Kent Academic Repository

John, Thomas (2022) *Service User Involvement in Recovery-oriented Care Planning: A Realist Synthesis.* Doctor of Philosophy (PhD) thesis, University of Kent,.

Service User Involvement in Recovery-oriented Care Planning: A Realist Synthesis

Thomas John

Word count: 87832

Date of Submission: January 2022

Academic school: Centre for Health Services Studies, University of Kent

Submitted in accordance with the requirements for the degree of
Doctor of Philosophy

Acknowledgements

I would like to thank Emeritus Professor Jenny Billings and Professor Patricia Wilson for their guidance and invaluable feedback, which has enabled me to complete this thesis. I am grateful for their unwavering support and kindness, especially during the more challenging periods of my PhD journey. I want to express my sincerest gratitude to all participants of this study, who shared their valuable time, thoughts, reflections and experiences with me. I also thank my fellow clinicians and PhD students, who have taken time to discuss my project and to read drafts of my chapters.

The study was predominantly funded by Kent and Medway NHS and Social Care Partnership Trust, for which I am truly thankful. The support and encouragement I received from the Research & Development Department of Kent & Medway NHS Trust has been most appreciated. I am also grateful to Sharon Walcott, Geri Coulls, Jacqui Wilson, Guy Powell and Tom Clarke for their support they gave me as managers at every stage.

My thanks also to my clinical supervisor Dr Phil Anscombe for his guidance and support during my studies. I am grateful to Paul Miller and Catherine Meade for their support in taking time to read my writings and offer suggestions.

I extend sincere thanks to Dr Jeff Wong for his helpful correspondence and to all my friends and wider family for their care and support.

I am indebted to my parents for their care, love and prayers, I hope I made you proud. I am very thankful to my wife, Kavitha, for her unconditional and unwavering support, gentle reminders and for multi-tasking to help me complete my studies. Despite not fully understanding my study, I am so grateful to my boys, Boaz and Stephan for giving me the time and space to complete my studies.

Finally, I cherish and am thankful to my dear sister, Happy, for her kindness, sense of humour and words of encouragement to uplift my spirit during the early days of my PhD journey and I dedicate this thesis in her fond and loving memory.

Abstract

Background: Service user involvement (SUI) is one of the main guiding principles in mental health care and is widely accepted as integral to recovery-oriented practice. Yet whilst there is a wealth of literature that advocates its benefits, service users are marginalised from recovery-oriented care-planning processes. A lack of effective implementation support; little guidance about how to facilitate SUI; and a number of barriers to genuine SUI in recovery-oriented care planning in acute inpatient units all indicate the complex nature of this issue. It remains an area that is currently under-researched and inadequately understood and warrants more sophisticated theorisation and explanation in order to support practice improvement.

Aim: This study investigated which changes to practice work best, in what circumstances, and to what extent, to embed an active role for service users' involvement in recovery-oriented care planning during acute inpatient care.

Design: A realist synthesis, combined with qualitative methods, was conducted to theoretically explore the causal mechanisms that underlie SUI in care planning and how contextual factors influence the link between these causal mechanisms and outcomes. The study was conducted in three stages: theory gleaning; theory refinement and theory consolidation. Initial programme theories related to SUI in recovery-oriented care planning were developed in the theory gleaning stage. These theories were refined iteratively, using evidence from a realist review (secondary data) and interview data (primary data). With stakeholder involvement, refined programme theories were finely tuned using 'if-then' statements in the consolidation stage.

Setting: This study was conducted in NHS mental health hospitals and community mental health centres in the south-east of England, which provide secondary mental health care for service users with mental health problems.

Results: Five programme theories relating to the acute care pathway were identified following the realist synthesis: 1) 'Provider-controlled care transition' (admission to acute inpatient units), referring to the limitations to service users' active involvement at this stage;

2) ‘Care plan as a recovery tool?’ – addressing the infrastructural and organisational limitations to active SUI in recovery-oriented care-plan formulation; 3) ‘Ward rounds as a non-inclusive arena for shared decision making’, highlighting their unfulfilled potential for shared decision making about treatment; 4) ‘Peer support worker intervention as a key factor in service users’ recovery’, concerning their positive impact; and 5) ‘Provider-controlled care transition from acute inpatient units’ (discharge practice), highlighting limitations of current practice in preparing service users for transition into the community.

Conclusions: The study identified practices required to embed an active role for service users to be involved in recovery-oriented care planning, namely multi-contextual interventions at various levels (macro, meso and micro) of the mental health system. The study uncovered blockages and contentions that restrain SUI in recovery-oriented care planning throughout the mental health system, impacting upon desirable outcomes.

Implications for practice: Five key practice improvement areas were identified:

1) The focus of care and access to acute inpatients units should be on a needs-led, rather than resource-led or demand-driven, basis. 2) The use of multidisciplinary meetings as a forum for care-plan formulation can create a cohesive approach and provide equal opportunities to contribute to the care plan, facilitating a shared ownership. 3) Limiting the number of professionals, particularly those who have not been involved with the service users’ care, may enhance an environment conducive for shared decision making. Service users should feel their views are validated by professionals. Professionals should focus on preparing service users for the ward-round process and meetings. Opportunities and access for service users to build therapeutic relationships with the treating doctors is a vital component. 4) Adding peer support workers as part of a multidisciplinary team has the potential to promote SUI in care planning. Their presence in ward rounds and care-planning meetings might create a more user-friendly atmosphere for service users. 5) Practice in acute inpatient units should have an increasing focus on preparing service users for transition into the community, and constraints on resources should not dictate or anticipate decisions on discharging service users, instead, wherever possible, it should be collaborative in nature.

Contents

List of tables

List of figures

List of abbreviations

AIMHU	Acute inpatient mental health unit
CAQDAS	Computer-assisted qualitative data analysis software
CMO	Context–mechanism-outcome
CMHC	Community Mental Health Centres
CQC	Care Quality Commission
CR	Critical realism
DoH	Department of Health and Social Care
EQUIP	Enhancing the quality of user-involved care planning
GMC	General Medical Council
HCPC	Health and Care Professionals Council
HRA	Health Research Authority
ImROC	Implementing Recovery through Organisational Changes
IPTs	Initial programme theories
IRAS	Integrated research application system
MDT	Multidisciplinary team
MRT	Middle range theory
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NHS	National Health Service
NMC	Nursing & Midwifery Council
NSUN	National Survivor User Network
PPI	Patient and public participation
PSW	Peer support worker
RAMESES:	Realist And Meta-narrative Evidence Syntheses: Evolving Standards
ROCP	Recovery-oriented care planning
ROP	Recovery-oriented practice
RR	Realist review
RS	Realist synthesis
SDM	Shared decision making
SUI	Service user involvement
UK	United Kingdom
WHO	World Health Organisation

Glossary of terms

Term	Description
Care plan	*"A written document recording the outcome of a care planning process."* (Burt et al., 2014, p.342)
Care planning	*"The process by which health care professionals and patients discuss, agree and review an action plan to achieve the goals or behaviour change of most relevance and concern to the patient."* (Burt et al., 2014, p.342)
Chain of inference	*"A chain of inference is a connection that can be made across articles based on the themes identified."* (McCormack et al., 2013, p.5)
CMO configuration	A CMO configuration is a proposition stating what it is about an intervention that works (or not works), for whom and in what circumstances.
Context [C]	Complex, layered conditions that influence the success or failure of different interventions or programmes. (Pawson, 2013).
Critical realism	A philosophy of science that distinguishes between the 'real' world and 'observable' world and presents an interface between the 'natural' and the 'social' world.
Experts by Experience	Experts by Experience are people who have recent personal experience (within the last five years) of using or caring for someone who uses health, mental health and/or social care services. **https://www.cqc.org.uk/about-us/jobs/experts-experience**
Initial Programme Theory (IPT)	The initial sketch of a theory that is used to frame and understand how, for whom, why, and under what circumstances complex interventions work or not.
Mechanism	In realist philosophy, mechanisms are agents of change. They describe how the resources embedded in an intervention

	influence the reasoning and ultimately, the behaviour of subjects.
Middle-range theory (MRT)	“*MRT is a level of theory abstraction that describes uniformities of social behaviour that can be expanded to form testable hypothesis by configuring features of an intervention together.*” (Groot et al., 2017, p.2)
Programme	Programmes are ‘theories incarnate’. Every programme has a theoretical underpinning, whether it is made explicit or not.
Programme theory	An explanation of how and why a programme is expected to work and is often expressed as a Context Mechanism Outcome (CMO) configuration.
Proposition	A statement that can be tested to affirm or dispute how something works.
Realism	“*Realism is a methodological orientation or a broad logic of inquiry that is grounded in the philosophy of science and social science*.” (Wong et al., 2013, p.5)
Substantive theory	Existing theories within particular disciplines used to help understand interventions.
Theoretical framework	A theoretical framework is the use of a theory (or theories) in a study that simultaneously conveys the deepest values of the researcher(s) and provides a clearly articulated signpost or lens for how the study will process new knowledge.

Outputs

John, T., Billings, J., Wilson, P. (2017). Enhancing service user involvement in care planning during acute inpatient mental health care pathway. Poster presentation; Royal College of Nursing 2017 Annual International Nursing Research Conference at Cardiff.

John, T., Billings, J., Wilson, P. (2022). Service User Involvement in Recovery-oriented Care planning: A Realist Synthesis. Poster presentation; Royal College of Psychiatrists 2022 International Congress at Edinburgh.

Chapter-1: Introducing the thesis

1:1 Introduction

This thesis presents a research study on service user involvement (SUI) in care planning in acute inpatient mental health units (AIMHUs). The introductory chapter provides a summary of the background to my study, its rationale and research questions, the motivation for the study and an overview of the chapters.

1:2 SUI in care planning: an overview

SUI continues to be a one of the guiding principles of current national and international mental health policy (Storm & Edward, 2013) and is recognised as the cornerstone of evidence-based practice (Sackett et al., 1998). In the United Kingdom (UK), the National Health Service (NHS) and Community Care Act (1990) provided a framework for SUI in order to deliver a tailored, responsive and flexible approach to meet individual needs of service users by introducing individualised care planning. The aim was to provide a stronger voice for service users in decisions about their care that required services to shift the focus of support from '*what is the matter with you?*' to '*what matters to you?*' (NHS England, 2017, p.7).

SUI is a complex and multi-dimensional concept that is used synonymously with participation, collaboration, engagement, therapeutic alliance and, more recently, co-production. There are numerous definitions for SUI, leading to a lack of consensus regarding its definition (Tambuyzer et al., 2014; Stringer et al., 2008). Additionally, a critique was made by Radermacher et al. (2010) that definitions often tend to be narrow and limited, as they are often defined by the 'dominant' group (non-disabled, professionals, heterosexual, white and westerners), whereas deeper issues of the non-dominant groups, such as equity and justice, can get overlooked. This can be problematic when working with these non-dominant groups (Nelson & Prilleltensky, 2005). The National Survivor User Network (NSUN) (2014) defines SUI as:

"*the active participation of a person with lived experience of mental distress in shaping their personal health plan, based on their knowledge of what works best for them*" (p.1).

This definition indicates that SUI provides an opportunity to articulate and inform what matters to them by engaging with professionals and utilising their personal resources, in 'shaping' their care plan. I will endeavour to use this as the working definition, as it is defined by individuals who have experienced mental health problems related to care planning and it encompasses the application of SUI at a personal level.

Involving service users in mental health care planning is central to international and national health policy and practice, as care planning is identified as a meaningful platform to involve service users in their care (Bee et al., 2015b). Care planning is a systematic way of supporting service users to express their individual needs and decide on their own priorities through a process of sharing information; discussing options; documenting the discussion (referred to as care plans) and monitoring the process through regular reviews (NHS England, 2017). From a mental health perspective, Miller et al. (2017) define care planning as:

"*an ongoing process of collaboration between an individual and his or her care team members (including their own community based or natural supports), which results in the co-creation of an action plan to assist the person in achieving his or her unique goals. Rather than viewing people as consumers of health and social care, they are involved as co-producers of collaborative plans where decision making is shared between providers, people in recovery, and their families*" (p.254).

It underlines service users' active role in the care-planning process, where they make shared decisions to attain their unique goals through co-produced care plans. Care plans in AIMHUs are formulated and reviewed in two ways (Coffey et al., 2019; Reid et al., 2018). In the first instance, nurses have the responsibility to formulate care plans during admission and update care plans with service users (Reid et al., 2018). The second type of care plan review takes place on a weekly basis with the multidisciplinary team, led by the psychiatrist, where major decisions about service users' treatment, such as medication, leave and discharge, are finalised. Care planning becomes user-focused when the service user and professionals develop a shared understanding of what the needs are and agree on goals to guide their working relationship (Department of Health and Social Care [DoH], 2009b; Care service improvement partnership, 2007).

In England, the Care Programme Approach (CPA) was introduced in 1991 (Simpson et al., 2003), as a whole-system approach that provides a framework for care co-ordination in secondary mental health services. It aimed to ensure that service users could access a range of services to meet their needs. As a result, care-planning practices in AIMHUs should not be treated in isolation from the wider contextual agenda that shapes systems and processes (Brooks et al., 2018). There is a commitment that all service users under the CPA will have a written care plan, by involving them in their care planning, and the opportunity to work with a multidisciplinary team (MDT) to review their care plan. Similarly, the National Institute for Health and Care Excellence (NICE) (2014) recommends that service users should develop a care plan with mental health professionals and should receive a copy with an agreed date of review. This means care planning requires proactive conversations between service users and professionals (NHS England, 2017). According to NSUN (2014), SUI is about service users asserting their viewpoints and being heard in their own right. It is about being active and not passive. Studies have identified service user insight (awareness of the illness) as a key influence on care planning as it is based on service users' strengths (Brooks et al., 2018; Bee et al., 2015b). Therefore, having a key role and insight is an essential component for active SUI in the care-planning process. As a result, I have taken a position that my study relates to those who are deemed to have the mental capacity to make an informed decision to accept an informal admission to AIMHUs and to engage in shared decision making (see Chapter 4, Section 4:4:1) about their treatment plans with professionals. It means, in the current context, the implications of this study are likely to exclude service users who lack capacity and there is a need to address practices pertaining to this group. However, it is beyond the scope of this study to include all service users who access AIMHUs. Additionally, the focus of this review was on the professional-user relationship. Therefore, this precluded an examination of the wider social network (i.e. family members, friends).

1:3 Benefits and rationale for SUI in care planning

The benefits of SUI in mental health care are well established. SUI in care planning creates trusting relationships between service users and professionals, minimises power differentials, improves quality of care and reduces long-term demand on health and social care services (Bee et al., 2015b). SUI can improve adherence with treatment, (Favod, 1993); promote positive experience and patient satisfaction (Valimaki & Leino-Kilpi, 1998; Essex et al., 1990) lead to better health; and a safer environment for service users and care providers (Davidson et al., 2005). Hickey & Kipping (1998) suggest three rationales for SUI that determine its application in the decision-making process. These are: a desire to provide a responsive service to meet their needs and wishes; their right to be involved in decisions that affect them; and lastly, the therapeutic significance of involving service users in decision making. This was further elaborated by Tambuyzer et al. (2014) providing four reasons used by its advocates, which are: ‘principle based’ (the most prevalent reason, where it is considered as a service user’s fundamental right); ‘therapeutic value’; ‘enhanced quality’; and ‘political’ reasons, where user involvement can increase any initiative’s legitimacy, and to meet governmental and funding requirements. This body of literature sums up the relevance of SUI in mental health practice and explains why it is portrayed as one of the guiding principles in mental health policies.

1:4 The driving forces of SUI in mental health

Globally, SUI has been an explicit policy goal and is enshrined in a number of mental health policies and guidelines (World Health Organisation [WHO], 2013). In the UK, SUI in the mental health domain is mainly driven by government policies (DoH, 2011; 2009a; 2003; 2001; 2000 & 1999), which are supported by professional bodies (Nursing and Midwifery Council [NMC], 2018; General Medical Council [GMC], 2019; Health and Care Professionals Council [HCPC], 2018); by independent regulatory bodies, such as the Care Quality Commission [CQC] (2017a); and by voluntary sector organisations, such as the Schizophrenia Commission (2012) and NSUN (2014). In the UK, SUI in care delivery became a legal requirement through the Health and Social Care Act (UK Parliament, 2001) and has gained considerable momentum in the last three decades from various agencies. Additionally, the Mental Health Act Code of Practice (DoH, 2015) stipulates ‘empowerment and involvement’ as one of its guiding principles and as an essential practice for practitioners.

However, recent policies and literature increasingly underline a focus on promoting service users’ recovery and recovery-oriented practice (ROP) (DoH, 2018; 2014a&b; 2009a & 2008). Additionally, the terminologies featured in recent literature such as ‘recovery-oriented or recovery-focused care planning’ (Coffey et al., 2019; Simpson et al., 2016) are some examples of this trend in mental health where the usage of SUI is intertwined, or even substituted, with the term ‘recovery’. National policies (DoH, 2014a, 2014b, 2011; 2008; 1999) outline expectations of recovery and involvement in decisions about treatment (Coffey et al., 2019). It is acknowledged that SUI does not work with a single-lever approach, as it is “*not a neat, single concept”* (Foot et al., 2014, p.12) instead it incorporates multiple perspectives, a range of inter-related approaches (consumerist, democratic, value-based, etc.), philosophies and terminologies (Foot et al., 2014), which explains the reason for this changing trend. This is a significant component in relation to this study where there is a need to recognise the paradigmatic shift in mental health system and practice, where recovery is seen as a dominant paradigm that encompasses all concepts within the participatory paradigm, including SUI. In the next section there will be a brief overview of how these two paradigms are interlinked.

1:5 SUI and ROP: inter-related concepts

Recovery is a broad empirical and philosophical paradigm (McKenna et al., 2014) introduced primarily by people who have recovered from mental health experiences, and has grown considerably. Recovery is the dominant theme in the transformation of mental health policy (Rogers et al., 2007). In the UK, mental health policies started to focus explicitly on recovery as the stated aim and guiding principle from 2001 (DoH, 2014a; DoH, 2009a; DoH, 2008; National Institute for Mental Health England, 2005; DoH, 2001). The most commonly cited definition for recovery states that it is:

“*a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the 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*” (Anthony, 1993, p.17).

SUI is widely accepted as the emblem of ROP in mental health (Tse et al., 2012) and involving service users in their care is one of the key features of ROP (Laitila et al., 2018). According to Waldemar et al. (2019), SUI is the cornerstone of ROP, especially during care planning. The principles of ROP are underpinned by person-centredness, collaboration between service users and professionals, empowerment and a focus on the strengths rather than deficits of an individual (Chester et al., 2016). This means working in ROP requires a shift in thinking from a symptom or deficit-focused approach (also referred to as illness-focused or problem-oriented) used by the medical model of practice, to the humanisation of care (De las Cuevas et al., 2012). ROP creates a culture of hope, autonomy and self-determination (Chester et al., 2016). As a result, SUI at any stage of care delivery is an outcome of ROP (Zuaboni et al., 2017).

Storm and Edwards (2013) identified the recovery model as one of the vehicles for the application of SUI alongside patient-centred care, shared decision making and patient participation, indicating the close connection between SUI and the recovery approach in practice. Addressing the operational aspects of the recovery approach may help to resolve some issues around SUI in the care-planning process (Newman et al., 2015). The proliferation of contemporary literature, policies, reports and research articles reiterates the evolving value and position of recovery in mental health practice. Here, it will be useful to have a brief explanation about recovery from a mental health perspective.

Recovery is currently categorised into personal, clinical and service-defined recovery (Le Boutillier et al., 2015a; Slade, 2009). Personal recovery has been defined as “a profound personal and unique process for the individual to change their attitudes, values, feelings, goals, abilities and roles in order to achieve a satisfactory, hopeful and productive way of life, with the possible limitations of the illness” (Ballesteros-Urpi et al., 2019, p.1). Within the Personal Recovery Framework (Slade, 2009), the individual experiences recovery through undertaking four recovery tasks, such as developing a positive identity outside of being a person with a mental illness; developing a personally satisfactory meaning to frame the experience, which professionals would understand as mental illness; taking personal responsibility through self-management and the acquisition of previous, modified or new valued social roles. As mentioned above, this study has taken a position to address the research question for those service users who are able to identify that their recovery journey aligns with this personal recovery framework. Clinical recovery is defined by Le Boutillier et al. (2015a) as a: “*deficit perspective where mental state is improved or stabilised using medication and risk-management intervention*” (p.5). Here professionals are seen as the experts. Clinical recovery often informs service-defined recovery and they share the traditional conceptualisation of ‘recovery from’ mental illness (Chester et al., 2016). Service-defined recovery is defined as: “*a concept owned by the organisation where administrative and financially driven goals shape practice*” (Le Boutillier et al., 2015a, p.6) which defines service accessibility and discharge. As a result, there is a sceptical view about the legitimacy of a policy drive towards ROP, perceived as a "*neoliberal smoke screen*" (Marrow, 2013, p.323).

Mental health policy is orientated towards supporting personal recovery that focuses on an individual's health, wellness and strengths, rather than pathology, illness and weakness (McKenna et al., 2014; Repper & Perkins, 2003). The emphasis on its strength-based approach and person-centredness highlights how the concept of ROP is closely associated and shares similar values with SUI. It is clear that both these concepts call for emancipatory practices that acknowledge service users as experts in their own lives and experiences (Fisher & Freshwater, 2014). Therefore, their ultimate goal is service user empowerment. I will acknowledge the close link between these concepts in my study by adding 'recovery-oriented' as a prefix to care planning. From now onwards, the term recovery-oriented care planning (ROCP) will be used throughout the thesis.

1:6 Application of SUI in AIMHUs

The government policy titled "No decision about me without me" (DoH, 2011) set out a vision for a clear role for SUI during ROCP. Despite the benefits of, and emphasis on, SUI, a number of studies (Simpson et al., 2016; Storm & Davidson, 2010; Stringer et al., 2008) suggest that service users are marginalised from the ROCP in AIMHUs (Brooks et al., 2018; Miller et al., 2017) and this is likely to remain an important issue in the mental health arena (Anthony & Crawford, 2000). The proliferation of conceptualisation leading to a lack of clarity about how to facilitate SUI in practice was also identified as challenging (Tambuyzer et al., 2014; Radermacher et al., 2010). Hence the impact of policy on clinical practice is still lacking (Bee et al., 2008). This is also the case with ROP, where there is a lack of clinical guidance on the practical application of ROP (Le Boutillier et al., 2011).

Service users' experiences and their level of involvement in care planning are seen in studies as a ritualised, task-oriented practice (Bee et al., 2015a). Bee et al. (2015a) also criticised the fact that secondary services have downgraded care planning to a linear, task-focused event, where success is measured in terms of outcome. Rather than looking at the quality of service users' experiences of involvement in ROCP, the 'mere' act of providing a copy of, and signing, their care plan has historically been perceived as evidence of SUI. This means, whether it is genuinely experienced or not, the ritualistic act to evidence SUI is designed to simply meet audit criteria. Previous studies (Lorien et al., 2020; Brooks et al., 2018; Bee et al., 2015b) show that service users are marginalised from developing their care plans. Therefore, the current status of SUI in ROCP in AIMHUs reflects Radermacher et al's (2010) statement with reference to the service user experience: "*It's about us but still without us!*" (p.333).

Several implementation barriers from systemic, organisational and structural levels have been identified as reasons for the problems associated with SUI (Radermacher et al., 2010). Funding systems designed to contain budgets and the influence of bio-medical orientation are classed as the systemic barriers to SUI in ROCP (systemic or macro level) (Miller et al., 2017). Some studies have identified organisational priorities, limited resources and culture as inhibiting factors for SUI in ROCP (organisational or meso level) (Brooks et al., 2018; Anthony & Crawford, 2000). This includes high staff turnover; fragmentation of service; and increased paperwork associated with bureaucracy, which is not often counted in staff workload (structural or micro level). Furthermore, in the inpatient context, Bee et al. (2015a) reveal that the focus on inpatient beds and the reliance on temporary staffing can further deplete time for therapeutic engagement. Anthony and Crawford (2000) highlight barriers to SUI in ROCP, such as mental capacity and lack of motivation of service users caused by debilitating mental illness; lack of information sharing; competing demands and professionals' attitude. It is evident that both the internal and external factors have created barriers to SUI in AIMHUs and signals the complex nature of this issue. Categorising barriers for SUI into macro, meso and micro level (Hickey & Kipping, 1998) is a useful way of understanding and addressing them. These categorisations will be drawn upon later on in the thesis.

1:7 Rationale for my study

Although the policy intentions on SUI in care planning are progressive, it is demonstrated that policy on care plans and the ROCP process have limited impact on service users' involvement and personal recovery. Recent nationwide studies, such as 'Enhancing the Quality of User Involved Care Planning in Mental Health Services' (EQUIP) (Grundy et al., 2016; Brooks et al., 2015; Bee et al., 2015b) and 'Cross-national comparative case study of recovery-focused mental health care planning and co-ordination' for community and inpatient setting (COCAPP and COCAPP-A) (Coffey et al., 2019; Simpson et al., 2016), both funded by the National Institute for Health Research (NIHR), illustrate the significance of this topic in the mental health field. However, active and genuine SUI in care planning in AIMHUs remains a policy aspiration, whereby "*the reality lags behind the rhetoric*" (Foot et al., 2014, p.6). As a result, there is a pressing and growing need to address this translational gap between policy and practice.

As aforementioned, implementation of SUI in ROCP requires a shift in the focus of support from 'what is the matter with you?' to 'what matters to you?' In order to apply this shift in practice, we need to address two issues: Firstly, infrastructural changes, or altering or supplementing existing practices, or training professionals alone might not produce significant improvement in ROCP in AIMHUs (Waldemar et al., 2018; Zuaboni et al., 2017; Rise et al., 2013). This requires substantial changes and multimodal approaches, including changes to the ROCP process (Dawson et al., 2021; Lorien et al., 2020). Theoretical explanations that reflect on how complex interventions implemented in a complex area, such as AIMHUs, interact and depend on their social context (individual, social, cultural and organisational) are limited (Brand et al., 2019). Hence, it is necessary to articulate what these changes might be at various levels within a mental health system. Secondly, the presence of barriers at various levels highlights the complexity of this issue. It means that addressing this translational gap, after completely eliminating all barriers, may not be feasible. In view of this, it is more prudent to investigate 'how SUI in ROCP within AIMHUs is supposed to work in the given context'. It is therefore argued that an area that is currently under-theorised warrants more sophisticated, practice-focused theorisation. This is in order to increase understanding by addressing the translational gap that occurs as a result of the complexity surrounding the implementation of SUI in ROCP. This will be the unique original contribution this study will add to the current knowledge in this area.

1:8 Research questions

The overarching research question for this study was:

1) What changes to practice work best, in what circumstances, and to what extent, to embed an active role for service users' involvement in recovery-oriented care planning during the acute inpatient care pathway?

This study also had two secondary questions, which were:

2) How is service user involvement in recovery-oriented care planning currently understood and experienced by service users and staff during an acute inpatient care pathway?
3) What changes in practice, in what circumstances, and to what extent, can sustain active service user involvement as a dynamic and transparent process in recovery-oriented care planning during an acute inpatient care pathway?

1:9 Motivation for the study

My research interest has followed me from the early days of my career as a nurse, but I started contemplating a PhD following the completion of my Masters in 2013. My interest and passion for my research topic stemmed from my clinical experience with adult mental health services and is an extension to the work I carried out as part of my Masters in developing 'Recovery Clinics' across all the AIMHUs within my organisation, with the aim to promote SUI in care planning (John, 2017) (see Appendix 2). This led me to witnessing at first hand the barriers for active SUI within the organisation. The experience and learning from implementing the recovery clinics made me think critically about how SUI can be implemented successfully in practice. As I developed professionally, and with continuing close links to mental health practice in acute inpatient units, I gained more insight into the complexity surrounding SUI in this area of practice and how this translated into the evident difficulties in embedding it as part of practice on a daily basis. I have embarked on this PhD project with the hope that I will be able to outline and articulate pragmatic actions to bridge this translational gap.

1:10 Organisation of the thesis

This thesis is organised into eight chapters and is summarised below. It is noteworthy that this is a realist study, therefore this thesis does not follow convention with respect to a traditional and initial literature review. Instead, the realist review examines the literature as part of the analysis.

Chapter 1: Introducing the thesis. The introductory chapter provides a summary of the background to my study, its rationale and research questions. The motivation for the study and the organisation of the thesis are also presented.

Chapter 2: Methodology. This chapter provides an overview of the methodology for my study and how the choice of methodology was shaped by the research questions. This chapter also describes and rationalises the underpinning philosophical approach and researcher's personal stance.

Chapter 3: Methods. This chapter provides an overview of Realist Synthesis (RS), which was applied in three stages: (a) Theory gleaning stage; (b) Theory refinement stage and (c) Theory consolidation stage. It explains the methods, access procedures, sampling, data collection and analysis used in each of these stages. It also provides an outline of how rigour was enabled and ethical issues addressed.

Chapter 4: Findings – Part 1. This chapter presents the theory refinement stage of this study (Stage-2) and presents the 1st, 2nd and 3rd refined programme theories developed using the realist review and subsequently refined by testing with the qualitative interview data.

Chapter 5: Findings – Part 2. This chapter continues to present the findings and details the 4th and 5th refined programme theories.

Chapter 6: Consolidation stage. This chapter presents the 'theory consolidation' stage (Stage-3), the last stage of this study, with a detailed account of how stakeholders were involved in consolidating the programme theories into middle-range theories.

Chapter 7: Discussion. This chapter presents the discussion of findings and study implications using a theoretical framework adapted from Gibson et al. (2017). It situates the emergent theory and the findings of the study within the context of the current theories regarding SUI in ROCP in AIMHUs.

Chapter 8: Conclusions and recommendations. Research questions are revisited and the key findings are summarised. The original contribution to knowledge from this study, along with its limitations, are presented. A reflexive account on my role as a researcher and recommendations for policy, practice and research are outlined.

1:11 Chapter summary

This chapter has provided a brief synopsis of my study, rationale and my research motivation, with the aim to provide an original contribution and additional knowledge to the current theory on this subject. It has articulated the research questions, and described the organisation of the thesis. The chapter provides an overview of the methodology for my study and rationalises the underpinning philosophical approach of my study.

Chapter-2: Methodology

2:1 Introduction

The aim of this chapter is to present the philosophical approach to my study. Underpinned by qualitative methodology, it will begin by explaining the research questions and will illustrate how expert SUI informed and refined the research questions and proposed study design. Philosophical assumptions will then be articulated, which are rooted in critical realism. The rationale for using realism as the philosophical orientation, and how it has informed the research approach, will then be presented. My personal stance as a researcher is also described in this chapter.

2:2 Research questions

Formulation of a research question is the initial and fundamental part of a research project. Research questions serve as the foundation upon which the whole study is built and formulation of a research question is not an easy task, as it requires significant knowledge in the subject area and research methodology (Kumar, 2014). It is the research question that leads the choice of method, and not vice versa (Streubert, 2011; Whitehead, 2007). This explains the significance of its role in the research process. Additionally, research questions can help to define the project, set boundaries, provide directions and define the success of a research study (Robson, 2011). According to Green and Ruff (2005), the reason researchers encounter problems in answering their research questions is due to flaws in the formulation of the research question at the early stages of the study. In order to formulate a good research question, the following characteristics are vital: research questions should be clear and unambiguous, showing the purpose of the project; they should be answerable, not trivial, and need to form a coherent interconnected set (Robson, 2011). In a qualitative study it is important to maintain flexibility, openness and freedom when research questions are formulated, in order to accommodate emerging and evolving ideas as the study progresses (Kumar, 2014). As a result, the initial sets of research questions formulated in qualitative studies should be provisional, and this was certainly the case when research questions were developed for this study.

Research questions have the ability to point out the purpose of a research study, as mentioned above. Knight (2002) points out that research questions fall into five categories: descriptive, evaluative, narrative, causal and effect. This is further illustrated by using ‘What’, ‘Why’ and ‘How’ typology. Onwuegbuzie and Leech (2006) suggest that qualitative questions are mainly open-ended and inclined to address ‘What’ and ‘How’ questions. The following are the research questions posed by this study, which start to indicate the paradigmatic framing of the research.

The overarching research question for this study was:

1) What changes to practice work best, in what circumstances, and to what extent, to embed an active role for service users’ involvement in recovery-oriented care planning during the acute inpatient care pathway?

This study also had two secondary questions, which were:

2) How is service user involvement in recovery-oriented care planning currently understood and experienced by service users and staff during an acute inpatient care pathway?
3) What changes in practice, in what circumstances, and to what extent, can sustain active service user involvement as a dynamic and transparent process in recovery-oriented care planning during an acute inpatient care pathway?

2:3 Expert SUI in the proposal stage of the study

The research proposal was presented to the Experts by Experience (E by E) service user group of the host NHS Trust. The aim of this presentation was to get an expert opinion from group members to inform this study. The proposal was presented to the group in a meeting on the 13th April 2016. The group made a few recommendations for the proposal. They advised that the title should be more specific and recommended amending this to its current version. The group also made recommendations regarding the main research question, by adding the specific area of study, which is care planning, and to specify the context for this study. The group also agreed with the proposed research design.

After considering terms, such as ‘collaboration’, ‘participation’, ‘involvement’ and ‘engagement’, the members advised ‘active involvement’ as a concept to use in the main research question and for the operational purpose of this study. Amendments were made to the research question, according to the suggestions made by the group. I have informed members that their recommendations regarding the study were appreciated and amendments were made to the proposal according to their suggestions.

2:4 Research philosophy

It is important for researchers to recognise and understand their philosophical orientation adopted for a specific research project (Hussey & Hussey, 1997), which makes research philosophy an inevitable component of a research study. Fawcett (2000) has defined philosophy as: "*a statement encompassing ontological claims about the phenomena of central interest to a discipline, epistemic claims about how those phenomena come to be known and ethical claims about what the members of a discipline value*" (p.6). Furthermore, Saunders et al. (2009) define research philosophy as: *"a system of beliefs and assumptions about the development of knowledge*" (p.124). The purpose of setting out a research philosophy is to inform others about the beliefs and values of a particular discipline and claims that the researcher might make from the findings and the foundation of such claims (Crotty, 1998). According to Snape and Spencer (2003), having an awareness of the underpinning philosophy can contribute valid findings, enhance the quality of the research and promote better research practice. Additionally, it helps to anticipate which type of research questions are important and what constitutes an answer to those questions (Robson, 2011).

A set of consistent and connected philosophical assumptions (ontology, epistemology and methodology, see Section 2:4:1 for details) will constitute a reliable research philosophy that will guide the methodological choice, research strategy, data collection methods and data analysis strategies to produce a coherent research project, a viewpoint echoed by Snape and Spencer (2003). Crotty (1998) has stated that these philosophical assumptions act as a set of distinct hierarchical levels of decision making within the research design. So, it is evident that there is a clear rationale for articulating the research philosophy of a study. However, Guba and Lincoln (2004) have pointed out that these beliefs must be accepted simply on faith, as their ultimate truthfulness cannot be established. Furthermore, Hesse-Biber and Leavy (2004) argue that the answers to ontological, epistemological and methodological questions are human constructions and are subject to human error. As a result, none of them can claim that they are incontrovertibly right and any supporters of a particular construction must base their trust on persuasiveness and utility, instead of finding proof for arguing their position.

Based on this, some researchers make the interpretation that research can be carried out in different ways and there is no single, precise way to carry it out. Trigg (2001) claims that the philosophy of social science should not be seen as an optional activity, but as: "*an indispensable starting point for all the social sciences*" (p.255). However, Bryman (2006) suggests that the suitability of specific methods for answering a research question is the fundamental arbitrator of choosing a methodological approach for a study, rather than a commitment to a paradigm and a particular philosophical stance upon which it is supposedly based. Similarly, Morgan (2007) has proposed that adopting a notion of paradigms as shared beliefs amongst a group of researchers, rather than being concerned with paradigms as a philosophical stance, is a way forward. Even though the two latter arguments have some convincing points, I believe that the advantages of articulating a research philosophy have the ability to provide a solid foundation to build any study. The reasons are discussed in the following section.

2:4:1 Philosophy or the world view – 'An indispensable starting point'

As previously mentioned, there are convincing reasons that support the need to articulate research philosophy, which involves explanation of three main philosophical positions: the ontological, epistemological and methodological positions of a research study. This will be explained in the following sections.

Ontology is the study of being or reality, and the first step in formulating a research design is to explain the ontology (O'Gorman & MacIntosh, 2015). This contradicts Crotty's (1998) stance, which conflates ontology with epistemology, by claiming that these two are interdependent and difficult to differentiate conceptually when debating a research topic. This argument will be explored further in following sections. According to Guba and Lincoln (2004), an example of an ontological question is: *"What is the form and nature of reality and, therefore, what is there that can be known about it?"* (p.21). They imply that the ontological assumption of a researcher about his social world acts as a filter in which research occurs by enquiring "*how things really are*" and "*how things really work*" (p.21).

The ontological position to develop new knowledge has two strands: objective reality and subjective reality. Descarte's view on objective reality maintains that the concepts of cause and effect could explain the human phenomenon, and this view was followed by researchers for a long time. This was refuted by Kant, who stated that reality cannot be explained by cause and effect, and introduced the concept related to perception that explains the place of subjective reality and its relevance to represent the views of people under study, especially in social science. According to Clark et al. (2008), a reflection on the assumptions of reality is vital, as it underpins methods. Furthermore, Crotty (1996) has warned that a lack of commitment to reflect on reality will weaken a study, as it may lack wider credibility, internal coherence and may be inadequately justified.

The second philosophical position that needs to be discussed is the epistemology. Robson (2011) explained epistemology as a "*theory of how things can be known*" (p.525). According to LoBiondo-Wood and Haber (2006), "*epistemology is the theory of knowledge; the branch of philosophy that concerns how people know how they know*" (p.563). Guba and Lincoln (2004) have added that epistemology is the nature of the relationship between the knower and what can be known. After stating an ontological position, the researcher is expected to draw links between the ontological reality and the steps that might be taken to build valid knowledge. In Guba and Lincoln's (2004) terms, the researcher is constrained by the answer that is given to the ontological question and any form of relationship cannot be postulated. This means that the ontological position should synchronise with the epistemological position, which validates Jackson's (2013) view that an ontological position determines the epistemological position. According to Jackson, "*an ontological view of knowledge as subject to interpretation means, epistemologically, that knowledge is arrived at through sense-making and meaning*" (p.54).

The third philosophical position that needs explanation is the methodology, which should be distinguished from term methods. Methodology deals with the method of inquiry in which relevant data can be obtained, whereas methods are techniques used by researchers to gather and analyse data relevant to the research question. (Hesse-Biber & Leavy, 2004). The ontology, epistemology and methodology collectively constitute the philosophy of a paradigm. At this stage it will be appropriate to look at the research paradigms that guided the research design of this study.

2:5 Research paradigms

The term ‘paradigm’ was coined by Kuhn (1970) and it refers to a specific group of beliefs and values shared by different scientific communities (Smith, 1991). These belief systems are based on ontological, epistemological and methodological assumptions (Guba & Lincoln, 2004). There can be variations in the system of reasoning with these paradigms, such as inductive and deductive reasoning. The former creates generalisations from specific observations from data, whereas the latter generates specific predictions from general principles. Positivism, post-positivism and constructivism are the three paradigms commonly used in health research (Parahoo, 2006) and will be further explained in the following sections.

2:5:1 Positivism

This was a dominant paradigm in health research for decades. Positivism is used as a synonym for objectivism, empiricism or universalism (Clark et al., 2008). Positivists believe in the existence of objective reality, which is independent of human observations. As a result, positivists believe that social phenomena can be observed in a detached way and they consider science as value-free facts. This paradigm supports quantitative research approaches that have strict and rigid rules and procedures. Empiricism is the ontological position of positivism, which means that facts can only exist if we can experience them with human senses. Its epistemology requires a deductive reasoning, using scientific methods to verify what they experience as reality (Wainwright, 1997). Positivists believe in the unity of science and support the application of scientific methods used in natural science, appropriate for the study of social phenomena. Furthermore, they also believe that universal laws can be deduced to explain human and social phenomena (Parahoo, 2006).

2:5:2 Constructivism

This paradigm came into being as a countermovement to positivism (Polit & Beck, 2008). It is also referred as interpretivism, perspectivism or antifoundationalism (Clark et al., 2008). Constructivists believe that the social world is actively constructed by human beings and reality is not a fixed entity. This paradigm looks at the ways in which the social world is interpreted by those who are part of it, by understanding their experience in social situations (Robson, 2011). Relativism is the ontological position of constructivism, which means multiple truths or multiple interpretations of reality are possible and what exists depends on what individuals perceive to exist. Hence the constructivist focuses on subjective experience, language and perception to understand the phenomena under study and believes that they cannot act as detached observers and are involved in the research process. The methods employed by constructivists are interactive and flexible. This paradigm supports qualitative research approaches and it uses inductive reasoning.

2:5:3 Post-positivism

This paradigm corroborates the positivist commitment to objectivity, but contests their notion of total objectivity. Post-positivists believe that there is a reality, but that it can only be understood imperfectly and probabilistically, due to the limitations of the researcher (Robson, 2011). In other words, they believe that it is possible to get close to the truth. According to Parahoo (2006), post-positivists recognise the probable nature of predictions in social science and refer to them as realist. This is because they believe in an external reality that is discrete from our interpretation of it. Its ontology emphasises that the structures creating the world are hidden, which follows with an epistemological position that these structures do not necessarily reveal the mechanisms that generate causal effects. Its methodology constructs theories in the form of statements that can explain situations or describe causal relationships (Wainwright, 1997). A number of post-positivist positions have been developed in which critical realism and social constructivism evolved as the two dominant forms (Cruickshank, 2012). In the following sections, I will begin to explain the philosophical position of this study and its rationale.

2:6 Philosophical positioning – Embarking on ‘the indispensable’ step

This section aims to explain the philosophical position taken that has guided this study. In relation to health research, many authors have used the term ‘competing paradigms’ when referring to the positivist and constructivism paradigms. This can be further explained with Corner’s (1991) critical observation that the scientific status of nursing knowledge is a contrast of two polarised approaches, namely: a positivist-deductive-quantitative, or a constructivist-inductive-qualitative approach. However, Polit and Beck (2008) have stated that health research is dominated with the post-positivist paradigm, which shows a shift since Corner’s observation. In other words, it is evident that the dominance of this dualism has been replaced with the use of the post-positivist paradigm, with a surge in research studies positioned within the realist domain (Williams et al., 2017). In essence, this marks the fruition of what Wainwright (1997) proposed can be witnessed in social science as "*the triad of paradigms*" (p.1262). He was advocating for realism, which is the philosophy of human and social science, along with positivism and constructivism. It is the role of the researcher to justify the criteria adopted to choose a paradigm that is compatible with a study.

2:7 Researcher's personal stance

I am a mental health nurse with twenty years' experience of working in the NHS. I have worked in the clinical, operational and corporate services. I operate with a belief that a single unequivocal social reality or truth does exist, but it is mind-independent. My interpretation is that reality is rooted in the belief that reality can only be known partially and probabilistically. It resonated strongly with my personal (including spiritual) perception that it is not possible to make an ultimate claim for certain knowledge, as all knowledge is open to further development. As a result, knowledge development is a non-linear and dynamic process, unfolding over the course of time. I believe research is a pragmatic process: "*to refine what we already know, not to re-establish if what we already know is what we already know…*" (Robson, 2011, p.230). As a result, I believe, it is not possible to make a claim of finality to the knowledge research produces. Therefore, my interpretation of reality (ontology), and the meaning I ascribe to the way knowledge is created (epistemology), runs in parallel with the tenets of critical realism (Bhaskar, 1975). I believe that my clinical, educational and professional experiences have influenced my epistemological framework as a researcher and have influenced the scope, focus, methodology and design of this study. In the following sections, I will explain critical realism, its philosophical underpinnings and the reasons for choosing this approach to this study.

2:8 Critical Realism (CR)

CR (Bhaskar, 1975) is a comprehensive meta-theory resulting from the pioneering work by Roy Bhaskar in the 1970s and it represents a relatively new approach to research. According to Archer et al. (1998), the phrase 'critical realism' has evolved from the expressions 'transcendental realism' and 'critical naturalism'. Its 'critical' element is similar to a 'transcendental' notion of ontology that goes deeper than what is immediately obvious and experienced. Bhaskar (1978) put forward a transcendental argument to promote a realistic approach to science that is: 1) recognising the objective and subjective value; 2) a stratified, emergent, generative ontology; 3) understanding deep causation in a complex and open system; 4) a recognition of complex agency and structure interaction; and finally, 5) a methodological eclecticism and post-disciplinary study. These points will be elaborated in the following sections. From a realist point of view, knowledge is a historic and social product that is specific to time and place, therefore, it is focused on the here and now (Williams et al., 2017; Stickley, 2006). CR maintains the existence of an external and independent reality that is independent of human interference, distinct to our perception and understanding (Danermark et al., 2002; Sayer, 2000; Collier, 1994). As a researcher, I agree with this notion put forward by Bhaskar.

One of the distinctive features of CR is its ontological position. Bhaskar argued that the human perceptions of the world (epistemology) might not be identical with the objective state of the world (ontology) (Clark et al., 2008). However, some philosophers, such as Crotty (2004), have postulated a different view to this. He implies that a world without the engagement of conscious being is a non-intelligible world. He continues to say, "*It becomes a world of meaning only when meaning-making beings make sense of it*" (p.10). For this reason, Crotty suggests that a world that is independent of our consciousness does not indicate that meaning exists independently of consciousness. Consequently, Crotty has excluded ontology from the philosophical framework he proposed for research. However, Crotty's argument is not convincing, as it does not persuasively address the following question: how can we come to know about things that exist or make meanings of things, without acknowledging what things exist in the first place? Therefore, Bhaskar's view argues that there is a reality independent of human construct. For example, we believed that the Earth was flat until Magellan and Columbus disproved it through their expeditions, but it is now understood that the Earth is spherical. However, reality had not changed; the human interpretation of reality was wrong. Similarly, the apple always fell downwards and it is important to acknowledge that the mechanism of gravitational force existed long before human interpretation of it. These examples illustrate the argument put forward by CR, which is built on the realist perspective that contests the assumption that what we know about the world is actually real

(Oltmann & Boughey, 2012). This convincingly reiterates Bhaskar's argument regarding the ontological position of CR.

CR concentrates on analysing the social world and attention is directed towards understanding what causes something to happen that leads to observable phenomena (Williams et al., 2017). As a result, CR is progressively viewed as a philosophical approach, which has unique potential to efficiently frame, recognise and identify complex phenomena that include the social science world, such as the health care system (Mertens, 2012; Modell, 2009). As previously mentioned, the important tenet that distinguishes CR from other paradigms is the position it holds about reality, in other words, its stratified ontological position (Schiller, 2016). CR illustrates that reality has multiple layers (Figure 2:1) and this means the reality is much more than what we can observe. These three stratified layers of reality are classified into three domains: the 'real', the 'actual' and the 'empirical'.

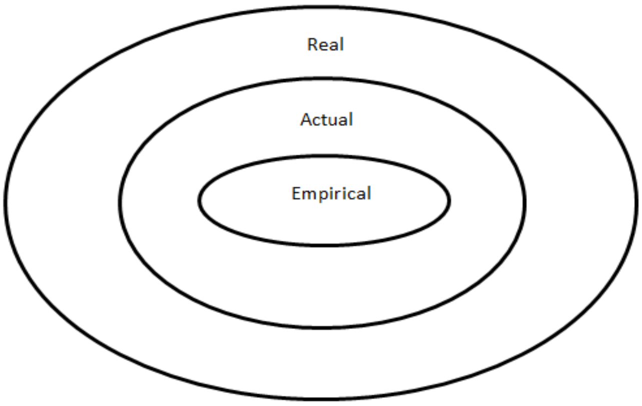


Figure 2:1 – A graphical representation of the stratified ontology (Elder-Vass, 2004)

2:8:1 The 'real' domain

This layer of reality is independent of human thoughts, interpretations and awareness, which makes it credible to say *"mind independent"* (Modell, 2009, p.44). This layer consists of underlying objects, their structures and causal powers that can produce phenomena or events. These phenomena in the 'real' domain may not be visible or influence the 'actual' domain at any particular point in time. These powers of structure in the 'real' domain can be active and influential in the right combination, in the right context, at the right time. The term 'generative mechanism' was used by Bhaskar (1998) when he referred to causal powers or tendencies that can be activated to create events. Generative mechanisms are fundamental in CR philosophy, as they are perceived as factors that result in outcomes. These mechanisms and structures are referred to as ‘intransitive objects’, but are identifiable through investigation (Schiller, 2016). Events are generated as a result of interplay between the agency factors (individual factors of how people act, based on personal meanings, values, beliefs and attitudes), structural factors (the circumstances that influence agency, such as social norms, culture, environment, geography) and mechanisms. From a realist perspective, observable events happen as a result of unobservable and underlying mechanisms (Julnes et al., 1998). According to Wainwright (1997), the most important aim of the realist approach is to expose these hidden mechanisms that always work through people’s actions. Similarly, Bhaskar (2008) suggested that the objective of science is to create knowledge about those generative mechanisms and structures that jointly produce events.

2:8:2 The ‘actual’ domain

The ‘actual’ domain is considered a subset of the ‘real’ domain (Bhaskar, 1978). This domain can experience a portion of every event and phenomena occurring as a result of complex interaction of the generative mechanisms, regardless of the human experience or interpretation. The fact remains as constant, regardless of the human experience or interpretation of that event. As explained by Clark et al. (2008), these events that happen in the ‘actual’ domains result from complex interactions of structures and mechanisms in the ‘real’ domain. These events must travel through the ‘actual’ domain, before they can reach the empirical domain (Schiller, 2016).

2:8:3 The ‘empirical’ domain

This layer consists of human perceptions and experiences known to humans through research and theories, which are human constructs. Therefore, they are mind-dependent and are referred to as a transitive level of reality. Human perceptions and experiences of this domain are considered as fallible descriptions of the ‘real’ domain (Clark et al., 2008). The information gained by humans in the ‘empirical’ domain is through their direct or indirect experiences in relation to the ‘actual’ domain. This means the ‘empirical’ domain has a circumstantial relation to the ‘actual’ and ‘real’ domains and Bhaskar (1978) stated that this domain is a subset of the ‘actual’ domain.

Through his seminal work, Bhaskar has put forward a clear argument for the relevance of CR by distinguishing it from positivism and constructivism. An argument was made by Guba and Lincoln (1994) pointing out that the knower should take a value-free position, or an objective detachment, to know precisely how things work. By suggesting this, they were implying a necessary link between CR and positivism. However, Bhaskar (1998) made a direct critique of positivism as an "*epistemic fallacy*" (p.27), where it tries to diminish reality, limiting it only to the ways in which we know. The realist ontology considers the belief that the features that form the world around us are invisible (Wainwright, 1997). Similarly, Bhaskar criticised the constructivist's position, who views reality as a human construct that reduces the ontology to language, narrative and discourse (Fletcher, 2017; Williams et al., 2017). The term "*linguistic fallacy*" (p.172) was used by Bergin et al. (2008) to describe the constructivist's position, by showing allegiance to Bhaskar's views and highlighted the epistemological limitations of positivism and constructivism. Contrary to these polarised arguments, CR takes a middle ground, as explained by Clark et al. (2008), "*it does not reduce the world to unknowable chaos or a positivistic universal order, nor does it place objective truth value on the perspectives of human beings or remove the influence and importance of human perspectives,*" (p.68). Therefore, Bhaskar suggested a shared ontology and epistemology to natural and social science (Sayer, 2000). In other words, the emphasis on epistemology is shifted back to the ontology (Williams et al., 2017).

It is reasonable to say that precedence is set by other research paradigms where the ontological position will be followed by articulating its epistemological position. Furthermore, there is a consensus that the ontology of a philosophical position decides the epistemological position of a research study (Greener, 2011). However, as previously mentioned, CR diverges from the precedence or the expectations set by these paradigms and maintains that knowledge of reality is not reducible to epistemology (Fletcher, 2017). Additionally, Wainwright (1997) states that CR's epistemology endorses that the events do not necessarily reveal the mechanisms that cause these events. So this will certainly raise a reasonable question: how do we get to know these mechanisms? In order to provide an understanding, CR takes on a crucial task of constructing hypotheses or theories to account for these mechanisms, which subsequently become its methodology (Wainwright, 1997). These theories will become the crucial tools that assist researchers to arrive at a more comprehensive understanding of the mechanisms (Maxwell & Mittapalli, 2010; Modell, 2009).

Such theories are constructed using a form of inference known as abduction (see Chapter 3, Section 3:8:10), where the researchers make use of their own personal experiences and perception in this process to explain these mechanisms (Schiller, 2016) (see Chapter 3, Section 3:7:1:3). This allows a practitioner researcher (like myself) ample opportunity to integrate their evidence-based practice experience and contemporary subject knowledge into the research process to make the personal and aesthetic knowledge gained from practice experience worthwhile. Other research paradigms arguably negate the use of invaluable practitioner experience with the process, known as bracketing (Parahoo, 2006), which is explained as a cognitive process, recognising and holding in abeyance any perceived beliefs and opinions about the subject under study. CR acknowledges that these theories cannot actually confirm the conclusion that is drawn from them, hence they are not treated as a true image of reality (Danermark et al., 2002). Furthermore, this reiterates that CR treats the world as theory-laden and not theory-determined (Clark et al., 2008). As suggested by Bergin et al. (2008), this ontological-methodological link allows the integration of various research traditions, which can strengthen the argument of research within a critical realist point of view. The distinctive features of CR, such as its stratified ontology, causality and generative mechanisms, and the dimensions of knowledge, such as intransitive and transitive knowledge, will influence this study. Therefore, CR will be used as a philosophical framework for this study.

2:9 Relevance of CR in this study

There are two credible reasons for choosing CR, over other paradigms, as a philosophical position for this study. Firstly, CR’s capability to address the research questions, by constructing theories that account for generative mechanisms; secondly, CR’s ability to bring about changes. The following sections will explain these reasons in detail.

CR has the capability to address the research question. This study deals with SUI in care planning. Despite policies, reports and recommendations from previous studies, SUI in care planning remains rhetoric. In the past, both large-scale and small-scale studies have used a positivist or constructivist paradigm, with a ‘what works’ approach, as the basis of their interrogations. However, a realist approach to this issue can be made explicit using Sayer's (2000) account. He explained, "*What causes something has nothing to do with the number of times we have observed it happening. Explanation depends instead on identifying causal mechanisms and how they work and discovering if they have been activated and under what conditions*" (p.14). Extracting the causative mechanisms is a vital task to address this deep-rooted issue. Stickley's (2006) reference to Collier's work (Collier, 1998) in relation to SUI in a mental health context can clarify this point further. If we continue to accept, recognise and try to influence the existing structures of SUI, then this is a position that Stickley correlates with what is referred to by Collier (1998) as 'shallow realism'. According to Collier, shallow realism examines 'what is', without exploring 'what is behind what is'. Whereas, if we try to explore the structures that support 'what is', it can bring about changes and that is what is referred to by Collier as 'depth realism'. As Stickley (2006) has pointed out, in critical realism there is the possibility of finding latent powers that remain untapped, with analysis of causation being one of the features of CR and its stratified ontology that can accomplish this task.

The second reason for choosing CR is its ability to bring about change. Bhaskar himself has quoted that, "*If CR is to be 'serious', it must be applicable*" (Bhaskar, 2014, p.7). From a realist perspective, Stickley (2006) argues that SUI may be considered as a historic concept and it anticipates empowerment. Stickley explains that, when a worker empowers a service user, the power is retained and the worker maintains a dominant power position. Furthermore, he argues that regardless of its potential, the control of SUI remains in the hands of the service provider. Hence, he advocates an emancipatory approach, which means "*the potential for individuals to take power rather than to have it given*" (p.574). Hence, emancipatory approaches entail action, rather than involvement. Due to CR's potential for emancipation, Stickley argues that CR is the most appropriate approach for SUI in the mental health arena. This is because of its ability to offer a theoretical framework, which can make meaningful changes that are not simply tokenistic. Jones (2003) points out that the potential for emancipation was a consistent and paramount theme of Bhaskar's contribution. CR can bring changes by stimulating the causal mechanisms, and not by the traditional way of opposing power and authority (Stickley, 2006). According to Wiling (1998), identifying relevant mechanisms and challenging the dominant discourses inevitably instigates the work of CR.

The application of CR in this study, therefore, is promising. Schiller (2016) has pointed out the rationale given by Kontos et al. (2011) for choosing CR for their study pertaining to dementia care. They highlighted CR's unique focus on context, its ability to deal with complexity, to embed interventions in settings and its impact and sustainability. All these rationales are relevant to this study.

2:10 Critique of CR

Even though the merits of CR are promising, it also faces some criticism. Critics have stated that as a philosophical approach, CR has not made any advances in developing its own methodological approach (Oliver, 2012; Yeung, 1997). However, it can be argued that this is one of the advantages of CR, in comparison with other paradigms. Being less prescriptive, CR allows the researcher to be more autonomous in choosing a methodological approach. Angus and Clark (2012) have made an observation that in CR it is the role of a researcher to develop methodological approaches that are compatible with the situation, by selecting and adapting methods that are suitable for the realist enquiry. This means CR does not restrict researchers to adopting a research approach or a particular method; in fact, it offers a methodological choice, which explains one of its features, known as methodological eclecticism (Clark et al., 2008). A literature review was carried out by Schiller (2016) on 13 published nursing studies that have used CR as the paradigm. She found that six of these articles used solely qualitative methods and mixed methods approaches respectively, to address their research question. However, it was interesting to find out that none of these studies have employed a purely quantitative approach. This reiterates that CR anticipates the choice for its methodology should be based on the phenomena under study and according to the nature of the research question (Sayer, 2000). The following sections of this chapter are dedicated to explaining the research approach chosen by this study.

