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ORIGINAL ARTICLE

Staff experiences of a novel in-reach rehabilitation and recovery service for people with profound and enduring mental health needs

Penn Smith[1] | **Alison Thompson**[2] | **Anna Madill**[3]

[1]School of Education, Language and Psychology, York St John University, York, UK

[2]Leeds and York Partnership NHS Foundation Trust, Leeds, UK

[3]School of Psychology, University of Leeds, Leeds, UK

Correspondence
Penn Smith, School of Education, Language and Psychology, York St John University, York, UK.
Email: p.smith2@yorksj.ac.uk

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Abstract

This organizational case study addresses the research question: *What are the experiences of staff who work in a novel in-reach rehabilitation and recovery service for people with profound and enduring mental health needs?* Fifteen purposefully sampled staff were recruited from across a novel mental health service that embeds the community sector within inpatient provision. The sample comprises twelve National Health Service and three community voluntary organization staff (four men and eleven women). Data were generated via photo-elicitation in which interviews focused on the photographs participants brought to help convey their experiences of the Service. Interpretative phenomenological analysis was used to analyse the transcripts. The analysis demonstrates that participants are oriented towards five 'meta-questions': *What is recovery? Who is valued and how is it demonstrated? Why are you frustrated in doing the best job you can and what support do you need? How can change occur in staff practices and approaches in an environment embedded in history*? and *How do we make the Service work in the context of constraints?* Eight paired themes were also identified regarding staff experience of the Service: *hope* and *individuality*; *culture* and *power*; *communication* and *confidence*; *accountability* and *limitations*. The conclusions of this organizational case study have wide relevance to clinical practice: staff (i) place importance on promoting and developing greater awareness of different approaches to care; (ii) aspire to develop better communication across multidisciplinary teams and (iii) desire greater awareness of the complexities of risk to improve staff confidence.

KEYWORDS
interpretative phenomenological analysis, mental health services, multidisciplinary teams, photo-elicitation, recovery-orientated care

INTRODUCTION

Since the mid-1980s the medical psychiatric model has faced challenges from the mental health service user/survivor movement (Beresford, 2002). In particular, service users/survivors have fought for an approach to mental health treatment which acknowledges social context and destigmatises the experience of mental health needs (Repper & Perkins, 2004). Studies demonstrate that increasingly more services are employing recovery-orientated practice to support individuals in a productive life despite ongoing mental health challenges (Sreeram et al., 2021). However, research continues to highlight problems delivering inpatient recovery-oriented services, calling for a nuanced understanding of service user and staff experience (Biran-Ovadia et al., 2023).

BACKGROUND

Early conceptualisation of the term 'recovery' developed from first-person accounts of emerging from a mental

health diagnosis, such as Deegan (1988) who described the process as 'recovering a new and valued sense of self and purpose within and beyond the limits of disability' (p.11). However, probably the most widely accepted definition of mental health recovery is offered by Anthony (1993):

> …a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness, recovery involves the development of a new meaning and purpose in life as one grows beyond the catastrophic effects of mental illness. (p.17)

The term 'recovery' has continued to be debated and subsequently varying definitions have been provided through the different lenses it has been studied. This has resulted in some confusion (see Davidson & Roe, 2007; Jacobson & Greenley, 2001; Pilgrim, 2008; Stuart et al., 2016). For example, whilst various authors agree recovery is not a linear process (e.g., Anthony, 1993; Deegan, 1988; Repper & Perkins, 2004), the meaning and origin of recovery are disputed amongst researchers as well as between people with lived experience of mental health needs, their carers and those who work with them (Edgley et al., 2012). This creates difficulties when attempting to embed a recovery orientation in health policy and service development (Pilgrim, 2008).

Unfortunately, mental health services have been accused of taking 'ownership of recovery' and reorienting the concept away from individual well-being and towards organizational structure and policy. Consequently, Perkins and Slade (2012) call for a paradigmatic shift in the attitude, values and practices of recovery-focused mental health services to avoid the concept of recovery being shoe-horned into the existing medical psychiatric model. Studies describe ways in which services have successfully delivered National Health Service (NHS) inpatient rehabilitation provision (e.g., Cowan et al., 2012) or attempted to implement recovery-orientated approaches to improve outcomes such as service user peer support pre- and post-discharge (Meurk et al., 2019; Simpson et al., 2014). However, a general finding is that additional research supporting service development is warranted.

