crisis plan that is communicated and reviewed, risk assessments are not static, they are continuous, and the care plan is the job, and it done in the way that is individual so that it is really really personalised, really safe, creative and out of the box. Then that is the kind of stuff, it's the enablers rather than a specific policy. [Anthony – Nurse Executive; semi-structured interview]

Trust policies viewed as having a positive influence over the implementation of recovery-orientated nursing practices were ones that emphasised the support of the person's physical health needs: "Because it [physical health policies] caters on the individual's holistic health" [Ashley - Staff Nurse, Inpatient; focus group]. This perspective was contextualised by a participant's assertion of their concerns around the mortality rate between those with a mental illness and those without.

> I think one of the big challenges we face is in mental health nursing is our patients are dying twenty years younger than the general population and I think this is, you know, in terms of if we're talking about recovery, I think this isn't a very good, this isn't a very good recovery example because actually it's bloody scandalous, it's awful, it's shocking [Mandeep – Nurse Executive; semi-structured interview]

As earlier explored, care planning was understood to be an essential nursing intervention in supporting the implementation of recovery-orientated nursing practices. The Trust's care planning policy was seen to offer nurses guidance that can help shape the care planning process, emphasising patient safety, but providing nurses minimal guidance for practical formulation:

> That could help, but does it really say how you should describe or formulate the care plan? It's more like guidelines, but to get into therapeutic interventions, they don't really have that, to be honest, it's all about safe practice, but which is good because that's also a way of, you know, enabling recovery. [Agnieszka - Charge Nurse, Inpatient; focus group]

It would appear that the culture of "ticking the boxes" [Katie – Nurse Executive; semi-structured interview] to "provide data" [Yaw – Nurse Executive; semi-structured interview] to meet a multitude of "targets" [Anthony – Nurse Executive; semi-structured interview], underpinned how several participants view care plans. Concerns around the practical formulation of care plans were not only noted by practice-based nurses, but also by participants at the strategic levels of the Trust:

> One of the gaps that we have, we have a transformation lead for this so I know it's a gap, is personalised centred care planning and skills and competence to do it properly. A lot of it is task orientated. Rio doesn't help, the way Rio is set up, the natural steps don't help. So if we could actually focus on the care planning that could deliver… [Anthony – Nurse Executive; semi-structured interview]

Within the constraints of competing priorities, nursing executives acknowledged having opportunities to work with high levels of autonomy. Where flexibility allowed and opportunities presented, nursing executives felt able to influence the strategic and operational direction of services:

> So, I have quite a lot of say in how, as much as anybody does in the modern NHS in between CQUINS and whatever else we have to do, but where we do have the flexibility to kind of craft how we want to do things, I guess I have a lot of say in that, so sitting on the board I can influence decisions that are made there. [Yaw – Nurse Executive; semi-structured interview]

Nursing executives viewed policies and procedures as instrumental in helping them influence the direction of clinical practice. Policies and procedures were seen as supportive mechanisms made available to practice-based nurses, helping them avoid doing something wrong:

> Policies and procedures are important because actually it's the thing that supports clinical practice so if an incident happens, if you've followed your policies and procedures you're in a much better place than if you haven't, if you haven't followed your policies and procedures, it's not a great place to be and actually, that's why it's quite critical. [Mandeep – Nurse Executive; semi-structured interview]

It was believed that if nurses follow policies correctly the implementation of recovery-orientated nursing practices would improve. The rationale is that if a policy is promoting person-centred care and service user engagement, their application by practice-based nurses would surely enhance the delivery of care:

> If people engage with those basic policies, recovery will be good. Recovery will be very good, because all those policies, think about it, all those policies, all they are doing is asking you to spend time with the patient, that's all. Most of our policies about patient care, is asking you to have a conversation with a patient. [Katie – Nurse Executive; semi-structured interview]

Practice-based nurses viewed the role of policies in a different way than their nursing executives' colleagues. Regardless of the intent, content or wording, practice-based nurses reported feeling detached from the formation and development of policies within

the Trust. It was perceived that policies are created and implemented without discussing their relevance with those who are meant to use them:

> So, if they involved me into the policy making, I work on the shop floor, lone working, for example, just give you this lone working, how does it work for me? They're not going out, I'm the one who's going out, how do I feel? So understanding me as a worker, than just implementing a policy, that's me. [Rowena – Community Mental Health Nurse; semi-structured interview]

Disputing this position, one nursing executive explained that a core component of their role was approaching and discussing the relevance of policies with practice-based nurses. The way this is undertaken was described as an ongoing iterative process, reviewing and amending the content of policies and procedures when needed:

> My job is to take what they've said and translate it, then to give it back to them and see if it works, tweak it this way and it works, tweak it that way and it doesn't quite work, or, "it's useless"… That's what they'd say. [Katie – Nurse Executive; semi-structured interview]

There was a recognition amongst the nursing executives that those delivering direct care may need the opportunity to engage with policy development. Engagement with practice-based nurses was said to occur primarily with the manager and deputy managers. Little was known about how these discussions are fed back and reviewed by junior nurses, where purportedly "sometimes things get lost in translation" [Mandeep – Nurse Executive; semi-structured interview]:

> But I think that probably like many inpatient services kind of with, there is a lot of influence with manager and charge nurse level, but when you get below that it starts to get diluted, so those band six and band seven nurses have quite a lot of influence over policy, they are involved in discussions, deciding what we are going to do. We want them to take that back to their teams and involve their teams in making sure we get the right policies, but how much that really happens I think varies depending on the skill and the workload of the individuals leading teams. [Yaw – Nurse Executive; semi-structured interview]

The role of the nursing executives towards implementing recovery-orientated nursing practices through the medium of policies was seen by some practice-based nurses as an abstract notion. The influence of the nursing executive within this context was said to be neither supportive nor hindering. It was felt that the ethical and moral underpinnings of the individual nurse, and the philosophy within their team, are more likely determinants for how recovery-orientated nursing practices occur:

> I don't tangibly feel that, I don't, for me, in terms of policy and, you know, senior management, I don't think I see enough tangible kind of experiential kind of stuff around our senior management advocating a recovery approach. Are they, kind of, encouraging? Are they enabling or disabling how I work in a recovery-orientated way as a practitioner? I don't feel that, I don't think I've… I have to be honest, I don't think I've ever felt that, I think what drives me is my own philosophy and my own, kind of, morals and ethics around what supporting somebody in mental distress should look like. [Marcia – Community Mental Health Nurse; semi-structured interview]

Changes to policies and procedures were seen to be a challenge for practice-based nurses. It was felt that changes were often decided at a more senior level of the Trust (nursing executive), removed from the practice setting. The frequency of changes was viewed to be difficult to manage, lacking clarity in purpose and application to practice:

> You know, so I'm not saying I mind doing that but often there's change, lots of changes or you'll do things one way, and someone'll say, "Oh no, no we're not doing it that way anymore", you know, "this is what you need to do now". And often that information hasn't filtered through. [Marcus – Community Team Manager; semi-structured interview]

The nursing executives echoed the same concern for messages of service change being lost in translation. There was a general sense that initiatives attempting to influence the implementation of recovery-orientated nursing practices are driven top-down and need to be revised for their intended purpose. It was acknowledged that using a strict hierarchical structure to implement strategic thinking could have been more conducive to change than hindering. A flatter hierarchy, with practice-based nurses working alongside their senior leaders, was viewed as being a necessary shift in Trust culture:

> I think it is top-down and I keep talking about care planning, I get the sense it is being forced top-down, what we are trying to do is influence a change bottom-up. I feel that the gap around it, I have thought about this for days now, is almost that shared governance, so I think we need more bright, motivated, new or just keen, particularly nurses, sitting at our table with our transformation lead, medical director and myself to shape it. I think that's the gap. [Sian – Nurse Executive; semi-structured interview]

The nursing executive acknowledged that channels of communication and engagement are often restricted at unknown points of the system ('lost in translation'). However, there was a recognition that engagement from the nursing executives with practice-based nurses occurs predominantly at the managerial and deputy manager level.

Managers and deputy managers are tasked with bringing changes and new ways of working to their teams, translating strategy into operation. However, nursing executives

report knowing very little about the level of involvement more junior nurses have. Creating channels of direct communication, rather than relying on the intermediary of their senior colleagues, was something seen as a necessary shift for the engagement of junior nurses to influence the implementation of recovery-orientated nursing practices:

> I don't want my manager to pass my message the way she feels manipulated, the way she wants, I want to say to someone senior and say what do you want, and then I can talk my experiences, because the way I will explain it, that's not how. [Janis - Staff Nurse, Inpatient; focus group]

The most appropriate means of communication for ensuring engagement with practice-based nurses was reported through direct discussion. It was emphasised that this should not be in the capacity of a consultation on already agreed changes: "I think when they already made a decision, let's talk about, it's going to sound funny when you, don't translate that!" [Rosemarie – Community Mental Health Nurse; semi-structured interview]. Proactive engagement from the nursing executive with practice-based nurses, co-developing responses to challenges in practice, was believed to have a more significant potential for the successful implementation of change and quality improvement:

> I think it would be better if they spent more time talking, you know, before they make changes and stuff, talk to people that are actually doing, that are having that contact and find out what works and what doesn't work and try and plan it round that rather than it feels like decisions are made around services or around teams or around practices, without actually knowing what goes on. [Gary – Community Mental Health Nurse; semi-structured interview]

Theme two highlighted the importance of access to ongoing training for nurses. However, practice-based nurses reported that receiving training only sometimes leads to the effective implementation of change. Any learning content must reportedly be contextualised within the specific practice settings. For example, training nurses to deliver an intervention or procedure that is perceived as being insufficient for their services may lead to a lack of engagement: "just because you've done the training doesn't mean whatever the training say it's alright, what fits in for you, what is fit for purpose within that context?" [Mitchell – Community Team Manager; semi-structured interview].

Through the various established communication and engagement methods, a unified message of recovery at the strategic and operational levels of the Trust is yet to be

established. It must not be forgotten that those seeking care and support are at the centre of this conundrum. If the nursing executives are to influence practice-based nurses towards implementing recovery-orientated nursing practices, their channels and methods of communication must be revisited:

> So, we can set and create all these frameworks about how we want people to work, we can role model it and we can talk about it in reflection and supervision, with all the embedded learning, and all the things. But actually, how far is that translating so that a service user, a patient, is experiencing support and guidance in a recovery-orientated way, so that I think that golden thread isn't through it yet. [Anthony – Nurse Executive; semi-structured interview]

Summary of findings

Participants described their experiences and observations and endeavoured to define recovery-orientated nursing practices within the context of mental health services. Both practice-based nurses and nursing executives primarily conveyed their understandings of recovery within a continuum of interrelated yet contrasting concepts: an objectively measurable outcome and an individually defined process. As a result, differences in views of recovery amongst participants were often nuanced and overlapping rather than divergent.

Organisational support for implementing the 'enabling principles' was said to be within the Trust's strategic priorities. However, despite some nursing executives seeing recovery as a philosophy of practice already embedded Trust-wide, it was regarded by others as an ambition rather than a current reality. In this instance, nurse leaders highlighted a potential implementation gap from strategy to policy and into practice. Conversely, another nurse leader argued that the 'enabling principles' are often impeded by opposing organisational priorities within mental health services. They aligned with the idea that other service-level targets can create a culture that hinders nurses from implementing recovery-orientated practices.

It was believed that both practice-based nurses and the nursing executive have a similar core goal, promoting the quality of care for service users and patients. However, priorities and methods for achieving this goal are only sometimes aligned. i.e. nursing executives prioritised numerically measurable targets, over-treating the service user as an individual.

In addition, how the nursing executives responded to issues in practice was said to be reactive rather than proactive.

A strict hierarchical structure hindered communication between those directly delivering care and those leading the Trust's strategic direction; 'visible leadership' and clinical leadership at all levels were seen as essential. In addition, nursing executives viewed policies and procedures as means to influence the implementation of recovery-orientated nursing practices. In contrast, practice-based nurses disregarded the role of policy as playing such an influential role.

Conclusion

This chapter presented the findings of this case study in exploring the question: How do practice-based mental health nurses and nursing executives experience implementing recovery-orientated nursing practices in one NHS Foundation Trust? Answering the three issue questions, the chapter presented participants' conceptual understandings of recovery-orientated nursing practices, enablers and barriers towards implementing recovery-orientated nursing practices and the nursing executives' role in influencing the implementation of recovery-orientated nursing practices. Finally, a summary of the findings is presented.

Chapter Five provides a theoretical and contextual critique of the findings, underpinned by the empirical literature of Chapter Two and the supporting literature of Chapter One. Lastly, a search of the contemporary literature beyond the date parameters of Chapter Two provides contemporary literature published from 2017 to 2022.

CHAPTER FIVE: THE CASE REPORT (THESIS DISCUSSION)

Introduction

The final stage of a case study is to write what Stake (1995: 121) calls “the report”. The report summarises the entire case study, reporting on the various stages of the research process. As this is a doctoral thesis, the whole body of writing, from Chapter One to Chapter Five, encompasses the necessary components of the report. However, in the eyes of Stake, a report by way of an extensive and richly detailed thesis would mar accessibility for the reader. Stake (1995) argues that a case report needs to be short and concise, honing in on the critical issues concerning the research question presented through a written narrative. The reader must always be centrally in the mind of the researcher.

In its conventional scholarly sense, this report is a thesis discussion chapter. The discussion (or report) can be “organised in any way that contributes to the reader’s understanding of the case” (Stake, 1995, p. 122). This discussion chapter moves the narrative beyond presenting participants' experiences towards critique and contextuality. The interconnectivity between the research questions (Chapter Three), the broader empirical contexts (Chapter Two), the sociopolitical and historical contexts (Chapter One), and the findings (Chapter Four) of the case is asserted (Stake, 1995).

Summary of key issues and Implications

Recovery-orientated practice has been defined and explored within clinical and personal spheres. This study argues that such polar positions do not epistemologically align with mental health nursing. Instead, recovery-orientated nursing practices are seen as enabling processes along a continuum rather than divergence. Barriers and enablers towards implementing recovery-orientated nursing practices are many and positioned within the Trust's micro, meso and macro system levels. Although the goals for service user outcomes are the same, the priorities of nursing executives and practice-based nurses differ, one prioritising service user outcomes and the other the external image of the Trust.

Opposed by practice-based nurses, policies and strategies were seen as how nursing executives can influence the implementation of recovery-orientated nursing practices. Visible leadership and role modelling were methods by which participants felt nursing executives could directly influence nursing practice and improve communication. However, a strict hierarchical structure within the Trust hinders senior leaders from influencing recovery-orientated nursing practices in mental health services.

This case study argues that, regardless of the objectively identifiable policies, processes and procedures created within the Trust, if practice-based mental health nurses do not feel connected to their leaders or contribute to and value their policies, nursing executives may bear little to no influence on implementing recovery-orientated nursing practices.

Chapter structure

Chapter Four presented three themes and multiple subthemes following inductive thematic analysis: The concept of recovery-orientated nursing practices, Internal and external factors that influence recovery – in and beyond control, and Organisational nursing leadership and the policy practice gap. In addition, this chapter provides a comprehensive discussion of the key findings (Chapter Four) within the contexts of the empirical literature (Chapter Two) and the sociohistorical and sociopolitical contexts of Chapter One. Finally, broader empirical literature published after this case study, between 2016 and 2022, is explored and referenced to ensure the discussion remains contemporary.

Rather than repeating the themes in Chapter Four, this chapter is organised by explicitly answering the three issue questions:

1. How do mental health nurses conceptualise recovery-orientated nursing practices?

2. What are the barriers and enablers towards implementing recovery-orientated nursing practices?

3. How do nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices?

In so doing, the critique of the findings and their contextualisation within the scholarly field of recovery-orientated nursing practices can follow a straightforward narrative that addresses the overarching aim of the case study: how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services.

Footnotes have been used within this chapter to refer the reader to the specific information referenced – i.e. where particular findings are discussed, the reader is linked back to where this is presented in Chapter Four.

Contemporary empirical context

This case study explores an issue within a fixed time, underpinned by many interconnected contexts (Stake, 1995). Accordingly, the case was investigated within its time's sociopolitical, sociohistorical and empirical contexts (2016/2017). Therefore, the case findings were interpreted against policies and literature published before 2017. Nevertheless, contemporary literature was explored to confidently identify and express this study's unique contribution to the existing knowledge.

The literature search, as set out in Chapter Two, was repeated to include the dates of 2016-2022 (see Appendix 6.1). One new empirical paper was found (Simpson et al., 2017) and one doctoral thesis (Mhlanga, 2022). Simpson et al. (2017) is a full report of an earlier paper by Coffey et al. (2012). Although exploring multi-professionals' views of recovery, the findings need to be more explicit to identify the nurse-only content and would not have met the inclusion criteria.

Simpson et al. (2017) found that administrative elements reduce recovery-focused and personalised work in care coordination. Recovery understandings differed between service users and staff, limiting shared goals. Furthermore, risks were not discussed, and assessments were not shared with service users. Recovery-orientated practices may be hindered by a reluctance to discuss risk management with service users.

Mhlanga (2022), in her doctoral thesis, undertook a qualitative case study exploring the implementation of recovery-orientated practice within mental health services. Although a multi-professional approach, mental health nurses were included in Mhlanga's (2022) study. While a clear cross-over exists between this case study and the one undertaken

by Mhlanga (2022), the ability to identify this study's unique contribution has been enhanced.

Question 1: How do mental health nurses conceptualise recovery-orientated nursing practices?

Summary

Participants described their experiences and observations and endeavoured to define recovery-orientated nursing practices within the context of mental health services. Both practice-based nurses and nursing executives primarily conveyed their understandings of recovery within a continuum of interrelated yet contrasting concepts: an objectively measurable outcome and an individually defined process. As a result, differences in views of recovery amongst participants were often nuanced and overlapping rather than divergent. A social constructivist framework for how mental health nurses within this case study conceptualise recovery-orientated nursing practices has been developed.

Discussion

As presented in Chapter Four, recovery was viewed as a stage of wellness proceeding the service user's crisis. Mental health nurses define crisis as a state of mental distress wherein the service user may require hospital admission or community support for care and treatment.[11]

Although widespread across the discourse of nurses within this case study, crisis was not an essential subject within the empirical literature explored in Chapter Two. However, in the context of risk, crisis management was referred to within a recent doctoral qualitative case study exploring implementing multi-professional recovery-orientated practices in mental health services (Mhlanga, 2022). How crisis is described within Mhlanga's study

[11] Chapter Four (p. 119)

establishes it as a form of nursing practice or intervention rather than a stage or state of the recovery journey.

In this study, getting objectively better (asymptomatic) and engaging with services were critical indicators used by some participants to determine when someone is no longer in the stage of crisis and now in recovery.[12] As explored in Chapter Two, many mental health nurses have, for at least a decade, referred to medication adherence, reduction of symptoms, and improved mental state, along with the removal and management of risk, as the fundamentals of nursing practice and indicators of recovery (Cleary et al., 2013; Aston & Coffey, 2012). As presented in Chapter One, such perspectives share their theoretical roots with the clinical recovery concept.

Clinical recovery within mental health services places the clinician as the expert within an established healthcare infrastructure, concerned with the psychopathological assessment and pharmaceutical treatment of symptoms to stabilise the service user's mental state (Slade, 2009). Recovery, in this sense, is measured by symptom remission, reduced levels of risk and relapse, where clinical tasks and interventions shape the delivery of recovery-orientated care (Le Boutillier et al., 2015b).

Participants acknowledged the relevance of recovering to a pre-crisis state as necessary for some but inappropriate for others.[13] This thinking aligns with Slade's (2009) theory of personal recovery, where although at times integral to an individual's recovery, clinical recovery should be a subset of personal recovery, where its focus may be beneficial for some but can significantly hinder the recovery of others.

Tangible sociopolitical conditions may have influenced participants' views of an objective recovery dependent on service engagement. Since 2001, national policy has, whether deliberate or inferred, accentuated the necessity for service user dependence upon mental health services for recovery to become a reality: "The vast majority have real

[12] Chapter Four (p. 119)

[13] Chapter Four (p. 120)

prospects of recovery – if they are supported by appropriate services, driven by the right values and attitudes" (DH, 2001a, p. 24).

Nevertheless, evidenced by the policy shift in mental health nursing (DH, 2006; NMC, 2014), as well as mental health services in general (DH, 2011), the profession has attempted to move away from its psychiatric routes (Barker & Buchanan-Barker, 2011), towards more empowered and empowering practices (McCrae & Nolan, 2016). However, several participants in this case study and the broader empirical literature adhere to the decades-old neoliberal idea that recovery can be achieved when people engage with the support provided by mental health services.

When we look deeper into the findings in Chapter Four, how nurses describe recovery and indeed crisis, the idea of an objectively measurable outcome appears to sit stronger with participants working within inpatient mental health settings, compared to community-based nurses and nursing executives. Furthermore, the broader empirical literature highlights how inpatient mental health nurses' understanding of recovery can vary from one service to the next (Coffey et al., 2019; Simpson et al., 2017). Finally, as inpatient-based participants in this study were representative of three separate hospitals, service-wide conditions may have reinforced these views.

The concept of individualised care was drawn out by several participants when discussing the meaning of recovery. The idea of the individual was typical to the participants within this case study.[14] These views align with the early first-person accounts of mental illness, a subjective phenomenon unique to the individual baring the fundamentals of hope, acceptance and the reclamation of a positive sense of self (Anthony, 1993; Deegan, 1988; Repper & Perkins, 2003; Lovejoy, 1982).

Presented in Chapter One, Leamy et al. (2011) emphasise that the conceptualisation of recovery should not be viewed as definitive, for the philosophy of personal recovery is grounded in the subjective phenomenon, consisting of individual experience and

[14] Chapter Four (p. 121-124)

meaning. This position is further stressed by Bird et al. (2014), who argue that given the individualistic nature of recovery, there will always be the need to understand the specific and often divergent contexts surrounding each service user.