2:11 Choice of study design

Methodology is sometimes referred to as research design that deals with the method of inquiry in which relevant data can be collected (Hesse-Biber & Leavy, 2004). It is the task of the researcher to formulate unique methodological approaches that suit their area of investigation by choosing methods that are in line with the tenets of the CR, with the substantive focus on inquiry (Yeung, 1997). While realist methodology is method neutral, a qualitative approach was deemed most appropriate route for my study for the following reasons. Firstly, a qualitative approach is widely accepted and respected in all areas of social research (Robson, 2011), as it allows exploration of the participants' perspectives. The main concept referred to in this study is SUI and the primary aim of this study is to understand and articulate practices that can embed active SUI in ROCP in AIMHUs. This requires information from service users who have received care in this area, where recovery and experience of ROCP is unique. A qualitative approach embraces the uniqueness of participants and focuses on their experiences. It allows participants to put their responses in context.

Secondly, qualitative research is holistic in nature. According to Morse (2006), the most common use of qualitative inquiry is to gain understanding and insight into service users' experiences.

Thirdly, a qualitative approach provides flexibility. It is an emergent design that can evolve during the course of this study, based on the reflection on data (Polit & Beck, 2012). It can merge different data collection strategies; decide the number of participants required and the sampling techniques. This flexibility also provides an opportunity for the researcher to be intensively involved and to be the research instrument.

Finally, the iterative process of data collection and data analysis helps to determine when data collection is complete (data saturation). All these factors have contributed to the decision to follow a qualitative approach within this study.

However, the fundamental factor that determines a study design is the research question (Robson, 2011). The research questions for this study aim to address lack of SUI in ROCP, which is considered as a complex issue. As a result, it requires a considerable depth of understanding of how human agency and structures or contexts (individual, organisational and system level) interact with each other. This is the reason why a phenomenological design that is confined to describing lived experience was not adopted.

As a practitioner researcher, I was concerned about the possibility of the 'Hawthorn effect', where other practitioners might consciously modify their behaviour because they know they are being studied (Payne & Payne, 2004). This can potentially distort (usually unintentionally) the research findings. Some branches of ethnography, e.g. classical ethnography maintain a philosophical assumption that through reflexivity, the researcher could remove personal bias from any interpretation, which is at odds with tenets of CR (Holloway & Todres, 2010). Additionally, the research question indicates the need for a multi-layered inquiry, rather than focusing exclusively on the culture within the area of practice. As a result, an ethnographic design was considered as not suitable for my study.

Even though grounded theory is used in qualitative studies for theory building, Bryant and Charmaz (2006) claim, however, that it can take a positivist, objectivist direction. This means grounded theory may not always begin with an existing theory or preconceived ideas. The involvement of 'Experts by Experience' at the early stage of this study in formulating research questions and using their subject knowledge (see Section 2:3), alongside my own experience as a practitioner, does indicate that research cannot be conducted without the influence of prior knowledge. According to Robson (2011), realist researchers enter a project with some specific ideas and understanding about the mechanisms that are likely to be in action that lead to an outcome. Additionally, grounded theory has its roots in symbolic interactionism (Mead, 1934) and is more concerned with human action, social relationships, interaction and meanings. Hence, grounded theory has been criticised as dealing predominantly with micro-issues and neglecting the macro-issues of society and its structures (Holloway & Todres, 2010). As a result, the prospect of pursuing a grounded theory method was discounted.

In line with the realist framework, Realist Synthesis (RS) (see Chapter 3, Section 3:2) was chosen as the right design to answer the research question, as its principles are attuned with the philosophical orientation of this study. Pawson subscribes to Bhaskar's notion of stratified ontology and 'generative causation' but disagrees with the closed system view of reality. Pawson acknowledges reality as a complex open system that is natural, uncontrolled, complex, observational and embedded in multiple social systems. Pawson considers how realist evaluation differs in its understanding of complexity from what he understands to be Bhaskar's stance as a 'critical realist'. The current social world comprises more unexplained patterns and results than ever, which explains the complexity of the social world. As a result, Pawson recognises the need for a plausible explanation for meaningful change and a greater recognition of complexity in theory and policy. Pawson and Tilley (1997) argued that in order to be useful for decision makers, evaluations need to identify 'what works in which circumstances and for whom?', rather than merely, 'does it work?'

Pawson (2013) argues that Bhaskar's work fell short of getting an empirical grip on complexity and the fundamental reason for this is that Bhaskar, as a philosopher, had limited command of the conduct of empirical research. Concurrently, Pawson (2016) contends that Bhaskar's overview of critical realist agenda has limited capability in progressing the practice of empirical research. Pawson (2016) proposes that, if one has to conduct a meaningful empirical inquiry, then a modest, intelligent and sceptical commitment to the principles of objectivity and value neutrality must remain the goal. Hence, the main differences between the two realisms lie in their approaches to the relationship between social structures and human agency, and between facts and values. However, Porter (2015a) critiqued that the limitations Pawson ascribes to critical realism are, for the most part, unsubstantiated, and that its differences with realist evaluation are not as crucial as Pawson makes them out to be. I concur with Pawson and Tilley on the basis that programmes, especially in the health care system, are implemented in an open system, which has implications at various levels and cannot be investigated in silos.

2:12 Chapter summary

This chapter has presented the research question and the way in which SUI has informed the research questions. An overview of CR and its justification as the underpinning philosophical orientation for this study was provided, with my personal stance as a researcher described. The chapter culminates in arguing the case for a research design that is capable of answering the research questions and is congruent with CR. The next chapter will discuss how the research design, RS, was applied in this study.

Chapter-3: Methods

3:1 Introduction

This chapter presents the research design and methods used in this study. A realist methodology was applied using Realist Synthesis (RS), which will be described in detail, including a critical appraisal and my rationale for choosing it for my study. The chapter provides an overview of RS, followed by a detailed account of the application of the RS in three stages namely: Stage-1: theory gleaning; Stage-2: theory refinement; and Stage-3: theory consolidation (Figure 3:3). The theory gleaning stage explains how initial programme theories were formulated for the programme under study (SUI in ROCP). The theory refinement stage describes how initial programme theories were refined iteratively through a realist review of secondary data and tested using primary data from qualitative, semi-structured interviews. Methods used for primary and secondary data collection and their rationale; the approaches used to collect data; and finally, the process of data analysis, will be explained. I will also explain the participant recruitment and data-handling strategy employed during the primary data collection. The theory consolidation stage explains the consolidation of findings from previous stages, using stakeholder involvement, where refined programme theories were finely tuned using 'if-then' statements. Key ethical aspects relevant to this study will be addressed, along with how research rigour was maintained.

3:2 Realist Synthesis (RS)

The RS is a theory-driven, flexible, iterative review methodology to synthesise existing evidence using a realist approach to make sense of complex social interventions or programmes (Hewitt et al., 2013). Complex interventions in health include *"a number of separate elements which seem essential to the proper functioning of the intervention, although the active ingredient of the intervention that is effective is difficult to specify"* (Medical Research Council, 2000, p.1). RS aims to provide empirical explanation about the causal mechanisms that underlie an intervention and to explore how contextual factors may influence identified mechanisms in generating outcomes from an intervention or a programme (Pawson, 2006). The most fundamental realist claim is that *"Interventions are* *theories"* (Pawson et al., 2004, p.4). A programme is also referred to as an intervention in RS, that works on the premise that programmes constitute ideas and fundamental presumptions about the way in which an intervention is supposed to work (known as programme theories) (Wong et al., 2013). A realist programme theory is an empirical explanation that includes a description of context, mechanisms and outcomes (see Section 3:2:1 for details).

RS reflects the open system perspective of the realist, which focuses on uncovering the relationship between the interconnected structures, mechanisms and context (Jagosh, 2019; Greenhalgh et al., 2018). A context [C] is considered as a medium in which a mechanism works to produce an outcome. Jagosh (2019) has explained context as a condition that triggers or modifies the behaviour of a mechanism. The concept of 'mechanism' [M] explains the relationship between context and outcome and it is the mechanism that produces the outcomes [O]. Mechanisms inform what it is that makes a programme or intervention work. Resources are offered in the context [C] through a programme, which enhances a change in reasoning in people that alters their response or behaviour, which leads to an outcome [O] (Jagosh, 2019; Dalkin et al., 2015). Therefore, the efficacy of a programme is determined by the context when a programme is introduced into an open system and Pawson et al. (2004) have highlighted four layers of contextual elements that influence the efficacy of a programme. They are: individuals, interpersonal relations, institution and infrastructure (Figure 3:1). Pawson et al. (2004) have explained these areas as follows:

Individual: This denotes the capacities and actions of actors and key stakeholders of the programme (micro or individual/unit level).

Inter-personal relations: This entails the working of individuals and teams within a system and the cultural norms (micro and meso level).

Institution: This element enables us to look into the culture, ethos and charter of an institution (meso or organisational level).

Infrastructure: This looks at the wider infrastructure and welfare system, which includes policy implications, political support and funding resources to support the programme (macro or system level).

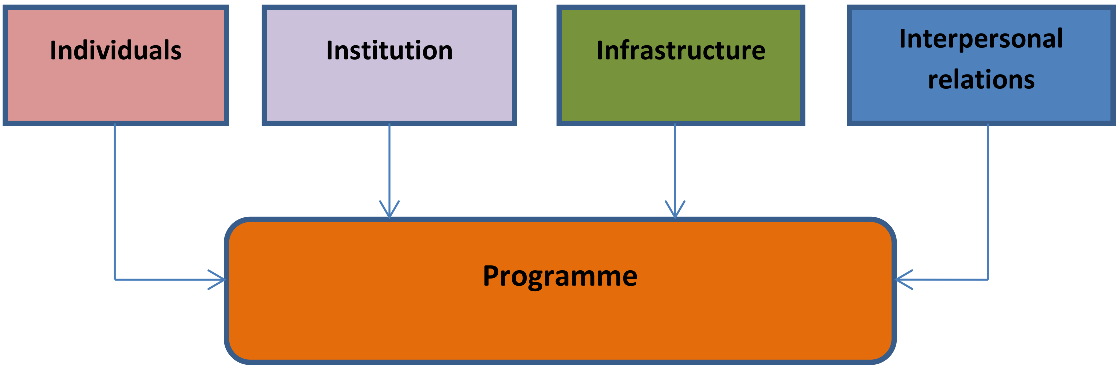


Figure 3:1 – Contextual elements for programme (Pawson et al., 2004)

Programmes alone are not capable of producing an outcome; instead, they rely on multiple, hidden mechanisms (but are inferred from the observable data), which act as causal forces to bring about an outcome. In realist terms, it is referred to as generative causation. Realist methodology is tailored to unpack these hidden mechanisms of how complex programmes work (Pawson et al., 2004). Therefore, the main role of a realist researcher is to identify the main mechanisms that make a programme work, using CMO configurations. These will generate a proposition that explains: "*in 'X' context, 'Y' mechanism generates 'Z' outcome*" (Wong et al., 2013, p.13). RS produces evidence-informed theories about the interactions between intervention mechanisms and their implementation contexts from a realist point of view, using context-mechanism-outcome (CMO) configurations, which are fundamental to the realist position (Williams et al., 2017). According to Jagosh et al. (2012), "*context-mechanism-outcome (CMO) configuration is a heuristic used to generate causative explanations pertaining to the data"* (p.316). This is illustrated in the diagram below (Figure 3:2). The CMO configurations are developed in the form of propositions, which are tested and refined into programme theories (see Section 3:2:1). The explanation of the processes that describe how an intervention leads to a particular outcome is formulated as a middle-range theory (MRT). MRT is a level of theory abstraction that is close enough to observed data, in the form of propositions that permit empirical testing (Pawson & Tilley, 1997). It is noteworthy that a CMO configuration in realist research represents a type of MRT (Groot et al., 2017). The programme that I refer to in this study is SUI in ROCP.

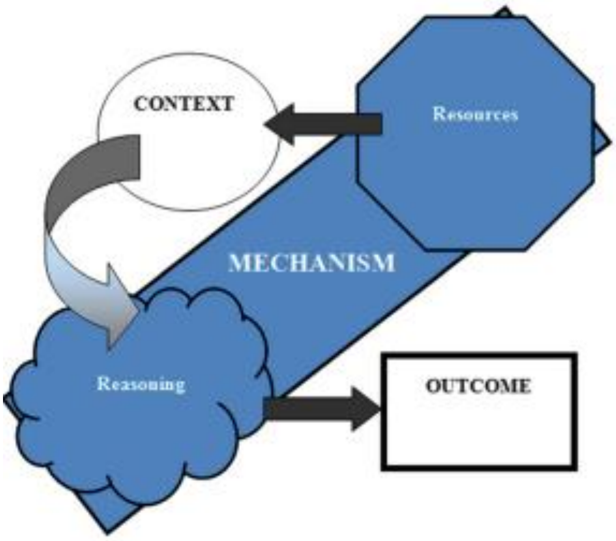


Figure 3:2 – Illustration of context-mechanism-outcome configuration (Source: Dalkin et al., 2015)

3:2:1 Programme theories

Complex interventions have long implementation chains and events (or decision-making points) that are susceptible to failures and misinterpretations. The realist approach is concerned with the development and refinement of theory in order to provide plausible explanation. As part of explanation-building, the first step of a realist researcher in identifying the programme theory or theories (theory explication) is to map out potential blockages and contentions that restrain programmes from producing desirable outcomes (see Section 3:7:2). These are explicated through propositions using CMO configurations. It is important to note that methods used for developing these propositions in realist research are varied and are often under-reported (Shearn et al., 2017). Propositions are also referred to as hypotheses, initial rough programme theories or provisional programme theories. Here onwards, I will use the term 'initial programme theories' (IPTs) throughout this study, as it resonates their nascent nature. (The formulation of IPTs is explained in, Section 3:7:3). The IPTs are refined throughout the review process by interrogating existing evidence from a range of sources (see Section 3:8).

3:3 RS or Realist Evaluation (RE)?

Realist research focuses on generative understanding of causality and looks to explain how and why the social world works, which is the fundamental principle of CR (Bhaskar, 1975). RS and RE are specific forms of realist research and use the CMO configuration to explain causality (Pawson & Tilley, 1997). They are underpinned by a principle that policies, programmes, initiatives, roles and resources are designed to solve a social problem, but they depend on human volition and a variety of other factors to propel them. However, RE uses mainly primary data (both qualitative and quantitative) usually using a mixed or multi-methods approach to explain a programme or programme theory. However, RS relies mainly on secondary data and the views and assumptions of stakeholders about how a programme is anticipated to work (The RAMESES II Project, 2017). It is recognised that realist researchers combine both these approaches where programme theories, developed using the RS, are implemented into practice and then use RE to assess success (The RAMESES II Project, 2017). In this study, the programme theories on SUI in ROCP are articulated predominantly based on secondary data. Subsequently, I am using primary data (from research participants) in conjunction with secondary data, for the purpose of theory testing and refinement. I am not ‘recasting’ the tentative programme theories in an ‘open system’ to evaluate the changes. This confirms that this study adheres to the principles of RS. In the following sections I will explain the rationale and the application of the RS in this study.

3:4 Rationale for RS in this study

There are a number of reasons for using RS in my study and these are explained under four headings in the following sections.

3:4:1 RS has an explanatory, rather than judgemental, focus

With respect to my study, it is clear that reports and studies have historically used an analytical lens, to view the application of SUI in practice. The focus of previous works was on finding a pragmatic solution to change the rhetorical state of SUI in ROCP to a reality, developing a theoretical ‘what works’ approach to address this issue. However, there is no clear evidence to suggest that these efforts have made any real impact to change the rhetoric to reality. This highlights a need to take a different approach to this issue, using a realist lens to understand "*what works for whom, in what circumstances, in what respects and how*" (Pawson, 2006, p.25) to address this deep-rooted issue. As a result, it endeavours to find practices that are sustainable and feasible to embed the application of this multi-dimensional concept of SUI in ROCP at the area of practice. This logic of inquiry provides generative understanding of causality. It helps to develop a more sophisticated understanding of how an intervention is thought to work using mechanisms of action (Pawson & Tilley, 1997). In this way, a realist approach may help to highlight the issues that SUI in ROCP has faced historically, with respect to its largely rhetorical nature.

3:4:2 RS has the ability to make sense of complex interventions

SUI is a multifaceted concept and its application is a complex process. This gets further complicated as service users who seek secondary mental health care have complex mental health care needs and the system in which care is delivered is also a complex system. Richardson and Allegrante (2000) have pointed out that health-related objectives in the 21st century require multi-sectoral, multidisciplinary and multi-component approaches. Additionally, health care teams are complex and function within a complex, open system, with professionals representing various disciplines (Greenhalgh & Papoutsi, 2018; Cunningham et al., 2018). RS acknowledges this complexity and is compatible with the complexities of the modern health care system (Pawson et al., 2004). Furthermore, in addition to the merits of an underlying idea of an intervention, RS is based on the premise that truth is multi-layered and therefore it looks at the macro, meso and micro levels of a system in which an intervention is delivered. RS tries to explain the mechanisms of complex programmes. This will help to understand the way in which SUI in ROCP can be facilitated within the context of this study.

3:4:3 RS can accommodate context-specific approach

It is acknowledged that quality improvement approaches have traditionally concentrated on the efficacy of the intervention and often paid less consideration to the context (Pfadenhauer et al., 2017; McDonald, 2013). However, there is a growing recognition of the significance of context in health improvement efforts (Goodman et al., 2017). A significant number of studies (Grundy et al., 2016; Brooks et al., 2015) have been conducted with a broader approach towards secondary care and are not context-specific to acute inpatient settings. RS acknowledges that interventions are not universally successful and "*nothing works everywhere or for everyone*" (RAMESES II project, 2017, p.1). In other words, RS steers away from the failed 'one size fits all' approach (Pawson et al., 2004) and recognises that the mechanism through which an intervention works will only function if the conditions are right (Pawson & Tilley, 1997). A realist investigation will help to uncover the factors in a setting that affect whether and how the programme works. This will undoubtedly help to answer the research questions of this study.

3:4:4 Ability of the RS to inform policy

SUI is a policy-driven concept and it is one of the principles of mental health policy (Storm & Edwards, 2013). However, tension exists between what is required by policy and what is delivered in practice (Hui & Stickley, 2007). Considering the rhetoric surrounding this concept, policy makers would prefer to know choices for delivering a particular service and to understand the reason for success or failure of policies. This is where RS has the ability to offer what works, for whom, in what circumstances, and its ability to identify the relationship between context, mechanisms and outcome. The RS is likely to contribute 'sense making' to policy makers and practitioners, to understand and interpret the situations they meet and the intervention they deploy. It therefore aims to produce a longer-term and more sustained shift in the way policy makers think (Pawson et al., 2004).

Additionally, RS has the advantage of using mixed methods, as it uses different forms of evidence from qualitative and quantitative studies (Greenhalgh, 2014) and RS stimulates flexible thinking, which leads to pragmatic conclusions, rather than alternative approaches (Rycroft-Malone et al., 2012). Therefore, it is evident that RS is an appropriate method to take this study forward.

3:5 Critique of realist methods

RS has raised its profile in the last decade and studies based on realist methods have been increasingly commissioned by policy makers in the health care sector to inform complex health interventions (Cunningham et al., 2020). Rose (2014) has suggested that realist studies are very descriptive and are considered as unique, which negates the opportunity for generalisability. I would argue that the explanatory nature of realist studies is required in order to make sense of a complex programmes by providing a comprehensive description (see Section 3:4:2) and it is also important to recognise that programmes are not universally successful (see Section 3:4:3).

Cole (1999) has reported that getting academic credibility was a huge stumbling block for realist research. This was mainly due to peer pressure, dissuading academic researchers from undertaking realist inquiries. Subsequently, it attracted some critique from experts within the realist domain. A literature review of studies that used the RE methodology was carried out by Marchal et al. (2012). Their aim was to examine the application of the concepts of RE in health systems research and to examine the methodological problems encountered in practice. They reported variation in the application of the philosophical concepts, the use of terminology and the scope of application in the research process. Additionally, lack of guidance on methodology continues to be a problem, despite the existence of methodological guidance provided by Pawson (1996). Marchal et al. (2012) recommended that more clarity is required concerning the definitions of mechanisms and context and how the configuration of context, mechanism and intervention can be explained and evaluated. However, I believe the quality standards (Appendices 3, 4, 5 and 6) as part of the RAMESES project (Wong et al., 2013) including RAMESES online training materials, provide clear guidance to conduct future realist studies.

Another criticism has been made by Porter (2015b), who argues that Pawson and Tilley's realist approach is inconsistent and self-contradictory. Porter proposes the need to distinguish between agency factors and social mechanisms. Furthermore, Porter (2015a) claims that, in their attempt to distinguish their realist approach from its rival perspectives, Pawson and Tilley have engaged in the condemnation of the philosophical position (CR) from which the realist approach was originally developed. He also argued against Pawson's interpretation about natural and social sciences and his charges on CR's "*totalizing ontology, its arrogant epistemology and its naive methodology*" (p.65) and urged realist researchers to make structure and agency explicit. Additionally, Porter (2015b) suggests revising the CMO configuration that can show the generation and testing of hypotheses during an evaluative process. By putting forward this suggestion, Porter seems to contradict himself from his earlier argument about realist approach, when he stated that it is an inconsistent and self-contradictory framework.

Despite this, the flexible and iterative nature of RS does, however, come with a disadvantage that it is not reproducible like traditional systematic reviews, where the key interest is to make the review as independent of the reviewer as possible. Byng et al. (2005) reported challenges at times in determining whether or not something was a context or a mechanism and this can be further complicated when some outcomes turn into contexts for other mechanisms. Additionally, Pawson et al. (2004) acknowledge the challenging nature of the RS, as it requires sustained thinking, judgement and imagination to articulate programme theories, and then design empirical testing. Additionally, it requires substantial skills and resources to tease out CMO configuration. Another concern often voiced about realist methods in general is that they are hard to undertake and more time-consuming than other approaches (Wong, 2018). I concur with Hewitt et al. (2013) that studies using the realist approach are not to be undertaken lightly, however, they provide an insightful and innovative perspective to enlighten our understanding of the complex programme under study.

3:6 Application of RS

Pawson et al. (2004) proposed four practical steps for the application of RS. They are: defining the scope of the review (which involves: identifying the question; clarifying the purpose of the review; finding and articulating the programme theories); searching for and appraising the evidence (search stage); extracting and synthesising findings; and drawing conclusions and making recommendations.

Pawson does, however, indicate that RS is not confined to one approach (Pawson, 2006). Furthermore, Hewitt et al. (2013) reported the challenges to follow the steps as exactly as recommended by Pawson et al. (2004) and they have taken a bespoke approach to suit the needs and resources for their realist study. Added to this, the choice of methods and approaches depends on the philosophical epistemology that underpins a study and by considering the practicalities, such as constraints on available time, and ethical aspects (Kumar, 2014). RS is ‘method neutral’ (Pawson, 2006), which means it does not impose or prescribe the use of a particular method in a study. As discussed in the previous chapter, it is the task of the researcher to formulate unique methodological approaches that suit their area of investigation by choosing methods that are in line with realist principles to answer the research questions. As a result, the application of the RS in my study was applied in three stages (theory gleaning, theory refinement and theory consolidation) which are adapted from the methodological guidance provided by Pawson (1996) originally for the purpose of conducting realist interviews (Figure 3:3). The following sections will explain the methods applied in each of the stages of the RS pertaining to this study.

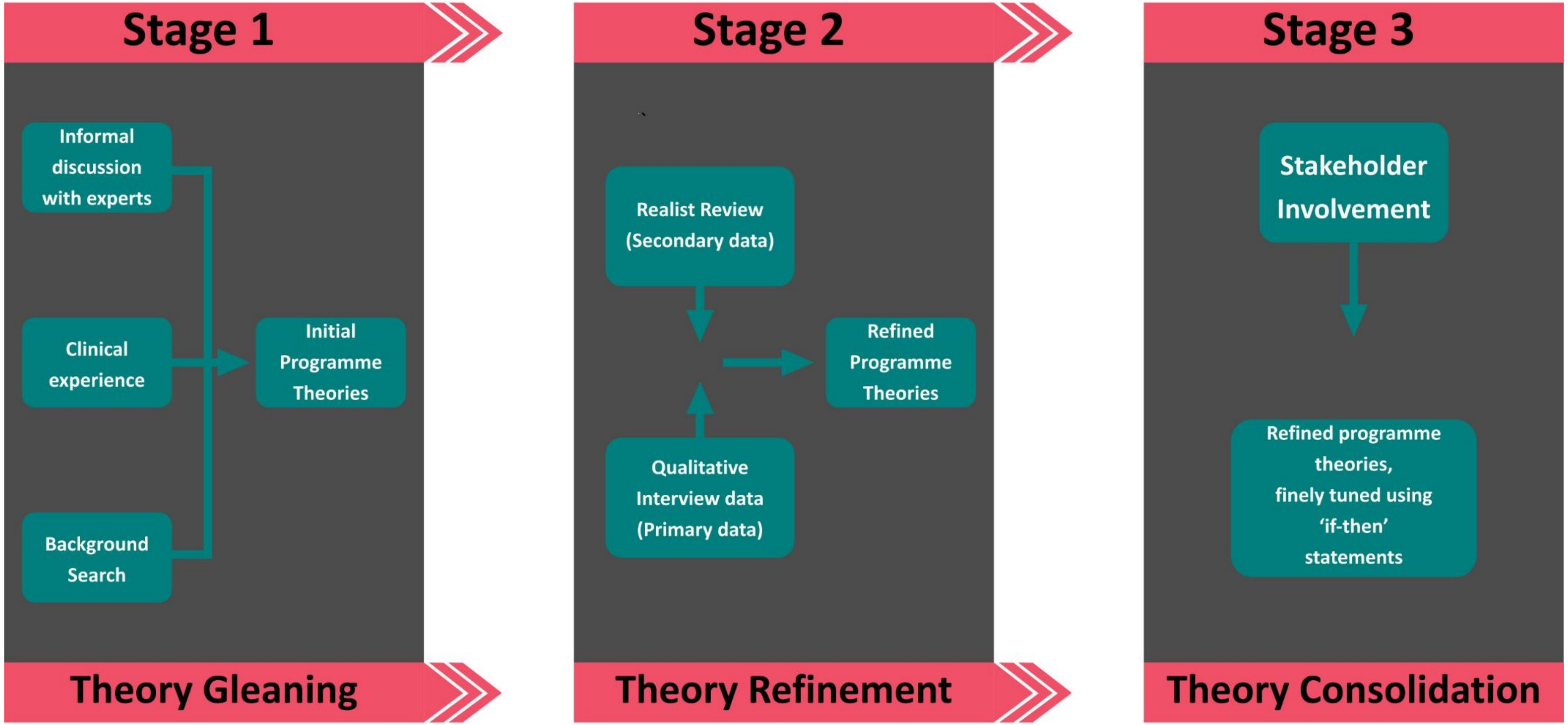


Figure 3:3 – Application of the RS in three stages

3:7 Stage-1: Theory gleaning

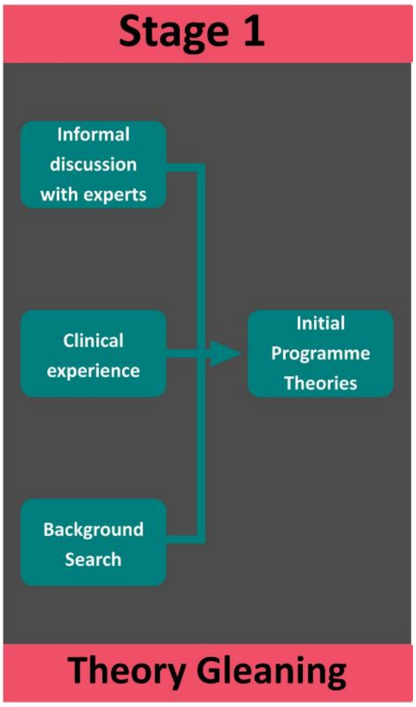


Figure 3:4 – Diagrammatic representation of Stage-1: Theory gleaning

3:7:1 Identifying and developing initial programme theories

The aim of this stage was to identify and develop IPTs, as they serve as the explanatory component in the RS (Pawson & Tilley, 1997). Substantive theories (theories that exist within a particular discipline) (Wong et al., 2013) are used to design programmes, or may be used to inform the development of IPTs, as a result of their ability to help understand interventions (Shearn et al., 2017). However, during my early interrogation of the literature, I did not come across any substantive theory during the development of IPTs. Similarly, a realist review undertaken by Jagosh et al. (2014) has reported difficulty in identifying substantive theories and they have made suggestions to customise RS to the area under study. Hence, I have customised my study for the purpose of identifying and developing IPTs. It involved: 1) Background search of the literature; 2) Informal discussion with experts; and 3) Clinical experience (Figure 3:4).

3:7:1:1 Background search of the literature

As a theory-driven approach, evidence from the literature was fundamental in formulating IPTs. The area of the programme covered in the body of evidence is vast, which proved challenging in terms of giving a summative and conclusive account of programme theories that cover all these areas. Additionally, the RS uses all parts of the primary study articles, grey literature, background documents and researcher interpretation (Jagosh, 2019). Pawson et al. (2004) recognise this extraordinary complexity, which can lead to theoretical limitations such as:

1) The territory that can be covered.
2) The nature and quality of the information.
3) What a reviewer can expect to deliver as recommendations following the RS.

Pawson et al. (2004) indicate that a comprehensive review about a programme may not be feasible. It was important here to concentrate on gathering evidence that was manageable to build programme theories pertaining to SUI. It is key to make sense of the literature from a realist perspective and build a comprehensive understanding of the interplay between various structural and agency factors that produce various mechanisms within a complex, open system and to ensure integrity of the programme theory. The central aspect of RS is aimed at explaining how a programme is supposed (or not supposed) to work (causal process). For this reason, a background search of literature was carried out at the outset of this study using a realist lens.

According to Pawson et al. (2004), a background search is the first step a researcher should undertake in order to "*get a feel for the literature, what is there, what form it takes, where it seems to be located, how much there is, etc.*" (p.19). This means a background search has the advantage in terms of narrating the architecture of a programme under study (J. Jagosh, personal communication, June 29, 2021) and it is seen as a precursor to a full realist review for Stage-2 and subsequent generative causal analysis using realist principles. Hence the background search for this study provided an opportunity to identify the underpinning assumptions; ideas and causal impact of SUI in ROCP; to pick out key points that may or may not be impacting on outcomes; and to imagine a broad range of CMO configurations (using IPTs, see Section 3:7:3). It is important to note that background searches distinguish themselves from a realist review, as they are not expected to evidence theories about the generative causal impact of the programme, and therefore this process does not anticipate the need for an audit trail (Pawson et al., 2004).

Articles were found, drawing on the references used to furnish the research proposal, searching electronic databases and through citation tracking of these papers. Additionally, I informally browsed academic literature (peer-reviewed articles, dissertations, doctoral theses) and grey literature (e.g. government reports, documents published by NHS England, King's Fund and CQC) in search of potentially relevant articles in relevant databases (JSTOR, ProQuest, ScienceDirect, ResearchGate and Web of Knowledge) and general search engines (e.g. Google Scholar). I meticulously reviewed and screened the search results, and articles that had the potential to contribute towards theory building were highlighted and retrieved for further review.

The over-abundance of empirical evidence and grey literature, along with lack of significant difference in outcome from previous studies, poses a huge challenge to identify areas that require further exploration. A complexity checklist set out under the acronym VICTORE (Volition, Implementation, Contexts, Time, Outcome, Rivalry and Emergence) was used as a tool to guide the development of IPTs. The VICTORE complexity checklist (Box 3:1) was recommended by Pawson (2013) to map out key aspects of complexity within a programme. VICTORE complexity checklist was used in previous realist studies (Cooper et al., 2020) as a guide to formulate IPTs. As shown in Box 3.1, some items of the checklist were helpful to identify areas for further exploration during background search; to go beyond the multi-layered level and multicomponent that account for interactions between programme elements (context, mechanism, outcome) related to SUI in ROCP during the acute inpatient pathway. Additionally, the checklist has informed and helped to guide my discussion with the experts.

Volition	What choices do service users have to make to achieve the ambitions of the programme? How does decision making at various levels throughout the programme impact on implementation, engagement and programme outcomes? What are the factors (external and internal) that influence decision making? How do stakeholders feel about the programme? *[This has helped to develop IPT around various decision-making points (admission, treatment decisions, endorsing care plans and discharge practices) within the acute care pathway. This has helped in the development of IPT-1. IPT-3 & IPT-5].*
Implementation	Map the implementation chains of the programme. Maps might begin to chart: flows of resources; chains of responsibility; reception and transmission points for service users, etc. Have programmes been implemented with high fidelity to the programme protocol? How do changes or adaptations, such as changing those delivering the programme, have an impact on programme outcomes? What are the contextual or broader socio-cultural factors that impact on programme fidelity? *[This was helpful to focus on transition points (admission and discharge practice) and the implications of resources and the way it affects the actions of professionals and organisation. Hence, this has helped in the development of IPT-1 & IPT-5.].*

Context	Map the pre-existing context in which the programme is embedded. Contexts vary from micro to macro, so the map might include: How does the programme fit with national/local/institutional policy? How does the programme fit within current ethos of recovery-oriented care/practice? How are the recovery needs of service users considered within the programme? What impact do these contextual factors have on uptake, engagement, implementation, and/or programme outcomes? *[This has helped to look at the implication of policies and the fidelity of the programme in relation to the policies in mental health that advocate for recovery-oriented practices. This has helped in the development of IPT-1 & IPT-5.]*
Time	What has happened previously will shape what happens next. Temporal mapping may include previous experience of service users and stakeholders, the success and failures of previous attempts, of whatever kind, to address the given policy objective. Do programmes differ in duration and dose? What are the factors that impact on programme timing (timely access to resources, workload, professionals' availability, etc.)? *[This point led me to focus on issues that constrain timely access to AIMHUs, impact of competing demands on nurses and task-oriented approach to ROCP. Hence this has contributed in the development of IPT-1, IPT-2 & IPT-5.]*
Outcomes	What were the tangible outcomes of the programme, both positive and negative? Planned and unplanned? Were any changes in behaviour or attitudes observed (intermediate outcomes)? What happens to programme outcomes over time/in replication/at scale? *[This factor has enabled me to think about the outcomes from the given context [C] within each of the IPTs.]*
Rivalry	How does previous experience impact on attitudes or behaviours during implementation? Is there conflict between programme messages and the lived experience of those involved in the programme? How are conflicts resolved within the programme? What impact does this have on the programme?
Emergence	How do changes in policy or governance impact on the programme? Are programmes responsive to change? How are emergent outcomes captured and accounted for in evaluation?

Box 3:1 – VICTORE complexity checklist (Adapted from Pawson (2013))

I also drew upon a concept analysis approach (Walker & Avant, 2005) to organise my search and thinking around the area. This was a novel approach, as guidance on theory gleaning using background search is currently limited. Concept analysis served as a framework to guide and organise my thinking in formulating CMO configurations. For example, antecedents from the concept analysis have guided my thinking around the possible contextual factors, whereas the factors associated with consequences have helped me to conjecture possible outcomes. I also reviewed a concept analysis that was conducted within the participation continuum, which includes a concept analysis on SUI in mental health conducted by Millar et al. (2016). This approach was undertaken in conjunction with some elements of the VICTORE complexity checklist (Box 3:2).

VICTORE checklist	**Antecedents (building a picture of the Context)**	**Attributes (speculating possible Mechanisms)**	**Consequences (articulating possible Outcomes)**
Volition: What choices do service users have to make to achieve the ambitions of the programme? What are the factors (external and internal) that influence decision making?	What is the '**vision and commitment**' about SUI as part of the admission process? *[Does the current focus of care promote individualised, care? [personal recovery or clinical/service recovery?]*	**Not applied**	Has this '**improved quality of care**' within AIMHUs?
Implementation: What are the contextual or broader socio-cultural factors that impact on programme fidelity?	Does the programme reflect a '**shared governance**'? *[Do the current bed capacities in AIMHUs have any bearing on programme fidelity?]*	**Not applied**	**Not applied**
Context: How does the programme fit within current ethos of recovery-oriented care/practice?	[What benefit does this programme offer from service user's perspective?]	Are the choices for admission based on a **person-centred approach**? *[What is the attitude and behaviour of professionals to this programme?]*	Has this programme helped with '**improved health outcomes**' for service users coming to AIMHUs?
Time: What has happened previously will shape what happens next.	What is the '**organisational attitude and behaviour**' towards the programme? *[What happens at the first point of entry into the acute care pathway i.e. admission?]*	**Not applied**	Has this helped to '**increase satisfaction with health care'**?

Box 3:2 – Adapted VICTORE complexity checklist along with the elements of concept analysis

3:7:1:2 Informal discussion with the experts

Informal subject-related discussions were facilitated with key informants, who were fellow mental health clinicians and stakeholders interested in this study. Stakeholders have been defined by Deverka et al. (2012) as: "*individuals, organizations or communities that have a direct interest in the process and outcomes of a project, research or policy endeavour*" (p.5). The key informants approached had specialist knowledge of, or were closely acquainted with, AIMHUs and were best placed to provide advice, feedback and diverse perspectives relating directly to the practice area. I engaged in discussions with five key informants: a consultant psychiatrist; clinical psychologist; senior occupational therapist; inpatient nurse; and a carer representative who also had lived experience of mental health problems. All clinicians shared information about the constraints of involving service users in ROCP due to their mental state at the time of admission to AIMHUs, which were attributed mainly to delays in finding inpatient beds. They also pointed out pressure on them to accelerate service users' flow through the system and a focus on discharge from AIMHUs. The carer representative provided an insight into the ongoing challenges they encounter in managing service users at home, due to the delay in accessing inpatient beds; the need for timely access to inpatient beds to avoid mental health crises; and the impact of unplanned discharges without consulting carers and adequately preparing service users for transition to community. During my conversation with key informants, the VICTORE complexity checklist helped me to locate human actions in generating outcomes to embed SUI in ROCP.

One of their suggestions was to involve literature on recovery from the early stages of this study, as it is a topical point of discussion in mental health and has aided my initial identification of relevant papers to draw on. Key informants' framing of the issues related to SUI in ROCP, along with possible solutions, helped to develop some "*hunches*", also known as "*educated conjecture*" (Wong et al., 2013, p.14) about the operationalisation of SUI in ROCP. Subsequently, these conversations enabled a focus on some decision points in the acute inpatient pathway that required further interrogation and widened contextual insight to include broader issues affecting SUI in ROCP at various levels (macro, meso and micro) within the acute care pathway.

3:7:1:3 Clinical experience

The IPTs may be based on previous research, knowledge, experience and the expectations of the programme designers about how the programme should work (Pawson, 2006). My clinical knowledge, gained through multiple sources and experience as a practitioner, played a substantial role in developing the IPTs. My 'insider' knowledge as a practitioner researcher (see Section 3:14), along with the use of the VICTORE complexity checklist, helped me to identify, recognise and make sense of various decision points and contextual elements referred by key informants. Additionally, my clinical experience helped me to locate barriers to SUI in ROCP during service users' journeys along the acute inpatient care pathway. Furthermore, my clinical experience greatly assisted the abductive reasoning process applied to develop IPTs, by using the CMO configuration as a framework. Abductive reasoning is a natural and instinctive explanatory process, a series of hunch-driven, pragmatic, educated guesses (Jagosh, 2020). It is: "*the point where novelty, innovation and creativity enter the scientific method*" (Mingers, 2014, p.53), which will be discussed later in this chapter (see Section 3:8:8 for details).

3:7:2 Developing initial programme theories

My customised approach to develop IPTs helped to identify and categorise broader issues; inspect the integrity of the implementation chain of SUI in ROCP during the acute care pathway; and examine what is required for its success, the barriers and the current contentions that marginalise SUI in ROCP. With the help of the VICTORE complexity checklist, four programme theories were initially located that have implications for various levels of decision-making points within the acute care pathway. It encompasses the interactions and interventions of key structural and agency factors during a service users' journey through an acute care pathway. These were:

IPT-1: The programme theory on 'Provider-controlled care transition' (admission to AIMHU) refers to the limitations to service users' active involvement in ROCP, because of the current approach in the use of AIMHUs in providing mental health care.

IPT-2: The programme theory on 'Care plan as a recovery tool?' addresses the issues and limitations to SUI in recovery-oriented care-plan formulation caused by infrastructural and organisational barriers.

IPT-3: 'Ward rounds as a non-inclusive arena for shared decision making'. Ward rounds are multidisciplinary meetings that provide opportunity for shared decision making about treatment. This programme theory examines the conditions that inhibit opportunity for shared decision making that give rise to undesirable outcomes.

IPT-4 (later IPT-5): 'Provider-controlled care transition from AIMHUs' (discharge practice) is identified as a programme theory pertaining to the limitations of SUI in ROCP resulting from current practice in preparing service users for transition into the community.

During the theory refinement stage (Stage-2), a fifth initial programme theory was identified around peer support worker intervention. Peer support workers (PSWs) are individuals with the knowledge of the mental health system and personal experience of mental illness. In contemporary mental health practice, the PSW is regarded as a key player in service users' recovery. This programme theory will examine the factors that influence PSW intervention in service users' recovery.

Figure 3:5 provides a diagrammatic representation of the acute care pathway and the locations of all five programme theories are highlighted within the acute care pathway.

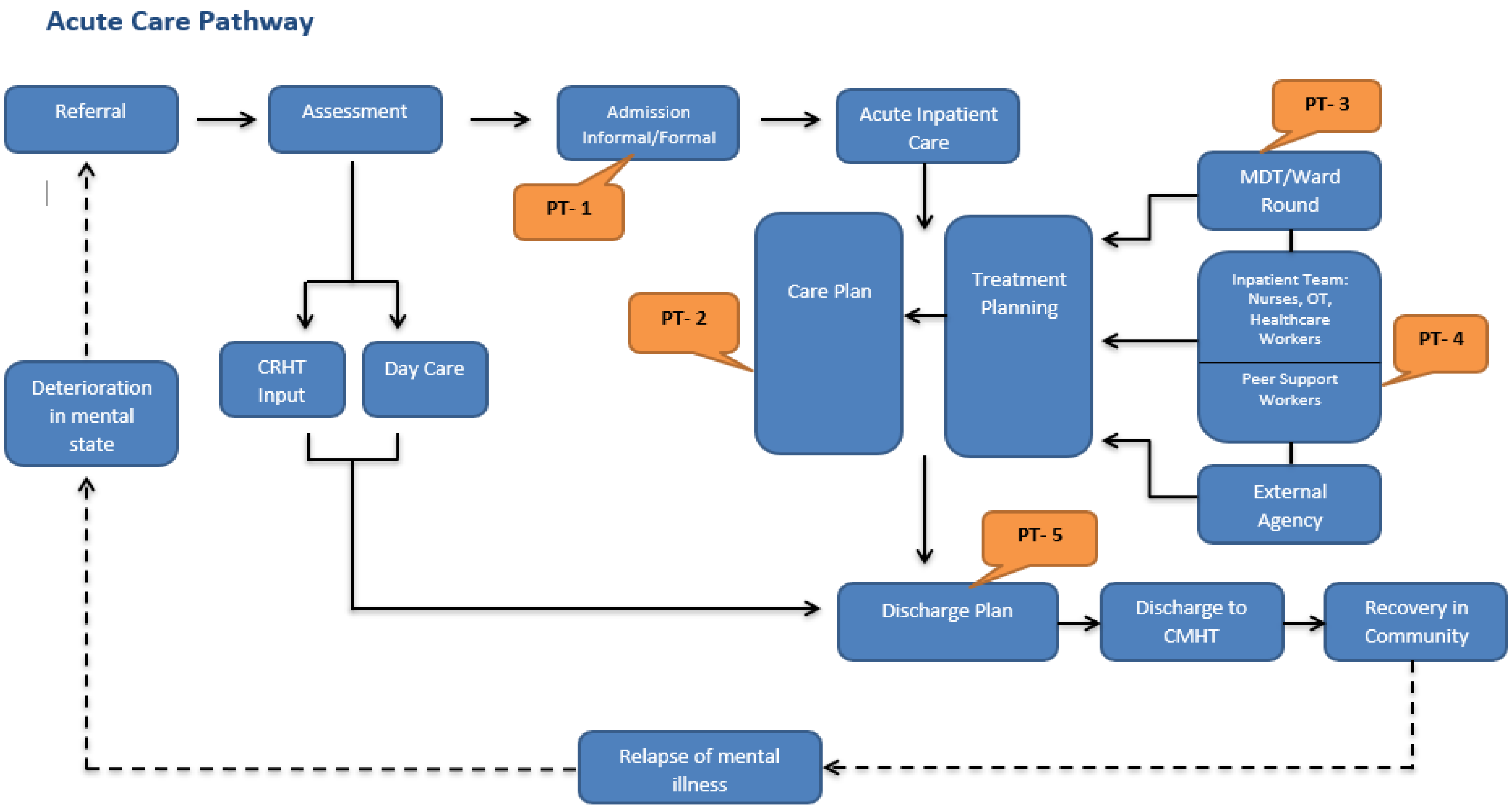


Figure 3:5 – Programme theories highlighted on acute care pathway (adapted from DoH [2013], p.3)

3:7:3 Articulating initial programme theories

The preliminary task of a realist researcher is to find and align the "*nugget of information*" (Pawson et al., 2004, p.23) from different sources against various elements of programme theory, to illustrate how a particular mechanism can produce a particular outcome in a particular context. As aforementioned, I undertook the RS with the intention to understand how SUI is supposed to work and subsequently uncover the mechanisms that create desirable or undesirable outcomes. The application of abductive reasoning was used to align and explain the link between context (C), mechanism (M) and outcomes (O) (see Section 3:2) of respective programme theories. Using the abductive inference, initial findings from the background search were hypothetically attached under the respective context, mechanism and outcome of the CMO configuration. This led to the formulation of five IPTs (Table 3:1) enabling me to focus on collating evidence in the next stage of the RS. Furthermore, it has laid the foundation for a realist literature review, as proposed by Pawson et al. (2004).

Initial Programme Theory-1 (IPT-1)	The current focus of care on AIMHUs challenges the overt application of ROP [C] as the professionals rely on clinical recovery as a means to meet organisational demand over service users' needs [M]. This practice contributes to the current non-therapeutic nature of the AIMHUs, with increased numbers of compulsory admissions and negative service user experience [O].
Initial Programme Theory- 2 (IPT-2)	If key workers' practice is "*driven more by the needs of the organisation than the patient*" or "*encumbered by institutional demands*" [C] as a result of unfavourable conditional factors or mechanisms exerted by other structural factors (e.g. audits), then it influences key workers to adopt either a task-oriented approach to ensure institutional efficiency than to satisfy the health-care needs of their patients [M] or may lead to intentional avoidance of therapeutic interaction [M], which may result in key workers developing

	care plans in silos and leaving active service users' involvement in care planning at a tokenistic level [O].
Initial Programme Theory-3 (IPT-3)	Active SUI in ROCP is experienced and promoted [O] when SDM on treatment is based on service user views and feedback [M] during care-planning meetings that take a synergic approach [C]. Ward rounds provide limited scope for the application of SDM during care planning [C]. Service users are less prepared with information regarding the topic of discussion for the meeting, their role and expectations of the meeting; at the same time, they are expected to participate in making sensitive decisions about their care with professionals with whom they have limited acquaintance [M]. This situation leads to service users feeling intimidated and unable to take part in the decision-making process [O].
Initial Programme Theory-4 (IPT-4)	Hiring PSWs to work as part of MDT in AIMHU to deliver peer support for service users and for training in-service staff [C] can promote ROP [O] as it instils hope, reduces stigma and complements interventions provided by professionals towards a user-focused direction [M].
Initial Programme Theory-5 (IPT-5)	The current discharge-planning process and interventions on AIMHUs are based on clinical recovery and service-defined recovery [M] that are inclined to meet organisational needs over service users' needs [C]. This contradicts the value of recovery principles, leading to disempowerment, service user dissatisfaction and failed discharge [O].

Table 3:1 – Initial programme theories

3:8 Stage-2: Theory refinement

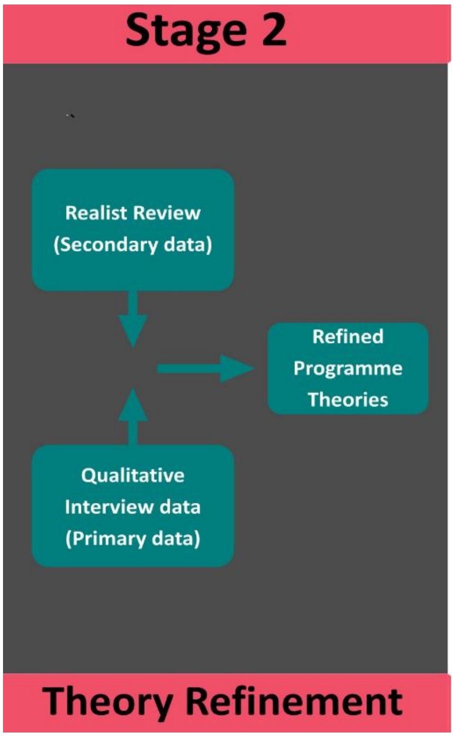


Figure 3:6 – Diagrammatic representation of Stage-2: Theory refinement

This stage involved the formal and iterative search for relevant data (evidence) from the literature (secondary data), and primary data from qualitative interviews. Both these sets of data were collected concurrently and were used to synthesise the evidence to refine or reject IPTs, to articulate refined programme theories for SUI in ROCP (Figure 3:6). I will elaborate on secondary and primary data collection methods, data handling measures and strategies used to synthesise the data to advance IPTs to refined programme theories.

3:8:1 Secondary data collection strategy using a realist approach

This section marks the beginning of the theory refinement stage of my study. It describes the methods used to search for secondary data using a realist approach, appraising the quality of the data and data extraction methods.

3:8:1:1 Searching for relevant evidence

After articulating the IPTs, my next step was to identify evidence from literature that is capable of refining IPTs using realist principles. As a result, a realist literature search was carried out. The aim was to retrieve data from literature in order to refine IPTs. According to

Pawson et al. (2004) this part of the RS is referred to as "*search proper*" (p.19), where a reviewer has moved on from the background search and is required to provide a formal audit trail in the final report. In the literature, the RS is also frequently referred to as a 'realist review' (Jagosh, 2019). As this stage (theory refinement) of my study is dedicated to the search for evidence from multiple sources, from here onwards I will refer to this formal search for evidence as the realist review (RR).

3:8:1:2 Rationale for using realist review

The reason for developing the RR based on realist principles was to overcome the shortcomings of traditional systematic reviews to reflect the real-world interaction between evidence and action (McCormack et al., 2013) and its limitations in capturing the complexity of programmes' effects and to provide pragmatic explanations (Pawson et al. 2004). RR is a theory-driven and interpretive type of literature review. According to Rycroft-Malone et al. (2012), the main purpose of RR is to establish interventions and strategies that are effective in enabling evidence-informed health care. Rycroft-Malone et al. (2012) make distinctions in the following ways: 1) A RR is iterative; 2) It can include a variety of information and evidence; 3) The evidence gathering is purposive and theoretically driven for the purpose of theory refining; 4) The outcome from a RR is explanatory, and as a result, there are distinctive differences between the traditional systematic reviews and RR (Table 3:2).

Realist review (RR)	**Systematic review (Meta-analysis)**
Theory-driven	Method-driven
Deprioritises methodology hierarchies and emphasises fallibility of all knowledge sources.	Appraises papers on the basis of a hierarchy of study design. Prioritises experimental design (i.e. randomised, controlled trial) as gold standard.
Uses all parts of primary research papers as evidence.	Uses the results of primary studies in meta-analysis.
Uses a variety of data sources, including grey literature, commentaries, etc.	Often uses primary research results only.
Moves away from generalisable claims and advocates for cumulation of evidence-informed theory over the course of time.	Seeks research results that can be generalised across contexts.

Table 3:2 – Paradigm differences between RR and traditional systematic review (Jagosh, 2019)

For the purpose of theory refinement, IPTs were subdivided into processes and components (Pawson et al., 2004). According to Wong et al. (2013), data that is useful in a RR is decided by its relevance to the IPTs, not related to the whole IPTs, but relevant to its subsections, and its ability to demonstrate any aspect of context, mechanisms or outcomes. They also highlight that the “*search strategies for realist reviews addresses the balance between a search process being comprehensive versus theoretical saturation*” (p.30). It is noteworthy that Pawson et al. (2005) suggest that RR draws on the qualitative research principle of saturation and this should be used to decide when to stop searching. The ‘Realist And Meta-narrative Evidence Syntheses: Evolving Standards’ (RAMESES) quality standards for search strategy (Wong et al., 2013) (see Appendix 7) were used as a guide to assist with this process, as these are the authorised guideline principles for undertaking the RR.

A literature search was carried out to scrutinise the IPTs using an inclusion and exclusion criteria (Table 3:3). It is noteworthy that inclusion criteria are refined based on emerging data (Pawson et al., 2004).

Inclusion criteria	Exclusion criteria
1. Literature in English language from 1990 onwards 2. Literature related to service user involvement 3. Mental health related 4. Literature related to acute inpatient setting 5. Care plan related	1. Community-based settings 2. Carers' involvement 3. Non-English literature 4. Literature prior to 1990

Table 3:3 – Inclusion and exclusion criteria for evidence gathering

This search was conducted using the following online databases: CINAHL, Medline, PubMed, PsycINFO, Scopus and Web of Science. The key terms used during the purposive search strategy were service user involvement; acute inpatient mental health unit; care planning and recovery, to find relevant publications (See Table 3:4 for search terms). The usages of truncations and Boolean terms was applied during this literature search. Grey literature was also searched by applying systematic search strategies into customised Google search engines, targeting grey literature websites (OpenGrey, OpenDOAR, ERIC) and consultation with experts to identify web-based sources (Godlin et al., 2015). I consulted and sought assistance from an academic liaison librarian for Medicine and Health Sciences who is trained in systematic reviews in the social and health sciences. The search strategy for the collection of evidence was a purposive and iterative approach, as suggested by Pawson et al. (2004). Snowballing techniques are processes of selecting data using networks (Kumar 2014). Pawson et al. (2004) suggest using this approach and this was also utilised with the help of a citation-tracking database and by lateral searching. Newly published articles were captured using electronic alerts. A comprehensive list of the data source (Table 3:4) and search strategy (Figure 3:7) is given below.

Electronic databases
• CINAHL (1990-2018) • MEDLINE (1990-2018) • PsycINFO (1990 -2018) • Scopus (1990 -2018) • Web of Science (1990 -2018)
Websites
• Care Quality Commission • Department of Health • Google Scholar • King’s Fund independent Charitable Foundation • MIND • National Survivors User Network (NSUN) • Rethink • Sainsbury’s Centre for Mental Health • OpenGrey • OpenDOAR • ERIC
Citation-tracking database / hand searches
• Journal of Psychiatric & Mental Health Nursing • Issues in Mental Health Nursing • Journal of Mental Health • Health Expectations • King’s Fund • Health Foundation • NHS England
Search terms used
• Population: service users, clients, patients, consumers, users.

- Concept: involvement, participation, co-production, engagement, collaboration, partnership, therapeutic alliance and recovery.
- Programme: Patient OR service user OR client OR consumer* part* in care plan*, Patient OR service user OR client OR consumer collaborat* in care plan*, Personal OR service user OR consumer OR patient recovery.
- Setting: Mental health OR Psychiatric units OR wards OR hospital OR Acute admissions OR Acute inpatients.