The United Kingdom service which is the focus of this case study initiated a novel approach to mental health care that meshes an NHS inpatient programme with community voluntary organizations to create a novel rehabilitation and recovery service for people with profound and enduring mental health needs, predominantly diagnosed with psychotic disorders. The Service studied was restructured in 2015 following stakeholder feedback that highlighted a need for better integration of inpatient provision –services that typically care for individuals admitted due to severe mental health challenges and can no longer be supported at home – and the community sector. Stakeholders consisted of service users and staff of three community inpatient units, NHS staff, community organizations and carers.

The redesign created a service that offers a stepped intensive pathway through inpatient care to support better the transition and reintegration of service users into the community (Barnes & Dilks, 2014). Hence, NHS inpatient and independent community voluntary organizations were brought together to provide holistic community care packages with links to colleges, community groups and volunteering opportunities (see Smith, 2019). The Service consists of 36 inpatient beds across an inpatient 'ward-environment' and an inpatient staffed 'house-environment' located on the same site away from NHS acute care, and supportive living in the community with the input of Service staff for up to 6 months after hospital discharge. Helping people to live meaningful, independent and fulfilling lives embodies the main ethos of the Service. The aim is less reliance on inpatient care through the full application of recovery-focused principles and the biopsychosocial model. The Service offers multidisciplinary and multi-agency assessment, formulation and intervention to service users that focus on developing their independence (see also Smith, 2019; Smith et al., 2021).

This research forms part of a larger organizational case study, in which we used photo-elicitation to explore staff and service user experience of the new Service. For this paper, we will concentrate on staff experiences (see Smith et al., 2021 for service user experiences). Hence, in this article, we address the research question: *What are the experiences of staff who work in a novel in-reach rehabilitation and recovery service for people with profound and enduring mental health needs?*

METHOD

NHS ethical approval was granted on 12th April 2016 by Yorkshire and The Humber, Leeds East Research Ethics Committee and Leeds and York Partnership NHS Foundation Trust.

Recruitment and participants

Participant recruitment commenced at the project launch and continued via email and word of mouth. Staff inclusion criteria included being at least 18 years old and to have worked within the Service for at least 6 months. A purposeful sampling strategy was employed to recruit staff from all three community voluntary organizations working with the Service, as well as NHS staff, and to include a wide variety of job roles, pay bands and service locations. Therefore, not all staff who volunteered could

be included and, on the other hand, three were invited directly to facilitate their inclusion in the study, i.e., the healthy living advisor, the dietician and the psychiatrist. At the end of the data collection period, approximately 78 NHS and 12 third-sector staff worked for the Service. In total fifteen members of staff were recruited comprising a good representation of role, specialism, location and gender and all three community voluntary organizations as well as NHS staff (four men and eleven women: Table 1).

Data collection

Photo-elicitation was used to explore staff experiences of the new Service. Photo-elicitation is a method in which participants are invited to take photographs that help them to convey their experiences around the topic of investigation. Images have been found effective in prompting memories and connecting to emotions (Bates et al., 2017) and help create rapport with the researcher (Collier, 1957; Hurworth, 2004). Discussion of the brought images can facilitate rich information providing the researcher with insight into the way participants interpret and understand the world (Bates et al., 2017). Taking a photograph can allow one to detach briefly from the environment and become an observer, which can enable a powerful moment of reflection away from the normative constraints of staff roles and place in organizational structures (Radley, 2010).

Data collection took place between June 2016 and January 2018. The first author, a qualified counsellor with experience in mental health organizations, conducted one photo-elicitation interview per participant. An initial meeting was held with each participant to go over the information sheet and obtain consent and provide a guidance leaflet about taking photographs. All participants were given an electronic tablet, purchased by the NHS Trust, as a way of thanking them for their time and to support the taking of photographs. Participants were invited to take photographs over the following 2 weeks and to select 5–7 which would help them discuss their experience of the Service at a pre-arranged interview. Interviews were conducted in staff offices or private meeting rooms within the Service and were audio recorded with consent. During the interviews, staff photographs were displayed on the researcher's laptop screen having previously been sent via email or printed pre-interview by the researcher for ease of viewing. The following lightly structured protocol formed the base of the photo-elicitation interviews: *Which photograph would you like to share first? What can you tell me about this photograph? What does this photograph express about your experience of the Service? Which photograph would you like to share next?* (See also Smith et al., 2021).

