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ORIGINAL ARTICLE

Competing Priorities: Staff Perspectives on Supporting Recovery

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

Some preliminary findings were presented at Refocus on Recovery 2012, London, UK, March 5–7, 2012.

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Introduction

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

The overarching aim of the recovery vision for services is to allow people opportunities and resources to lead meaningful and productive lives, and to redefine the long-term prognoses of people with severe and enduring mental

illness (Henwood et al. 2014). Attention is given to the recognition that there is more to a person than illness and primacy is given to each person in determining the stage and direction of their own individual recovery journey (Chen et al. 2013; Farkas 2007). Further clarity on what constitutes recovery support and how recovery orientation might be operationalized in practice has been attempted. A framework based on an international review identified four practice domains: promoting citizenship, organizational commitment, supporting personally defined recovery, and working relationship (Le Boutillier et al. 2011).

Despite research on the diffusion of innovations (Rogers 2003), the growing discipline of implementation science (Tansella and Thornicroft 2009), and guidance on developing complex interventions (Craig et al. 2008), a translational gap remains between knowledge and routine implementation of recovery-oriented practice (Brown et al. 2010; Salyers et al. 2009; Tse et al. 2013). Rose and colleagues advise that a multi-perspective evidence base is paramount in supporting adoption in practice (Rose et al. 2006). Clinician and manager perspectives are central to understanding how recovery support can be adopted in mental health care because they provide front-line services, and they are the vehicle bridging the gap between policy rhetoric and clinical practice (Hardiman and Hodges 2008). Current evidence indicates that research is early-stage (Piat and Lal 2012) and a knowledge gap remains, with one of the biggest obstacles to implementation being the lack of a shared understanding of what recovery means in practice and how it can be best supported (Le Boutillier et al. 2011; Salyers et al. 2011). The aim of this study was to identify factors that help or hinder clinician and manager efforts to provide recovery support, by investigating what staff say they do to support recovery.

Method

Study Design

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

Data Collection

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

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

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

Separate focus groups were conducted with team leaders and clinicians at each site to allow perspectives to be shared with others with similar managerial and clinical responsibilities. Each 90-min focus group started by exploring staff perspectives on barriers and facilitators to providing recovery support. A conceptual framework of recovery-oriented practice was used in the early focus groups to organize the topic guide and generate discussion by providing examples of what recovery might mean in practice (Le Boutillier et al. 2011). However, the discussion aimed to follow individual's interpretation of recovery-oriented practice, prompting the lack of a shared understanding of what recovery means in practice to emerge as an early finding. The many meanings of

recovery-oriented practice quickly became apparent as an influence on what was actually being implemented. Barriers and facilitators to providing recovery support were also identified as an influence on how staff understood recovery as applied to their practice (one example is that participant understanding was frequently informed by system messages such as recovery equals service throughput). The aim to investigate what staff say they do to support recovery was subsequently added. The research became progressively focused and theoretical explanations were tested and revised with further data collection (Strauss and Corbin 1990). Focus groups were led by authors CL or ML and moderated by authors ML or JW between May and August 2010, and were audio recorded and transcribed verbatim.

Focus group data analysis identified a methodological limitation, where participants had difficulty in eliciting individual accounts of recovery-oriented practice in a group context. Interviews (n = 32) were therefore conducted to allow deeper probing to explore individual practice examples alongside barriers and facilitators to supporting recovery. Participants with a range of characteristics were sought to test out and refine the emerging theory (Strauss and Corbin 1990). For example, clinicians and team leaders with greater work experience were actively recruited to examine whether they were more likely to support recovery, and those who perceived themselves as successful in supporting recovery in practice were identified and recruited to explore the factors which enabled their success. Senior NHS managers were also recruited to examine the organizational factors identified as instrumental in shaping the meaning and success of supporting recovery. Recruitment continued until theoretical saturation was reached.

Interview participants were approached and recruited by authors CL or VB (London site), the 2gether research team (2gether site) or local MHRN Clinical Studies Officers (non-London sites) via the telephone, email or face-to-face. The interview schedule for clinicians and team leaders and a separate interview schedule for senior managers focused on using practice examples of recovery orientation to identify blocks and enablers to incorporating recovery into their routine clinical practice. Both interview schedules were revised iteratively to further explore emergent themes and deviant cases. For example, the category 'competing priorities for practice' emerged from focus group data, and was subsequently explored in interviews. Focus group participants were asked 'What are your priorities and goals for practice? Describe how, and to what extent you have been able to implement recovery-oriented practice; senior managers were interviewed and asked 'Can you describe how this organisation supports recovery? What do you see as the current organisational priorities?' Clinician and team leader individual interview participants were specifically asked if and how they prioritise recovery-oriented practice. Example clinician/team leader and senior manager individual interview schedules are included in supplementary data 2 and 3. Interviews were conducted across NHS sites, lasted around 1 h, and were audio recorded and transcribed verbatim. Where requested, transcripts were returned to participants for comment and correction. Interviews were conducted by authors CL, ML or the 2gether research team between January 2011 and August 2012.

Data Analysis

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

Results

Participants

A total of 65 staff (clinicians and team leaders) participated in focus groups, and 32 staff (clinicians, team leaders and

Table 1 Staff participants (n = 97)

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

senior managers) in interviews. Their characteristics are shown in Table 1.