Table 3:4 – Data sources for the review

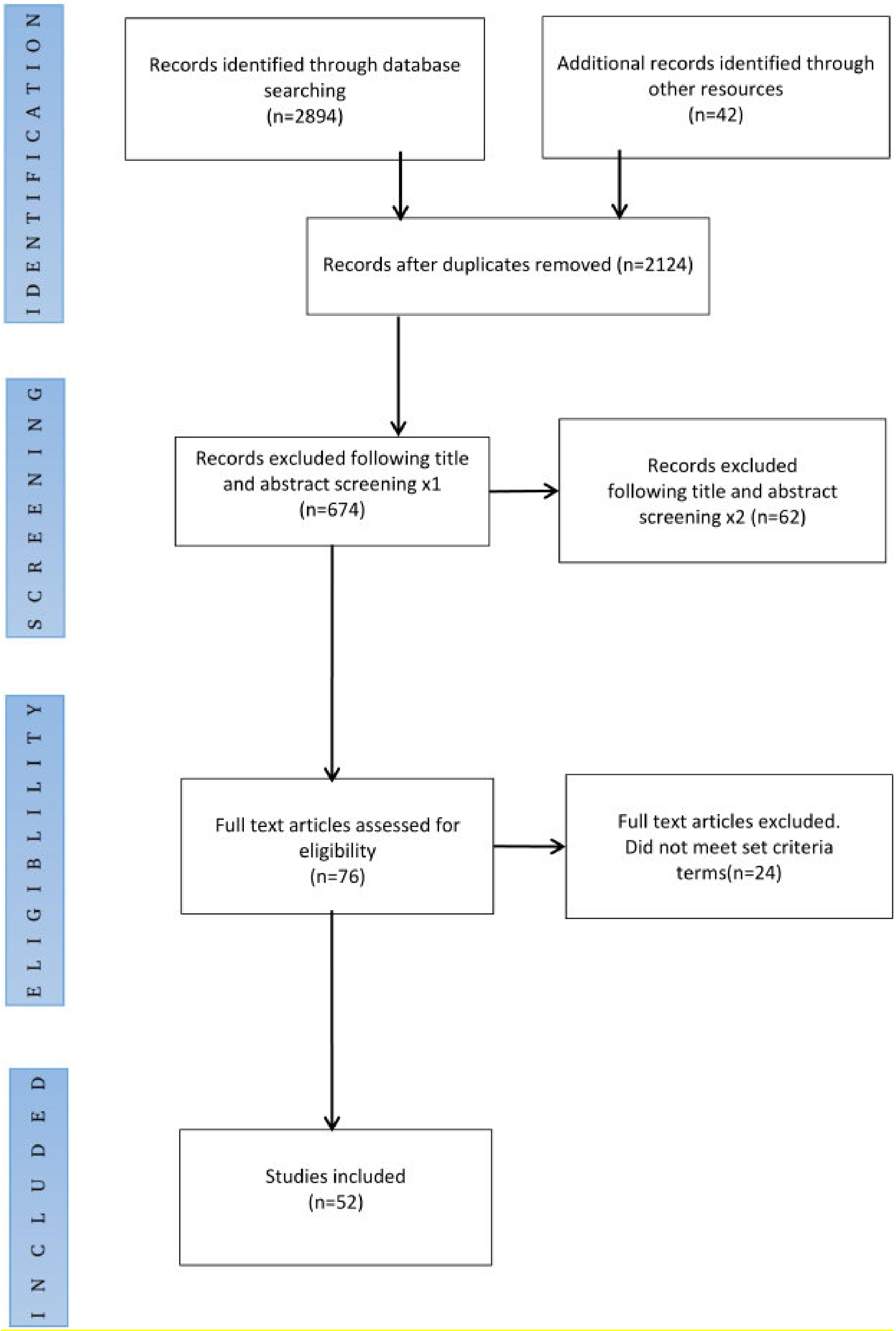
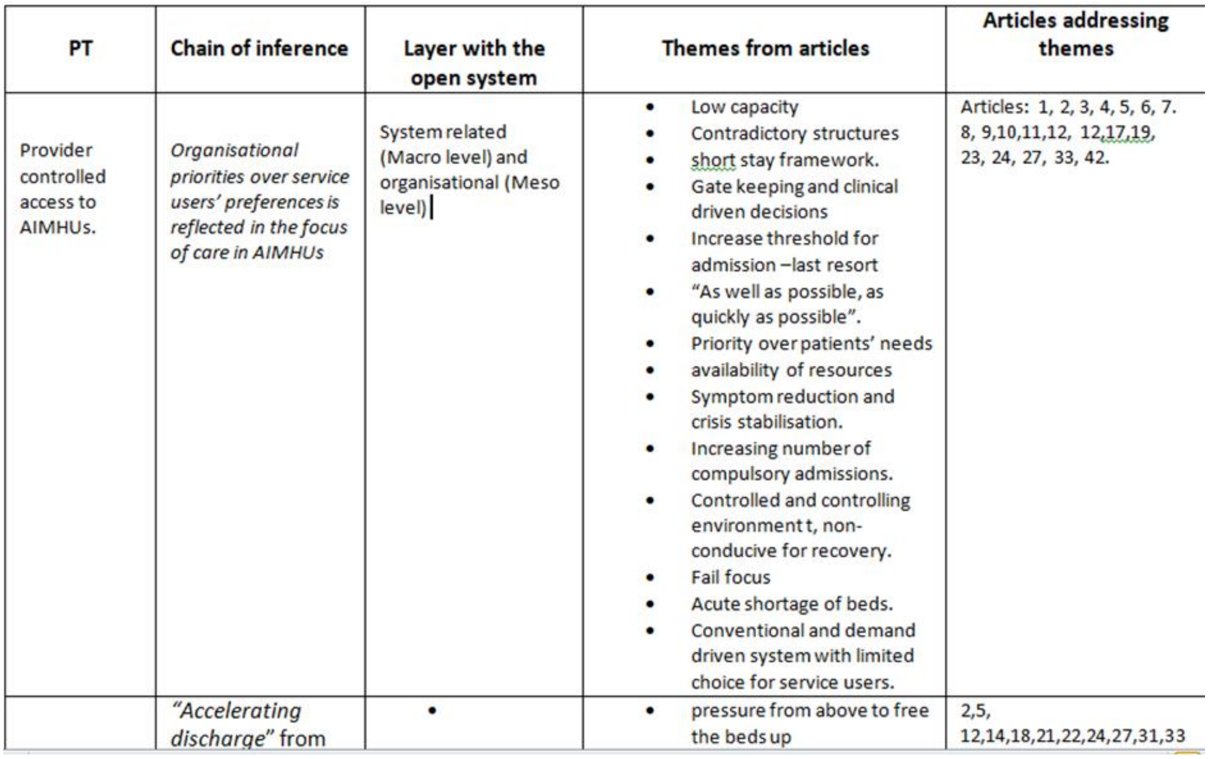


Figure 3:7 – Search strategy

3:8:1:3 Appraising the quality of evidence from the RR

The RAMESES quality standards (Wong et al. 2013) (see Appendices 3, 4, 5, 6 and 7) were used in appraising the quality of data. A wide variety of documents may cover data required for theory refinement, but realist reviews need judgement about the relevance and robustness of the particular data (Wong et al., 2013). Pawson et al. (2004) have pointed out two criteria (relevance and rigour) that require consideration for the purpose of appraising a document. Hence, during the selection and appraisal of documents, I screened potentially relevant titles, and abstracts for: (1) relevance (does the article contribute to building or testing programme theories?); and (2) rigour (does the study use methods that are credible and trustworthy?).

Following the title and abstract review, the document was taken forward for full text review. Careful reading and rereading of identified conceptual articles was undertaken, which involved an iterative and reflective process. This was a time-consuming and laborious task, but helped to identify themes, using the chain of inference emerging from the articles related to the IPTs. A chain of inference is defined as "*a connection that can be made across articles based on the themes identified*" (Rycroft-Malone et al., 2012, p.7). At this stage, articles were themed and grouped under relevant IPTs and layers with in the open system (Table 3:5). A shortlist of documents was made for further scrutiny to appraise relevance and rigour. This list included papers from the background search, documents from the grey literature and other hand-picked documents, such as contemporary reports and policies related to the area of investigation. The practice of appraising study quality with 'hierarchies of evidence' is often rejected by realist authors (Pawson & Manzano-Santaella, 2012), who contend that policies may work as a prelude to testing and refining initial programme theory.



PT	Chain of inference	Layer with the open system	Themes from articles	Articles addressing themes
Provider controlled access to AIMHUs.	*Organisational priorities over service users' preferences is reflected in the focus of care in AIMHUs*	System related (Macro level) and organisational (Meso level)	• Low capacity • Contradictory structures • short stay framework. • Gate keeping and clinical driven decisions • Increase threshold for admission –last resort • "As well as possible, as quickly as possible". • Priority over patients' needs • availability of resources • Symptom reduction and crisis stabilisation. • Increasing number of compulsory admissions. • Controlled and controlling environment t, non-conducive for recovery. • Fail focus • Acute shortage of beds. • Conventional and demand driven system with limited choice for service users.	Articles: 1, 2, 3, 4, 5, 6, 7. 8, 9,10,11,12, 12,17,19, 23, 24, 27, 33, 42.
	"Accelerating discharge" from	•	• pressure from above to free the beds up	2,5, 12,14,18,21,22,24,27,31,33

Table 3:5 – Chain of inference linked to themes, PTs and original articles

3:8:1:4 Extracting the data

At this point, it is noteworthy that in realist studies, analysis of data takes place simultaneously with data collection. The screening, extraction and additional literature search for data occurred iteratively and articles were thoroughly interrogated, both for causative and conflicting accounts, as some of the extracts have overlapping features that can fit either as a context, mechanism, or even an outcome. Discussion with experts in the theory gleaning stage was useful to recognise these overlapping features. I assessed whether the extract fitted as a resource or as an actor's response. Direct quotations from articles were often most informative to help in these situations. Particular attention was paid to identifying causal chains by specifically searching for the mechanisms featured in articles that explain the success or failure of the programme, and noting these findings to build the narrative. For example, once a chain of inference related to the care plan (Programme Theory-2) was identified, it was subsequently attached to the CMOs of the care plan, whereas information related to shared decision making about care was linked to the CMOs that relate to ward rounds (Programme Theory-3).

According to Pawson et al. (2004), this stage involves "*sifting, sorting and annotation of primary source materials*" (p.23). The main aim was to identify a chain of inference related to each of the IPTs. In most of the literature, I found only fragments of evidence that were relevant to make chains of inference in terms of context, mechanism and outcome configurations for various PTAs. These were summarised in a data extraction forms that were adapted from McCormack et al. (2006) (see Appendix 8). In the RR, a theoretical model is made visible through the data extraction forms (Rycroft-Malone et al., 2010), which can also serve as an audit trail. Data extraction forms provided a template to interrogate the articles based on their relevance and rigour. Additionally, the data extraction forms helped to highlight the extracted data and their source (original article). According to Rycroft-Malone et al. (2012), the main objective of the data extraction process is to populate the evaluative framework with evidence. This has helped to identify 'chain of inference' from various articles.

This stage was iterative, as I was moving between different sets of data and bringing new sets of evidence as IPTs were refined. The information from primary data collection (qualitative interviews, Section 3:8:2) also contributed to the need to take an iterative approach in extracting data, as new information was revealed relating to IPTs. This is how the programme theory on Peer support worker intervention was created. This reiterates Pawson et al.'s (2004) statement that RR do not follow a linear path, but they are iterative and interactive.

3:8:1:5 Articulating refined programme theories

Aligning various 'nuggets of evidence' to CMO configurations helped to explain how specific elements of the intervention may (or may not) work and helped to provide a cumulative picture of the context, mechanism and outcomes of this programme. This process served as an explanatory feature in the refinement process of IPTs. It also provided a narrative to summarise the inference applied in connecting the context, mechanism and outcomes within a programme theory and the features underpinning them in synthesising IPTs to a refined programme theory. This will be discussed in Chapters 4 and 5.

3:8:2 Primary data collection strategy

This section is the second part of the theory refinement stage, where primary data from qualitative interviews were used simultaneously with the secondary data (evidence from the RR) to test and refine IPTs. The main focus of theory testing was to ascertain whether there was evidence that supported or rejected a particular theory, using logical consistency and explanatory powers. The following section will discuss the primary data (qualitative) collection methods used in this study; setting for data collection; its rationale; study participants; data handling strategies; data analysis and key ethical considerations (see Section 3:11).

3:8:2:1 Setting for data collection

This study was conducted in three NHS mental health hospitals and in two community mental health centres (CMHC) in the south-east of England, which provide secondary mental health care for service users with mental health problems. AIMHUs are part of mental health hospitals where service users who experience acute mental health problems are admitted and an acute inpatient care pathway begins. Admission to these units can be voluntary or involuntary. The latter will require the application of the Mental Health Act (amended in 2007) (Jones, 2020). These inpatient teams consist of psychiatrists, nurses, psychologists, occupational therapists and care support workers. When service users are admitted to these units, a key worker is allocated to each service user, usually nurses are allocated as part of their role.

CMHC provide care and support for service users in the community, following discharge from acute inpatient units. Each community mental health team has a geographically designated acute inpatient unit to admit acutely unwell service users from their respective communities. These centres involve professionals from various disciplines, such as medical, nursing, psychology, social work and occupational therapy. In order to support and monitor service users' recovery in the community, a care co-ordinator from one of these disciplines will be allocated to service users following discharge from acute inpatient units. The care co-ordinators work closely with service users in the community and are responsible for coordinating care provision for service users in the community.

3:8:2:2 Realist theory-driven focus groups and semi-structured interviews

The data collection from service user participants, mental health staff participants and national/regional stakeholder participants was carried out separately through realist theory-driven interviews from the participating study site. The 'realist' decision for using this specific method was due to its ability to reveal elements of the CMO configuration in each of the IPTs. The development and expression of mechanisms requires unpacking the qualitative nature of social objects, their behaviours and relationships (Maxwell & Mittapalli, 2010). A rationale for using these methods with these groups of participants can be further explained through Stame's (2004) words: "*It is not programmes that make things change, it is people, embedded in their contexts, who, when exposed to programmes, do something to activate given mechanisms and change*" (p.62). The option for focus groups and face-to-face interview was offered to the first two sets of participant groups and the national/regional stakeholders were given the option of face-to-face or telephone interviews.

Focus groups are recognised as a highly efficient technique for qualitative data collection and have a major advantage of collecting valuable data quickly and cheaply (Parahoo, 2006). According to Stewart and Shamdasani (1990), participant strength of a focus group is between eight and 12. Krueger and Casey (2000) pointed out the possibility of well-established dynamics within groups of people who know and work closely with each other, where their current relationship and hierarchy can influence their contribution. However, the constraints of time for mental health staff during working hours and lack of willingness to participate in such groups turned out to be a hindrance in facilitating focus groups. The plan for focus groups in this study was finally discarded, as it turned out to be unfeasible, due to low attendance rates. This corresponds with the observation made by Omeni et al. (2014), who had very low responses from frontline staff from the participating mental health NHS Trust where they conducted their study, related to service user involvement. Similarly, facilitating focus groups with service user participants also turned out to be impracticable, mainly due to their reluctance to take part in groups and the inability to get the minimum number of participants to facilitate a focus group within the time scale of this study.

A study by Fern (1982) on the comparative efficiency of interviews and focus groups was one of the rare methodological studies that involved direct comparison between these two methods. Findings from this study revealed that focus group participants produced only 60 to 70% of ideas, compared to individual interviews. Similarly, Klapowitz (2000) compared data from focus groups and interviews, and revealed that individual interviews were 18 times more likely to bring up discussion topics around socially sensitive matters, compared to focus groups. Apart from all these findings, as a researcher, I was more inclined to give priority for the preference and convenience of all eligible participants who expressed their interest to take part in my study.

Participants from both these groups were receptive to taking part in interviews that were offered initially as an alternative for focus groups. Interviews are one of the most commonly used primary data collection methods in health care research, where researchers question a participant verbally, using open or closed-ended questions (Tod, 2010; Whittemore & Grey, 2006). An interview functions on the basis that a participant will disclose their views, beliefs, attitudes and behaviour, depending on the researcher's skill and trust built up with the participant (Parahoo, 2006). A realist treats this data as indicative of the participants' lived reality, while recognising that the meaning related to experience is arbitrated by socio-cultural context (Willig, 1998). According to Kumar (2014), interviews are more appropriate for complex situations where the questions can be explained to the participant. This makes it feasible for wider application to collect in-depth information. Kumar also highlighted that the quality of data from the interview depends on the quality of interaction and upon the quality of the interviewer.

I found the experience of being a practitioner researcher useful for conducting interviews. However, Tod (2010) has pointed out the difference in interviews conducted in a clinical context, compared to a research context, where a practitioner freely responds to the patient's health-related questions. When conducting an interview for research purposes, a boundary needs to be drawn between the respective roles and the manner by which the interview is conducted. This means judgements taken by the researcher differ from those of the practitioner. In relation to this study using realist methodology, the purpose, structure and content of the discussion and my role as an interviewer was in line with the methodological guidance provided by Pawson (1996) to perform a realist interview. I will discuss this further in the following sections.

3:8:2:3 Semi-structured interviews

A realist interview differentiates itself from a qualitative interview, based on the purpose of the interview. Realist interviews are used to advance data for the purpose of falsifying, inspiring, validating and modifying it into a theory (Manzano, 2016). Furthermore, data collected in realist studies using realist interviews are used as evidence for real phenomena and processes for making inferences (Maxwell, 2012). In comparison, the focus of qualitative interviews is to explore aspects and concepts, whereas realist interviews are focused on focusing on events and processes that assist with investigating IPTs. Furthermore, in a realist interview, the interviewer is pursuing the programme's story by capturing the interviewee's story, as their experience with the programme illustrates events, processes and diverse outcomes of the programme under study (Patton, 2003). As a result, the interviewer needs to take an active role to direct the questions and to keep the focus on the programme under study. Unlike qualitative interviewers, which take a naïve approach to reduce the risk of data contamination, the realist interviewer takes control of the interview, uses their subject knowledge and directs it to their topic of interest (Manzano, 2016). Upon reflection, it provides the opportunity to be open and honest with research participants as depicted in the Health and Social Care Research Policy (HRA, 2017a). However, Manzano (2016) maintains that both qualitative (in general) and realist interviews share the fact that they lack an authoritative version or an account of how to perform an interview.

Methodological guidance on how to perform a realist interview was proposed by Pawson (1996). As prescribed in this guidance, the interview schedule is guided by the researcher's programme theory and realist interviews should take place in three stages: theory gleaning, theory refining and theory consolidation. In the theory gleaning stage, Pawson (1996) recommends presenting the theories to interviewees for the purpose of confirming, falsifying and refining the programme theories. Pawson views this relationship as a teacher-learner cycle, where the researcher teaches the interviewee, the theory under test, subsequently the interviewee having learnt the theory, is expected to teach the researcher about those components of the programme. So, the roles of teacher and learner in this context are not static, but are interchangeable. During the theory refinement stage, tentative theories about the programme are explained to the interviewee to use their knowledge as a tool to refine the theory. Arguably, this phase can act as an intermediary phase between CMO configuration and middle-range theory, as recommended by Marchal et al. (2012), following their literature review of realist evaluation studies. The final stage, theory consolidation interviews, is viewed as a second level of theory refinement and follows the teacher-learner cycle.

The literal application of these principles arguably raises a number of methodological problems for my study. For example, understanding programme theories itself poses intellectual challenges, illustrated by Pawson et al. (2004) as, "*sustained thinking and imagination to track and trace the initial map of programme theories"* (p.38). There may be difficulties faced by my participants in fully engaging with IPTs and understanding how to inform on the subject area. Another issue is the unique concept of emergence in realist studies (Pawson, 2013) where programme theories continue to change and get refined as more information is gained after conducting a few interviews. The exact application of this unique nature of the interview has limitations with this study, as each change from the approved version of the research protocol needs to be reviewed and approved by the respective National Health Service Ethics Committee (Health Research Authority, 2017b). This process can be time-consuming and can interrupt proceedings and lengthen the duration of the study. In order to overcome these issues, I have used the ethos of RS itself: 'what works, in what circumstances, to what extent and why'. This is detailed in the following section.

3:8:2:4 Devising data collection methods

Semi-structured interviews were used as a means to collect primary data in this study for three groups of participants, namely mental health service users, mental health professionals and stakeholders versed in policy and strategy (national and regional). Semi-structured interviews are used as a means to collect primary data in realist studies. The legitimacy of using qualitative interviewing for the purpose of theory building in realist studies has been challenged in the literature, however, the method-neutral nature of realist research opens up the feasibility of using them (Mukumbang et al., 2020). Additionally, Pawson (1996) suggests that qualitative interviews offer a valuable approach to generate, validate, refute and modify theories in realist studies. Cunningham et al. (2020) have used Critical Incident Technique (CIT) as a means for data collection to overcome the demanding task and limited guidance on conducting realist interviews. It indicated adaptations to techniques, tailored for each area, are possible and this has led me to choose semi-structured interviews for the purpose of primary data collection.

The interview schedules were developed based on the IPTs. In other words, the IPTs laid the foundation for formulating the interview schedules (Pawson et al., 2004) and were focused on investigating IPTs. To overcome the methodological issue mentioned in the previous section, I firstly formulated questions that linked to each of the IPTs. Informal discussion with experts during the theory gleaning stage (see Section 3:7:1) and discussions with my clinical and research supervisors have helped to develop the interview schedule into a more appropriate format that would enable participation based on IPTs.

Three interview schedules were developed for my study: one for service users (see Appendix 9); one for mental health staff (see Appendix 10); and one for stake holders at the strategic and policy level (see Appendix 11). Primarily questions were structured as broad, open-ended inquiries that would allow the emergence of new events or phenomena that have not previously been uncovered. With the help of probing, participants were able to convey their perspective through their story, facilitating confirmation, addition or refutation of mechanisms. Furthermore, open-ended questions using 'who', 'what', 'where', 'why' and 'how' can help participants to bestow their perspectives without much limitation (Chenail, 2011). This also had the ability to reveal mechanisms that remained unpacked. The process of linking questions to the IPTs was applied within interview schedules for all three groups of participants. The average length of all interviews was approximately 35 minutes. All interviews were recorded using a digital recorder and were transcribed. Towards the end of the interview, all participants were informed about the next stage of this study (theory consolidation) and the opportunity to be involved as stakeholders (see Section 3:10). The study sample will be described more in the next section.

3:8:2:5 Study sample and recruitment process

In this study, I used convenience sampling with all participants. According to Kumar (2014), "*convenience sampling is a non-probability sampling design that focuses on gaining information from participants (the sample) who are 'convenient' for the researchers due to their easy accessibility, geographical proximity, known contacts and ready approval for undertaking the study or being part of the group.*" In realist studies, convenience sampling is quintessential as it needs information-rich cases. Pawson and Tilley (1997) recommend that the recruitment of participants should be based on their CMO investigation potential (interrogation of IPTs) as each element (context, mechanism and outcomes) in the IPTs generates the need for different kinds of participants. Participants were selected based on the IPTs and their relation and acquaintance with the programme (Pawson & Tilley, 1997). As a result, service users, mental health staff (both these groups from the study setting) and stakeholders were considered as good sources for gathering information, as they see the programme from different angles. Multiple perspectives from participants were encouraged, not to ensure consensus or balance, but to scrutinise informal patterns and unintended outcomes (Blamey & Mackenzie, 2007). According to Emmel (2013), a sample size in realist research can only be a rough estimate because the realist process of theory testing is unstable, unpredictable and uncertain. He maintains that an approximate sample size can only be estimated following conversations with frontline staff, which is the point where theory starts to develop. This poses problems for any short-term studies such as this, where NHS ethical approval requires an estimated sample size prior to the commencement of the study. This is another area where I have used my clinical knowledge and experience about the practicality of getting approximate participant numbers to comply with Health Research Authority (2017a) requirements.

All participants were provided with an information leaflet (Appendices 12, 13 and 14) regarding the study, prior to interview, which outlined: the aims and objectives of the study; the reason for the request to participate in the study; the benefits and risks of participating in the study; maintaining their confidentiality; their right to withdraw at any point during the study; and usage of data. Richards and Schwartz (2002) recommended that participant information should include the scope and purpose of the study, the type of questions that may be asked, how the results will be utilised and how their identity will be protected.

3:8:2:6 Service user participants

Convenience sampling was used to adopt a targeted approach of the population group from two different CMHCs of the participating NHS Trust. The rationale for targeting eligible service users in the community was because they were not in the acute phase of their illness and are deemed to have mental capacity. The subjects or recipients of the programme (in this study, the service user participants also meet this criteria) are fundamental because they are more informed about the outcomes (Manzano, 2016). According to Pawson and Tilley (1997), they are experts who can describe how programme mechanisms have influenced their outcomes.

Following approval from the Research and Development office of the participating NHS Trust, I approached the Clinical Lead nurses on both CMHCs to help gain access to eligible participants by using the inclusion and exclusion criteria (Table 3:6).

Inclusion criteria	**Exclusion criteria**
1. Service users who were admitted to acute inpatient units within the last 3 years. 2. Age limit 18 years and above. 3. Service users with mental capacity to consent for this study. 4. Those who can provide informed consent. 5. Those who can communicate in English.	1. Below 18 years of age. 2. Lacks mental capacity. 3. Unable to provide informed consent. 4. Those who are not able to communicate in English.

Table 3:6 – Inclusion and exclusion criteria for eligible service user participants

The Clinical Lead nurse did not have any involvement with anyone on the CMHC caseload, so it helped to achieve an independent, unbiased selection. I met with the Clinical Lead nurse, who has access to the caseloads of all the care co-ordinators who work in the CMHC. I discussed and provided written information about this study to Clinical Lead nurses and to care co-ordinators. This included aims and objectives, inclusion and exclusion criteria, service users' information sheets (Appendix 12) and contact forms (Appendix 15), which confirm expression of interest. Following this meeting, the Clinical Lead nurses identified eligible service users who were under the care of the respective CMHC. A total number of 23 eligible service user participants were identified by lead nurses from two participating CMHCs. The Clinical Lead nurse allocated care co-ordinators to hand out information regarding this study to eligible service users, which included a contact form that gave permission for me to contact service users, should they express an interest to take part. The service users had one week to decide whether or not to take part in this study and provide hand-completed forms to the care co-ordinators. After one week, contact forms were collected by care co-ordinators and were returned to me for the purpose of screening through the inclusion/exclusion criteria.

After a thorough screening through the inclusion and exclusion criteria, I contacted eligible participants by phone. Ten eligible participants agreed to participate and gave informed verbal consent to participate (Table 3:7). Nine eligible participants declined to participate and three eligible participants did not respond to requests. Table 3:7 provides a brief description of service user participants who took part in this study.

Service user participants	Gender	Age bracket	Number of admissions in the last three years
Participant-A	Male	Between 60 - 70 years	2
Participant-B	Male	Between 20 - 30 years	2
Participant-C	Female	Between 30 - 40 years	3
Participant-D	Male	Between 40 - 50 years	1
Participant-E	Female	Between 30 - 40 years	1
Participant-F	Female	Between 60 - 70 years	1
Participant-G	Female	Between 70 - 80 years	1
Participant-H	Male	Between 50 - 60 years	2
Participant-I	Male	Between 30 - 40 years	1
Participant-J	Female	Between 50 - 60 years	2

Table 3:7 – Service user participant information

I confirmed with all eligible participants whether they had received information leaflets, and provided an explanation to their questions regarding the study. Following this, I invited them to take part in the study. The option for focus group and interview was given, but as discussed above, all eligible participants were more inclined to take up the option for interview, which was arranged in a convenient space with easy access for participants. Prior to interviews, I asked participants whether they had any more questions for clarification and took written consent from all eligible participants.

3:8:2:7 Mental health staff participants

This group of participants has the implicit knowledge regarding the programme under study. According to Manzano (2016), following the top-down implementation of the programme, this group of participants can provide rich information about the barriers and unintended consequences. Furthermore, she recommends to begin data collection from this group, as they know what goes on with the programme. The intended sample size was five to ten mental health staff from various disciplines (psychiatrists, nurses, psychologists, occupational therapists and care support workers). Practitioners from various disciplines experience and perceive the programme process differently and it is important to capture these varied experiences (Manzano, 2016).

For this purpose, I met with Inpatient Quality Lead nurses to discuss involvement and to provide written information, which included a staff information sheet (Appendix 13) and a contact form (Appendix 16). Following this meeting, Inpatient Quality Lead nurses approached eligible mental health staff from the proposed study sites and handed out information sheets regarding this study. This included a contact form that gave permission for me to contact the staff, should they express an interest to take part. Potential participants had seven days to decide whether or not to take part in this study, and to hand completed forms to team administration staff. After seven days, contact forms were collected by team administration staff, and were returned to me for further screening. A total of 30 staff initially responded. After a thorough screening through the inclusion and exclusion criteria (Table 3:8), I contacted all eligible participants who had expressed their interest to take part in this study. After gaining their verbal consent, I invited all participants to take part in the study. I offered the option of focus group or interview, but all the participants (except three) from this group preferred interviews. The inclusion and exclusion criteria for mental health staff were as follows.

Inclusion criteria	Exclusion criteria
1. Mental health staff registered with a relevant professional body in United Kingdom (UK). 2. National Health Service (NHS) employees who have experienced mental health problems and had hospital admissions. 3. A minimum of 6 months experience of working in acute inpatient units in the last 3 years. 4. Unqualified staffs who currently work on acute inpatient units. 5. Peer support workers (who have lived experience with mental health problems) and volunteers who works for NHS in acute inpatient units.	1. Mental health staff not registered or worked in UK. 2. Mental health staff with less than 6 months in acute inpatient units. 3. Staff who do not consent to participate.

Table 3:8 – Inclusion and exclusion criteria for eligible mental health staff

Fifteen eligible participants (Table 3:9) were interviewed, varying in professional qualification and experience, which was more than initially planned for. Eight eligible mental health participants did not respond to the study request and seven participants declined to participate in this study.

Participant	Gender	Role	Band
Participant-A	Female	Senior occupational therapist	7
Participant-B	Male	Occupational therapist	6
Participant-C	Female	Occupational therapist	6
Participant-D	Female	Occupational therapist	6
Participant-E	Male	Peer support worker	3
Participant-F	Female	Clinical psychologist	8A
Participant-G	Male	Consultant psychiatrist	8D
Participant-H	Female	Ward manager	7
Participant-I	Female	Senior nurse practitioner	7
Participant-J	Male	Senior nurse	8A
Participant- K	Female	Staff nurse	5
Participant- L	Female	Health care worker	3
Participant- M	Female	Deputy ward manager	6
Participant-N	Female	Psychology practitioner	7
Participant-O	Female	Consultant psychiatrist	8D

Table 3:9 – Mental health staff participant information

3:8:2:8 Stakeholder participants

All national/regional stakeholders were recruited to this study using convenient sampling. This group included experienced carers, representatives of voluntary organisations, commissioners, managers of mental health NHS Trust and academics who are likely to be informed on the topic. Pawson and Tilley (1997) suggest that it is imperative to work with a purposively selected, broad range of programme stakeholders, as they possess in-depth information regarding the underlying programme theory. The inclusion and exclusion criteria used for recruiting stakeholders are given in Table 3:10.

Inclusion criteria	Exclusion criteria
1. Experience in acute mental health service provision. 2. Experienced carers, commissioners who work for CQC, members of charitable organisations who work in mental health, and academics specialising in this field. 3. Relevant policymakers. 4. Individuals providing informed consent.	1. Stakeholders from other than mental health background. 2. Non-English-speaking stakeholders.

Table 3:10 – Inclusion and exclusion criteria for eligible national/regional stakeholders

Potential participants of this group were contacted by an introductory email (Appendix 17) with an information sheet (Appendix 14) attached. An email invitation was sent to ten eligible participants from this category. After receiving a response from potential participants, written consent (Appendices 18, 19 and 20) was taken from all participants prior to the commencement of the interview. I did not receive any response from four of the eligible participants and one responded and agreed to participate, but was unable to respond to emails to schedule an interview. One of the participants decided to terminate the interview and withdrew their consent as they felt they had misread the information sheet and were not in a position to respond to the questions. Four eligible participants (Table 3:11) from this group were interviewed face to face, which lasted for approximately 30 minutes. The option for telephone interview was offered to all participants. This group of interviewees helped to provide expert opinions, views and suggestions related to IPTs (Manzano, 2016) which helped to unearth any practices or initiatives that were not published or used in other settings or disciplines.

Participant	Gender	Specialist area of expertise
Participant-A	Female	Carer representative
Participant-B	Female	Mental health advocacy service
Participant-C	Female	Academic
Participant-D	Female	CQC specialist advisor

Table 3:11 – National/regional stakeholder participant information

3:8:3 Data handling strategy

Data are described as the information gathered by researchers during a study (Parahoo, 2006). The safe usage and handling of data is one of the core responsibilities of a researcher from an ethical point of view (HRA, 2017a). In addition to compliance with the ethics framework, researchers are legally accountable regarding the way in which they deal with the data (General Data Protection Regulation (GDPR), 2018). According to Lin (2009), management of data is a complex, but important, task because it safeguards truthfulness of the data and protects research participants. She advocates that data management involves confidentiality, protection of human subjects, data sharing, data storage and ownership. The following section will explain this further.

3:8:4 Collection and processing of data

The purpose of the information I collected from all the participants was to refine IPTs. The nature of this information was explained in the information sheet for all participants, including their right to withdraw at any time during the study, without having any implications on their care. A unique code was applied immediately to each participant's interview data following the interview (audio recording) and was used to label the transcripts of interviews. Following the application of this unique code to the data, any information that enabled identification of the participant was removed from the research data.

3:8:5 Maintaining confidentiality of data

Care was given to maintain the confidentiality of the data. As Patton (2002) rightly quoted, "*The evaluator's scientific observation is some person's real-life experience. Respect for the latter must precede respect for the former*" (p.207). All data were treated in accordance with the General Data Protection Regulation (GDPR) (2018). All information collected was treated as strictly confidential and identity of participants was protected by replacing the participant's name with unidentifiable unique codes immediately following data collection. I had sole access to and management of data.

3:8:6 Storage of data

All electronic data were stored on a password-protected network at the university. These data were not transferred from the network on to personal computers. Any data in paper form, such as response forms and consent forms, were stored in locked filing cabinets in offices that are locked when unoccupied. Secure archiving facilities at the university were used to store all relevant data of this study and they will be destroyed after five years.

3:8:7 Analysis and reporting of data

The interview transcripts were anonymised and with no link back to the personal data. In doing so, I took great care to ensure that participants were not distinguishable in written reports and that all quotes could not be traced back to the person concerned.

3:8:8 Data analysis

Data analysis requires researchers to immerse themselves in the data. According to Basit (2003), "*it is a dynamic, intuitive and creative process of thinking and theorising*" (p.143). The purpose of qualitative data analysis is to protect the uniqueness of each participant's lived experience while interpreting the phenomenon under investigation (Banonis, 1989). Furthermore, in qualitative research, the researcher becomes immersed in the data to identify codes and themes; transcribes statements to index cards; finds a relationship with statements of participants; and finally, identifies how conceptual themes are emerging and are connected to each other (Streubert & Carpenter, 2011).

However, the realist approach to data analysis is unique and it takes a different course compared to the traditional ways of qualitative data analysis. In a realist framework, data analysis is not a prescribed stage of the research process, but an iterative process from the time of data collection (Manzano, 2016). In a realist analysis, theory, practice and evidence are in constant engagement, interpreting and reinterpreting data (Emmel, 2013). For this purpose, it uses the processes of abduction (Figure 3:8) and retroduction (Figure 3:9).

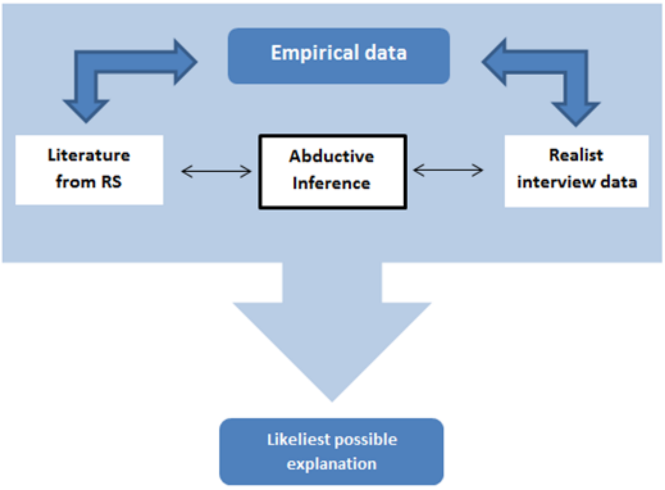


Figure 3:8 – Diagrammatic representation of abduction (Adapted from ACAPS, 2016)

Abduction is defined as "*inference or thought operation, implying that a particular phenomenon or event is interpreted from a set of general ideas or concepts*" (Danermark et al., 2002, p.205). It typically starts with an incomplete set of observations and proceeds to the likeliest possible explanation of the phenomenon under study. The application of abduction in this study is diagrammatically represented above (Figure 3:8). Whereas, retroduction demands a researcher's counterfactual thinking based on their knowledge and experience. According to Danermark et al. (2002) it is: "*the ability to abstract and to think about what is not, but what might be*" (p.101). The application of retroduction in this study is diagrammatically represented below (Figure 3:9).

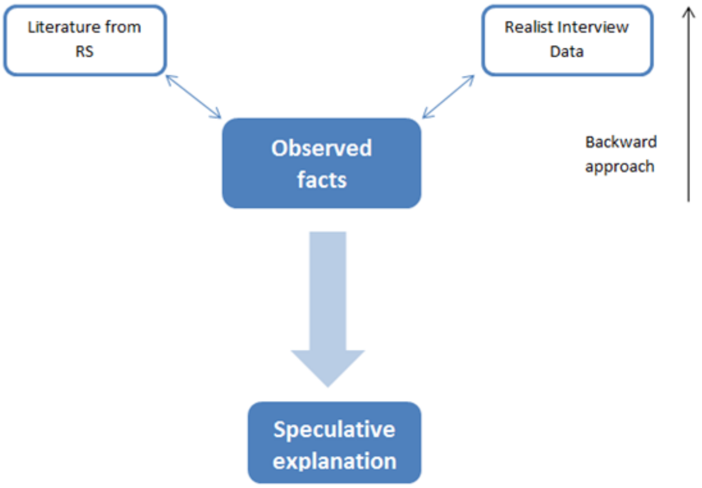


Figure 3:9 – Diagrammatic representation of retroduction (Adapted from ACAPS, 2016)

It therefore allows researchers to move between empirical and deeper levels of reality to understand the phenomenon under study (Bergin et al., 2008). This means, in realist terms, data analysis is an iterative process of adding small chunks of information – ‘placing nuggets’ and not considered a separate stage of the research (Pawson, 2006). So, taking a realist stand in the analysis of data involves finding out which mechanisms are in operation. This means the process of coding, categorising, developing themes and constructing concepts in qualitative data analysis (Saldana, 2016) is replaced by theory identification and refining (Pawson, 1996).

In a realist framework, it is expected that theory, rather than data or the methods employed to gather that data, is central to explaining reality (Robson, 2011). Therefore, the unit of analysis in realist studies is not the participants, but the events and processes around the programme under study (Manzano, 2016). Using the stages of theory identification and theory refining, the basic analytical task of a realist researcher is to “*find and align the evidence*” (Wong et al., 2013, p.41) in order to illustrate that particular mechanisms, generate particular outcomes. According to Emmel (2013), “*The quest of realist research is good interpretation and explanation*” (p.69). At this point, it is noteworthy that the ‘*notion of emergence*’ is another principle in realist studies (Pawson, 2013, p.18) that indicates the possibility of refinement, refuting and construction of IPTs. The RAMESES quality standards for realist principles in analysis (Wong et al., 2013) (see Appendix 6) was used as a guide to assist with this process.

Having explained my data analysis approach, there is the need to draw on an analytical framework within which to apply it. The realist approach gives a realist researcher the liberty to draw on appropriate analytic techniques (Wong et al., 2013). To identify inference about generative mechanisms from the primary data that can be linked to IPTs from Stage 1, I have used the Framework method of analysis (Ritchie & Spencer, 1994), which is a popular approach in the management and analysis of qualitative data in health research. It is most appropriate for analysing large amounts of interview data, as its matrix form provides an instinctively organised overview of summarised data, thereby ensuring rigour and transparency in analysis (Gale et al., 2013). To further assist with this process, the framework matrix from NVivo 11 qualitative data analysis software (QSR international, 2015) was used.

Data analysis using a Framework method involves following seven steps:

Step 1: Transcription

Step 2: Familiarisation with the data

Step 3: Coding

Step 4: Developing a working analytical framework

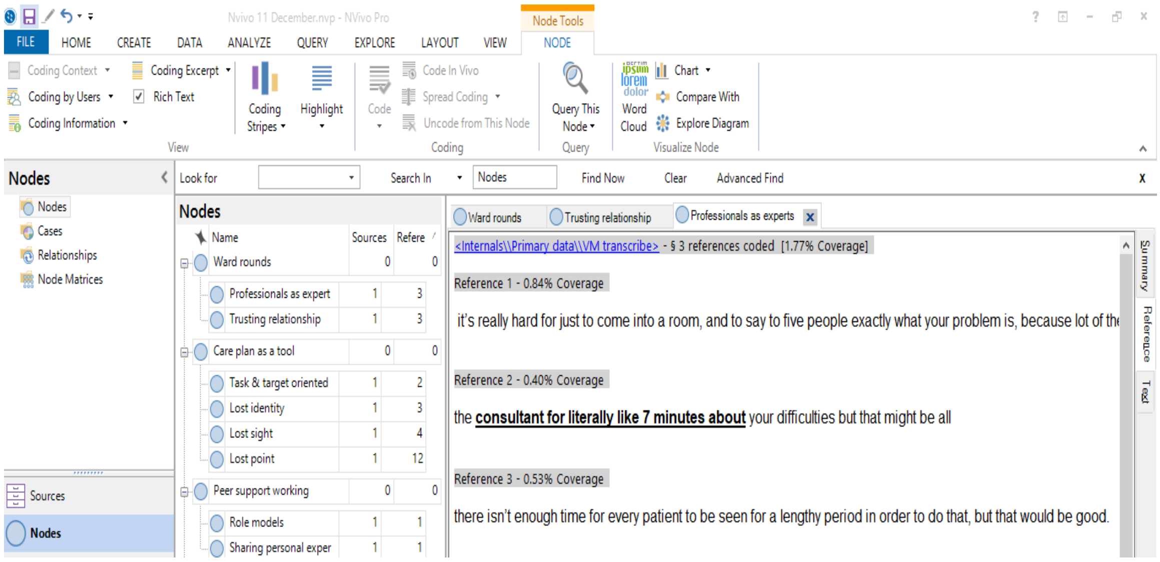
Step 5: Applying the analytical framework

Step 6: Charting data into the framework matrix

Step 7: Mapping and interpretation of data

Verbatim transcription of interviews (Step-1) from the digital recorder gave me the opportunity for familiarisation with the data. The process of transcription is recognised as an opportunity to get immersed in the data and is strongly recommended for naïve researchers (Gale et al., 2013). Following the completion of the first draft of transcribing, I took time to re-listen to the interview, whilst reading through the first draft and proof-reading concurrently to produce a second draft (Step-2). During this process, any words, phrases or recurrent themes were highlighted, bracketed or bolded and notes were made in my research journal for analytical consideration while the study progressed. Bernard and Ryan (2010) propose that rich text features of word-processing software can also assist initial coding and categorisation as data are transcribed. Layder (1998) recognises this process as pre-coding and encourages the researcher to utilise this opportunity. In summary, these exercises provided ample opportunity to become familiarised with the data prior to the coding process. Following this, I imported the transcribed data into NVivo 11.

The coding in Step-3 of this approach was adapted for realist standards and used for theory refinement. This means data were coded based on the events or processes, using both inductive and deductive codes. The deductive codes were used from the refined programme theories developed from the RR, and parent nodes (themes) were created (Step-4) based on each of the programme theories (Figure 3:10). Nodes are central features in data analysis on NVivo as they help retrieve related concepts and evidences in one place. For this purpose, parent codes such as structural factors, agency factors, condition factors and emerging mechanism were created in NVivo 11. Similarly, inductive codes were also developed as the analysis progressed, to chart emerging events or processes and these were linked to the parent nodes. Additionally, whenever new information was identified, a parent node was created to link the emerging findings from data (Step-5). For example, new information that emerged from interview data on peer support intervention prompted developing a new programme theory. Subsequently, child nodes were also created to chart emerging sub themes that can be classed under each of the parent nodes.



Name	Sources	Refere
Ward rounds	0	0
Professionals as expert	1	3
Trusting relationship	1	3
Care plan as a tool	0	0
Task & target oriented	1	2
Lost identity	1	3
Lost sight	1	4
Lost point	1	12
Peer support working	0	0
Role models	1	1
Sharing personal exper	1	1

<Internals\\Primary data\\VM transcribe> - § 3 references coded [1.77% Coverage]

Reference 1 - 0.84% Coverage

it's really hard for just to come into a room, and to say to five people exactly what your problem is, because lot of the

Reference 2 - 0.40% Coverage

the **consultant for literally like 7 minutes about** your difficulties but that might be all

Reference 3 - 0.53% Coverage

there isn't enough time for every patient to be seen for a lengthy period in order to do that, but that would be good.

Figure 3:10 – Displaying parent and child nodes to align interview data with programme theories

Framework matrix on NVivo 11 was used for charting data from Step 6 of the framework analysis. Findings from the framework analysis (Step-7) were utilised in two ways. Firstly, they were used to refine the IPTs and to further elaborate the CMO configurations to explain refined programme theories (Box 3:3). Secondly, the findings also played a vital role in finalising transferable salient actions in order to embed SUI in ROCP in AIMHUs.

Measuring unit: Interview transcript	Condensed measuring unit: Manifest	Condensed measuring unit: abductive and retroductive reasoning	Event/phenomenon
"*You guys are pushed, you have fewer beds, so the idea is to get people stabilised and put them in touch with other things*"	Availability of inpatient beds are limited; therefore, the idea is to stabilise people and to signpost them.	It indicates an orientation towards a resource-led approach, where providers take control of the situation in order to meet the demands of the system, rather than meeting the needs of service users.	The organisational/ system wants to use the limited inpatient bed judiciously; as a result, inpatient beds are specifically for crisis stabilisation and symptom reduction which is a 'one size fits all' approach. The Context here is 'one size fits all' approach used implicitly by organisation/system, to manage bed crisis.
"As you know, getting a bed on our inpatient units is very difficult as they're oversubscribed and under resourced"	Bed availability on inpatient units are limited as the need for bed is higher than what is available.	This evidences an imbalance between what is required in terms of inpatient beds and what is currently available to meet this requirement.	

Box 3:3 – The use of the Framework approach when analysing qualitative interviews

3:9 Synthesising the evidence from primary and secondary data

This was the last step of the RS and was carried out synchronously with filtered evidence from the literature and using primary data. Box 3:4 provides an example of how both sets of data were coded simultaneously. A realist position influences how one interprets the data obtained by employing these methods because realists acknowledge the possibility of making judgements about the value of data on rational grounds, however, these judgements in realist terms can be fallible and are disposed to errors (Robson, 2011).

Layer within the open system	Themes from the RR related to the context of PT-1	Interview data in support of the Context of PT-1	Memo
System related (macro level) and organisational (meso level)	Low capacity Acute shortage of beds Increase threshold for admission	*"You guys are pushed, you have fewer beds, so the idea is to get people stabilised and put them in touch with other things"*	The theme of bed crisis resulting from deinstitutionalisation is highlighted in the RR data and this is seconded by the interview data. It indicates why there is a notion to use AIMHUs as the last resort which is a possible mechanism triggered by this event?
	'As well as possible, as quickly as possible' Symptom reduction and crisis stabilisation Short stay framework	*"the idea is to get people stabilised"*	The theme around the focus of care in contemporary articles are supported in the interview data. It indicates a similar approach with all service users which is not in line with the person-centred approach instead it's a 'one size fits all' approach. This explains the reliance of clinical recovery by professionals as a mechanism that spurts out from this Context.
	Priority over patient's need conventional and demand driven system	*"As you know, getting a bed on our inpatient units is very difficult as they're oversubscribed and under resourced"*	Both sets of data confirms shortage of resources in the system that impacts on service users needs. It indicates prioritisation and operation of MH services with a check list, known as 'gate keeping' to see who needs admission, which signals another mechanism?

Box 3:4 – Simultaneous coding of primary and secondary data

Pawson et al. (2004) suggest that the synthesis of evidence focuses on four dimensions: interrogating the integrity of a programme theory; adjudicating between competing theories; considering the same theory in comparative settings; and finally, comparing official expectation with actual practice. As current policies have limited impact on SUI in ROCP (translational gap), I have paid particular attention to compare official expectation with current practice. Thus, the combination of primary and secondary data provided a systematic approach to refine the IPTs into refined programme theories for SUI in ROCP in AIMHUs. At this point, stakeholder involvement was sought for the purpose of validating and consolidating programme theories (see Chapter 6). Following this process, programme theories were advanced to middle-range theories using 'if-then' statements, which helped in finalising the salient transferable actions. This stage concluded by drawing conclusions and framing recommendations based on evidence from secondary and primary data, which forms the last chapter (see Chapter 8; Sections 8:6; 8:7 & 8:8) of this thesis. The methods adopted in the stakeholder involvement are explained in the next section (consolidation stage) of this study.

3:10 Stage-3: Theory consolidation

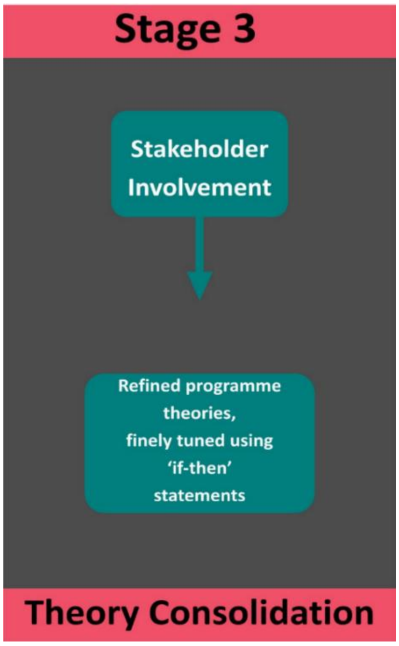


Figure 3:11 – Diagrammatic representation of Stage-3: Theory consolidation

Theory consolidation was the final stage of this study (Figure 3:11) using stakeholder involvement. The purpose of this phase was to validate, refute and for "*fine tuning*" (Pawson et al., 2004, p.12) of the programme theories with stakeholders, following testing and refinement of IPTs using the interview data in Stage-2. Realist studies (Alvarado, 2013) have used the term 'respondent validation' for this process, which is similar to member checking in qualitative research. I have used the term 'stakeholder validation' to avoid any confusion with the involvement of stakeholders and their role in my study, compared to study participants. This is because some of the study participants who have shown immense interest in the topic during the data collection stage have also self-nominated for involvement as stakeholders. It is noteworthy that this stage was not used for data collection. In the following sections, I will provide a brief introduction on the place of stakeholder involvement in the RS, and how it has been reconceptualised as stakeholder validation by some realist researchers. I will then provide a detailed account of how I have adopted this approach and the way in which stakeholder validation has helped to refine my programme theories using the 'if-then' statements. In the next section I will provide a brief account of stakeholder involvement in health research.

3:10:1 Stakeholders' involvement in health research

The concept and role of stakeholder involvement is gaining more popularity in health service research (Boaz et al., 2018; Beresford, 2003). Involving stakeholders in research can significantly improve the quality, content, consistency, experience and value of health research studies to its end users (South et al., 2016). According to Boaz et al. (2018), the use of stakeholder involvement in research requires close attention in three areas: 1) Mapping out potential stakeholders for a study (the 'who'); 2) Outlining the rationales for stakeholder involvement (the 'why'); and 3) Considering approaches to stakeholder involvement (the 'how').

Regardless of the call for approaches that foster openness and reciprocity to support patient and public involvement in research, the reporting on their involvement in evidence synthesis and research more broadly is inadequate (Price et al., 2018). In the next section I will provide a broader view of the 'who' and 'why' of stakeholder involvement in research studies, and in subsequent sections I will explain 'how' stakeholder involvement is used and conceptualised in realist studies.

It is important to find out 'who' can be considered as stakeholders in a study. The '7Ps' framework developed by Concannon et al. (2012) in a transatlantic study is regarded as a helpful tool to identify stakeholders in health research. The 7Ps are patients and the public, purchasers, providers, product makers, payers, principal investigators, public policy-makers and policy advocates working in the non-governmental sector. The reason 'why' stakeholders could be engaged in a linkage and exchange approach in health services research is because: 1) They have expert knowledge that should be considered; 2) They offer pluralisation of perspectives to a study, based on 'real-life' experience; 3) They have self-interest in a given issue and have an interest in the outcome of the study that could improve the championing and implementation of the findings (Boylan et al., 2019; Deverka et al., 2012).

In order to engage with the stakeholders, strategies such as the 'linkage and exchange model' (Lomas, 2000) are applied in health research with the aim to bring research findings and decision making closer together by emphasising interpersonal connections (interactions) as the mechanism that drives research into practice. As a result, stakeholder involvement, especially in health research can be rationalised and is more likely to contribute to the quality and legitimacy of subsequent actions. Boaz et al. (2018) have proposed design principles that are useful for planning stakeholder involvement within research programmes, and in monitoring and evaluating stakeholder involvement. It encompasses three groups, namely: organisational factors, values and practices. In the next section, I will illustrate 'how' stakeholder involvement is applied in realist studies and the way realist researchers' conceptualise stakeholder involvement in studies.

3:10:2 Stakeholders' involvement: a key characteristic in realist studies

Stakeholder involvement has been a key feature in realist studies. The idea behind stakeholder involvement in realist studies is for "*casting the net wide*" (Wong et al., 2013, p.12) by engaging lay or content experts to build up evidence to support theories on the basis of coherence and plausibility. Realist studies have referred to stakeholder involvement as advisory groups (Hewitt et al., 2014), the RS committee (Hudon et al., 2017) and stakeholder groups (Hashem et al., 2020). Additionally, studies have employed various methods to collect information and evidence to advance studies. As part of engaging with stakeholders, some studies (William et al., 2016; McCormack et al., 2013; Rycroft-Malone et al., 2012) have used workshops, colloquium meetings, telephone conferences and blog discussions as methods for obtaining information from stakeholders; on the other hand, studies (Abrams et al., 2020) have reported the use of informal conversations as a means to refine programme theories.

The use of stakeholder involvement in various stages of a study has been highly regarded by its proponents (Wong et al., 2013; Pawson et al., 2004) and other realist experts (Abrams et al., 2020; Cunningham et al., 2018; Wilson et al., 2015). Large-scale realist studies are informed by stakeholder reference groups that incorporate experts in the form of multidisciplinary communities of researchers, policy makers, service user representatives and practitioners, who were consulted at crucial stages of the review process. Stakeholders play a key role in helping to devise and reshape programme theories as the study progresses (Abrams et al., 2020; Abrahamson et al., 2020). In RS, the focus of the synthesis results from a negotiation between reviewers and stakeholders (Rycroft-Malone et al., 2012). As a result, the role of stakeholder involvement throughout the process is significant and has been used in the following stage of realist studies, such as: formulation of review questions; assisting with keywords for literature searches; and suggesting relevant literature.

3:10:3 Customisation of stakeholder involvement in realist studies

There is not a single prescribed approach for undertaking the RS (Pawson, 2006) but it demands much of the reviewers' ability to think flexibly and deal with complexity. This presents a unique challenge for the realist reviewer. Realist researchers have tailored the way in which they have used stakeholder involvement to meet the needs of individual studies. Some realist studies (Cunningham et al., 2018; Rycroft-Malone et al., 2012) used stakeholders in the process of 'validating' the emerging findings and in dissemination activity. Rycroft-Malone et al. (2012) also confirmed that they used stakeholder involvement to validate their own views, whereas Cunningham et al. (2018) relied on stakeholders for consistency.

Stakeholder involvement was used as a knowledge resource in some realist studies (Williams et al., 2016) for the purpose of developing the scope of the study and in developing IPTs (Hashem et al., 2020). Realist studies have also used stakeholder involvement for the purpose of advice, feedback, getting diverse perspectives; testing and refinement of CMO configurations to final programme theories; and discussing the findings, with the goal of developing plausible recommendations (Abrams et al., 2020; Abrahamson et al., 2020). It confirms that stakeholder involvement was used in such a way to meet the needs of individual study and that there is no prescriptive way of using stakeholder involvement in realist studies. There are a variety of arguments in the literature highlighting the pros and cons of the validation process. Buchbinder (2011) warns that stakeholders may not want to disagree with the findings, due to the power differentials between the researcher and the stakeholders, hence questioning the validity of this process. Some have argued that the validation process can cause harm to stakeholders (Hallett, 2013), whereas others have found it to be therapeutic (Koelsch, 2013) and of potential use as a reflective experience (Candela, 2019).

In the next section I will provide an account of how I have adopted stakeholder involvement for my study from its original plan, and due to the pandemic, how I adapted stakeholder involvement and how it helped refine my programme theories.

3:10:4 Rationales for adapting stakeholder involvement for my study

The unexpected emergence of the COVID-19 pandemic necessitated a detour from the study protocol that was originally submitted for the approval from Health Research Authority (see Section 3:11). The co-production network that was originally identified for the purpose of stakeholder involvement for my study became dormant and a need for alternative arrangement became inevitable.

While stakeholder groups are endorsed by RS, as described in Section 3:10:2, setting one up for my study was not performed, as it would have created challenges beyond the scope of my study parameters. Firstly, the potential time restraints in organising such a group and the feasibility of co-ordinating it during the COVID-19 pandemic presented difficulties. Secondly, organising a stakeholder group single-handedly appeared to be an unrealistic and time-consuming task that was not factored in the initial proposal. Thirdly, as this is a doctoral study, I concur with Abrams et al. (2020) about the likelihood of contention in the ownership of the new knowledge created as part of the stakeholder group. Although referring to larger realist studies, the authors have acknowledged that the contribution made by stakeholder groups at a later point in the study can be challenging for researchers, as it is difficult to ascertain the exact nature of involvement or contribution, if required or queried by funders, journal editors or other stakeholders. Additionally, at the outset, the stakeholder group can help balance the power dynamics through democratic conversation, but it also poses a risk of becoming entangled with the power dynamics between stakeholders and their preferences, which can digress from the research objectives (Rycroft-Malone et al., 2012). All these factors have contributed to taking the decision to move away from the prospect of having a fully-fledged stakeholder reference group. However, I decided to use stakeholder involvement on a one-to-one basis in my study, with the view to validate or challenge my findings, to refine my programme theories, and to get a diverse perspective from stakeholders regarding recommendations and methods for disseminating the findings.

