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Exploring the barriers and enablers to the implementation and adoption of recovery-orientated practice by community mental health provider organizations in England

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ABSTRACT

In England, implementation and adoption of recovery-orientated (RO) practice has been slow and uneven. This qualitative study explored the barriers and enablers to the implementation and adoption of RO practice in community mental health provider organizations. Thirteen registered managers took part in semi-structured interviews. Four themes were identified: RO practice is not an entirely alien concept; RO practice is a labor intensive and skilled activity; Families need to be on onboard with RO support; and Limited community capacity for RO support. The most salient barriers and/or enablers were: staff training, public misconceptions of mental illness, and joint-working with families.

Introduction and rationale

Diagnosis of severe mental illness (SMI), including schizophrenia spectrum and bipolar affective disorders, was once related to a lifetime of disability with little prospect of improvement or recovery (Frost et al., 2017). Such negative and debilitating notions discouraged service-users from engaging in regular activities, such as paid employment, education, parenthood, intimate relationships, and independent living, and encouraged the development of service-dependent lifestyles, involving long periods of institutionalization, high-doses of psychotropic medication, prosaic recreational activities, and supervised housing (Drake & Whitley, 2014).

In the 1980s, pessimistic views about SMI as a chronic unremitting illness with poor outcomes were challenged by the publication of findings from a longitudinal research study that suggested the course of schizophrenia was not inevitable deterioration (Harding, Brooks, & Ashikaga et al., 1987). Several studies followed, which suggested approximately 50% of people diagnosed with schizophrenia experienced good outcomes, measured by significant reductions in symptoms, and improved quality of life and role function over

prolonged periods of time (Bellack & Drapalski, 2012). Alongside new data on long-term outcomes, a series first-person narratives from within the growing consumer movement was published, which described the remission of symptoms and meaningful and fulfilling lives despite the persistence of symptoms (Deegan, 1988; Fisher, 1994).

By the turn of the millennium, the language of recovery was widely used in mental health policy and the concept of recovery was at the forefront of discussions about the transformation of mental health services in several countries (Piat & Sabetti, 2009). The concept of recovery has been variously defined by scholars, practitioners, and service-users. At least two types of recovery can be differentiated. The first type is personal recovery, which is generally understood as a non-linear journey or process. Personal recovery is judged by the service-user themselves and the extent to which they perceive their life to be meaningful and fulfilling even though they may continue to experience symptoms of mental illness. The personal recovery journey is one often linked to feelings of hope, self-determination, engagement, and social connectivity (Ridgway, 2001). Personal recovery may or may not be related to interventions by health services. The second type of recovery is clinical recovery, which is frequently understood as an outcome, a judgment made by a professional observer, which emphasizes the remediation of symptoms and effective interventions by health services (Slade, 2010).

Differences in definition have posed challenges for both services attempting to operationalize the term recovery (Meehan, King, & Beavis et al., 2008) and researchers attempting to evaluate recovery-orientated (RO) interventions (Simpson & Penney, 2011). To aid its translation into practice, Le Boutillier et al. (2011) conducted a qualitative analysis of international practice guidance to develop a conceptual framework describing the factors characterizing RO practice. The framework grouped key themes into four practice domains: promoting citizenship (enabling social integration through greater community connection and recognition of people with mental illness as equal citizens), organizational commitment (ensuring a working environment that values RO practice), supporting personally defined recovery (empowering people to shape their treatment and support by defining their own needs, goals, and aspirations), and working relationship (showing a genuine commitment to supporting people to achieve their potential and to shape their own lives). In England, RO quality statements include: helping people choose and work toward personal goals; helping people find meaningful occupations and build support networks; helping people gain skills to manage their everyday activities and their mental health; providing opportunities for sharing experiences with peers; encouraging positive risk-taking; developing self-esteem and confidence; and validating people's achievements (National Institute for Health and Care Excellence (NICE), 2020).