TABLE 1 Overview of staff recruitment in interview order.

Organization	Gender	Band	Location	Interview length (min)
Third sector	Female	6	Recovery Centre	67
Third sector	Male	3	Recovery Centre	95
NHS	Female	7	Ward & House	73
NHS	Male	5	House	55
NHS	Female	8	Recovery Centre	81
NHS	Female	6	House	77
Third sector	Female	3	Recovery Centre	84
NHS	Female	8	Recovery Centre	85
NHS	Female	6	Recovery Centre	74
NHS	Female	4	Recovery Centre	86
NHS	Female	6	Ward	58
NHS	Male	3	Ward	91
NHS	Female	6	Ward	61
NHS	Male	3	Ward & House	73
NHS	Female	9	Ward & House	88

Data analysis

The interviews were transcribed professionally, checked for accuracy by the first author, and then analysed using interpretative phenomenological analysis (IPA). IPA is a method of thematic qualitative analysis which focuses on how people make sense of their lived experiences (Smith et al., 2009). In order to become familiar with the content of each interview, the first author created a pen-portrait (see King & Horrocks, 2012) of each participant which captured the main issues around which their narrative cycled. Each transcript was read and reread several times and, through discussion between the first and third author, comparisons were then made between pen portraits to identify commonalities and differences (see also Smith, 2019). This allowed the identification of how participants oriented towards five 'meta-questions' independent of the data collection procedure and eight thematic foci derived from the data set. The aim of this was to retain the idiographic focus whilst being able, also, to extrapolate meaningfully across the group (Smith et al., 2009). Rigour and credibility were facilitated by ongoing discussions of the developing analysis with the third author, a professor in psychology with experience in qualitative and visual methods, and the study Steering Group that represented a range of stakeholders, which included the second author, NHS Head of Research & Development (*Leeds and York Partnership*

NHS Foundation Trust), as well as other representatives of NHS, community voluntary sector and service user groups (see also Smith, 2019).

RESULTS

The analysis is structured by the five meta-questions: *What is recovery? Who is valued and how is it demonstrated? Why are you frustrated in doing the best job you can and what support do you need? How can change occur in staff practices and approaches in an environment embedded in history? How do we make the Service work in the context of constraints?* Each meta-question is explored by way of the eight themes presented in the following pairs: *hope* and *individuality*; *culture* and *power*; *communication* and *confidence*; *accountability* and *limitations*. Evidence for the analysis is provided through quotes from the interviews, each participant are represented at least once. To enhance trustworthiness, Table 2 provides additional quotes in support of each theme. Five photographs are included, one to illustrate each meta-question. Pseudonyms are used throughout and, to enhance trustworthiness and for conciseness, we use […] where a short section of text has been omitted mid-quote.

What is recovery?

Hope and Individuality

Across the Service, participant staff see their role as one of facilitating, rather than leading, the recovery process. For example, Aimee captures this in a visual metaphor of a combination lock: 'I always knew the combination, but actually, for her, she's had to go through that journey' (Figure 1). Viewing service users as enabled individuals helps staff to instil a sense of hope within their approach to recovery which encourages self-acceptance, personal accountability, resourcefulness and empowerment. Hence, recovery involves maintaining a sense of hope for service users until they can find their own, individual way forward.

Culture and power

Participants acknowledge that huge barriers exist for service users due to a culture of stigma surrounding mental health needs in society. To address the power differential this creates staff place value on developing a compassionate understanding of each service user's life story to see the person behind the diagnosis. As explained by Dan: 'Mental health isn't about supporting ill people. It's about the real fundamentals like how do we view the world, how do we view ourselves and each other, and how do we navigate all that mess'. Hence, recovery involves creating a positive culture of shared values through activities, such as group work, to support service users towards an empowered place in society.

Communication and confidence

Participants value human connection built through good communication. However, the ability of service users to express themselves and convey their needs could be impacted by their medication, current mood and even time of day. As explained by Holly, this can dent staff confidence in their own ability to connect: 'Sometimes you walk away from some input with someone and feel like you're not really sure what you came out with'. Hence, recovery requires supporting staff to create positive encounters that build good communication and two-way relationships.