3:10:5 Organising stakeholder involvement for my study

During realist studies, it is anticipated that conflicts of interest and ethical dilemmas can emerge at every stage over time (The RAMESES II, 2017). Numerous recruitment strategies were employed in realist studies to recruit stakeholders, from open invitations on research sites, invitations to content experts and to the extent where stakeholders themselves were "*self-selected to participate*" (McCormack et al., 2013, p.3). However, the details on any ethical issues encountered related to the recruitment process of stakeholders, and how they overcame these issues was seldom reported in published, peer-reviewed realist studies. On the other hand, some realist studies (Hudon et al., 2017) have reported the use of stakeholder involvement in key stages, including data collection, analysis and interpretation, and were content that ethical approval was not required and that they had followed the publication guidance set out in the RAMESES project (Wong et al., 2013). It is noteworthy that the guidelines provided by RAMESES do not make explicit recognition of the ethical dilemma on this topic. However, Wilson et al. (2015) have highlighted and addressed the ethical dilemma of the dual role of an individual in a single study as both a stakeholder and as a study participant as one that needs thoughtful consideration. The authors have provided valuable suggestions about the need to delineate the dual role of a study participant who may also fill the role of a stakeholder. This is pertinent to my study, as I have encountered a similar situation and, in the following section, I will explain the proactive measures I took, without breaching the delicate ethical line of the dual role of some stakeholders.

My approach and planning for stakeholder involvement were informed and underpinned by the design principles proposed by Boaz et al. (2018) for planning stakeholder involvement within research programmes (Appendix 21) and by using the key realist principle that states: "*ethical for whom, in what contexts, in what ways and how*?" that can be followed when encountering the ethical implications of realist studies (The RAMESES II project, 2017, p.1) (see Section 3:11). The next section will provide an account of how I applied these principles during the enrolment of stakeholders.

3:10:6 Enrolment process of stakeholders for the consolidation stage

Drawing on from the '7P' framework (Concannon et al., 2012), I identified and approached expert stakeholders including clinicians, members of the co-production network and some study participants, to inform them of the opportunity to become involved as stakeholders in my study by email. Some individuals approached had expressed their interest during the previous stage of this study. Given the unprecedented work pressure resulting from the pandemic, the medium of email was thought to provide a relatively easy, 'no-obligation' route to contact people. Additionally, physical access to sites was restricted as part of the government's COVID-19 guidelines.

Following the first phase of the enrolment process, I received responses from nine individuals who explicitly expressed their interest to work as stakeholders (Table 3:12). Those who responded to my request were apprised of the opportunity for the validation of findings (refining the programme theories) and its purpose, again the opportunity was left to the personal choice of each individual, without rendering any compulsion or coercion.

Stakeholders	Stakeholder roles	Stakeholders' responses to request for their involvement in the validation process
Stakeholder-1	Carer	Declined, related to COVID -19 pandemic
Stakeholder-2	Staff nurse	No response
Stakeholder-3	CQC specialist advisor	Accepted & contributed
Stakeholder-4	Service user	No response
Stakeholder-5	Occupational therapist	Accepted & contributed
Stakeholder-6	Occupational therapist	Declined, due to time constraints
Stakeholder-7	Academic	No response
Stakeholder-8	Peer support worker	Accepted & contributed
Stakeholder-9	Health care worker	Accepted & contributed
Stakeholder-10	Consultant psychiatrist	Accepted & contributed
Stakeholder-11	Psychology practitioner	Accepted & contributed
Stakeholder-12	Independent mental health advocate	No response
Stakeholder-13	Service user	Accepted & contributed
Stakeholder-14	Staff nurse	No response

Table 3:12 – Demography of stakeholders

During the time of enrolment, my discussions with stakeholders were informed by the three factors of the design principle for arranging stakeholder involvement (Boaz et al., 2018) and this helped to organise and inform the areas that needed to be discussed during the early stages. Additionally, this provided assurance that the stakeholders were aware of what the role of stakeholder entailed and were given time to reflect on the stakeholder role following our discussion. After giving careful consideration based on the key realist principle on ethics, the terms of reference set for the stakeholder involvement included the following:

1) Our engagement will be based on the ‘linkage and exchange model’;
2) No personal data would be collected and no direct quotes will be used in the thesis;
3) No recording of the event will take place and the conversation will be informal;
4) Stakeholders have the right to dis-engage; and
5) The process of engagement will not be a group activity, in line with COVID-19 guidelines.

The next section provides details of how the programme theories were refined using stakeholder involvement.

3:10:7 The process of engagement with stakeholders

I embraced the ‘linkage and exchange model’ (Lomas, 2000) during the stakeholder involvement as the interpersonal connection provides opportunities for stakeholders to use their expertise to refine, or refute the programme theories. In other words, it provides an opportunity to confirm or deny the accuracy and interpretations of the evidence synthesis from multiple data sources. In my study, I used stakeholder involvement for validation and to generate recommendations. The next section will explain how the refinement process using the ‘linkage and exchange’ model was carried out using the stakeholder involvement.

As indicated in the Table 3:12, seven stakeholders were engaged in this stage of the study. Programme theories were sent to all stakeholders by email prior to the meeting. Additionally, refined programme theories were presented to the stakeholders in a printed format and this was written using plain English, without any abbreviations. Stakeholders were given adequate time to read the information sent and were asked whether they had any questions prior to our discussion. Presenting a visual synopsis of the programme and underlying elements of context, mechanisms and outcomes that can stimulate reflection and reasoning among stakeholders, allows them to think retrospectively, encourages them to clarify their thoughts and helps them to funnel information to identify underlying mechanisms and processes (Rycroft-Malone et al., 2016; Eastwood et al., 2014; McEvoy & Richards, 2006). Following this, a discussion was facilitated in a teacher-learner cycle (adapted from the realist interview technique). The validation process started with discussing each programme theory and I opened by providing an explanation about each of the programme theories and their contents, ensuring full understanding. Having reflected on the theories, stakeholders provided their views and opinions on various components of the programme theories and, in this way, the role of researcher and the stakeholder was interchanging (Manzano, 2016).

3:10:8 The significance of ‘if-then’ statements

Refined programme theories were finely tuned using ‘if-then’ statements, which provide logical and plausible explanations of the programme for the purpose of empirical testing (Pawson, 2013). Programmes always begin as theories and start their journey from the minds of policy makers, to implementation by practitioners, and finally reach the users of the programme. According to Pawson (2013), this journey is an ‘if-then’ hypothesis or proposition. The basic assumption behind this proposition is that ‘if’ certain resources or right processes operate in the right conditions, ‘then’ it might instigate reasoning in the recipients and generate a change in their behaviour or action. Thus ‘if-then’ statements have a key implicit contextual purpose, where they have the ability to explain what will happen if the assumptions are (or are not) implemented in a particular way for all programme users in all similar contexts (Ebenso et al., 2019). ‘If-then’ statements provide critical details about a programme, as it renders programme theory into its constituent and interconnected elements. Therefore, casting an ‘if-then’ proposition provides a starting point to evaluate programme theories (Pawson, 2013). In other words, the ability to subject ‘if-then’ propositions for empirical testing makes it qualify as a middle-range theory (Hewitt et al., 2013). As the ‘if-then’ statements contained fine-grained, contextualised information, it was invaluable for writing recommendations for practice.

3:11 Key ethical considerations

This study has strictly adhered to all the requirements and standards stipulated by the Research Governance Framework for Health and Social Care, as directed by the Health Research Authority (2017a). This study was reviewed and approved by the London-Camberwell and St. Giles Research Ethics Committee (REC ref: 17/LO/1681) (Appendix 22). As explained in the previous sections, this study was conducted in three stages and ethics approval was obtained at the commencement of Stage-1 for the purpose of primary data collection, using semi-structured interviews.

3:11:1 Informed consent

Informed consent (both written and verbal) from all participants who expressed an interest to take part in the study was obtained prior to interview (see Appendices 18, 19 and 20). According to Gerrish and Lacey (2010), informed consent is "*the process of ensuring that research participants are fully aware of what the study involves, and freely agree to take part*" (p.529). I used the following steps suggested by Boynton (2005) in gaining consent from participants. They are: providing information leaflets and explaining the study to participants; providing time to think about participating; providing a consent form for participants; and verifying participants' understanding about the study. This was a requirement of the Health Research Framework (Health Research Authority, 2017a) based on international codes of ethics, such as the *Nuremberg Code* (1949) and the *Declaration of Helsinki* (1964) (revised in 2013) (Streubert & Carpenter, 2011). Participants were made aware of their right to withdraw their consent at any point during the study. Participants were reassured that all information they provided would be maintained in strict confidence. The following section will provide details of the process involved in recruiting all three groups of participants.

3:11:1:1 Service user participants

It was not anticipated that major ethical issues would arise from this study. This study required information from service users who have received care in this area, where recovery and experience are unique. As a result, service users' experiences, views and interpretations, were quintessential to addressing the research questions. However, I was aware that service user participants are on their journey to recovery, and discussion of sensitive issues, such as an unpleasant personal experience and potential exposure to bad practice, can provoke anxiety and distress. I have experience working with these population groups and have skills in dealing with sensitive areas. Furthermore, I was aware that to be a part of focus groups can also provoke anxiety. Therefore, eligible participants were offered the option of a one-to-one interview, instead of the focus group.

I ensured that written informed consent was obtained from the participant at the point of data collection. Participants were given the opportunity to take intermissions during interviews. Participants were also reassured that exercising their right to withdraw from the study would not affect any care they received from the participating NHS Trust.

I offered £20 worth of shopping vouchers, and also reimbursed travel expenses for all service user participants who took part in this study. The incentives provided were not sufficiently coercive to over-ride freely given consent, considering the financial status of the participants targeted. Specifically, the vouchers involved only covered reasonable recompense for the time given to take part in the study.

3:11:1:2 Mental health staff participants

Mental health staff participants have a very demanding work schedule, and have clinical responsibility. Due to constraints on time, participation from this group of participants relied on my sensitivity to participants' time. I planned to arrange focus groups at an optimal time for mental health staff participants, to avoid undue stress and burden. As an example, focus groups could have been facilitated following team meetings, in order to minimise impact on mental health staff participant time, and I planned to provide refreshments. I also provided a choice between focus groups and interviews to all eligible mental health staff participants. In the event, I conducted interviews to accommodate their convenience and preference.

3:11:1:3 Stakeholder participants

I was aware of the national/regional stakeholder participants' time constraints and commitments. I planned to arrange interviews with this group of participants at a time convenient to them, and that their interview would not take any longer than 30 minutes.

3:11:2 Changes to study design in response to COVID-19 pandemic

The original plan was a consultation phase with the co-production network of the host NHS Trust for the purpose of theory consolidation. As it did not anticipate any data collection, ethics approval was not required for this stage, but this was explained in the research proposal that was submitted for ethics approval from Health Research Authority. However, the co-production network meetings were disbanded due to the unexpected emergence of the COVID-19 pandemic, which forced me to come up with a plan to mitigate this situation. Stakeholders who were interested in my study, including some study participants who expressed their desire to be involved in the study, were approached individually to be involved in the consolidation stage to validate the findings and refine programme theories. This alteration from the previously agreed plan did not require ethics approval for following reasons:

1) There was no data collection involved in this stage;
2) The change did not affect participants' taking part in the theory refinement stage;
3) The change did not affect the scientific value of the study and the same task (validation of findings and theory refinement) was achieved using individual stakeholder involvement and not just in the form of a network meeting;
4) There were no additional ethical risks to individuals from the change.

This plan of change and its potential ethical issues were discussed during supervision and was clarified with the Research Ethics and Governance Manager of the University of Kent that a formal request to HRA for an amendment was not required.

3:12 Managing participants' well-being during interviews

I was aware that taking part in an interview can provoke anxiety. In the event of a participant expressing signs of any distress, I planned to immediately offer support to the participant and to stop the interview, take the participant aside and ensure they had a chance to recover from immediate distress. A distress-management protocol (Appendix 23) was developed, which explains the actions I would take in these circumstances.

3:13 Intentional breaking of confidentiality

It is recognised that there may be occasions when researchers feel the need to break confidentiality when they hear something that may indicate a risk to the participant or others (Masson, 2004). To protect the participant, or others, from risk of harm, the researcher may be obliged to share this information with those caring for the participant, but the researcher would keep the participant fully informed about this. In the event of recognising bad practices by mental health staff that place service users at risk of harm or neglect, the researcher has a duty of care to report it to the respective manager of the mental health staff participant. I mentioned this in the information sheet for service user participants (Appendix 12) and for mental health staff participants (Appendix 13).

3:14 The researcher as instrument

Researcher as an instrument is recognised as one of the characteristics of a qualitative researcher who plays multiple roles as an observer, inquirer and interpreter, which can cause subjective bias (Streubert & Carpenter, 2011). In any research study, the integrity and honesty of a researcher are vital. According to Poggenpoel and Myburgh (2003), in qualitative research, the researcher as instrument can pose a significant threat to trustworthiness. It is the responsibility of a researcher to be truthful to the data and, for that reason, the researcher should acknowledge any personal bias and interpret data that accurately reflects the participants' views and reality (Coup & Schneider, 2007). I believe that meeting the research participants for the purpose of theory refining and consolidation with the stakeholders has helped me to remain truthful to the data.

Research, such as my study, that is carried out from within an organisation is sometimes known as 'insider research' (Robson, 2011). It must be recognised that this can arguably create conflict of interest, validity and risk of coercion, which raises ethical concerns. Furthermore, Van Heugten (2004) has pointed out that, if insider research is carried out without self-awareness, honesty and reflection, it will produce a biased report of limited use. However, evidence from the literature suggests that the strengths of 'insider research' (Dodd & Epstein, 2012; Smith, 2009) outnumber the ethical concerns raised by insider research. Firstly, this includes the practitioner researcher's knowledge of systems; established networks for a sample of participants' awareness and proximity to practice problems; and having relationships in place that can promote the trust needed for openness in responses. As mentioned, the research question and design have been discussed with the Experts by Experience (service users) group and co-productive network of this NHS Trust, who were very keen to see the progress of this study and its outcome.

Secondly, insider research can also help practitioners to engage in research-minded practice, which will help to establish a sense of ownership of the research (Nutley et al., 2007). Being an employee of the NHS Trust gives me a unique position as a practitioner researcher to study a particular issue in depth, with special knowledge about that issue and to utilise local resources. However, I do maintain a distance from practice, which permits a necessary degree of detachment in reducing the potential for coercion in recruitment, and enabled participants to freely express their opinions. I do not manage any mental health staff on acute inpatient units or in the community teams, nor do I have any clinical responsibility for any service users in either area. Additionally, I am geographically detached from the study sites, and I am not a member of staff from any of these study sites. I was able to successfully complete the 'Good Clinical Practice' (GCP) training course provided by the National Institute for Health Research (NIHR), and I am aware of the regulations and guidelines of GCP. I also work as a registered practitioner, and am bound by the code of practice of the respective professional body (NMC, 2018).

3:15 Research rigour

It is important to communicate the quality of a study and what constitutes the findings of a study as scientific evidence (Nelson, 2008). When research lacks rigour, it is worthless and becomes fiction with no value (Morse et al., 2002). The debates on using the concepts of reliability and validity versus the concept of trustworthiness in qualitative studies are recorded extensively in literature (Guba & Lincoln, 1989). However, the objective of rigour in qualitative research is to personify participant's views and experiences (Streubert & Carpenter, 2011). From a realist perspective, all truths are considered as fallible and tentative, therefore I agree with Hammersley's (1992) notion of subtle realism, which provides a more reconciliatory position. This means research is more focused on illustrating what is regarded as reality, rather than trying to present truth accurately.

Rigour must be built into the research process, rather than making it a post-inquiry evaluation (Cypress, 2017). The terms that describe operational techniques put forward by Guba and Lincoln (1994) support rigour in research. These are: credibility, dependability, confirmability and transferability.

3:15:1 Credibility

This involves actions that increase the probability of producing credible findings. Validation of the researcher's findings by stakeholders is a way to confirm credibility. Stakeholder involvement was seen as a means to validate the findings from this study, through which the researcher's interpretation of the data is compared against the research stakeholders' views, thus adding credibility to the findings (Candela, 2019; Mays & Pope, 2000). According to Doyle

(2007), this process can validate, assess or verify the trustworthiness of research findings to minimise researcher bias. The formulation of IPTs, and developing interview schedules based on these IPTs, has certainly enhanced the credibility of the findings from this study. By presenting sufficient references and quotes to illustrate my arguments, I hope the reader will recognise the validity of my interpretation, and trust its credibility. Furthermore, the process involved in theory refinement, theory consolidation and validating the salient transferable actions by stakeholders, facilitates the credibility of this study.

3:15:2 Dependability

Dependability refers to the stability of data over time and under different conditions (Sandelowski, 1998). To enhance the dependability of the findings, this study included space and person triangulation, which is classed under data triangulation (Denzin, 1989). The use of primary data from multiple sites helped to achieve space triangulation. Recruiting different levels and types of participants in this study (service users, mental health staff and stakeholders) has helped to increase the confidence in the data and to achieve person triangulation. The uses of the RR to gather evidence from secondary data and collection of primary data through qualitative interviews, has arguably provided methodological triangulation. Streubert and Carpenter (2011) have acknowledged this as a recognised triangulation method and Wilson and Hutchinson (1991) have given an example of using two qualitative methods within a study design. Furthermore, during data analysis, the IPTs were considered as common denominators. By using the deductive and inductive approach to refine, validate, falsify and refute these IPTs during data analysis, I argue that this study has also used theoretical triangulation. The triangulation used in this study promotes the dependability of its findings.

3:15:3 Confirmability

Conformability refers to the objectivity, that is, the potential for congruence between two or more independent individuals about findings, relevance and meaning (Polit & Beck, 2012). The use of audit trails during evidence gathering is recommended by Pawson et al. (2004) and the process involved in articulating, refining and consolidation of programme theories is explained in the respective chapters. However, it is noteworthy that the RR is not standardised or reproducible (Pawson et al., 2004). In line with this, Morse (1991) and

Sandelowski (1998) have suggested that the decisions and findings of a study can only be confirmed by an original researcher.

3:15:4 Transferability

This refers to the ability to apply findings from this study in a similar setting. Realist studies try to explain ‘what works, for whom, in what circumstances, and why’. This is a context-specific method, which tries to address research questions that are applicable in all similar areas of practice. Hence, I argue that this study satisfies the transferability criteria.

3:16 Chapter summary

This chapter illustrated the way in which the research design was formulated, based on realist principles, to address the research questions concerned with the lack of SUI in ROCP. RS was used as the realist methodology, and was applied in three stages: theory gleaning stage (Stage 1), theory refinement stage (Stage-2) and theory consolidation (Stage-3). IPTs were formulated in the theory gleaning stage, following a background search of the literature. Informal discussions with experts and my clinical experience have also informed the formulation of IPTs.

In the theory refining stage (Stage-2), a realist search for relevant evidence (RR) and realist theory-driven interviews (qualitative) were carried out concurrently with the view to refine the IPTs.

The study recruited three types of participants: service users, mental health staff and regional/national stakeholders. Eligible participants were selected using a recruitment strategy that involved eligibility criteria. A clear data-handling strategy was used to maintain the confidentiality of data, in accordance with the General Data Protection Regulation (2018). For data analysis, a framework method with the assistance of the NVivo-11 computer software programme was used. The primary and secondary data were analysed and synthesised using the process of abduction and retroduction, which led to the initial refinement of IPTs.

In the theory consolidation stage, refined programme theories were validated using stakeholder involvement. Subsequently, refined theories were advanced and consolidated to middle-range theories using ‘if-then’ statements. From these theories, salient transferable actions that have implications for clinical practice within the context of this study were developed. By applying the operational techniques such as credibility, dependability, confirmability and transferability, as recommended by Guba and Lincoln (1994), rigour and quality for this study have been enhanced and its findings can be treated as scientific evidence. This chapter has also considered various ethical aspects related to this study.

Chapter-4: Findings – Part 1

4:1 Introduction

This chapter presents the first three refined programme theories (PTs) pertaining to SUI in ROCP during an acute care pathway using evidence from the RR, which was concurrently refined by testing with the interview data. They are PT-1: Provider-controlled care transition: 'admission to AIMHUs', PT-2: Care plan as a recovery tool? and PT-3: Ward rounds as a non-inclusive arena. The presentation of findings for each PT commences with IPT and a brief background. This will be followed by a rich narrative account of the evidence from the RR used to refine IPTs using abductive inference (see Chapter 3, Section 3:8:8) and will be displayed using a CMO configuration. Subsequently, a descriptive account of the interview data will be presented to illustrate further refinement and testing, using retroductive inference (Chapter 3, Section 3:8:8). A refined CMO configuration will be presented at the end, from which refined programme theories were synthesised and articulated. Even though the refinement process with both sets of data took place concurrently, I have chosen to present the refinement process in a systematic and linear fashion. This approach was adopted to make the refinement process more transparent. I will use an italic font (in bold text) to highlight the sections in the CMO configuration that were refined using the interview data. In order to avoid repetition by re-quoting participants' responses from interview data, and to maintain a logical flow, some quotes that illustrate key linkage between C, M and O are featured in boxes, and the quotes that are presented in the main body of the text represent a particular Context [C], Mechanism[M] or Outcome[O]. Furthermore, the quotes in the boxes have multiple references and may be relevant to various elements of the CMO. The chapter ends by presenting a narrative form of the 1st, 2nd and 3rd refined PTs as a concise summary to facilitate understanding.

4:2 Programme Theory (PT)-1: Provider-controlled care transition: 'admission to AIMHUs'

This PT refers to the limitations to service users' active involvement in their care, from their transition of care from the community to AIMHUs, as a result of the current approach in the use of AIMHUs in providing mental health care. The IPT identified during the theory gleaning stage (see Chapter 3, Section 3:7:1) was:

"*The current focus of care on AIMHU challenges the overt application of ROP [C] as the professionals rely on clinical recovery as a means to meet organisational demand over service users' needs [M]. This practice contributes to the current non-therapeutic nature of AIMHUs with increased numbers of compulsory admissions and negative service user experience [O]*."

I have already illustrated the link between SUI and ROP (see Chapter 1, Section 1:5). Evidence from the RR indicates a number of challenges for the overt application of ROP in AIMHUs, which ultimately impacts on SUI in ROCP. Findings from the RR suggest that adherence to ROP at the outset of the service user's' journey to AIMHU is quintessential for making conditions favourable for service users to have an active role to be involved in ROCP. Based on the chain of inference (see Chapter3, Section 3:8:1:3) and themes emerging from the RR, three mechanisms were identified for this PT that led to producing undesirable outcomes. I will explain the challenges for ROP in AIMHUs in the next section.

4:2:1 Background

Being a policy-driven approach, the onus on translating the principles of recovery into practice lies with the health care professionals (McKenna et al., 2014). This means services are supposed to work with service users as active participants and equal partners from admission (McCloughen et al., 2011). However, evidence from the RR indicates that its application into acute inpatient practice has encountered significant challenges for staff and organisations (Box 4:1:1).

> *"While there is much rhetoric regarding the intent of services to work with consumers as active participants and equal partners, in reality this is seldom the case, and it should be recognized that the ethical ideal and practical reality of having consumers collaborate in their care must be understood as more than a simple matter of believing in that ideal or acknowledging that reality."* (McCloughen et al., 2011, p.48)
>
> *"While achieving the knowledge and attitude of recovery orientation theoretically, health professionals in inpatient settings seem to have significant difficulties in modifying their practice accordingly."* (Waldemar et al., 2019, p.319)

Box 4:1:1

Additionally, the RR identified challenges encountered during its application in AIMHUs (Box 4:1:2).

> *"In acute inpatient mental health settings characterised by high acuity, rapid turnover, a perception of risk, and involuntary treatment, mental health nurses are grappling with how recovery-oriented practice applies in their workplace."* (McKenna et al., 2014, p.526)

Box 4:1:2

The next section will use evidence from the RR to articulate the elements of CMO that have helped to create a plausible explanation, using a CMO configuration. These are illustrated under the following headings:

1. "*Contemporary focus of care in AIMHU is crisis stabilisation and symptom reduction*"
2. "*Low capacity" and "competing demands*" versus "*individual needs of the patient*".
3. "*Admissions to AIMHUs as a 'last resort' approach*"
4. "*Clinician-driven decision making in short-stay frameworks*"

4:2:2 "*Contemporary focus of care in AIMHU is crisis stabilisation and symptom reduction*"

AIMHUs are an integral part of the mental health care system where it provides care for service users in a hospital setting. Admissions to these units can be on a voluntary or involuntary basis. The role and purpose of the AIMHU is described below (Box 4:1:3):

"The purpose of an adult acute psychiatric inpatient service is to provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness. It should be for the benefit of those service users whose circumstances or acute care needs are such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restrictive residential setting." (DoH, 2002, p.5)

Box 4:1:3

The contemporary focus of care in AIMHUs is crisis stabilisation and a symptom-reduction approach (Waldemar et al., 2016; Yarborough et al., 2016; Glick et al., 2011) and admissions to these units are controlled and closely monitored by organisations through professionals. In the following sections, I will explore how it impacts the promotion of ROP in AIMHUs, using the literature from the RR.

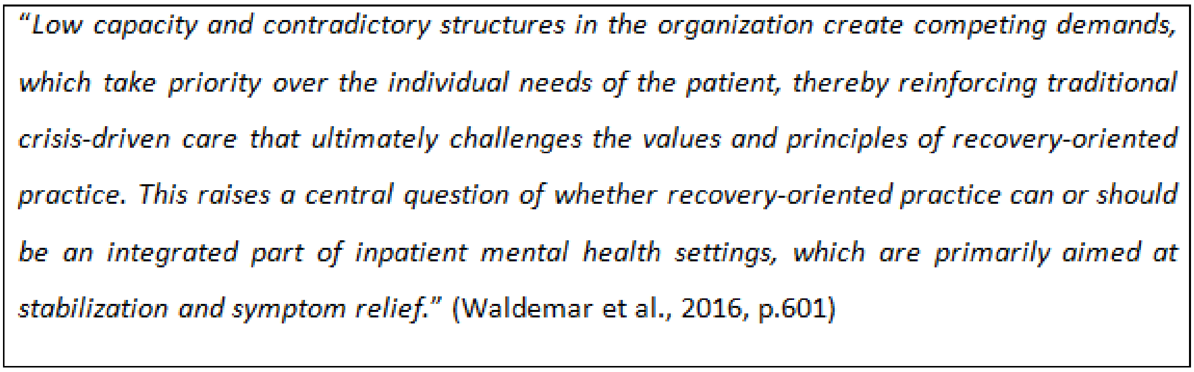
As part of a global trend toward deinstitutionalisation of mental health care from inpatient care to community-oriented care, there has been a steady decline in the number of AIMHU beds in the UK. The bed numbers plummeted from 67,122 in 1997–1998 to 26,929 in 2007–2008 (Niehaus et al., 2008). As part of this change, organisations have adopted measures to accommodate the demands for inpatient beds in AIMHUs. These changes are reflected in the role and focus of care delivered in AIMHUs. A policy document furnished to provide guidance for commissioners (Box 4:1:4) has made some notable changes to the way it describes the focus of care and the changes it anticipates in the function of AIMHUs to meet new demands.

"Inpatient wards have an important place within the acute care pathway and should have a focus on enabling patients to get as well as possible, as quickly as possible." (Joint Commissioning Panel for Mental Health, 2013, p.17)

Box 4:1:4

The phrases in the above statement such as, "*as well as possible, as quickly as possible,*" describe the two areas that are currently the focal point of care in AIMHUs. This is consistent with other evidences from the RR that indicate organisations have embraced crisis stabilisation, safety and symptom-reduction as the current focus and approach to care in

AIMHUs (Wyder et al., 2017; Waldemar et al., 2016; Yarborough et al., 2016; Glick et al., 2011). According to Waldemar et al. (2016), this approach places the focus on clinical outcome (clinical recovery), whereas ROP is based on values and principles of person orientation and involvement. It therefore creates a context that contradicts the overt application of ROP and, as a result, I have identified it as a context [C] for this PT. The rationale for adopting this approach by organisations is explained by Waldemar et al. (2016) (Box 4:1:5), which also unravels the mechanisms [M] emanating from this context. They have stated that implementation of ROP can be compromised when the demands of the organisation take priority over service users' expectations and goals (personal recovery). Further to the evidence from the RR, interview data from my study also identified and supported this as 'events' that staff encounter in their practice (see Section 4:2:9).



> *"Low capacity and contradictory structures in the organization create competing demands, which take priority over the individual needs of the patient, thereby reinforcing traditional crisis-driven care that ultimately challenges the values and principles of recovery-oriented practice. This raises a central question of whether recovery-oriented practice can or should be an integrated part of inpatient mental health settings, which are primarily aimed at stabilization and symptom relief."* (Waldemar et al., 2016, p.601)

Box 4:1:5

4:2:3 "*Low capacity*" and "*competing demands*" versus "*individual needs of the patient*"

As previously mentioned, evidence from the RR suggested that admissions to AIMHUs are controlled and closely scrutinised by organisations through the professionals (Wright et al., 2016; Light et al., 2014; Lammers & Happell, 2004) based on the availability of resources (in this instance, inpatient beds). Due to the shortage of beds in AIMHUs, inpatient beds are tightly managed by organisations using composite measures. I have noticed increasing reference to phrases such as 'gatekeeping' (Box 4:1:6) in recent policy documents (DoH, 2002; 1999).

> *"It refers to services that providers do for commissioners. Gatekeeping involves assessing the service user before admission to hospital to consider whether there are alternatives to admission and the CRHT* [Crisis Resolution Home Treatment Team] *(or equivalent) involvement in the decision-making processes that result in admission. An admission has been gate kept by the CRHT if they have assessed the service user before admission and if they were involved in the decision-making process which resulted in admission."* (NHS, 2018)

Box 4:1:6

Organisations maintain a 'gatekeeping' role to ensure that inpatient beds are assigned to meet the criteria for clinical recovery set by the organisations (Olasoji et al., 2017). In acute mental health care, 'gatekeeping' is a practice that is mainly undertaken by professionals. It was also evident during the RR that a 'gatekeeping' role was adopted to evade any unnecessary admissions and to make them available for the most unwell service users in the community. This reasoning indicates the presence of a mechanism [M] for this PT. This mechanism arguably creates unfavourable conditions for SUI, as debilitating mental illness is often referred to in literature as a barrier to SUI (Stringer et al., 2008). Evidence suggests that this practice has at times undermined and discounted service users' needs (Box 4:1:7). This explanation neither indicates treating service users as equal partners, nor anticipates a choice in treatment decision at the time of admission.

> *"Service users can experience stigma and discrimination from the negative attitudes of mental health staff. Within the literature, particular prominence is given to those with comorbid substance misuse issues and those diagnosed with personality disorder. More negative attitudes are expressed when individuals are perceived to be 'not ill' and therefore wasting precious resources or being in some way responsible for their predicament."* (Wright el al., 2016, p.374)

Box 4:1:7

From a realist point of view, "*as well as possible, as quickly as possible*" is a 'resource' for organisations and professionals to meet the increasing demands for beds in AIMHUs, which was caused by a reduction in bed numbers. This has helped professionals to take necessary measures to meet these demands by controlling admissions to AIMHUs. Even though the purpose of ‘gatekeeping’ is to look for alternatives for admission, increasing evidence from the literature suggests that the basic drive for this action from professionals is to meet the demands of the organisation and this leads to increasing the threshold for admissions to AIMHUs (McNicoll, 2013a&b). This contributes to providing control and power to professionals, to make unilateral decisions about the use of AIMHUs. The hidden factor (mechanism) that drives professionals is their pursuit to meet organisations’ competing demands on beds over service users’ needs. Additionally, anticipating this approach from professionals to mitigate organisational demands questions the legitimacy of policy-preferred, recovery-oriented mental health care and practice. The observation made by Warrender (2016) fits well to explain this scenario. He stated that: “*the notions of the patient having control, self-management and self-efficacy, are at odds with the primary purpose of acute mental health, which is to manage crisis*” (p.1). Additionally, a study conducted by Wright et al. (2016) has revealed that service users lose their voice at the time of transition (admission or discharge), which is disempowering and gives a negative experience to service users and carers during transition processes. I was able to see this as one of the outcomes (Table 4:1:1, Outcome 3) produced as a result of the context of this PT, which also emerged as a theme during the interviews (see Sections 4:2:10 and 5:3:9). Furthermore, service users and carers felt that they are unable to wield any influence regarding a service user’s admission to the AIMHU.

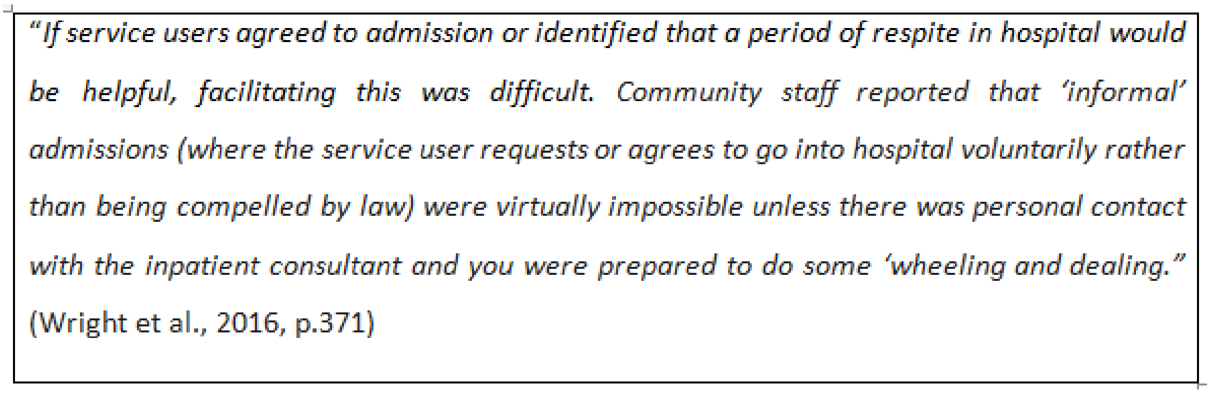
4:2:4 “*Admissions to AIMHUs as a ‘last resort’ approach*”

In the previous section, it was clear that the threshold for admissions to AIMHUs has been raised. As a result, admissions to AIMHUs are taking place at a later stage of illness, when service users are increasingly disturbed (Cleary, 2003). Admissions are offered to service users as a last resort, when all avenues for safe delivery of care are exhausted (Bowers, 2005). Reports from the CQC (2020; 2015a&b) have revealed a consistent rise in the use of compulsory admissions under the Mental Health Act (Jones, 2020) in England, which substantiates this finding. A study conducted on AIMHUs by Bowers et al. (2005) provides valuable explanation to this manifestation (Box 4:1:8).

> *"Admission was a 'last resort', and that community psychiatric services and teams were strongly geared towards keeping people out of hospital and treating them in the community as far as possible. This was considered to be the function of Community Mental Health Teams, Home Treatment Teams, and Assertive Community Treatment Teams. Over occupancy of ward beds was another factor leading to only the most severe and emergency cases gaining admission. However, as one respondent remarked, this huge emphasis on keeping people out meant that when an admission did have to occur, it could be seen in a negative light, as a failure."* (Bowers et al., 2005, p.628)

Box 4:1:8

This finding has shed light on a mechanism that is relevant to this PT, where organisations use AIMHUs as a *"last resort"* and *"in a negative light, as a failure".* This is to deal with the shortage of beds in AIMHU and admissions are prioritised for the most unwell people in the community. I did not find any evidence that supports a "*last resort*" approach was taken exclusively in line with the least restrictive principles of the Mental Health Act (Jones, 2020). A government directive to commissioners in mental health has made a recommendation to dissuade them from the approach of using admissions to AIMHUs as a 'last resort' (Joint Commissioning Panel for Mental Health, 2013). On the contrary, there are a number of evidences suggesting admissions to AIMHUs as problematic (Crisp et al., 2016; Wright et al., 2016; McNicoll, 2013a), which indicates the depth of this issue. Furthermore, this practice often results in instigating conflict between mental health organisations (inpatient and community teams), carers and service users (Olasoji et al., 2017; Ewertzon et al., 2012; Highet et al., 2005), where organisations take unilateral decisions about admissions to AIMHUs. A recent national inquiry into acute mental health care has revealed that access to AIMHU acute care for the severely mentally unwell is insufficient (Crisp et al., 2016). Additionally, findings from a recent study reveal tensions between community and inpatient teams trying to get access for service users (Box 4:1:9). Therefore, reasonable evidence from the RR indicates a clear reasoning in using AIMHUs as a 'last resort' by organisations, which makes it one of the mechanisms [M] for this PT.



> *"If service users agreed to admission or identified that a period of respite in hospital would be helpful, facilitating this was difficult. Community staff reported that 'informal' admissions (where the service user requests or agrees to go into hospital voluntarily rather than being compelled by law) were virtually impossible unless there was personal contact with the inpatient consultant and you were prepared to do some 'wheeling and dealing."*
> (Wright et al., 2016, p.371)

Box 4:1:9

These findings can illustrate the reason for the increased level of acuity, increased disturbed behaviour and high number of compulsory admissions to AIMHUs. One of the evidences from the RR indicated that: "*features of acute wards are a consequence of the policy shift away from hospital care so that only the most unwell and complex service users are admitted to hospital in the first place*" (NICE, 2011, p.106). In light of the evidence that suggests debilitating mental illness is a barrier to SUI, it can be argued that this practice shapes the AIMHU as chaotic, unpredictable and a non-conducive place for recovery, as reported by the Mental Health Taskforce (2016). I was able to identify it as an outcome [O] of this approach taken by the organisations and professionals (Table 4:1:1; O-1). Due to service users' presentation, "*the acute unit takes this control to ensure safety when the person struggles to maintain it themselves*" (Warrender, 2016, p.1). Mental health services are strongly risk averse (Wyder et al., 2017) and when service users pose a risk to themselves or others, the priority of the AIMHUs switches from a therapeutic role to custodial care, which can constrain service users' autonomy. Cleary et al. (2013) have stated that risk management in hospitals is a constraint for SUI. As a result, service users develop a negative experience about their care in AIMHUs and they perceive that admissions to these units are for custodial reasons (Nolan et al., 2011; Currid, 2009), which I identify as a negative mechanism created by this approach (Table 4:8:1:1, M-2). This leads to a "*sense of separation between staff and service users*" (Isobel, 2019, p.110) that creates an "*us and them dichotomy*" (Rose et al., 2015, p.94), which I found to be an undesirable outcome (Table 4:1:1, O-4). Additionally, it reinforces the point made by Kidd et al. (2014a) that the acuity of service users who are admitted to AIMHUs is posing a lot of constraints for the overt application of ROP in AIMHUs.

4:2:5 “*Clinician-driven decision making in short-stay frameworks*”

> *“Delivering care driven by the agenda of a vulnerable, distressed patient who may be detained against his or her will may seem to run counter to ward practices that increasingly emphasize risk management and clinician-driven decision making in short-stay frameworks.”* (Kidd et al., 2014a, p.222)

Box 4:1:10

The evidence provided in Box 4:1:10 indicates the background staff encounter in relation to providing care for service users who are admitted to AIMHU. A recent study (Wyder et al., 2017) has identified a change in service users’ characteristics at the time of admission. They have stated that “*because of a decrease in the number of suitable beds, there was an increased acuity of the mental state of consumers on admission*” (p.535). During service users’ admission to AIMHUs, staff perceive that they are too unwell to be involved in decision-making processes and staff are under pressure from the system to transfer service users swiftly out of the AIMHU to free up beds (Wyder et al., 2017). When the onus on translating the principles of recovery into practice lies with the professionals, it is paradoxical that the system puts pressure on staff to move service users swiftly through the system. Arguably, here the system is anticipating the use of clinical recovery. Warrender (2016) has observed that: “*whilst many acute environments are recovery orientated in terms of staff philosophy and approach to patients, the system itself has a ‘fail-focus’, being set up to intervene ‘when things go wrong*” (p.1).

Additionally, Cusack et al. (2016) observed that “*the medical profession uses a symptom-focused approach to mental healthcare delivery and that this can stifle the development and implementation of recovery-orientated practice”* (p.102). Therefore, the acute nature of the illness, along with the focus on symptom reduction, results in professionals from multidisciplinary teams taking a symptom-focused and problem-oriented approach that reinforces the medical model of practice. The response of staff to the “*pressure from above to free the beds up*” (Wright et al., 2016, p.372) attenuates principles of ROP and attunes their practice towards the medical model of care. Professionals’ take control over service users’ treatment using their professional knowledge and the emphasis is on promoting clinical recovery, which might be different to the personal recovery goals of service users. The hidden mechanism that switches ROP into the medical model of practice in this context is the professionals' way of responding to the pressure from the system to free up beds. It subsequently marginalises service users and carers from treatment, leading to negative experience, which I identified as another outcome (Table 4:1:1, O-3) created by the context [C].

4:2:6 Refined CMO configuration based on the RR for PT-1: Provider-controlled care transition: 'admission to AIMHUs'

Context [C]	The contemporary nature and the focus of care in AIMHUs, based on a crisis-driven and symptom-reduction approach adopted by organisations, contribute to limitations on service users' choice and autonomy, which contradicts the value associated with recovery-oriented practice.
Mechanism-1 [M-1]	The decisions about admission and discharge from AIMHUs are controlled predominantly by using professional expertise and are based on their understanding that care in AIMHUs is an increasingly limited resource. Organisations are aware of the limited availability of inpatient beds on AIMHUs and to manage this situation they take on a "*gatekeeper*" role to scrutinise and control the use of beds on AIMHUs. The precautionary action taken by professionals and organisations leads to the rise in acutely unwell service users, who lose their voice during transition of care. They have limited ability to use their personal resources to influence their treatment decisions.
Mechanism-2 [M-2]	In order to comply with the least restrictive principles endorsed by the Mental Health Act policy, health organisations use AIMHUs as a 'last resort' for treating service users, after exhausting all other options in the community. Service users who are admitted to these units are acutely unwell, with a higher number subjected to compulsory admissions where units are overburdened with a high number of service users with complex problems. Professionals are risk averse; they prioritise risk management

	and symptom stabilisation in order to progress service users rapidly through the system.
Mechanism-3 [M-3]	The current focus of care and the approach to admissions adopted by mental health services anticipates and promotes the use of a symptom-focused and problem-oriented approach that reinforces the medical model of care, which contravenes the principles of recovery-oriented practice.
Outcome-1 [O-1]	The AIMHUs remains chaotic, unpredictable and not conducive to promoting service users' recovery.
Outcome-2 [O-2]	There are increasing numbers of compulsory admissions that contribute to the chaotic and unpredictable nature of AIMHUs, which ultimately creates an area of practice that is not conducive for recovery.
Outcome-3 [O-3]	Service users are disempowered and have negative experiences of the acute inpatient care pathway.
Outcome-4 [O-4]	Service users feel powerless and lack control in contributing to their care. It creates an 'us and them' divide between service users and staff.

Table 4:1:1 – Refined CMO configuration based on the RR for PT-1: Provider-controlled care transition: 'admission to AIMHUs'

4:2:7 Refinement of CMO using interview data for PT-1: Provider-controlled care transition: 'admission to AIMHUs'

Data from the RR clearly indicated challenges to recovery-oriented practice (ROP) in AIMHUs. Correspondingly, interview data also supports this finding and confirms the existence and relevance of this PT. The interview data has helped to refine the CMO configuration further. In the next section I will provide a detailed account of the refinement process, using the interview data through the application of retroductive inference.

4:2:8 "*The idea is to get people stabilised*"

Many participants made implicit reference to the identified context of this PT and one of the stakeholder participants summed it up by saying, "*the key issues are not individuals [professionals], it is the system*" (Stakeholder Participant-1[see Chapter 3, Section 3:8:2:8]). This was to describe the approach adapted in mental health practice in relation to the context [C], which was identified from the RR (see Section 4:2:2), where the system and mental health providers have developed a custom where service users are being admitted for symptom reduction and crisis stabilisation. In relation to bed occupancy on AIMHUs, one of the staff participants stated that AIMHUs are *"oversubscribed and under-resourced"* (Staff Participant-6), which reveals a situation where there is an imbalance in the demand for beds, compared to the actual number of available beds in AIMHUs. As the providers "*are pushed"* and *"have fewer beds"*, the focus for professionals is to "*get people stabilised*" (Box 4:1:11) to meet the demands of the system for beds. The interrogation of the data reveals a situation where providers anticipate admissions to AIMHUs predominantly for 'symptom-based treatment', as their strategy for managing their bed crises. This is evident in professionals' attitudes, such as *"don't want people in hospital"* (Service User Participant-4) due to the shortage of beds. It highlights an inclination towards a resource-led approach, where providers take control of the situation in order to meet the demands of the system, rather than meeting the needs of service users. Additionally, it indicates a *'one size fits all'* approach by providers, when the fundamental principle of ROP is based on the fact that recovery is unique for different individuals. Hence this practice may not align with the principles of ROP [O-2], which is an undesirable outcome resulting from this context. Interview data has identified three areas that generate mechanisms, which are:

1) "*You guys are pushed, you have fewer beds*";
2) "*You are often detained*"; and
3) "*AIMHU – A short-term Band Aid*".

These areas will be discussed in the following sections.

4:2:9 "*You guys are pushed, you have fewer beds*"

The mechanism that instigates the use of AIMHUs for crisis stabilisation and symptom reduction is generated by the mental health system itself. In relation to accessing beds on

AIMHUs, professionals encounter situations where they "*are pushed*", due to the high demand for inpatient beds. In order to cope with the high demand for beds, and to use them judiciously, providers take control of bed usage where they dictate admissions to AIMHUs using stipulated criteria (Box 4:1:11). This highlights where professionals are impelled to make decisions that align with their organisation's priority to manage inpatient beds, using gatekeeping assessments, which might conflict with service users' and their carers' views or preferences. Responses such as: "*I know the daughter I'm looking for, you don't*" (Stakeholder Participant-1) signal the disagreement in decisions between carers and professionals during the care transition of service users. This is a mechanism [M-1] adopted by the providers to control and scrutinise the usage of inpatient beds and it concurs with the evidence from the RR. Additionally, it indicates the influence of organisations' preferences and demands in shaping professionals' practice and its impact on ROP as a whole [O-2].

> *"When someone comes in for an acute admission, often it's kind of symptom-based treatment, isn't it? You guys are pushed, you have fewer beds, so the idea is to get people stabilised and put them in touch with other things."* [Stakeholder Participant-3]

Box 4:1:11

4:2:10 *"You are often detained"*

The above statement (Box 4:1:11) also points out the presence of another mechanism [M-2] given in the CMO configuration. In addition to the shortage of beds, admissions are often delayed and are not considered at the onset of an episode. The account of one of the participants that states "*You are often detained"* (Stakeholder Participant-4) suggests that the admissions are delayed to the point where service users lose their ability to make a meaningful contribution in discussions. Service users are "*uprooted and brought there* [AIMHU]*, they are very very unwell, very frightened*" (Stakeholder Participant-2) further reiterating the presence of a mechanism [M-2], where admissions to AIMHUs are often considered as a last resort, when service users lose their agency to contribute effectively during discussions. The response of a service user participant that states, "*It's a disempowering process when most people coming in to a ward are being sectioned"* (Service User Participant-2) indicates the consequences of AIMHUs being used as a 'last resort' for recovery, as identified in O-2 for this PT. Additionally this leads to a situation where service users feel that professionals have taken away their choices and are doing things "*to you"* instead of doing things "*with you*", which contributes to a situation where service users have low morale and less choice (Box 4:1:12). This can mean it is more challenging to build an alliance between service users and professionals, leading to an 'us and them' divide, as identified in O-2.

"In the community that person is more well, they got their own choices and they make their own choices every day about what they eat, when they get out, all of these things that make them feel empowered and when they are in an acute unit, not only that they are least functional, their morale is at a low, right, choices is taken away from them, all empowerment, everything that it might empower them, or tell them they are able to do things, is taken away. If we then top that off with an approach that says, 'we doing to you', rather than 'doing with you' then you are not creating an alliance anyway." [Stake holder Participant-2]

Box 4:1:12

The response above (Box 4:1:12) was in the context where mental health services are reluctant to offer choices for service users to make informed decisions regarding admission to the AIMHU when they still have the agency to make their own decisions. As a consequence of disempowerment, service users feel excluded from having a say in their treatment. It therefore explains how service users can lose their voice during transition, resulting in an increasing number of compulsory admissions to AIMHUs, as observed by the CQC (2020; 2015a&b), which is not conducive for recovery (O-2). Additionally, the increasing numbers of compulsory admissions to AIMHUs can account for the unpredictable and chaotic nature of AIMHUs, as identified in O-1.

4:2:11 AIMHU – “*A short-term Band Aid*”

> “*People feel that they are not individuals sometimes, yeah, but they are on that treadmill that they can get medicated, then get discharged. Yeah, I think more, is just …. a lot of people, and this phrase crops up a lot in the community, but I think it just as apposite on the ward.*” [Service User Participant-9]

Box 4:1:13

Interview data identified the third mechanism: to meet the demands of the system that has limited beds. The feeling of being “*on that treadmill*” (Box 4:1:13) indicates service users’ perception that their treatment and transition is geared to maximise the flow of service users through the system. Another service user participant used the phrase “*short-term Band Aid*” (Service User Participant-1) to portray their stay in AIMHUs. It illustrates the way in which AIMHUs are functioning with a very short length of stay. The emphasis on ‘symptom-based treatment’ indicates that professionals are more deficit or problem focused rather than working with service users’ strengths, which is a characteristic feature of the medical model of care. Additionally, the phrases such as “*we doing to you*”, “*get medicated*”, and having a “*culture of kind of doing upon to a person”* (Staff Participant-2) is testimony to the medical model of care with in the current system. The reliance on the medical model of care, with a huge emphasis on pharmacological treatment, is to accelerate service users’ clinical recovery in order to maximise their flow through the system, thus bowing to the organisation’s priorities [M-3]. It leads to a situation where service users do not have a positive experience of their treatment [O-2].

4:2:12 Summary of PT-1: Provider-controlled care transition – ‘admission to AIMHUs’

This PT has identified a context where admissions to AIMHUs are focused on crisis stabilisation and symptom reduction; it indicates that the organisations have adopted and have been using a ‘one size fits all’ approach that benefits the organisation, in order to resolve its bed crisis. It leads to a situation that contradicts the principles of ROP. Based on the awareness of a bed shortage, professionals are impelled to use gatekeeping assessments prescribed by the organisation as a means to control admissions to AIMHUs; admissions to AIMHUs are delayed and are considered a last resort; a symptom-based treatment anticipates a problem-focused approach that features the presence of the medical model of practice to accelerate service users' clinical recovery to maximise their flow through the system. As a result, the outcome of this PT was evidenced by the unpredictable and chaotic nature of AIMHUs, with high levels of compulsory admissions, and service users feeling dissatisfied and disempowered, which also creates a divide between service users and professionals. The interview data has confirmed the CMO based on the RR and helped to elucidate the context by identifying the relationship between the current focus of care and increasing demand for inpatient beds. Furthermore, the interview data has pointed out that the current focus of care is a 'one size fits all' approach that triggers the use of the medical model of practice and I will return to this in the discussion. Additionally, the interview data has helped to coalesce some of the outcomes in the CMO, based on the RR. The refined CMO configuration is listed on Table 4:1:2 and has led to the development of a refined PT.

4:2:13 Refined CMO configuration based on the interview data for PT-1: 'admissions to AIMHUs'

Context [C]	The contemporary focus of care in AIMHUs, based on 'crisis stabilisation' and 'symptom reduction', ***indicates a 'one size fits all' approach, used implicitly by organisations to meet the increasing demand for inpatient beds and to manage their resources judiciously.***
Mechanism-1 [M-1]	The decisions about admission to AIMHUs are resource led and are controlled predominantly by professionals, to meet the increasing demand for beds in AIMHUs. Health providers take on a 'gatekeeper' role to scrutinise and control the use of beds in AIMHUs.
Mechanism-2 [M-2]	Admissions to AIMHUs are often delayed and are used as a last resort to manage bed shortages and to comply with the least restrictive principles, after exhausting all other options in the community.
Mechanism-3 [M-3]	AIMHUs are perceived as a setting where service users can "*get medicated then get discharged*". As part of the symptom-reduction approach, professionals rely on the ethos of medical model of practice, where they are inclined to focus on deficit or problems, rather than strengths, to

	accelerate clinical recovery to maximise the flow of service users through the system.
Outcome-1 [O-1]	***AIMHUs remain chaotic, unpredictable and not conducive to promoting service users' recovery. The criteria stipulated by professionals and providers to control access to AIMHUs has led to a rise in acutely unwell service users, who lose their voice during transition of care. They have limited ability to use their personal resources to influence their treatment decisions. There is an increasing number of compulsory admissions that contribute to the chaotic and unpredictable nature of AIMHUs, which ultimately creates an area of practice that is not conducive for recovery.***
Outcome-2 [O-2]	***Service users are disempowered and have negative experiences about the acute inpatient care pathway, which contradicts the principles of ROP. Service users feel powerless and lack control in contributing to their care. It creates an 'us and them' divide between service users and staff.***

Table 4:1:2 – Refined CMO configuration based on the interview data for PT-1: 'admissions to AIMHUs'

4:3 Programme Theory (PT)-2: Care plan as a recovery tool?

This PT addresses the issues and limitations to SUI in care-plan formulation caused by infrastructural and organisational barriers. As aforementioned, policies (DoH, 2008; 2002; 2000) have stated that organisations and professionals are accountable to provide written care plans to service users as part of their treatment plan. However, a large amount of evidence from the RR highlights service users' disappointment with current practice in formulating care plans in AIMHU. Following the background search, there was a large number of multi-dimensional challenges and barriers, which means a few contextual elements were observed to be in play that limit SUI. The IPT was developed in an attempt to acknowledge these factors. The IPT compiled during the theory gleaning stage was:

"If key workers' practice is 'driven more by the needs of the organisation than the patient' or 'encumbered by institutional demands' [C] as a result of unfavourable conditional factors or

mechanisms exerted by other structural factors (e.g. audits), then it influences key workers to adopt either a task-oriented approach to ensure institutional efficiency than to satisfy the health-care needs of their patients [M] or may lead to intentional avoidance of therapeutic interaction [M], which may result in key workers developing care plans in silos and leaving active service users' involvement in care planning at a tokenistic level [O]."

4:3:1 Background

Care planning in secondary mental health services has increasingly become an area of interest in recent years for service users, carers, professionals and commissioners. The care plan and care-planning process play a fundamental role in mental health care and practice, as they guide and articulate the treatment for service users (Reid et al., 2018). However, Brooks et al. (2018) have identified that the implications of policy on care plans and the care-planning process have limited impact on service users' involvement and personal recovery. They came across a large amount of evidence about service users', carers' and professionals' frustration with the current care plan and care-planning process. Gibbons (2017) reported issues in the current care-planning process in mental health as problematic because of its ill-focused, medically oriented and paternalistic nature.

A large amount of evidence from the RR indicates practical and system-related issues linked to care plans that seldom make them user-friendly documents (Rose et al., 2015). Major critiques involve the use of clinical jargon and professional language to serve organisational agendas, which is not easy for service users to follow (Brooks et al., 2018). Care plans were labelled as excessive bureaucracy, administratively burdensome and were seldom consulted with service users and carers. (Simpson et al., 2016; Bee et al., 2015a). Lack of shared language was identified as another barrier to involving service users (Coffey et al., 2019). Some felt that care plans were lengthy and unwieldy documents that were difficult to follow (Coffey et al., 2019) and described as an "*off-the-peg suite of forms"* by a participant in a study conducted by Le Boutillier et al. (2015b, p.433). Conversely, previous studies have indicated that service users prefer to have short, written agreements with professionals directly involved in their care (Hopkins et al., 2009). Additionally, the use of electronic systems has further complicated the process of devising a care plan. As a result, the care plan in its current form has limited scope and value in mental health care.

The RR has found that care plans are not adequately responding to service users' daily needs (Brooks et al., 2018). Interestingly, service users value the process involved in care planning more than the care plan itself. Participants from a study conducted by Brooks et al. (2018) indicated that they valued the connection and understanding more than the care-planning process. Additionally, Reid et al. (2018) pointed out that service users' value the time spent on the process of collaboration as having equal importance as the care-planning process. It therefore indicates a difference in perception by service users regarding the current way in which care plans are formulated and reviewed. The next section will use evidence from the RR to articulate the elements of CMO that have helped to create a plausible explanation, using a CMO configuration.

4:3:2 Understanding "*my goals*" and "*my plans*"

A significant observation identified through the RR was the lack of impact care plans have on informing service users' views and suggestions in their treatment decision-making process due to the ritualised way it is practised. Previous studies have indicated professionals' attitude, service users' capacity and motivational issues, organisational structures and limited information sharing as major barriers that limit service users' ability to influence and contribute during shared decision making. Evidence from the RR indicates gaps in service users' and carers' understanding of the care-planning process and its application within the inpatient setting (Bee et al., 2015a). Some studies have identified that service users were not clear about the purpose and scope of collaborative care plans and how they were communicated with others in the team (Reid et al., 2018). Studies have reported the care plan as a document being created at the time of admission and then forgotten about by service users and professionals, who do not revisit or review it on a daily basis (Reid et al., 2018; Simpson et al., 2016). Additionally, care plans are viewed as a document where service users retrospectively endorse paternalistic decisions taken by professionals (Bee et al., 2015a). It therefore supports the observation made by Simpson et al. (2016) that care plans are not viewed as active or dynamic documents, indicating that the current practice of care-plan formulation has limitations to influence treatment decisions.

On the other hand, one study (Reid et al., 2018) has reported service users' disappointment, as the plan they developed with nurses was not integrated into treatment planning and was seemingly discounted by the multidisciplinary team. This then confused them about the purpose and also limited their feelings of being able to influence the care that they received. Additionally, Bee et al. (2015a) highlighted that care plans lack the ability to prospectively influence treatment plans. A response by a service user participant from a study conducted by Reid et al. (2018) evidenced this concern in AIMHUs (Box 4:2:1) and this was also echoed by participants in my study (see Section 4:3:7).