There is increasing demand for empirical proof of efficacy, effectiveness and efficiency in healthcare practice. According to Simpson and Penney (2011), bringing recovery into the realm of clinical research necessitates fashioning the aforementioned practice domains into objectively measurable treatment outcomes. Clinical recovery is arguably more conducive to empirical evaluation than personal recovery. However, studies investigating clinical recovery do not necessarily report findings which reflect the recovery journey that service-users perceive themselves as having experienced. To that end, Frost et al. (2017) recommended that evaluation strategies adopt mixed methods approaches, which incorporate both qualitative and quantitative components, including service-user narratives, clinical recovery outcomes (e.g. symptoms and treatment adherence), personal recovery evaluations (e.g. self-reported wellbeing, vocational activities, quality of life, and community networks); and service-related outcomes and evaluations (e.g. hospital attendances, engagement with community services, staff perceptions, and policy and guideline awareness).

Mental health policy in England has supported the concept of recovery since 2001 (Department of Health, 2001). However, adoption of RO practice has been slow and uneven (Gilburt, Slade, Bird, Oduola, & Craig, 2013). For example, Perkins and Slade (2012) report policy and practice as being disconnected, with organizational policies advocating recovery and teams re-branding as "recovery and support" teams, whilst following clinical practices which prioritize symptomatic relief over recovery support.

Various studies have explored the barriers and/or enablers to implementing RO practice. One recent systematic review exploring the implementation of RO practice in hospital-based mental health services (Lorien, Blunden, & Madsen, 2020) identified several enablers to implementation, which included knowing the evidence for recovery from the service-user perspective, cultural change to more optimistic attitudes about recovery, and facilitation of a multifaceted approach that comprises staff training, service-user programmes, and changes to care planning processes. The authors argued that for RO interventions to be adopted, several barriers needed attending to, including consumer involvement, staff attitudes toward recovery, and broadening organizational priorities to include processes that support connections with others (i.e. making time to talk with service-users). Further barriers were the deeply rooted biomedical model, and organizational priorities centered on maintaining safety and clinical treatment for symptom control, over RO practice.

Whilst no synthesis of the research literature on the barriers and/or enablers to RO practice in community settings has been identified, various studies have explored the factors that influence the adoption of RO practice in mental health services closer to home. For example, Whitley, Gingerich, Lutz, & Mueser, 2009) examined the factors that promote or hinder

successful implementation of recovery in community mental health settings in 12 community mental health centers in the United States. The researchers conducted regular observations of routine practice and undertook qualitative interviews with practitioners and leaders involved in implementation. They found that the main factors that combined to effect implementation were leadership, organizational culture, training, and staff and supervision. The authors concluded that implementation was facilitated through strong leadership, an organizational culture that embraces innovation, effective training, and committed staff. Another practitioner perspective is provided by Piat and Lal (2012), who recruited participants from mental health services in Canada and identified a number of barriers including: uncertainty and inconsistency around the meanings of recovery, concerns about the applicability of RO practice in short-term and crisis services, bureaucratic RO tools which emphasized outcomes rather than process, limited leadership support and, societal stigma and social exclusion of persons with mental illness.

In England, community-based mental health teams provide care and treatment for adults who need care over and above what can be provided in primary care (i.e. general practice). Typically, the people to whom community-based mental health teams provide care have a SMI diagnosis. Community mental health teams are comprised of psychiatrists, psychologists, community psychiatric nurses, social workers and occupational therapists. These teams use the Care Programme Approach (CPA) to comprehensively assess the needs of a person with SMI. Following assessment, the service-user receives a care plan, which sets out what day to day support will be provided and who will provide this support. According to need, this will include help and support with medication, housing, and physical health needs. It will also include help and support with activities of daily living, such as help and support getting out of the house, keeping in touch with friends and family, getting a job or taking part in education or training, cleaning the house, preparing meals or shopping, managing money, taking part in leisure activities, and contributing to society (e.g. volunteering and being in a club). Current policy stresses that care and support should be provided in ways which promote recovery and which reflect collaborative and individually tailored or personalized care (NHS England, 2016). As part of the CPA, the care plan is regularly reviewed.