Within the sociopolitical landscape, the neoliberal discourse of individualisation (DH, 2007; DH, 2012a) moved mental health care away from its paternalistic roots (care as determined by clinicians) towards personalisation (Callinicos, 2013). As explored in Chapter One, personalisation is often referred to in its contemporary form, person-centred care. Person-centred care recognises people as empowered individuals, acknowledging their strengths and social networks in planning care and treatment (Carr, 2010).

Understanding how participants could measure or assess recovery-orientated nursing practices was a key component explored in this study, given the complexities of an individually defined recovery. In the context of clinical recovery (as explored in Chapter One), recovery outcomes can be measured through symptom remission, reduced risk levels and relapse occurrence, shaped by the delivery of clinical tasks and interventions (Le Boutillier et al., 2015b).

Further emphasising the individual nature of recovery, participants disputed the appropriateness of using objectively observable measuring tools to assess the implementation of recovery-orientated nursing practices. In addition, participants had an evident ethical and moral conflict when using outcome measures to define someone's recovery.[15]

Mental health nurses raised similar concerns within the broader empirical literature. Nurses argued that recovery-orientated nursing practices should primarily focus on understanding and promoting service users' views and individual needs (Jacob et al., 2015), not solely on the objective management of risks and reduction of symptoms (McKenna et al., 2014). Although contended as a measure of individual recovery, outcome measures were seen by participants in this case study as something that can

[15] Chapter Four (p. 125)

be beneficial for some, enabling the service user to see how their mood and symptoms have changed over time.

Within an inevitable myriad of competing perspectives and expectations, one participant argued that nurses should focus on empowerment and shared responsibility with the service user, where mental health nurses can act as conduits enabling recovery to be more owned by the service user rather than by mental health nurses and mental health services.[16]

The principles of ascertaining the particular meaning of recovery, rather than defining what recovery is by way of interventions or outcomes, were seen by participants as the foundation of recovery-orientated nursing practices. In this sense, some mental health nurses viewed recovery as a philosophical or theoretical orientation rather than a definitive activity, a set of enabling principles: seeing the service user as an individual, setting short-term goals, and promoting choice through positive risk-taking.

The added suggestion that recovery is a process rather than a distinctly identifiable outcome or intervention was echoed across the dataset, not the beginning or end of treatment, nor the specific interventions or care being delivered.

The recovery processes are identified as most centrally relevant to research and clinical practice; they are connectedness, hope and optimism about the future, identity, meaning in life and empowerment, forming the acronym CHIME (Leamy et al., 2011). In mental health nursing, the Tidal Model theory of recovery has focused on the processes of engagement between nurse and service user as the vehicle for supporting service users through their recovery journey (Barker & Barker, 2008).

Participants in this case study regarded enabling service users to articulate their goals as a means by which mental health nurses and service users can capture recovery as an individually defined process.[17] Similarly, Cleary et al. (2013) found that determining goals

[16] Chapter Four (p. 121)

[17] Chapter Four (p. 123)

was how mental health nurses collaborate daily with service users to promote personal recovery. In services considered recovery-orientated, clinicians were said to set goals as defined by the service user rather than focusing solely on clinical goals (Mhlanga, 2022).

Participants emphasised setting short-term goals rather than aiming for a longer-term outcome. By setting short-term goals, participants believed the service user and the nurse could jointly identify and address critical needs while enabling the recovery process to continue beyond the support of mental health services. Rather than positioning the clinician's views in opposition to the service user, the principles of enabling the setting of short-term goals imply collaboration. However, where recovery understandings may differ between service users and mental health nurses, the ability to set shared goals may be hindered (Simpson et al., 2017).

Within the theoretical context, seeing mental health nurses as enablers for implementing recovery-orientated nursing practices is not new. For example, Barker (1989 pp: 138) suggests that it is fundamental to the role of the mental health nurse to facilitate the "provision of the necessary conditions for the promotion of growth and development", using whatever resources available (Barker & Buchanan-Barker, 2011).

Within the empirical context, mental health nurses have been described as facilitators who join the person to support the journey (Jacob et al., 2015 pp: 12). Participants in McKenna et al. s. (2014 pp: 531) study report: "we do our best with the resources we have got, with the knowledge we have, to empower [the service user] enough to get them going through the next step…". In this context, it was seen that mental health nurses should try to foster the essence of hope and optimism to facilitate empowerment and promote personalised recovery pathways (Gale & Marshall-Lucette, 2012; Cleary & Dowling, 2009).

Recovery-orientated practices may be hindered by a reluctance to discuss risk assessment and management with service users (Simpson et al., 2017). Moreover, the service user's goals may not always align with nurses' views or fit within the scope of mental health services. Exploring this potential arose the concept of positive risk-taking,

which participants described as considering mental capacity while empowering people to make decisions others may deem unwise.[18]

As explored in Chapter One , positive risk-taking is a collaborative process (DH, 2008) and has been identified as a fundamental skill that mental health nurses should be confident and competent at implementing; ‘being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk’ (DH, 2009 pp: 11).

As participants informed, positive risk-taking is not always easy for mental health nurses to follow. For example, a service user setting a goal to stop taking their prescribed medication may pose a moral or ethical dilemma for nurses in that doing so could lead to relapse and potentially harm the service user. Nevertheless, mental health nurses can offer interventions other than medication to enable the service user to achieve or pursue their individualised recovery, for example, increasing the frequency of contact with the service user and speaking to and supporting family members.[19]

Implementing choice is often wrapped up in the constraints of neoliberal ideology. Such ideology would argue that the mental health nurse has the expertise to know what is best for the service user. If the service user disregards the nurse’s recommendations, the consequences of their decision, whether positive or negative, sit with the service user alone.

Within the sociopolitical context underpinning contemporary mental health services of the past two decades, “the ideal of choice and its conflation with responsibility thus creates the possibility for the removal of choice. Choice is contingent on conformity” (McWade, 2016, p. 16). In other words, people are rewarded for making right decisions and can be punished for making wrong decisions (Braslow, 2013).

[18] Chapter Four (p. 123-124)

[19] Chapter Four (p. 124)

Despite the sociopolitical critique of choice at the core of positive risk-taking, the overall principle of positive risk-taking provides a current process by which nurses can focus on the individual needs of the service user in contention with the potential conflicts of clinical expertise and service expectations. For participants in this case study, positive risk-taking helps them to see the service user as a being with thoughts, feelings and preferences rather than a set of symptoms or risks that require managing or containing.

Once aligned towards the enabling principles of seeing the person as an individual, setting short-term goals, and promoting choice through positive risk-taking, participants argued that nurses must set out to instil hope in the service user. The term hope is engrained within the philosophy of recovery, a belief in the possibility of living a meaningful life beyond the limitations caused by mental illness (Anthony, 1993). In addition, within the empirical literature of Chapter Two, the term hope was raised within the discourse of most reviewed studies.

McKenna et al. (2014) found that inspiring hope for the service user is supported through narrative discussion and respect for the service user's unique circumstances. In addition, Gale and Marshal-Lucette (2012) report that if a service user is to gain a positive vision of the future, nurses must have a sense of hope and optimism in implementing care and therapeutic engagement.

Within Chapter Two, it needed to be clarified if all mental health nurses hold a shared conceptual understanding of hope or its applicability to the implementation of recovery-orientated nursing practices. Similarly, some participants, only tentatively, without apparent meaning or application, implied the idea of hope as being associated with recovery-orientated nursing practices. For example, participants of one focus group highlighted hope as being relevant to recovery but questioned each other to validate this position.[20]

[20] Chapter Four (p. 124)

Cleary and Dowling (2009) echoed that some mental health nurses needed help to co-develop realistic service user expectations. However, other participants explained why instilling hope was central to implementing recovery-orientated nursing practices, a means by which nurses can help service users set and focus on goals in the short, medium and long term.[21]

Although highlighting hope within this section, participants did not use the term as frequently as expected. Participants who referred to the term hope positioned it as an envisioned outcome of recovery-orientated nursing practices formed by embedding the enabling principles. Given its central position within the empirical literature and recovery philosophy, it was anticipated that participants would have placed a more significant emphasis towards its relevance.

The surrounding narrative of recovery-orientated nursing practices weighs heavily on morality and ideology rather than considering applicability and reality within mental health services. One end argues that recovery is an objective reality that can be achieved when people engage with the support provided by mental health services. The other end sees recovery as subjective, a phenomenon definable only by the service user and, seemingly, in opposition to the conception of a clinically-defined recovery.

As explored in Chapter One, the values-based philosophy of recovery is often viewed as scientifically insignificant (Davidson & Roe, 2007), conceptually complex (Kusdemir et al., 2022) and lacking a consensus of understanding (Hopper, 2008), which has proved problematic for empirical investigation and service operationalisation (Slade, 2009).

Confusion around the applicability of recovery starts at the semantic level, let alone the conceptual. In other healthcare domains, the term recovery refers to returning to good health after an episode of illness through treatment or cure. It does not resemble the “unique process” described by Anthony (1993). It is essential to note this challenge when

[21] Chapter Four (p. 124)

considering the seemingly opposing perspectives of some participants compared to others.

However, seeing the two types of recovery in complete opposition would be an inaccurate denotation of recovery-orientated nursing practices, as participants in this case study reported. Within the extent of implementing recovery-orientated nursing practices, the concept of recovery must "connect into clinicians' sense of their context and the challenges they face, their history and resources, and their understanding of the cultural barriers and drivers for change" (Lynch et al., 2018). To better comprehend the contextually complex, subjective and objective elements of, what we call, the recovery-continuum requires a depth of philosophical framing.

In his guide for mental health professionals, Slade (2009) calls for a constructivist approach when practising through a recovery orientation, where professionals can integrate clinical models of care and treatment, along with acknowledging the uniqueness of the individual. Slade's proposed constructivist epistemology positions the clinician's knowledge as nomothetic (underpinned by empirical evidence) and the service user's knowledge as ideographic (individual and distinct from others).

Slade's constructivist position speaks to many clinicians who practice through rigorous empirically-based interventions (such as psychological therapies and pharmacological interventions). However, ever-evolving sociopolitical and sociohistorical factors have hindered mental health nursing in developing a coherent professional knowledge base (McCrae & Nolan, 2016; Chatterton, 2004; Health Education England, 2022). As a result, mental health nursing lacks an identifiable and universally agreed nomothetic base to fully accept Slade's epistemological propositions.

That said, the core tenets of social constructivism can help us understand the philosophical nature of the recovery continuum, as has emerged through the nuances of participants within this case study. As explored in Chapter Three, social constructivism is a paradigm based on interpretivism, where the emphasis is placed on the construction of knowledge through the personal interactions of and between individuals or groups (Weaver & Olson, 2006).

Constructivism focuses on the individual's knowledge relative to their experiences and interpretations; thus, the explanation of reality is multiple. Social constructivism accepts that these numerous realities are subjectively constructed through our lived experiences and interactions with others (Creswell, 2013). These constructions are not set in stone or viewed as absolute truth; they can alter as they become better informed and sophisticated (Guba & Lincoln, 1994).

Participants of this case study suggest that recovery-orientated nursing practices are not specific clinical interventions. Instead, they are processes by which mental health nurses can help co-create the conditions that enable the service user to identify a state of being, subjectively or observably defined by the individual as wellness or fulfilment. A place or process that one may (or may not) call recovery.

Table 14 provides a social constructivist framework for how mental health nurses within this case study conceptualise recovery-orientated nursing practices. From here on, recovery-orientated nursing practices refers to the continuum within this philosophical framework.

Table 14. Recovery-orientated nursing practices continuum

Assumption	Philosophical question	Characteristics of social constructivism	As applied to recovery-orientated nursing practices
Ontology	What is the nature of reality, its form, and what can be known about that reality?	Our lived experiences and interactions with others construct multiple realities.	The nature and form of recovery may differ from one person to the next. However, the clinical and personal experiences of the mental health nurse, interacting with the person's lived experiences, will lead to the co-construction of an individually defined recovery. These constructions of recovery, or the reality of recovery in any given context, can alter as they become better informed and sophisticated through direct interactions with others.
Epistemology	What is the relationship between the mental health nurse and the person? How are the claims of recovery-orientated nursing practices justified?	The interactions between people, shaped by individual experiences, co-construct the meaning of reality.	The nature of the relationship between the mental health nurse and the person may be fraught with power imbalances and competing perspectives of reality. The mental health nurse must acknowledge these potential differences, setting out to see the person as an individual. The nature of recovery-orientated nursing practice sits on a continuum of observable and subjective phenomena. Therefore, the claim for implementing recovery-orientated nursing practices is justified by the co-creating articulation of the person's meaning of recovery.

Assumption	Philosophical question	Characteristics of social constructivism	As applied to recovery-orientated nursing practices
Axiology	What is the role of values?	Values are honoured and negotiated between and among individuals.	The nature of recovery-orientated nursing practices is laden with individual and aggregated values, morals and beliefs. What matters to one person may not matter so much to another. A deviation in values may pose a significant ethical and moral conflict for mental health nurses. The role of values must be negotiated between the mental health nurse and the person.
Methodology	What process can nurses take to discover what they believe can be known?	The inductive method of emergent ideas – developing truth through consensus.	Recovery-orientated nursing practices are not specific practical interventions. Instead, they are processes by which mental health nurses can help co-create the conditions that enable the person to identify a state of being, subjectively or observably defined by the individual as personal wellness or fulfilment. Recovery-orientated nursing practices are characterised by but are not limited to, the enabling principles: seeing the person as an individual, setting short-term goals, and promoting choice through positive risk-taking. Individually defined recovery, within the context of recovery-orientated nursing practices, can only be known through collaboration between the person and the mental health nurse. The meaning of an individual's recovery can be known through consensus of understanding.

Question 2: What are the barriers and enablers towards implementing recovery-orientated nursing practices?

Summary

This case study has found there to be a multitude of reported barriers and enablers towards the implementation of recovery-orientated nursing practices. Most of these relate to various service processes and procedures (i.e. risk management, paperwork, admission and discharge) or how mental health nurses engage with others (i.e. service users, families and carers, and other professionals).

Practice-based nurses needed more power and control to overcome systemic challenges at the micro, meso and macro system levels (i.e. opposing professional paradigms, untenable service demands and social issues). In the way of barriers, many of the problems reported by participants could be inferred as engrained sociocultural issues rather than measurable or justifiable processes and procedures.

Discussion

To better understand the system barriers and enablers influencing the implementation of recovery-orientated nursing practices, this section presents the answers to this question within the micro, meso and macro systems levels (Babbie, 2014). In so doing, systems theory helps frame these issues within their sociocultural, sociopolitical, socioeconomic and sociohistorical contexts.

Micro-level sociocultural issues

At the micro-level within inpatient settings, the presentation of some service users was seen to be a barrier towards implementing recovery-orientated nursing practices, where the higher demands of some can hinder the delivery of care to others. In addition, nurses felt that they frequently have to deescalate acutely unwell people on a shift, taking them away from other activities and tasks and focusing instead on safety

and risk management (reducing the likelihood of harm occurring to the service user and others around them).[22]

The diversity of people's needs and the acuity of inpatient wards were highlighted as conditions that impact the successful implementation of recovery-orientated nursing practices (McKenna et al., 2014; Aston & Coffee, 2012).

Where nurses reported struggling to implement recovery-orientated nursing practices within managing acuity, there is a need to look deeper into this perspective. For example, the findings suggest that ‘louder’ service users may occasionally be seen as less acutely unwell than others deemed ‘quiet’. Furthermore, quiet service users were viewed as ‘less troublesome’.[23] This perspective of acuity suggests that these participants may judge some visibly agitated or in a heightened state of arousal as less in need than others.

This notion is familiar within nursing via Safewards Model through understanding conflict and containment in psychiatric wards. As Bowers et al. (2014) explain, conflicts threaten staff or service user safety, including verbal abuse, physical aggression to others, self-harm, suicide, and absconding. Containment means those things nurses do to prevent these events or minimise the harmful outcomes, including using a sedating medication, therapeutic observation, manual restraint, and seclusion.

As is aligned with the Safe Wards model (Bowers et al., 2015), participants report that engaging with service users was seen to put nurses in a position to use their interpersonal skills to provide preventative support to disturbed service users rather than having to respond to conflict via containment.

Within their control, nurses believed it paramount to have protected engagement time with service users during every shift to promote the therapeutic relationship. Engagement with nurses is essential to recovery-orientated nursing practices (Aston & Coffey, 2012). This statement rings true to early nursing theory. For example, Peplau (1952) first noted that interpersonal skills were essential in forming therapeutic relationships between mental health nurses and service users.

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[22] Chapter Four (p. 136)

[23] Ibid

Aston and Coffee (2012) eluded to the finding that constant [therapeutic] observations[24] made it difficult to implement recovery-orientated nursing practices in the inpatient environment. Conversely, participants within this case study saw therapeutic observations as a means by which nurses formally prioritise and focus on service user engagement, where nurses are less likely to be disturbed by other service demands, focusing instead on implementing recovery-orientated nursing practices.

Engaging with service users was seen by participants as the true purpose of the inpatient mental health nursing role. However, in calling therapeutic engagement 'proper work', participants have implied that they also undertake activities unaligned with what they see as core nursing practice.[25] This assertion is revisited in the context of a rigid culture of monitoring and control later in this chapter.

The care of service users within an environment that restricts people's liberties through detention under the Mental Health Act (1983) was seen to be another barrier towards implementing recovery-orientated nursing practices and a cause of distress for the service users. Although participants blame the Mental Health Act as the barrier to implementing recovery-orientated nursing practices, when looking deeper into the issue, participants' phrases, such as 'they will keep knocking, and they will keep knocking', suggest that the service user's actions may be seen as a barrier. More accurately, how detained service users engage with nurses may be interpreted as, at times, tedious.[26]

Such a position resonates with the well-versed sociocultural power imbalance within mental health establishments, first articulated by Goffman (1961) and later Foucault (1971), whose writings of anti-psychiatry challenge the established culture within institutions. The reality of recovery through empowerment and choice for people detained under the Mental Health Act presents a paradox (McWade, 2016). As discussed above, this notion is familiar within nursing via Safewards Model through understanding conflict and containment in psychiatric wards.

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[24] A 'task' to monitor the risk and presentation of service users

[25] Chapter Four (p. 136)

[26] Chapter Four (p. 137)

Within this section, the assertion has been made that nurses may hold sociocultural biases towards the service user, which is non-conducive to implementing recovery-orientated nursing practices. Moreover, participants outrightly described prejudice against the service users who seemingly present with issues considered behavioural rather than a symptom of a diagnosable mental illness.

For almost two decades, the Department of Health (2006) has stated that implementing recovery-orientated nursing practices "means working towards meaningful aims to the person, being positive about change and promoting social inclusion for mental health users and carers". Although inexplicitly within the context of recovery, the All-England Review of Mental Health Nursing (Health Education England, 2022) does refer to mental health nurses' role in engaging with and supporting families and carers adjacent to the needs of the service users.

What is known in the empirical literature is that the concept of recovery in the eyes of families and carers may be more aligned with the idea of returning to a pre-illness state rather than aligning to an individually-defined recovery (Jacob et al., 2015). Nevertheless, participants in this case study found that families and carers were invaluable resources in helping nurses implement recovery-orientated nursing practices.

Moreover, families and carers were seen by participants as a vital resource in helping nurses to better understand 'challenging' service users as unique individuals, of whom nurses readily and openly express holding ingrained biases. In so doing, the role of families and carers also helped nurses establish a therapeutic relationship with the service user, mainly where the service user may be unwilling or unable to provide information. Finally, engaging with families and carers was seen by participants as a means to help nurses understand the service user's individual needs and personal circumstances.[27]

Where mental health nurses within this study seemingly endeavoured to provide holistic care (biological, psychological and social needs), addressing all holistic domains were often seen as challenging. Nurses' engagement with families and

[27] Chapter Four (p. 128)

carers purportedly helped to identify and address some of the social needs of service users that could have otherwise been overlooked.

Furthermore, nurses offering guidance to families and carers on supporting their loved ones at home was believed to promote recovery beyond the hospital setting and avoid future crises. Although the depth of the available data on the role of carers within this case is limited, recognising their role in enabling recovery-orientated nursing practices is worth noting.

Meso-level sociopolitical issues

In this case study, recovery as a process was often articulated against the system transition points within mental health services, namely: assessment, inpatient care and treatment (crisis), discharge to community care (recovery) and independence without services (beyond). Barriers towards implementing recovery-orientated nursing practices were reported when bottlenecks between the transition points occurred, delaying the service user's recovery journey through and beyond the system.

The empirical literature in Chapter Two proposed that discharge planning was a means by which mental health nurses could implement recovery-orientated nursing practices (Cleary et al., 2013). In addition, early planning towards discharge was reported to be a way mental health nurses promoted hope towards a future beyond the hospital setting and mental health services (McKenna et al., 2014).

Moving from crisis to recovery was seen to occur at the transition point of inpatient care and treatment and discharge to community care. It was within this system context that participants within the inpatient services and those in the community held a sense of blame towards each other for creating barriers towards implementing recovery-orientated nursing practices.[28] Despite the existing empirical literature mentioning the relevance of discharge planning, framing potential barriers and enablers at the system transition points appears to be newly explored within this study.

[28] Chapter Four (p. 133)

Service users value the therapeutic relationship with care coordinators, which is central to supporting recovery (Simpson et al., 2016). Participants in this case study believed that people's recovery journey through the hospital setting and discharge to the community was greatly hindered when the service user's care coordinator needed to be more actively engaged with their care and treatment in the hospital setting.[29]

Contrary to blaming the lack of engagement of care coordinators, poor communication and engagement within and from inpatient mental health services with community services was identified, by community-based participants, as a reason why service users may need more timely community support.[30]

For those without pre-existing community support, inpatient-based mental health nurses also saw allocating a new care coordinator as a barrier towards implementing recovery-orientated nursing practices. In addition, excessive delays to someone's discharge from a hospital setting due to lack of community support were said to, at times, take the service user from a stage of recovery into one of crisis.

Aligning with the concerns of inpatient-based mental health nurses, the delay in allocating new care coordinators was a consensus among community-based participants, attributing the issue to a seemingly extensive waiting list and high workload demand.