Accountability and limitations

Participants understand it can take time to support service users to build life skills but, while taking responsibility for doing the best job possible, acknowledge that not every service user can use the opportunities provided to move forward. As noted by Fred: 'we've got so much that people can do but still they won't do it'. Equally, the approach offered by the Service will not fit the requirements of every service user and some need to be given particularly specialist care. Hence, recovery requires a work culture in which staff take accountability for their role in the process while the organization recognizes the limitation of what can be achieved in some circumstances.

Who is valued and how is it demonstrated?

Hope and individuality

Participants value learning from the experiences of the service users but realize that the institutional nature of the Service could mitigate against people feeling able to express their individuality. However, staff like Curtis expressed hope that they could address this in their personal interactions: 'my whole ethos when I try to work with people is to […] imagine how they would feel and how I would feel in their position, in an environment, in an institution where there are different levels of power'. Moreover, the staff supervision process was discussed positively as a way in which people could find individual validation and support.

TABLE 2 Themes and additional illustrative quotes from across the data.

Theme	Illustrative participant quotes
Hope	"This photograph is what I think rehab's about in a way, I really do, and it's about empowerment and change, and seeing a smile on someone's face." (Jane)
	"I'm just guiding them to a destination, and it's not my destination, it's their destination." (Aimee)
	"I think there's something around where people fit into the world and what their goals can be and achievable goals and ambitions." (Jane)
	"So, it's a picture of two chairs together, it's just a picture of where my colleague sat with me, and just how much I really appreciate colleagues' time and support." (Aimee)
Individuality	"Imagine being in here and not going out, for whatever reason, he doesn't feel he can." (Curtis)
	"We try to make people feel at home, so for me this is exactly what I will be doing with family at home." (Andrew)
	"It was really good because it sorts of opened up avenues of interest that [they] wouldn't get on a day-to-day." (Curtis)
	"Normally when I start my shift, I like things to be clean. For me it's really important for things to be clean, tidy, organised." (Andrew)
Culture	"I think most of the people working here really care and want people to recover, but we are definitely held back by old structures, old ways of being trained and thinking about people's problems." (Dan)
	"This house reminded me that actually it's got this new fancy exterior, but how much has actually changed inside?" (Faye)
	"I took a picture of the musical instruments because, for me, it evokes a type of idea around mental health that's maybe a little outdated, but that I kind of miss." (Dan)
	"It was just that little shift… and a bit of change and a slightly different perspective change that actually is really significant for this service user." (Faye)
Power	"Sometimes the door is locked, obviously if you wanted to go outside you can go and get permission." (Zoe)
	"You might have skill and expertise, but if you're not in that position it doesn't change anything and that gets really frustrating." (Pam)
	"The policy is that we're smoke free, so staff and service users must stop or abstain from smoking whilst at work." (Zoe)
	"There's a real resistance within society, within the Trust maybe as a whole, within individuals particularly, maybe, psychiatrists on some of the acute wards, and also within service users themselves." (Pam)
Communication	"Patients are getting really good input a lot of the time from different people - psychology, nursing, OT, dietitian and healthy living, it's really comprehensive, but it feels chaotic to me and sometimes it's really hard to untangle the communication." (Rachael)
	"It overlooks the garden, which is nice, so people could be in the garden, and they'll sometimes come in or they'll go out and chat to the others out there." (Carmen)
	"The stuff that I see that makes people feel happier or more connected, is the very ordinary stuff like doing a bit of knitting and chatting." (Rachael)
	"I don't know, there's something quite communal about smoking and social and the fact that's taken away, probably is why people aren't using the garden as much." (Carmen)
Confidence	"I'm still trying to find my feet actually and I want to progress and actually at times I still feel like a kid." (Tori)
	"I'm always the person that has to ask where I can sit, and I have to move if I'm at someone else's desk." (Holly)
	"I guess this is reflecting how hard it is sometimes to actually do my job, which is to engage people in groups on the wards and out in the community - it is really tough." (Tori)
	"I do get on with the team really well, but it's just… feeling a little bit undervalued I suppose… my role not seen as important as the other roles within that team." (Holly)
Accountability	"There are other models out there which work and I'm not saying necessarily that other models are better than the medical model, but there are other models to go at and we seem to put everyone on medication." (Fred)
	"I think people have been allowed to get away with wanting and expecting too much." (Jo)
	"If you have depression and noise is something that you don't want, there are places here where people can go." (Fred)
	"It kind of feels like I literally open the door and hit the ground running sometimes." (Jo)
Limitations	"In terms of making it better for everybody to work and come to work you have to take into account all those things and it is labour-intensive, and it takes time." (Louise)
	"There are some really good ideas and good evidence-based practice that comes in to us but unless we all buy into it and get on board with it, it doesn't filter out into the everyday stuff." (Louise)