> *"I put it in front of my psychiatrist and he kind of gave it a cursory glance and then asked me a few questions that would've been easily answered if he read it. So, he really – I mean he didn't even pick it up to pull it that couple of inches closer and angle it so he could read it. He just glanced at it and then asked me a couple of questions... Yeah, I felt like me individually and me with the nurses' input had spent a fair bit of time on it and on making it clear and on – and not – for me it was a personal document that kind of structured my goals a bit and the interventions towards that. But it was also to show the treating team what my plans were for maintaining my health and they didn't seem interested at all."* (Reid et al., 2018, p.1208)

Box 4:2:1

It therefore verifies the conclusions made by Tunmore and Thomas (2000) that the impact of the care plan on service users' treatment and clinical outcome is insignificant. This has major implications in relation to SUI, as a recent study has highlighted that the ability to influence treatment decisions was seen as the core element of participation in care planning (Stomski & Morrison, 2017). This was identified as a context for this PT, where the current practice and focus of formulating a care plan allows limited scope for service users to influence treatment decisions [C]. Additionally, it confirms findings from previous studies (Grundy et al., 2016; Bee et al., 2015b), reports by the CQC (2019) and service user discourse on why service users feel marginalised, excluded and dissatisfied from the care-planning process [O-2]. It begs the question about the current role of the care plan and its scope in contemporary practice in AIMHU and renders the question "*is it time to abandon care planning in mental health service?*" (Brooks et al., 2018, p.597) both pertinent and convincing. A call for change to the care-planning process from a recent study (Lorien et al., 2020) further highlights the limitations of current approaches to the care-planning process. Evidence from the RR has pointed out mainly three themes that can instigate mechanisms [M] capable of producing undesirable outcomes in relation to the care-planning process in AIMHUs. They are:

1. Care plan: a document to evidence organisational commitment?
2. Decision-making power: external to nurse-service user relationship; and
3. Changing the direction of care: invalidating the agreed care plan.

In the following sections I will elaborate on these factors to unpack the mechanisms.

4:3:3 Care plan: a document to evidence organisational commitment?

Recent studies have concluded that care planning in mental health prioritises an organisational agenda and is more profitable for the organisation (Waldemar et al., 2019; Brooks et al., 2018). This means organisations focus on the areas that they prioritise to meet the demands set by commissioners. According to Newman et al. (2015), an understanding of service users' views is vital in contemporary mental health to recognise the extent to which a service is accomplishing its aims and purpose and service users are identified as the most reliable sources to provide feedback about their care. Care plans are subjected to quality assurance and, as a result, organisations take great interest in meeting the quality indicators, with the view to measure and evaluate the performance of an organisation. This means care plans are used as evidence to provide feedback for commissioners (Brooks et al., 2018) and for demonstrating an organisation's commitment to the best practice (Borgstrom, 2015). Audit tools are in place to assess an organisation's performance against the quality indicators (Brooks et al., 2018). This is contradictive to service users' outlook about care plans, as they consider the care plan as the outcome of relational work between themselves and professionals and value the process involved in the formulation of care plans. Furthermore, it is important to note that the organisational priorities have a direct impact on the practice of nurses (Waldemar et al., 2018). This has a huge impact in relation to this PT, as nurses are the largest work force in AIMHUs and spend a more significant amount of time with service users than any other professional groups in the care-planning process (Wyder et al., 2017; Delaney & Johnson, 2014; Whiteford, 1998). Additionally, the RR highlights some nurses' approach in the care-planning processes that are not conducive to involving service users.

The mechanism that emanates from this context [C] is the nurses' response to meet the organisations' demands by meeting the audit standards on care plans. In this effect, nurses orientate their work to satisfy the audit demands on care plans and they set it as their main target. They perceive care planning as a task-oriented activity to meet their targets and to avoid getting reprimanded. The statement charted (Box 4:2:2) from one of the papers from the RR substantiates this mechanism [M-1] that they encounter in clinical practice.

> *"Nurses were caught in a conundrum regarding their practice; where organizational documentation requirements conflicted with the nurses need to deliver patient care: You would choose the documentation . . . because it is the paperwork that we can be held accountable for, not the patient contact. Nowhere in the unit manual protocols does it say that we must have contact with patients and develop a therapeutic relationship, yet this is what we believe our job is about."* (Flourie et al., 2005, p.139)

Box 4:2:2

Additionally, Bee et al. (2015a) (Box 4:2:3) has already noted that care planning in secondary mental health has been reduced to an outcome and task-focused activity, which concurs with, and exemplifies, the explanation given above.

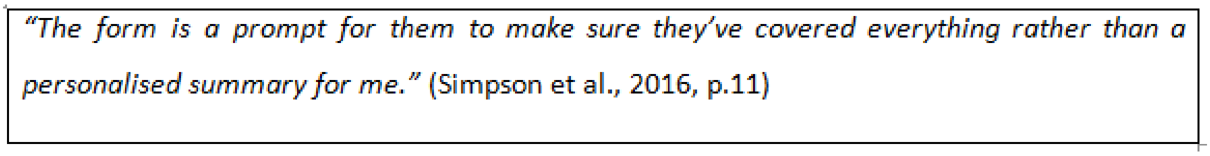
> *"User-involved care planning has over time been diluted to a series of practice-based activities designed to comply with auditor standards, rather than enhancing the quality of the experience that these standards were originally designed to deliver. Quantifiable performance indicators are advantageous to audit and clinical research and in themselves may not be detrimental to meaningful patient-centred interactions."* (Bee et al., 2015a, p.110)

Box 4:2:3

In order to meet their targets, nurses give less priority to non-auditable and non-quantifiable interventions, such as therapeutic interaction and establishing therapeutic relationships with service users (Cleary et al., 2012; Bee et al., 2006). Additionally, nurses view these activities as a time-consuming intervention that can hinder their task within an already busy environment (Cleary, 2004). The recent observation by Aston and Coffey (2014) reported a dramatic decline in relational work by inpatient nurses, which can be interpreted as a result of their ritualised, task-oriented work (Wyder et al., 2017; Awty et al., 2010; Berg & Hallberg, 2000). Interview data from my study substantiated the presence of this practice among nurses (see Section 4:3:8). Numerous references were identified during the RR about the time nurses spend in offices and in front of computers (Rose et al., 2015). Nurse participants in a study have recognised that *"psychiatric care had become so impersonal nowadays"* (Berg & Hallberg, 2000, p.327).

On the other hand, evidence from the RR has found another mechanism that anticipates nurses to continue with task-oriented and routine administrative work. Due to the short length of admission in AIMHUs, nurses are uncertain about the benefit of building therapeutic relationships with service users and they do not perceive that their efforts are contributing any therapeutic benefit, even if they involve service users in formulating care plans [M-2] (Pazargadi et al., 2015). This view of nurses reverts them back to task-oriented activity that leads nurses to formulate care plans in silos, which is identified as another undesirable outcome [O-1]. This is detrimental from the recovery perspective, as a humanistic, interpersonal relationship is viewed as the most important contribution a nurse could provide for service users' recovery (Cleary et al., 2013).

Subsequently, the decline in relational work has instigated another mechanism where service users felt distanced and removed from the care-planning process (Coffey et al., 2019; Brooks et al., 2018). Service users do not feel a sense of ownership or control of their care plans (Coffey et al., 2019; Jørgensen et al., 2018; Hopkins et al., 2009) but were "*going along*" with the care plans furnished by nurses. Service users did not find a role or practical use for the care plans that were developed in this way [M-3]. On the other hand, service users felt that care plans are for communication between the professionals and are used as an audit trail to monitor professionals' practice. This is indicated in the response made by one of the service user participants (Box 4:2:4) in a recent study (Simpson et al., 2016), leading to dissatisfaction with their involvement in the process [O-2] (Stomski & Morrison, 2017).



"The form is a prompt for them to make sure they've covered everything rather than a personalised summary for me." (Simpson et al., 2016, p.11)

Box 4:2:4

4:3:4 Decision-making power: external to nurse-service user relationship

The RR identifies the prevalence of tension between professionals in multidisciplinary teams due to the disparity of power they hold between them, which empowers one group of professionals over the other. The dominance of the medical model in service delivery was identified as a major barrier for ROP because the primacy of medical knowledge and legal authority generated substantial power differentials and interpersonal barriers (Byrne et al., 2016). Studies have highlighted power imbalance as a key challenge for embedding ROP (Waldemar et al., 2019) as it creates hierarchical relationships that disempower service users [O-3] (Dilks et al., 2013). A number of studies have observed the dominance of the medical model of practice in AIMHUs that anticipates an illness or deficit-based approach where treatment is focused on impairments and professionals hold control in taking decisions about service users' care. (Cusack et al., 2017; Tondora et al., 2014). Using their statutory powers, the consultant psychiatrist takes the lead role in care-planning meetings that happen on a weekly basis and endorses treatment decisions. In this model of practice, the majority of decisional power rests with a psychiatrist and curtails the ability of other mental health professionals, including nurses, from practising in an empowering way (Bee et al., 2015a; Rose et al., 2015). This phenomenon was referred to by Smith and Bartholomew (2006) as a 'stove pipe' system, where there is limited lateral authority, which does not support effective communication and building trusting relationships between professionals to promote ROP.
Additionally, the inclination towards a symptom-focused approach by medical professionals has been identified by nurses as one of the primary inhibitors to recovery-oriented practice.

Due to the hierarchical position of doctors in multidisciplinary teams, treatment decisions are "*done sometimes over the nurses heads"* (Berg & Hallberg, 2000, p.330) as psychiatrists have the final say about any interventions that go into service users' care plans. Regardless of multiple responsibilities and knowledge, nurses have limited authority to act independently in terms of making decisions about service users' care. This was revealed by Flourie et al. (2005), which means that the care plan furnished by nurses can be overruled by a psychiatrist. It therefore verifies a tension between members of the multidisciplinary team in relation to the care-planning process. This signals a mechanism [M-4] where nurses perceive a sense of powerlessness and lack of control in contributing effectively in care planning and prospective goal setting with service users and carers. An abstract charted from the RR (Box 4:2:5) can further explain this phenomenon:

> *"A sense of powerlessness was also revealed by nurses in this study, in that they perceived a lack of control within a framework of systems and processes in which they worked. Where decision-making power was held by others external to the nurse–consumer relationship, for example, when other members of the multidisciplinary team held greater influence over clinical treatment and management decisions, including granting of leave and medication titration, nurses felt they were unable to collaborate effectively with consumers on treatment decisions."* (McCloughen et al., 2011, p.53)

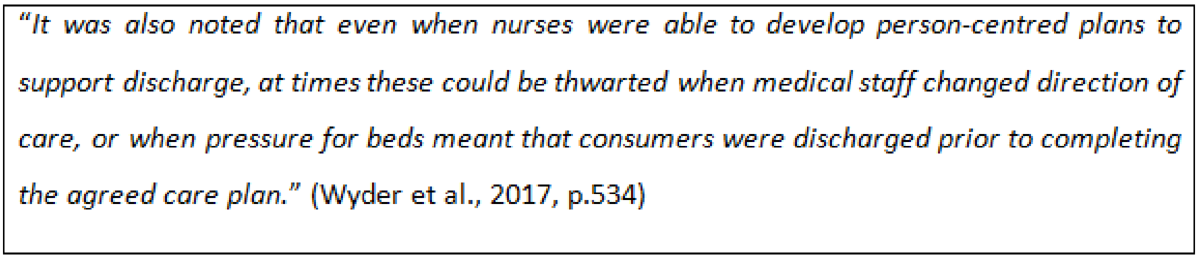
Box 4:2:5

Furthermore, both nurses and service users found care planning to be a 'pointless' activity, as both these groups perceive themselves as 'disempowered groups' (Rose et al., 2015) who have less ability and control in the overall care-planning process and decisions. Service users with previous or current experience of being on compulsory treatment orders might have experienced little value in collaborating with professionals, as they felt a lack of control in making decisions about their care. Moreover, service users find no advantage in negotiating their treatment plan with nurses, as they are aware that nurses have very limited authority to endorse treatment decisions or changes (McCloughen et al., 2011). This acts as a mechanism [M-5] where service users find less value and confidence in creating care plans with nurses that can actively contribute and influence their treatment decisions. This results in service users feeling disempowered [O] and is a negative experience of the care-planning process [O-3].

4:3:5 Changing the direction of care: invalidating the agreed care plan

In addition to the mechanism elicited in the previous section, the RR has identified a mechanism as a result of the tentative nature of treatment trajectory in AIMHUs. Care plans based on service users' personal goals and expectations have direct relevance to service users' everyday lives and they view care plans as a gateway to communication with the multidisciplinary team, to validate the plans they formulated with nurses (Reid et al., 2018).

However, the care plan remains tentative in nature, as its endorsement by multidisciplinary teams depends on clinical recovery and available resources within the system. The care plan endorsed by multidisciplinary teams is based on clinical recovery, with emphasis on symptom reduction and on service-defined recovery that safeguards the financial interests of the organisation (Le Boutillier et al., 2015a). Both these approaches arguably have common objectives that are antagonistic towards personal recovery, but are capable of fulfilling the demands of the organisation. According to Waldemar et al. (2016), the application of ROP is affected when the demands of the organisation take priority over an approach that supports personal recovery. Additionally, Wyder et al. (2017) have identified unexpected changes made to the course of treatment by medical teams (Box 4:2:6). This indicates the prevalence of clinical recovery in the care-planning process, which was not envisaged by service users or by nurses.



"It was also noted that even when nurses were able to develop person-centred plans to support discharge, at times these could be thwarted when medical staff changed direction of care, or when pressure for beds meant that consumers were discharged prior to completing the agreed care plan." (Wyder et al., 2017, p.534)

Box 4:2:6

Additionally, the RR found evidence that in contemporary mental health practice, the course of inpatient treatment relies heavily on resources available within the system (Waldemar et al., 2019; Le Boutillier et al., 2015a). This outlook at the time of developing care plans can weaken the prospect of embracing and fulfilling service users' views and choices in their treatment. Furthermore, nurses believe that their practice is driven more by the needs of the organisation than that of service users. (Waldemar et al., 2018; Flourie et al., 2005). Resources in AIMHUs were identified as a major challenge in embedding ROP (Waldemar et al., 2016). Additionally, Chester et al. (2016) have noted that limited resource provision by organisations can impede ROP and can only offer little noticeable benefit to service users and carers for engaging with the care-planning process. On the other hand, in AIMHUs, professionals are forced to maintain a high discharge rate and they accelerate the service users' treatment to make them ready for discharge (Waldemar et al., 2019). This was articulated by participants from studies by using phrases such as: "*pulled in out of the blue to be told 'right, you can go'*"

(Coffey et al., 2019, p.12). The response of a participant recorded in a study summarises this practice in AIMHUs (Box 4:2:7).

> *"Patient Theo and the peer support worker are talking about a hospital they've both been to. A nurse comes and tells Theo that he must go see the psychiatrist and he leaves with her. Twenty minutes later Theo returns to the living room and declares that he has to say goodbye now because he is being "kicked out." He says that he thought he was going to see the social worker but that there apparently are too many other acute things the health professionals need to deal with and other patients that need his bed and so he has to leave."*
> (Waldemar et al., 2019, p.325)

Box 4:2:7

It therefore indicates that the treatment planning in AIMHUs can take place in a haphazard manner, which questions the relevance of a care plan formulated prospectively between service users and nurses. According to Reid et al. (2018), if the collaboration in developing a care plan fails to create further collaboration in the care being delivered, then the whole process can be viewed as a pointless exercise. Due to this experience with care plans, both service users and nurses do not find much value in taking an active role in formulating care plans and perceive it as a meaningless activity [M-4 & M-5]. This subsequently contributes to the marginalisation of service users from care planning and makes nurses feel dissatisfied about their role [O-2]. The next section (Table 4:2:1) presents the CMO configuration for this PT.

4:3:6 Refined CMO configuration based on the RR for PT-2: Care plan as a recovery tool?

Context [C]	The current approach and focus towards care-plan formulation in AIMHUs allows less scope to inform service users' views and personal resources during the decision-making process of their treatment.
Mechanism-1 [M-1]	Nurses prioritise their work to satisfy the audit demands on the care plan and they set it as their main target. They perceive formulation of care plans as a task-oriented activity to meet their targets and to avoid getting reprimanded. In this effort, non-auditable or measurable interventions, such as therapeutic interaction and establishing therapeutic relationships with service users, will attract less priority from nurses.
Mechanism-2 [M-2]	Nurses feel there is a futility in building therapeutic relationships with service users, due to the short length of admission in AIMHUs and they do not perceive that their efforts are contributing any therapeutic benefit, even if they involve service users in formulating care plans.
Mechanism-3 [M-3]	Development of care plans by nurses with reduced relational work makes service users feel distanced and removed from the care-planning process. Service users do not feel a sense of ownership or control about their care plans and did not find a role or practical use for the care plans that were developed in this way.
Mechanism-4 [M-4]	Nurses perceive a sense of powerlessness and lack of control in contributing effectively in care planning and prospective goal setting with service users. This is because the care plan furnished between nurses and service users can be overruled, based on professional opinion, clinical recovery or service-defined recovery.
Mechanism-5 [M-5]	Service users do not find any benefit or value in formulating, negotiating and taking an active role in creating treatment plans with nurses, as they are aware that nurses have very limited authority to endorse treatment decisions.

Outcome-1 [O-1]	Care plans are formulated in silos that do not reflect service users' goals and needs.
Outcome-2 [O-2]	Service users feel marginalised; their involvement in care planning is pointless and they feel dissatisfied with the care-planning process.
Outcome-3 [O-3]	Care-planning process discounts service users' views and disempowers service users, rather than empowering them.
Outcome-4 [O-4]	Nurses feel dissatisfied about fulfilling their role in care planning with service users.

Table 4:2:1 – Refined CMO configuration based on the RR for PT-2: Care plan as a recovery tool?

4:3:7 Refinement of CMO using the interview data for PT-2: Care plan as a recovery tool?

The interview data indicates a huge emphasis on the care plan as a symbolic and non-dynamic document, with limited scope for meeting the needs of service users. One of the stakeholder participants stated that: "*People need to strip things back and go back to basics and really look at that whole question, what is the purpose of the care plan because I think we've completely lost sight and I think it's lost its identity*" (Stakeholder Participant-4). This account indicates that, in contemporary practice, care plans have digressed from their original purpose and identity: to meet the needs and recovery goals of service users. This raises questions about the integrity of the care plan in relation to the treatment of service users. Moreover, the expressions from participants, such as "*care plans trying to do too much*" (Box 4:2:8, Evidence-1) and "*if our regulators turn up they want to see evidence*" (Box 4:2:8, Evidence-2) reveal a great deal of expectation and vested interest in care plans by external stakeholders. This sets the scene for the context [C] of this PT, which will be explored in the next section.

In order to meet the expectations of the regulators, care plans are regarded by organisations as a showcase document to evidence the care provided for service users and are "*one good way of demonstrating*" (Box 4:2:8, Evidence-2) their involvement in treatment to commissioners and external regulators. Organisations are keen on improving the quality of this document and expect nurses to adhere to 'a list of things', as defined by the organisation.

This creates a situation where the focus of the organisation is more on the product (care plan created by nurses) than the process (relational work) involved in creating care plans. One of the staff participants' responses indicates that these approaches have an enduring effect, which might curtail the person-centred aspect of a care plan: "*Managers would give almost like a list of things that needed to be in the care plan to staff, and they use it as a guide but it shouldn't be prescriptive and that takes away the person-centred element*" (Staff Participant-3). It is evident from a stakeholder participant's response: "*we all use the phrase 'person centred', but I think that the patient needs to know that it is person-centred that it's about them and I think that sometimes escaped not intentionally"* (Stakeholder Participant-2). This indicates service users do not feel that the care plans are about them and this is evident from interview data where a few of the service user participants reported that they were not sure whether they even had a care plan, which further supports findings from the RR.

Additionally, the format and design of the care plan is geared to favour organisational preferences and interests (Box 4:2:8, Evidence-3). Therefore, it suggests that the current scope, role and expectations of care plans are multi-dimensional, at the expense of service users' interests and benefits (Box 4:2:8, Evidence-1 & 2). In other words, care plans are predominantly seen as a means to foster organisational needs and demands, which then limits their scope in meeting the needs of service users. It therefore illustrates why the care plan in its current form has "*lost sight*" and "*lost its identity*".

Evidence-1	*"At the moment, the care plans are trying to do too much. It's a document for the staff, but it's also meant to be a document for service users, but some information for the service users, maybe, is not always the information that is helpful for them, so it feels that it is doing too much anyway"* [Stakeholder Participant-3]
Evidence-2	*"We live in a world where evidence is needed, so I guess one still wants their signature on their care plan, if it's printed, because of course, if our regulators turn up, they want to see evidence that they have been involved and actually that is really one good way of demonstrating that they been involved in the care plan."* [Staff Participant-11]

Evidence-3	*"I don't know if it helps patients so much. I think it probably helps staff more than it helps patient. I think giving the care plan, it's not clear the actual bit of paper perhaps we put – is not clear and is not easy to understand there is boxes everywhere and it's all very odd, it doesn't really work. I think it works for us to be able to communicate between professionals, but in terms of the actual written care plan for a patient, I don't think it really matters to them, they need to know what their plan is, what the idea is. If that was on a white board, or on a bit of paper or on the back of a napkin, I don't think it would matter, they just need to know what the plan is."* [Staff Participant-10]

Box 4:2:8

Additionally, information on care plans might have less significance and relevance for service users (Box 4:2:8, Evidence-1), raising questions about the ability of these care plans to address service users' views and desires during the care-planning process. This is because the information relevant to the care plan is collated from preloaded information on an electronic system by other professionals and multidisciplinary team members and is not first-hand information collected from service users. It is important to note that the information nurses record on care plans in this manner has already been processed for decision making about treatment. In other words, the information on a care plan is retrospective in nature and has less bearing when it comes to contributing towards the decision-making process. Therefore, the role of care plans in drawing attention to service users' views and opinions about their treatment during the decision-making process in multidisciplinary meetings is limited. This practice sets the context for this PT, which supports and refines the findings from the RR that the care plan in its current form has lost sight and identity, which precipitates the context [C] identified in this PT (Table 4:2:2). It has pointed out three distinctive features related to this context that give rise to mechanisms that lead to the outcomes identified in the RR. These distinctive features are illustrated under the following headings:

1) *"Lost sight": "CQC will go mad if there aren't any* [care plans]";

2) *"Lost identity"*: *"A perfect piece of work that looked right, and ticks the boxes"*; and

3) *“Lost point”*: *“It needs everyone to really subscribe to it”*

4:3:8 “*Lost sight*”: “*CQC will go mad if there aren’t any* [care plans]”

It was identified that the length of stay in AIMHUs is relatively lower, compared to other areas in the mental health care system. This was also supported by the interview data (Box 5:5:6, Evidence-2). Regardless of the duration of stay in AIMHUs, there is a general expectation that all service users should have a care plan within a stipulated time frame set by the organisation, following their admission to an AIMHU. In AIMHUs, nurses have conflicting roles and responsibilities, and one such responsibility is to work as a primary nurse for an assigned set of service users. Care-plan formulation with service users is part of their role. The interview data (Box 4:2:9 and 4:2:10) suggests that the practice of care-plan formulation by nurses in AIMHUs is influenced by the need to create a care plan within a stipulated time span during their busy shift. The response from staff participants reveals that there is an imperative for inpatient nurses to comply with the regulatory guidelines, above meeting service users’ needs. Evidence from interview data (Box 4:2:9) underlines that this practice is directed to meet the demands stipulated by the organisation.

> *“I think at the moment the attitude is we’ve got to have a care plan because CQC will go mad if there aren’t any. At the moment it’s just becoming a paper work exercise, where we just throw something on the computers, so if we are inspected it looks like everybody has got a care plan.”* [Staff Participant-15]

Box 4:2:9

The expression “*we just throw something on the computers”* reveals that nurses’ approach the care plan as a “*paper work exercise*” that “*has to be done*”. Additionally, the determination shown to create a care plan *“within very short time”* (Box 4:2:10, Evidence-2) also demonstrates nurses’ perception of care-plan formulation as a task-oriented activity for fulfilling criteria set by the organisation and commissioners (Box 4:2:11, Evidence-1). Hence, care plans are formulated in AIMHUs whether the service users may or may not have the ability to be involved. In other words, care plans are viewed as a task-oriented activity by nurses and are formulated as a reactive response to meet the demands of the organisation [M-1]. This is supportive of the evidence identified in the RR (see Section 4:3:3).

The expressions such as "*the boss gets off your back*" (Staff Participant-3), indicates a sense of fear about being reprimanded and to avoid this predicament, nurses take ownership of the care plan [M-1A]. It serves as "*a form of protection for staff*" that evidences the care provided for service users and evidences nurses' work (Box 4:2:10, Evidence-3 & Box 4:2:11, Evidence -2). It therefore explains why nurses 'rush' into doing care plans. Some participants during interview felt that genuine SUI seldom happens in the early stages of service users' admission to AIMHUs because of their mental state, unfamiliar staff and environment. So a care plan early on in treatment was more beneficial for professionals than the service users (Box 4:2:8, Evidence-3). Nurses achieve this target by formulating care plans in silos and ignoring SUI in the process (Box 4:2:11, Evidence-2), which instigates another undesirable outcome [O-2]. This practice is evident from the response of a staff participant (Box 4:2:10, Evidence-2).

A response made by one of the service user participants that states "*it's not something that comes in a piece of paper and has to be filled in but the nurse coming in doing a one-to-one*" (Service User Participant-1) signals the importance service users place on relational work. Another service user participant has identified the care plan as a 'journey' with staff that means it's not limited or tied into a document per se, but it is part of an ongoing process through relational work (Box 4:2:10, Evidence-1). Therefore, the interview data emphasises the significance of relational work between nurses and service users, which corresponds with the data identified in the RR (see Section 4:3:3) and it indicates that it acts as a scaffold that builds and transfers the ownership of care plans. Due to the short stay of service users in AIMHUs, nurses develop an attitude that putting effort into building therapeutic relationships with service users as part of the care-planning process is a "*waste of my time*" (Box 4:2:13, Evidence-1) and they lack the motivation for relational work. They become disillusioned about the relevance of establishing therapeutic relationships with service users [M-2]. Subsequently, it leads to another mechanism, where the lack of relational work distances service users from the care-planning process, where they do not feel a sense of ownership for the document [M-3]. It is concerning that there is much less emphasis on the value of therapeutic engagement for establishing a rapport or trust with service users as part of developing their care plan. This leads to an outcome where there is limited scope in current practice to build therapeutic relationships between nurses and service users in AIMHUs [O-3].

Evidence-1	*"I'll be honest, it is just tick boxes, it's just that I have done that, we cared for them, there you go we ticked a box, move on to next one. It shouldn't be like that. I think it should be more personal, caring, gentle process, that we should adapt to each person, based on that person's requirement, not the staff, we adapt to them, chat to them first, it's kind of bring out a bit of more relaxed way, a more open mentality, rather than boom, boom, boom, which too often happens. People aren't even prepared. I think it should be an ongoing process, throughout the whole stay in the hospital, it shouldn't be one day you get a knock on the door in your room and someone says, 'Can you sign this'… Less rushed, take time, just to be bit more real with us, I think genuinely people respond to warmth and love and kindness of any form, I think, if the approach is that way."* [Service User Participant-4]
Evidence-2	*"I think it is motivated by the drive that it has to be done within very short time once that person has been admitted, and the turnover for our patients is 72 hours, yeah, and a care plan needs to be in place at the soonest point possible and there is that kind of drive as a service that, again, regardless of whether that person wants to engage or not, regardless of whether staff have time, to do it properly, yeah, it has to be done. So there are times when a care plan will be created, but has not necessarily had so much service user involvement, it might draw from the information that has come from the crisis team regarding the admission, it might draw information from ward round, it might draw information from here, there and there, but it hasn't necessarily been a one-to-one directly with that patient, and again that's down to staff time, right?"* [Staff Participant-4]
Evidence-3	*"Care plan is not the piece of paper that has to be followed in a very procedural way, it's about something that's much larger than just filling out a form, it's the meaning behind it has to have action written within it, it is not just a document that is there to be a form of protection which I think in some senses it is seen as that, a form of protection for staff, but if you approach it more casually that this is something for you and for us to work with together, to guide care, rather than this has to be done as part of the process of care, it feels much more enriching and lively for that person."* [Stakeholder Participant-4]

Box 4:2:10

The responses of staff participants (Box 4:2:11) sums up how the mental health system and practitioners have 'lost sight' of the role and original purpose of the care plans.

Evidence-1	*"I think in practice it becomes task orientated rather than personal orientated and so I think it becomes about fulfilling a criterion to become somewhat a tick box exercise. People wanted a perfect piece of work that looked right, and ticks the boxes, but actually they miss the whole engagement part, which is the basis of it. I think what happens is, people are trying to hit target in terms of the care plan has to be written by this date, it has to hit all of these things it must include this, this, this, this and this, and they are trying to get all of those aspects in to make sure they done it what seems to be done right and they are missing the whole point of it."* [Staff Participant-3]
Evidence-2	*"Staff saying oh, so and so care plan needs updating and they will sit in the office and update it, and then they might print it off and then give it to the person after, or they might not, or they might just update it because it's a tick box exercise, as it's gone out of date according to the board, and therefore it needs to be updated and now it's updated, so I've done my job and I have ticked that box, which I don't think it's always healthy or useful for the service user really."* [Staff Participant-4]
Evidence-3	*"Because we have to meet certain deadlines and care plans have to be done within 72 hours."* [Staff Participant-11]

Box 4:2:11

It also highlights the tension faced by nurses as a result of the demands placed by the system that infringe their autonomy in practice and place time constraints on establishing therapeutic relationships with service users. I will return to this in the discussion.

4:3:9 "*Lost identity*": "*A perfect piece of work that looked right, and ticks the boxes*"

Interview data identified a huge emphasis on the care plan manuscript. As identified in Evidence-1 (Box 4:2:11), the drive for nurses is to create a "*perfect piece of work*" to "*hit target*" set by the organisation through audits. However, service users are less concerned about the impeccable nature or appearance of a care plan, whether it is "*on a white board, or on a bit of paper or on the back of a napkin*" (Box 4:2:8, Evidence-3) (Staff Participant-10). So it points out a drive in nurses to "*meet a target*" (Box 4:2:12, Evidence-1 & 2) that can satisfy care plan audits set by the organisation. The phrases used by participants such as "*the person gets squeezed out" and "doesn't touch a patient*" (Box 4:2:12, Evidence-1 & 2) indicate the manner in which nurses respond to meeting the target, which outlines the presence of another mechanism [M-1B]. It leads to an undesirable outcome where service users get marginalised from their care plans [O-2].

Evidence-1	*"I think if we are focusing on 'Oh, I have to get that care plan done by whatever day', the likelihood with the pressures of all the things to be done, the person gets squeezed out, the work gets done, an audit gets met, so that your boss gets off your back but you haven't actually engaged the person."* [Staff Participant-3]
Evidence-2	*"Doing a care plan, that doesn't touch a patient, that ticks a box, that satisfies an audit, but the care plan is completely meaningless, a huge number are driven by the need to meet a target and to have done a care plan, so completed a task, rather than to have to produce a useful document that informs the care and involves the patient."* [Staff Participant-9]
Evidence-3	*"I'm an inpatient nurse, let's write a care plan to tick a box that we think probably ought to happen but actually it's not. In that case, there is no buy-in from the professionals who are going to be involved."* [Staff Participant-9]

Box 4:2:12

4:3:10 "*Lost point*": "*it needs everyone to really subscribe to it*"

The interview data also highlighted that the care plans formulated by nurses in silos [O-1] lack buy-in from other professionals within the multidisciplinary team (Box 4:2:12, Evidence-3). Care plans have limited input from senior clinicians from multidisciplinary teams, such as the consultant psychiatrist (Box 4:2:13, Evidence-1). The findings from interview data suggest that there is a lack of commitment from the consultants towards care plans developed between service users and nurses. One of the staff participants in a senior nursing role reported that, *"I think lots of consultants aren't that keen on our care plans. They find them a bit too woolly. I think they find the person centeredness a bit woolly, they actually would like clear hard facts in them, you know, rather than patients' wishes"* (Staff Participant-11). This clearly suggests a lack of commitment from consultants towards care plans and it indicates the presence of an outcome [O-5] (Table 4:2:2) that was not identified during the RR. This outcome triggers another mechanism [M-4] as a ripple effect, where nurses do not recognise that the care plan they formulate has any meaningful impact in service users' care, as it gets overruled by the multidisciplinary team (Box 4:2:13, Evidence-1). The changes to service users' treatment take place regardless of what nurses drew up in the care plan with service users, as consultants 'dictate' and endorse care plans (Box 4:2:13, Evidence-1 & 2). In other words, treatment plans endorsed and created by multidisciplinary teams do not always subscribe or align with the actions identified in the care plan (Box 4:2:13, Evidence-3) and can undermine the care plan formulated by nurses [Outcome-5]. So the care plan remains a futile and passive document, instead of guiding the treatment.

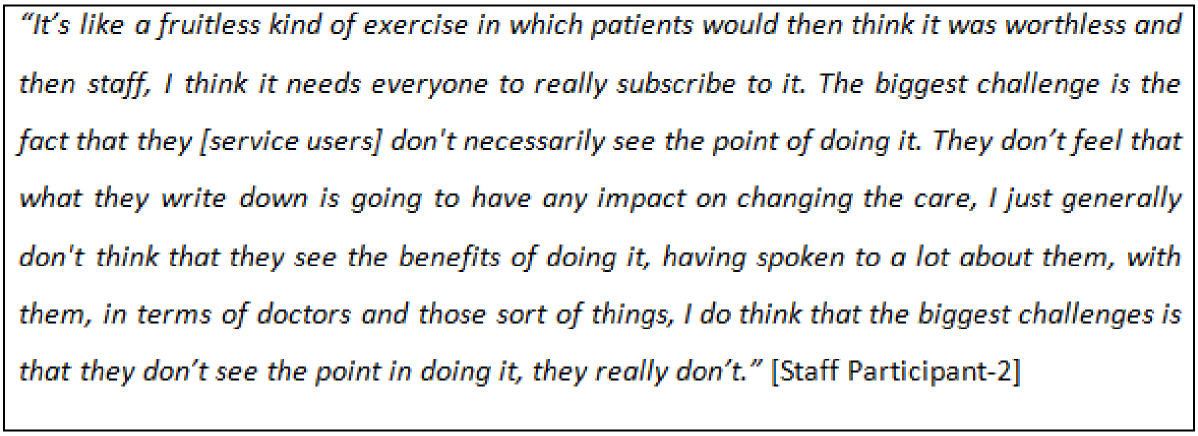
Additionally, phrases such as "*it needs everyone to really subscribe to it"* indicate a lack of a cohesive approach by all members of the multidisciplinary team towards care plans, which makes them "*worthless*". This again shows how Outcomes 2 and 3, identified during the RR (Table 4:2:1), materialise in practice. This exemplifies that nurses are not able to see the value of care plans and they perceive them as a means to meet the requirements of the organisation and commissioners, which have limited impact on service users' treatment [M-4]. The phrase "*what is the point?*" (Staff Participant-15) illustrates nurses' frustration and explains nurses' dissatisfaction with their work on care plans in AIMHUs, which leads to another outcome identified in this PT [O-4].

Evidence-1	*"She [consultant psychiatrist] is a very influential person, she tends to dictate how long the patient will stay, so she is quite an important person to input into the care plan, but I don't think she does normally. I sometimes think to myself, what is the point? He [service user] is going to be discharged in two days that is waste of my time, I'd rather go and talk to another patient. So I need to be more motivated to do it, I got to see the point of it. I think the biggest challenge is, yeah, seeing the point of it."* [Staff Participant-15]
Evidence-2	*"I think there are concerns that you know, we say something different to what they say in ward review and having more of a team approach, I guess. Because you do find that you know you could go and write someone's care plan and they will say, 'the doctor said to me that I can do this,' and you know, it's kind of trying. I don't want to say team splitting, because is not the intention of a patient, but I think it can sometimes get people's backs up and get them on the defence."* [Staff Participant-5]

Evidence-3	*“You don’t need a care plan to get the treatment, but the treatment is still going on, it’s just not care-planned.”* [Staff Participant-12]

Box 4:2:13

Concurrently, interview data also reveals that, service users have the experience and awareness that it is possible for treatment to take place in the absence of a care plan (Box 4:2:13, Evidence-3), and this awareness among service users can be seen as a mechanism [M-5], where service users have reservations about the impact of care plans on their treatment. Creating care plans with nurses is perceived by service users as a “*fruitless kind of exercise*” (Box 4:2:14) as they have not experienced any impact it may have made on their treatment. Additionally, service users are aware that the doctor *“tends to dictate”* and can overrule the care plan they have devised with nurses (Box 4:2:13, Evidence-1 & 2). Responses such as *“doctor is the most important person in their eyes”* (Staff Participant-2) indicate service users’ views of their confidence in doctors. It highlights another issue in relation to care-plan formulation, where there is lack of buy-in from service users.



“It’s like a fruitless kind of exercise in which patients would then think it was worthless and then staff, I think it needs everyone to really subscribe to it. The biggest challenge is the fact that they [service users] don't necessarily see the point of doing it. They don’t feel that what they write down is going to have any impact on changing the care, I just generally don't think that they see the benefits of doing it, having spoken to a lot about them, with them, in terms of doctors and those sort of things, I do think that the biggest challenges is that they don’t see the point in doing it, they really don’t.” [Staff Participant-2]

Box 4:2:14

4:3:11 Summary of PT-2: Care plan as a recovery tool?

Care plans are used as a key document through which organisations can evidence the care provided for service users, and organisations are keen on improving the quality of this document. In contemporary practice, nurses are tasked with producing care plans to the standards prescribed by the organisation for developing recovery-oriented care plans. The focus is more on the product (care plan) than the process (relational work) involved in developing care plans. The interview data helped to refine the context by adding care plans as a showcase document geared towards meeting organisational priorities more than service users' preferences. Three distinctive features identified from interview data suggested mechanisms resulting from the context that lead to undesirable outcomes. Additionally, interview data was able to uncover a further two mechanisms [M-1A & M-1B] and outcomes [O-3 & O-5] as part of this PT. This is illustrated in the next section (Table 4:2:2).

4:3:12 Refined CMO configuration based on the interview data for PT-2: Care plan as a recovery tool?

Context [C]	***Care plans are used by organisations as a key document to evidence SUI and the care they provide for service users. In AIMHUs, nurses are tasked with developing recovery-oriented care plans to the standards prescribed by the organisation***. The current approach and focus towards care-plan formulation allows less scope to include service users' views and personal resources during the decision-making process for their treatment, ***as it is geared towards meeting organisational priorities.***
Mechanism-1 [M-1]	Nurses prioritise their work to satisfy the audit demands on the care plan and they set it as their main target. They perceive formulation of care plans as a task-oriented activity, to meet their targets and to avoid getting reprimanded. In this effort, non-auditable or measurable interventions, such as therapeutic interaction and establishing therapeutic relationships with service users, will attract less priority from nurses.
Mechanism-1A [M-1A]	***Nurses take the ownership of care plans, as they perceive the care plan as a form of protection that evidences their work.***
Mechanism-1B [M-1B]	***Nurses perceive care plans as target-oriented activity where they focus on creating a perfect piece of work that can meet the targets set in the audit by the organisation.***
Mechanism-2 [M-2]	Nurses are uncertain about the value and relevance of building therapeutic relationships with service users, due to the short length of admissions in AIMHUs and they do not perceive that their efforts are contributing any

	therapeutic benefit, even if they involve service users in formulating care plans.
Mechanism-3 [M-3]	Service users feel distanced and removed from the care-planning process and they do not feel a sense of ownership or control of their care plans developed by nurses.
Mechanism-4 [M-4]	Nurses do not see the point in creating a care plan with service users; they perceive limited autonomy in contributing effectively in care planning and prospective goal setting with service users. This is because the care plan developed between nurses and service users can be overruled by consultants and multidisciplinary team.
Mechanism-5 [M-5]	Service users view doctors as ‘the most important person’ and recognise them as the decision makers in their care. Therefore, service users do not view any benefit or value in formulating, negotiating and taking an active role in creating treatment plans with nurses, as they are aware that nurses have very limited authority to endorse treatment decisions.
Outcome-1 [O-1]	Care plans are formulated in silos that do not reflect service users’ goals and needs. It allows less scope to include service users’ views and personal resources during the decision-making process for their treatment.
Outcome-2 [O-2]	The care-planning process discounts service users’ views and disempowers service users, rather than empowering them. Service users feel marginalised; their involvement in care planning is pointless and they are dissatisfied with the care-planning process.
Outcome-3 [O-3]	***Current practice in developing care plans provides limited scope for building therapeutic relationship between nurses and service users.***
Outcome-4 [O-4]	Nurses feel dissatisfied about fulfilling their role in care planning with service users.

Outcome-5 [O-5]	***Care plans are formulated by nurses and have less multidisciplinary team involvement, which leads to lack of buy-in from other professionals within the multidisciplinary team.***

Table 4:2:2 – Refined CMO configuration based on the interview data for PT-2: Care plan as a recovery tool?

4:4 Programme Theory (PT)-3: Ward rounds as a non-inclusive arena for shared decision making

Ward rounds are multidisciplinary meetings that provide opportunity for shared decision making about treatment. This PT examines the conditions that inhibit the opportunity for shared decision making, which gives rise to undesirable outcomes. SUI in care planning in this study refers to the extent in which service users are enabled to make decisions about their care and this PT refers to the arenas within AIMHUs for making such decisions. Various models were identified to promote SUI in AIMHUs, and shared decision making is one such model that has direct implications for the care-planning process (Storm & Davidson, 2013). Historically, mental health service users with serious mental health problems lacked empowerment, and participating in treatment planning is one way of empowering service users (Linhorst et al., 2002). Ward rounds are identified as one of the main infrastructures within AIMHUs where SUI in treatment decisions can be facilitated. There was a significant amount of reference during the background search that signifies the importance of shared decision making during care planning. Based on this, the IPT was developed, which has helped to direct the RR to collate more evidence related to shared decision making during ward rounds. The IPT developed for this PT was:

"*Ward rounds provide limited scope for the application of shared decision making during care planning [C]. Service users are less prepared with information regarding the topic of discussion for the meeting, their role and expectations of the meeting; at the same time, they are expected to participate in making sensitive decisions about their care with professionals with whom they have limited acquaintance [M]. This situation leads to service users feeling intimidated and unable to take part in the decision-making process [O].*"

Evidence from the RR has led to the development of a CMO configuration that portrays the way in which shared decision making is practised in ward-round meetings.

4:4:1 Background

‘No decision about me without me’ (DoH, 2012) demonstrated the governments’ stance on decision making in mental health affairs and has implications for individual treatment plans. It signalled the direction of mental health care as a shift from “*provider-centric decision making*” (Curtis et al., 2010, p.15) towards more person-centred care and “*preference sensitive decisions*” (p.16). Genuine involvement of service users takes place when service users are actively involved in the decision-making process. Studies have established that mutual dialogue and understanding between service users and professionals is essential to achieve the objective of participation to enhance recovery. As a result, shared decision making is the preferred model during treatment decision-making events to embrace SUI (Storm & Davidson, 2013).

Shared decision making is a style of communication that resonates and deepens the principles of person-centred care. It is defined by Elwyn et al. (2012) as: “*an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences*” (p.1361). It involves three distinctive steps: a) information exchange required for making decision; b) interactive process of discussion to explore service users’ reaction to information, to generate a shared decision known as deliberation; and c) to have an opportunity to review and revise the decision (Curtis et al., 2010). Previous studies have identified that service users anticipate having more involvement in decision making regarding their treatment than they currently experience (Klein et al., 1998). Studies (Roe et al., 2009; Hamann et al., 2006) have highlighted that service users who are in receipt of mental health care have a greater desire to be involved in decision making regarding their medication. However, a recent study conducted by Zisman-llani et al. (2017) found a gap between the theoretical model of shared decision making and its practical application in mental health care settings. The next section will be used to explore the gap created between the theoretical model of shared decision making and its issues in its practical application, based on evidence from the RR to create a plausible explanation using a CMO configuration.

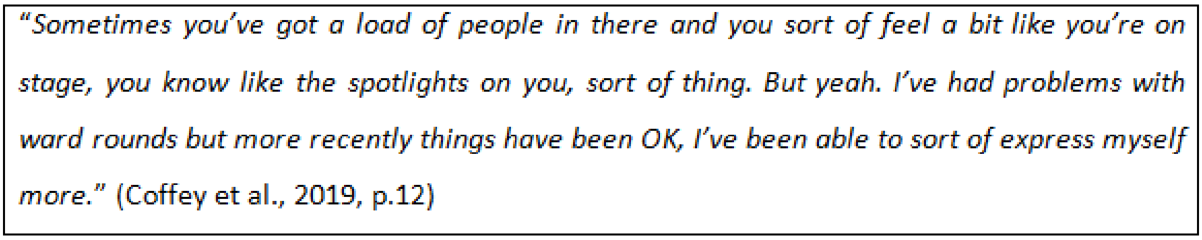
4:4:2 “*Feels more like an interrogation*”

In AIMHUs, treatment decisions and care plans are endorsed in forums that are commonly known as ward rounds or ward review meetings (Fiddler et al., 2010; Wagstaff & Solts, 2003). Fiddler et al. (2010) summarised the key features of traditional ward rounds in AIMHUs as:

1. It takes place once a week at a prearranged, set time;
2. The service users being present;
3. The presence of an array of professionals from various disciplines, including psychiatrist, nurses, occupational therapists, pharmacist and social workers; and
4. It does not take place at the bedside.

Ward rounds are identified as the only forums to crystallise a multidisciplinary approach in care led by the consultant psychiatrist. Hence exploring the dynamics within ward rounds is important, as they are seen as the main arenas for shared decision making in AIMHUs (Hodgson et al., 2005).

A recent study (Coffey et al., 2019) has indicated that service users find ward rounds an opportunity for face-to-face interaction with their consultant psychiatrist and to meet the multidisciplinary team. However, a substantial number of studies have pointed out that ward rounds have lots of disadvantages that create challenges for shared decision making. Studies (Wagstaff & Solts, 2003; Hodgson et al., 2005; White & Karim, 2005) have highlighted that ward rounds can provoke anxiety, limited SUI in decision making and can be intimidating. Participants in a study conducted by Wagstaff and Solts (2003) made statements such as: “*I hate going in*” and “*it feels more like an interrogation than a formal meeting*” (p.2). Ward rounds are a crowded environment where professionals outnumber service users (Coffey et al., 2019). Studies (Cappleman et al., 2015; Armond & Armond, 1985) have linked anxiety about ward rounds as a result of the size of the ward-round meeting with professionals (Box 4:3:1) that are unknown to service users and due to the lack of provision of timely information about ward rounds.



> *"Sometimes you've got a load of people in there and you sort of feel a bit like you're on stage, you know like the spotlights on you, sort of thing. But yeah. I've had problems with ward rounds but more recently things have been OK, I've been able to sort of express myself more."* (Coffey et al., 2019, p.12)

Box 4:3:1

A study by Palin (2005) has revealed that ward rounds might serve as a venue to safeguard the interest of professionals, rather than service users. Furthermore, Hodgson et al. (2005) reported that ward rounds are used as learning environments for teaching students from various disciplines. Conversely, evidence indicates that their purpose is not always clear to staff and service users, which can develop unrealistic expectations about their outcome (Milner et al., 2008). It therefore concurs with the observation made by Fiddler et al. (2010) that conducting a ward round is a complex task and creates conditions that are challenging for shared decision making. Therefore, it is identified as a context [C] for this PT. The RR also identified six factors that trigger mechanisms from the identified context [C] and this will be explored further in the following sections. They are:

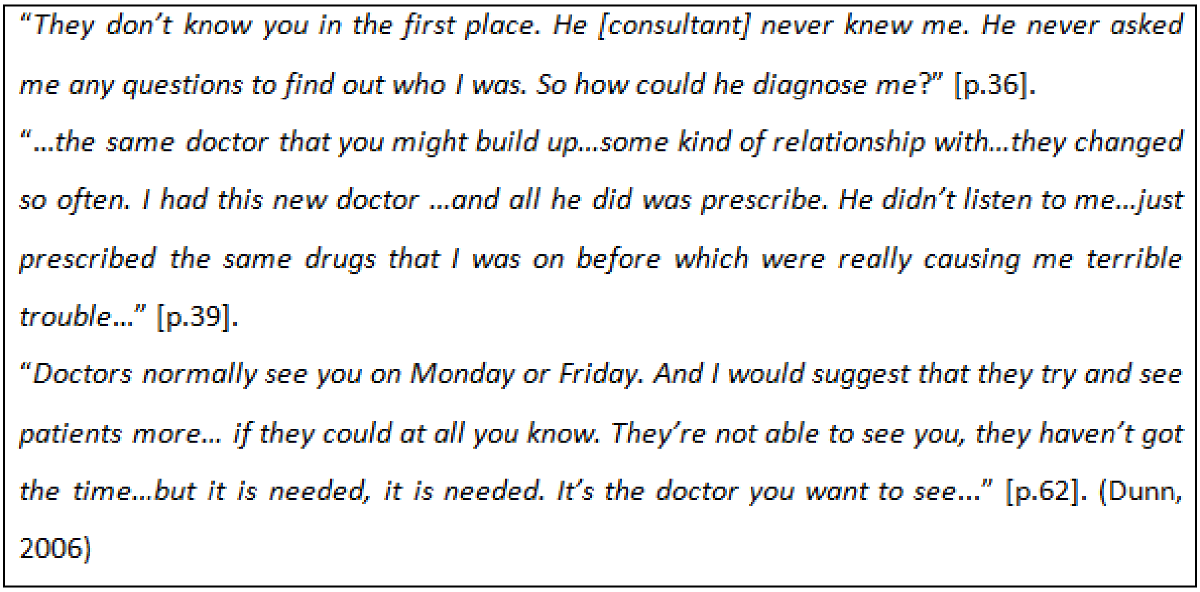
1. "*He never asked me any questions to find out who I was*";
2. Limited sharing of information;
3. "*An illusion of choice*";
4. "*I can say what I think but I don't have the final say*";
5. "*The power sits with the doctor*"; and
6. Risk aversion versus ROP.

I will elaborate on this from the next section onwards.

4:4:3 "*He never asked me any questions to find out who I was*"

The role of trusting relationships between professionals and service users is a key component in mental health care (Hopkins et al., 2009). Ward rounds can be overcrowded, with large numbers of professionals who outnumber service users, including professionals who have no prior acquaintance with service users. Evidence from studies indicated this practice often provokes anxiety and intimidation, creating an unfavourable condition for shared decision making. This was also supported by evidence from the interview data (see Section 4:4:10).

Being a person responsible for service users' care and with a lead role in ward rounds, a trusting relationship between the treating doctor and service user is vital. According to Gilburt et al. (2008), developing a trusting relationship is vital for the practice of medicine, as it affects inclination to seek help, divulge sensitive information, treatment concordance and to accept doctors' recommendations. Engaging and spending time with service users is necessary to establish a trusting relationship with service users and their willingness to open up (Waldemar et al., 2018). Additionally, excellent communication is required for creating a shared vision about one's recovery (Gould, 2012). Service user participants in a study conducted by Isobel (2019) revealed that doctors have minimal interactions with service users and, as a result, their understanding about service users' conditions is limited. As mentioned above, ward rounds are led by the consultant psychiatrist and communication between consultants and service users was often described as unsatisfactory (Dunn, 2006). The response from service user participants from a study commissioned by The Mental Health Commission (Dunn, 2006), to understand the views of adult mental health service users on the organisational aspects of publicly funded mental health services, made the following remarks about their relationships with doctors, evidencing the depth of the issue (Box 4:3:2).



"They don't know you in the first place. He [consultant] never knew me. He never asked me any questions to find out who I was. So how could he diagnose me?" [p.36].

"...the same doctor that you might build up...some kind of relationship with...they changed so often. I had this new doctor ...and all he did was prescribe. He didn't listen to me...just prescribed the same drugs that I was on before which were really causing me terrible trouble..." [p.39].

"Doctors normally see you on Monday or Friday. And I would suggest that they try and see patients more... if they could at all you know. They're not able to see you, they haven't got the time...but it is needed, it is needed. It's the doctor you want to see..." [p.62]. (Dunn, 2006)

Box 4:3:2

The RR indicates that service users have limited contact and engagement with their consultants outside ward-round meetings and their knowledge about service users is limited (a view that was shared by my study participants during the interviews). Service users do not perceive that the consulting doctors have a good understanding about them, as they lack a trusting relationship with them. This impedes service users' "*willingness to open up*" (Isobel, 2019) and ability to articulate their views in the decision-making process during ward rounds. This evidently works as a negative mechanism [M-1] that leads to a situation that leaves service users as passive recipients of mental health care and disempowerment [O].

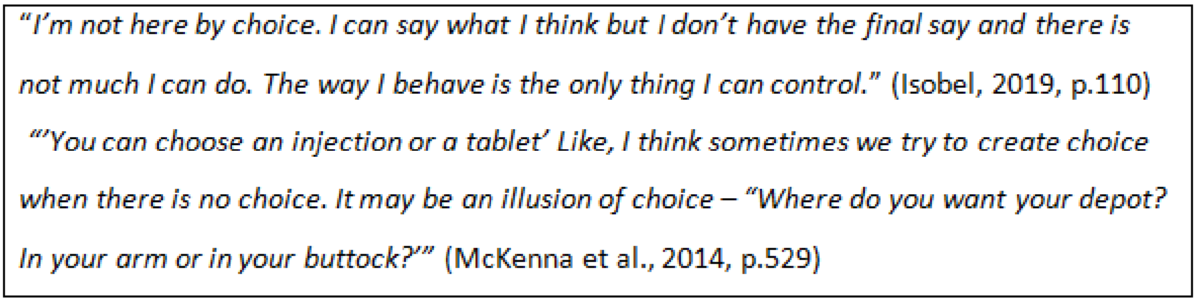
4:4:4 Limited sharing of information

Provision of information is the first step in the shared decision-making process that provides a starting point for the decision-making process, identified in previous studies (Anthony & Crawford, 2000) as a factor that facilitates SUI. Furthermore, preparing service users for the ward rounds by identifying their expectations and setting their agenda can help to share relevant information (Coffey et al., 2019). Dunn (2006) has identified that service users continued to experience poor communication and lack of continuity of care in mental health care. Studies have identified information is withheld from service users and they are not adequately prepared for ward rounds when decisions about their treatments are made (Cappleman et al., 2015). Furthermore, service users are not informed about the process involved in ward rounds, their role and the expected outcomes. This arguably limits the scope for service users to engage in the process of deliberation during shared decision making. Interview data from my study participants have verified this phenomenon (see Section 4:4:12). Service users perceive that decisions about their treatment were made by professionals who are expecting them to be compliant with their plans [M-2]. As a result, service users felt disempowered (Isobel, 2019), which is considered as an undesirable outcome [O] for this PT. Service user participants from a study conducted by Grundy et al. (2016) reported that their role is limited to the retrospective endorsement of professionals' decisions about their care. This exemplifies the existence of this mechanism in current practice, triggered by this context.

4:4:5 "*An illusion of choice*"

The focus of care in AIMHUs is symptom reduction and stabilisation to accelerate the discharge process (Waldemar et al., 2019). As a result, the treatment on AIMHUs is predominantly about medication management and the focus is on clinical recovery, where medication is considered as the vital aspect of admission to AIMHUs (Waldemar et al., 2018).

Service users are aware that the degree of choice and influence they have in their treatment decisions on AIMHUs is limited. It means professionals understand service users' needs in mental health terms, such as compliance, medication and insight, which differs from service users' views on recovery, which involve safety, employment, housing, and personal feelings, such as self-respect and dignity (Chinman et al., 1999). Coffey et al. (2019) revealed variations among service users', professionals' and carers' views in relation to shared aspirations and realities of recovery. To accomplish clinical recovery and accelerate the discharge process, professionals are interested in stabilisation of mental health using medication management, which leaves less choice and influence for service users' views and feedback [M-3]. Participants in the study conducted by Waldemar et al. (2018) revealed that their choice and influence in their treatment is limited to accepting or declining doctors' recommendations. This was further verified by my study participants during the interviews (see Section 4:4:14). Participants' responses from two studies (Box 4:3:3) reflects the lack of choice and autonomy they have in the decision-making process.



"I'm not here by choice. I can say what I think but I don't have the final say and there is not much I can do. The way I behave is the only thing I can control." (Isobel, 2019, p.110)

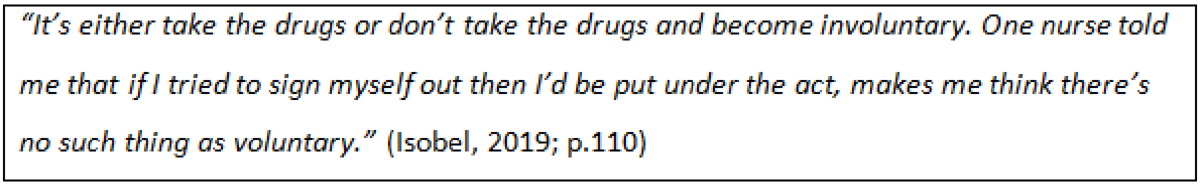
"'You can choose an injection or a tablet' Like, I think sometimes we try to create choice when there is no choice. It may be an illusion of choice – "Where do you want your depot? In your arm or in your buttock?'" (McKenna et al., 2014, p.529)

Box 4:3:3

This indicates that reliance on clinical recovery can limit choice and service users' ability to negotiate their care. They are bound by the choice and autonomy prescribed by the professionals, leading to disempowerment [O].