Care coordinators actively involved at the point of care and treatment were seen as enablers towards implementing recovery-orientated nursing practices, supporting people's transition from the hospital to the community. However, even when people are discharged from a hospital setting with an active care coordinator, they can still relapse, move into a state of crisis and return to a hospital setting.

The micro-level idea of positive-risk taking was discussed earlier in this chapter as an enabling principle of recovery-orientated nursing practices. Within its sociocultural context, the notion of risk-aversion exists as a meso-level concept engrained within the discourse of recovery-orientated nursing practices. For example, when a

[29] Chapter Four (p. 131)

[30] Chapter Four (p. 130)

community team recommends admission based on potential but not immediate risk, the inpatient team questions the assessment and deems the risk levels unsuitable.

Participants believed that there was a risk-averse culture within the Trust when identifying people's admission suitability, admitting people who, in their view, were not posing substantial risks to themselves or others.[31] In Chapter Two, McKenna et al. (2014) highlight that mental health nurses viewed a risk-averse culture as a competing priority, a barrier to successfully implementing recovery-orientated nursing practices. Outside of their control, nurses felt disempowered within inpatient mental health services to implement positive-risk approaches when other clinicians decide to admit.

Moreover, towards implementing recovery-orientated nursing practices, participants stated that risk-averse practices could negatively impact how they view the service users. For example, the service users perceived to be unsuitably admitted under the precedence of a risk-averse decision appeared to be attributed with a level of blame for their role in the process.

This issue depicts the sociopolitical tension between neoliberal risk principles and recovery's existential positive-risk taking. Neoliberal policies aim to reform citizenship as a project to pursue self-improvement through individual responsible risk-taking. One is rewarded for making the right decision but can be punished for making the wrong decision (Braslow, 2013).

The neoliberal policy principles that apply to mental health service users also apply to mental health nurses (Wand, 2017). In addition, such policies fuel a blame culture, further instituting a risk-averse approach within mental health services. For example, Cleary & Dowling (2009) noted the dissonance nurses report, where one policy may set out to support the service user and the mental health nurse to take positive risks (i.e. a recovery policy), while another may arouse a risk-averse approach. Moreover, bureaucratic management approaches arise, where individuals are assigned accountability for their actions, even for issues attributed to system-level failures (Khatri et al., 2009).

[31] Chapter Four (p. 132)

It has been argued that nurses would further embrace positive risk-taking if their organisation better supported them to do so (Le Boutillier et al., 2015b). However, against the sociopolitical backdrop of neoliberal policy, the influential risk-averse culture, and the overbearing fear of doing something wrong, implementing positive-risk taking within mental health services requires a significant change at all system levels.

Underpinned by the neoliberal principles discussed in the previous paragraphs, participants reported a further meso-level barrier to implementing recovery-orientated nursing practices, a culture of monitoring and control, underpinning the well-versed notion that 'if it is not written down, it did not happen'.[32] The empirical literature in Chapter Two found that mental health nurses who work in rigid task-orientated services report frustrations and increased time pressures impinge on their ability to implement recovery-orientated nursing practices (Aston & Coffee, 2012; McKenna et al., 2014).

Excessive and unmanageable demand for the routine completion of paperwork to provide data to meet many corporate targets was viewed as one of the most significant barriers to implementing recovery-orientated nursing practices.[33] In addition, this imposed structure indicates a loss of control for nurses in practice. The burden of excessive paperwork is illustrated within and across the broader literature as a barrier towards implementing recovery-orientated practices (Mhlanga, 2022; Hannigan et al., 2018; Simpson et al., 2016).

These organisational demands align with the notion of a service-defined-recovery (Le Boutillier et al., 2015a); a corporate agenda that uses nurses as a means to meet targets that satisfy the demands of external commissioners (Mhlanga, 2022), with the ultimate aim of reducing costs for the organisation (Gilburt et al., 2013; Cleary et al., 2013).

The principles of a service-defined recovery align with command-and-control managerial thinking (Seddon, 2008): a top-down functional design, reactive to political

[32] Chapter Four (p. 142)

[33] Chapter Four (p. 141-142)

agenda for change, bearing a contractual attitude towards staff and service users. The role of management is to meet the organisation's measuring criteria of outputs, targets and standards driven by organisational budgets.

Against this complex sociopolitical meso-level barrier, implementing recovery-orientated nursing practices is an expected challenge for mental health nurses. Decision-making, power and autonomy must be more evenly shared between service users, practitioners and managers of mental health services if this barrier is to be overcome (West et al., 2020; Tse & Whitley, 2014; Shepherd et al., 2010; Boardman & Shepherd, 2009; ImROC, 2017b; Ham, 2014).

Macro-level socioenvironmental and sociohistorical issues

At the macro level beyond the control of the Trust, participants reported increasing demands on mental health services as a barrier to implementing recovery-orientated nursing practices. During this case study, there was a steadily growing demand for the Trust's mental health services month after month, increasing by 8% between April 2016 and March 2018 (NHS Digital, 2022a).

There was a steep drop-off in people accessing the Trust's mental health services at the beginning of the first Covid-19 lockdown (over one-third) between March 2020 and April 2020. However, demand reaccelerated to a 26% increase from April 2020 to March 2022 (NHS Digital, 2022a). This is a 21% increase in demand from April 2016 to March 2022. As such, the increasing demand placed on mental health services, raised by participants at the time of this case study, is almost threefold the issue today as it was then.

As a barrier towards implementing recovery-orientated nursing practices, inadequate staffing numbers were seen to be aligned with excessive caseloads caused by increasing service demand. Participants explained how the challenge of insufficient staffing is not only about the total number of nurses available on each shift but has more to do with the specific skills, knowledge and experience required to support the implementation of recovery-orientated nursing practices.[34] Regardless of the quality

[34] Chapter Four (p. 138)

of experienced nurses available within services, where caseloads exceeded what was considered manageable, work pressures increased, and nurses could not implement recovery-orientated nursing practices.[35]

Clinicians reported similar findings within Mhlanga's (2022) case study, where community nurses struggled to implement recovery-orientated practices due to excessive service demand. The lack of adequate nursing staff to meet these increasing demands were highlighted in this case study as a meso-level barrier to implementing recovery-orientated nursing practices. Again, this issue is outside the control of practice-based nurses but is believed to be within the control of nursing executives.

However, the impact of workload pressures and macro-level service demands was noted at all levels of the Trust. The constraints experienced by nursing executives hindered the implementation of recovery-orientated nursing practices. Competing tasks such as recruitment, sickness management, and managing safe staffing (reporting on safe staffing) took leaders away from where care is being delivered.[36]

During this case study, there was a steady reduction of nurses within the Trust month after month. A decrease in full-time equivalent nurses and health visitors by 6% between April 2016 and March 2018 (NHS Digital, 2022b). Against the steep increase in demand for mental health services between April 2020 to March 2022, there has been a 4% reduction in full-time equivalent nurses and health visitors within the Trust during this same period (NHS Digital, 2022b). The data does not break down the field of practice for nurses within the Trust (i.e. adult vs mental health nurses). However, this is undoubtedly a contemporary issue that persists beyond the confined time period of this case study.

Nationally, there has been a 21% increase in community-based mental health nurses from April 2016 to August 2022. However, there has been a 10% reduction of mental health nurses within other services. As a result, the number of mental health nurses has grown in community care but at the expense of inpatient services which have lost

[35] Chapter Four (p. 138)

[36] Ibid

more than 6,000 registered nurses over the past decade (Jones, 2021), aligning with an almost 25% reduction in mental health beds within the same period (The Kings Fund, 2021).

Although concerning for hospital-based recovery-orientated nursing practices, this is a significant milestone in advancing mental health nursing, moving away from its institutional roots to community care (Brimblecombe, 2022). Consequently, more mental health nurses are practising in the community for the first time in England's history than working within hospitals.

As discussed in Chapter One, a central tenet of neoliberal mental health policy is to decrease service user dependency upon the state-run NHS; to reduce the 'burden of demand' and government spending (McWade, 2016; Braslow, 2013). Nevertheless, what is evidenced within this case study is that people are becoming more dependent on NHS mental health services, and the demand is increasing. However, the number of mental health nurses to meet that demand is seemingly diminishing.

A discourse amongst participants was around socioenvironmental factors' influence on people's mental health. This was seemingly a macro-level issue beyond the control of mental health nurses and outside of the provision of the Trust's services.

Participants argued that most admissions to inpatient settings were underpinned by complex social and emotional needs rather than the care and treatment of a mental illness.[37] Accordingly, mental health nurses in England have called for evaluating the current capacity and structure of crisis and community-based mental health services for people who do not effectively respond to the traditional offer of psychiatric treatment (RCN, 2021a). Such a shift in service user needs undoubtedly challenges the crisis-orientated status quo of many secondary mental health services.

Participants believed it was within their control to address some social needs (i.e. completing benefit applications and undertaking referrals to social care). However, substance misuse, dysfunctional families, poor social networks, inadequate housing,

[37] Chapter Four (p. 135)

and supporting marginalised groups such as asylum-seekers to access public funds were seen as challenges beyond the direct control of mental health nurses.[38]

When people's social needs remain unaddressed, it was felt that the implementation of recovery-orientated nursing practices was impeded. Once service users' clinical symptoms and risk levels had reduced, they were often discharged to the unchanged social environments that contributed to their crisis.[39] In the broader literature, the persistent issue of 'revolving-door' service users was said to prevail when people were discharged early or their social needs remained unaddressed (Mhlanga, 2022).

As a macro-level issue, accessing appropriate housing was considered a fundamental need that could significantly enable or impede someone's recovery beyond the hospital setting. It was believed that the time it takes to acquire appropriate accommodation resulted in significant delays in people's discharge from the hospital to community care, contributing to relapse and additional periods in the hospital setting.[40] This finding is echoed by Mhlanga (2022), who further identified mental illness stigma and social exclusion as a likely pretext for why some people experience delays in receiving support from housing agencies.

Within the extensive socioenvironmental challenges facing nurses towards implementing recovery-orientated nursing practices, there remains a possibility that the eventual introduction of Integrated Care Systems (ICS) will lead to better coproduction and transition between health and social care (Health and Care Act, 2022). In that case, operational processes within ICS need to enable mental health nurses to review, develop and adapt the structure and delivery of services in direct response to the needs of local populations (Health Education England, 2022; 15).

The clash between personal and clinical recovery was comprehensively explored in Chapter One and discussed within this case study's context when considering how mental health nurses conceptualise recovery-orientated nursing practices. The issue of opposing professional paradigms has already been situated within the micro-level

[38] Chapter Four (p. 135)

[39] Ibid

[40] Ibid

and meso-level of the Trust, in direct control of practice-based nurses and nursing executives. However, as explored in Chapter One , the lack of identity and varying practice paradigms of mental health nursing are saturated with sociopolitical and sociohistorical complexity (Jones, 2023a).

With participants reporting that psychiatrists make the most critical clinical decisions, particularly in the hospital setting, the so-called ‘medical model’ was the dominant paradigm influencing nursing practice.[41] The measure of recovery is from a biological (recovering through pharmacological treatment) rather than a psychosocial (considering and addressing social and psychological factors) perspective.

The sociohistorical power struggle between mental health nursing and psychiatry remains a cornerstone of contention within the field of mental health nursing today (Brimblecombe, 2005; Nolan, 1993; Sands, 2009). It is within the macro-level context that this barrier needs to be understood. Acknowledging the dominance and limitations of a paternalistic medicalised model of mental illness can promote the diversity of alternative practice methods, which may better suit the needs of individuals (Kidd et al., 2015; Slade, 2009).

Notwithstanding participants’ general criticality that nursing practice is heavily influenced by and aligned towards a medicalised mode of care, the practice paradigms of psychological therapists' were also seen as a barrier towards implementing recovery-orientated nursing practices, inadvertently negating the biosocial needs of service users when seen as the primary intervention.[42]

In Chapter Two, interdisciplinary working was presented as something that may help nurses identify and manage their professional values and practices towards a more recovery-orientated approach (Cleary et al., 2013). However, nurse-to-patient and interdisciplinary collaboration can be impeded by determents of power such as knowledge, information and expertise (McCloughen et al., 2011), where there may be competing practice paradigms among multi-professional clinicians.

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[41] Chapter Four (p. 140)

[42] Chapter Four (p. 141)

Despite feeling trapped by domineering practice paradigms, mental health nurses believed that their ability to form unique therapeutic relationships, underpinned by their 24-hour engagement with the service users (within the hospital setting), empowered them to have exceptional knowledge to influence holistic clinical decisions (i.e. appropriate treatment pathways and suitability for discharge).[43]

Explored in Chapter One , the Nursing and Midwifery Council (NMC, 2014; 2018b: 15) stipulates that registered mental health nurses must focus on "social inclusion, human rights and recovery, that is, a person's ability to live a self-directed life, with or without symptoms, that they believe is meaningful and satisfying." Furthermore, the NMC not only give mental health nurses responsibility for practising in a personal recovery orientation but stipulate that "Mental health nurses must contribute to the leadership, management and design of mental health services. They must work with service users, carers, other professionals and agencies to shape future services, aid recovery and challenge discrimination and inequality" (NMC, 2018b: 17).

However, the power granted to mental health nurses to change policy and practice at the micro, meso and macro systems still needs to be improved and not remain secondary to the influence of other professional groups. Therefore, mental health nurses' professional obligations towards implementing whole-systems recovery-orientated nursing practices will only be successful when macro-level and organisational policies move away from polarised care paradigms towards more holistic biopsychosocial thinking.

Question 3: How do nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices?

Summary

Participants argued that nursing executives often conflicted with opposing organisational priorities within mental health services, hindering them from directly

[43] Chapter Four (p. 141)

influencing practice-based nurses towards implementing recovery-orientated nursing practices. In addition, despite some nursing executives seeing recovery as a philosophy of practice already embedded Trust-wide, others regarded it as an ambition rather than a current reality. Therefore, nursing executives highlighted an implementation gap from nursing strategy to policy and into practice.

Furthermore, nursing executives viewed policies and procedures as a means to influence the implementation of recovery-orientated nursing practices. However, practice-based nurses reported needing more connection with creating and operationalising policies. Moreover, a strict hierarchical structure hindered communication between those directly delivering care and those leading the Trust's strategic direction. Therefore, visible leadership through role-modelling at all levels is essential if nursing executives are to influence practice-based nurses towards implementing recovery-orientated nursing practices.

Discussion

Despite the national strategic drive towards recovery, complex challenges remain to successfully transform mental health services towards a recovery orientation (Slade et al., 2017a). With its multi-dimensional nature, determining the 'correct' meaning of recovery within an interrelated and variable set of organisational, professional, sociopolitical and sociohistorical contexts presents a significant challenge for practice-based nurses and nursing executives within this case study.

As with any system change, careful consideration and ongoing implementation evaluation are necessary for successful change to occur (Weiss, 1995) or be tangibly observable. Delivering good quality care and positive service user outcomes were generally accepted by participants as the core goals of both practice-based nurses and nursing executives within this case study. However, although believing this to be the case, an apparent conflict prevailed around how these goals are implemented, measured and promoted within the Trust.[44]

[44] Chapter Four (p. 147)

The issue of continuity within systems leadership from board to ward is a prerequisite for implementing recovery-orientated nursing practices and remains a significant hurdle across mental health services (Slade et al., 2017b). For example, practice-based nurses argued that nursing executives often prioritised measurable targets (i.e. the number of contacts made and service throughput) rather than considering processes that promote individual outcomes, the latter being central to recovery-orientated nursing practices and ostensibly the priority of most practice-based nurses.

In such circumstances, several participants felt that most targets were in place to make it seem like good practice was occurring within services, even when it may be an inaccurate reflection of reality.[45] Moreover, Mhlanga (2022) found that what was prioritised and measured by commissioners became a priority for service providers. Aligned with this conclusion, practice-based nurses believed that nursing executives prioritised the image of the Trust to external commissioners more than they sought to internally influence nurses towards implementing recovery-orientated nursing practices.

Participants appreciated the good intentions behind setting commissioner-led service targets; the issue was not with the targets themselves but with how seemingly pressured Trust leaders attempted to measure and guarantee their objective implementation in practice. Nursing executives also recognised the divergence within their role in building the business reputation of the Trust while also being responsible for developing and influencing the implementation of recovery-orientated nursing practices.[46]

Although this case study did not illuminate the particular measures or processes commissioners use to determine the efficacy of mental health services, participants deemed that the actions of nursing executives needed to be more explicitly personal recovery-orientated rather than following a service-defined recovery approach, as similarly observed by LeBoutillier et al. (2015b). Furthermore, the empirical literature highlights mental health nurses' concerns that recovery appears to be a corporate

[45] Chapter Four (p. 145)

[46] Ibid

agenda; aimed at reaching targets to satisfy government and ultimately reduce costs for the organisation (Gilburt et al., 2013; Cleary et al., 2013).

Although the ambition of the nursing executives to provide exemplary service user care within the Trust was not disputed, the level of attention placed upon finances was another competing priority, overshadowing their ability to influence the implementation of recovery-orientated nursing practices. Validating this assumption, nursing executives proclaimed that putting such pressures restricted practice-based nurses' ability to proactively implement recovery-orientated nursing practices in fear of going over heavily monitored and constrained budgets.[47]

This issue further compounds the concerns discussed earlier in this chapter around command-and-control thinking and a service-defined recovery, where at least partly, the role of nursing executives may well be to meet the organisation's targets measured by service throughput and accessibility, driven by financial and administrative goals, to reduce costs and shape practice (Le Boutillier et al., 2015a; Seddon, 2008). Additionally, a primary focus on finances over a primary emphasis on recovery-orientated nursing practices echoes the central tenets of neoliberal economics and citizenship prevailing through a financially constrained health service (NHS, 2016).

As per the philosophical framework outlined in Table 13, the nature of recovery-orientated nursing practices is laden with values, morals and beliefs. As it is between nurse and service user, a deviation in values between practice-based nurses and nursing executives may pose a significant ethical and moral conflict. Participants having potentially opposing values, whether implicitly or explicitly, pose a challenge to the identity of mental health nursing and, consequentially, recovery-orientated nursing practices. As Romme (2016) would argue, the foundations of professional identity are built on a shared purpose, defined by the professional's knowledge and values, along with the associated interventions.

Where the priorities of practice-based nurses and the nursing executive were varied and, at times, unaligned with one another, participants regarded the Trust values as essential grounding for influencing the implementation of recovery-orientated nursing

[47] Chapter Four (p. 145)

practices.[48] Parallel divergences in organisational priorities can be extracted from Mhlanga's (2022) case study, where similarly, senior leaders identified Trust values as a source of influence underpinning standard operational procedures.

Within the sociopolitical context at the time of this case study, against the backdrop of the "enduring values of nursing" (DH, 2012b, p. 5), the topic of values became a focal point for all nursing policy, education and practice from 2012 to 2016 in direct response to the failures outlined in the Francis Report (Francis, 2013). Furthermore, the enduring values of nursing continued into the 2016 nursing strategy in England: Leading Change, Adding Value (NHS, 2016), and the domain of values remains prominent in today's mental health nursing policy (Health Education England, 2022).

With mental health nurses perceiving recovery-orientated nursing practices in multiple ways in various system contexts, a philosophical consensus and a shared purpose are required at all levels of the Trust if nursing executives are to influence the implementation of recovery-orientated nursing practices. As pointed out by Le Boutillier et al. (2015a pp: 13), 'no stakeholder's interests are served if incompatible and unmeetable expectations are placed on staff to support all three types of recovery fully' (personal, clinical and service-defined-recovery).

The role of policies and procedures as a means for nursing executives to influence mental health nurses towards implementing recovery-orientated nursing practices is underexplored in the empirical literature. Moreover, the role of policies as a means to influence recovery-orientated practices was not explicitly explored within the findings of Mhlanga's (2022) case study.

Nursing executives viewed policies and procedures as instrumental in helping them influence the direction of clinical practice. The rationale was that if a policy promotes patient-centred care and therapeutic engagement, their application by practice-based nurses would undoubtedly enhance care delivery.[49]

In addition, they saw policies and procedures as supportive mechanisms made available to practice-based nurses, helping them avoid doing something wrong. It was

[48] Chapter Four (p. 146)

[49] Chapter Four (p. 151-154)

assumed that if nurses followed guidelines correctly, the implementation of recovery-orientated nursing practices would improve.

Conversely, practice-based nurses viewed the role of policies differently from their nursing executive colleagues. Regardless of the intent, content or wording, practice-based nurses reported feeling detached from forming and developing policies within the Trust. It was perceived that policies were created and implemented without discussing their relevance with those meant to use them.[50]

The role of the nursing executives towards implementing recovery-orientated nursing practices through the medium of policies was seen by some practice-based nurses as an abstract notion. The influence of the nursing executive within this context was said to be neither supportive nor hindering. Instead, it was felt that the ethical and moral underpinnings of the individual nurse, and the clinical teams, are more potential determinants for implementing recovery-orientated nursing practices.

Further opposing nursing executives' views, policies were primarily viewed by practice-based nurses as arbitrary guidelines of procedural processes, having little impact on how nurses implement recovery-orientated nursing practices. They argued that Trust policies even increased administrative nursing responsibilities. For example, it was believed that prioritising service user interactions through therapeutic time was against Trust policy because nurses are not documenting.[51]

However, when participants in this case study were asked which policies contributed to these issues, they could not identify specific documents. Nevertheless, the apparent service culture of prioritising administrative tasks persisted within the discourse.

In addition, mental health nurses in the broader literature report dissonance between a recovery-orientated culture and local policy; one may set out to support and empower service users and professionals to take positive risks, while another promotes a risk-averse approach to practice (Cleary & Dowling, 2009; McKenna et al., 2014).

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[50] Chapter Four (p. 153)

[51] Chapter Four (p. 151)

Participants reported no specific recovery policy within the Trust. However, the necessity for having a recovery policy was disputed. Instead, the enablers of recovery-orientated nursing practices were seen to be influenced by the practical application of nursing interventions, where policies were regarded only as guides that could help shape the frameworks and boundaries of care delivery.