Support with activities of daily living is commissioned by Local Authorities and/or Clinical Commissioning Groups from private sector and non-for-profit mental health provider organizations registered with the Care Quality Commission (CQC). Despite the role mental health provider organizations play in supporting and helping people with SMI, there is a paucity of research exploring their perspectives of the barriers and/or enablers to RO practice. To address this gap, the aim of this study was to explore the barriers and/or

enablers to the implementation and adoption of RO practice by adult community mental health provider organizations in England.

Methods

Design

The study adopted a pragmatic qualitative research design. COREQ (COnsolidated criteria for REporting Qualitative research) guidelines were adhered to for reporting the study (Tong, Sainsbury, & Craig, 2007).

Setting

The study took place in London, England.

Sampling and recruitment

The study sought to recruit registered managers. A registered manager is a provider's most senior employee and is registered with the CQC. They are responsible for ensuring that the service meets all legal and regulatory requirements. As well as taking responsibility for quality and governance issues, they also take responsibility for leading a team of social care support workers, managing resources, safeguarding and protection, and staff training and development.

To ensure experience in developing and implementing policies related to RO practice in the employing organization, participants were only recruited from organizations that had been trading for at least six months. Purposive sampling was used to capture a wide range of perspectives on the phenomenon under investigation. The intention was to sample participants from a range of small-scale providers, medium-sized providers, and large-scale providers. Size was determined using criteria set by the Centre for Strategy and Evaluation Services (2014).

The Care Directory (Care Quality Commission (CQC), 2020) was used to identify mental health provider organizations operating in London. Given the first author (CE) was the managing director of a mental health provider organization in Hertfordshire, to avoid any potential conflict of interest, organizations operating across both London and Hertfordshire were excluded. In total, 69 eligible community mental health provider organizations were identified.

Recruitment was undertaken by CE. Prospective participants were contacted by e-mail, whose contact details were found in the CQC Care Directory. In the e-mail, CE declared thier position, and set out the purpose, methods and intended uses of the research and what participation would

entail. A participant information sheet was attached. Three days after sending the initial e-mail, a follow up contact was made via telephone. Anyone who expressed an interest in taking part was asked to select a convenient time and date for the interview to take place. Participation was strictly voluntary.

In determining sample size, the guiding principle was data saturation. An a priori sample size for the first round of analysis was set at ten. After ten interviews, the point of data saturation was defined as being when three further consecutive interviews had been conducted with no new ideas emerging (Francis et al., 2010). Eligible organizations were approached in turn until data saturation was achieved. In total, 27 organizations were approached.

Data collection

Data were collected in one-to-one interviews by CE, who had completed qualitative research training. The interview comprised two parts. In the first part, demographic information was collected including professional affiliation, years of experience in mental health, and years working in current organization. The second part was a semi-structured interview using a topic guide. Six key questions framed the guide: What does RO practice mean to you; What does RO practice mean to your organization; How is RO practice part of your day to day work; What stage is your organization in implementing RO practice; What challenges have you encountered when implementing RO practice; and What has helped you to implement RO practice?

The guide was piloted with two people who shared similar characteristics with the chosen sample and amended following the researchers' reflections. Pilot data were not included in the analysis. Data were collected between July and September 2020. The interviews were audio-recorded with participants' permission. Data saturation was deemed to have occurred after thirteen interviews.

The study was undertaken during the COVID-19 pandemic. In the context of the pandemic, additional safeguards were put in place. First, extra consideration was given to whether participation in the proposed study would overburden frontline managers. To that end, prior to seeking ethical approval, CE canvased the opinion of registered managers by posting messages on a registered managers' online forum. In response to their post, six managers confirmed their capacity to participate. No one raised concerns about the timing of the proposed study. Second, to ensure social distancing, all interviews were conducted via Zoom video-link. The study received ethics approval from the School of Health Sciences Research Ethics Committee at City, University of London (Ref: ETH1920-1014).

Data analysis

All interviews were transcribed verbatim by the first author. The second author (CM) quality checked the first two transcripts to confirm their accuracy.