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

Core Category and Sub-categories

The developed theory is a result of the interrelationships between a central phenomenon or 'core category' and the sub-categories (Strauss and Corbin 1990) identified as influencing staff implementation of recovery-oriented practice. Findings identified many implementation challenges alongside a difficulty of articulating examples of recovery-oriented practice. Despite the study focus on success stories, staff appeared to identify more barriers than facilitators to supporting recovery. An early finding was that barriers and facilitators identified by staff shaped their understanding of recovery as applied to practice. The core category to emerge from the data was Competing Priorities. Participants' accounts of recovery-oriented practice appeared to be informed by priorities across different levels (for example, organizational level, staff level etc.) of the health system. One major challenge for participants was understanding recovery-oriented practice and the compromises that they feel have to be made when supporting recovery. Three sub-categories relating to the competing priorities were identified: Health Process Priorities where clinical systems dictate the direction of practice; Business Priorities where financial concerns take primacy; and Staff Role Perception where the values and priorities of individual workers that support recovery shape their practice.

Core Category: Competing Priorities

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

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

> independent clinicians out of the mix and it takes being able to treat clients as individuals and unique people out of the mix as well [5.6, occupational therapist].

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

Sub-category: Health Process Priorities

One of the sub-categories to emerge strongly in participants' accounts was Health Process Priorities. Participants suggested that recovery has been made to fit a health infrastructure where its meaning is shaped by a traditional focus on hierarchy, clinical tasks, professional language, medicalization and psychiatric power.

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

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

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

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

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

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

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

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

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

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

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

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

Sub-category: Business Priorities

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

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

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

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

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

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

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

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

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

Sub-category: Staff Role Perception

The category Staff Role Perception encompasses how staff understand their work roles and how staff prioritise work tasks. Despite reported frustrations, a few workers identified an ability to support recovery outside organizational priorities and described ways of balancing statutory demands and fulfilling service user priorities. A social worker stated: "I was working til half six last night with someone and I'm a 9 to 5 worker but I sometimes work at eight in the morning, sometimes work at half six if it suits the client."

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

> I say to my team I really don't give a toss about those figures, if I know you are going out and you are knocking on employers doors… thinking well who will take up, that is a good use of your time and I will

> stand up and be counted against when they look at our numbers, that's what I think [1.14, team leader, nurse].

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

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

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

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

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

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

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

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

Discussion

This study aimed to investigate staff perspectives on supporting recovery in order to better understand how staff support recovery in their practice, alongside the associated barriers and facilitators to providing recovery-oriented practice in mental health services. This grounded theory study identified a core category, of Competing Priorities, where staff struggle to make sense of recovery-oriented practice in the face of conflicting demands, informed by different priorities of different health system levels. Three sub-categories outlining the competing priorities were identified: Health Process Priorities, Business Priorities and Staff Role Perception.

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

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

The strong emphasis on health processes alters recovery-oriented practice. Health organizations function in a context where the recovery support is modified to fit a

health infrastructure organized around diagnosis, symptoms and risk. While support for recovery is evident in contractual arrangements, it is one objective among many, and services define the concept flexibly to meet other commissioning demands and targets. For example, successful recovery support has been operationalized in terms of discharge, reduced hospital admissions, improved clinical outcome scores, and return to employment (Slade et al. 2014).

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

Whitley and colleagues identified four staff influences when supporting the success of implementing a specific recovery intervention in the United States; leadership, innovative organizational culture, effective training, and committed staff (Whitley et al. 2009). Gilburt and colleagues identified organizational hierarchy as a barrier to recovery support, the power of the system viewed as conflicting with service user aims (Gilburt et al. 2013). There is concern that recovery is translated to support service cuts or to exclude those individuals in most need of support (Dickerson 2006) where individuals are labelled as either recovered or not recovery-ready. Equally, some organizations have stipulated a time frame in which one should recover. For some recovery has simply become a new term for rehabilitation. Because the call for recovery-oriented services is happening alongside the current financial climate, there is concern that recovery could be co-opted as a concept and left without content (Roberts and Hollins 2007).

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

Implications for Policy and Practice

The findings of the study are clinically important, relevant to current health priorities, and influence the mental health system at both policy and practice levels. While mental health staff are encouraged to transform their practice towards a recovery orientation, they reported the need to manage competing organisational and financial imperatives, which compromised their ability to support recovery. The findings point to the need for organizational alignment around a shared focus on recovery support, including how recovery support is conceptualised in practice. Staff understanding of recovery-oriented practice is a significant factor influencing the success of implementation.

Strengths and Limitations of the Study

The study followed the systematic research methodology and procedures of grounded theory (Strauss and Corbin 1990). Use of a pre-defined recovery practice framework in early focus groups may have influenced the descriptions of recovery-oriented practice provided by participants, although efforts were made to encourage individual's own conceptualisations. Although the total number of staff approached was not recorded, data collection and analysis continued until theoretical saturation was reached where the accounts of 97 members of staff (with diverse job roles) were explored, making the scope large for a qualitative study. Participants were recruited using purposive and theoretical sampling strategies. Nursing staff made up the majority of the sample as they were considered the majority of the workforce. While researcher reflexivity was

present throughout, researcher interpretation is evident. The pros and cons of having worked in a role similar to that under study, and sharing a staff perspective, were explored in reflective diaries. The findings are specific to the study context, that is five NHS mental health Trusts, from 2010 to 2012. This study also focused on mental health service community care provision and did not address staff understanding of recovery as applied to in-patient care.

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

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Conflict of interest None.

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