Practice-based nurses reported a disconnect between them and members of the nursing executive. In addition, a strict hierarchical managerial structure hindered communication between those directly delivering care and those leading the Trust's strategic direction. The nursing executive acknowledged the communication gap between them and practice-based nurses. It was felt that the strategic message is often lost in translation as it filters down through multiple layers of the managerial hierarchy into practice.[52]

Where practice-based nurses reported feeling detached from the formation, development and implementation of policies within the Trust, a unified message of recovery at the strategic and operational levels of the Trust is yet to be found. If the nursing executives are to influence practice-based nurses towards implementing recovery-orientated nursing practices, they must create direct communication channels. Not attempting to engage through the intermediary of their senior colleagues is a necessary shift for the engagement of junior nurses to influence the implementation of recovery-orientated nursing practices.

The empirical literature in Chapter Two and the contemporary research explored within this chapter has not touched upon the issue of a hierarchical-nursing structure influencing the implementation of recovery-orientated nursing practices. However, the contextual literature in Chapter One discussed a service-defined recovery (Le Boutillier et al., 2015b), implicitly identifying a hierarchical barrier to implementing recovery-orientated practices. Moreover, the theoretical issues of command and control management (Seddon, 2008) better emulate the challenge around hierarchy as reported here.

[52] Chapter Four (p. 154-155)

Participants observed a disjoint between strategy and implementation as marred by measurements and targets seemingly unaligned with the original strategic vision for recovery-orientated nursing practices, as discussed earlier in this chapter. Here we can see Seddon's (2008) command-and-control thinking, a top-down functional design, reactive to political agenda for change, bearing a contractual attitude towards staff and service users, where the role of management is to meet the organisation's measuring criteria of outputs, targets and standards, concerning budgets.

Although it is one of the most observed concepts, no universally accepted definition or theory of leadership exists (Scully, 2015). However, within this case study, the idea of visible leadership was regarded by participants as a means for the nursing executive to cut through the managerial hierarchy and directly influence the implementation of recovery-orientated nursing practices. Participants believed being present, articulate and accountable at all Trust levels was crucial to a visible leader's repertoire.[53]

Within the broader literature, the most recent idea of visible leadership in nursing came to the forefront during the Covid-19 pandemic. However, this conceptualisation of visible leadership has more to do with making the role and decision-making of nurse leaders more visible to others (Rosser et al., 2020) rather than a means by which nursing executives are visible to practice-based nurses.

Synonymously aligned with visible leadership was the idea of role modelling. The concept of role modelling is already engrained in nursing leadership theory (RCN, 2022). The RCN articulates role modelling as aligned with the Chartered Institute of Professional Development (CIPD, 2022) definition of leadership: 'the capacity to influence people, using personal attributes and behaviours, to achieve a common goal.' Furthermore, role modelling in practice develops capability within people and services while inspiring a shared purpose (NHS Leadership Academy, 2013).

Nursing executives saw direct clinical supervision or line managing those who supervise other people as a means of engagement through the managerial hierarchy to influence the implementation of recovery-orientated nursing practices. Clinical

[53] Chapter Four (p. 149)

supervision was believed to be where nurses explored the meanings of their therapeutic relationships with service users while critically reflecting on the care provided.[54] Although there is no universally accepted definition of clinical supervision, its relevance in critically developing the capabilities of nursing practice is widely acknowledged (Jones, 2023b).

Nevertheless, practice-based nurses did not provide insight into the purpose and scope of clinical supervision within the remits of implementing recovery-orientated nursing practices. Instead, supervision was only highlighted as a means by which practice-based nurses could raise concerns with a senior colleague one-to-one, addressing issues locally and within their teams, a tool aligned with the hierarchical communication channels.[55]

This finding resonates with Masamha et al. (2022), who found that managerial and clinical supervision in nursing often coalesces into one. Moreover, mental health services in England have used clinical supervision to implement performance management interventions (White & Winstanley, 2021).

In conclusion, nursing executives acknowledged that using a strict hierarchical structure to influence the implementation of recovery-orientated nursing practices from strategy, through policy and into practice was an impeding process rather than conducive to service change and improvement. Therefore, developing a flatter hierarchy, with practice-based nurses working alongside nursing executives, was considered a necessary shift in Trust culture and system design (Seddon, 2008; Ham, 2014).

Finally, developing individuals and valuing the voice of practice-based nurses was seen as essential in ensuring the strategic drive for implementing recovery-orientated nursing practices is achieved. However, the perceived lack of visible leadership and engagement has potentially eroded the trust between those setting the Trust's strategies and those delivering care. Even if the nursing executives sincerely aim to

[54] Chapter Four (p. 150)

[55] Chapter Four (p. 150)

develop and support their staff in new ways, practice-based nurses may feel unable or unwilling to accept it.

Conclusion

The aim of this study, which was to explore how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services, has been achieved. This chapter has shown how mental health nurses conceptualise recovery-orientated nursing practices, the barriers and enablers towards implementing recovery-orientated nursing practices within mental health nursing across the Trust, and how nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices.

Participants described their experiences and observations and endeavoured to define recovery-orientated nursing practices within the context of mental health services. Both practice-based nurses and nursing executives primarily conveyed their understandings of recovery within a continuum of interrelated yet contrasting concepts: an objectively measurable outcome and an individually defined process. As a result, differences in views of recovery amongst participants were often nuanced and overlapping rather than divergent.

Organisational support for implementing the enabling principles was said to be within the Trust's strategic priorities. However, despite some nursing executives seeing recovery as a philosophy of practice already embedded Trust-wide, others regarded it as an ambition rather than a current reality. In this instance, nurse leaders highlighted a potential implementation gap from strategy to policy and into practice. Conversely, another nurse leader argued that the enabling principles are often impeded by opposing organisational priorities within mental health services. They aligned with the idea that other service-level targets can create a culture that hinders nurses from implementing recovery-orientated nursing practices.

It was believed that both practice-based nurses and the nursing executive have a similar core goal, promoting the quality of care for service users. However, priorities and methods for achieving this goal are only sometimes aligned. i.e. nursing executives prioritised numerically measurable targets, over-treating the service user

as an individual. In addition, how the nursing executives responded to issues in practice was said to be reactive rather than proactive.

A strict hierarchical structure hindered communication between those directly delivering care and those leading the Trust's strategic direction; visible leadership and clinical leadership at all levels were seen as essential. In addition, nursing executives viewed policies and procedures as a means to influence the implementation of recovery-orientated nursing practices. However, practice-based nurses reported needing more connection with creating and operationalising policies.

CHAPTER SIX: CASE SUMMARY, SCHOLARLY CONTRIBUTIONS, IMPLICATIONS AND RECOMMENDATIONS

Introduction

This chapter provides a final case summary, the background literature, and findings. Scholarly contributions are discussed. The implications and recommendations of this study for practice-based nurses and executive nurse leaders are outlined. Finally, the study limitations are noted.

Summary of literature (Chapters One and Two)

Chapter One: The emergence of recovery in theory, policy and mental health nursing practices

Although the term recovery has become engrained in national policy (Department of Health (DH), 2011) as well as the professional standards for mental health nurses (Nursing and Midwifery Council (NMC), 2014; 2018b), the concept of recovery in mental health did not come from policy-makers, professionals or academics. Instead, recovery emerged through the personal accounts of those with lived experiences of mental ill health (Deegan, 1988; Lovejoy, 1982; Repper & Perkins, 2003). As such, recovery is often defined as personal recovery, emphasising the individual's experience of mental illness. For example, Anthony (1993) defines personal 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 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."
>
> (Anthony, 1993: 15)

Some have viewed the application of the recovery as philosophy as problematic due to the uncertainty of its use and conceptualisation into practice. Leamy et al. (2011) sought to rectify this pitfall, undertaking a systematic review to develop a conceptual framework for personal recovery. As a result, the recovery processes were identified

as most relevant to research and clinical practice. They are connectedness, hope and optimism about the future, identity, meaning in life and empowerment, forming the acronym CHIME (Leamy et al., 2011). However, as Chapter One outlines, clinical recovery (Slade, 2009) and a service-defined-recovery (Le Boutillier et al., 2015a) have shown that dissonance remains between the practice-paradigms of different clinicians, as well as the mental health service itself.

Further critiqued in Chapter One, recovery in the policy context (DH, 2001a) has been viewed as part of the wider-neoliberal agenda of new labour (Braslow, 2013; McWade, 2016; Tyler, 2010), moving away from the paternalistic approach to care, towards citizenship underpinned by empowerment, choice, and personalisation. Today, empowerment, choice and personalisation are core tenets of the Care Act (2014). What is more, the Five Year Forward View (Mental Health Taskforce (MHT), 2016) emphasises that there remains a need to embed further the broad principles of recovery into mental health services, where empowerment, choice and personalisation remain ways by which service users suffering from mental illness may experience better recovery-outcomes.

Empowerment, choice, and personalisation are here to stay. Not only does their emphasis continue to be fixed within national policy, but their core tenets have become embedded within the Care Act (2014). What is more, the Five Year Forward View for Mental Health (Mental Health Taskforce (MHT), 2016) emphasises that there remains a need to embed further the broad principles of recovery into mental health services, where empowerment, choice and personalisation remain ways by which service users suffering from mental illness may experience better recovery-outcomes.

With the increasing financial strains on public services, the neoliberal notion of economics and citizenship remain central tenets within the discourse of the NHS's response towards Implementing the Five Year Forward View for Mental Health (NHS, 2016). Despite the personal-recovery focus within the Five Year Forward View for Mental Health (MHT, 2016) and more recently, Commitment and Growth: advancing mental health nursing now and for the future (Health Education England, 2022), the NHS uses the term Recovery as something that is to be achieved, measured as an end goal for service users of mental health services, something that can be obtained following treatment or psychological intervention.

Since New Labour's agenda for empowerment, choice and personalisation, power in the NHS has shifted away from professionals towards patients and service users. In response to these changes, the mental health nursing profession has adopted the principles of recovery as a paradigm to underpin their practices. As a result, mental health nursing has become professionally obliged to implement recovery-orientated practices, and they must also contribute to the leadership, management, and design of mental health services.

NHS services comprise many people, whereas other professional and non-professional groups will have their worldviews, evidence-base and agendas, be it recovery or not. Suppose mental health nursing is to implement recovery-orientated practices and contribute to the design of the services where practice takes place. In that case, the profession may have to contend with many challenges. Therefore, building upon Chapter One (recovery) and Chapter Two (mental health nursing), Chapter Two set out to critically evaluate the empirical literature exploring how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services.

Chapter Two: How mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services

Chapter Two is a critical review of empirical literature to critically analyse how mental health nurses experience the implementation of recovery-orientated nursing practices in mental health services. The analysis and synthesis of the seven reviewed studies pointed to dissonance in mental health nurses' beliefs, values, and traditions towards implementing recovery-orientated nursing practices within mental health services. Although there was evidence to suggest that many but not all mental health nurses have a good knowledge of the processes and principles of recovery, there still exists a notable discrepancy around its conceptualisation and use in nursing practice.

A section discusses hope-inspiring relationships. However, it also highlights that some mental health nurses hold a paternalistic clinically-orientated view of recovery. Such ideas have been articulated in the broader literature, where the paternalistic perspective of staff in acute inpatient mental health services has been found to affiliate with statements such as promoting and restoring the health of the service user, providing exemplary care and assuming responsibility for the service user's recovery

(Pelto-Piri et al., 2013). Through a paternalistic lens, recovery is made to a service user, determined by the professionals' perceptions of the benefit of that service user (Aston & Coffey, 2012; Cleary et al., 2013).

Even where service users are happy for mental health nurses to lead on their care, practices that are not person-centred and without collaboration are non-conducive to recovery. Some service users may be unable to make decisions or pose a risk to themselves or others. In such circumstances, it was suggested that mental health nurses take an advocacy role, making the service user's concerns heard at a cross-disciplinary level, an approach that may still facilitate collaboration and foster empowerment, despite the acuteness of their illness.

Furthermore, mental health nurses believe care should focus more on the service user's needs (Jacob et al., 2015), not only on managing risks and reducing symptoms (McKenna et al., 2014). This allows mental health nurses to foster the essence of hope and optimism to facilitate empowerment and promote individualised recovery pathways (Gale & Marshall-Lucette, 2012; Cleary & Dowling, 2009). These findings align with the conclusions of a systematic review synthesising multi-professional staff's understanding of recovery-orientated mental health practice. As a result, there has been a shift from a clinical recovery to a personal recovery, but it is incomplete (Le Boutillier et al., 2015a).

Mental health nurses have been described as 'facilitators who join the person to support the [recovery] journey' (Jacob et al., 2015 pp: 12). The notion of facilitation is not new to the discourse of mental health nursing. Peplau (1952) first noted that interpersonal skills were vital in forming therapeutic relationships between mental health nurses and service users. For many years, mental health nurses have adopted a six-category intervention analysis (Heron, 1976) as a holistic approach towards interpersonal communication (Ashmore, 1999). Heron (1976) proposes two polarised overarching approaches to communication: facilitative and authoritative, each containing three secondary categories: cathartic, catalytic, supportive (facilitative) and prescriptive, informative, and confronting (authoritative).

A facilitative approach emphasises power on the person with lived experience of their mental illness, where the nurse promotes and values that experience through active listening and an empathic commitment to support their thoughts and feelings. Finally,

an authoritative approach centres on the nurse as a source of information, challenging the service user's thinking while prescribing advice and guidance for how the person behaves. Although undertaking a pure facilitative role would fit with the nurse's position in the individual's recovery journey, all six categories in Heron's framework have equal relevance (Sloan & Watson, 2001).

Beyond the use of any formal communication method, Barker suggests that it is fundamental to the role of the mental health nurse to facilitate the "provision of the necessary conditions for the promotion of growth and development" (Barker, 1989 pp: 138) using whatever resources available (Barker & Buchanan-Barker, 2011). Through this process, mental health nurses can intentionally acquire an insight into a person's life, better understand their individual story and appreciate their experience of mental illness (Barker, 1996).

This literature review found that in environments where facilitative and therapeutic relationships are most successful, there is an emphasis on collaborative working, a contribution from both the nurse and the service user. Mental health nurses viewed collaboration as imperative to empowerment and central to supporting hope; care planning, determining goals, and discharge planning were ways to engage in daily partnerships with service users. Nevertheless, a more significant shift towards working more collaboratively in the planning of care, engagement with service users and the use of language is still needed. The Care Quality Commission (CQC) (2016) reports that those using NHS mental health services identified experiencing impersonalised care underpinned by poor collaboration and unshared decision-making.

Interdisciplinary collaboration was crucial for supporting the holistic needs of service users. It may help nurses address their professional values and practice skills towards a more recovery-orientated approach. It is important to note that nurse-to-person and interdisciplinary collaboration can be impeded by determents of power such as knowledge, information, and expertise (McCloughen et al., 2011), where there may be competing practice paradigms amongst multi-professional clinicians. Acknowledging the dominance and limitations of a paternalistic medicalised model of mental health illness can promote the diversity of alternative practice methods, which may better suit the needs of individuals (Kidd et al., 2015; Slade, 2009).

This literature review uncovered suggestions of external influencers outside of the nurses to person relationship; contextual conditions are reported to influence how recovery-oriented practices are adopted and implemented service-wide. There was a clear suggestion that a lack of training and education around the concept of recovery negatively impacts mental health nurses knowledge and understanding of the approach, reducing their ability and confidence in implementing recovery-orientated practices (Gale & Marshall-Lucette, 2012; Cleary et al., 2013; Cleary & Dowling, 2009; Jacob et al., 2015; Gaffey et al., 2016).

Those who were trained or educated in recovery were better equipped to describe the philosophy of the approach. Nevertheless, it was noted that there is insufficient educational support available to mental health nurses in the form of continued professional development (CPD) around recovery. An independent review of mental health nursing (Butterworth & Shaw, 2017) reports a need for CPD opportunities for graduate mental health nurses in the NHS, with options continuously decreasing yearly. With any future training and education needs, it is recommended that opportunities to which both the mental health nurse and the service users can contribute should be promoted and encouraged (Aston & Coffee, 2012; Butterworth & Shaw, 2017; Health Education England, 2022).

The diversity of people's needs and the acuity of inpatient wards were viewed as conditions that impact the successful implementation of recovery-orientated practices (McKenna et al., 2014; Aston & Coffee, 2012). In addition, mental health nurses report dissonance between a recovery-orientated culture and local policy; one may set out to support and empower service users and professionals to take positive risks, while another promotes a risk-averse approach to practice (Cleary & Dowling, 2009; McKenna et al., 2014).

Positive risk-taking is a collaborative process (DH, 2008) and has been identified as a fundamental skill that mental health nurses should be confident and competent at implementing; 'being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk' (DH, 2009 pp: 11). A study exploring the barriers and facilitators towards implementing recovery in practice (Le Boutillier et al., 2015b), highlights that mental health professionals viewed the statutory clinical obligation of risk management as a competing priority; staff would further embrace positive risk taking if their organisation better supported them to do so.

Some mental health nurses saw the claim of recovery by employers as a 'rhetoric' lacking policy direction and adequate resources. Despite the national strategic drive, complex challenges remain to transform mental health services towards a recovery orientation successfully (Slade et al., 2017a). With mental health nurses perceiving recovery in multiple ways, a conceptual consensus at all levels of mental health nursing must be achieved: 'no stakeholder's interests are served if incompatible and unmeetable expectations are placed on staff to support all three types of recovery fully' (personal, clinical and service-defined-recovery) (Le Boutillier et al., 2015a pp: 13). Furthermore, the challenge of recovery focused leadership at every level and culture of recovery, remains a significant hurdle yet to be overcome (Slade et al., 2017b, p. 14).

The studies in this review highlight that if mental health services are to influence the implementation of recovery-orientated mental health nursing practices, decision-makers need to be focused on promoting individual outcomes for service users rather than focusing primarily on meeting organisational performance outcomes (Aston & Coffee, 2012). However, this requires extensive commitment at all levels; it cannot be an add-on to existing services (Cleary & Dowling, 2009) and requires some administrative changes to coordinate recovery system-wide (Cleary et al., 2013).

Summary of Findings: How do practice-based mental health nurses and nursing executives experience implementing recovery-orientated nursing practices in one NHS Foundation Trust?

This study explored how practice-based mental health nurses and nursing executives experience implementing recovery-orientated nursing practices in one NHS Foundation Trust. The three questions guide the findings, helping ensure triangulation and contextualisation throughout. Below is presented a summary of each of these issue questions.

How do mental health nurses conceptualise recovery-orientated nursing practices?

Participants described their experiences and observations and endeavoured to define recovery-orientated nursing practices within the context of mental health services. Both practice-based nurses and nursing executives primarily conveyed their understandings of recovery within a continuum of interrelated yet contrasting concepts: an objectively measurable outcome and an individually defined process. As a result, differences in views of recovery amongst participants were often nuanced and overlapping rather than divergent.

Several participants in this study and the broader empirical literature adhere to the decades-old neoliberal idea that recovery can be achieved when people engage with the support provided to them at the behest of mental health services.

When describing their role in implementing recovery-orientated practices, participants saw themselves as potential enablers for a person's recovery. Rather than describing specific interventions or models of care, participants conceptualise recovery-orientated nursing practices as a set of enabling principles: seeing the person as an individual, setting short-term goals, and promoting choice through positive risk-taking. In addition, participants associated the idea of instilling hope as an additional component of the mental health nursing role in implementing recovery-orientated practices.

Participants in this case study further add to the existing knowledge around the relevance of seeing the individual with a unique perspective of their recovery. Nevertheless, this highly-subjective version of recovery-orientated practices remains abstract and needs clear form. Furthermore, the narrative surrounding recovery-orientated nursing practices weighs heavily on morality and ideology rather than considering applicability and reality within mental health services.

Unique to the participant group of nursing executives, some saw the concept of recovery, in its abstract sense, as an established organisational philosophy underpinning all nursing practices. Recovery as a corporate philosophy was not regarded as a new concept but rather seen as the rephrasing or rebranding of historical and contemporary approaches to nursing care, the tenets of which were

believed to have already been embedded within mental health nursing practices for some time.

With its multi-dimensional nature, determining the correct meaning of recovery within an interrelated and variable set of organisational, professional, socio-political, and sociohistorical contexts may present a significant challenge for practice-based nurses and nursing executives within the Trust. Careful consideration, and ongoing evaluation of implementation, are necessary for successful change to occur (Weiss, 1995) or certainly be tangibly observable.

A concept detached from the multitude of contexts in which it is being applied would further aggravate issues of uncertainty. Therefore, within the scope of implementing recovery-orientated practices, the concept of recovery must "connect into clinicians' sense of their context and the challenges they face, their history and resources, and their understanding of the cultural barriers and drivers for change" (Lynch et al., 2018).

What are the barriers and enablers towards implementing recovery-orientated nursing practices?

This case study has found there to be a multitude of reported barriers and enablers towards the implementation of recovery-orientated nursing practices. Most of these relate to various service processes and procedures (i.e. risk management, paperwork, admission and discharge) or how mental health nurses engage with others (i.e. service users, families and carers, and other professionals).

Practice-based nurses needed more power and control to overcome systemic challenges at the micro, meso and macro system levels (i.e. opposing professional paradigms, untenable service demands and social issues). In the way of barriers, many of the problems reported by participants could be inferred as engrained sociocultural issues rather than measurable or justifiable processes and procedures.

How do nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices?

Participants argued that nursing executives often conflicted with opposing organisational priorities within mental health services, hindering them from directly influencing practice-based nurses towards implementing recovery-orientated nursing

practices. This thinking was underpinned by the idea that other service-level targets can create a culture that may impede nurses from implementing recovery-orientated nursing practices.

Nursing executives' commitment towards influencing the implementation of recovery-orientated nursing practices was said to be set out and embedded within the Trust's nursing strategy priorities. However, despite some nursing executives seeing recovery as a philosophy of practice already embedded Trust-wide, others regarded it as an ambition rather than a current reality. Therefore, nursing executives highlighted an implementation gap from nursing strategy to policy and into practice.