To support the analysis of data, the authors drew on the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009). This framework was designed to explore the factors that influence the effective use of evidence-based practice and innovation in healthcare. The CFIR consists of five major domains and 37 underlying constructs derived from multiple fields (including psychology, sociology, and organizational change) to provide a comprehensive, multidisciplinary taxonomy of constructs likely to influence the implementation of complex interventions. The five domains indicate a whole systems approach covering characteristics of an intervention, inner setting, outer setting, characteristics of individuals, process of implementation (see Table 1). These domains appeared to reflect what is known from the

Table 1. Consolidated framework for implementation research (Damschroder et al., 2009).

Domain	Underlying construct
Characteristics of the intervention	• Intervention source
	• Evidence strength and quality
	• Relative advantage
	• Adaptability
	• Trialability
	• Complexity
	• Design quality and packaging
	• Cost
Outer setting	• Patient needs and resources
	• Cosmopolitanism
	• Peer pressure
	• External policies and incentives
Inner setting	• Structural characteristics
	• Networks and communications
	• Culture
	• Implementation climate
	• Available resources
	• Access to knowledge and information
	• Leadership engagement
	• Compatibility
	• Goals and feedback
	• Tension for change
	• Relative priority
	• Organizational incentives and rewards
Characteristics of the individuals involved	• Knowledge and beliefs about the intervention
	• Self-efficacy
	• Individual stage of change
	• Individual identification with the organization
	• Other personal attributes
Process of implementation	• Planning
	• Engaging
	• Executing
	• Reflecting and evaluating
	• Champion
	• External change agent
	• Formally appointed internal implementation
	• Opinion leaders

literature about the factors that influence the adoption of RO practice such as organizational priorities centered on maintaining safety and clinical treatment for symptom control (inner setting – relative priority), staff attitudes toward recovery (characteristics of the individuals involved – knowledge and beliefs about the intervention), and evidence for recovery from the service-user perspective (characteristics of the innovation – evidence strength and quality).

The data were sifted and interpreted using the Framework Approach to qualitative data analysis (Ritchie & Spencer, 1994). This approach was deemed appropriate because it enables the analytical process to be guided by issues designated in advance (i.e. domains and constructs with the CFIR) as well as new and emerging concepts (Gale, Heath, Cameron, Rashid, & Redwood, 2013).

In the Framework Approach, the transcription process is followed by six key stages of analysis: interview familiarization; coding; analytical framework development; analytical framework application; data charting into the framework matrix; and data interpretation. The study adopted both deductive coding (using pre-defined codes derived from the CFIR) and open coding (capturing anything additional that might be relevant). After the analytical framework was developed and data were charted, the data were interpreted, and analytic themes developed. Preliminary data analysis was undertaken by CE and the findings were cross-checked and discussed with CM at each stage of the data analysis process. The study was undertaken as part of a full time MSc Advanced Practice in Health and Social Care. Time limitations prevented participant checking.

Findings

Thirteen registered managers were interviewed. The mean interview duration was 26 minutes. Five participants were employed by medium-scale providers, four by large-scale providers, and four by small-scale providers. Five participants were affiliated to either the Nursing and Midwifery Council (N = 3) or the British Social Work Association (N = 2). The remainder had no professional affiliation. Participants had worked in mental health services between 5 and 30 years (mean 14 years) and had been employed within their current organization between 1 and 15 years (mean 5 years).

Four key themes emerged from the qualitative data analysis: RO practice not an entirely alien concept; RO practice is a labor intensive and skilled activity; Families need to be on onboard with RO support; and Limited community capacity for RO support.

Recovery-orientated practice is not an entirely alien concept

This theme captures participants' understanding of RO practice and their perspectives on their organizations' understanding of and commitment to

recovery. The majority of participants were able to provide a definition of the term recovery and most articulated recovery within the context of personal recovery, rather than clinical recovery. These participants presented recovery as a journey and one that consumers defined for themselves, often in the presence of ongoing symptoms:

> Recovery is when an individual realizes a meaningful or fulling life in spite of whatever conditions he might be dealing [with]. Recovery support [is the] support rendered to help them achieve their recovery goals. What is meaningful to you is different to what is meaningful to them, so we have different values, different beliefs, different principles about our lives, so recovery is personal . . . We let the individual lead and determine what is of value to them (P04).