4:4:6 "*I can say what I think but I don't have the final say*"

The increasing use of compulsory detentions and the dominance of the medical model of practice has the potential to create unequal power relations between service users and professionals. According to Bennetts et al. (2011), "*power involves the capacity to enforce the will of a person or group of people to produce different behaviours in others; in other words, to bring about change*" (p.156). The superiority and power of professionals over service users can be illustrated through the use of clinician language that service users cannot understand, thereby limiting their contribution. The statutory power of professionals enables them to use legal coercion towards service users, which challenges the notion of equal partners in decision making (Waldemar et al., 2019). Threats and coercion were identified as influential elements that subdued the service users' role in the decision-making process (Storm & Davidson, 2010). Service users believe that professionals have predetermined plans regarding treatment and they hold the power to override their choice and decisions. This leaves less choice and fewer options for service users and their views and feedback have less impact on influencing their treatment plan. Participants from a study conducted by Isobel (2019) voiced 'pervasive fear' and identified 'subtle threats' in mental health care that rendered no options to the prescribed treatment (Box 4:3:4).



"It's either take the drugs or don't take the drugs and become involuntary. One nurse told me that if I tried to sign myself out then I'd be put under the act, makes me think there's no such thing as voluntary." (Isobel, 2019; p.110)

Box 4:3:4

Service user participants in a study conducted by Isobel (2019), reported fearing that they described as being "*stuck in the system*" (p.110), as they witnessed other service users who disagreed with the prescribed treatment plan receiving more aggressive treatment and restriction orders. This leads to a situation where service users feel powerless to influence the decision-making process, as they perceive their views and feedback may attract professionals' responses that are detrimental to their personal recovery goals [M-4]. This was voiced by my study participants during the interviews (see Section 4:4:15). In this situation, service users reluctantly agree with professionals, without voicing their desires, which leaves service users as passive recipients of mental health treatment [O] (Chester et al., 2016).

4:4:7 "*The power sits with the doctor*"

In mental health, professionals take a dominant role when it comes to decision making (Farrelly et al., 2014) and service users felt excluded from planning their care and creating their treatment plan (McKenna et al., 2014; Cleary et al., 2013) leading to disempowerment [O]. According to Goodwin and Happell (2006), AIMHUs are highly susceptible to using the medical model and most likely to use the law to control service users. Therefore, service users' participation was seen as harder to implement, given the custodial and paternalistic attitudes dominating in these settings. Studies have illustrated doctors as the domineering decision-making professionals in AIMHUs, which is illustrative in the words of participants from a study conducted by Bennetts et al. (2011) (Box 4:3:5).

> *"The power sits with the doctor; medical model. As I say, it's very infrequently will a consumer come in and actually discuss their needs. The medical agenda still comes first."* (Bennetts et al., 2011, p.160)

Box 4:3:5

According to Dahlqvist-Jonsson et al. (2015), service users need to feel that their experiential knowledge, emotions, values and feelings are taken seriously by professionals and that it was important to discuss each other's perspective on treatment. This can create a feeling of equality, regardless of the outcome of the decision. Curtis et al. (2010) have pointed out that a good decision is not always based on the end product of the decision itself, but it should be one that is satisfying to those engaged in the process. However, professionals perceive that service users who are diagnosed with serious mental illness are unable to recognise their needs for treatment, underestimating service users' interests in the participation process and consider themselves in a position of knowing what is best for service users [M-5] (Mathisen et al., 2016; Linhorst et al., 2002; Chinman et al., 1999). The attitude of professionals has already been highlighted as a barrier for service users' participation in a number of studies (Goodwin & Happell, 2008; 2006; Middleton et al., 2004). Studies have also highlighted that some professionals have difficulties in balancing their role as advisory experts with the experiential-based knowledge of service users, which dissuades them from relinquishing their powers [M-6] (Chester et al., 2016; Dilks et al., 2013; Bennetts et al., 2011). On the other hand, service users perceive that their ability to influence treatment decisions is limited, as their experiential-based expertise and knowledge is not taken seriously by professionals [M-7] and they passively accept the treatment decisions. As a result, the medical model of care continues to be the prominent model of practice and disempowers service users and ROP [O].

4:4:8 Risk aversion versus ROP

Balancing service users' rights with professionals' duty of care is a sensitive and delicate notion in inpatient mental health care (McGuiness et al., 2013). Challenges are recognised between supporting choice and dignity, while promoting safety and duty of care (Australian Government, 2013). Professionals recognise that their primary responsibility is inpatient treatment and safety (Waldemar et al., 2016) and they feel apprehensive about working in recovery-oriented ways when they perceive that service users are at increased risk of suicide or other serious incidents of self-harm [M-8] (Forchuk et al., 2003). As a result of this mechanism, professionals take control over the situation and marginalise service users from being actively involved in the shared decision-making process [O]. The findings from the RR have helped to identify numerous mechanisms that explain the existence of the context in relation to this PT and explain why ward rounds remain an area that continues to challenge the prospect of shared decision making in care planning. The following section (Table 4:3:1) will illustrate possible CMO configuration (refined) based on evidence.

4:4:9 Refined CMO configurations based on the RR for PT-3: Ward round as a non-inclusive arena for shared decision making

Context [C]	In AIMHUs, ward rounds are arenas for the purpose of care planning where decisions about service users' care plans take place. However, these meetings limit the prospect of meaningful contribution in shared decision making by service users.
Mechanism-1 [M-1]	Service users do not perceive that the consulting doctors have a good understanding about them, as they lack a trusting relationship with them. This curtails service users' "*willingness to open up*" and to articulate their views in the shared decision-making process that takes place in ward rounds.
Mechanism-2 [M-2]	Service users are less informed about the process involved in ward rounds, their role and the expected outcomes. Service users perceive that the decisions about their treatment were made by professionals, who are expecting them to be compliant with their plans.

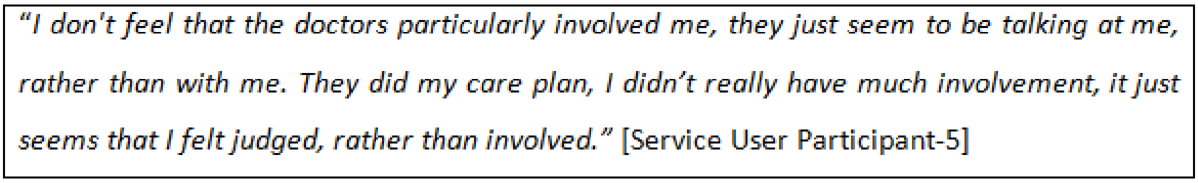
Mechanism-3 [M-3]	In order to accomplish clinical recovery and to accelerate the discharge process, professionals are interested in stabilisation of mental health using medication management, which leaves less choice and influence for service users' views and feedback.
Mechanism-4 [M-4]	Service users feel powerless to influence the decision-making process, as they perceive their views and feedback may result in a professional response that becomes detrimental to their personal recovery goals.
Mechanism-5 [M-5]	Professionals perceive that service users who have serious mental illness are unable to recognise their needs for treatment, underestimating service users' interest in the participation process and consider themselves in a position of knowing what is best for service users.
Mechanism-6 [M-6]	Professionals have difficulties in balancing their role as advisory experts with the experiential-based knowledge of service users, which dissuades them from relinquishing their powers.
Mechanism-7 [M-7[	Service users perceive that their ability to influence treatment decisions is limited, as their experiential-based expertise and knowledge is not taken seriously by professionals.
Mechanism-8 [M-8]	Professionals recognise that their primary responsibility is inpatient treatment and safety and they feel apprehensive about working in recovery-oriented ways when they perceive that service users are at increased risk of suicide or other serious incidents of self-harm.
Outcome	Service users do not experience that they had active input in the shared decision-making process during care-planning meetings and feel they are marginalised and disempowered in the process. Service users find the outcomes from ward rounds do not match their expectations and needs.

Table 4:3:1 – Refined CMO configurations based on the RR for PT-3: Ward round as a non-inclusive arena for shared decision making

4:4:10 Refinement of CMO using the interview data for PT-3: Ward round as a non-inclusive arena for shared decision making

A great deal of interview data verified and explained that ward rounds have the potential to be a valuable platform for care planning, where treatment decisions are taken regarding service users' care. The factor that maximises the ward round's credentials as an appropriate arena for care planning is its multidisciplinary perspective, as it has the ability to bring professionals from various disciplines together, to contribute towards the care plan. One staff participant described it as a valuable platform because: "*There is a multidisciplinary approach there, rather than just being a nurse and the patient discussing the care plan and there are the other disciplines discussing it with the patient*" (Staff Participant-2). It therefore brings a broader approach to care planning, by taking views from multiple perspectives and knowledge bases. Therefore it leads to a situation where "e*verybody heard the same words at the same time because they were all in the same room. They all had the same goal, to get the best care plan, for this individual"* (Stakeholder Participant-1).

Regardless of the potential that ward rounds offer, service users' experiences of ward rounds remain a concern. Based on their experiences, different participants used various terms to explain ward rounds. One of the stakeholder participants [1] described it as *"an extremely scary and daunting environment"*, whereas staff participants [12] portrayed ward rounds as a *"regimental and formal meeting"*. Various service user participants observed ward rounds as: *"disjointed, embarrassing, intimidating, anxiety provoking, off-putting, overwhelming and rushed"*. It corroborates the response made by of one of the service user participants (Box 4:3:6).



"I don't feel that the doctors particularly involved me, they just seem to be talking at me, rather than with me. They did my care plan, I didn't really have much involvement, it just seems that I felt judged, rather than involved." [Service User Participant-5]

Box 4:3:6

The phrase "*talking at me rather than with me*" indicates that service users are not being 'heard' or 'listened to' by professionals during the ward rounds, and this was a recurring theme in the interview data, which is a cause for concern. It denotes the limitations in the form of reduced opportunity for the process of deliberation in ward rounds, which limits service users' contribution in the shared decision-making process. This statement also echoed the view shared by many staff participants in this study. The responses from service user participants were consistent in that the ward rounds do not provide a favourable condition for their meaningful involvement in the shared decision-making process [C] which corroborates with findings from the RR.

> *"I was admitted and then the consultant who saw me when I was first admitted went on holiday for two weeks and in that two-week period, I wasn't seen by anybody and then the next time I was seen by somebody, who is discharging me or talking about discharge, and I felt that I'd had nothing from the very beginning, no input and then suddenly we were talking about discharge and that completely threw me."* [Service User Participant-9]

Box 4:3:7

The response from the service user participant (Box 4:3:7) using the phrase "*threw me*" indicates that the discussions during the ward round were not going in the direction that was expected by the service user. In this case the expectation of service users can differ from the professionals' expectations and views. This contradicts what was stated earlier (Stakeholder Participant-1) "*all had the same goal*". It begs the question as to why this difference in expectation occurs. The interview data has enabled the identification of some features of the ward round that help to explain the mechanism [M] that leads to the outcome [O] stated in the CMO configuration. It includes doctor-patient relationships; ambiguity around ward-round schedules and the agenda for discussion; application of various care models and approaches in ward rounds; professionals' priorities that overshadow service users' choices; and unwanted consequences. Additionally, the interview data overwhelmingly highlighted ward rounds as a "*daunting environment*" that gave rise to mechanisms that lead to the outcome [O] identified in the PT. The interview data has identified six themes that are capable of generating mechanisms. They are:

1. Doctor-patient relationship;
2. Ambiguities around ward-round schedules and agenda for discussion;
3. Applications of various models and approaches in ward rounds;

4. Professionals’ priorities take precedence over service users’ choice;
5. Unwanted consequences; and
6. Ward rounds as a ‘daunting environment’.

These themes will be explored in the following sections to explain the relevant mechanisms.

4:4:11 Doctor-patient relationship

Participants in this study have portrayed consultants in AIMHUs as a “*dominant force*” (Staff Participant-2) “*that controls everything*” (Stakeholder Participant-4). The interview data has exposed practices where there is very limited scope for service users to meet their consultant outside the ward round (Box 4:3:8, Evidence-1 & 2). Evidence-1 indicates that service users anticipate more involvement with their consultants with more one-to-one discussion, as opposed to limiting their meetings only to the ward rounds. Evidence-2 substantiates that doctor-service user interaction hardly happens outside the ward rounds. The limited direct contact between service users and their consultants is evidence of limited opportunities to establish a trusting relationship between consultants and service users. Additionally, service user participants in the study stressed the importance of having trust with the professionals involved, especially treating consultants or doctors, in order to discuss and express their issues in a comfortable manner. The responses such as: “*the doctor only sees you once a week”* (Box 4:3:9, Evidence-1) and “*you might speak to the consultant for literally like seven minutes about your difficulties”* (Box 4:3:9, Evidence-2) indicate a limitation in the time available to establish a relationship with the consultants. An account given by one of the service user participants such as, “*he has to go on with what new information he is given,”* (Box 4:3:8, Evidence-2) indicates a practice where consultants rely on second-hand information about service users that is passed on to them by other professionals or resources and not directly from service users. Consultants tend to rely on this information that would otherwise have been gathered from conducting one-to-one conversations with service users (Box 4:3:8, Evidence-3). Interview data indicated a prevalence of this practice among consultants as a means to understand service users’ recovery.

Evidence-1	*"I guess more input from consultants and doctors, I was probably only seen by the consultant couple of times in that 10 days and I think in order for me to become more involved in the process there would need to be more, you know, more involvement from consultants, as opposed to 15-minute session."* [Service User Participant-8]
Evidence-2	*"Doctor doesn't do one-to-one, you see him once a week and basically once a week and he has to go on with what new information he is given, because he is not actually on the ward every day."* [Service User Participant-9]
Evidence-3	*"We need to stop having a discussion as group of professionals beforehand and then inviting the patient in after, because that seems to be the format that all of the consultants use, where they will have a discussion as professionals and then the service user is called in after, a sort of like an afterthought and all the plans have already been made."* [Staff Participant-4]

Box 4:3:8

It therefore highlights a situation about the lack of contact time between service users and treating consultants. As a result, service users find it difficult and are reluctant to 'open up' during ward-round meetings, as they do not feel comfortable in expressing their views and opinions. This highlights that the doctor-patient relationship [M-1] has significant implications in making the ward round a favourable condition for shared decision making and verifies the evidence from the RR.

Evidence-1	*"I did find it quite intimidating and you don't really want to open up too much, because there are so many people there, but I mean, the doctor only sees you once a week, and they see you with all these other people there and you don't really, I don't feel that you can open up as much, whereas maybe you would be able to more on like a one-to-one basis."* [Service User Participant-5]
Evidence-2	*"You might speak to the consultant for literally like 7 minutes about your difficulties but that might be all, so I think the very least, people should be*

	having, you know having individual conversations with their consultant." [Staff Participant-15]

Box 4:3:9

4:4:12 Ambiguities around ward-round schedules and agenda for discussion

As discussed previously, interview data has identified that service users' encounter outcomes from ward-round meetings that can be contrary to their expectations. When this was explored further, interview data suggested that service users are less informed and seldom prepared for attending ward rounds, resulting in limited understanding about ward-round schedules and objectives (Box 4:3:10). The phrase "*just whipped in from their room, you are going to see the doctor now*" (Box 4:3:10, Evidence-1) indicates lack of forewarning and preparation. Additionally, the majority of service users are not aware of utilising the ward round for their benefit (Box 4:3:10, Evidence-2). This means service users are attending the ward round without a decisive plan to engage in a discussion with professionals regarding matters related to their recovery. On the contrary, the response of a service user participant (Box 4:3:10, Evidence-3) indicates that the ward round's agenda was led by professionals. Moreover, it leads to a situation where service users are unaware of their role during ward rounds. Further to the evidence from the RR (see Section 4:4:4), interview data also verified the lack of preparation to equip service users for the ward-round meetings, which blurs their awareness about ward-round proceedings and their own role in ward-round meetings [M-2].

Evidence-1	*"Would be good so maybe somebody was able to know when a ward round would be, for example, know that it was an appointment that they would be seen, and we all know that things happen, but if they had a definite time, when they knew ward round would be, they could prepare for it, they were told it was going to happen, not just whipped in from their room, 'You are going to see the doctor now.' If they were told that they could bring maybe a family member, that they were told that they could have an advocate… one of the big problems we have, no one will tell the patients, let alone the advocates, when their ward rounds are going to be, not even which day."* [Stakeholder Participant-2]
Evidence-2	*"I would say majority do not know how to use the ward review in their best interest, you know, they go in there and ask, I think, because I always advise people you know, it's like going into a doctor's appointment or something, write a list of what you want to discuss in there."* [Staff Participant-12]
Evidence-3	*"It was more them saying what they thought they ought to do, which went down the normal route should I say."* [Service User Participant-6].

Box 4:3:10

4:3:13 Applications of various models and approaches in ward rounds

Interview data indicates that the ward round has become more 'disjointed' as different models of care are pursued by professionals representing different disciplines within the multidisciplinary team in the ward-round meetings. The medical professionals within multidisciplinary team embrace the ethos of the medical model (Box 4:3:11) that tends to prescribe the treatment direction by taking unilateral decisions (Box 4:3:10, Evidence-3). The phrases such as, *"I am the consultant, I will decide what's good for you"* (Box 4:3:11, Evidence-1 & 2) suggest the dominance of the medical model approach, which projects a sense of authority and reaffirms a level of hierarchy that positions consultants or doctors as 'authority figures' and 'expert advisors'. This is contrary to the preferred recovery-oriented model of practice adopted in contemporary mental health care. The professionals that are more sympathetic towards ROP engage with service users *"on an equal understanding, on an equal level"* (Box 4:3:11, Evidence-1). It denotes willingness to hand over some level of control to service users, in contrast to the medical model approach. This inter-professional tension is evident from the account given by a non-medical professional that states: *"I think people need to be coming from a recovery point of view rather than a kind of medicalised way"* (Box 4:3:11, Evidence-1). It therefore highlights the tension that exists in ward rounds as a result of embracing the ethos of different models in practice by different professionals. The existence of this tension, resulting from the use of different models, gives rise to the presence of some of the mechanisms [M-3, M-4, M-5, M-6, M-7 & M-8] illustrated in the CMO configuration of this PT following the RR. This will be further explored in the next sections.

Evidence-1	*“I think people need to be coming from a recovery point of view rather than a kind of medicalised way ‘Oh I am the consultant, I will decide what’s good for you’. It takes a certain kind of person to let go of their ego a little bit, and to be able to engage the person. I have seen consultants who are really good at it. You can engage the person saying, ‘I hear what you are saying about that medication, I know what you meant, it does put on weight, how about we try this with this?’ Or, ‘What do you think about that?’ And engage them and other consultants that won’t listen and would just say, ‘This is what I am doing to you.’ I think all staff are engaging with the client and meeting them on an equal understanding, on an equal level, and coming from the same model of working. There is no point me doing a piece of work with somebody, care planning, them saying ‘I don't like this medication it’s not good for me it makes me feel like this, blah, blah, blah,’ and we do a whole piece of work together about building rapport and understanding; and we walk into the ward review together and somebody else is, ‘No, you are not doing that, I’m not listening to you, you are having this and that’s the end of it.’ There has to be that approach that seeing that person as equal, that has to happen at ward review too.”* [Staff Participant-3]
Evidence-2	*“It was predetermined what was going to be said, what was going to be done. They said, we are going to go down this route, this is the route we use, this is the system we go through. As a relative you felt, didn’t matter how much you were saying, they were ignoring that, and the system has to be followed where you had months, two months, where the person is getting worse rather than getting better because everything was being ignored, right, to certain extent, because this is what the route we have to do, we have to use this to the drug, (that doesn’t work), we got this one to work, in the end she was there long time.”* [Stakeholder Participant-1]

Box 4:3:11

In the medical model approach consultants maintain “*control of the offer”* (Box 4:3:12) and it discounts the experiential knowledge base of service users. They endorse their authority by prescribing an intervention and not being “*open to the idea that the patient might have something to contribute to it*’’ (Box 4:3:12). The professional embracing this model is reinstating and projecting themselves as the expert. Service users’ responses such as “*it was more them saying what they thought they ought to do”* (Service User Participant-5) indicate that professionals display their expertise during the decision-making process. This is indicative of a mechanism [M-5], where professionals understand themselves to be the experts and, based on this, professionals perceive that they are able to choose the best option for service users. This confirms evidence identified from the RR (see Section 4:4:7). They also demonstrate that they are content with their position of authority. "*It takes a certain kind of person to let go of their ego a little bit*" (Box 4:3:1:1, Evidence-1) is a sceptical remark, directed towards those professionals' who expect to hold on to their position of authority. They are reluctant to relinquish their power and have difficulty in balancing their role as advisory experts with service users' experience-based knowledge [Mechanism-6]. This means service users have limited room for sharing and to apply their experiential knowledge in the shared decision-making process.

"The interventions that you offer, so you as the professionals are in some ways flexible around it, but you are in control of the offer, but the things that I'm not going to accept are the things that I'm in control of that, unless it is overridden by Mental Health Act or something. It's being open to the idea that the patient might have something to contribute to it, and it's being open to the idea that it might be reasonable for them to decline what you're offering." [Service User Participant-9]

Box 4:3:12

The statement indicating that professionals "*are in control of the offer"* (Box 4:3:12) was evident in the response given by service user participants who were dismayed by this practice. Even though service users are aware about the option to have the treatment of their choice, the medical model of practice has restricted options for flexibility and negotiation, which is meant to take place as part of the deliberation process during shared decision making. The responses from a service user participant, such as "*we are going to put you on this one", "no one listens to me"* (Box 4:3:13, Evidence-1) and "*I got no say in it*" (Box 4:3:13, Evidence-2) illustrates the authority displayed by professionals where service users' views are not taken seriously during ward rounds. The professionals are displaying their authority and reinforcing their position as the experts [M-7]. Additionally, it undermines the level of 'control' service users hold during the process of deliberation and does not show any anticipation for flexibility.

Evidence-1	*"To have a bit of choice, I didn't really get a choice they just said, 'Right, okay, this one doesn't seem to be working with you, we are going to put you on this one,' rather than saying, 'We got this option, we got that option, what do you think? Is there any that you would like to go on?' I mean, I did want to go on a depot, just because it stays in your system bit steadier than the tablet. So I did opt for the depot, but I didn't really get a choice which one."* [Service User Participant-5]
Evidence-2	*"The biggest complaint, that we come across is 'no one listens to me', 'I got no say in it', 'I'm powerless'. Yeah, 'They won't listen to me', ok, a... a perception is it's all, 'I am going to go in there, the doctor going to give me medication, he is going to say I got to take it and then I will be discharged, you know'. We very often start by saying, 'This is your meeting, this is about you...' you know... 'What do you want to say?' and 'What do you want to ask the doctor?' And quite often we will get, 'He won't talk to me'."* [Stakeholder Participant -2]

Box 4:3:13

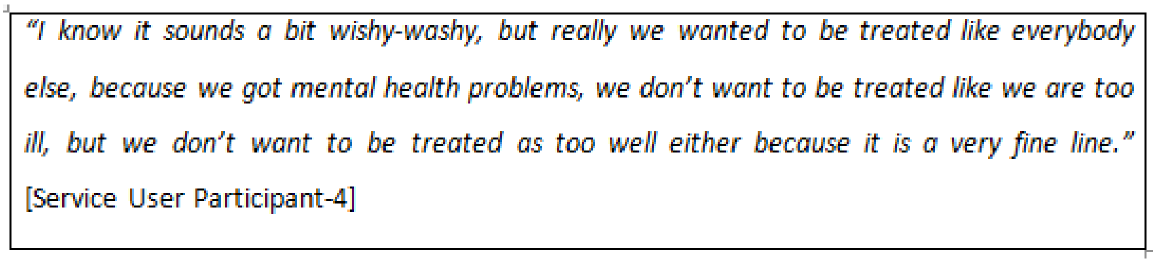
4:4:14 Professionals' priorities take precedence over service users' choice

The interview data (Box 4:3:13, Evidence-1) suggests instances where service users are deprived of their choices and their treatment gets dictated by the professionals. This indicates the presence of two mechanisms that are portrayed in the CMO configuration of this PT. Firstly, service users are aware that the professionals can change the direction of treatment in accordance with their views and priorities. Even though service users want to be part of the decision-making process, the response of a service user participant that states "*more than you make decisions, they are making decisions about what should happen and what should go on*" (Service User Participant-5) portrays a situation where service users feel powerless to influence decisions about their care. Another service user participant revealed that they "*feel like everything is completely out of your control and you don't really know what's going on*" (Service User Participant-9). It reiterates that service users feel disempowered and demonstrates their feeling of being lost in the ward-round meetings [Outcome]. A stakeholder participant opined that the decisions taken by professionals "*very quickly leans towards priority sometimes of clinicians, that's what it's felt like and if someone hasn't got that much agency, I think it can be very hard for people to state priorities in a quite anxiety provoking environment*" (Stakeholder Participant-4). It therefore suggests that professionals are inclined to endorse their priorities, which might include organisational priorities (to accelerate discharge process) [Mechanism-3], which is portrayed in the CMO configuration.

Secondly, in the instance where service users' safety is at risk, professionals tend to take control of the situation. This is evident from the response from one of the staff participants that states, "*once risk has increased then it would make sense to go into the care plan and think about how we are going to manage that"* (Staff Participant-5). It indicates a tendency from professionals to 'manage' risk by taking control of the situation; with the view to minimise the risk of harm to service users that might incur sanctions on the service users' autonomy. However, professionals perceive that "*to manage that*" (risk) is part of their role and responsibility which prompts them to take actions to minimise risks [M-8]. These findings further support evidences identified in various sections (4:4:5 & 4:4:8) in the RR.

4:4:15 Unwanted consequences

The service user would like "*to be treated like everybody els*e" and they recognise that there is a "*fine line*" between wellness and illness (Box 4:3:14). They want to be treated neither as "*too ill*" nor "*too well*". It implies that service users would like to see a balanced approach taken by professionals when decisions are taken in ward rounds. However, service users encounter situations where professionals step over this "*fine line*" especially in ward rounds, where decisions about their care are taken.



"I know it sounds a bit wishy-washy, but really we wanted to be treated like everybody else, because we got mental health problems, we don't want to be treated like we are too ill, but we don't want to be treated as too well either because it is a very fine line."
[Service User Participant-4]

Box 4:3:14

Service users recognised that their response to professionals could sometimes lead to actions that might be detrimental to their personal goals (Box 4:3:15, Evidence-1). Responses such as, "*I don't want to get stuck in there by going against their opinion*" (Box 4:3:15, Evidence-1) illustrate service users' fear of the potential repercussions of vocalising opposition to decisions. As a precautionary measure to avoid any sanctions, service users "*don't want to* *say too much*" as they fear they can do a disservice to themselves by being self-incriminating (Box 4:3:15, Evidence-2). In other words, service users take cautious steps to avoid any sanctions or unwanted consequences by limiting the information they share with the professionals in the ward-round meetings. This indicates the presence of the mechanism [M-4] that is illustrated in the CMO configuration of this PT.

Evidence-1	*"More than you make decisions, they are making decisions about what should happen and what should go on, so you think the decision should be made jointly, but I am happy to go with it as I don't want to get stuck in there by going against their opinion."* [Service User Participant-3]
Evidence-2	*"It makes you feel like you don't want to say too much because you don't want to like incriminate yourself."* [Service User Participant-5]

Box 4:3:15

4:4:16 Ward rounds as a 'daunting environment'

A persistent theme that recurs in a lot of the interview data was about the ward round environment and how it affects service users' involvement and engagement in the ward-round meetings. Ward rounds were described by service user participants as very formal, bringing embarrassment, and being daunting, overwhelming environments that do not provide favourable conditions for contributing constructively in the decision-making process. It was highlighted that service users are often outnumbered in the ward-round meetings (Box 4:3:16) as a result of over-representation by the professionals, where some of the professionals might not have previous acquaintance with service users.

"When I first attended there were 18 people in that room, I am sure it was 18 because I got so ratty about it, this person, this person, this person, they weren't all taking notes. They were there to observe obviously, but they didn't need that many. You should have maximum of six people, including the person who is the patient." [Service User Participant-6]

Box 4:3:16

Some service user participants described their ward-round experience as "*sitting in front of the board*" and others described it as appearing before a "*panel of people*". Ward rounds are "*anxiety provoking*" meetings, as service users find them very intimidating, especially when they are required to respond to questions directed at them. Additionally, service users find ward rounds very “*off-putting*” as “*a whole bunch of people*” are “*staring at them*”. The experience of one of the service user participants illustrates how anxiety affects them during a ward round (Box 4:3:17).

> *“It’s quite embarrassing for me to do that because I felt embarrassed about, just about being there. When I went into the room with psychiatrist and his colleagues and that, I was quite often sweating, you know, I came into sweat because I was unable to cope with the questions they are asking, my brain wasn't all that with it, so I just, you know… sort of flopped because my confidence just diminished.”* [Service User Participant-3]

Box 4:3:17

The service users feel embarrassed and often “*felt intimidated by so-called authority figures”* and they found it very hard to articulate what was going on in their lives. This is because the discussion in ward rounds is viewed as an interrogation by some service users, which produces heightened anxiety that even makes them sweat (Box 4:3:17). The demeanour portrayed by this service user participant from their personal experience illustrates the feeling of powerlessness and helplessness, resulting from the atmosphere in the ward-round meetings. Some service user participants stated that they “*felt judged rather than involved*” and the meetings were ‘rushed’, which does not make them feel involved. The feeling of being judged and intimidated dissuades service users from articulating their opinions and makes it difficult to actively participate in ward-round meetings. Statements such as: “*I was unable to cope with the questions they are asking,*” indicate how ward-round proceedings and environment became instrumental in constraining their participation and was identified as a mechanism [M-9] for this PT.

4:4:17 Summary of PT-3: Ward rounds

Ward rounds are considered as an appropriate arena for shared decision making about service users’ treatment, as they provide a joint platform for multidisciplinary teams and service users to contribute in shared decision making. However, service users find the ward round a challenging environment to contribute effectively in shared decision making, which was identified as the context for this PT. Service users feel intimidated and judged during ward rounds. As a result, service users feel marginalised, disempowered and they do not find a role for themselves in the ward rounds. A few mechanisms were unpacked from the interview data that have helped to explain how the context leads to the outcome**.** The interview data has validated that the doctor-patient relationship; ambiguity around ward-rounds schedules and agendas for discussion; application of various care models and approaches in ward rounds; professionals' priorities that overshadow service users' choices; and unwanted consequences and daunting environments are the features that generate the mechanism that leads to the outcomes. Additionally, the interview data was able to identify another mechanism [M-9], which was instrumental in generating another undesirable outcome for this PT. The interview data has helped to refine the CMO configuration developed during the RR and is illustrated in Table 4:3:2.

4:4:18 Refined CMO configuration based on the interview data for PT-3: Ward round as a non-inclusive arena for shared decision making

Context	In AIMHUs, ward rounds are arenas for the purpose of care planning where decisions about service users' care plans take place. However, these meetings limit the prospect of meaningful contribution in shared decision making by service users.
Mechanism-1	Service users do not perceive that the consulting doctors have a good understanding about them, as they have not had the opportunity to build a trusting relationship with them. This curtails service users' 'willingness to open up' and to articulate their views in the shared decision-making process that takes place in ward rounds.
Mechanism-2	Service users aren't adequately informed about the process involved in ward rounds, their role and the expected outcomes. Service users perceive that the decisions about their treatment were made by professionals, who are expecting them to be compliant with their plans.
Mechanism-3	In order to accomplish clinical recovery and to accelerate the discharge process, professionals are interested in the stabilisation of mental

	health using medication management, which leaves less room for choice and influence from service users' views and feedback.
Mechanism-4	Service users feel powerless to influence the decision-making process, as they perceive their views and feedback may attract unwanted consequences that become detrimental to their personal recovery goals.
Mechanism-5	Professionals perceive that service users who have a serious mental illness are unable to recognise their needs for treatment, underestimating service users' interest in the participation process, and consider themselves in a position of knowing what is best for service users.
Mechanism-6	Professionals have difficulties in balancing their role as advisory experts with the experiential-based knowledge of service users, which dissuades them from relinquishing their powers.
Mechanism-7	Service users perceive that their ability to influence treatment decisions is limited, as their experiential-based expertise and knowledge is not taken seriously by professionals.
Mechanism-8	Professionals recognise that their primary responsibility is inpatient treatment and safety and they feel apprehensive about working in recovery-oriented ways, when they perceive that service users are at increased risk of suicide, or other serious incidents of self-harm.
Mechanism-9	***Service users find ward rounds an anxiety-provoking environment as they are outnumbered by the professionals, where some of them have limited acquaintance with service users. Service users feel intimidated and judged in ward rounds and they find it difficult to express their views and opinions.***

Outcome	Service users do not experience that they had active input in the shared decision-making process during care-planning meetings and feel they are marginalised and disempowered in the process. Service users find the outcomes from ward rounds do not match their expectations and needs.

Table 4:3:2 – Refined CMO configuration based on the interview data for PT-3: Ward round as a non-inclusive arena for shared decision making

4:5 Programme theories

The RS starts with theory and ends with theory. This means the end product of the RS is programme theories of a programme under study. It denotes the level of abstraction at which a theory is transcribed, detailed and close enough to the data for creating testable hypotheses, on the other hand, abstract enough to apply them to other conditions (Wong et al., 2013). The development of IPTs, through to the refinement of the CMO configurations, proved to be a 'detective's task'; one that involved both interrogation with different data sets and abductive and retroductive inference. This has enabled me to conceptualise, synthesise and formulate programme theories that are detailed and close enough to the data related to each of the PTs. The programme theories are detailed in the following sections.

4:5:1 PT-1: Provider-controlled care transition: 'admission to AIMHUs'

The contemporary focus of care in AIMHUs, based on crisis stabilisation and symptom reduction, indicates a 'one size fits all' approach, that is being used implicitly by organisations to mitigate the pressure on beds and manage them judiciously. Based on an understanding of the limited availability of beds, providers use gatekeeping as a means to control admissions to AIMHUs; admissions to AIMHUs are anticipated as a last resort for treatment and a clinical recovery approach is adopted to maximise flow of service users through the system. This practice contradicts the value of ROP and leads to an increased proportion of compulsory admissions, which disempowers and dissatisfies service users. It creates an 'us and them' divide between service users and professionals, and contributes to the unpredictable nature of AIMHUs.

4:5:2 PT-2: Care plan as a recovery tool?

Care plans are used by organisations as a key document to evidence SUI and the care they provide for service users. In AIMHUs, nurses are tasked with developing recovery-oriented care plans to the standards prescribed by the organisation. The current approach and practice in formulating care plans by nurses provides less scope for service users to influence the decision-making process in their treatment. Nurses take ownership of care plans, as they perceive it as a task-oriented activity to meet audit demands and to evidence their work. Nurses do not find relevance in establishing therapeutic relationships with service users as part of the care-planning process during their short stay in AIMHUs. The lack of relational work with nurses makes service users feel distanced from the care-planning process and they do not feel any ownership of the document. Neither service users nor nurses have the confidence that the care plan they formulate has an impact on service users' care. As a result, care plans are created in silos by nurses and have less buy-in from service users and by the MDT. Service users feel disempowered and marginalised from the care-planning process and nurses are less satisfied with their job role.

4:5:3 PT-3: Ward rounds as a non-inclusive arena for shared decision making

The scope for meaningful involvement in shared decision making by service users during the care-planning process in the ward round is limited. Service users have less clarity and awareness about their role and expectations from the ward round, which makes them feel disempowered. Service users are outnumbered during the ward round and find it intimidating to open up in the ward round with doctors with whom they have not established a good therapeutic relationship. Service users perceive that the doctors and other professionals do not take their views seriously and feel they have preconceived ideas about treatment decisions that align more with professional knowledge and organisational needs than service users' needs. Service users are mindful that reinforcing their views and needs can attract unwanted consequences and they do not find the outcomes from ward rounds meet their expectations. However, professionals find it difficult to relinquish their power and responsibility and to work in a recovery-oriented way when it comes to decision making about safety-related issues. As a result, service users do not feel that they have active input in the decision-making process during ward rounds.

4:6 Chapter summary

This chapter presented the refinement of 1st, 2nd and 3rd PTs using evidence from the RR, which was further tested and refined using the interview data. The refinement of each of the PTs using evidence from the RR and interview data, was illustrated using CMO configurations. The chapter ends with a narrative form of refined PTs, and a concise summary of CMOs to facilitate understanding. The next chapter will present the 4th and 5th refined PTs.

Chapter-5: Findings – Part 2

5:1 Introduction

This chapter continues with the findings and details of programme theories, (PT)-4: Peer support worker intervention and PT-5: Provider-controlled care transition from AIMHUs (discharge practice). The structure of presenting the findings is similar to the way it was presented in Chapter 4 and ends by presenting refined programme theories.

5:2 Programme Theory-4: Peer support worker intervention

Peer support workers (PSW) are individuals with the knowledge of the mental health system and personal experience of mental illness. Peer support working in mental health has gained momentum in recent years as it is considered a resource that can enable organisations to make recovery-focused changes in practice (Repper et al., 2013). This PT will examine the factors that influence PSW intervention in promoting SUI in ROCP. While not identified as a PT during the background search, the evidence included for review of the other PTs indicated that PSWs were a significant influence on ROP and SUI. Additionally, a significant number of references to PSW interventions were generated in the interview data (see Section 5:2:7), which instigated an iterative search to retrieve evidence for PSW intervention.

The evidence base for PSW intervention is continuing to expand. This was noticeable during the RR, as the reference density for PSW intervention has been growing steadily in recent studies and reports. As individuals, PSWs have substantial influence in shaping and delivering ROP in contemporary mental health services. The experience from the Implementing Recovery through Organisational Changes (ImROC) programme (Repper et al., 2013) illustrated that the introduction of peer support working is a powerful way to drive ROP within organisations. In contemporary mental health practice, the role of PSW is regarded as a key player in ROCP. An IPT was developed regarding PSW intervention and further evidence was gathered during the RR. The IPT formulated was:

"Hiring PSWs to work as part of MDT in AIMHU to deliver peer support for service users and for training in-service staff [C] can promote ROP [O], reduces stigma and power imbalance [O] as PSW intervention can instil hope for recovery."

5:2:1 Background

The idea of peer workers originates from North America and the trend of employing peer support workers in mental health is rising (Gillard et al., 2013; Davidson et al., 2012; Resnick & Rosenheck, 2008). It offers a novel cultural context in the mental health arena for healing and recovery (Mead et al., 2001). Peer support workers are defined as "*people in recovery who support others who are experiencing mental distress within the context of the principles of social inclusion*" (DoH, 2007, p.32). Hornik-Lurie et al. (2018) defined PSWs as "*individuals with a lived experience of mental illness and recovery, who use their personal knowledge and life experience to support others with similar conditions*" (p.571). Interest in PSW intervention has grown in mental health as part of embracing the principles of ROP (Jacobson et al., 2012). Terms such as 'peer support worker' and 'peer support specialist' have been used interchangeably to identify this role. Evidence from various studies has revealed that PSWs produce more positive experience and user-focused outcomes when compared with non-peer staff and are more effective in some areas (Hornik-Lurie et al., 2018; Solomon, 2004; Simpson & House, 2002). PSW input has also been highlighted as a concrete component that can assist in the shared decision-making process (Elwyn et al., 2012; O'Connor et al., 2009).

The introduction of PSWs in mental health has been driven in part by national policies (DoH, 2009a & 2007) as more evidence advocates peer support as an important aspect in mental health recovery, as well as an intervention that provides good value for money (DoH, 2009c). The introduction of PSWs in the mental health system was offered as an opportunity to address the capability and skill mix in mental health teams and organisational productivity (DoH, 2009c; 2007). Peer support is an emotional support, frequently coupled with instrumental support (Gartner & Reissman, 1982). As a result, it has been highlighted as an important component in ROP (Deegan & Drake, 2006). The next section will use evidence from the RR to articulate the elements of CMO that have helped to create a plausible explanation, using a CMO configuration. These are illustrated under the following headings:

1. *"People in recovery who support others";*
2. Peer support by sharing personal experience;
3. PSWs: *"Someone to look up to";* and
4. PSWs as change agents in team culture.

5:2:2 "*People in recovery who support others*"

Evidence from the RR indicates that PSW interventions are beneficial for promoting service users' recovery and to shape cost-effective, recovery-oriented practice in organisations. Even from the time when empirical evidence for the impact of PSWs in mental health services was limited, Solomon (2004) strongly supported and advocated that PSW intervention could benefit service users and mental health systems. Since then the evidence base for PSW intervention has expanded considerably. The emphasis of peer support is on person-centred outcomes, such as social inclusion and empowerment, rather than traditional, clinical outcomes, such as symptomatology (Puschner et al., 2019). It brings mutual benefits to PSWs and to the service users through practical and emotional support, positive self-disclosure, promoting hope, feelings of empowerment, self-efficacy, mutual empowerment, self-esteem and confidence in expanding social networks (Davidson et al., 2012; Shepherd et al., 2008; Resnick & Rosenheck, 2008; Corrigan, 2006; Davidson et al., 2006; Repper & Perkins, 2003; Davidson et al., 1999; Klein et al., 1998). These factors collectively indicate benefits to service users from a recovery-oriented perspective [O-1].

There is some evidence that is less complimentary of PSW intervention, which is a contrast to the interview data that was overwhelmingly complimentary of the PSW interventions. Jacobson et al. (2012) noted that poorly defined job roles, including role ambiguity within the organisations (Asad & Chreim, 2016) pose considerable challenges for PSWs to be successful and hinders their integration into the MDT. The risk of turning PSW's role into a more clinically focused approach was also identified in the interview data, which summates the need for a clearly defined job role for PSWs in AIMHUs (see Section 5:2:10). Walsh et al. (2018) highlighted the concerns regarding the risk of 'over-professionalising' the role of PSWs and emphasised the significance of supervision and work place support. Additionally, NICE (2014) (Box 5:4:1) indicated some reservations about the clinical and cost-effectiveness of PSW interventions with people suffering from psychosis and schizophrenia.

> *"Service users have supported the development of peer support interventions, which have recently proliferated in the UK, but current evidence for these interventions in people with psychotic disorders is not strong and the studies are mainly of very low quality. Moreover, the content of the programmes has varied considerably, some using structured interventions, others providing more informal support. There is therefore an urgent need for high-quality evidence in this area."* (NICE, 2014, p.34)

Box 5:4:1

An observation made by Trachtenberg et al. (2013) can shed light on the limitations of 'high-quality evidence' into the effectiveness of peer support. They stated that the variable quality of the evidence and using different samples of studies has led reviewers to varying conclusions. However, there was no evidence to suggest that PSW interventions produce worse health outcomes for service users (Pitt et al., 2013; Trachtenberg et al., 2013). Furthermore, there were a number of studies indicating that inclusion of PSWs in the workforce produces the same or better results, when compared with workforces without peer staff (Davidson et al., 2012; Repper & Carter, 2011; Simpson & House, 2002). Finally, a recent study conducted by NESTA & NATIONAL VOICES (2015) has found some compelling evidence that supports the effectiveness of PSW interventions (Box 5:4:2). This evidence collectively indicates that PSW interventions can promote ROP by empowering service users, which was identified as an outcome [O-1] for this PT. Additionally, a study conducted by Trachtenberg et al. (2013) suggested that PSW intervention can reduce inpatient bed usage, which can be treated as another outcome [O-2] for this PT, especially from an AIMHU perspective.

> *“More than 20,000 studies were screened and 1,023 studies were identified for inclusion. In total, 524 of these studies examined the outcomes of peer support and the others described processes and this review examines the effect of various types of peer support on people’s experience, behaviour and health outcomes and health service use. Based on the totality of evidence, the review concludes that the top three most useful types of initiatives for improving emotional and physical well-being may be: face-to-face groups run by trained peers which focus on emotional support, sharing experiences, education and specific activities such as exercise or social activities; one-to-one support offered face-to-face or by telephone; and online platforms such as discussion forums. (Edited publisher abstract)”* (NESTA, NATIONAL VOICES, 2015)

Box 5:4:2

The findings from the study conducted by NESTA, NATIONAL VOICES (2015) corroborates previous studies (Coatsworth-Puspoky et al., 2006) which identified that the personal characteristics of PSWs have benefited service users. PSWs can make a meaningful connection with service users, as they understand service users in a way that is real and empathetic (Jacobson et al., 2012). Additionally, PSWs were also seen in the role as educators, by sharing their expertise from lived experience to service users and staff. It therefore provides valuable evidence to illustrate the benefits of PSWs when they are employed in mental health teams to work alongside multidisciplinary teams and to utilise their knowledge in staff training. Although findings from the RR support the context [C] that is explained in the PT, findings from RR further refines the context by highlighting the need to have a clear job role for PSWs when working with multidisciplinary teams.

5:2:3 Peer support by sharing personal experience

One of the main advantages PSWs have over mental health staff is the knowledge gained through their personal experience of overcoming mental health problems, which can act as a mechanism [M-1] that generates outcomes. Admission to AIMHUs has been described by service users as a traumatic and frightening experience due to the acute nature of the illness and the nature of environment on these units (Currid, 2009). Numerous studies have found that PSWs can foster hope for service users in crisis. When PSWs share their personal experience with service users in crisis, it enables them to identify with others like them. Service users feel a connection with PSWs that creates a reciprocal relationship; it instils a sense of hope and belief in a better future. Due to their experience and knowledge in using the mental health system, service users view PSWs as educators, advocates and as knowledgeable brokers, who are able to link them to the community and inpatient-based supports and resources (Jacobson et al., 2012). Service users are able to feel authentic empathy and validation when they share their experience with PSWs (Repper & Carter, 2011; Mead et al., 2001). Hence peer support by sharing experience and knowledge about personal recovery between PSWs and service users was identified as a mechanism [M-1] of this PT.

5:2:4 PSWs: "*Someone to look up to*"

PSWs are seen as role models, as their presence on AIMHU is perceived as a symbol and example to both service users and staff. Based on PSW's lived experience and knowledge about the illness and mental health system, they can instil a sense of hope and optimism to engage in the self-management of care (Yarborough et al., 2016). They are seen by service users as "*someone to look up to*" (Jacobson et al., 2012, p.8) in relation to the management of their recovery and achieving their goals, which was been referred to by Davidson et al. (2012) as being "*street smarts*" (p.124). According to Repper and Carter (2011) the inspiration generated by successful role models (PSWs) is difficult to overstate. The evidence provided by Davidson et al. (2012) confirms service users' perceptions of PSWs. Additionally, Walker and Bryant (2013) found substantial evidence that service users in recovery perceived PSWs as role models. Evidence suggests staff, especially on AIMHUs, show reservations regarding the real prospect of recovery approach, as they regularly see service users in the acute stage of illness (McKenna et al., 2014). The presence of PSWs is seen as an exemplar of recovery in action (Jacobson et al., 2012). Studies have found that having PSWs in teams can also be perceived as role models who have experienced the service at first hand, encouraging service users to engage with the service (Gillard et al., 2013). Hence the presence of PSWs' in teams has undoubtedly helped to instigate the perception of the potential for recovery in mental health amongst both service users and staff. This has developed as a result of their effect as role models and can be seen as another mechanism [M-2] for this PT.

5:2:5: PSWs as change agents in team culture

The third mechanism found through the RR can help to make changes in the teams' culture as a result of PSWs' interventions. Their presence in the team, along with skills and resources, can have an impact on the way in which staff shape their practice. The mental health system has a notoriously paternalistic past, characterised by reports of stigmatisation and coercive practice (Cutcliffe et al., 2015). Evidence from the RR suggests that current practice in mental health still shows some stains of paternalism in the form of the negative attitude of staff towards ROP; prevalence of the medical model; intentional avoidance of service users (Rose et al. 2015); lack of respect; and condescending communication with service users. This was evident from a study conducted by Isobel (2019) (Box 5:4:3). Additionally, Hornik-Lurie et al. (2018) reported that mental health professionals have shown increased awareness about the manner in which they made reference to service users in the presence of PSWs.

> *"They determined quickly who were the staff that would listen or care or they were informed by the other inpatients. Some 'don't even smile' while 'the ones that treat me like a human being make a big difference'."* (Isobel, 2019, p.111)

Box 5:4:3

Similarly, Gillard et al. (2013) reported that PSWs can provide insight to the teams in order for them to be more user focused. They can help to articulate the service users' perspective, minimise stigma and enhance professionals' understanding of service users and their needs (Moran, 2018; Mahlke et al., 2014; Davidson et al., 2012). Furthermore, a study conducted by Brooks et al. (2018) has revealed that the input from PSWs can complement the interventions of health care professionals and can progress the care-planning process towards a more user-focused direction, away from the paternalistic culture, clinical norms of surveillance, organisational restrictions and control associated with statutory rights. The skills and capability exhibited by PSWs encourages staff to use more strength-based approaches than problem-oriented approaches, which is supported by the observation made by Christie (2016) (Box 5:4:4).

"Peer support could play a significant role by contributing to a culture change which is more strengths-based and works to empower people to play a central role in any care and support they receive." (Christie, 2016, p.1)

Box 5:4:4

According to Repper et al. (2013), PSWs can challenge three areas: firstly, they can challenge stigma; secondly, they can challenge staff to reflect on their practice; and, thirdly, PSWs can challenge the assumption that service users primarily and always require professional help. Self-stigma among service users was reported by many authors. A programme that delivered structured intervention to service users by professionals, in an inpatient unit for a period of six weeks, has shown encouraging results in reducing self-stigma (MacInnes & Lewis, 2008). It involved discussing personal experience, diagnosis and symptoms. As aforementioned, opportunity for sharing experiences with PSWs appeared to address issues related to self-stigma. This is very relevant in light of the fact that negative staff attitudes and stigmatisation are identified as barriers to SUI, and have a significant impact in changing the culture within teams towards mental health practice. This might help to reduce the 'sense of separation' that prevails between service users and staff, creating a 'them and us' attitude, which is seen as one of the outcomes [O-3]. Hence the presence of PSWs in teams increases the awareness of staff and it can shape their practice. The following section (Table 5:4:1) will be used to illustrate the refined CMO configuration.

5:2:6 Refined CMO configuration based on the RR for PT-4: PSW intervention

Context [C]	Proactive approach to employing more people with lived experience in AIMHUs, with clear role specification, supervision and workplace support, can create favourable conditions for recovery-oriented practice.
Mechanism-1 [M-1]	PSWs' have the advantage of having practical knowledge and experience gained through their own recovery process about how to overcome mental health problems. When PSWs share their personal experience with service users who are currently in crisis, it generates knowledge transfer and enables service users to identify with others like them. Service users

	feel a connection with PSWs, as they see common ground, which creates a reciprocal relationship and a belief in a better future for service users in crisis.
Mechanism-2 [M-2]	The presence of PSWs is seen by service users as *“someone to look up to”* in relation to the management of their recovery, in order to achieve their goals, and they are perceived as exemplars of recovery in action. The presence of PSWs’ in teams has undoubtedly helped to instigate the perception of the potential for recovery in mental health amongst both service users and staff.
Mechanism-3 [M-3]	The presence of PSWs can challenge stigmatisation, initiates a more humane, positive and respectful approach towards service users by staff and it enables a culture that instigates collaborative working.
Outcome-1 [O-1]	PSW interventions can promote ROP by empowering service users and can instil hope for mental health recovery among service users and staff.
Outcome-2 [O-2]	PSW intervention could potentially reduce inpatient bed usage.
Outcome-3 [O-3]	Peer support workers can reduce the ‘them and us’ culture within teams and can promote ROP.

Table 5:4:1 – Refined CMO configuration based on the RR for PT-4: PSW intervention

5:2:7 Refinement of CMO using interview data: PSW intervention

The interview data regarding PSWs mirrors the findings from the RR and has shown clear consistency in supporting the fact that the role of the PSW in AIMHUs can promote ROP in AIMHUs. Service users felt at ease when working with PSWs, which enabled them to talk about *“anything and everything”* in a *“comfortable”, “relaxed” and “less formal”* manner. It shows that service users find PSWs’ approachable, less intimidating and that they make themselves available to talk to service users, unlike inpatient staff, who are often busy. Even though PSWs are employed by the organisation, the interview data indicated that service users do not view them as staff members, which can help to minimise the ‘us and them’ divide between service users and the team. The response from service user participants (Box 5:4:5) has indicated that they "*sit and drink coffee together*" and "*swap stories"*, and this signals that they see "*a common ground*" (Staff Participant-6) with PSWs, as they have "*had very similar experience"*. It therefore indicates service users' readiness to be more open with PSWs.

> *"I could relate to them, we sit and drink coffee together, talk often about how we were, our illnesses, sort of swap stories. I think that's therapeutic in the respect that you are talking to someone who has had very similar experience, very similar illness."* [Service User Participant-8]

Box 5:4:5

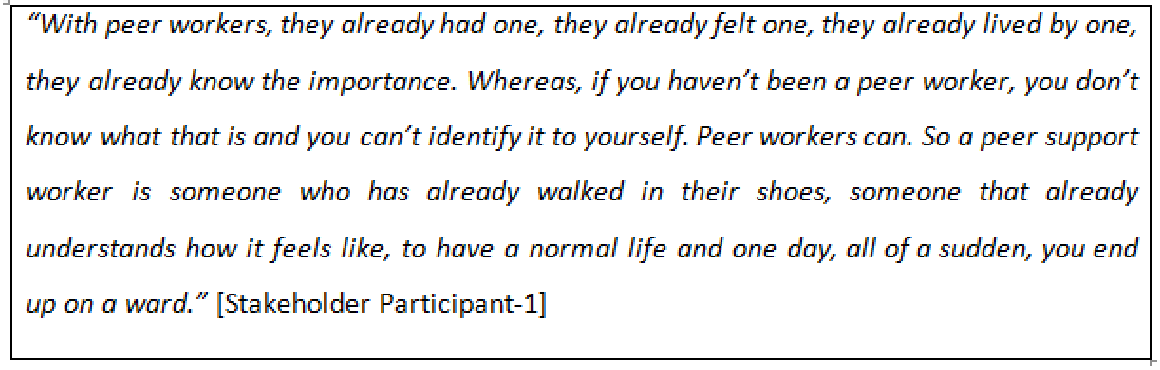
Additionally, it provides a 'therapeutic' benefit for service users; as PSWs can understand and 'relate' to what is really going on in the service users' lives. Service users' value PSWs' experience, which makes the role of the PSW 'unique'. Interview data indicates that service users' have "*no anxiety attached in having a frank conversation with them"* (Staff Participant-1). This provides an advantage for PSWs to work closely with service users and enable them to work as a "*facilitator for meaningful involvement*" (Stakeholder Participant-4). The PSWs engage with service users with the understanding that *"you don't really learn anything by being told, you have to come to it by yourself"* (Staff Participant-6). It is suggestive of the significance they give to the uniqueness of recovery for each individual and to empowering them to find answers for their own personal recovery. It therefore illustrates that hiring PSWs to work on AIMHUs can facilitate ROP and it validates the context [C] identified in the CMO configuration. The mechanisms that promote the outcomes [O] from PSW interventions were identified from the interview data under three themes. They are:

1. PSWs as someone who "*already walked in their shoes*";
2. PSW *"a boost"* for service users;
3. "*I am much more than my diagnosis*."

I will explore these themes in the following sections.

5:2:8 PSWs as someone who “*already walked in their shoes*”

The interview data demonstrated that the lived experience and knowledge of PSWs were key resources that can make a significant impact in service users’ recovery and in promoting ROP in AIMHUs. As they had “*already walked in their* [service users’] *shoes*” (Box 5:4:6), PSWs are in a unique position to understand service users’ experience, compared to professionals, and have a personal story to share. Moreover, PSWs are able to empathise and understand how mental health problems can impact on a person’s daily life, based on their personal story and experience, which gives PSWs an advantage over professionals.



“With peer workers, they already had one, they already felt one, they already lived by one, they already know the importance. Whereas, if you haven’t been a peer worker, you don’t know what that is and you can’t identify it to yourself. Peer workers can. So a peer support worker is someone who has already walked in their shoes, someone that already understands how it feels like, to have a normal life and one day, all of a sudden, you end up on a ward.” [Stakeholder Participant-1]

Box 5:4:6

In a PSW, service users find someone with lived experience, which gives them the advantage of identifying others who were in a similar situation to themselves. This awareness makes them feel connected and they can develop a reciprocal relationship. This is evident from the way in which service users interact and behave with PSWs in a group setting jointly facilitated by a PSW and one of the staff participants (Box 5:4:7).

> *“Patients are definitely more open with peer workers. As I sat in a group this morning, with the peer support worker and he kind of led the group, we both agreed the format together based on the patient mix, but he led that group and there were patients there who hadn’t previously been very open with me or, you know, but all of them were discussing: ‘I have these hallucinations, this is a delusion, do you think this is a delusion?’ You know, ‘These are my relapse signs, I have trouble sleeping too,’ and it was really nice because he wasn’t staff in their eyes, he was just someone else, another human, he'd experienced the same thing and I think that was what changed that group dynamic and I actually felt you know, I’m just an observer here I'm not involved in this, I have just been excluded, ha ha ha, that’s fine, I'm*

happy with that because they are getting so much more rich and meaningful discussion out of it." [Staff Participant-1]

Box 5:4:7

In the real-life group scenario given in Box 5:4:7, service users are open and engaging spontaneously with PSWs, as they do not see them as staff. The change in the "*group dynamics*" provides valuable evidence about the rapport developed between service users and PSWs that has enabled a 'rich and meaningful discussion'. The dialogue with service users creates an opportunity for PSWs to share their learning and experience and helps service users to think proactively about their own recovery goals. Sharing personal experience enables knowledge transfer, which helps service users to have a better understanding about their condition and instils a sense of hope for their future [M-1], which helps to empower service users [O-1]. This finding further supports the evidence identified during the RR (see Section 5:2:3).