Furthermore, nursing executives viewed policies and procedures as a means to influence the implementation of recovery-orientated nursing practices. However, practice-based nurses reported needing more connection with creating and operationalising policies. Moreover, a strict hierarchical structure hindered communication between those directly delivering care and those leading the Trust's strategic direction. Therefore, visible leadership through role-modelling at all levels is essential if nursing executives are to influence practice-based nurses towards implementing recovery-orientated nursing practices.

Original contribution

The award of a PhD requires an original contribution to existing knowledge (Quality Assurance Agency for Higher Education, 2014). This section highlights this doctoral research's original contribution to the current practice field.

The recovery philosophy

This study has contributed to the existing research on recovery-orientated nursing practices. Elements of personal, clinical, and service-defined recovery emerged and added further empirical context to the practice field.

Previous research on recovery has framed recovery in two opposing philosophical perspectives: personal and clinical recovery. Research into recovery is predominantly critical of the psychiatric medical model, instead aligning with the ideals of mental health services becoming more service user-led.

Moreover, a unique contribution underpinned by a sociohistorical and sociopolitical critique, this case study has found that these two seemingly opposing theoretical concepts do not entirely epistemologically align with mental health nursing practice. Instead, recovery-orientated nursing practices must be seen on a continuum rather than within rigid contrasting models. As such, a social constructivist framework was presented to assist nurses in philosophically framing the meaning of recovery within mental health nursing practices.

Methodology

At the beginning of undertaking this study, a case study methodology still needed to be applied to explore recovery-orientated nursing practices. However, a case study has now been undertaken, exploring the implementation of recovery-orientated practices (Mhlanga, 2022). Nevertheless, how each case study is applied varies from project to project. For example, where Mhlanga (2022) looked at a broad perspective of multi-professional participants, her case study was defined by the structure of the Trust in which mental health services are provided. However, this case study bound itself by a particular professional group, mental health nurses, within and through an NHS Foundation Trust's micro, meso and macro system structure.

Unique in its approach, this case study explored the perspectives and relationships between practice-based mental health nurses (microsystem) and nursing executives (mesosystem). Although research has already explored the views of senior managers on implementing recovery-orientated practices (Mhlanga, 2022; Le Boutillier et al., 2015a), the interrelationship between practitioners and leaders within the NHS required exploration.

Moreover, how this case study explored the role of mental health nursing from board to the ward, underpinned and defined by its deep and complex sociohistorical and sociopolitical context, provides a unique contribution to how recovery-orientated nursing practices have been investigated and understood. Such context had yet to be explored within the existing research.

Existing knowledge

The literature review in Chapter Two shows that the particular system conditions underpinning practice-based mental health nurses towards implementing recovery-

orientated nursing practices must be explored. In addition, there needed to be more research exploring the experiences of senior nurses who may have created, influenced, and shaped such conditions. This study examined how practice-based mental health nurses and senior leaders experience implementing recovery-orientated nursing practices in one NHS Foundation Trust, addressing the dearth of information in the literature and offering an original contribution to existing knowledge.

Many of the issues discussed when exploring how mental health nurses conceptualise recovery-orientated nursing practices support the existing research critiqued in Chapter Two. Furthermore, rather than identifying specific interventions, participants saw recovery-orientated nursing practices as a set of enabling principles: seeing the person as an individual, setting short-term goals, and promoting choice through positive risk-taking. Moreover, promoting choice through positive risk-taking appears to be an original contribution to the existing knowledge, something aligned predominantly with mental health nurses, laden with moral, ethical and sociopolitical challenges.

Although many of the barriers and enablers identified through this study complement the findings within the existing research, how this study has explored and presented these at the various system levels (micro, meso and macro) seems original in its approach. In addition, the sociocultural, sociopolitical, sociohistorical, and socioenvironmental contextual framing of these findings is another original contribution.

Lastly, how this case study explored the interrelationships between practice-based mental health nurses (microsystem) and nursing executives (mesosystem) seems original in its approach. Although similar views have been reported in the empirical literature on recovery-orientated practices around competing priorities within NHS Trusts, this deeply interconnected and contextualised account, to our knowledge, has yet to be replicated elsewhere.

Identifying the strict hierarchical structure within the Trust, be it internally developed (mesosystem) or formed by the contributions of external factors (macrosystem), has provided new knowledge in understanding the crucial role of leadership in influencing recovery-orientated nursing practices within the Trust. Furthermore, the findings presented on the part of strategy and policy in influencing recovery-orientated nursing

practices and, indeed, nursing practice in its broadest sense is an original contribution of note.

Implications and recommendations

For practice

This case study explored how practice-based mental health nurses and senior leaders experience implementing recovery-orientated practices in one NHS Foundation Trust. The findings show the range of understandings mental health nurses have around the established conceptualisations and definitions of recovery (i.e. personal and clinical recovery). However, the term recovery held meaning to all participants explored within this case study, whether or not it aligned with conventional interpretations.

Participants did not describe their experiences of recovery-orientated nursing practices as attempting to implement a strategic or policy-driven idea of recovery. Instead, their underpinning sociohistorical and sociopolitical professional contexts influence their views of recovery. Moreover, for those knowledgeable in the conventional meanings of recovery, the concept was intertwined with the established multimodal role of mental health nursing within mental health services.

As such, instead of viewing recovery-orientated nursing practices as a particular intervention process, of which nurses appear to implement an ever-changing and countless amount, the role of mental health nursing was seen to be an enabler of recovery within and beyond the hospital. Moreover, the enabling principles: seeing the person as an individual, setting short-term goals, and promoting choice through positive risk-taking should be essential factors underpinning the development and evaluation of nursing practices.

Developing the systems-leadership knowledge of all nurses, from board to ward, should be considered. Practice-based nurses implementing recovery-orientated nursing practices are constrained and enabled by micro, meso and macro systems factors. Helping develop their systems knowledge will better enable nurses to understand where barriers to recovery-orientated nursing practices are coming from and how to overcome them. This knowledge should also help overcome practice cultures that may be considered toxic and hindering service user care (i.e. prioritising

paperwork, stigmatising certain service user groups, being risk-averse, being fearful of blame).

Lastly, having better mechanisms in place to support the delivery of clinical supervision that adopts the restorative, formative and normative elements should improve the implementation of recovery-orientated nursing practices while finding effective and supporting mechanisms to overcome system barriers and recognise enablers of recovery-orientated nursing practices.

For policy

With mental health nurses perceiving recovery-orientated nursing practices in multiple ways at various system contexts of the Trust, a philosophical consensus and a shared purpose are required at all levels if nursing executives are to influence the implementation of recovery-orientated nursing practices. As pointed out by Le Boutillier et al. (2015a pp: 13), ‘no stakeholder’s interests are served if incompatible and unmeetable expectations are placed on staff to support all three types of recovery fully’ (personal, clinical and service-defined-recovery). As such, senior nurses must be central in supporting, developing, and driving the implications and recommendations for practice.

A core Trust-wide policy articulating the meaning and applicability of recovery-orientated nursing practices should be developed. To be effective, the policy must be jointly created with mental health nurses, nurse leaders and those who use services. The methodology for creating this policy would be strengthened if underpinned by the core principles of co-production in mental health (Skills for Care, 2018).

The Trust's existing hierarchical managerial and reporting structures are non-conducive to implementing recovery-orientated nursing practices. Findings suggest that nursing executives should not rely on communication between multiple layers of line management to influence recovery-orientated nursing practices. As noted by nursing executives, messages are often lost in translation by the time they are communicated from strategy and operationalised in practice.

Engagement with practice-based nurses should be broader than ward managers and charge nurses to influence recovery-orientated nursing practices. If implementing

recovery-orientated nursing practices is to improve, direct means of engagement between nursing executives and practice-based nurses must be established.

Finally, regardless of the objectively identifiable policies, processes and procedures created within the Trust, if practice-based mental health nurses feel disconnected from their leaders or do not contribute to and value the policies they make, nursing executives may bear little to no influence on implementing recovery-orientated nursing practices.

For research

There remains a dearth of published empirical research understanding the purpose and role of mental health nursing in implementing recovery-orientated nursing practices (as per Chapter Two). Where recovery-orientated nursing practices sit on a continuum rather than aligning to distinctive concepts (personal and clinical recovery), future research into implementing recovery-orientated practices within mental health services must consider the uniqueness of different professional groups. There is no one size fits all recovery approach for people who use services, nor is there one for those who provide care and treatment within them.

Although this study provides an in-depth exploration of the issue, the case is in only one Trust and within one region of England. Where transferability to other Trusts and organisations may be possible, claims of the generality of the findings within this study are not. To ascertain if the finding within this study is relevant to mental health nursing in other NHS Trusts, the development and rollout of a regional or national survey informed by the results of this study would be a recommended next step.

A system-thinking perspective should be held when undertaking future research into mental health nurses' challenges in implementing recovery-orientated nursing practices. That is framing issues within the multiple system levels of the micro, meso and macro. In so doing, solutions can be considered as those that mental health nurses have direct influence over (i.e. delivery or care), those where mental health nurses have less influence but senior leaders do (i.e. service structure and operational policy), and those factors that mostly sit outside the influence of both senior leaders and mental health nurses (i.e. local authority/ICB, NHS England, Care Quality Commission).

This study has identified barriers towards implementing recovery-orientated nursing practices that sit at the macro level, outside of the direct influence of nurse leaders and mental health nurses. There needs to be more evidence exploring the impact such bodies, organisations and entities have on developing organisational policy, strategy, process and care delivery. Research into the effects of the macro-level context of mental health services and NHS Trusts may provide invaluable solutions in transforming care responsive to people's individual and collective needs.

Lastly, co-production, or at least patient and public involvement (PPI), has become embedded within research development, delivery and interpretation. However, an area of practice that needs to be empirically investigated is how co-production has been embedded at all system levels within mental health services, from creating an organisational strategy to delivering and evaluating care. Such a study would provide invaluable insight into the system-wide recovery orientation of services.

Limitations

Hyett et al. (2014) propose that case studies can be criticised when researchers need to adequately understand or apply the critical principles of case study methodology to their research issue. Creswell (2013) argues that case study researchers' most significant challenge is identifying the case: clearly outlining the focus, design, and boundaries. Yazan (2015) suggests the primary reason is the varying epistemological assumptions underpinning case study research.

To overcome this challenge, as this study set out to explore participants' individual and collective experiences of recovery-orientated nursing practices through a social constructivist lens, Stake's (1995) constructivist and existentialist worldview aligned best with the specific research issue. Stake's (1995) case study principles were applied throughout this research's design, delivery, analysis and writeup.

Another methodological limitation is that case studies are exploratory and descriptive. Consequently, they cannot produce answers to research questions that are considered generalisable. Instead, research questions seek solutions that give insight into a particular issue within a specific setting through individual perspectives (Stake, 1995). With its deep description, readers may see the transferability rather than the

generality of the findings between this case and other organisations with similar contexts (Korstjens & Moser, 2018).

Furthermore, the answers to case study research questions can never be viewed as final or definitive; findings will always be bound to the case and influenced by the worldview interpretations of the researcher. As with other qualitative research, it is almost impossible to completely replicate the processes of a case study and end up with the same interpretation as another researcher.

On reflection, a limitation of this study was the need for more PPI. Although this case study's unique contribution is its contextually rich exploration of mental health nursing and recovery-orientated nursing practices, local populations to the Trust are the recipients of care and the reason why recovery-orientated nursing practices exist in the first place. Even if not empirically exploring the perspectives of service users, their families, and carers, coproducing this research from planning to interpretation may have asked more pertinent questions and yielded more meaningful results.

To overcome this barrier, a summary of the case was provided to lived-experience experts of the mental health system for them to critique and respond to the findings and discussion of this case study. A reflective account of this feedback is provided in Chapter Seven.

A final limitation is the age of the data and the relevance of the findings today following the Covid-19 global pandemic. To overcome this limitation, a summary of the key findings was shared with senior nursing executives responsible for the overall nursing governance within the Trust. In addition, written feedback on the summary was presented, validating the relevance of all findings and recommendations while identifying processes that may have changed or are changing.[56] A reflective account of this feedback can be found in Chapter Seven.

[56] Feedback received April 2023

Conclusion

This chapter provided a final summary of the case, the background literature, and the findings. Scholarly contributions were discussed. The implications and recommendations of this study for practice-based nurses and executive nurse leaders were outlined. Finally, the study limitations were noted.

CHAPTER SEVEN: PERSONAL REFLECTIONS: FROM NOVICE TO VIVA-READY RESEARCHER, BUT NOT QUITE DOCTOR

Introduction

This chapter provides my reflective account from novice through to viva-ready researcher. Firstly, I provide insight into my early novice self in my doctoral journey. Secondly, I give an extract from an early reflection of my first participant interview. Then, I reflect on the journey through the PhD, its ups and downs and how I have persevered to who and where I am due to this journey. Next, a reflection on the feedback from lived experienced practitioners. Finally, sense-checking via participant feedback, the study's relevance today, is examined.

Looking back at my novice days

My doctoral journey, or at least my interest in pursuing a PhD, began in the final stages of my undergraduate mental health nursing education. At that time in nursing, there was a prevailing debate between seeing the role as a vocation vs a university-educated degree-level profession. No classroom can teach you to be human, to engage and care for another person or truly understand many of the complexities and challenges within practice. However, I found that degree-level education provided a base, a framework that helps you better understand what you do, why you do it and how you can do it better.

The ability to better understand the world around me and how to position myself within that world was my initial driver for pursuing a PhD. I had no ambition for a personal accolade or to align this qualification with a career or future role. However, I knew the doctoral journey would inevitably lead to a place where I could better influence nursing practice, policy and research.

When I look back to the first days of applying for a PhD at the University of Greenwich, I see how naive I was. I went straight from my BSc into the doctoral programme with no research experience or acquisition of a master's degree. Though many people told me that the gap between undergraduate learning and PhD is substantial, I endeavoured nonetheless. Was it challenging? Yes. Was it what I expected? Not

quite. Yet, my ambition helped me through, having hope that things would eventually align and make sense.

It took two to three years before I got my head around ontology and epistemology. But I eventually got there with a combination of classroom sessions, reading Guba and Lincoln's paper on pain and multiple YouTube videos. Today, I somewhat have a geeky affinity for exploring and understanding world-views. Within the national strategy and policy space where I now work, the purpose of paradigms has played an invaluable role in helping me articulate my views while understanding the positioning of others, challenging and lobbying for change.

My first participant interview

For several weeks after receiving my ethical approval, I felt ready to begin recruiting my participants for the study. However, due to the recent CQC visit to the Trust and the come down of its process, I decided to allow a month of breathing space before asking the selected participants to participate in the study. In early June, I decided to start the ball rolling and sent my first invitation to the director of nursing. Having received a swift response, the information and consent forms were sent within twenty-four hours of first contact. A meeting date was to be arranged between myself and their PA.

In a supervision meeting on June 7th 2016, the indicative interview guide was discussed, and slight alterations were made; none of which would affect the ethical considerations for the study but offered refinement and clarity to the questions to be asked. I was encouraged to contact the PA of the director of nursing via telephone to arrange the meeting, which was to be done as soon as the supervision had ended.

Telephone contact was successful, and a request to meet ASAP was made. To my surprise, the next available meeting date was approximately one week later, on the 15th of June. Due to experience, I anticipated a four to six-week waiting period before the meeting, so this was much sooner than expected. Initially, I thought, "This is too soon" and "It's not enough time to prepare". Nonetheless, after a brief consultation with my first supervisor, I went ahead with this time for the interview.

As this was the first research interview I was to undertake, I felt nervous and slightly unprepared. I was worried about getting equipment in time, testing it and practising

my interview techniques. With much of the literature encouraging novice researchers to practice before applying, I felt it was essential for me to do so. I planned to meet with a colleague within the department to run through the process. Nevertheless, when arranging a time for the practice session, I was reminded that I interview service users at work daily, many of whom have complex issues and need to be constantly supported to maintain focus and engagement.

It was then I realised that the skills I was attempting to rapidly acquire were transferable skills I had already gained. So with that, I decided to approach the interview as if any other interview in my experience; to proceed in the facilitative, objective and engaging way I know how. This gave me confidence and reduced my anxiety about feeling underprepared.

As agreed and outlined in the ethics and RDA forms, the interviews would begin with the nursing director and then the nursing associate director. I would then recruit the heads of nursing for the working-age adult directorate, older adult directorate, forensic directorate and child and adolescent mental health services. Even though I had a plan of whom to approach following the initial interviews, I decided before the meeting with the director of nursing that I would ask for guidance on the most appropriate individuals to recruit and interview. The snowball sampling method, if you will.

My experience of the doctoral journey

Early in the doctoral journey, I took the phrase: *a PhD is not only about discovering and articulating new knowledge. It is about finding and expressing who you are*. Of course, such a philosophical view would come from a mental health nurse dedicated to recovery-orientated practices. However, applied to my journey, this was the case. Arguably a single case study and therefore un-generalisable, yet the core reality of my experiences over the past decade (no jest intended, maybe a little!).

As aforementioned, my journey started pre-novice, almost blindly walking into the realms of philosophy and research. It shocked the system, particularly the brain, yet I remained committed from day one. The university was extremely accommodating and supportive. Even before beginning the PhD course, I had a knowledge gap analysis, and a bespoke learning programme was created.

For the first year of the doctoral journey, I attended weekly sessions with the master's students in the business school, predominantly learning about methodology and applied methods. I also joined the professional doctorate programme for educators to learn more about philosophy and theory. The latter felt far more alien to me, yet something of a challenge I wished to grasp.

I officially began my MPhil/PhD programme in September 2015. I practised (in clinical care) twice weekly and was seconded by the NHS to study for three days a week. I started as a full-time student, aiming to complete my degree within three or four years. Looking back now, I should never have mentally committed to such a quick turnover of time. Likewise, I would never encourage anyone to undertake a full-time doctorate part-time. Yet, I have learned from this experience, even if highly challenging.

The real challenge arose when I approached my transfer viva from MPhil to PhD a year later than planned. I felt I hadn't quite reached a point where I was confident in my writing, yet I rushed through to hit this milestone within the full-time student expected period. At the viva, I was commended on my ability to defend my position. However, the lack of in-depth critique and overuse of complex theory meant I had to make significant amendments before officially moving on to the PhD programme.

This experience, although beneficial for my progression and professional development, contributed to a period of personal struggle, or indeed, stress. There were many competing and concurrent challenges around me then, yet my overly-ambitious plans to complete within three or four years had been halted and was the straw to break the camel's back. As a result, I took interruptions from studies for two episodes of three months that year to put myself in a better mental position.

Having sought professional support to understand what was happening to me and where to go next, I learned much more about who I am and how I think. For example, I was unaware that I could be considered an all or nothing thinker. How that manifested was that I put my ambitions to finish the doctorate as my utmost priority. My career, relationship, and other meaningful life experiences had been put on hold, not by the doctorate, but by me.

What struck me the most was not how this way of being impacted me but how my approach to the doctorate impacted those around me, particularly my partner's ambitions for herself and us. Equipped with this new self-awareness, I completely

flipped my focus on its head. I registered part-time at the university, which relieved some pressure. Within the next few months, I was engaged, bought a new home and applied for a new job that better aligned with my acquired knowledge and skills. Unfortunately, I was holding off on these significant personal ambitions and actions until after attaining the PhD.

Although my way of approaching some activities can be one of my greatest strengths, it can also become my most significant barrier. Having changed my focus away from the PhD and nothing else, there was the real risk that my all-or-nothing approach may lead to my disconnect from studies and inability to complete. I was acutely aware of this, particularly given the number of people I knew who did not complete, the longer their studies persisted.

The intensity and drive I had to finish the PhD weaned once I successfully passed my MPhil viva. Sometimes, months would pass, and I didn't even look at the thesis. However, the weight of carrying the PhD is a genuine phenomenon. It's always on your shoulder and occupies your mind, even if you are somewhat disconnected.

Several times, I had contemplated if this was the right journey for me, if I would ever finish and if I should call it a day. At this time, the support of my supervisors was invaluable in helping me reflect on where I was at. The pressure from my now-wife to complete the programme also kept me going. She frequently told me how unhappy I would be if I wasted all this time and did not come out with the qualification - candidly blowing my over-comforting philosophical crutch out of the water - that the journey matters, not the destination.

The pandemic added to the strain, mainly when I had to take two clinical redeployments, completely stopping my engagement in the doctoral programme. Something I noted many of my student peers also had chosen to do during that uncertain time. Through all the toils and tribulations, I persevered. I experienced a reboot of passion and energy for my studies in 2022. I surprised myself to have a complete thesis drafted and ready to share with my supervisors by the beginning of 2023.

Where I am at today

Beginning my doctoral journey in 2015 as an absolute novice in philosophy and research seems so long ago, yet so familiar and recent when reflecting. I wouldn't say I am an expert; far from that. However, I can see where this journey has taken me and where I am today. I know far more about who I am and how I see the world, helping me see how others view the world around them.

Reflecting on my knowledge development, it is also interesting to note how my thinking of recovery and mental health nursing has become more and more refined. At the beginning of my journey, I believed all nursing practices should be personal recovery-orientated, with little relevance to practices that align more with a clinical model of care. However, the emergence of the recovery continuum through this study has shown me how eclectic and diverse recovery-orientated nursing practices are.

As is the mental health of people individually and collectively, the role of mental health nursing is often complicated and complex. As such, neatly defining the role of mental health nursing and the practices of mental health nurses is far from a straightforward, if not an impossible, task. Yet, I see this as the profession's greatest strength in adapting to the diverse needs of those in our care. While at the same time, I acknowledge that a lack of definition can lead to quality and consistency issues across the piece.

After all this time, am I surprised to be writing this reflection? Yes, I certainly am. Although I always held hope, I did not believe I could get this thesis to a place where it could be submitted for examination. So do I feel a sense of achievement for getting this far? Of course. But in truth, the real merit will only come when this chapter of my journey is once and for all closed. An exciting yet hugely intimidating prospect - what next when the PhD is no longer on my back?

Like the concept of recovery, the topic I have lived and breathed for the best part of a decade, I do not see the learning journey ever ending. Yes, I may be successful in achieving recognition for my work through the award of a PhD or not. Yes, that may mean that I am seen as *an expert* in this narrow knowledge space or not. However, my self-learning and the acquired critical thinking through the doctoral journey will only grow and never be seen as an endpoint.