Several participants articulated recovery within the context of both personal and clinical recovery:

> The clinical aspect of recovery is still important to be integrated in the recovery approach whereby the responsible clinician will continue treating individual symptoms by pre-scribing medication to help them achieve what they want (P01).

These participants regarded clinical recovery as the responsibility of their clinical colleagues and personal recovery as their responsibility as social care practitioners. An exception to this was when a service-user was in crisis and lacked capacity to make their own decisions. In this situation, one participant described how they would follow a clinical recovery pathway until such a time as the patient was able to engage with their own personal recovery journey and another described involving an advocate to support decision-making.

One participant defined recovery along the lines of neither personal recovery nor clinical recovery, but a more paternalistic model of healthcare:

> It's getting someone from point A to . . . where we want them to be . . . We and the professional support team . . . we know what is best for this person. For their best interest, we can put a plan [in place to get them to] where we want them to be (P11).

Most participants felt their employers had a good understanding of the concept of personal recovery, one which was articulated and promoted in internal policies and procedures, and the values statement that listed the principles and ethics to which the organization adhered. However, the extent to which organizational policies, procedures and values statements reflected RO practice differed across different organizations. Several participants reported their organizations were founded on the principles of RO practice and as such these principles were well-established and woven into the fabric of the organization:

> We have principles, and we have policies and we have our own values, everything we do is based on achieving people's goals . . . Right from the onset [the organization] set out . . . that we want to support people to achieve their goals to recover . . . It has always been at the forefront of what we do (P02).

Where this was the case, participants described recovery as being a concept adopted and prioritized by all staff within the organization, regardless of their position or seniority:

> We are recovery-focused. It means everything . . . right from the senior management, to the front-line staff (P07).

For other participants, RO was a more recent development, one they had lobbied for and whose implementation they had driven. Like recovery itself, these participants saw the implementation of RO practice as a journey, and one subject to continuous improvement:

> Before I joined the organization, they weren't recovery-oriented at all . . . the word "recovery" was alien to them . . . I have managed to pitch recovery-focused support to the organization and now . . . the policies and procedures are in place supporting recovery-oriented services . . . We are creating the culture (P08).

Whilst most practitioners felt their employers had a good understanding of the concept of RO practice, this was not always the case. Two participants complained their organizations were risk adverse and pursued solely clinical recovery outcomes rather than personal recovery goals:

> My organization doesn't understand personal recovery. They are more of thinking from a clinical recovery perspective. I'm still working with the directors and the senior managers to introduce personal recovery approach. I am currently facing huge challenges getting the directors to buy into the idea (P13).

Participants highlighted the presence of two further enablers to the adoption of RO practice within their organization. The first enabler was themselves, practitioners who made change happen by inspiring and influencing others. The second enabler was the presence of local authority commissioning standards that focused on personal recovery. Participants offered two suggestions for increasing the adoption of RO practice at an organization level. One idea was the development of national recovery guidelines by governmental bodies such as NICE. Another idea was the incorporation of RO practice into the CQC inspection framework for community and residential adult social care.

Recovery orientated support is a labor-intensive and skilled activity

This theme reflects practitioners' experience of RO practice in relation to workload and the capacity and capability of practitioners. Participants described how help and support in the context of recovery was far more time consuming and labor-intensive than traditional forms of support. They also identified RO help and support as being a more skilled activity than traditional forms of support.

At the point of first assessment, service-users need to be engaged in their recovery journey and participants described how they needed time to both

explain the concept of recovery and engage service-users in identifying their goals and aspirations. Participants described how eliciting goals and aspirations could be challenging because service-users either lacked mental capacity or had become increasingly risk adverse during a recent inpatient admission. To that end, motivational interviewing skills were a key assessor competency:

> We should be able to talk to an individual [and] encourage them to do a personal assessment of . . . where they think they are in their [recovery journey] . . . what are the things that they have to adjust . . . Encourage them to think of a lifestyle change . . . . (P04).