FIGURE 1 Aimee's photograph.

FIGURE 2 Jo's photograph.

Culture and power

Participants perceived there to be an established culture in their wider work environment in which their professional expertise is not always acknowledged. Specifically, at times, they experienced the traditional psychiatric approach to have over-riding authority, leaving some staff feeling deskilled and demoralized. Faye explained: 'I felt really frustrated and it brought up all the stuff for me about trying to bring a psychological perspective into the Service… a lot of people are very resistant to it'. Although underway, establishing a fully multidisciplinary, multi-sectorial culture in which all staff feel valued takes effort and time.

Communication and confidence

Participants report that value is typically placed on professional expertise as opposed to lived experience. Hence, many participants expressed a lack of confidence at work, such as Toni who said: 'I think it is to do with experience. I hate to say it, but because they are part of a professional registered body, I do feel a bit of an idiot'. However, when their concerns are communicated and listened to, some described how they had been offered opportunities to undertake further training. When this occurred, training had a positive impact on their confidence. However, feeling valued is also about being confident that one's experience is recognized and that this is communicated strongly throughout the organization.

Accountability and limitations

Participants with high levels of professional responsibility feel a great deal of pressure to support other staff, although accept this as an important part of their role. However, some struggled to balance this with meeting their own needs at work and it could have a negative impact on their ability to spend time with service users. This left some senior staff feeling uneasy in their managerial position. For example, looking at her photograph of practical footwear (Figure 2), Jo explained: 'I feel quite tied because I automatically want to go and leave the management stuff and go back to clinical'. While accepting that all roles in the Service entailed accountability, in practice making sure that all staff and service users feel valued and supported can be difficult.

Why are you frustrated in doing the best job you can and what support do you need?

Hope and individuality

Although attempting to respond to service users as individuals, staff could experience tension between the service user voice and their own professional responsibilities. However, many expressed hopes that a balance could be struck such that, where possible, staff priorities did not always supersede that of service users. One way identified to encourage this is for staff to engage in reflective practice with peers. As expressed by Jane: "If you're asking other people to make changes in their lives,

perhaps you need to go through that yourself". However, taking time to stop and reflect as an individual was perceived to be inconsistently valued across the Service and participants hoped this could be promoted more strongly.

Culture and power

Many participants feel frustrated that they were not consulted in the development of the new Service and suggest there is a mismatch between its aims and their experience of what they are able to achieve currently in practice. We can hear this resonate in Pam's statement: 'This Service is being touted and marketed as being the solution to lots of things before it's even been properly evaluated'. Participants suggest more needs to be done to empower staff and service users to feel that they have a contribution to make to progressing the huge potential benefits of systemic culture change.

Communication and confidence

Many participants experience the Service environment as challenging and suggested simple adjustments that might improve staff confidence and communicate how all roles are valued. For example, differences in desk and office space allocation can communicate the difference in status. As Carmen says: 'I just think for the workforce to feel valued, they should be given a bigger room, more computers, more space'. However, participants suggest communicating value and promoting staff confidence is more than environmental and extends to allocating time for staff to discuss a range of concerns relating to doing the best job that they can.

Accountability and limitations

Participants expressed frustration that external pressures, such as limited funding, could have such a strong influence on decisions. Although recognizing accountability to the financial budget, it could feel that such limitations underestimated the complexity of the work. Fred explained while looking at his photograph of a comfortable space for sharing in the Service (Figure 3): 'I've had people with horrendous childhoods of abuse… And I've been one of the very few people that they could talk to'. Participants suggest staff experience is a valuable resource when considering how best to deal with the consequences of such challenging work and needs to be factored into the decision-making process at all levels.