A lived experience perspective

Part of my research process was to seek feedback from lived experience practitioners within the Trust. Although looking back, the research could have been strengthened through co-production and, indeed, service user participant input, the study did not go down this route. A limitation, but certainly a point that is now at the forefront of all my day-to-day work.

For context, lived experience practitioners are situated within mental health services to work with service users diagnosed with mental health conditions. They have experienced their mental health problems and draw upon their lived experience of mental health challenges and their recovery journey to develop empathetic relationships and support recovery in others. Lived experience practitioners are in paid roles across all of the Trust's directorates and work within multi-disciplinary teams.

The lived experience practitioner holds a unique perspective in that they work within the complexities of mental health services and have their own experiences of using those services as service users. In addition, given the whole systems-level emphasis of this case study, these people are highly suited to provide a critical eye and constructive feedback, which may not have been accessible via any other service user group.

It is essential to restress that the lived experience practitioners were not participants in this study. Nevertheless, their critical views offer a complementary perspective to the findings and conclusion of this study. To maintain anonymity and confidentiality, no names or places of work were obtained. Instead, feedback was provided via an online questionnaire, providing some structure and ample room for open-ended discussion.

The lived experience practitioners were asked to reflect on a summary of the findings and recommendations. Having read the case study's findings, they were also asked if they considered any new suggestions for next steps that could help improve the implementation of recovery-orientated nursing practices within the Trust.

In general, the findings resonated with the experiences of those lived experience practitioners who provided critical feedback on the findings and recommendations. Interestingly, comparisons were made between the role of the mental health nurse implementing recovery-orientated nursing practices and that of the lived experience

practitioner. It was felt that implementing a recovery orientation to mental health services through the role of the lived experience was also hindered by a lack of system-wide consensus on the meaning of recovery.

It was argued that the turnover of registered mental health nurses within teams meant that people were potentially less appreciative of enabling people's recovery through co-production. It was suggested that mental health nurses could benefit from working alongside lived experience practitioners for extended periods to understand better and apply co-production to recovery. This point was especially relevant when the study found a lack of personal-recovery orientation amongst nurses in acute inpatient settings.

Lived experience practitioners recognised some of the barriers towards implementing recovery-orientated practices. Multiple layers of management and various targets were agreed to be central challenges for nurses to work with service users towards a recovery orientation. In addition, it was decided that service processes and procedures must be streamlined and meaningful should mental health nurses effectively implement recovery-orientated practices.

A next step recommendation was made to enhance the implementation of recovery-orientated nursing practices through co-production. Workshops jointly held between the lived experience practitioners and mental health nurses could strengthen co-production and recovery-orientated practices. A further consideration was to explore how mental health nurses could encourage people to continue their recovery journey with more independence from mental health services.

Although the feedback was more supportive than critical of the findings, my interpretations and the recommendations, it was interesting to see how the study aligned with some of the observations of lived experience practitioners. It shows the relevance and importance the design of mental health services should have towards practices and processes facilitating the recovery continuum, to be ever refined and developed through co-production.

The relevance of the findings today

At the same time as seeking critical feedback and reflections from lived experience practitioners, so too were the views of nursing executives sought. The purpose of

seeking thoughts from the nursing executives was to sense-check the relevance of the findings and recommendations within the Trust today. As the data was gathered more than five years ago and before a worldwide pandemic, this process was necessary to ensure the thesis was still a contemporary interpretation of the phenomenon explored.

How mental health nurses conceptualise recovery-orientated nursing practices is said to be highly relevant today. Articulating the role of mental health nursing practices against the concept of recovery provided a timely and ideal opportunity for the Trust to engage in broader discussions about the meaning and application of recovery-orientated nursing practices.

The summary of the barriers and enablers reflects what nursing executives see as the somewhat intangible culture in teams (i.e. "*how we do things here*"), issues practice-based nurses are said to often raise in action learning sets. In addition, the more technical and transactional elements resonated with today's challenges within mental health services, areas the findings of this study may assist with addressing.

In its broadest sense, the findings regarding how nursing executives influence practice-based nurses towards implementing recovery-orientated nursing practices were considered as much of a bedrock of nursing leadership today and relevant for the future as they were during this case study. However, it was noted that processes and procedures within the Trust have significantly shifted in how the nursing executive engages with practice-based nurses compared to during the data gathering for this study.

It was said that there is now a greater emphasis on engagement and coproduction with practice-based nurses and those with lived experiences of using mental health services. Furthermore, quality improvement approaches and psychological safety have been embedded, which are seen to empower practice-based nurses to take the lead and influence practice more. Key examples of how practising-based mental health nurses have driven initiatives include *Relational Security* using the *See Think Act Framework* and *Trauma Informed Care*.

The idea and increased need for visible leadership and role modelling was said to remain essential. It was noted that whilst the Covid-19 pandemic enabled a more significant reach through digital technology, nursing executives recognise that they

must continuously invest their time in high visibility, building meaningful connections and developing positive, trusting, empowering relationships with all nurses.

It was noted that several initiatives had been implemented since the data collection for this study to facilitate better nursing practices towards implementing recovery-orientated nursing practices. Examples included more effective use of DIALOG+[57] and co-production. However, how these initiatives support or influence the implementation of recovery-orientated nursing practices remains to be discovered.

As for the recommendation to enhance access to reflective practice and clinical supervision, nursing executives noted that the Trust had recently invested in training for clinical supervisors. Namely supporting nurses to train as Professional Nurse Advocates[58] enabling them to provide restorative clinical supervision to others.

Moving away from previous incident reporting processes, something seen as a barrier for nurses towards implementing recovery-orientated nursing practices, the Trust is transitioning to using the Patient Safety Incident Response Framework[59], underpinned by systems thinking and rooted in human factors.

As with the feedback from lived experience practitioners, nursing executives considered the scope of enhancing quality improvement initiatives led by practice-based nurses, involving people with lived experience of using mental health services. It was also considered how recovery-orientated nursing practices are relevant and reflected in the Trust's approaches to trauma-informed care.

Lastly, the idea of how nursing executives can more effectively engage practice-based mental health nurses will be an ongoing and ever-developing question that must be at

[57] DIALOG is a scale of 11 questions. People rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale. DIALOG provides a score for subjective quality of life and treatment satisfaction. DIALOG + is an approach developed to make routine patient-clinician meetings therapeutically effective. It is based on quality-of-life research, concepts of patient-centred communication, IT developments, and components of solution-focused therapy, and is supported by an App. (Obtained online at: https://www.elft.nhs.uk/dialog).

[58] The Professional Nurse Advocate (PNA) programme delivers training and restorative supervision for colleagues across England. The programme launched in March 2021, towards the end of the third wave of COVID-19. This started at a critical recovery point: for patients, services, and our workforce. (Obtained online at: https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/professional-nurse-advocate).

[59] The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for learning and improving patient safety. (Obtained online at: https://www.england.nhs.uk/patient-safety/incident-response-framework/).

the forefront of everything the nursing executives and Trust leaders set out to do. In conclusion, this study's findings and recommendations remain contemporary and relevant to the Trust in which this case study took place.

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APPENDICES

Appendix: 1.1 A history of mental health nursing

The position of contemporary mental health nursing can only be understood with its socio-historical and socio-political context. Exploring the socio-historical context helps clarify a role enriched with a past, a present and a future (Leishman, 2005).

Nursing – historical dynamics of social power

It was not until the 1580s that the English term nurse first referred to a “person who takes care of the sick” (OED, 2017). This etymology of nurse derives from the earlier Latin noun nutricius, meaning “that suckles; nourishes”, and the later Old French norrice, meaning “foster mother; wet-nurse; nanny” (OED, 2017). The original concept of a nurse (or norrice) implies a feminised character tasked with nurturing children. Although the idea of a nurse has dramatically evolved since the early days of the wet nurse, some of the female-typical assumptions associated with the role remain.

The maternal role in early nursing

In the early 20th Century, the nurse’s position was subordinate to the medical physician. The term handmaiden has been used to define the (feminine) role of the nurse, subordinate to that of the dominant (masculine) medical physician (Sellman, 1997; Willmott, 2003). Such a social distinction emerged through the socio-political context of the Victorian era, policies underpinned by authoritarian paternalism, justifying the disciplining, conditioning and controlling of young women, the backbone of the nursing population of that time (Lorentzon, 2003). The Victorian’s authoritarian approach has been likened to much of the neoliberal ideals of citizenship embedded within today’s health and social care policies (Simon & Sparks, 2012) (see Chapter One – Recovery in the neoliberal agenda – empowerment, choice and personalisation).

When aligning the positions of power between physicians and nurses of the Victorian era within the social-hierarchal structure of men to women, the nurse is depicted as a

maternal figure, with the physician being a paternal figure. The maternal figure embodies a discourse highlighting the nurse's biologically based or socially conditioned differences from men, typically associated with women, emphasising the distinctive connections and responsibilities in their role to their husband, family and society (Chase & Rogers, 2001). This analogy has been well-worn through a feminist critique of nursing. Gamarnikow (1978) describes the relationship of the doctor-nurse-patient as homologous to the nuclear family unit: male-female-child. The nature of the Victorian nurse symbolises a position of nurturer, caring for the needs of their patients (children) as well as obediently supporting the directions of the physician (husband), or at least making it seem that he is making the decisions.

Moreover, Berghs et al. (2006) have explored the morality of Victorian nursing, pointing to the virtues of obedience evident within the role, based primarily on the social-hierarchical structure of an authoritarian society, reflected by hospitals in the late 1800s and early 20th Century. Despite the provenance of despotic paternalism within hospitals, nurses not only adopted the virtues of obedience through their passivity to others (Able-Smith, 1960), but senior nurses used the virtues of obedience to manipulate and influence the very physicians they were subordinate to, making changes to improve standards of patient care while allowing physicians to believe they were the ones who instigated it (Lorentzon & Brown, 2003).

Such dynamics parallel Stein's (1967) view of the doctor-nurse game. With doctors having ultimate responsibility for patients, "nurses had to be bold, have initiative and be responsible for making significant recommendations, while at the same time, she must appear passive. Furthermore, this must be done in such a manner to make her recommendations appear to be initiated by the physician" (Stein, 1967: 699). A heritage echoed by the formidable female hospital matrons, who held supreme power and control over their nurses and greatly influenced the decisions of the medical physician (Able-Smith, 1960), albeit from a passive, subordinate position. Revisiting these assumptions two decades later, Stein et al. (1990) found a significant shift in the dynamics underpinning the doctor-nurse game, where both doctors and nurses practised with further autonomy and more collaboration. At the turn of the 21st Century, matrons were revived as the respected modern matrons. This role is an androgynous nurse-manager position within the NHS (DH, 2001b), influencing the clinical and managerial direction of the hospital setting.

Men, in general nursing

Despite the authoritarian power indifference noted between the Victorian nurse and the physician, men wanting to enter the nursing field faced equal prejudice from their female counterparts. Such an issue became prominent through Florence Nightingale's campaign to feminise nursing. Nightingale argued that men were incapable of providing the caring, empathetic and intimate nature that society required, a character only women could possess as an extension of their maternal nurturing roles within domestic family life (Brown et al., 2000). It was not until 1951 that male nurses could join the professional register alongside their female colleagues (Thomas, 2016) and not until 1961 that they could join the Royal College of Nursing (RCN).

Nightingale's highly stereotypical view of men in nursing was a further manifestation of the authoritarian nature of Victorian England, continuing well into the mid-20th Century. Men who joined the female-dominant nursing profession did not fit the traditional ideals of their patriarchal societal role. Despite the increase in the number of men joining the profession in the second half of the 20th Century, the feminisation of nursing continues today (Masters, 2009). Men who enter nursing may still be considered unmanly, facing prejudice and discrimination based on the socially constructed role of the female nurse (Evans, 1997). In concurrence with these continued assumptions, Lupton (2000) found that men claim to face challenges to their sense of masculinity when embarking on non-traditional occupations such as nursing. As a result, Leishman (2005) proposes that men within the nursing field have increasingly moved towards the more traditional patriarchal roles of management and administration. Such ambition has been contentiously noted as a hidden advantage for men pursuing a nursing career, or in this case, seeking a career through nursing (Evans, 1997).

Men in mental health nursing

Using the explanation of gender relations to argue the power difference between mental health nurses and psychiatrists would be highly inaccurate (Brimblecombe, 2005), as traditional mental health nursing consisted mainly of men (Chatterton, 2004). Asylum attendants (traditional asylum-based mental health nurses) of the Victorian era held more of a custodial role than one resembling Nightingale's caring and

nurturing female nurses. Despite their equal gender, attendants were utterly subordinate to the medical superintendent (physician). The superintendent held complete control over every aspect of the attendants' lives, where rulebooks outlined conditions of immediate dismissal if orders were disobeyed (Brimblecombe, 2005). This power imbalance has been explored and articulated in academic writing over the years (Goffman, 1961; Foucault, 1971), consisting of the same anti-psychiatry critiques that drove deinstitutionalisation in the UK and influenced the emergence of recovery by those with lived experience of mental illness (see Chapter One – anti-psychiatry in the 60s and 70s).

Across the broader field of nursing, Christensen & Hewitt-Taylor (2006) maintain that evidence-based medicine has and continues to drive the clinical direction and leadership within the NHS, where the traditional demographic differences that had previously eluded to the unchanged power distinction between the nurse and physician, are a now predominantly a historical precursor. For psychiatry and mental illness, the emergence of anti-psychotic medication affirmed the dominant position of medical psychiatrists over mental health nurses within institutions (Leishman, 2005; Brimblecombe, 2005). Such an advancement strengthened the medicalisation argument for mental illness, ensuring physicians continued to lead and determine the direction of care. Understanding power imbalances in nursing today necessitates the review of evidence-based practices and requires understanding the same settings and services where practices occur.

Mental health nursing – training and education

The birth of education in nursing traces its roots to the mid-19th century in England through the endeavours of Florence Nightingale, who established nurse training at St Thomas's Hospital, influencing the establishment of nursing schools around the world (McDonald, 2009). By the early 1900s, many hospitals had established their nurse training schools inclusive of two-to-three-year placements, where students provided free care as payment for their training and education (Thomas, 2016). Despite the power imbalance within the asylums, early psychiatry's influence and drive initiated mental health nurse education (McCrae & Nolan, 2016; Chatterton, 2004).

From attendant to mental health nurse

Commonly referred to as The Red Book, the Medico-Psychological Association (MPA, 1885) produced The Handbook for the Instruction of Attendants on the Insane. The book covered the primary areas of anatomy, physiology and principles of nursing care, as well as areas of mental illness (psychology, symptoms and mental disorders). Psychiatrists predominantly gave lectures on mental illness, the quality of which varied, with many focusing on the paradigm of psychiatry rather than nursing (RCN, 2015). The MPA later developed national training schemes for attendants in 1891, using The Red Book as the basis for the syllabus (Chatterton, 2004). Written examinations and a Viva-voce were devised to assess attendants' knowledge, where successful completion led to the attainment of certification (Nolan, 1993). Created by physicians, The Red Book maintained a strong emphasis towards the total obedience of attendants under medical authority (McCrae & Nolan, 2016). Such a stance ensured that the certified attendants, empowered by their new knowledge, could not threaten the existing power infrastructure with the asylums.

Where the nursing role was developing alongside general medicine, superintendents pushed to have 'mental nursing' accepted as a branch of general nursing, where psychiatry's claim of being a medical specialism could be strengthened (Brimblecombe, 2005). By the early 1900s, attendants had become recognised as mental nurses (McCrae & Nolan, 2016). Additionally, the new field of mental nursing became affiliated with the legislation driving the agenda of the General Nursing Council (GNC) - meeting their statutory commitment of creating and facilitating an appropriate educational syllabus for all nurses. Despite the intentions of superintendents to strengthen their position as a medical specialism, the move from attendant to mental nurse initiated a 30-year rivalry between the GNC and the MPA training schemes, where general nursing and psychiatry contended for influence over the newly recognised mental nursing role (Chatterton, 2004). By 1951 the Royal MPA relinquished their educating role where the GNC maintained sole ownership over mental nurse training in the UK (McCrae & Nolan, 2016).

Hospital vocation to university-educated profession

From the time she co-founded the British Nursing Association (BNA) in 1888, Fenwick, a retired matron of St Bartholomew's Hospital, sternly campaigned for the state registration of nursing (Hector, 1973). Fenwick believed that through state registration, nursing would acquire professional recognition and a higher social status (Able-Smith, 1960). Not all nurse leaders shared Fenwick's vision. In particular, Florence Nightingale firmly opposed the registration of nurses. Nightingale believed nurses were not yet educated enough or adequately distinguished from medicine to become registered professionals (Helmstadter, 2007). Fenwick's campaign eventually led to the passing of The Nurses Registrations Act (1919), establishing the General Nursing Council in 1920. Regulated by the GNC, all nurses were required to be listed under the professional register. Specialist fields of nursing were distinguished in their registration, with a general registration for trained general nurses, a supplementary register for mental nurses, and a separate one for male nurses (Fenwick, 1920).

Despite the new professional register, in the 1940s, the nursing workforce experienced a shortage of skilled workers to address the current and unique demands of a war-struck society. The new State Enrolled Nurse was created to fill the gap (Thomas, 2016). The State Enrolled Nurse was provided with two-year hospital training to support registered nurses. Despite acquiring much of the same experiential skills and knowledge as their registered counterparts, the position of State Enrolled Nurse was kept subordinate to the professional nurse role. Where Fenwick and the members of the BNA assumed state registration of nursing was the best route to professionalisation (Lynaugh, 2005), Nightingale maintained that only through a professional education could nursing indeed become a profession (Helmstadter, 2007).

Visions for moving nursing into higher education emerged through the 1950s. However, there were views that the "education standard of a nurse should not be raised too high" for many without a higher education would still make admirable nurses (Abel-Smith, 1960: 66). The 50s also saw the emergence of the first pioneer of British mental health nursing, Annie Altschul, whose vision for mental health nursing diverged from the traditional biological interventions of that time (Davis, 2002). Altschul outlined what mental health nursing should look like in her books Psychiatric Nursing (1957) and Aids to Psychology for Nurses (1962). These books were the first in the UK to

focus on the clinical application of social psychology, specifically for nurses (Winship et al., 2009). From 1962-1964, Alts-shul was a member of an RCN Special committee, producing a prominent report recommending the Reform of Nursing Education. First printed in 1964 and again in 1969.

In 1976, the Briggs Co-ordinating Committee advised that nursing practice should be based on empirical evidence, founded through a degree qualification. They suggested that registered nurses should be supported to embark on higher-level training and education to bolster the professional knowledge base of the role. The committee's work created the Nurses, Midwives and Health Visitors Act (1979). The Act abolished the GNC and other nursing bodies, replacing them with the UK Central Council for Nursing (UKCC) and four national boards for each of the four UK nations (i.e. the English National Board for Nursing, Midwifery and Health Visiting (ENB) - National Archives [NA], 1983-1982).

The Nurses, Midwives and Health Visitors Act (1979) placed a legal obligation on the ENB to assess and approve the provision of nurse training in higher education and the hospital setting. Through the continued shift towards further professionalisation, the UKCC set up a new professional register in 1983, removing the position of State Enrolled Nurses and focusing instead on developing registered nurse education. In 1986, Project 2000 set out to altogether remove training from hospitals, creating a one-route entry for the attainment of a nursing qualification through the completion of a college or university diploma (Thomas, 2016). Project 2000 was not only to produce safe but to produce educated nurses that could improve the quality of patient care (Glen, 1999).

By the early 90s, through Project 2000, the students of mental health nursing were brought alongside the general nursing students within universities (Chatterton, 2004). Many mental health nurses did not appreciate the structure of Project 2000, for they were expected to undertake the same 18-month standard foundation training as their general nursing colleagues (McCrae & Nolan, 2016). Although through Project 2000, mental nurses received equal footing to other forms of nursing, they needed a specialised discipline-specific education to strengthen their knowledge base and position compared to other mental health professions such as psychology and psychiatry (Brimblecombe, 2005).

By 2002, following the 1999 independent review of the Nurses, Midwives and Health Visitors Act (1979), recommendations were made to create a strategic and streamlined Nursing Council, paving the way for the creation of the Nursing and Midwifery Council (NMC), replacing all the previous nursing authorities in the UK (NA, 1982-1983).

Twenty-five years earlier, the Briggs Co-ordinating Committee advised that nursing practice should be based on evidence, founded through a degree qualification. Yet, it wasn't until 2004 that the RCN voted for Nursing to be a degree-only preparation, and by 2009 all nursing courses in the UK offered a degree-level route (Thomas, 2016). Up until 2013, nursing students had the option to either register under the diploma or degree route. However, from September 2013, all nursing programmes became degree-only, removing the option of a diploma.

Moreover, in 2016 the bursary support for nurse training was removed, and nursing students are now required to cover their tuition fees like any other university course. Although intended to allow more students to study nursing (as bursary places were capped), initially, the abolishment of the bursary saw a decline in the overall number of applications made to undertake the nursing degree (RCN, 2018; Universities and Colleges Admission Service, 2018).

However, in 2021/22, we saw an increase in the number of applications and acceptances to mental health nursing, believed to be inspired by both the depicted heroism of nursing during the Covid-19 pandemic. The introduction of a soft bursary along with the fully-funded nursing degree apprenticeship, a new route into registered nursing (Department of Health and Social Care, 2016), provided an affordable pathway to allow healthcare staff to become registered nurses while remaining firmly within the organisations where they work.

Furthermore, the vacancy rates for nurses in the NHS continue to increase yearly (NHS Digital, 2017), while the total number of NMC registered nurses has decreased (NMC, 2018). With the increased shortage of registered nurses, there has been the rise of the new nurse associate role to "bridge the gap" between healthcare support workers and registered nurses (DH, 2015b), a role bearing the characteristics of the enrolled nurse of the early to mid-twentieth century.