Having undertaken the assessment, the next step is planning. However, participants described how the level of help and support required by service-users was sometimes beyond commissioner funding thresholds. For example, one participant recalled an occasion when the provision of a personalized and robust support package was prohibitively expensive:

> A client need[ed] 2:1 to go out to swim . . . and [the] social worker says they don't have enough funding and they can only provide [funding for 1:1] . . . That means the risk of supporting this individual in the swimming pool becomes very hard . . . . So, when that happened, then the client had to compromise in doing other activities rather than what they really wanted to [do] (P02).

In contrast, at other times, participants found commissioners receptive to more expensive care packages:

> There was a client . . . that they said that just need three hours 1:1 each day support but the person, upon the assessment . . . was very low on the [recovery] ladder and required a lot of support in order to achieve improvement . . . So, myself and the senior manager had some dialogue with the social worker and commissioners . . . afterwards they increased the package (P07).

The next step is implementation of the care plan by social care support workers. Practitioners described help and support with activities as varied as overseeing medication administration, managing money, assisting with personal care, and helping to write job applications, as well as accompanying service-users to healthcare appointments and church services, and engaging service-users with animal assisted therapy. The manner in which the care plan is implemented in the context of recovery is different to the manner in which a care plan might be implemented in the context of more traditional forms of support:

> And then the staff changing from doing things for people and then doing things with them (P08).

To be able to deliver RO support, participants argued that support workers needed to understand the concept of recovery and the benefits of RO practice. They also emphasized the importance of communication skills, a non-

judgmental attitude, and a commitment to self-determination. As such, training was deemed essential:

> [Support workers] are not aware of this, they [have] not been educated enough to understand what recovery-focused support is all about (P01).

Some participants outlined the extent and nature of the training, support, and supervision they provided support workers:

> Newcomers are supervised by more experienced staff . . . We also provide training . . . We also do workshop[s] where people can ask questions on how problems are to be solved and then they are able to develop their skills. We also provide mentorship where a senior member of staff can mentor a junior member to take on complex tasks . . . . When incident[s] happen, we go through reflective practice with our staff to make sure they are reflecting on what happened and make the right changes (P03).

However, this level of staff support was expensive:

> Staff need to be trained . . . but it is gonna be costly, it's gonna be expensive that's another challenge we have in implementing this program (P12).

Furthermore, efforts to upskill frontline staff were sometime hampered by high staff turnover levels:

> Because there is high turnover in the Health and Social Care industry and one of the reasons is . . . based on lack payment, lack of good payment to retain the experienced staff (P07).

After a period of implementation, the care plan is reviewed. The review is conducted by the assessor in collaboration with other members of the multi-disciplinary team. To conduct the review, the assessor needs evaluation skills. However, some participants reported difficulties conducting the review:

> I think there is an issue of accuracy [in] assessing the outcome . . . how do we assess the outcome or the progress that we are making? It's kind of difficult, you have to rely on the service-user . . . what is working and what they think is not working. So how do you accurately measure the progress they are make? I don't know, how to make them give genuine feedback . . . without exaggerating or holding back? (P04).

The Recovery Star, a tool for supporting and measuring change when working with adults who experience mental health problems, was identified by one participant as helpful when reviewing and evaluating the care plan.

Families need to be onboard with recovery-orientated support

This theme integrates participant perspectives on the effect of service-users' family members on RO practice. Participants described how some service-users wanted their family members involved in their care whilst others wanted them kept at a distance. Similarly, they described how some family members

wanted to be involved in care and others who did not want to be involved. When family members were involved, some participants cited occasions when their involvement was a barrier to the implementation of RO practice, whilst others recounted occasions when adopting a family centered model of practice enabled RO practice.

Participants who cited occasions when family members were a barrier to the implementation of RO practice, recounted instances where the goals and aspirations of family members were not aligned to the goals and aspirations of service-users:

> You find certain family interfering with what you are doing and they will dictate what you do with the client instead of what the client actually wants to do. So. you end up doing what the family member wants rather than what the service-user is actually is looking for (P02).