How can change occur in staff practices and approaches in an environment embedded in history?

Hope and individuality

Many participants want to trust the multidiscipline team environment and strive towards embracing the principles of recovery. Andrew, for example, expressed his hopefulness saying: 'The recovery model is about helping people to become self-sufficient, to be resourceful, to be pragmatic, to be independent'. However, some staff expressed difficulty letting go of embedded practices. For example, staff with greater levels of organizational responsibility could find reassurance within a hierarchy with tried and tested procedures. Hence, a balance needs to be struck between the security of the known and allowing individual staff creativity and responsiveness in a supportive team environment.

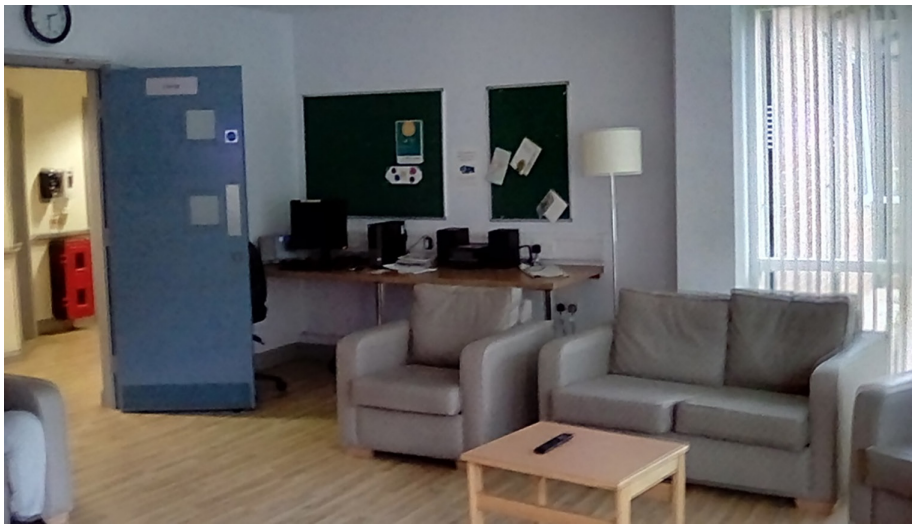

FIGURE 3 Fred's photograph.

Culture and power

Participants endeavour to create a therapeutic culture which empowers both service users and staff through boosting self-worth and independence. However, some participants feel demoralized because the Service had not yet overcome the culture of low engagement often endemic in psychiatric service and did not have the power to tackle this in their job. For example, Zoe wanted to create change but said: 'there has been no engagement, if any, from service users but also from staff'. Participants suggest that staff should leverage the power they have as a community to promote the variety of activities offered across the Service and create a culture of engagement.

Communication and confidence

To fully embrace the recovery model, many participants want the freedom to follow new ideas and to be more creative. However, their confidence to do so is dented due to the traditionally risk-averse messages communicated throughout the Service. For example, communication can be through the built environment, as Rachel illustrates in one of her photographs (Figure 4): 'It's a hospital. You've got the group board and your hand sanitiser and everything's anti-ligature, and I just wonder what that's like for patients'. Participants believe that providing positive messages throughout the Service environment in-line with a recovery approach will improve staff confidence and trust in each other's code of practice and ways of working.

Accountability and limitations

Participants describe an ingrained working environment resistant to challenge and change. Moreover, demanding workloads can make it easy to lose sight of, and accountability for, the overall recovery aims of the Service. Louise explains: 'The people on the ground doing the work don't see the big picture about what the Service is trying to achieve, and we get locked into just being our little bit of a service'. Participants acknowledge the limitations of this often short-sighted process, and that, unfortunately, it serves to retain aspects of a more traditional approach to care.

How do we make the service work in the context of constraints?

Hope and individuality

Participants suggest a growing level of hope and trust in the recovery model. This is most noticeable in the aspects of the Service that are addressing power disparities between staff and service users by providing opportunities to promote service user voice. These opportunities can be low-resource and include creative expression activities, service user involvement schemes and well-being reviews. In addition, good cross-team communication provides an opportunity to get to know each other as individuals with unique experiences to offer. Jane explains that making the Service work can be about bringing the right people together rather than about expenditure per se: 'This office represents the coming together of different people, and it's a reflection of trying to then offer to service users the best match or the best fit for those people's needs'.