As the role of the associate nurse is yet to be standardised, embedded or evaluated in mental health care, it is not yet clear how or when such a position will genuinely help with the sustainability of nursing as a registered profession or the impact it will have on the uptake of degree nursing.

Nursing education and a lack of compassion in practice

Thomas (2016) argues that given its educational development over time, nursing progressively attained the four fundamental characteristics of a profession: the formation of a highly skilled role underpinned by knowledge based on evidence, leading to the formation of trained competencies required before being able to register to practice, autonomously, under a code of professional ethics and standards (Blane, 1991).

Over the past decade, there has been increased criticism in public media, arguing that degree-level nurses are over-educated and have become too posh to wash (Chapman & Martin, 2013; Fletcher, 2009). Although such a claim is unfounded in research (Oliver, 2017), such a belief has emerged through the idea that nurses spend more time attending to the role's technical aspects than listening to patients' personal-care needs. That being said, nursing as a profession is evolving, where many nurses are performing the tasks and interventions that were once the sole responsibility of doctors (i.e. becoming nurse prescribers and Approved Clinicians).

Nevertheless, the scandal in Mid Staffordshire NHS Foundation Trust (Mid-Staffs) has significantly impacted the nursing profession, highlighting the inadequacy and failings of both qualities of basic care and fundamental values of nurses (Francis, 2013). Within his report, Francis (2013: 76) recommends that nursing education needs to refocus on “a culture of compassion and caring in nurse recruitment, training and education”, with “practical hands-on training” being a prerequisite to joining a nurse training course.

In response to the Francis Report (Francis, 2013), the “enduring values of nursing” (DH, 2012b: 5) became a focal point for policy, education and nursing practice from 2012 to 2016. The then Chief Nursing Officer led the creation of a values-based framework, emphasising what was viewed as the fundamental requirements of safe

and compassionate nursing: care, compassion, competence, communication, courage and commitment (The 6Cs) (DH, 2012b).

Despite the drive for compassion in practice, the term compassion is inadequately defined within nursing literature (Schantz, 2007). Where compassion is often viewed as either a skilled professional activity or an innate characteristic, such definitions have fuelled the stereotypical assumption that nurses are born and do not require an education to become a nurse (Maxwell, 2017).

The move to higher education was intended to give nurses the skills and knowledge to enhance patient safety and improve the quality of care (Glen, 1999). However, there remains no evidence to suggest that a degree level of education contributes to or influences a nurse's station of compassion in practice (Oliver, 2017; Maxwell, 2017).

Although there is a dearth of empirical evidence exploring the correlation between higher education and compassion, in their extensive study of European hospitals (n = 300), Aiken et al. (2014) have found that patients in hospitals where there are more nurses with a bachelor's degree have significantly lower mortality rates than those that have lower numbers of bachelor's degree nurses. A study in the USA has found that along with higher ratios of qualified nurses to unqualified staff, the higher educational attainment of nurses leads to higher levels of patient satisfaction (Aiken, 2002).

Maxwell (2017) argues that compassion without clinical expertise is not enough to create therapeutic relationships or to deliver person-centred care. Nurses require proficiency not only to formulate what matters to the person but to understand how the person's broader (often complex) health status will impact the achievement of their individual goals. Such an argument resonates with the philosophical values and conceptualisation of recovery, emphasising the importance of person-centred care in mental health nursing practices.

The enduring values of nursing have continued to the latest nursing strategy in England: Leading Change, Adding Value (NHS, 2016). The implementation of compassionate care remains a current priority for all fields of nursing. However, there is inadequate evidence to suggest that higher-education influences the delivery of compassionate care; the failings and lessons learned from Mid-Staffs cannot be ignored.

Nevertheless, with the continued decline in the nursing workforce, a high level of professionally-educated knowledge and expertise is vital if nursing remains safe and critically adapts to new and changing societal demands (Beer, 2013). Notwithstanding the required knowledge and expertise, the quality of compassionate nursing care will ultimately be judged by the experiences of patients, service users and carers. Therefore, nurses will need to pay as much attention to their interactions with the people they care for as they do to the quality of the technical processes and interventions underpinning their contemporary practices.

Appendix: 3.1 Research Papers Matrix

Research Title, Authors, Date	Aims and objectives	Research Methods and Ethical Issues	Population and Sample Size	Strengths and weaknesses of methodology	Main Findings	Implications for Practice
Cleary M, Horsfall J, O'Hara-Aarons M and Hunt G (2013) Mental health nurses' views of recovery within an acute setting	Aim: to ask acute inpatient MHN about their understanding of recovery and how they are incorporating a recovery paradigm in their day- to-day nursing practice. Aim: to identify practical realities that acute care nurses can take to aid recovery and identify barriers that hinder its implementation during and immediately after a	Face-to-face interviews were conducted. Used semi-structured, open-ended questionnaire. A form of thematic analysis was used to analysis the data (Borbasi & Jackson 2008). Ethical approval has been sought and given.	**Australia** *n* = 21 nurses across four inpatient units within one health service	No formal conceptual framework or validated infantry was used for formulating the questionnaire. Nevertheless, the questions were designed through literature and sought face-validity. Used formal interpretive process (thematic analysis) Not generalisable due to a small cohort of staff in one health service. Used 'saturation point' for finishing interviews to add validity to the findings.	Respondents recognize that positive attitudes, person-centred care, hope, education about mental illness, medication and side-effects, and the acknowledgement of individual recovery pathways as essential for preventing readmission. However, most saw the recovery orientation as rhetoric rather than as an appropriately resourced, coordinated, and	Findings reflect the limitations of any recovery in mental health when the medical model and psychosocial paradigm is so focused on the individual, compliance, and readmission. To improve the culture, staff education will be needed as well as some administrative changes to help coordinate recovery in a system-wide manner. Changes are required within acute inpatient units to enact authentic cross-disciplinary collaboration and to address issues relating

	relapse.			Findings were checked by two other researchers to ensure they conveyed the intended meanings.	integrated program.	to professional values and practice skills to ensure a recovery orientation is successful.

Research Title, Authors, Date	Aims and objectives	Research Methods and Ethical Issues	Population and Sample Size	Strengths and weaknesses of methodology	Main Findings	Implications for Practice
Gale J and Marshall-Lucette S (2012) Community mental health nurses' perspectives of recovery-oriented practice	To establish the extent to which CMHN are confident in their existing knowledge of and skills required in applying the recovery model in their daily practice. To examine the extent to which the current continuing professional development (CPD) curriculum meets the educational needs of CMHN's knowledge and skills of the recovery model. To identify CMHN's educational and training needs	Mixed methods approach: Self-efficacy questionnaire - content validity and face validity undertaken. Content analysis of CPD course documents - used key concepts in the literature which underpin the principles and values of the recovery model. Descriptive statistics were generated using sass. Qualitative data analysis was undertaken to gain documentary evidence from the	UK *n* = 23 (23 CMHN) *n* = 28 (course documents)	Used a mixed methodology which is suitable for answering the aim and objectives. Face validity undertaken for questionnaire ensuring its stability and tool for purpose. Descriptive statistics were created using SPSS. Statistics cannot show generality through cause and effect, correlation or relationship given such a small cohort. Content analysis lacks the use of a validated and comprehensive conceptual analysis of	The findings suggest a gap in the nurses' perceived ability and confidence in implementing recovery-oriented practice and their understanding of the model, with what is taught academically.	The discrepancy found between CMHN's confidence in their knowledge of recovery-oriented practice and the shortfalls in direct education and training received through the CPD curriculum may raise implications for practice and can potentially hinder application of the mental health services' strategy. Ultimately, to ensure that nursing education reflects the strategy on recovery and social inclusion, it is necessary for recovery-focused knowledge and skills to be more widely

	required in the application of the recovery model.	Mental Health CPD curricula. No Ethical issues		recovery. Interpretation can be open to scrutiny and may miss key components of the recovery process.		included in the curriculum.

Research Title, Authors, Date	**Aims and objectives**	**Research Methods and Ethical Issues**	**Population and Sample Size**	**Strengths and weaknesses of methodology**	**Main Findings**	**Implications for Practice**
Aston v and Coffey M (2012) Recovery: what mental health nurses and service users say about the concept of recovery	The aim of this study was to explore multiple perspectives of service users and mental health nurses regarding the concept of recovery and how it fits within mental health services.	Data were collected from two focus groups, one group of service users and one group of nurses. Thematic analysis was undertaken using Krueger and Casey's framework identifying 4 key themes: *understandings of recovery, semantics, therapeutics* and a *journey*. Ethical approval was granted by the local research ethics committee. Signed consent was obtained from all participants who were reassured that they would remain	**UK** Inpatient mental health services in one region. The nursing group were registered nurses (n = 5) of various grades and experience. Service user group (n = 6) were adults with previous or recent experience of inpatient mental health services.	Framework analysis was used to manage the data as this involves several distinct interconnected stages: familiarisation, identifying a thematic framework, indexing, charting, mapping and interpretation. The use of programs such as NVivo could bolster the validity; with only one interpreter of the data, there may be a lack authenticity of the findings. Nevertheless, the data provided by the participants underwent a rigorous process of analysis and interpretation.	Key themes were identified: *understandings of recovery, semantics, therapeutics* and a *journey*. There remains ambiguity around its concept and the practicalities of its implementation in acute mental health services. Further studies in this area could address how shared and contrasting understandings are enacted in practice settings. The lack of information, training and working in rigid task-oriented systems that created frustrations.	Creating an optimistic positive approach to all individuals who use mental health services. The move from medically oriented services to viewing mental illness as more than a biological phenomenon with access to a broader range of interventions. Joint training and education for service users and nurses on recovery. Mental health services need to focus more on personal outcomes rather than organisational performance outcomes and have a clear vision

		anonymous in reporting of the study.		Data cannot be generalised due to single locality and small cohorts.		of what their expectation of recovery is for mental health.

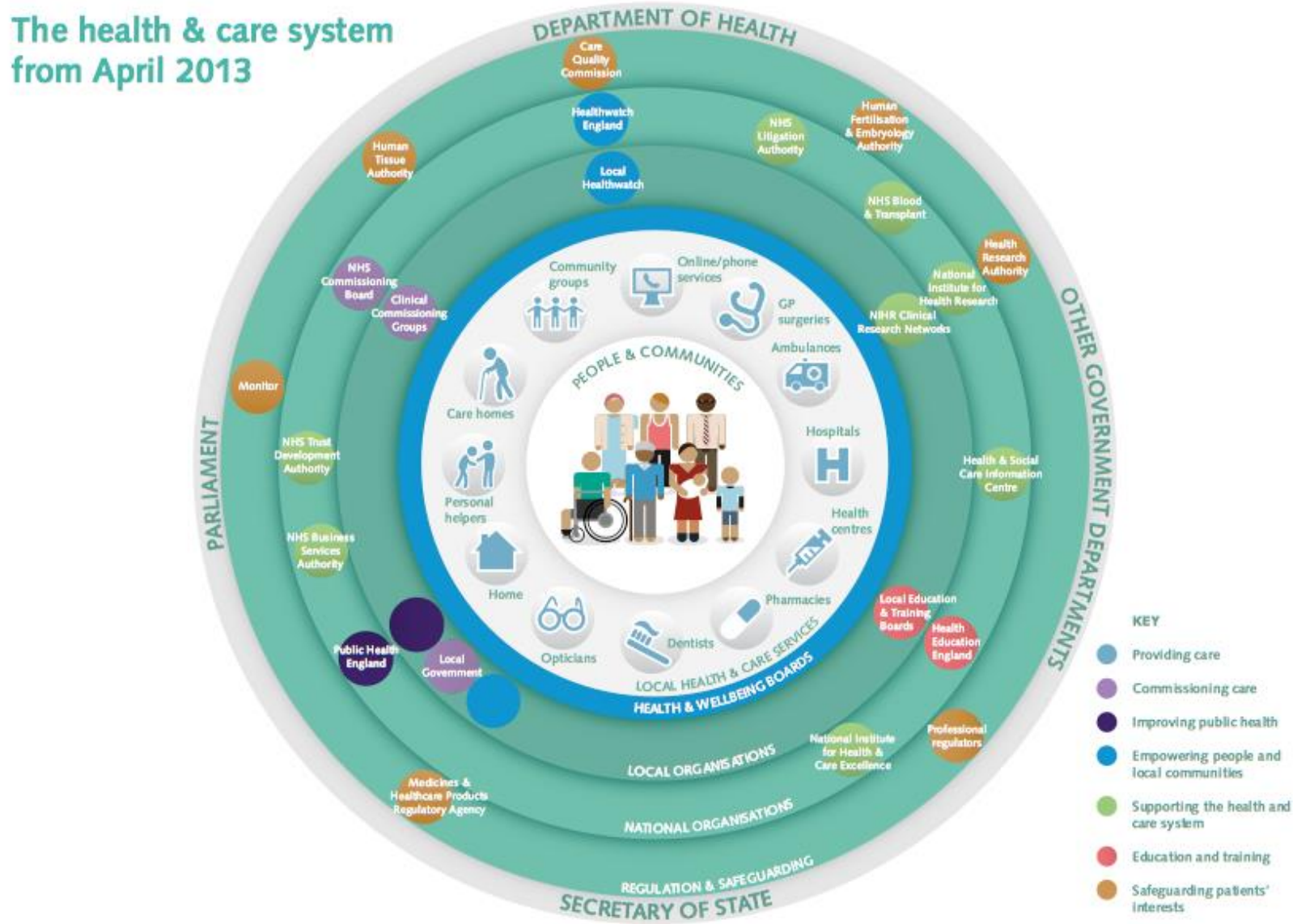
Research Title, Authors, Date	Aims and objectives	Research Methods and Ethical Issues	Population and Sample Size	Strengths and weaknesses of methodology	Main Findings	Implications for Practice
Cleary A and Dowling M (2009) Knowledge and attitudes of mental health professionals in Ireland to the concept of recovery in mental health: a questionnaire survey	The purpose of this study was to examine the knowledge and attitudes of mental health professionals to the concept of recovery in mental health.	Used the Recovery Knowledge Inventory (RKI) (Bedregal *et al*. 2006). The RKI consists of 20 statements on a 5-point Likert scale. The questionnaire included five demographic questions and three closed questions. Two open questions were included to seek views regarding the skills professionals require to promote recovery. Local research	**Ireland** A total of 264 nurses and 53 other mental health professionals were used as the sampling frame for the study. Nurses (*n* = 100) were randomly selected from the sample frame (*n* = 264). Other disciplines were included in the study (*n* = 53)	The study was undertaken across one service provision area. Findings will not be generalisable. An 85% response rate was achieved. But, the sample size is too small for a statistical comparison between professions. The data gathering process and analysis was sufficient in identifying the specific responses of nurses. The methodology utilised a validated tool (RKI). A content analysis framework was adapted to	Respondents indicated their positive approach to the adoption of recovery as an approach to care in the delivery of mental health services. They were less comfortable in encouraging healthy risk taking with service users. Respondents were less familiar with the non-linearity of the recovery process and placed greater emphasis on symptom management and compliance with	Multidisciplinary mental health care teams need to examine their attitudes and approach to a recovery model of care. The challenge for the present and into the future is to strive to equip professionals with the necessary skills in the form of information and training. Implementing such recovery-orientated services will undoubtedly require extensive commitment from services and professionals at all levels embracing a willingness to change

		ethics committee approval obtained.		examine and code the two open question data.	treatment.	and be innovative about practice.

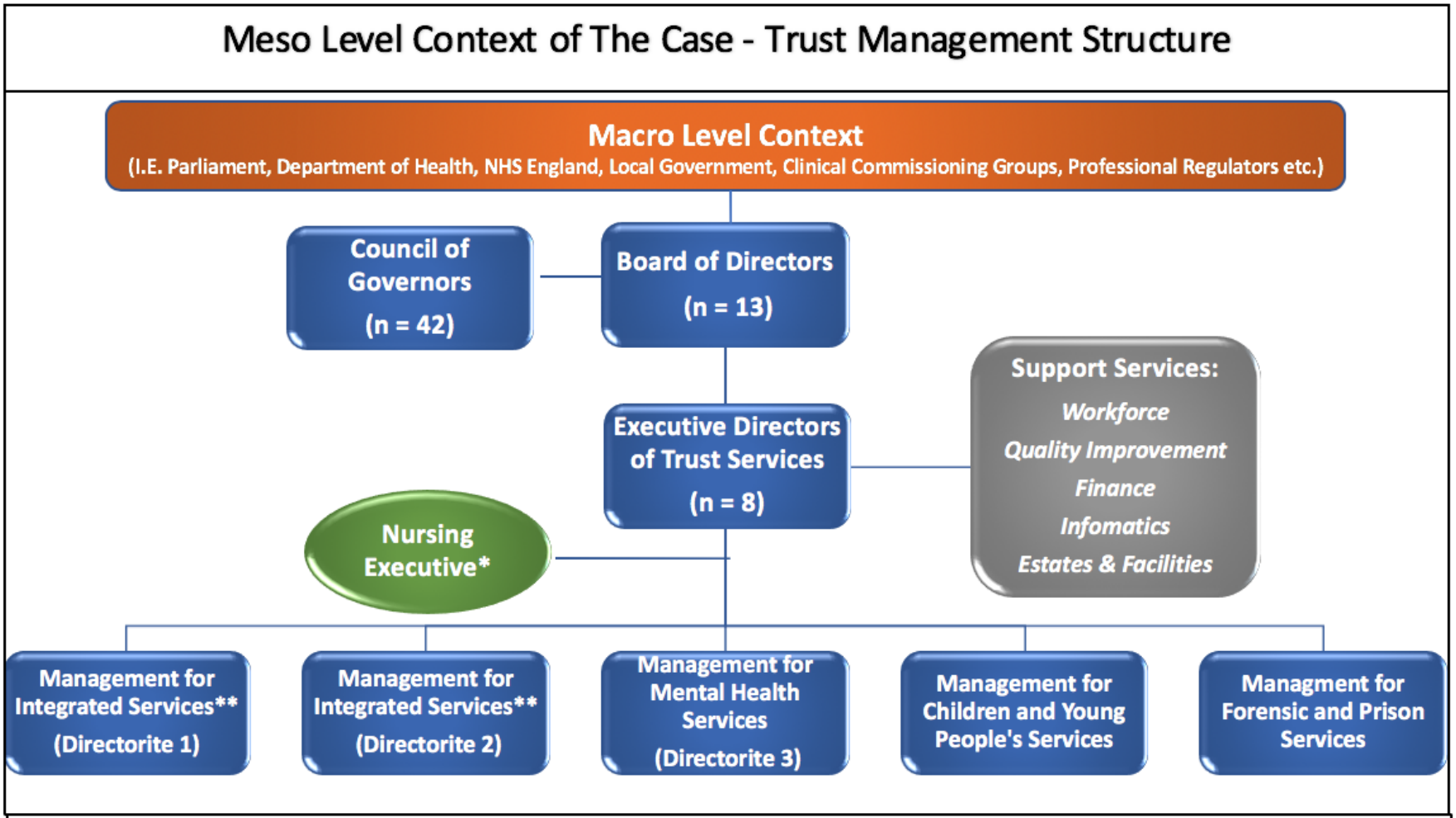
Research Title, Authors, Date	Aims and objectives	Research Methods and Ethical Issues	Population and Sample Size	Strengths and weaknesses of methodology	Main Findings	Implications for Practice
Jacob S, Munro I and Taylor B (2015) Mental health recovery: lived-experience of consumers, carers and nurses	Outline the results of a qualitative study on mental health recovery, which involved mental health consumers, carers and mental health nurses.	A qualitative hermeneutic phenomenological methodology. A semi-structured interview schedule was developed and in-depth interviews were conducted using the core questionnaire. Ethical approval was sought from two ethics bodies and was granted.	**Australia** Carers, service-users and mental health nurses form community based services. Nurses: *n* = 9; Carers: *n* = 8; Service-users: *n* = 9.	The initial data analysis was ongoing during the data collection process until the saturation of the data, followed by thematic analysis. Presented in such a way that the specific perspective of mental health nurses could be obtained and explored. Methodology gives an individualistic and context rich understanding of the issue. Small cohort does not offer generality.	Themes suggested that the cohort had varying views on recovery. Similar views were categorised under two processes: an external process. These two processes involved reclaiming aspects of oneself, living life, cure or absence of symptoms and contribution to community. The dissimilar views involved returning to pre-illness state and recovery was impossible.	This study highlights the need for placing importance on the person's sense of self in the recovery process.

Research Title, Authors, Date	Aims and objectives	Research Methods and Ethical Issues	Population and Sample Size	Strengths and weaknesses of methodology	Main Findings	Implications for Practice
McKenna B, Furness T, Dhital D, Ennis G, Houghton J, Lupson C and Toomey N (2014) Recovery-oriented care in acute inpatient mental health settings: An exploratory study	The aims are to determine the extent to which elements of existing nursing practice resemble the domains of recovery-oriented care and to provide a baseline understanding of practice in preparation for transformation to recovery-oriented services reflected in policy directives.	A 60–90-minute focus group was conducted at each acute inpatient service (n = 5). Interview schedule was based on the domains of recovery-oriented care in the Australian context. A general inductive approach was used to analyse the qualitative data. Ethical approval sought and obtained.	**Australia** A purposive sample of mental health nurses was recruited in five acute inpatient services within a large mental health service provider. A total of *n* = 46 mental health nurses participated.	Analysis was undertaken with the use of NVivo software evidencing the emergence and coding of the data. Rigor was enhanced by collective agreement among the research team on the categorical analytic framework, emergent patterns, and supporting evidence. The population size was small and localised. It is not generalisable.	Results show that nurses can identify recovery and articulate with pragmatic clarity how to care within a recovery-oriented paradigm.	The results of this study indicate that regardless of how the National policy of recovery-oriented care may be applied, mental health nurses are challenged more by the structure of the health service than the comprehension of recovery-oriented care as a new paradigm of mental health service delivery.