This participant resolved differences of opinion between family members and service providers by involving the social worker and asking them to intervene. Another participant described how differences of opinion had on occasion been settled in court:

> There is one adult that I assessed . . . and [the] local authority wanted this young man to be supported in the community . . . but the family preferred another type of support which meant the individual would have been taken to a care home very far away . . . the family insisted that was the best care . . . . [The local authority] did not agree with that, and my assessment did not agree with that . . . To resolve this, it had to go to court . . . (P03).

Other participants found engaging with family members from the point of admission an important precursor to effective joint working in the future. This involved explaining the concept of personal recovery to family members, and then negotiating a family centered care plan:

> What works well . . . is having a clear plan . . . For example, if you go into someone's home and at the onset you ask the question and families are there . . . deliberate on what needs to be done and we all agree on one course of action then that becomes part of the person's support plan, once it becomes part of the support plan, everybody agrees to it, so it becomes easy to deliver (P02).

Not only did this approach ensure that goals and aspirations were aligned, but that there was clarity and agreement on what aspects of care provision family members would want to implement themselves.

Limited community capacity for recovery-orientated support

This theme captures participants perspectives of the barriers to promoting active citizenship amongst people with a diagnosis of SMI. Participants recognized community integration and the appreciation of people with mental illness as equal citizens by community members as key outcomes of RO

practice. However, environmental barriers and social barriers often stood in the way of service-users achieving citizenship.

Environmental barriers to recovery included poverty and the absence of secure housing. One participant described the impact of limited community mental health facilities coupled with poor public transportation systems:

> Another challenge is limited infrastructure ... Infrastructure could include centers, halfway houses [for people with substance misuse issues], it could be partial hospitalization centers [for people with borderline personality disorder]. [These] are not common in the community. So, people find it difficult to access this care ... Like one of our patients [had to] travel almost for 5-6 hours to access care and it was difficult (P12).

Another participant highlighted limited access to culturally appropriate services:

> There should be more fight for these hard-to-reach individuals that are having mental illnesses to be able to support them ... especially people from BAME group. There should be more awareness and more support available for them, even the provision for people from their ethnic group to be able to support them to accept services that are recovery-focused (P01).

In terms of social barriers, participants related the impact of stigma and discrimination on social integration. Stigma and being perceived as different was identified by participants as disincentives to help seeking by people experiencing mental health problems, whilst instances of discrimination included the unfair treatment of service-users by prospective employers. One participant illustrated the long-term impacts of stigma and discrimination on health and wellbeing:

> We had a client that wanted to go back to work but accessing employers that provide employment support for someone with mental illness posed difficulties. We couldn't get any employer to accept this person to volunteer for them ... the lack of [opportunities] poses health and economic inequality for these people that we support ... The trauma, the mental health stigma and discrimination out there (P06).

Participants attributed much of the stigma and discrimination people with mental health problems experienced to lack of knowledge in communities and society about mental health. Some participants were using community newsletters to try to dispel myths and increase awareness of mental health. They were also engaging with local employers to identify apprenticeship initiatives for people with mental health problems. However, participants ardently believed far greater efforts were needed to overcome the barriers posed by stigma and discrimination.

Discussion

Whilst some empirical studies have explored the barriers and facilitators to the implementation of RO support, the present study is the first to explore the barriers and enablers to the adoption of RO practice in community mental health provider organizations in England. In total, 11 barriers and nine enablers were identified (see Table 2). The most salient in terms of the frequency with which they were raised by participants were staff training, public misconceptions of mental illness, and joint-working with families.

In the CFIR, staff training was located within the "inner setting" (that is the internal socio-cultural context of the provider organization). Our finding pertaining to staff training reflect the findings from research exploring the barriers and enablers to the implementation of RO practice in hospital and community mental health teams outlined in our literature review (Lorien et al., 2020; Whitley et al., 2009). However, the skill mix in community mental health provider organizations is very different to the skill mix in both hospital and community mental health teams. The latter are comprised of psychiatrists, psychologists, psychiatric nurses, social workers and occupational therapists, whereas the former is comprised of managers, who may or may not be registered health or social care professionals, and social care support workers, who are not registered health or social care professionals. It is social care support workers who implement the care plan. The absence of a biomedical background is potentially beneficial in that support workers might not be predisposed to the clinical recovery approach; however, in the absence of appropriate training, support workers may focus on *doing for* service-users rather than *doing with* service-users, thereby hindering personal recovery.