Culture and power

Despite challenges, participants reveal how they are beginning to recognize the value of a culture that combines different approaches within the Service. For example, Faye alluded to power struggles as she looked at one of her photographs (Figure 5): 'Sometimes we get caught up in fighting for a particular model and then you can dismiss the other. You can get into battles about what's the right way of understanding, actually, the right way is probably bringing things together, isn't it?'. Participants agree that to make the Service work, they should not constrain themselves to what they already know but be open to learning about other approaches.

Communication and confidence

Many participants believe finding common ground through building better relationships helps build mutual confidence. They describe challenging perceived institutional constraints and improving communication through opportunities to share experiences. For example, social activities are particularly valued as a way of facilitating positive change, even in little things, because this builds momentum and develops confidence in each other. Holly explains: 'When something really positive does happen, it can sometimes be something really small, but it makes a massive difference.' Offering variety around the choice of activities increases the chances of engagement from both staff and service users to help make the Service work.

Accountability and limitations

A major constraint described by participants is the stretched resources, particularly human resources, across the Service. The NHS, and possibly the local Trust, is understood to be accountable for this issue. Louise states this clearly: 'There's spaces and it's like a

FIGURE 4 Rachel's photograph.

FIGURE 5 Faye's photograph.

staffing issue. I suppose I can't apply it just to the Trust but the NHS generally. There's still space for more people. We need more people'. However, many acknowledge the complexity of resourcing the Service and the effort everyone is putting in to making it work.

DISCUSSION

In this article we address the research question: 'What are the experiences of staff who work in a novel in-reach rehabilitation and recovery service for people with profound and enduring mental health needs?' We used photo-elicitation to generate data from a purposefully sampled range of staff representing the organizations, roles and locations associated with the Service. We now discuss our findings in relation to staff experience of implementing recovery principles into a novel NHS mental health service that embeds the community sector within inpatient provision.

First, we consider the structure of the Service via the themes of *culture*, *confidence* and *power*, whilst highlighting the *limitations* faced by staff. Research demonstrates that staff within key mental health disciplines, such as mental health nursing, psychology and psychiatry, hold mixed opinions regarding the value of the recovery model in clinical practice (Biran-Ovadia et al., 2023; Gale & Marshall-Lucette, 2012; Hardiman & Hodges, 2008). Therefore, issues can occur when attempts are made to implement recovery principles into the workplace. We saw this in the current study where staff expressed concerns about organizational *culture* including the

challenge of interprofessional teams (Campbell, 2011; Copeland et al., 2014; Fournier et al., 2007) and barriers between staff using different approaches associated with the different health care professions and associated professional identities (Hall, 2005). Some staff reported feeling pressure to conform, engrained working practices and differing attitudes to risk and the amount of autonomy services users should be afforded. This resulted in low *confidence* and misunderstanding across teams making it difficult for staff to support service users to take the small risks required to progress their independence (Higgins et al., 2016; Schrank & Slade, 2007). This is commensurate with previous research which suggests that challenges implementing service user-led practice can be connected to duty-based ethical frameworks established in professional training and the tendency of clinical-led practice to be the dominant approach (Gale & Marshall-Lucette, 2012; Slade, 2017).

Despite some embedded *cultural* differences, many staff appreciated the aspiration to create a work environment in which they experienced a greater sense of agency in their roles and more equal *power* between staff and with service users. The value of building trusting relationships, improving understanding around difference and rebalancing *power* to improve the service user experience has also been reported by Gilburt et al. (2008). However, we also found that *limitation*s within the Service could create a feeling of *powerlessness* in staff. *Limitations* included tight resources, inconsistent practice and *power* inequalities. Similarly, Le Boutillier et al. (2015) state that managing competing organizational and financial priorities is a common concern for mental health staff and can impact the physical environment as identified in our study (see also Curtis et al., 2007). However, despite *limitations* and constraints staff in our study do report encountering positive change and growth within the Service.