The spontaneous nature of the response from the service users to PSWs in groups (Box 5:4:7) indicates that they find confidence in initiating discussions with PSWs. This suggests that service users find confidence in using their agency to initiate conversations, in contrast to the situations identified in all other PTs, where they take a passive role. A participant in the PSW role has indicated that "*sometimes they will talk to me more than they might talk to a member of staff*" (Staff Participant-6) and has alluded to the fact that this is as a result of a common ground they share with service users. The staff participant (Box 5:4:7) who was present in that group also indicated observing a change in the group dynamics. It therefore reiterates that the intervention with a PSW is therapeutic in the sense that it enables empowerment of the service user and brings a rejuvenated hope for their recovery. It therefore aligns with the outcome [O-1] indicated in the CMO configuration.

5:2:9 PSW "*a boost*" for service users

As discussed above, service users see PSWs as someone who has already walked in their shoes, but also as individuals who were able to manage their recovery and are placed in positions where they are able to share their experience with service users. One of the stakeholder participants commented that the presence of PSW is "*such a boost*" (Stakeholder Participant-2) as it allows service users and professionals to observe them and to work with them.

Evidence-1	*"They won't talk about themselves, but they ask questions of me, but I know by their questions of me they are relating it to themselves. I'm getting them to think about what's gonna happen once they leave hospital. Because recovery in acute inpatient setting, in my experience, was only a small step in my long-term recovery."* [Staff Participant-6 (PSW role)]
Evidence-2	*"If I know them a little bit, and I sense that there is an understanding, I might hint or try to nudge, but ultimately that has to come from them. It is allowing them to increase their awareness, it is not to tell them what to do, I see."* [Staff Participant-6]

Box 5:4:8

Service users' eagerness and their anticipation to know PSWs' experience, and the way service users respond spontaneously to PSWs indicates that service users view PSWs as people they can look up to and follow. A response from one of the participants in a peer-support role states "*they won't talk about themselves but they ask questions of me*" (Box 5:4:8, Evidence-1) demonstrates that service users are motivated and are using their initiative to find answers to their situation by using PSWs' experience of illness and their recovery. Service users find it credible to utilise the knowledge and experience of PSWs and are trying to apply that in their situation, because they view it as a success story. Moreover, by "*relating"* PSWs' experience with theirs (the service users') it suggests that PSWs' are perceived as role models and service users use them as an exemplar for comparison with their own recovery journey and for reflection [M-2]. This further explains and supports the mechanism identified during the RR (see Section 5:2:4).

The ability of PSWs in "*getting them to think about what's gonna happen once they leave hospital*" indicates that PSWs are coaching service users by provoking them to think and to identify and develop skills for achieving their personal recovery goals. Additionally, in Evidence-2 (Box 5:4:8), the PSW here is helping service users to think, whereby helping service users to come up with their own solutions and personal goals. In essence, the role of the PSW helps to boost service users' confidence and helps them to look forward [M]. It also suggests that PSW intervention in this respect is empowering service users and confirms Outcome-1 of the CMO configuration. Additionally, it promotes service users' forward planning "*what's gonna happen once they leave hospital",* which might arguably lead to a situation that enables them to think more about transition, which might help to shorten their stay in inpatient units [O-2].

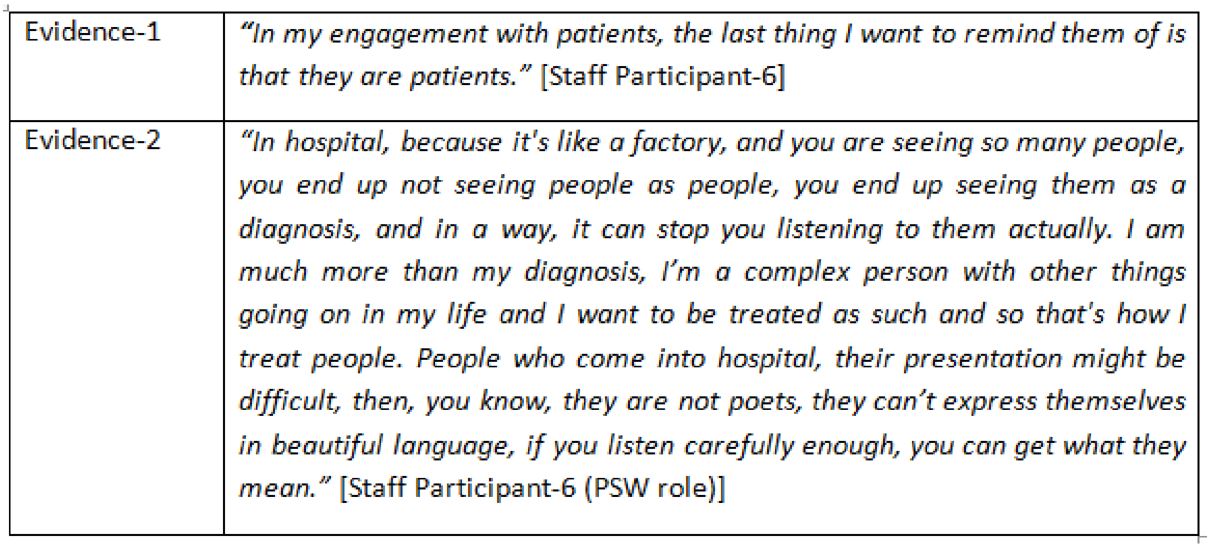
5:2:10 "*I am much more than my diagnosis*"

The role of PSWs holds a unique position where they use their lived experience and knowledge for the benefit of service users and professionals, as they work as part of an MDT. PSWs are able to promote practices that are sympathetic towards ROP, at the same time, they can point out practices that are stigmatising and debilitating for service users' recovery. The role gives them an opportunity to be on a 'middle ground' where they are able to have a broader view of the challenges and barriers for embracing the principles of ROP from 'both sides'.

> *"Because I think they get to see both sides of it, they fit in that middle ground where they are staff and they are, or have been, a patient, so they can see both sides of it. They can see the pressures of the ward, they can see the challenges, and the barriers, but then also pick on some unhealthy practices and they can shed some light on what would have helped, or what would have been useful."* [Staff Participant-4]

Box 5:4:9

The fact that PSWs are able to "*pick on some unhealthy practices"* (Box 5:4:9) indicates that PSWs are able work as agents who can make constructive contributions by pointing out practices that demote the principles of ROP. Additionally, PSWs are able to enlighten professionals by providing constructive feedbacks on their practices, based on PSWs' knowledge and experience. PSWs are in a better position to share their views and opinions on individual and collective practice. Evidence-1 (Box 5:4:10) illustrates that PSWs evade reinforcing the 'sick' role, which means the focus is on their strengths and not on their weaknesses, which aligns with the principles of ROP. In Evidence-2 (Box 5:4:10), the phrase that states "*I am much more than my diagnosis*" reiterates the need to see and hear service users as individuals, rather than seeing them as just a diagnosis. Again, *“that's how I treat people”* imparts what would be useful.



Evidence-1	*“In my engagement with patients, the last thing I want to remind them of is that they are patients.”* [Staff Participant-6]
Evidence-2	*“In hospital, because it's like a factory, and you are seeing so many people, you end up not seeing people as people, you end up seeing them as a diagnosis, and in a way, it can stop you listening to them actually. I am much more than my diagnosis, I’m a complex person with other things going on in my life and I want to be treated as such and so that's how I treat people. People who come into hospital, their presentation might be difficult, then, you know, they are not poets, they can’t express themselves in beautiful language, if you listen carefully enough, you can get what they mean.”* [Staff Participant-6 (PSW role)]

Box 5:4:10

PSWs are in a better position to identify practices that do not align with the principles of ROP. As PSWs are viewed as advocates and ‘facilitators of meaningful involvement’, their presence and intervention might help to instigate a culture that supports collaborative practice. The interview data has supported evidence from the RR by pointing out that PSWs can capture practices that incite stigmatising service users based on their diagnosis (Box 5:4:11) and are calling for professionals to have a better understanding about service users’ situations. The abstract of data in Box 5:4:11 indicates PSWs can unpick practices and cultural values that reinforce stigmatisation. It therefore indicates that they are able to contribute positively by challenging unhealthy attitudes, to make conditions favourable for ROP [M-3].

> *"As patients, their behaviour is more challenging on the surface. It's quite difficult, it consumes a lot of staff attention, to the detriment of other patients. I can tell they find it annoying, they don't like those patients, they are difficult, they consider them manipulative and childish, but the things is that, if they had an understanding that a lot of personality disorders are based on trauma, sexual abuse, child neglect and it would reduce that, I would say, stigma, towards that patient it would ease their interactions with that patient."* [Staff Participant-6 (PSW role)]

Box 5:4:11

The statement in Box 5:4:11 appeals for a more humane approach from professionals, which suggests that PSWs' interventions might help to minimise the 'us and them' culture between service users and allow room for collaborative working. Additionally, their ability to 'see both sides' might also help to minimise the 'us and them' culture, which is classed as one of the Outcomes [O-3]. This aspect of PSWs' interventions can make conditions favourable for service users. The presence of PSWs in AIMHUs enables service users' to have a positive experience during their time in AIMHUs, which might arguably lead to a situation where service users can reduce their length of stay in inpatient units [O-2]. However, interview data has warned that the uniqueness of the PSW role and its impact on ROP can only be sustained if their practice does not turn into a more clinically focused approach. Responses such as *"as long as that* [practice of PSWs] *does not merge their boundaries and change them into a clinical role rather than the special nature of their roles"* indicates a potential risk of these roles becoming ineffective in AIMHUs. I will return to this in discussion.

5:2:11 Summary of PT-4: PSW interventions

Evidence from the RR has identified that the role of PSWs has a valuable place in promoting ROP, as they are able to apply their personal experience and knowledge. The interview data has verified this finding from the RR and has further refined the CMO configuration. The interview data enabled me to expand the context with PSWs' practical knowledge and experience (resources, in realist terms). Service users find their engagement with PSWs therapeutic, as they are able to swap stories and experiences. Service users find a common ground between themselves and PSWs, which makes it easier to develop a rapport that helps to create a reciprocal relationship. Sharing experience and knowledge enables knowledge transfer, which instigates hope and it results in empowering service users. The interview data has helped to identify that service users perceive PSWs as role models, as they are seen as someone who has walked in their shoes and has a story to share [M-2]. Moreover, they have developed skills to cope with challenges and to manage their recovery. They are viewed as an example for recovery in action and it helps to instil thoughts for the future in service users. The interview data has identified the unique position of PSWs to work as part of a multidisciplinary team with lived experience that helps PSWs to unpick practices that reinforce stigmatisation and demote ROP. On the other hand, PSWs can shed light on practices that are useful, to create favourable conditions for ROP and to minimise the 'us and them' culture, only if their practice does not turn into a more clinically focused approach. It therefore indicates that employing PSWs can add value to the therapeutic milieu of AIMHUs and can promote ROP. A refined CMO configuration is illustrated in Table 5:4:2.

5:2:12 Refined CMO configuration based on the interview data for PT-4: PSW intervention

Context [C]	***PSWs have the advantage of having practical knowledge and experience, gained through their own recovery process, about how to overcome mental health problems.*** A proactive approach to employing more people with lived experience within AIMHUs, with clear role specification, supervision and workplace support, can create favourable conditions for recovery-oriented practice.
Mechanism-1 [M-1]	When PSWs share their personal experience with service users who are currently in crisis, it generates knowledge transfer and enables service users to identify others like them, which gives a sense of hope. Service users feel a connection with PSWs, as they see common ground, which creates a reciprocal relationship and a belief in a better future for service users in crisis.
Mechanism-2 [M-2]	***PSWs are perceived by service users as role models, as they have already walked in their shoes and have a story to share about the way in which they managed their recovery, in order to achieve their goals***, and they are perceived as exemplars of recovery in action. The presence of PSWs'

	in teams has undoubtedly helped to instigate the perception of the potential for recovery in mental health amongst both service users and staff.
Mechanism-3 [M-3]	***The presence of PSWs enables the highlighting of practices that reinforce stigmatisation, and might inspire service users to actively engage with professionals in planning their care.*** Their presence can initiate a more humane, positive and respectful approach towards service users by staff and it enables a culture that encourages collaborative working.
Outcome-1 [O-1]	PSW interventions can promote ROP by empowering service users and can instil hope for mental health recovery among service users and staff.
Outcome-2 [O-2]	***PSW intervention can motivate and enhance service users' experience during their stay in an AIMHUs,*** which might reduce the length of stay in the AIMHU.
Outcome-3 [O-3]	Peer support workers can reduce the 'them and us' culture within teams and can promote ROP.

Table 5:4:2 – Refined CMO configuration based on the interview data for PT-4: PSW intervention

5:3 Programme Theory (PT)-5: Provider-controlled care transition from AIMHU (discharge practice)

This PT discusses the limitations to SUI resulting from current practice in preparing service users for transition into the community. There is a wealth of literature on this topic and a number of studies have been conducted on discharge planning, which is undoubtedly viewed as a complex and stressful period for service users and their families. According to Steffen et al. (2009), the objective for discharge planning is to allow a smooth transition of care between inpatient and community by co-ordinating a fragmented service in order to improve service user outcomes, medication adherence, prevent readmission and aid cost saving. Evidence suggests that discharge planning continues to be an area where organisations, professionals, service users and carers encounter various challenges and this contributes to outcomes that do not reflect the principles of recovery-oriented practice. The IPT formulated for this PT was: *"The current discharge-planning process and interventions on AIMHUs are based on clinical recovery and service-defined recovery [C] that are inclined to meet organisational needs over service users' needs [M]. This contradicts the value of recovery principles, leading to disempowerment, service user dissatisfaction and failed discharge [O]."*

5:3:1 Background

The global trend and priority in mental health care recently has been large-scale deinstitutionalisation (WHO, 2013). As a result, policy makers have attempted to reduce the NHS's reliance on hospital-based treatment, leading to the reduction of inpatient beds and shorter lengths of stay (Gilburt, 2015). The main focus was to provide community-based treatment as an alternative for inpatient treatment (Clibbens et al., 2018). In accordance with this movement, mental health inpatient beds in England have reduced dramatically from 67,122 in 1997–1998, to 26,929 in 2007–2008 (Niehaus et al., 2008). This has paved the way to building a modernised mental health practice that evades excessive or unnecessary inpatient episodes by facilitating early discharge of service users who may not have fully recovered from their mental health crises (Hegedűs et al., 2018; Hengartner et al., 2017). Irrespective of this approach, unsustainable bed occupancy levels remained a continuous theme with regard to acute inpatient beds (Gilburt, 2015). Rhodes and Giles (2014) indicated that a shortage of inpatient beds was linked to the flow of service users through acute care in the UK. Quirk and Lelliot (2001) contended that the reconfiguration of the service brought about by deinstitutionalisation accounts for the perilous state of AIMHUs today. This has accounted for the change in the focus and function of mental health units from long-term to short-term admissions by facilitating crisis / early discharges (Steffen et al., 2009).

In recent years, mental health service research has dedicated substantial effort to finding out how to enhance the transition between AIMHU and community teams, and researchers have progressively focused on system-level variables, such as readmission rates, length of stay, post-discharge follow-up and discharge planning (Steffen et al., 2009). This is based on the understanding that discharge from AIMHUs can be critical, stressful and emotionally charged (Clibbens et al., 2018; Hegedűs et al., 2018; Wright et al., 2016). Additionally, a number of the following risk factors were identified during the immediate post-discharge period from AIMHUs. This includes the high-risk period for suicide (The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness [NCISH], 2016); increased risk of relapse and readmission (Steffen et al., 2009); re-adapting to home environment (Owen-Smith et al., 2014); loneliness (Beebe, 2010); disputed family environment (Loch, 2014); stigma resulting from admission to AIMHUs (Keogh et al., 2015); and disengagement with community services (Bowersox et al., 2013). Considering the complex nature and plethora of risk associated with this transition, policies and guidance were issued to minimise these risks and to ensure furnishing robust discharge plans (NICE, 2016; DoH, 2008). However, evidence from the RR indicates a number of loopholes in practice that do not reflect the overt application of ROP. The next section will be used to explore context, mechanism and outcomes identified through evidence from the RR and to align that in a CMO configuration. These are illustrated under the following headings:

1. "*I want to send you home today*";
2. Limited preparation and time for personal recovery;
3. Paternalistic attitude of mental health staff; and
4. Emphasis on clinical recovery.

5:3:2 "*I want to send you home today"*

In this section I will start to articulate the context [C] relevant for this PT from the evidence gathered through the RR. Organisations would appear to anticipate early discharge of service users from AIMHUs as a means to counter the shortage of beds on AIMHUs (Coffey et al., 2019; Hegedűs et al., 2018; Hengartner et al., 2017). In line with this notion, the focus of care in AIMHUs has an impact on the current practice on AIMHUs where staff prioritise meeting the demands of the organisation by accelerating the discharge process and moving people around swiftly (Waldemar et al., 2019; Flourie et al., 2005). It is identified that short lengths of stay prevent preparing service users adequately for discharge from AIMHUs (Niehaus et al., 2008) and this approach limits opportunities to deliver care that enhances sustained recovery (Glick et al., 2011). Some studies have made a critique about this practice and have maintained that current practice leads to situations where service users need to fit in with the service or organisations' priorities (Waldemar et al., 2019; Le Boutillier et al., 2015a).

According to Yarborough et al. (2016), a recovery-oriented mental health system should realign their service to accommodate service users' needs, rather than requiring service users to adapt their priorities to fit in with the limited options of service provisions available. Additionally, concerns were also raised by service users that mental health services misuse the concept of recovery to meet service demands (Le Boutillier et al., 2015a). This is evident from a statement made by one of the participants in a study conducted by Le Boutillier et al. (2015b) (Box 5:5:1).

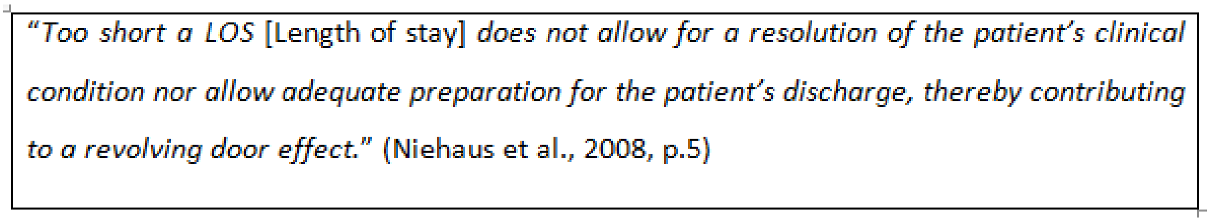
> *"I feel recovery has been hijacked as an agenda to save money and get people squeezed quickly out the services before they're well enough."* (Le Boutillier et al., 2015b, p.434)

Box 5:5:1

The statement provided in Box 5:5:1 indicates an outcome [O] that favours organisations where they are able to use beds on AIMHUs to meet their needs to manage bed crises [O], which can be an organisational priority in the current financial climate, but may not be in line with the priorities of service users [O] (Le Boutillier et al., 2015a). It correlates with the findings from a study conducted by Keogh et al. (2015) on service users' experience of transition from AIMHUs to their homes that "*key indicators of recovery-oriented practices were often absent from service users' experiences of service provision*" (p.715). Moreover, it underlines the observation made by Slade et al. (2014) that it is difficult to capture the essence of ROP in terms of service orientation and delivery. All the evidence from the RR shows conclusively that current discharge-planning practice on AIMHU provides little scope to embrace the principles of ROP. I have identified this as the context [C] that can generate mechanisms and outcomes. Data emerging from the interviews were also supporting this as a context that is recurring in AIMHUs (see Section 5:3:8). The next section will articulate three factors that are instrumental in generating mechanisms that produce outcomes.

5:3:3 Limited preparation and time for personal recovery

A crisis or early discharge is a sudden and unplanned discharge process. When there is pressure for early discharge due to a bed crisis, discharge planning was often reported as ad-hoc and reactive (Wyder et al., 2017). This practice on AIMHUs can arguably thwart the time required for resolving service users' mental health crises or in preparing service users and carers during the transition of care. A systematic review on discharge planning has established that good clinical practice in mental health care would consider at least one planned meeting with the professionals concerned and family, prior to discharge (Steffen et al., 2009). Service user participants in numerous studies (Waldemar et al., 2019; Coffey et al., 2019; Wyder et al., 2017) have revealed that their discharge was unexpected and their recovery time in the AIMHU was curtailed due to circumstances that were out of their control. Interview data from service user participants in my study also verified the occurrence of these events in AIMHUs (see Section 5:3:9). According to Niehaus et al. (2008), (Box 5:5:2), a very short length of stay may not be able to effectively resolve service user issues or prepare them effectively for discharge and this might contribute to a 'revolving door effect' that leads to a failed discharge, which is identified as one of the outcomes [O-1].



"Too short a LOS [Length of stay] *does not allow for a resolution of the patient's clinical condition nor allow adequate preparation for the patient's discharge, thereby contributing to a revolving door effect."* (Niehaus et al., 2008, p.5)

Box 5:5:2

An independent survey conducted by MIND (mental health charity) (2017) with service users' regarding their discharge planning from AIMHUs has revealed the following findings: one in three participants (38%) felt they were discharged from hospital sooner than they should have been; and one in five participants (21%) reported that they were unaware of their discharge from hospital. This even took place when people have been in hospital for a long time: one in three people (33%) in hospital for more than a month were given less than 48 hours' notice that they were being discharged, or no notice at all. Additionally, two out of five participants (37%) stated that there was no plan for further care and support, which was contrary to guidelines. This indicates the depth of issues faced by service users as a result of crisis discharge from AIMHUs and the MIND website has shared the experience of one of the service users (Box 5:5:3) to illustrate how it was experienced by service users' in practice.

"Phillipa is 34 years old and has been diagnosed with both emotionally unstable personality disorder and a long-standing eating disorder. She was in hospital in January 2016. I'd been in my local mental health unit for a week, when one morning I woke up to be told that there was a taxi waiting for me downstairs, and to get ready. Dazed and confused, still half asleep, I didn't understand. Did I have an appointment? Was I visiting somewhere? Did they have the right person?

Within minutes I found myself in the taxi, with all my belongings shoved into four bin liners. Handed not enough medication to get me through the weekend, I was now off suicide watch and, with a staff member, apparently headed for my local Community Mental Health Team (CMHT). I didn't know the time, if I had my door key, if I had money on me or if I had my bus pass. No one could explain what had just happened. How would I get meds at the weekend? Did I have food in the house? Did I have money on the electricity meter, the gas meter? Did my phone have battery? What would I do? Was there anyone around this weekend? How will I get home from the CMHT? My brain froze. I went into a state of shock. Was I even awake? I cannot do this. I don't think most people could have coped, and in my already fragile state of mind, I really had no chance." (MIND, 2017)

(Source MIND website): https://www.mind.org.uk/news-campaigns/news/one-in-three-people-sent-home-from-hospital-too-early-with-no-plan-for-further-mental-health-care/

Box 5:5:3

Admission to AIMHUs can be a traumatic experience and has an enduring negative impact that alters service users' sense of self and their perception of themselves as valid individuals. As a result, their "*recovery involves reconciliation with their discredited self-concept*" (Keogh et al., 2015, p.721). In line with this observation, service users who encounter situations similar to Phillipa do not have adequate time to reconcile with their discredited self-concept, thus hindering their recovery process. This is particularly important as it is well established that recovery is unique to individuals and it varies from one person to another (Anthony, 1993). The expression used by a participant in a study conducted by Wright et al. (2016) (Box 5:5:4) that states "*I didn't feel ready to go out*" (p.372), portrays that interventions currently offered in AIMHUs are not adequately preparing service users for their transition into the wider community. Post-discharge interviews from participants in a study conducted by Nolan et al. (2011) have identified that interventions provided by staff in AIMHUs are not adequate to prepare them for what they might encounter following discharge. Moreover, studies have also reported that service users themselves are not able to identify what would make them ready for discharge (Waldemar et al., 2018). Drawing on this evidence, the mechanism identified here emanates from service users' perceptions that AIMHUs offer limited interventions to prepare them for the transition into the community [M] that might contribute to a failed discharge, which is an undesired outcome [O-1]. This corroborates with the findings made by Clibbens et al. (2018), who have identified a gap in applying transitional intervention into practice.

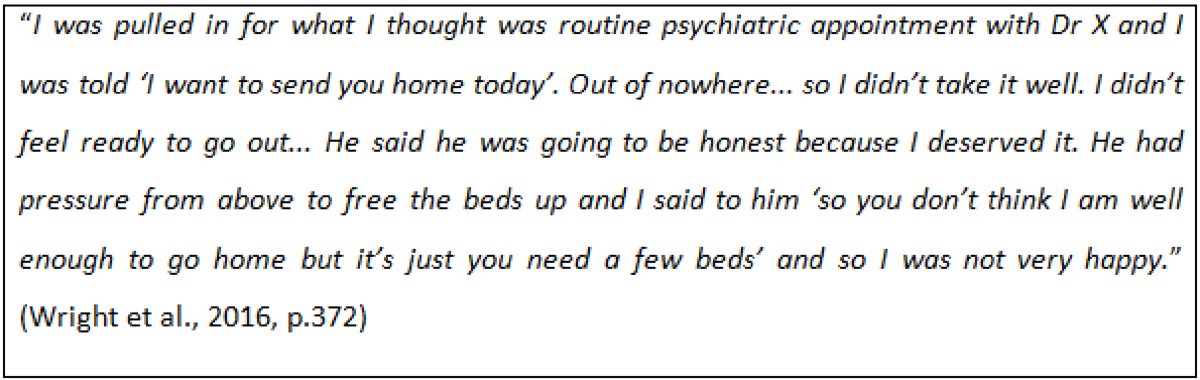
5:3:4 Paternalistic attitude of mental health staff

The culture within the mental health system is renowned for its paternalistic attitude towards service users, which was identified in many studies as a barrier to SUI and ROP. The statements from service users, such as: "'*Some don't even smile' while 'the ones that treat me like a human being make a big difference'*" (Isobel, 2019, p.111) indicate this attitude still exists among professionals in AIMHUs. The clinical management of frequently admitted service users, who are labelled as 'regulars', may affect the professionals adversely through demotivation and therapeutic nihilism (Niehaus et al., 2008). This corroborates the observation made by Wright et al. (2016) where professionals were using phrases such as, "*being bounced from one pathway to the next*", "*being dumped back*" and "*shipping them out*" (p.372) to describe service users' transitions through the mental health care system. When professionals view service users as not 'ill enough' to be in hospital, they gradually develop a negative attitude towards these service users, as they are seen to be wasting precious resources and are responsible for their own predicament (Wright et al., 2016). It signals the presence of a mechanism where professionals fear that service users prefer to stay ill, rather than engage with recovery and place too much hope on recovery, and that practising in recovery-oriented ways may not work (Forchuk et al., 2003) [M].

5:3:5 Emphasis on clinical recovery

The emphasis on clinical recovery can yet again produce mechanisms that create undesirable outcomes. Professionals and service users have different perceptions about needs and outcomes (Yarborough et al., 2016). Regardless of this understanding, some organisations have specified a time frame in which one should recover and be assessed by professionals, who make their own judgements about service users' progress (Le Boutillier et al., 2015b). This practice inevitably discounts service users' views and opinions about their recovery. Arguably, this approach attenuates the principles of ROP and reinforces the medical model of practice that values symptom reduction as a sign of recovery. Nolan et al. (2011) has noted that care in AIMHUs can induce a temporary deceptive sense of well-being, and compliance with the unit procedures can be perceived by professionals as a sign of improvement. The RR has identified instances that trigger mechanisms that compel staff to take a clinical recovery approach. In the first instance, some professionals perceive that service users are not able to make sensible decisions about their care during the acute phase of their illness and use their clinical expertise to make decisions on service users' behalf. Additionally, some professionals might have experienced previous unsuccessful attempts with talk therapies for service users with serious mental illness that make them believe ROP is not applicable in AIMHUs (Chester et al., 2016; Le Boutillier et al., 2015b). Professionals therefore take the lead and make decisions on behalf of service users, based on clinical recovery. This results in generating undesirable outcomes where service users feel marginalised from their care and disempowered [O].

In the second instance, professionals respond to the demands of the service and take decisions on behalf of service users to meet organisational demands. The priorities set by organisations can influence how staff understand recovery-orientated practice and can subsequently influence its delivery, management and evaluation (Waldemar et al., 2016; Le Boutillier et al., 2015a). An account given by a participant in a study conducted by Wright et al. (2016) (Box 5:5:4) illustrates how the discharge process manifests in practice.



"I was pulled in for what I thought was routine psychiatric appointment with Dr X and I was told 'I want to send you home today'. Out of nowhere... so I didn't take it well. I didn't feel ready to go out... He said he was going to be honest because I deserved it. He had pressure from above to free the beds up and I said to him 'so you don't think I am well enough to go home but it's just you need a few beds' and so I was not very happy." (Wright et al., 2016, p.372)

Box 5:5:4

The statement in Box 5:5:4 indicates a background that can compromise the overt application of ROP due to the overemphasis on resources over service users' needs. Regarding the transition of care, Wright et al. (2016) reported that: "*the more restricted the resources the increased likelihood that the service user voice will be lost*" (p.373). This can be seen as another outcome [O] of this PT. This indicates the gravity of this issue, the way it constrains and controls professionals' practice and contributes to an unpleasant experience for service users [O]. It is evident that professionals are constrained by the "*pressure from above to free the beds up*" and this has implications in the way they practice. Additionally, it acts as a mechanism [M] that drives professionals' practice and approach towards discharge planning. Recent studies (Box 5:5:5) underline the presence of this mechanism, which drives contemporary discharge practice of professionals working in AIMHUs.

Evidence-1

"*Nurses reported that they feel pressure to discharge patients who may not have yet fully recovered in order to free up beds.*" (Sharac et al., 2010, p.910)

Evidence-2

"*It was also noted that even when nurses were able to develop person-centred plans to support discharge, at times these could be thwarted when medical staff changed direction of care, or when pressure for beds meant that consumers were discharged prior to completing the agreed care plan.*" (Wyder et al., 2017, p.534)

Evidence-3

"*We're in a position now that we're having to make some very difficult decisions and discharging people into circumstances that years ago we wouldn't have dreamed of. So we are discharging people without allocated care co-ordinators with just crisis as a 7 day follow up... we've had a couple of incidences where we've had to discharge people to the pavement with no accommodation... And I think as X, I feel very uncomfortable but we're having to do that increasingly more.*" (Wright et al., 2016, p.372)

Box 5:5:5

The next section (Table 5:5:1) will present the refined CMO configuration for this PT.

5:3:6 Refined CMO configurations based on the RR for PT-5: Provider-controlled care transition from AIMHUs

Context [C]	The discharge-planning practice based on the contemporary focus of care on AIMHUs contradicts the values of recovery-oriented practice when preparing service users for smooth transition into the community.
Mechanism-1 [M-1]	Service users perceive that the interventions or preparation for discharge planning neither provided adequate time to reconnect with their social network in the community, nor enabled them to reconcile with their discredited self-concept.
Mechanism-2 [M-2]	Professionals develop a negative attitude and take a medical model approach towards some service users, who are perceived by them as "*regulars*", "*not ill enough*", "*being in some way responsible for their predicament*" and "*therefore wasting valuable resource*". Professionals fear that service users prefer to stay ill, rather than engage with recovery and place too much hope on recovery, and that practising in recovery-oriented ways may not work.
Mechanism-3 [M-3]	Professionals perceive that service users are not able to make sensible decisions about their care during the acute phase of their illness and use their clinical expertise to make decisions on service users' behalf. Additionally, some professionals might have experienced previously unsuccessful attempts with talk therapies for service users with serious mental illness that make them believe ROP is not applicable in AIMHU. Professionals use the clinical recovery approach, such as compliance with unit rules and regulation, stabilisation and symptom reduction as an indicator for discharge.
Mechanism-4 [M-4]	The practice of professionals is driven by meeting organisations' demands, such as 'pressure for beds' and they value this over service users' needs, which becomes instrumental in discharging service users prematurely from AIMHUs.

Outcome-1 [O-1]	This can contribute to premature or failed discharges of service users from AIMHUs.
Outcome-2 [O-2]	Organisations are using early discharges based on clinical recovery to release their bed pressure on AIMHUs.
Outcome-3 [O-3]	Service users feel disempowered and dissatisfied with the service provided on AIMHUs.
Outcome-4 [O-4]	Service users' voices will be lost during their transition period and they feel marginalised from their care.

Table 5:5:1 – Refined CMO configurations based on the RR for PT-5: Provider-controlled care transition from AIMHUs

5:3:7 Refinement of CMO using interview data: Provider-controlled care transition from AIMHUs

The interview data has helped to identify four distinctive factors related to this context that give rise to mechanism that leads to the outcomes identified in the RR. These distinctive factors are illustrated under the following headings:

1) *"Focus on getting out";*
2) *"Discharge was a complete shock";*
3) *"A huge impact in the way we work";* and
4) *"They are on that treadmill".*

5:3:8 "*Focus on getting out*"

The context identified for this PT through the RR (Table 5:5:1) suggests that the discharge practice in AIMHUs was not embracing the principles of ROP. The interview data has helped to elaborate the context [C] further by refining the discharge practice that contradicts the values of ROP. A response from a stakeholder participant (Box 5:5:7, Evidence-1) that states "*you guys are pushed, you have fewer beds*" indicates the background that activates this context [C] and impedes ROP, prompted by limited organisational resources (inpatient beds). The response of a staff participant (Box 5:5:6, Evidence-1) illustrates that professionals in

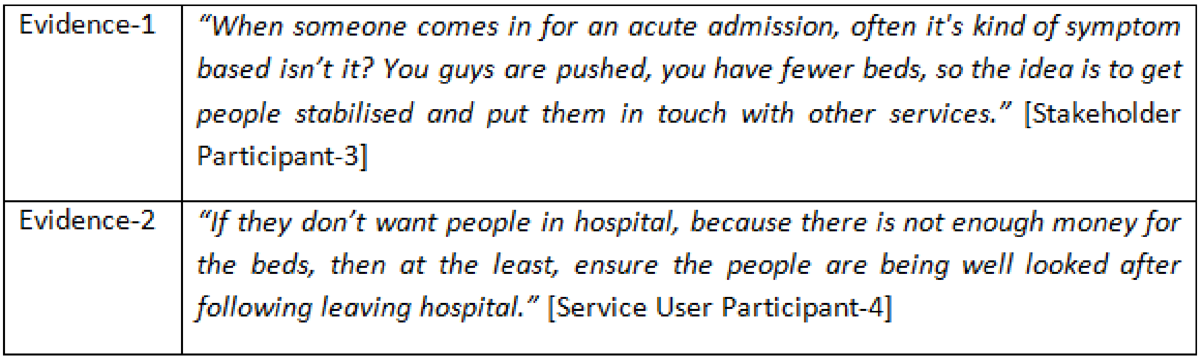
AIMHUs focus heavily on discharge, rather than taking time to deal with the issues that primarily led to the admission.

Evidence-1	*"It's not a comfortable, familiar environment for the service users and a lot of these just focus on getting out, as opposed to dealing with the issues that brought them in the first place,"* [Staff Participant-1]
Evidence-2	*"If suddenly someone comes around and says, you know, 'It's Friday, we need beds for the weekend, actually that person, that person and that person can probably be discharged,' that in itself, you know, can then make people rather think, 'What is the point? What is the point in sitting down and doing that work with someone, if you, kind of, force me to be a bit of a liar?' If I sat with someone, and this is what we're working towards, this is what we are doing, but then, because of pressure on beds, we then stopped it, that makes me kind of feel like, I have let that person down. So, in terms of resources, the normal pressures that kind of the NHS face, and all those things, have a huge impact in the way we work."* [Staff Participant-2]

Box 5:5:6

Furthermore, the response from another staff participant (Box 5:5:6, Evidence-2) indicates the existence of a practice where service users are talked into discharge from hospital by professionals, in order to free up inpatient beds, which signals that professionals are caught up in a situation where they need to act in the interests of the organisation. The phrase "*you kind of force me to be a bit of a liar"* indicates professionals are reluctantly working as agents to meet the needs of the organisation. This is further elicited in the response of a service user participant (Box 5:5:7, Evidence-2) where it states, *"they don't want people in hospital,"* which resonates with service users' frustration about their experience of discharge-planning practice in AIMHUs. An in-depth interrogation of participants' responses from all three different groups (stakeholders, service users and staff participants) such as "*you guys are pushed", "don't want people in hospital" and "focus on getting out"*, signals a situation that professionals in AIMHUs encounter in their practice, where they are expected to respond and to adapt their practice to resolve the bed crisis within the organisation. In other words, there is an implicit pressure on professionals to act in the interests of the organisation, even though organisations explicitly advocate their professionals should embrace the ethos of ROP. Using a realist lens, it uncovers the basis of an undesirable, yet frequently occurring, context [C] where professionals are expected to resolve the bed crisis within an organisation and are tacitly entrusted to adapt their practice by accelerating patient flow through the system. Interview data has highlighted the mechanisms generated by this context [C], which will be explained in the following sections.

Being the recipients of care, service users' outlooks towards this practice are vital. The response from service user participants (Box 5:5:7, Evidence-2) illustrates that service users are dissatisfied, as they are being squeezed out from AIMHUs against their wishes, which reiterates that the discharge-planning practice contradicts the overt application of ROP [O-2]. Additionally, responses such as *"there is the door been shut on you, and you are out, and you got to face everything on your own"* (Service User Participant-1) reveal service users' believe they are being discharged prematurely, against their wishes, without giving adequate time for reconnecting with their social networks for support in the community [O-1] and that they do not feel that they have reached the point of transition.



Evidence-1	*"When someone comes in for an acute admission, often it's kind of symptom based isn't it? You guys are pushed, you have fewer beds, so the idea is to get people stabilised and put them in touch with other services."* [Stakeholder Participant-3]
Evidence-2	*"If they don't want people in hospital, because there is not enough money for the beds, then at the least, ensure the people are being well looked after following leaving hospital."* [Service User Participant-4]

Box 5:5:7

The second section in Evidence-2 (Box 5:5:7) also indicates a fragmented service provision in the current transition arrangements. As discussed in the RR, the post-discharge period is considered a high-risk period for relapse and leaves service users vulnerable to other risks. This is echoed in the statement *"the chain is often broken"* (Box 5:5:8, Evidence-1), which indicates the presence of a *"lack of joined-up thinking"* (Staff Participant-6) between professionals working in inpatient teams and the Community Mental Health Teams. The lack of "*follow-on*" care (Box 5:5:8, Evidence-3) following discharge, due to the broken chain and lack of joined-up thinking, can lead to a failed discharge by the system. In other words, the context [C] creates an undesirable state that can contribute towards failed discharge [O-1], which is an outcome identified during the RR. The statements from the service user participant such as "*dumped at home*" and "*feel like failures, system failing them"* (Box 5:5:8, Evidence-2) substantiates that this context [C] is contributing to multiple outcomes [O-1 & O-3]. The mechanisms that lead to these outcomes are illustrated below under the following headings: "*discharge was a complete shock*", "*a huge impact in the way we work*", and "*they are on that treadmill".*

Evidence-1	*"It's erroneous that the chain is often broken, because they can't reach people in the CMHT, they can't find out what's happening, things break down too often, CPAs* [Care Programme Approach] *happen, care co-ordinators don't turn up, somebody is left with not knowing what's going on with their care package."* [Stakeholder Participant-2]
Evidence-2	*"So if there is anything they can do to kind of transition, the transition period between in hospital, out of hospital. It can't just be the case where you are in hospital you get cared for, then you get dumped at home, it's not good enough. I see it happen over and over again with people in the hub* [Hub is a social care funded safe and friendly drop-in centre for people experiencing mental health difficulties]. *I been going to the hub for 2 years, and I got deep compassion for them, and I know that they do feel like failures, system failing them in many ways, unfortunately."* [Service User Participant-4]
Evidence-3	*"There wasn't follow-on, so when I came out of the hospital and it was all new."* [Service User Participant-2]

Box 5:5:8

5:3:9 "*Discharge was a complete shock*"

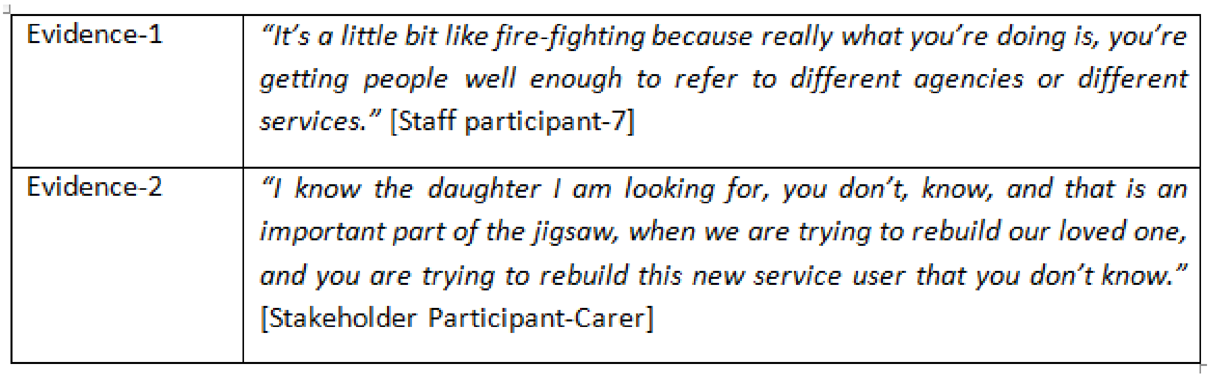
The interview data is consistent with the evidence from the RR about service users' outlook about the progress in their transition from AIMHUs into the community. This is evident from the service user participant's response (Box 5:5:8, Evidence-2) that suggests service users are not experiencing readiness to move on from the AIMHU to the community. They do not feel that the therapeutic interventions have benefited them during their stay on the AIMHU. The response from one of the service user participants regarding the 'gap' (Box 5:5:9) indicates a vacuum where service users do not feel ready for transition (discharge) to the next stage of their recovery. Additionally, the focus to discharge service users, without giving priority to resolve the issues that triggered their admission to the AIMHU (Box 5:5:6, Evidence-1) is indicative of a scarcity of therapeutic intervention to aid service users' recovery and to assist their preparation for a smooth transition into the community [M-1]. Furthermore, it indicates service users are not part of the discussion related to their transition from AIMHU and it explains why service users feel marginalised during the transition period [O-2].

> *"I felt very scared then, as much as you want to get off section, and you want to get out of there, I felt very scared because it was the first time I've heard about it, whereas, again, if communicated every step of the way, then discharge shouldn't be a surprise, I don't think. There is a huge gap between admission and discharge, so discharge was a complete shock, whereas I don't think discharge should be a shock, I think you should be naturally working towards that."* [Service User Participant-10]

Box 5:5:9

5:3:10 *"A huge impact in the way we work"*

One of the staff participants used the phrase "*fire-fighting*" (Box 5:5:10, Evidence-1) to articulate their practice in the AIMHU in relation to discharge planning, where professionals arbitrate and accelerate service users' recovery. The reason for "*fire-fighting*" is because professionals are stretched, due to high service user turnover and lack of inpatient beds (Box 5:5:10, Evidence-1). In order to cope with this situation, professionals want to maintain the discharge rate in AIMHUs. This is evident from the phrase *"you're getting people well enough"* (Box 5:5:10, Evidence-1). This reveals that professionals take the responsibility for service users' recovery, based on their perception of recovery (clinical recovery) getting them just to the point of recovery, in order to move service users swiftly through the system. Professionals prioritise organisational demand over service users' needs [M-4]. Additionally, the service user response (Box 5:5:7, Evidence-2) reveals a connection between early discharge and a lack of resources (inpatient beds). This further clarifies that the Outcome [O-2] illustrated in the CMO is a consequence of *"fire-fighting"*. On the other hand, at the expense of *"fire-fighting"*, a short-term benefit for the organisation is provided by releasing pressure on inpatient beds, which is identified as an outcome [O-3A]. However, the data also reveals that professionals' are frustrated and dissatisfied with the care they deliver, as the current bed crisis is preventing them from using their skills for the benefit of service users and they feel that they let service users down (Box 5:5:6, Evidence-2), which is identified as an another outcome [O-3B].



Evidence-1	*"It's a little bit like fire-fighting because really what you're doing is, you're getting people well enough to refer to different agencies or different services."* [Staff participant-7]
Evidence-2	*"I know the daughter I am looking for, you don't, know, and that is an important part of the jigsaw, when we are trying to rebuild our loved one, and you are trying to rebuild this new service user that you don't know."* [Stakeholder Participant-Carer]

Box 5:5:10

5:3:11 "*They are on that treadmill*"

One of the stakeholder participants stated that *"they* [service users] *just feel they are part of a conveyor belt, and it's not person centred at all"* (Stakeholder Participant-2). The participant used 'conveyer belt' as a metaphor to illustrate service users' feelings of being in AIMHUs for a period of time, with limited therapeutic benefit and autonomy. The use of clinical recovery as a measure to maintain discharge flow is evident from interview data in two instances, which generate two mechanisms (M-3 & M-2). In the first instance, professionals perceive that service users are not capable of making decisions about their care and they want to "*take over*". This is because professionals perceive that service users are unwell and do not know what is required for their recovery (Box 5:5:11), which is indicative of the presence of a mechanism [M-3] identified in the RR. Additionally, the response from a stakeholder participant reveals that carers' expertise or views are not utilised effectively during transition (Box 5:5:10, Evidence-2). They claim that their knowledge is more authentic and validated, compared to professionals' knowledge and their involvement "*is an important part of the jigsaw*" during transition from the AIMHU. It therefore reiterates the emphasis and use of clinical recovery during transition [M-3].

Evidence-1	*"In the acute service because sometimes people are floridly ill, they are not able to be involved."* [Staff Participant-13]
Evidence-2	*"They can't do it themselves, we will take over, which for some people is the case, but there is a lot of people who that's not true."* [Stakeholder Participant-4]
Evidence-3	*"You could argue that they don't really know what is in their best interest, and particularly people with the diagnosis of personality disorder, they think, 'Just let me stay in hospital, I will be alright, just let me stay for a week or two, I feel safe here,' and actually the research is showing that sort of is counterproductive for them to stay in hospital, too long, so they don't always know what's in their best interest, but then part of our role is to try to educate them about that."* [Staff Participant-15]

Box 5:5:11

In the second instance, interview data reveals differences of opinion between service users and professionals regarding inpatient stay. This is apparent in relation to service users who have a diagnosis of personality disorder (Box 5:2:11, Evidence-3). In this instance, professionals take the view based on evidence that a long inpatient stay can be counterproductive, which is contrary to service users' views. Additionally, professionals recognise that service users with the diagnosis of personality disorder are considered as manipulative, childish and take up lot of professionals' time (Box 5:5:12). Professionals find these behaviours and presentations "*annoying*" and obstructive when they are "*fire-fighting"* to meet the service's demands. Professionals take a dislike to this group of service users. As identified in M-2, this is where professionals feel that service users are "*wasting valuable resources"* and are "*not ill enough*" and use clinical recovery measures to accelerate their discharge from AIMHUs into the community [M-2]. Concurrently, it reveals a culture that dehumanises and patronises service users during their inpatient stay.

"As patients, their behaviour is more challenging on the surface. It's quite difficult, it consumes a lot of staff attention, to the detriment of other patients. I can tell they find it annoying, they don't like those patients, they are difficult, they consider them manipulative and childish, but the things is that if they had an understanding that a lot of personality disorders are based on trauma, sexual abuse, child neglect and it would reduce that, I would say, stigma, towards that patient, it would ease their interactions with that patient." [Staff Participant-6]

Box 5:5:12

In this situation service users lose their voice and it therefore leads to a situation where service users feel disempowered and dissatisfied with the service [O-2]. Service users do not see or experience that their needs were met by the service or by professionals. The response below (Box 5:5:13) indicates that these actions from professionals make service users feel disempowered and dissatisfied with the service.

"I think people do find, feel, that they're not individuals sometimes, yeah, but that they are on that treadmill, that they can get medicated, then get discharged." [Stakeholder Participant-2]

Box 5:5:13

5:3:12 Summary of PT-5: Provider-controlled care transition from AIMHUs

The interview data supports the CMO configuration for this PT, which was identified during the RR. The interview data was used to trace back the validity of the CMO developed following the RR and it has helped to illustrate and refine the context [C] for this PT and identified two additional outcomes [O-3A & O-3B]. The refined CMO configuration is illustrated in Table 5:5:2.

5:3:13 Refined CMO configurations based on the interview data for PT-5: Provider-controlled care transition from AIMHUs

Context [C]	***The current focus of care in AIMHUs is on crisis stabilisation, characterised by shorter inpatient stay for service users in AIMHUs, to meet the increased demand for beds in AIMHUs. Professionals' working within AIMHUs are encumbered to resolve the ongoing bed crises within organisations and are tacitly entrusted to adapt their practice to accelerate patient flow through the system.***
Mechanism-1 [M-1]	Service users find discharge from the AIMHU a surprise, as they do not perceive that the interventions or preparation for discharge planning either provides adequate time to reconnect with their social network in the community, or enables them to reconcile with their discredited self-concept.
Mechanism-2 [M-2]	Professionals develop a negative attitude and take a paternalistic approach towards service users, who are perceived by them as "*regulars"*, "*not ill enough*", "*being in some way responsible for their predicament*" and "*therefore wasting valuable resources*". Professionals fear that service users prefer to stay ill, rather than engage with recovery, and place too much hope on recovery, and that practising in recovery-oriented ways may not work.
Mechanism-3 [M-3]	Professionals perceive that service users are not able to make sensible decisions about their care during the acute phase of their illness and use their clinical expertise to make decisions on service users' behalves. Professionals solely rely on the clinical recovery approach, such as compliance with unit rules and regulation, stabilisation and symptom reduction as an indicator for discharge.
Mechanism-4 [M-4]	The practice of professionals is driven by meeting the demands of the system and organisations, such as "*pressure for beds*". Professionals value and prioritise the demand of the system over service users' needs.

	Professionals take the responsibility for service users' recovery and anticipate early discharges from AIMHUs.
Outcome-1 [O-1]	This can contribute to premature or failed discharges of service users from AIMHUs, ***which can instigate readmissions.***
Outcome-2 [O-2]	The current discharge-planning practice in AIMHUs contradicts the values of ROP when preparing service users for smooth transition into the community based on clinical recovery. Service users feel disempowered and dissatisfied with the service provided in AIMHUs as they are marginalised from their care.
Outcome-3A [O-3A]	***The practice of professionals with the intention to free up beds provides short-term benefit for organisations by creating inpatient bed capacity.***
Outcome-3B [O-3B]	***Professionals' are frustrated and dissatisfied about the care they provide, as the current bed crisis is preventing them from using their skills for the benefit of service users and they feel that they let service users down.***

Table 5:5:2 – Refined CMO configurations based on the interview data for PT-5: Provider-controlled care transition from AIMHUs

5:4 Programme theories

5:4:1 PT-4: Peer support worker interventions

Employing PSWs to AIMHUs with a clear role specification, supervision and workplace support creates an opportunity to promote ROP. PSWs are seen as exemplars of recovery in action, as they already have a story of their own recovery to share. When PSWs share their experience, service users feel a connection and it generates knowledge transfer that provokes service users to think about their own personal recovery. Service users perceive PSWs as role models, as they have been successful in managing their recovery. PSWs are able to identify and address practices that are not aligned with ROP. PSWs' interventions on AIMHUs can lead to empowering service users, motivating and enhancing their experience, which might lead to reduced inpatient stay and reducing the ‘us and them’ gap between the service users and professionals.

5:4:2 PT-5: Provider-controlled care transition from AIMHU (discharge practice)

The current focus of care in AIMHUs is based on crisis stabilisation to meet the demands of the system by promoting shorter inpatient stay, where professionals are expected to resolve bed crises and are tacitly entrusted by the organisation to adapt their practice to accelerate patient flow. Service users do not experience that the current interventions are preparing them for discharge to the community; professionals become sceptical and develop a negative attitude towards service users who frequently use AIMHUs, and the plans for their discharge are predominantly based on clinical recovery to meet the demands of the system. This contradicts the principles of ROP in preparing service users for transition to the community and leads to premature or failed discharge, service users feeling disempowered and dissatisfied with services and feeling marginalised from their care.

5:5 Chapter summary

The chapter presented the process by which IPTs were developed into refined programme theories for PT-4 and PT-5, using evidence from the RR and were further refined and tested using the interview data. The refinement of each of the PTs, using evidence from the RR and interview data, was illustrated using CMO configurations. The chapter ends with a narrative form of refined PTs, conceptualisation of refined CMO configurations to facilitate understanding. The next chapter is dedicated to consolidating these programme theories, using stakeholder involvement.

Chapter-6: Consolidation stage

6:1 Introduction

This chapter presents the ‘theory consolidation’ (Stage 3), the last stage of this study (see Chapter 3, Section 3:10), using stakeholder involvement. The stakeholder involvement was not for the purpose of data collection, but it was used as a platform to finely refine the programme theories again using stakeholder validation into ‘if-then’ statements (see Chapter 3, Section 3:10:8). I will start the next section with stakeholders’ responses to programme theories that were synthesised using the evidence from the RR and qualitative interviews.

6:2 Stakeholder responses

I received mixed responses from the stakeholders, but there was consensus in their statements, as all the stakeholders said all the programme theories were relatable and pertinent for those who have a connection with the contemporary mental health system. A large proportion of the discussions were based on the ‘context’ within the programme theories. One of the stakeholders reported that they found the PTs lengthy and hard to grapple with and wanted to see recommendations from the findings instead of programme theories. Another stakeholder reported that it was challenging to pick each element of CMO, as they all seemed to be relevant and connected. One stakeholder commented that their day-to-day experience helped them to see the connection they made (connection meaning CMO). Some stakeholders did not identify any issues with the way it was presented.

During the process, stakeholders made a valuable suggestion to focus on the main mechanisms created by the context, as some of my PTs had several mechanisms. I have observed that some realist studies have adopted this approach to avoid the risk of digressing from the main issues. Based on their suggestion, during the refinement process, I paid more attention to the mechanisms identified by stakeholders as more relevant to them.

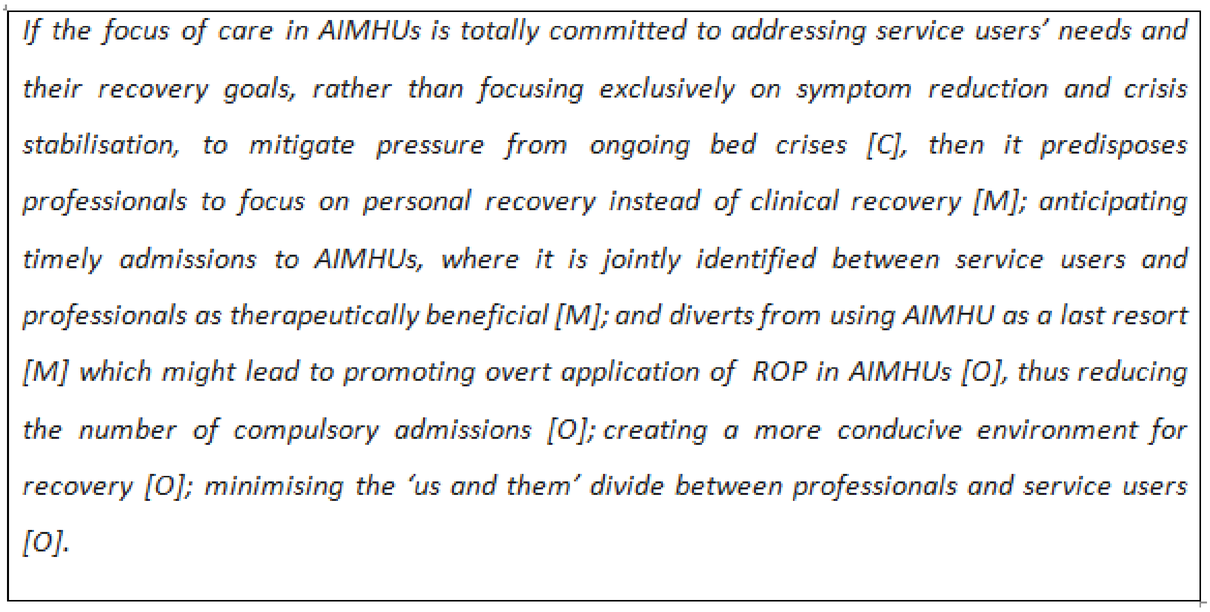
6:3 Consolidation of Programme Theory-1 (Provider-controlled access to AIMHUs)

The contemporary focus of care in AIMHUs, based on crisis stabilisation and symptom reduction, indicates a 'one size fits all approach', that is being used implicitly by organisations to mitigate the pressure on beds and manage them judiciously. Based on an understanding of the limited availability of beds, providers use gatekeeping as a means to control admissions to AIMHUs; admissions to AIMHUs are anticipated as a last resort for treatment and a clinical recovery approach is adopted to maximise flow of service users through the system. This practice contradicts the value of ROP and leads to an increase in compulsory admissions, which disempowers and dissatisfies service users. It creates an 'us and them' divide between service users and professionals, and contributes to the unpredictable nature of AIMHUs.