Table 2. Summary of barriers and enablers to RO practice.

Barriers	Enablers
Characteristics of the intervention	
• RO practice is labor intensive	• Application of Recovery Star
• RO practice is a skilled activity	
• Difficulties reviewing outcomes associated with RO practice	
Outer setting	
• Commissioner funding thresholds	• Flexible commissioner funding thresholds
• Limited access to culturally appropriate care	• Local authority commissioning standards
• Mental health stigma and discrimination	
• Lack of secure housing	
• Poverty	
Inner setting	
• High staff turnover	• Staff training for skills acquisition
• Risk averse provider organizations	• Staff supervision and mentorship
	• Organizational commitment to RO practice
Characteristics of individuals involved	
• Misaligned service-user and family member goals and aspirations	• Motivational interviewing skills
	• Family involvement in care planning
Process of implementation	
	• Registered managers championing RO practice

Doing for approaches have previously been reported in literature relating to the provision of home care for older people (Metzelthin et al., 2017). Nevertheless, the home care workforce, particularly those employed within the private sector, reportedly have limited access to training (National Institute for Health and Care Excellence (NICE), 2015). We recommend that mechanisms are put in place to ensure support workers receive specific training on the recovery approach.

Joint-working with families was located within "characteristics of the individuals involved" in the CFIR. Family support is recognized as being critical to an individual's recovery (Ward, Reupert, McCormick, Waller, & Kidd, 2017). However, some participants in our study identified occasions when family members attempted to shape the care plan according to their own goals and aspirations rather than the goals and aspirations of the service-user. At the same time, some participants found it helpful to involve family members in initial assessment and care planning in order to avoid future conflict. An integrative review of family-focused practice in adult and child mental health services supports a collaborative approach, recommending family members are involved care planning and goal setting, a process they argue can be facilitated by various mechanisms including instrumental, emotional and social support and psychoeducation (Foster et al., 2016). We recommend community mental health provider organizations explore ways of effectively involving family members in care planning and goal setting, according to service-user wishes.

In the CFIR, public misconceptions of mental illness were located within the "outer setting" (that is the wider socio-cultural and infrastructure context). Stigma and discrimination are extensively reported in the mental health research literature. Our findings reflect those from research exploring the barriers and enablers to the implementation of RO practice outlined in our literature review (Piat & Lal, 2012). Whilst participants in our study attributed stigma and discrimination to lack of knowledge of mental illness within communities, other research suggests stigma and discrimination are complex and multifaceted problems (Groholm, Henderson, Deb, & Thornicroft, 2017). Whilst several strategies such as peer services, mental health literacy campaigns, legislative and policy change have been used effectively in some areas to produce a short-term reduction in public stigma (Committee on the Science of Changing Behavioral Health Social Norms, 2016), we support calls for further research to provide robust evidence to support decisions on investment in interventions to reduce stigma and discrimination in the long-term (Thornicroft et al., 2016).

One potential limitation of our study was that participants were all registered managers. Obtaining the experiences and perceptions of social care support workers would have been of interest and could be a focus of future research. Another potential limitation was that interviews were undertaken by

a researcher who was themselves a managing director of a community mental health provider organization. Whilst this may have led to social desirability bias, participants appeared to provide open and honest accounts, which included criticisms of organizational policies and procedures.

Conclusion

Findings from this study provide a whole system understanding of the factors affecting the implementation and adoption of RO practice by community mental health provider organizations in England. The findings suggest that many of the barriers and enablers to adoption and implementation relate to characteristics of RO practice, the internal socio-cultural context of provider organizations, and the characteristics of the individuals involved. However, it also highlights barriers pertaining to the wider socio-cultural and infrastructure context.

Disclosure statement

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