Second, an important aspect of our findings is the way in which *hope* can be viewed as an agent of change. *Hope* appears to be embedded in the staff belief system and includes a strong belief in the inherent value of the individual. *Hope* is a key concept in mental health care (e.g., Cleary et al., 2016; Pitt et al., 2007; Spandler & Stickley, 2011), providing the motivation to believe that service users can develop a sense of purpose and move forward into a meaningful future (Spandler & Stickley, 2011). Hence, *hope* can support recovery through sustaining 'a process of change and desire for change' (Pitt et al., 2007, p.58).

Finally, we speculate how change may occur through exploring the themes of *individuality*, *accountability* and *communication*. Organizational *accountability* varies across role, high levels of responsibility sometimes result in risk-averse practices which reduce opportunities for service users to express their *individuality* and increase their independence. Therefore, to support a recovery-oriented service, an environment must be created in which *individual* staff feel safe to implement meaningful therapeutic practice (Slemon et al., 2017). Change in this direction may involve developing a process of shared responsibility (Gulliver et al., 2003; Slemon et al., 2017) and promoting excellent *communication* between teams. However, unfortunately, *communication* challenges were reported in our study, as documented in other research on services which, as is typical, involve multiple health professions (e.g., Hall, 2005).

Photo-elicitation was used to explore staff experiences and feedback on the method was invited at the end of each interview. Participants described the process of taking photographs as enjoyable, allowed them to reflect on their work experiences as they decided what image to take, and helped them to identify personal conflicts, while also facilitating their sense-making through developing connections between their experiences. Staff appreciated being provided with a space in which to share their views and felt valued at the end of the interview. In line with IPA methodology, photo-elicitation helped to generate data with a detailed and layered description of lived experience (Smith, 2011), particularly through the use of visual metaphors which added depth to the interviews (Duara et al., 2022). Our sample reflects reasonably well the staff profile of the Service (see Table 1), however, due to the high volume of interested staff a strategic approach to recruitment had to be adopted to ensure a diverse selection of roles and organization involvement. As a result, certain staff, whose roles had already been captured, were unable to be involved with the project. Overall, photo-elicitation aided staff in sharing their experiences of the service, however, rules restricting images, such as not photographing service users for reasons of privacy and safety, potentially reduced participant choice and scope. Although we studied only one service, this paper has discussed our findings regarding the wider literature and shown similarities with the larger area of healthcare research. Hence, we propose that our findings may be transferable broadly to organizations which embed similar recovery principles and work with similar service users.

CONCLUSIONS

Overall, staff of the Service constituting the organization case study felt hopeful towards the future and saw great potential in the Service and its integration of NHS inpatient provision with community voluntary organizations. Equally, they have acknowledged that conflicting approaches to care, and unequal power between health professionals and between staff and service users can make it difficult to implement a service which fully embraces recovery principles (McCabe et al., 2018). However, they have suggested it is possible and provided important insights towards this goal. We identify three key conclusions:

- Staff place importance on promoting and developing greater awareness of different approaches to care. Opportunities to learn more about the roles and approaches can promote a sense of belonging and mutual respect between teams and specialisms.
- Staff aspire to develop better communication across multidisciplinary teams. Emphasis needs to be placed on sharing successful examples of good practice to improve rapport and understanding amongst staff.
- Staff desire greater awareness of the complexities of risk to improve staff confidence. This could include training in recovery-oriented principles, the inclusion of the service user perspective, and developing a process of shared responsibility.

RELEVANCE TO CLINICAL PRACTICE

This research offers learning that likely transfers to many health and social care settings. From the literature, it is clear that implementing recovery principles in an NHS environment where interprofessional teams operate has many challenges. However, prevalent themes in the literature have commonalities with those in our findings. Specifically, transferable learning regarding staff experience includes the importance of: (i) promoting awareness of different approaches to care and acknowledging the strengths and values of different cultures; (ii) increasing awareness of risk management and (iii) increasing transparency regarding the implementation of recovery principles.

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NHS ethics approval was sought and granted on 12th April 2016 by Yorkshire and The Humber, Leeds East Research Ethics Committee and Leeds and York Partnership NHS Foundation Trust.

PATIENT CONSENT FOR PUBLICATION
Consent for publication was obtained as part of informed consent for the study.

ORCID
Penn Smith https://orcid.org/0000-0001-7522-4461
Anna Madill https://orcid.org/0000-0002-9406-507X

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