Appendix 4.1: Macrosystem context of the case



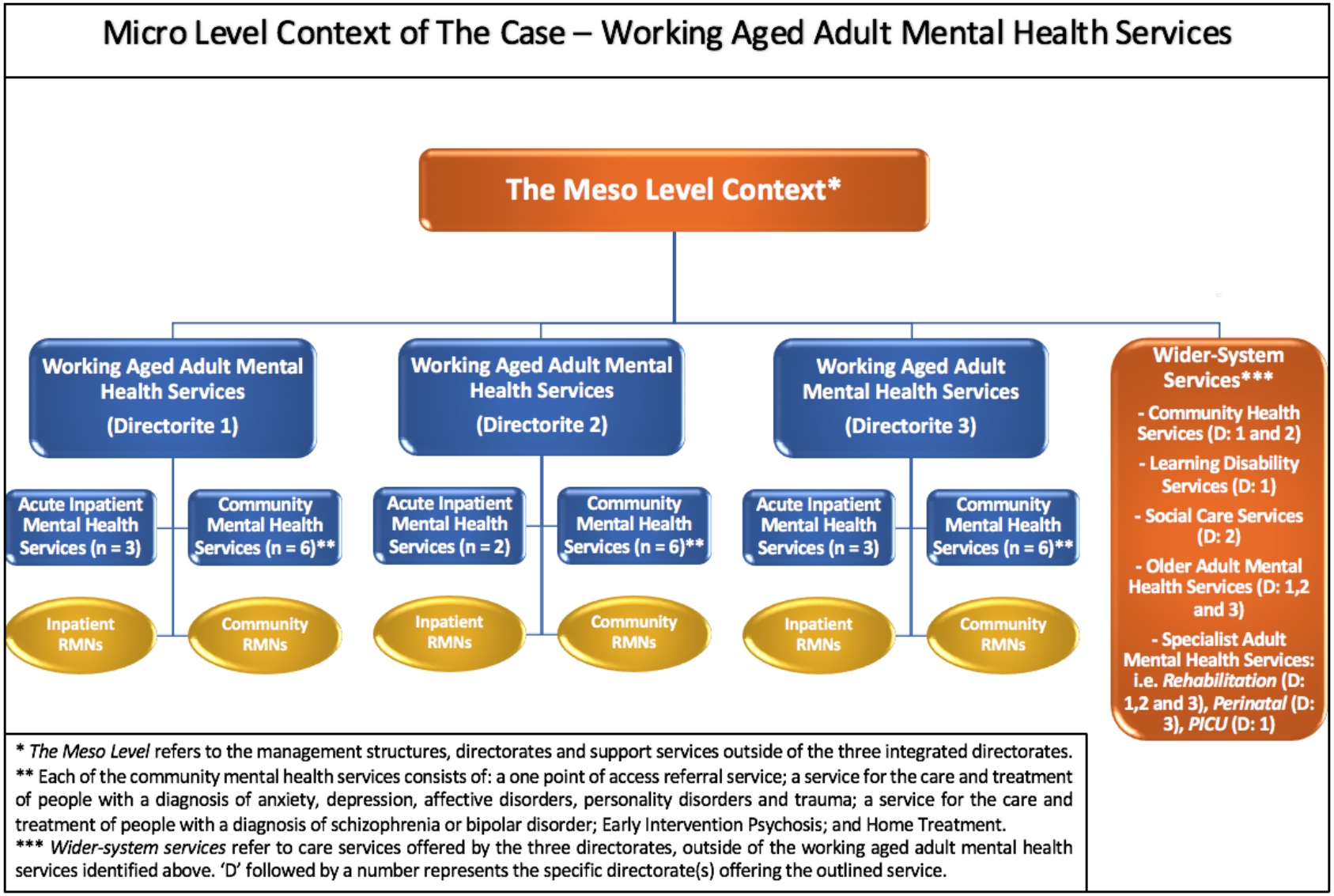
Appendix 4.2: Mesosystem context of the case



* Not part of the formal organisational management structure. Strategic group formed of multi-disciplinary nurses from both the Board of Directors and the five Trust service directorates. Identified as the unit of analysis for nurse leaders in the organisation – nurses that are best positioned to influence practice based mental health nursing towards implementing recovery-orientated practice.

** Integrated Services refers to directorates that offer both mental health and physical health and/or social care services within their specific commissioning catchment area.

Appendix 4.3: Microsystem context of the case



Appendix 4.4: Indicative Topic Guide for Interviews

Interview Schedule	
Title of Study: An exploration of policy, management and recovery-orientated Mental Health nursing practice **Ethics Committee Ref:** UREC/15.3.5.9 **CSP/IRIS Ref:** 200362	
1.	Introductions
	Chief researcher will introduce themselves formally and describe their role for the purpose of this study. The researcher will make it clear that there are no 'right or wrong' answers and the research is interested in the participant's personal views and experience. The researcher will emphasis confidentiality and anonymity arrangements.
2.	Explain the research and cover the key points on the information sheet and reiterate the aims of the research
	This study aims to explore the influence trust policy and management has on the delivery of recovery-orientated mental health nursing care. The project will explore the relationships between the three key sources - Trust Policy, Executive Nurse Managers and Mental Health Nurses; identifying and presenting key findings which may be used to enhance policy pathways, managerial delivery and mental health nursing care.

	The overarching question for this interview is: How does the Trust's nursing executive influence the delivery of recovery-orientated mental health nursing practice? The researcher will inform the participant that this is not a scrutiny of them as an individual/professional or their practice, but rather a process which will allow the researcher to answer the aim of the research. Prior to the commencement of the interview, the researcher will give the participant an opportunity to ask any further questions. They will then ensure that informed written consent is received and that the information sheet has been given to the participant.
3.	Begin interview exploring topic areas:
a	*Topic 1:* The role of the executive nursing leads: What is your role within the Oxleas NHS Nursing Executive? What are your main responsibilities? How is this role situated within the (*Trust/directorate*) management structure?
b	*Topic 2:* The delivery of recovery-orientated nursing in practice: How do you influence the delivery of front-line personal recovery-orientated nursing practice? How well do you feel personal recovery-orientated mental health nursing practice is delivered in practice? *why?* How do you measure personal recovery-orientated nursing in practice? Do you feel that there are any competing priorities that may influence the delivery of personal recovery-orientated practice?
c	*Topic 3:* The influence they have upon trust policy:

	How do you contribute to the formation of nursing practice policy within the trust? What are the specific Trust policies that guide recovery-orientated mental health nursing practice within your service?
d	*Topic 4:* Things that could be done differently: Are there any obstacles that impede on your ability to influence recovery-orientated nursing practice? *If so, what do you feel these are?* Is there anything else the Service/Trust could do differently to influence the delivery of recovery-orientated nursing practice? *If so, what do you feel these are?*
e	**Outlier Topics and Clarifications:** Anything else you would like to add to what you have said? You said earlier…. Could you just run through that to make sure I understand what you meant? Finally, is there anything that you think we should have covered, which you would like to talk about?
	Thank you for your participation

Appendix 4.5: Indicative Topic Guide for Interviews

Indicative Focus Group Schedule Title of Study: *An exploration of policy, management and recovery-orientated Mental Health nursing practice* Ethics Committee Ref: UREC/15.3.5.9 CSP/IRIS Ref: 200362	
1.	Introductions
	Chief researcher will introduce themselves formally and describe their role for the purpose of this study. The researcher will make it clear that there are no 'right or wrong' answers and the research is interested in the participant's personal views and experience. The researcher will emphasis confidentiality and anonymity arrangements. Participants will be reminded to respect each other's opinions and abide by professional standards and conduct.
2.	Explain the research and cover the key points on the information sheet and reiterate the aims of the research
	This study aims to explore the influence trust policy and senior nurse leaders have on the mental health nurses towards implementing of recovery-orientated care. The project will explore the relationships between the three key sources - Trust Policy, Executive Nurse Managers

	and Mental Health Nurses; identifying and presenting key findings which may be used to enhance policy pathways, managerial delivery and mental health nursing care. The researcher will inform the participants that this study is not a scrutiny of them as individuals/professionals or of their practice, but rather a process which will allow the researcher to answer the aim of the research. Prior to the commencement of the Focus group, the researcher will give the participants an opportunity to ask any further questions. They will then ensure that informed written consent is received and that the information sheet has been given to all the participants.
3.	Begin focus group presenting initial findings for discussion in these topic areas:
A Conceptual Context	*Topic 1:* The role of the mental health nurse and perception of recovery. How would you define your role within your service? What does recovery mean to you and what does recovery look like in practice?
B System Process Context	*Topic 2:* Views of recovery-orientated nursing in practice (*enablers and barriers*): What is the purpose of your service? How are people referred to your service? What determines a person's suitability for admission? Who decides if a person is suitable for admission or not? Once a person is admitted to your service, how are care and treatment plans formulated?

Flow	How do you decide if a person is ready to be discharged from your service? Where do people tend to get discharged to? *Enablers and Barriers* What enables you to implement recovery-orientated practices at the point of: *assessment for admission*, during *care and treatment;* and at point of *discharge*? What barriers do you face towards implementing recovery-orientated practices at the point of *assessment for admission*, during *care and treatment;* and at point of *discharge*?
C Management thinking/ system conditions	*Topic 3:* **The influence of nursing executives** How do you feel senior nurse leaders/managers enable you to implement recovery-orientated practices? To what extent do you feel able to shape nursing practice within your service? To what extent do you feel the priorities of senior nurse leaders/managers are the same as yours? What could senior nurse leaders/managers do differently to influence you towards recovery-orientated practice?
D	*Topic 4:* **Policy formation and influence** How do you contribute to the formation of trust policy? Are there any particular policies that you feel support or hinder you towards implementing recovery-orientated practices? *How and why?*
	Topic 5: **Any other barriers**

	In your service, do you feel that you face any other barriers towards implementing recovery-orientated practices? What do you feel could be done differently to remove or reduce these barriers?
e	**Outlier Topics and Clarifications:** Is there anything else you would like to add to what you have already said? You said earlier…. Could you just run through that to make sure I understand what you meant? Finally, is there anything that you think we should have covered, which you would like to talk about?
	Thank you for your participation

Appendix 4.6: Information sheet for interviews

INFORMATION SHEET FOR INTERVIEWS

(some original information has been edited for anonymity)

All participants will be given a copy of this sheet.

Title of Research Project:

An Exploration of Policy, Management and Recovery-orientated Mental Health Nursing Practice

Introduction:

My name is Stephen Jones. I am a post graduate research student at the University of Greenwich and a Mental Health Nurse. From my position as a post graduate research student, I would like to invite you to take part in a research study. Joining the study is entirely up to you. I would like you to understand why the research is being done and what it would involve for you. This information sheet should provide an overview of what is to come.

Before you agree to take part, I will go through this information sheet with you face to face or over the phone. This will help you decide whether or not you would like to take part and at the same time allow me to answer any questions you may have. I would suggest that this discussion should take approximately 5-10 minutes before the interview begins. Please feel free to talk to others about the study if you wish.

Research Aims:

This study aims to explore the influence trust policy and management have on the delivery of recovery-orientated mental health nursing care. The project will explore the relationships between three key sources - trust policy, executive managers and mental

health nurses; identifying and presenting key findings which may be used to enhance policy pathways, managerial delivery and mental health nursing care for the future.

Why have you been asked to participate?

You have been invited to participate in this study due to your position within the Trust management structure along with your influence and expertise over your mental health directorate.

What will happen to you and where will it take place?

This study is being undertaken within your Trust's premises only. You will be given a choice of whether you wish to be interviewed face to face or over the telephone. The interviews will be arranged for a time of your choosing. The face to face interviews will be conducted in a quiet area within the trust, such as your personal office or a meeting room.

Preferably, the face to face interviews will be recorded using a digital recording device. However, if you do not wish to be recorded, the conversation will be written verbatim by the investigating researcher (me) at the time of interview. If you choose to partake in a telephone call, it may be recorded using digital media; either by recording loudspeaker conversation or the use of phone call recording software. The interviews will take approximately 30-60 minutes.

How will your privacy be maintained?

Everything discussed in the interview will remain completely confidential unless you share information which would indicate that your own health and safety, and/or the health and safety of others is in imminent danger.

All personally identifiable information will be replaced by a coding reference as to maintain your privacy and confidentiality. With your permission, this information about you will be used to support other research in the future, and may be shared anonymously with other researchers.

The interview transcripts will be kept on encrypted computers at the University of Greenwich, NHS encrypted USB dongles, with paper transcripts kept locked in filing cabinets at the University of Greenwich research office.

Anonymity within the directorate staff group may be difficult to achieve due to your position in the Trust. Nevertheless, the data will be managed in such a way that you will not be identified outside of the Trust. All discussions will be held in confidence and a transcript of your interview can be provided to you on written request.

Consent:

It is entirely up to you to decide whether you take part in this study or not. You are free to withdraw from this study at any time without giving any reason. If you decide to take part, you will be given this information sheet and be asked to sign a consent form.

If you have further questions about the study, please contact:

PhD Student and Chief Researcher:

Stephen W Jones
Bronte Building (B117),
Department of Family Care
and Mental Health, Education
and Health, Avery Hill,
University of Greenwich
SE9 2UG
Email: [redacted]
Tel: [redacted]

Project Supervisor:

Dr. John Crowley
Mary Seacole Building (1st floor)
Department of Family Care & Mental Health, Avery Hill,
University of Greenwich
SE9 2UG

Appendix 4.7: Information sheet for Focus Groups

INFORMATION SHEET FOR FOCUS GROUPS

(some original information has been edited for anonymity)

All participants will be given a copy of this sheet.

Title of Research Project:

An Exploration of Policy, Management and Recovery-orientated Mental Health Nursing Practice

Introduction:

My name is Stephen Jones. I am a Doctorate student at the University of Greenwich and a Mental Health Nurse at the NHS Foundation Trust. I would like to invite you to take part in my research study. Joining the study is entirely up to you. I would like you to understand why the research is being done and what it would involve for you. This information sheet should provide an overview of what is to come.

Before you agree to take part, I will go through this information sheet with you. This will help you decide whether or not you would like to take part and at the same time allow me to answer any questions you may have. I would suggest that this should take approximately 5-10 minutes before the commencement of the focus group discussion. Please feel free to talk to others about the study if you wish.

Research Aims:

This study aims to explore the influence trust policy and senior nurse leaders have on the mental health nurses towards implementing of recovery-orientated care. The project will explore the relationships between three key sources - trust policy, nursing executive leaders and practice-based mental health nurses; identifying and presenting key findings

which may be used to enhance policy pathways, managerial delivery and mental health nursing care for the future.

Why have you been asked to participate?

You have been invited to participate in this study due to your position as a registered mental health nurse, along with your experience within your specific practice area – Acute inpatient and/or community mental health services.

What will happen to you and where will it take place?

This study is being undertaken within trust premises only. A suitable date and time will be arranged with you and your work place manager so that you can be supported to attend the focus group discussion.

The focus group discussions will be recorded using a digital recording device. Audio recorded data will be transcribed verbatim before the recordings are destroyed. The focus will last up to a maximum of 60 minutes.

All participants are expected to uphold their professional standards throughout the focus group discussions. Participants should respect each other's opinions and avoid conflict. Any escalating disruptions will cause the focus group to come to an immediate close. Everything discussed within the focus group must be kept confidential by all participants. These expectations will be formally agreed by you once signing the consent form.

How will your privacy by maintained?

Everything discussed in the interview will remain completely confidential, unless you share information which would indicate that your own health and safety, and/or the health and safety of others is in imminent danger.

All personally identifiable information will be replaced by a coding reference as to maintain your privacy and confidentiality. With your permission, this information about you will be

used to support other research in the future and may be shared anonymously with other researchers.

The interview transcripts will be kept on encrypted computers at the University of Greenwich, NHS encrypted USB dongles, with paper transcripts kept locked in filing cabinets at the University of Greenwich research office.

Consent:

It is entirely up to you to decide whether you take part in this study or not. You are free to withdraw from this study at any time without giving any reason. If you decide to take part, you will be given this information sheet and be asked to sign a consent form.

If you have further questions about the study, please contact:

PhD Student and Chief Researcher:

Name: Stephen W Jones Email: [redacted]

Tel: [redacted]

Project Supervisor:

Name: Dr. John Crowley Email: [redacted]

Tel: [redacted]

Appendix 4.8: Participant consent form

PARTICIPANT CONSENT FORM

This form is to be completed by the participant of the study titled:

'An Exploration of Policy, Management and Recovery-orientated Mental Health Nursing Practice'

Please read all the information carefully and complete the form once you are satisfied with the statements outlined below. Please initial the boxes and sign at the bottom of the page.

<table>
<tr><td colspan="2">Please initial
I have read the information sheet about this study.
I have had an opportunity to ask questions and discuss this study with the researcher.
I have received satisfactory answers to all my questions.
I have received enough information about this study.
I understand that I am free to withdraw from this study at any time without giving any reason, without my professional and/or legal rights being affected.
I understand that the information collected about me will be used to support other research in the future and will only be shared anonymously with other researchers.
I agree to take part in this study.
I am happy for the researcher to contact me again in the future for the purpose of this study.</td></tr>
<tr><td>Signed (participant):</td><td>Date:</td></tr>
<tr><td colspan="2">Name in block letters:</td></tr>
<tr><td>Signature of researcher:</td><td>Date:</td></tr>
<tr><td colspan="2">This project is supervised by:
Name: Dr. John Crowley Email: [redacted]
Tel: [redacted]</td></tr>
<tr><td colspan="2">Researcher's contact details:
Name: Stephen W Jones Email: [redacted]
Tel: [redacted]</td></tr>
</table>

Appendix 6.1. Contemporary Empirical Literature search

Search 1: "mental health" AND "nurs*" AND "recovery" (n=105 – same parameters - 2016-2022)

Search 2: "psych*" AND "nurs*" AND "recovery" (n=75 – same parameters - 2016-2022)

Table 6.1 *How do mental health nurses conceptualise recovery-orientated nursing practices?*

Empirical Literature				
Authors	Country	Setting	Nurse Participants	Methods
Gale and Marshal-Lucette (2012)	UK	Community	n=23	Mixed method (two-part study): descriptive questionnaire used to identify nurse perspectives
Aston and Coffey (2012)	UK	In-patient	n=5	Qualitative: Focus Group
Cleary et al. (2013)	Australia	In-patient	n=21	Qualitative: Semi-structured interviews

Cleary and Dowling (2009)	Ireland	In-patient and/or Community	n=92	Mixed Method: Closed descriptive questionnaire. Two open questions
Jacob et al. (2015)	Australia	Community	n=9	Qualitative: Semi-structured interviews
McKenna et al. (2014)	Australia	In-patient	n=46	Qualitative: Focus Groups (five)
Gaffey et al. (2016)	Ireland	In-patient and/or Community	n=136	Mixed Method: Closed descriptive questionnaire. Two open questions
Coffey et al. (2012)	UK	Inpatient	n=156	Not explicit enough for just nurses – similar to LeBoutillier et al.
Simpson et al. (2017)	UK	Inpatient	N=156	The full report of the above publication

Table 6.2 *What are the barriers and enablers towards implementing recovery-oriented nursing practices?*

Empirical Literature				
Authors	**Country**	**Setting**	**Participants**	**Methods**
Gale and Marshal-Lucette (2012)	UK	Community	n=23	Mixed method (two-part study): a descriptive questionnaire used to identify nurse perspectives
Aston and Coffey (2012)	UK	In-patient	n=5	Qualitative: Focus Group
Cleary et al. (2013)	Australia	In-patient	n=21	Qualitative: Semi-structured interviews
Cleary and Dowling (2009)	Ireland	In-patient and/or Community	n=92	Mixed Method: Closed descriptive questionnaire. Two open questions

Jacob et al. (2015)	Australia	Community	n=9	Qualitative: Semi-structured interviews
McKenna et al. (2014)	Australia	In-patient	n=46	Qualitative: Focus Groups (five)
Gaffey et al. (2016)	Ireland	In-patient and/or Community	n=136	Mixed Method: Closed descriptive questionnaire. Two open questions

Table 6.3 *How do nursing executives influence, practice-based nurses, towards implementing recovery-orientated practices?*

Empirical Literature				
Authors	**Country**	**Setting**	**Participants**	**Methods**
Gale and Marshal-Lucette (2012)	UK	Community	n=23	Mixed method (two-part study): a descriptive questionnaire used to identify nurse perspectives
Aston and Coffey (2012)	UK	In-patient	n=5	Qualitative: Focus Group
Cleary et al. (2013)	Australia	In-patient	n=21	Qualitative: Semi-structured interviews
Cleary and Dowling (2009)	Ireland	In-patient and/or Community	n=92	Mixed Method: Closed descriptive questionnaire. Two open questions

Jacob et al. (2015)	Australia	Community	n=9	Qualitative: Semi-structured interviews
McKenna et al. (2014)	Australia	In-patient	n=46	Qualitative: Focus Groups (five)
Gaffey et al. (2016)	Ireland	In-patient and/or Community	n=136	Mixed Method: Closed descriptive questionnaire. Two open questions

Wider literature on mental health nursing and recovery

Evaluation of training programmes:

Implementation of a Recovery-Oriented Training Program for Psychiatric Nurses in the Inpatient Setting: A Mixed-Methods Hospital Quality Improvement Study. (USA)

Risk assessment and recovery:

There is more to risk and safety planning than dramatic risks: Mental health nurses' risk assessment and safety-management practice. (Ireland)

Concept of recovery:

Reality of working in a community-based, recovery-oriented mental health rehabilitation unit: A pragmatic grounded theory analysis. (Aus)

Spiritual Perspectives, Spiritual Care, and Knowledge of Recovery Among Psychiatric Mental Health Nurses. (Aus)

Using Q-methodology to explore mental health nurses' knowledge and skills to use recovery-focused care to reduce aggression in acute mental health settings. (Aus)

The experience and meaning of recovery-oriented practice for nurses working in acute mental health services. (New Zealand)

Developing acute care-based mental health nurses' knowledge and skills in providing recovery-orientated care: A mixed methods study. (Aus)

The role of MH nurse:

Mental health nursing: Daring to be different, special and leading recovery-focused care? (Aus)

Hurley, J. et al. (2022), Utilizing the mental health nursing workforce: A scoping review of mental health nursing clinical roles and identities, *International Journal of Mental health Nursing*. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/inm.12983