Box 6:1 – PT-1 (Provider-controlled access to AIMHUs)

PT-1 (Box 6:1) was presented to each of the stakeholders. There was clear consensus amongst all the stakeholders about the challenges faced by organisations resulting from low bed numbers and they were able to recognise the 'events' that these create. One of the stakeholders acknowledged that the current focus of care is an easier and convenient option for organisations, but not in service users' best interests. Some of the stakeholders suggested that in the list of options for treatment, an organisation should be able to present AIMHUs as one of the first resorts, rather using them as a 'last resort', along with some alternative services in the community. Some stakeholders alluded to the fact that the 'last resort' option has both advantages and disadvantages, but were of the opinion that this option should not be controlled by professionals or organisations. Again, stakeholders shared their views that the feeling of disempowerment was associated with the medical model of practice, which is identified as a mechanism in the PT.

One of the stakeholders highlighted the need to have resources in the community, such as crisis houses or day hospitals, whereas another stakeholder recommended that organisations should have adequate bed capacity, realistic to the geographic area and the population they serve, in order to offer timely admission. Stakeholders commented on the need for a proactive approach to admissions, rather than a reactive approach, and a need to communicate the role of AIMHUs as to what they are trying to achieve. The process has enabled the verification and refinement of the synthesis of evidence from various resources articulated in PT-1 and demonstrated that it is relatable to those who work closely with AIMHUs. Stakeholder validation enabled me to refine this PT further using the 'if-then' statement (Box 6:2). Configuring the refined PT into an if-then statement enables a conduit to be made between the PT and pragmatic recommendations for practice.



If the focus of care in AIMHUs is totally committed to addressing service users' needs and their recovery goals, rather than focusing exclusively on symptom reduction and crisis stabilisation, to mitigate pressure from ongoing bed crises [C], then it predisposes professionals to focus on personal recovery instead of clinical recovery [M]; anticipating timely admissions to AIMHUs, where it is jointly identified between service users and professionals as therapeutically beneficial [M]; and diverts from using AIMHU as a last resort [M] which might lead to promoting overt application of ROP in AIMHUs [O], thus reducing the number of compulsory admissions [O]; creating a more conducive environment for recovery [O]; minimising the 'us and them' divide between professionals and service users [O].

Box 6:2 – Refined PT-1 (Provider-controlled access to AIMHUs)

6:4 Consolidation of Programme Theory-2 (Care plan as a recovery tool?)

After discussing PT-1, I have presented PT-2 (Box 6:3) to each of the stakeholders. The 'urgency to create' a care plan was the main focus of discussion from some stakeholders. They highlighted a lack of connection with the process and a lack of 'one to one' conversation with the nurses.

Care plans are used by organisations as a key document to evidence SUI and the care they provide for service users. In AIMHUs, nurses are tasked with developing recovery-oriented care plans to the standards prescribed by the organisation. The current approach and practice in formulating care plans by nurses provides less scope for service users to influence the decision-making process in their treatment. Nurses take ownership of care plans as they perceive it as a task-oriented activity to meet audit demands and to evidence their work. Nurses do not find relevance in establishing therapeutic relationships with service users as part of the care-planning process during their short stay in AIMHUs. The lack of relational work with nurses makes service users feel distanced from the care-planning process and they do not feel any ownership of the document. Neither service users nor nurses have the confidence that the care plan they formulate has an impact on service users' care. As a result, care plans are created in silos by nurses and have less buy-in from service users and by the MDT. Service users feel disempowered and marginalised from the care-planning process and nurses' are less satisfied with their job role.

Box 6:3 – PT-2 (Care plan as a recovery tool?)

Most of the stakeholders have indicated that care plan audits had an impact on the way it is undertaken, but a couple of stakeholders have highlighted that service users are sometimes too unwell to contribute to the care plan. Another stakeholder indicated that the current way of creating a care plan is viewed as a waste of time, as they do not get time to sit down with service users due to the fast pace of work. It corresponds with the mechanism identified in the PT. A number of stakeholders highlighted the need for nurses to build therapeutic relationships with service users and almost all stakeholders have emphasised that nurses in AIMHUs should focus on relational work as their primary task. Thus, the contribution from stakeholders through discussion has helped to refine the PT further. Following the discussion with stakeholders, I was able to have a look at the PT and was able to refine it further using the 'if-then' statement (Box 6:4).

If care plans are to be seen as dynamic and prospective documents to inform service users' views to influence the decision-making process in their treatment, rather than creating a retrospective document that is treated as evidence of commitment to SUI [C], then it requires nurses to engage in relational work with service users to identify their immediate needs and recovery goals for transition from AIMHUs [M]; service users should feel a sense of ownership of their care plan [M], and the care plan should have buy-in from professionals within the multidisciplinary team to focus on addressing those needs pointed out in the care plans [M] which can lead to genuine and active SUI in care planning [O], help prevent care plans being created in silos [O] and can empower service users in the care-planning process [O].

Box 6:4 – Refined PT-2 (Care plan as a recovery tool?)

6:5 Consolidation of Programme Theory-3 (Ward rounds as a non-inclusive arena)

The scope for meaningful involvement in shared decision making by service users during the care-planning process in the ward round is limited. Service users have less clarity and awareness about their role and expectations from the ward round, which makes them feel disempowered. Service users are outnumbered during the ward rounds and find it intimidating to open up in the ward round with doctors with whom they have not established a good therapeutic relationship. Service users perceive that the doctors and other professionals do not take their views seriously and feel they have preconceived ideas about treatment decisions that align more with professional knowledge and organisational needs than service users' needs. Service users are mindful that reinforcing their views and needs can attract unwanted consequences and they do not find the outcomes from ward rounds meet their expectations. However, professionals find it difficult to relinquish their power and responsibility and to work in a recovery-oriented way when it comes to decision making about safety-related issues. As a result, service users do not feel that they have active input in the decision-making process during ward rounds.

Box 6:5 – PT-3 (Ward rounds as a non-inclusive arena)

All of the stakeholders were able to identify the ward round as a routine practice that happens on AIMHUs that does not appear to provide a good experience for service users. Some of the stakeholders shared the experience of service users feeling alienated in the ward rounds, as they get ignored by professionals, which validates the feeling of powerlessness identified in the PT. Another stakeholder added that, creating more opportunity for having ‘two-way’ conversations can improve service users’ experiences of the ward rounds. This has confirmed the context [C] articulated within the PT that results in delivering the undesirable outcome [O].

Another stakeholder recalled a comment to a service user in the ward round where professionals were asking service users to approach other professionals outside the ward round to clarify their doubts and were rushing the ward round. This summed up the limited opportunity for ‘two-way’ conversation in ward rounds and also emphasised the inclination towards clinical recovery. It arguably identifies limited opportunity to develop a therapeutic relationship between consultants and service users. A stakeholder has acknowledged this mechanism [M] and attributed it to constraints on consultant’s time, and demand. Additionally, this stakeholder also pointed out that the shift in consultants’ practice from a ‘sector-based model of care’ (where a consultant psychiatrist remains medically responsible for service users for their inpatient and community care) to a ‘functionalised’ model’ of practice (where consultant psychiatrists practise in either an inpatient setting or in community mental health teams) has curbed the relational continuity. This explanation further strengthens and provides further evidence for this mechanism. Overall, this process has helped to confirm that the current PT has provided the most suited existing explanation related to ward rounds in AIMHUs. This process has helped me to further refine the PT using the ‘if-then’ statement.

If service users' meaningful involvement in treatment decisions during ward rounds is anticipated, then service users' need to be prepared for ward rounds where they can discuss their needs and recovery goals with the multidisciplinary team [M], where they can engage with mutual respect to have meaningful conversations with the professionals with whom they are already acquainted [M] and have a trusting relationship, especially treating doctors [M], which can lead to genuine SUI in decision making and can promote service user empowerment [O].

Box 6:6 – Refined PT-3 (Ward rounds as a non-inclusive arena)

6:6 Consolidation of Programme Theory-4 (Peer Support Worker (PSW) interventions)

Employing PSWs to AIMHUs with a clear role specification, supervision and workplace support creates an opportunity to promote ROP. PSWs are seen as exemplars of recovery in action, as they already have a story of their own recovery to share. When PSWs share their experience, service users feel a connection and it generates knowledge transfer that provokes service users to think about their own personal recovery. Service users perceive PSWs as role models, as they have been successful in managing their recovery. PSWs are able to identify and address practices that are not aligned with ROP. PSWs' interventions on AIMHUs can lead to empowering service users, motivating and enhancing their experience, which might lead to reduced inpatient stay and reducing the 'us and them' gap between the service users and professionals.

Box 6:7 – PT-4 (Peer Support Worker interventions)

PT-4, based on peer support workers intervention in AIMHUs (Box 6:7), was presented to each of the stakeholders. During discussion, all of the stakeholders maintained that the role of PSWs in AIMHUs was invaluable. Stakeholders did not give any indications that this PT required any changes. One of the stakeholders identified PSWs in AIMHUs as inspirational. This substantiates the mechanisms [M-1 & M-2] identified in the PT. Another stakeholder perceived that the role of PSWs has a huge impact in the team and went on to explain about the change in attitude and perception towards service users and their difficulties. During discussion, one of the stakeholders put forward a suggestion that the presence of PSWs in the ward rounds can be a game changer. The responses have provided sufficient reassurance that the PT outlines a close-enough explanation of the significance of PSW interventions in AIMHUs. Based on the discussion with stakeholders, I was able to apply the 'if-then' statement (Box 6:8) to refine the PT, to make it more viable to draw out recommendations.

If organisations take proactive steps to employ PSWs in AIMHUs with a clear role specification, supervision and workplace support [C], then it creates opportunities to project PSWs as role models and exemplars for recovery in action [M]; sharing of PSWs experiences might help to create a connection with them [M] and can provoke service users to think about their own personal recovery [M], leading to empowering service users [O], motivating and enhancing service users' experiences; this might lead to reducing their inpatient stay [O] and reducing the 'us and them' gap between the service users and professionals [O].

Box 6:8 – Refined PT-4 (Peer Support Worker interventions)

6:7 Consolidation of Programme Theory-5 (Provider-controlled care transition from AIMHUs [discharge practice])

The current focus of care in AIMHUs is based on crisis stabilisation to meet the demands of the system by promoting shorter inpatient stay, where professionals are expected to resolve bed crises and are tacitly entrusted by the organisation to adapt their practice to accelerate patient flow. Service users do not experience that the current interventions are preparing them for discharge to the community; professionals become sceptical and develop a negative attitude towards service users who frequently use AIMHUs, and the plans for their discharge are predominantly based on clinical recovery to meet the demands of the system. This contradicts the principles of ROP in preparing service users for transition to the community and leads to premature or failed discharge, service users feeling disempowered and dissatisfied with services and feeling marginalised from their care.

Box 6:9 – PT-5 (Provider-controlled care transition from AIMHUs [discharge practice])

PT-5 (Box 6:9) was presented to each stakeholder to generate discussion. Stakeholders were very articulate about this PT and several stakeholders engaged in in-depth dialogue to further explain how this was manifested in their experience. One of the stakeholders recalled recurrent reminders from the patient flow team (the team that is created by the participating organisation to manage inpatient beds) anticipating discharge for some service users. This stakeholder perceived this question as emotional blackmail that forces professionals to toe the line and respond to organisational demand to resolve the ongoing bed crisis. Hence, early discharge was a mechanism to help them meet the pressure and conform with the organisation. The emphasis on pharmacological therapy was seen as an easy option to achieve this. Additionally, in the absence of a comprehensive discharge plan and the lack of resources in the community, the crisis teams are used as a misnomer to anticipate early discharge from AIMHUs. Another stakeholder has validated this by adding that they feel discharges happen far too soon in AIMHUs. One of the stakeholders who has received care from AIMHUs has indicated that there were limited interventions in AIMHUs to help prepare for discharge. The reflections of experiences from stakeholders are embraced in the PT and therefore it validates the discharge practice on AIMHUs. All stakeholders unanimously highlighted the need for a shift in focus, from early discharge to 'timely discharge' from AIMHUs and to have adequate resources in the community to support the transition process as a recommendation to take forward. The stakeholder involvement has enabled me to refine the PT further (Box 6:10).

If professionals can focus on addressing service users' needs and personal recovery goals without submitting to the tacitly entrusted demand from the organisation to tackle the ongoing bed crisis [C], then it will enable the delivery of interventions that can prepare service users for timely transition to the community [M], this may lead to the overt application of ROP [O], minimising the number of failed discharges [O], and increasing satisfaction with the service [O].

Box 6:10 – Refined PT-5 (Provider-controlled care transition from AIMHUs [discharge practice])

6:8 Reflection on stakeholder validation

This process has enabled a novice researcher like myself to gain first-hand experience about the value stakeholder involvement can add to research. It is often acknowledged that research can change its direction (Robson 2011) and the COVID-19 pandemic has certainly forced a change from the original plan outlined in the research proposal. This has provided me with another experience of adapting to changes that are outside my remit as a researcher, and highlighted the need for flexibility and the creative thinking required to meet the needs of a research study. It is noteworthy that none of the stakeholders disagreed with the findings, instead they agreed with what is articulated in the programme theories by making validating comments to authenticate their approval. Such validating comments from stakeholders also helped with my reflexivity and to validate my own thoughts about the findings, by providing the assurance that is recognisable to others who receive and provide care through the organisation. I was aware of a possible bias where stakeholders may not want to disagree with my findings, but I encouraged honesty and openness. Stakeholders actively engaged in the process and reported that they found it helpful to read the programme theories prior to the discussion.

Upon reflection, the COVID-19 pandemic has changed the way meetings are held and virtual events are increasingly being used and accepted as a more viable option. Stakeholders can stay at the place they prefer, and, as they are not within the immediate vicinity of the researcher, they may have more autonomy and become more empowered to express their views. When conducting small-scale studies in future, organising a virtual platform may be one practical way to maximise stakeholder involvement.

6:9 Chapter summary

This chapter has presented the outcomes from the consolidation stage, where stakeholders were involved in fine refinement of the PTs. All five PTs were reconfigured and articulated using ‘if-then’ statements, which provided an opportunity for developing pragmatic conclusions and recommendations. The next chapter discusses the findings, through the lens of a theoretical framework.

Chapter-7: Discussion

7:1 Introduction

This chapter presents both a discussion of findings and their contribution to new knowledge. This is articulated in the form of realist PTs. To draw the PTs together and explain how they intermesh across systems, a theoretical framework adapted from Gibson et al. (2017) is used to discuss the findings. For this purpose, the chapter is categorised into three sections. The first section (7:2) provides an overview of this study and its findings. A detailed description of Gibson et al.'s (2017) theoretical framework will be provided at the start of the second section (7:3). Following this, I will illustrate how the theoretical framework adapted from Gibson et al. (2017) illuminates the findings of this study. The third section (7:4) comprises a critical analysis of the findings (PTs), informed and guided by the substantial theories embedded within the aforementioned theoretical framework. A summary will be provided at the end of this chapter.

7:2 An overview

The background search for this study clearly identified a translation gap between theory and practice in relation to SUI in ROCP in AIMHUs (see Chapter 1, Section 1:7). The aim of this study was to explore practice in AIMHUs that can embed SUI in the ROCP and to understand how SUI in ROCP can be facilitated, considering the challenges in AIMHUs. An NHS Trust Experts by Experience service user group was involved at the proposal stage of this study and made a significant contribution to the development and refinement of the research question of this study. The study was guided by the following research questions:

The overarching research question for this study was:

1. What changes to practice work best, in what circumstances, and to what extent, to embed an active role for service users' involvement in recovery-oriented care planning during the acute inpatient care pathway?

This study also had two secondary questions, which were:

2. How is service user involvement in recovery-oriented care planning currently understood and experienced by service users and staff during an acute inpatient care pathway?
3. What changes in practice, in what circumstances, and to what extent, can sustain active service user involvement as a dynamic and transparent process in recovery-oriented care planning during an acute inpatient care pathway?

As referred to in the introduction (Chapter 1, Section 1:2), this study relates to those service users who have the mental capacity to be involved in the process of developing ROCP with professionals. This excludes people who are likely not to have mental capacity in this area (although no formal assessment has been carried out). This will be referred to in the recommendation section (see Chapter 8, Section 8:7).

Facilitating SUI in ROCP is inherently a dynamic and complex concept (Laitila et al., 2018), which can vary due to the barriers faced when applied within an open system such as the AIMHU. Additionally, its application in a health care system with complex bureaucracy (Leach, 2008) and with finite resources, further illustrates the complex nature of this intervention or programme (see Chapter 3, Section 3:2). Following a background search, four initial PTs were identified. These were: 1) Provider-controlled care transition: 'admission to AIMHUs'; 2) Care plan as a recovery tool? 3) Ward rounds as a non-inclusive arena; 4) Provider-controlled care transition from AIMHU (discharge practice). Using an iterative approach to evidence gathering from the RR and interview data has helped to identify Peer support worker (PSW) interventions as another PT that can significantly contribute to embed SUI in ROCP.

A set of IPTs were developed and these were refined during the RR. These were further tested and refined, using interview data. I have used stakeholder involvement to consolidate the refined PTs further and these PTs are listed below for quick reference (Table 7:1) and are the ultimate findings of this study.

Programme Theory-1	If the focus of care in AIMHUs is totally committed to addressing service users' needs and their recovery goals, rather than focusing exclusively on symptom reduction and crisis stabilisation to mitigate pressure from ongoing bed crises [C], then it predisposes professionals to focus on personal recovery instead of clinical recovery [M]; anticipating timely admissions to AIMHUs, where it is jointly identified between service users and professionals as therapeutically beneficial [M], and diverts from using AIMHU as a last resort [M], which might lead to promoting overt application of ROP in AIMHUs [O], reducing the number of compulsory admissions [O], creating a more conducive environment for recovery [O], minimising the 'us and them' divide between professionals and service users [O].
Programme Theory-2	If care plans are to be seen as dynamic and prospective documents to inform service users' views to influence the decision-making process in their treatment, rather than creating a retrospective document that is treated as evidence of commitment to SUI [C], then it requires nurses to engage in relational work with service users to identify their immediate needs and recovery goals for transition from AIMHUs [M]; service users should feel a sense of ownership of their care plan [M]; and the care plans should have buy-in from professionals within the multidisciplinary team to focus on addressing those needs pointed out in the care plans [M], which can lead to genuine and active SUI in care planning [O], help prevent care plans being created in silos [O] and can empower service users in the care-planning process [O].
Programme Theory-3	If service users' meaningful involvement in treatment decisions during ward rounds is anticipated, then service users' need to be prepared for ward rounds, where they can discuss their needs and recovery goals with the multidisciplinary team [M], where they can engage with mutual respect to have meaningful conversations with the professionals with whom they are already acquainted [M] and have a trusting relationship, especially treating

	doctors [M], which can lead to genuine SUI in decision making and can promote service user empowerment [O].
Programme Theory-4	If organisations take proactive steps to employ PSWs in AIMHUs with a clear role specification, supervision and workplace support [C], then it creates opportunities to project PSWs as role models and exemplars for recovery in action [M]; sharing of PSWs experiences might help to create a connection with them [M] and can provoke service users' to think about their own personal recovery [M], leading to empowering service users [O], motivating and enhancing service users' experiences; this might lead to reducing their inpatient stay [O] and reducing the 'us and them' gap between the service users and professionals [O].
Programme Theory-5	If professionals can focus on addressing service users' needs and personal recovery goals, without submitting to the tacitly entrusted demands from the organisation to tackle the ongoing bed crisis [C], then it will enable the delivery of interventions that can prepare service users for timely transition to the community [M]; this may lead to the overt application of ROP [O], minimising the number of failed discharges [O], and increasing satisfaction with the service [O].

Table 7:1 – Refined programme theories

The contexts [C] that have been identified in four out of the five PTs indicate a heavy focus on a resource-led or resource-driven approach to care. This is unsurprising in view of what is likely to be continuing limited resources. This limit on resources means that system-generated organisational priorities will normally be given precedence over service users' interests and experience, which contradicts the principles of recovery-oriented practice. This can be demonstrated in my study, which has found noticeable evidence of organisational influence in professionals' practice, as they are tacitly entrusted to meet the demands and priorities of the organisation and finite resources. As a result, professionals' practice is shaped and programmed to accomplish their organisations' priorities. Furthermore, the findings indicate that the priorities set at an organisational level do not provide conducive opportunity to actively involve service users in developing ROCP. In many ways, the difficulties for the organisation in finding the resources to fund ROP are mirrored on the ground, where staff are unable to meet the unachievable expectations asked of them.

My study has identified mechanisms that appear to predispose professionals to lean towards the medical model, which influences their practice in a way that would seem to diminish opportunities to establish therapeutic relationships. In order to meet organisational priorities, financial limits and demands, professionals appear inclined to be more deficit or problem-focused, rather than working with service users' strengths, and this approach exemplifies professionals' reliance on the medical model of care. The findings suggest that accelerating service users' clinical recovery by focusing on pharmacological treatments minimises symptoms faster and increases 'patient flow' through the system. This could be viewed as one of the reasons why the medical model appears to prevail within the current mental health system.

Some of the routine practices related to the care in AIMHUs, such as the formulation of care plans, ward rounds, admission and discharge practices, would appear geared up to safeguard organisational priorities over those of the service users'. This explains the erosion of relational work on AIMHUs, especially by nurses, which would seem to contribute to the lack of opportunities in building therapeutic relationships. It is therefore suggested that external factors have direct implications for the practice of professionals within AIMHUs, which is incongruent with service users' views, preferences and expectations. Additionally, the study highlights limitations on professionals' autonomy and how it marginalises service users from the decision-making process that affects their care. Another finding from the study indicated that PSWs add much value in promoting recovery-oriented practice. PSWs are seen as exemplars of recovery in action and as role models, as they have been successful in managing their recovery. When PSWs share their experience, service users feel a connection and it generates knowledge transfer that provokes service users to think about their own personal recovery. In the next section, I introduce the theoretical framework that has helped to conceptualise the tensions and challenges within the contemporary mental health system, and provides the lens for discussion and critical analysis of the findings.

7:3 Theoretical framework

My quest to find an appropriate substantive theory (see Chapter 3, Section 3:7:1) guided me to the theoretical framework developed by Gibson et al. (2017) for the purpose of enhancing patient and public participation in research. While the central role of middle-range theories in the RS cannot be overemphasised (Shearn et al., 2017; Pawson, 2006) my search for a middle-range theory during the evidence review was a challenge and became futile. Regardless of its philosophical orientation, I found the vast majority of papers were mainly focused on the practice-related issues of SUI and seldom made reference to substantive theories, except one study (Brooks et al., 2015), which indicated Normalisation Process Theory (May & Finch, 2009).

I considered middle-range nursing theories, such as Peplau's Theory of Interpersonal Relationship (1997), Tidal Model (Barker, 2001) and the Recovery Alliance Theory (Shanley & Jebb-Shanley, 2007). However, I found limitations in their explanatory power as a middle-range theory for the purpose of looking at macro (system transformation) and meso level (organisational culture change) within publicly funded health services like the NHS. Findings from a recent study on nursing theory development strategies (Im, 2018) identified that theories initially proposed as middle-range theories by proponents were later identified as situation-specific theories that are limited to explanation at the micro level (phenomena pertinent to the nursing discipline), and lack explanatory power at macro (societal values and system level) and meso levels (organisational). Additionally, for future development of middle-range theories, Im (2018) recommended collaborative efforts across disciplines that are grounded in robust and consistent philosophical and methodological bases that can be strongly linked to research and practice.

Even though there are compelling arguments that middle-range theories should be used as a scaffold to build new knowledge (Shearn et al., 2017; Pawson et al., 2004), it is evident that earlier realist reviews have encountered similar challenges in identifying middle-range theories that are abstract enough for developing new knowledge (Jagosh et al., 2014). In order to conceptualise and overcome these challenges, I have looked into the possibility of using a theoretical framework. A theoretical framework is defined as "*the use of a theory (or theories) in a study that simultaneously conveys the deepest values of the researcher(s) and* *provides a clearly articulated signpost or lens for how the study will process new knowledge"* (Collins & Stockton, 2018, p.2). The ability to harness multiple theories can arguably deal with multiple PTs and require multiple middle-range theories. However, Collins and Stockton (2018) warn against the over-reliance on theory, as it may limit the ability to see emergent findings in the data. In my study, I have used a theoretical framework adapted from Gibson et al.'s (2017) four-dimensional theoretical framework (Figure 7:1) to make sense of the PTs and their relevance in an open system. It also helped to organise and connect data.

7:4 Four-dimensional theoretical framework by Gibson et al. (2017)

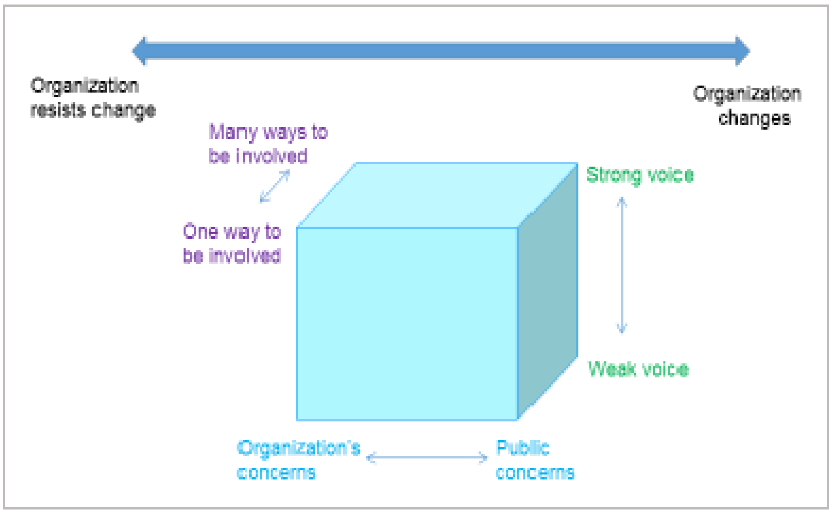


Figure 7:1 – Four-dimensional theoretical framework by Gibson et al. (2017)

Gibson et al.'s (2017) four-dimensional framework was developed to analyse the nature of patient and public involvement (PPI) in research, based upon the works of Arnstein (Arnstein, 1969); Habermas (Habermas, 1987); Bourdieu (Bourdieu, 1987); and Fraser (Fraser, 1989a), regarding the role of power and inequality in participation and decision making. These dimensions included:

1. Organisation's concerns versus public concerns;
2. Weak voice versus strong voice;
3. One way to be involved versus many ways to be involved;
4. Organisation changes versus organisation resists change.

These dimensions are viewed as points along a continuum that may move back and forth over time. The next section explains each of these dimensions in detail.

7:4:1 Dimension-1: Organisation's concerns versus public concern

This dimension is based on Habermas's (1987) concept of communicative and strategic action. Theory of communicative action is a critical social theory that anchors Habermas's (1987) concept of communicative rationality. Habermas views language as a medium for coordinating action where it requires individuals to adopt a practical stance towards reaching a common understanding and cooperative action. When individuals interact with this practical attitude, they engage in what Habermas refers to as communicative action, which is a consensual form of social coordination in which individuals understand the potential for rationality. On the other hand, when individuals are not in mutual understanding, Habermas refers to it as strategic action. It is characterised by instrumental action for attaining specific targets and goals set by certain individuals or organisations, which can either be open or concealed. According to Habermas, these different modes of action emanate from two distinct social spheres within society, namely 'life-world' and 'system'. An example of 'system' can be the bureaucracies, markets, policies and economic drivers of health organisations and the 'life-world' refers to service users and the public.

Habermas introduced 'colonisation of the life-world', which refers to the imbalance between these two elements (life-world and system) in which the system is increasingly rationalising and intruding upon ('colonising'), and thereby eroding, the life-world. Much of Habermas's discussion of this process highlights the examples of the increasing influence and involvement of the state in aspects of everyday life. McCarthy (1991) critiqued that Habermas has oversimplified the permeating dynamics of social institutions, whereas Fraser (2009, 1997 & 1985) stated it as covertly ideological, concealing the nature of patriarchal and economic control. Regardless of these critiques, I believe Habermas's theory has the explanatory power to critique the multi-layered reality that resides within the PT for discussion under this dimension.

Drawing on these two concepts (communicative action and strategic action), Gibson et al. (2017) highlight the tensions that prevail between service users' experience, choice and needs, against the need of organisations to deliver health care in a rational and efficient manner with limited resources. I have adapted this dimension for my study and for practice-oriented discussion, into a continuum from '*service users' priorities versus* *system/organisational priorities*'. In relation to my study, this dimension illuminates PT-1 (Provider-controlled care transition: admission to AIMHUs).

7:4:2 Dimension-2: Weak voice versus strong voice

This dimension was derived from Fraser (1997 & 1990), who built on Habermas's work on the upsurge of the public sphere in bourgeois society. Fraser suggests that the public sphere is formulated where private individuals assemble to discuss issues publicly. Hauser (1999) defined a public sphere as "*a discursive space in which individuals and groups associate to discuss matters of mutual interest and, where possible, to reach a common judgment about them. It is the locus of emergence for rhetorically salient meanings*" (p.61). Fraser claims that the interests of social groups in the public sphere constantly overlap, as its boundaries are not fixed and there are also areas of diverse interest, leading to frequent conflicts. According to Fraser, not all publics have the equal ability to influence decision making. She makes a distinction between weak and strong publics (weak voice and strong voice). A strong public is defined as one where discussions take place and it also has the capability to influence decision making. Weak publics are publics that discuss issues, but have little chance of influencing decision making. Fraser's theory on social justice, which is based on the concept of 'participatory parity', requires social arrangements that allow all members of society to interact with one another as peers (Fraser, 1997). It is noteworthy that, for Fraser (1997), social justice means 'parity of participation'. Fraser views social inequality and the "*politics of need interpretation*" (Fraser, 1989b, p.292) as two distinctive factors that can trigger conflict, which subsequently makes participation purely tokenistic. These two factors are discussed in the following section.

7:4:2:1 Social inequalities

Any practice that hinders the opportunity to participate in social life as peers must be called unjust (Fraser, 1997). Principles include ensuring proper participatory procedures; recognising minority viewpoints and perspectives; attending to the framing of public issues; and remediating inequitable social structures. Fraser argues that it is inadequate to propose that participants should act 'as if' they are equal when participating in public spheres. This is because inequality taints debate within publics. One of the key preconditions for such participation to take place is that all systematic social inequalities between actors must be ‘eliminated’. Fraser concludes that participatory parity can only be achieved if underlying status, economic and political inequalities are first addressed.

Fraser has identified three types of social inequality that lead to injustice. These can happen when people may be denied the social status (cultural injustice), economic resources (economic injustice) and the political voice (political injustice) that they require to participate on an equal footing with others. The cultural injustice includes: cultural domination, as expressed in dress codes, patterns of speech and body language; non-recognition (being rendered implicitly by means of authoritative, representational, communicative and interpretative practices); and being disrespected. Fraser terms this as the politics of recognition. The economic injustice happens in an attempt to reallocate resources to redress the deficit and is termed as the politics of redistribution. Finally, political injustice contributes to marginalisation and misrepresentation, whereby political decision rules incorrectly deny the right for some actors to participate in decision making. It is termed by Fraser as the politics of representation.

7:4:2:2 ‘Politics of need’ interpretation

Secondly, Fraser explains her concept of participatory parity through the term ‘thin needs’ and ‘thick needs’, where she posits that “*the focus of inquiry is not needs but rather discourses about needs*” (Fraser, 1989b, p.292). According to Fraser, the former is universal and objective, where it is relatively uncommon for anyone to argue that homeless people need accommodation for them to survive, for example. However, disagreements surface when further deliberations take place on the type of accommodation, duration and who the responsible provider will be, which Fraser refers to as ‘thick needs’. This is significant in terms of looking at the way in which discussions about service users’ views are taking place in a public sphere.

The expediency of Fraser’s theory for disability research has already been shown and has been significant for disability campaigning (Mladenov, 2016). However, Armstrong and Thompson (2009) suggest that it is exceedingly difficult and may be impossible to determine what participatory parity will look like in specific circumstances. They view Fraser’s theoretical explanation as a ‘preliminary effort’ that requires more attention. Adding to the critique, Blue et al. (2019) recognise that Fraser’s theory may not translate easily into practical application.

Nevertheless, Fraser provides principles to guide planners in ascertaining what is just and unjust in participatory initiatives. In my study, Fraser's ideas can be used to analyse contemporary issues in clinical decision making practice.

This happens not merely because of inequalities in economic resources, but also because of subtle processes of social and cultural dissimilarity, as expressed in dress codes, patterns of speech, and body language. Drawing from Bourdieu's work, Fraser concludes that participatory parity can only be achieved if underlying economic and status inequalities are first addressed. This dimension can predominantly contribute to the analysis of PT-2 (Care plan as a recovery tool?) and PT-3 (Ward rounds as a non-inclusive arena).

7:4:3 Dimension-3: One way to be involved versus many ways to be involved

This dimension was developed based on Bourdieu's seminal work that conceptualised the idea of social capital, which confers privileged status to certain social and cultural groups within a society (e.g. commissioners, professionals) compared to others (e.g. service users, carers). In other words, numerous forms of social capital indicate the potential for knowledge to exist in a variety of forms that may not be equally valued. Bourdieu (1987) argues that people from different social positions differ from one another with regard to their possession of various forms of capital: economic, social, cultural and symbolic capital. Furthermore, possession of these forms of capital, determines people's position of power in specific fields.

Economic capital refers to material assets that are 'immediately and directly convertible into money and may be institutionalised in the form of property rights' (Bourdieu, 1987). It includes all kinds of material resources (for example, financial resources, and land or property ownership) that could be used to acquire or maintain better health.

Bourdieu framed social capital as a property, actual or virtual resources acquired by individuals or groups, derived primarily from one's social position and status. Social capital enables a person to exercise power on the group or individual who mobilises the resources (Bourdieu, 1987).

Cultural capital comprises the social assets of a person, such as accumulation of knowledge, behaviours, and skills that a person can tap into to demonstrate one's cultural competence and social status that promote social mobility in a stratified society. Symbolic capital can be referred to as the resources available to an individual on the basis of honour, prestige or recognition, and serves as value that one holds within a culture.

Bourdieu's work on multiple forms of capital indicates the potential for knowledge to take on various forms (e.g. abstract, conceptual, concrete and experiential), but he warns that these forms may not be equally valued, leading to a perpetuation of inequality. According to Bourdieu, complementarity between multiple forms of understanding, rather than maintaining a hierarchy of knowledge, is a way to overcome this form of inequality. Since different social groups produce different forms of knowledge, that is, service users' express themselves in different ways, efforts are required to diversify the ways in which patient knowledge is elicited.

Based on this, Fraser has proposed that a single approach for participation with other experts is likely to perpetuate inequality. According to Fraser, the existence of any single approach is liable to privilege the expressive norms of one social or cultural group over the other. In other words, channelling a variety of cultural forms of expression using a single involvement approach is likely to perpetuate inequality. She concludes that the notion of engaging with diverse social or cultural groups on an egalitarian footing will only become meaningful if there is a plurality of public arena in which social groups with diverse values and discursive norms can participate. In my study, this dimension will be referred to as: '*Uni-dimensional approach to SUI in ROCP versus multi-dimensional approaches to SUI in ROCP'.* This dimension is employed for the analysis of PT-2 (Care plan) and PT-4 (PSW intervention).

7:4:4 Dimension-4: Organisation changes versus organisation resists change

This dimension is referred to as a cross-cutting dimension, where policy and decision makers have to legitimise the structure they are supporting or recommending. The degree of change depends on several contextual factors, such as economical resources and national policies. In my study, this dimension will be referred to as: '*Organisation resists change versus open to changes*'. I will use this cross-cutting dimension to identify the implications for organisations in making changes to embed active SUI in ROCP.

7:5 Rationale for using Gibson et al.'s (2017) four-dimensional framework

Gibson et al.'s (2017) framework has helped to highlight the tensions, competing demands and conflicting interests of professionals and providers in practice within the mental health care system, and also illuminates a broader political context. According to Gibson et al. (2017), this framework is intended as a theoretical and practical tool that can offer a platform for reflecting on current practice, as a mode of instigating new ways of thinking about involvement and helps to identify the potential barriers and facilitators to develop new engagement structures. Finally, the theories used in this theoretical framework by Gibson et al. (2017) are congruent with my epistemological position as a researcher and the research philosophy of this study.

7:6 Critical analysis of the strengths and limitations of Gibson et al.'s (2017) framework

The dimensions in this framework were developed by drawing on the concepts of well-established middle-range theories, such as the *theory of communicative action, theory of participatory parity,* and *social capital*, which have been used in previous mental health and realist studies (Sawyer et al., 2019; Wilson et al., 2015; Pinxten & Lievens, 2014; Davies et al., 2014). This is suggestive of a strong theoretical basis of this framework. Even though a number of conceptual frameworks were identified within the patient and public involvement (PPI) domain, such as Hamilton et al. (2018), Tritter (2009), and Oliver et al. 2008, Gibson et al.'s (2017) framework has the advantage of having both an empirical and theoretical basis (Evans et al. 2018), alongside methodological synergy with realist approaches.

The strength of this framework, resulting from its theoretical richness, has arguably also accounted for some of its weakness; due to the complexity created by various constructs within each dimension and is not easy to understand. This was identified by Gibson et al. (2017) as very challenging, in their attempt to refine their framework using empirical data. Although Gibson et al. (2017) supported each of the dimensions with relevant theories, it is unclear why the cross-cutting dimension 'organisation changes versus organisation resists change' is left without a theoretical explanation. Gibson et al. (2017) highlight that the need for any debate of patient and public involvement must be firmly grounded in an understanding of the central role of power. However, I would argue that Gibson et al. (2017) have not explicitly illustrated how power is applied and experienced in their framework. I also argue that the implicit nature of power demonstrated within the theories in each dimension is regressive in nature (this means power is viewed as resource that a group or individual possess and exercise illegitimately to control others). A study conducted with the objective to improve usability of frameworks in PPI by Greenhalgh et al. (2019) has found limited transferability within PPI frameworks and has concluded that "*a single, off-the-shelf framework may be less useful than a menu of evidence-based resources*" (p.785) and they have taken a position in recommending "*build your own framework*" (p.785). The following section will illustrate the adaptation I have made to Gibson et al.'s (2017) framework.

7:7 Adapting Gibson et al.'s (2017) framework

As mentioned, the theoretical framework proposed by Gibson et al. (2017) is adaptable in various areas and it incorporates multiple theories. The theory-driven, methodologically neutral and pluralistic feature of the RS allows the addition of theories without compromising or constraining the philosophical orientation of this study. As a lens for the discussion, I suggest a five-dimensional theoretical framework, adapted from the four-dimensional theoretical framework initially proposed by Gibson et al. (2017). In order to tailor this framework to my study, whilst keeping true to its objectives, another cross-cutting dimension, with the ability to shed light on the power relations that exert pressure within a complex open system, has been used to adapt Gibson et al.'s (2017) framework. This makes it a five-dimensional framework and the fifth dimension is further elaborated in the following section.

7:7:1 Dimension-5 (adapted): Power relations

In Gibson et al.'s (2017) framework, each dimension is presented on a continuum that indicates the possibility of movement between one extreme and the other, for example, 'strong voice versus weak voice' and 'organisation's preferences versus service users' preferences'. According to Tambuyzer et al. (2014), power is a fundamental concept that has a significant role in theory building around SUI and in mental health care. Most of the contexts [C] of the PTs illustrate the presence of tensions that exist within contemporary mental health care and practices, and the way in which power relationships are manifested within an open system. As a result, the power continuum is adopted as a second cross-cutting dimension for this framework. In the following sections, I will explain why Foucauldian analysis of power was used as my preferred approach to outline the notion of power within this framework.

In order to demarcate the concepts that underpin the theory of power, I have explored major theories that have made significant contributions to explaining the notion of power. I have considered Galbraith's (Galbraith, 1983) and Lukes' (Lukes, 1974) perspective on power. Galbraith's theory is mainly addressing the labour market power and one of the main criticisms is that his early works were mainly addressing overt conflicts (Kesting, 2005). Lukes' theory offers a comprehensive account of power as domination, that draws into question the concepts of 'compliance' and 'interests', while retaining a focus on actors. However, Lukes left a significant gap by not explaining the social mechanisms and features of power that enable institutions or individuals to exercise power over the other (Dowding, 2006; Bradshaw, 1976). This is where Foucault's explanation can make a significant contribution, as he articulates how power operates in various levels in society and acknowledges the theoretical categories of structure and agency (Foucault, 2001; 1991); a fundamental component for a realist study.

Foucault claims that power is not just repressive, but is diffusive and productive (Foucault, 1982). Power over life is characterised by the aims of modifying human life in order to render it both manageable and productive (Foucault, 1978). Power in the health sector is viewed as a possession, a quantifiable entity possessed by professionals, but lacked by service users. However, for Foucault, power is not a character or resource that is possessed by a group or individual and used as a repressive force. Instead, Foucault views power as a relational and productive force that constructs individuals to act, reason and expect certain responses from themselves and others.

Foucault shows how power operates and power techniques infiltrate human beings through practices and discourses. According to Foucault, modern power essentially manifests itself in a human desire to control and modify life. This occurs through the two dimensions of the same architecture of power: firstly, on the level of individuals through disciplinary techniques, and secondly, on the level of population through bio-power and its techniques, i.e. bio-politics. Both of these modes of power aim to maximise and extract forces from human bodies, in other words, produce life in a given form, by utilising techniques of disciplinary subjection and bio-political techniques of reinforcing life.

7:7:1:1 Disciplinary power

Disciplinary power trains and controls individuals through institutions and scientific discourses, thereby it shapes and normalises subjects who ultimately become, speak, think and act in similar manners (Foucault, 1991). It transforms an individual into a tool for other interests, for the purpose of increasing productivity and effectiveness. It uses the "*carrot and stick approach*" (Lilja & Vinthagen, 2014, p.114) in a measured and predictable way. Thus, it is enforcing through surveillance, which is an integral part of disciplinary practices. Foucault uses Bentham's Panopticon as a paradigmatic architectural model of modern disciplinary power. It is a design for a prison, built so that each prisoner is separated from, and invisible to, all the others and each prisoner is always visible to a monitor situated in a central tower. Monitors do not, in fact, always see each prisoner; the point is that they could at any time. Since prisoners never know whether they are being observed, they must behave as if they are always under surveillance. As a result, control is achieved more by the possibility of internal monitoring of those controlled, than by actual supervision or heavy physical constraints.

The principle of the panopticon can be applied, not only to prisons, but also to any institution or system of disciplinary power (a factory, a hospital, a school). In general, Foucault's point in disciplinary power is to show what kinds of procedures were linked to specifically modern forms of power. The effects of disciplinary power are created especially through hierarchies, divisions, control over daily rhythm; constant presence of either punishment or reward; and norms and rules according to which individuals must conform. A characteristic feature of modern power (disciplinary control) is its concern with what its subjects have not done, that is, with a person's failure to reach required standards. Thereby using simple instruments, such as hierarchical observation, normalising judgement and examination, disciplinary power focuses on activity control to enhance productivity that creates positive economy. The framework for this study will apply this form of power as '*power exerted on professionals*' where professionals' practices are monitored, scrutinised and controlled by the organisations or providers.

7:7:1:2 Bio-power

Bio-power is a formulation of power believed to be unique to the modern era, in that it emphasises the government of life and it is concerned with *"taking charge of life"* (Foucault, 1978, p.143). Foucault was interested in how, in contemporary times, the governing of conduct was progressively focused on the management of populations. He claims that the dominance of bio-power as the paradigmatic form of power means that we live in a society in which the power of the law has receded, in favour of regulative and corrective mechanisms based on scientific knowledge. Bio-power penetrates traditional forms of political power, but it is fundamentally the power of experts and administrators.

Unlike disciplinary power, aimed at the training of individual bodies, the management of populations relies on bio-power, understood as the policies and procedures that manage births, deaths, reproduction, and health and illness, within the larger social body. Bio-power is interested in navigating the general behaviour and therefore it is interested in improving overall productivity by creating a society of control. In order to govern a population, one needs other techniques than solely disciplinary, which is focused on individualisation. Bio-power is exercised by its infiltration through public institutions to control, monitor and organise the infrastructure and increase the productivity through training and education. In relation to its application for this study, biopower will be portrayed in the framework as '*power exerted by the system*'. This means the fifth dimension within the adapted framework of this study will have a continuum that illustrates '*power exerted on professionals*', versus '*power exerted on organisation by the system*'. This will be an addition to the original cross-cutting dimension that was proposed by the proponents (Gibson et al., 2017). This is illustrated in Figure 7:2.

In summary, I adapted Gibson et al.'s (2017) four-dimensional framework to a five-dimensional framework by adding Foucault's theories related to power, which will be used to inform and guide further discussion encompassing the continuums illustrated below:

- *Service users' priorities versus organisations' priorities.*
- *Weak voice versus strong voice.*
- *Uni-dimensional approach to SUI in ROCP versus multi-dimensional approaches to SUI in ROCP.*
- *Organisation resists change versus open to changes.*
- *Power exerted on professionals versus 'power exerted on organisation by the system.*

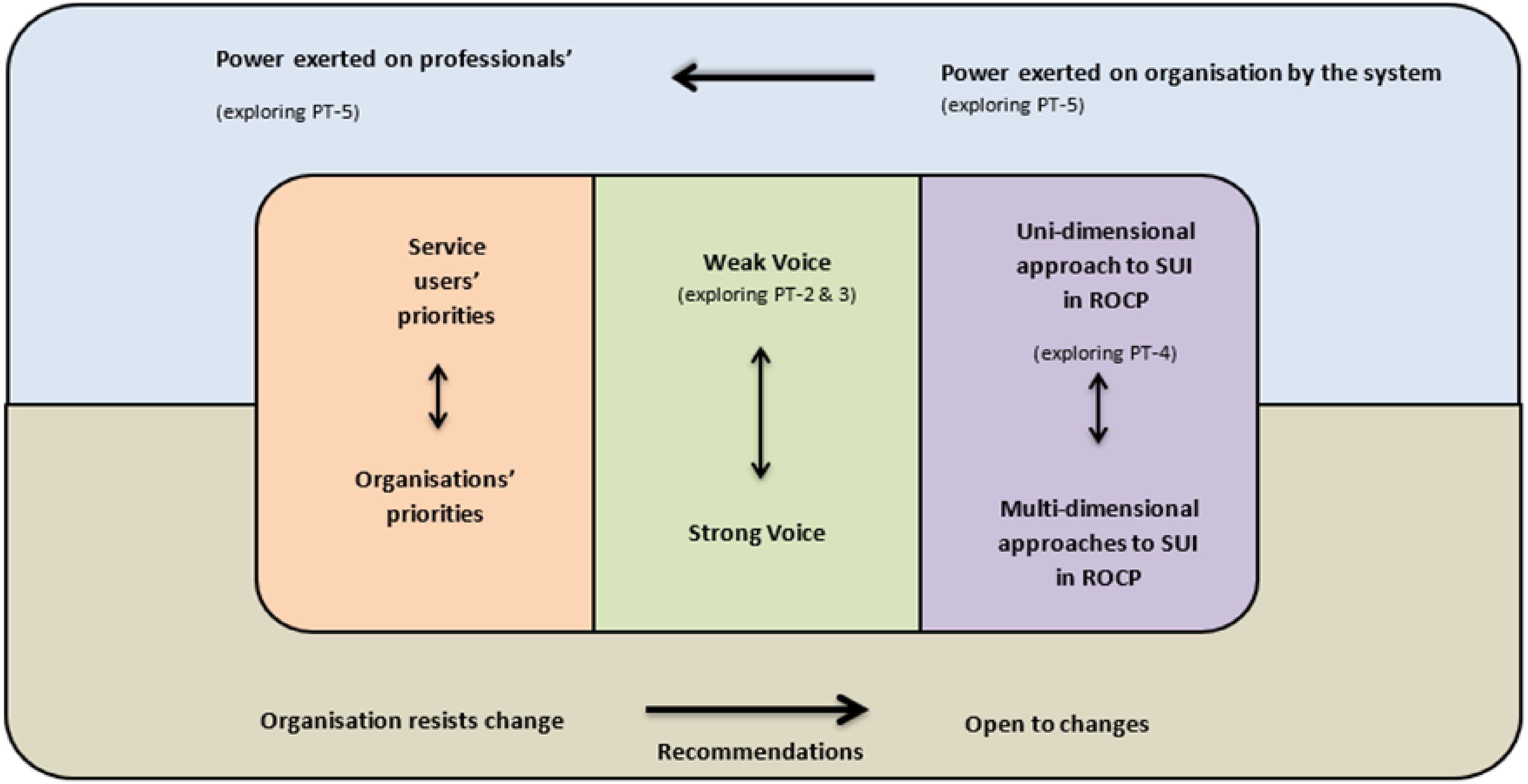


Figure 7:2 – Five-dimensional theoretical framework (adapted from Gibson et al. 2017 by adding Foucault's notion of power [1978])

The dimensions within this framework, provide an opportunity for contextualising the significance of the refined PTs in light of previous empirical studies and theories, and explain a new understanding of the issues. I will use the following sections to illuminate the findings of this study, using various dimensions of the theoretical framework, except Dimension-4 (Organisation resists change versus open to changes), which will be used to inform the recommendations from this study (see Chapter 8, Sections 8:6; 8:7; 8:8). The next section will be used to explore the first dimension (service users' priorities versus organisation's priorities) illustrated in the theoretical framework.

7:8 Dimension-1: Service users' priorities versus organisations' priorities (PT-1: Provider-controlled care transition: 'admission to AIMHUs')

Dimension-1 of the adapted framework (Service users' priorities versus system/organisations' priorities) will be used as a lens to discuss the first PT (Provider-controlled care transition: 'admission to AIMHUs'). This PT illustrates an interplay between an organisation's focus on using AIMHU beds judiciously (organisations' priorities) and the challenges it poses to the overt application of ROP (service users' priorities) that impedes active SUI in ROCP. The middle-range theory incorporated within this dimension (Theory of Communicative Action by Habermas) provides a theoretical basis for the critical analysis of this PT and will be interwoven. The next section will begin by providing an overview of the priority set by systems and organisations in this area.

7:8:1 Current focus of care: An organisational priority?

My study conducted in mental health identified that the current focus of care in AIMHUs (symptom reduction and crisis stabilisation), is a 'one size fits all' approach, led by the ongoing bed crisis within organisations, whilst at the same time contradicting the principles of recovery. In realist terms, if this is so, then it creates 'circumstances' where active SUI in ROCP fails to work. Using the lens of theory of communicative action, I would argue that the current focus of care is used as an economic driver enacted by the system to curtail the health care expenditure in AIMHUs (Naylor & Bell, 2010) and will be explored in following sections. Findings from my study identified that access to AIMHUs is controlled and managed by organisations through professionals, using 'gatekeeping' measures, to manage beds in AIMHUs judiciously. Additionally, admissions to AIMHUs are viewed as a last resort and place a huge emphasis on 'clinical recovery'. Thus, it highlights that the principles of ROP are contradicted at the very outset of service users' journey into AIMHUs. Additionally, the current focus of care with the view to managing and addressing the current bed crisis in AIMHUs also increases the number of compulsory admissions and has contributed to their current unpredictable and chaotic state, which is not conducive for active SUI in ROCP. Therefore this study highlights the significance of how the current focus of care is employed by the mental health system and organisations to work in their interests, impeding opportunity for active SUI in ROCP. It will be useful to start by providing a brief account of how the current focus of care has manifested in mental health practice.

7:8:2 The role of policy in developing the current focus of care: A communicative action transformed into strategic action?

Following the deinstitutionalisation of old asylums, fuelled by the users' movement (Rose et al., 2008), mental health policies placed an emphasis on reducing the institutional form of care and replacing it with community-based services, with a view to integrating people with mental health disorders back into society (Storm & Edwards, 2013; DoH, 1999). The consensual nature of social coordination of the service user movement exemplifies how the concept of communicative action (Habermas, 1987) takes place in the real-world setting. The formation of home treatment teams and assertive outreach teams were part of this move to provide care for service users in their home environment (DoH, 2001). As part of a consumerist agenda to make services efficient and effective, the National Service Framework for Mental Health (NSFMH) (DoH, 2002; 1999) set out standards for shaping a service model for AIMHUs. It proposed the use of inpatient beds for people requiring a short duration of intensive intervention and monitoring, which is indicative of an open strategic action set by the system. This has set the tone for prioritising investments and focus for the community services, but at the expense of neglecting inpatient care (Currid, 2009; Bowers et al., 2005). Docherty and Thornicroft (2015) observed that National Service Framework in England enforced a standard model of care implemented through a financial incentive system. It is indicative of a concealed strategic action, which explains the way in which system influences and rationalises the life-world (colonisation of the life-world).

According to Lagasnerie et al. (2015), the cost of hospital care has played a part in encouraging policy makers to consider new ways of meeting increasing demand that rely less on hospitals (a strategic action in Habermas's terms). The emphasis on recovery in the community and less so in the hospital setting was portrayed as an effort to create a 'neo-liberal smoke screen' to hide the radical deinstitutionalisation that took place in mental health (Morrow, 2013). The transformation programmes focus on reducing cost and transferring demands away from the acute services (Gilburt, 2015). It has been criticised that the evidence base for the pathways and models of care supported by the National Service Framework is limited, as the change that promised to reduce demand on beds in AIMHUs has not yet been reflected in practice (The Strategy Unit, 2019; Gilburt, 2015). On the other hand, poorly integrated financial monitoring mechanisms have contributed to a failure to warn the NHS about the extent to which resource reduction has damaged the quality and quantity of mental health care (Docherty & Thornicroft, 2015). It therefore indicates the dominant characteristics of the 'system' over the 'life-world' through strategic actions (Habermas, 1987) using bureaucracy and political agendas that spill over into policies.

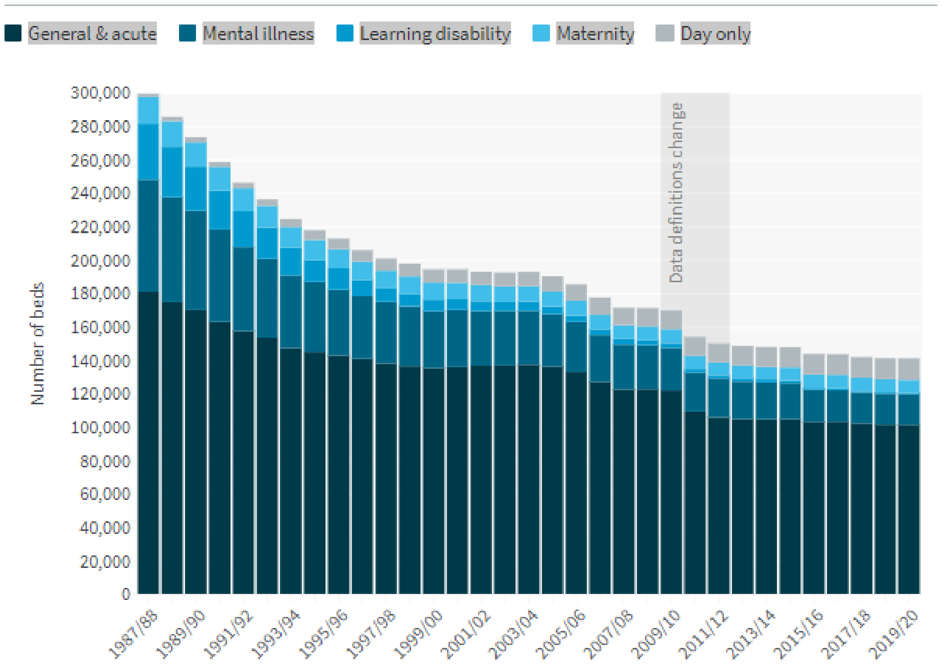


Figure 7:3 – The number of hospital beds fell between 1987/1988 and 2019/2020

Source: The King's Fund (2021)

Reports suggests that mental health beds have decreased by 73% since 1987/88 (Figure 7:3) and that an additional 1,060 inpatient beds across England would be necessary to meet the recommended rate of 85% bed occupancy (The Strategy Unit, 2019).

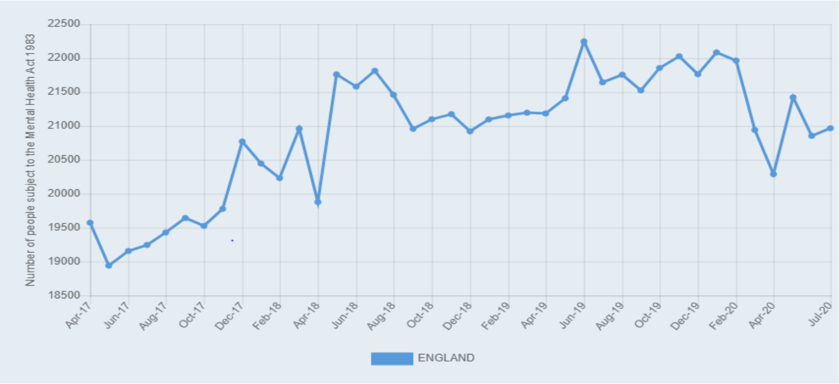


Figure 7:4 – Mental Health Act detentions across England. Source: Mental Health Watch (2020)

Source: https://mentalhealthwatch.rcpsych.ac.uk/indicators/people-subject-to-the-mental-health-act-1983

It has precipitated an unprecedented situation where data indicates that from 2000/2001 to 2015/2016, Mental Health Act detentions (Jones, 2020) increased (Figure 7:4), whilst the total number of admissions to mental health beds reduced (The Strategy Unit, 2019) (Figure 7:5).

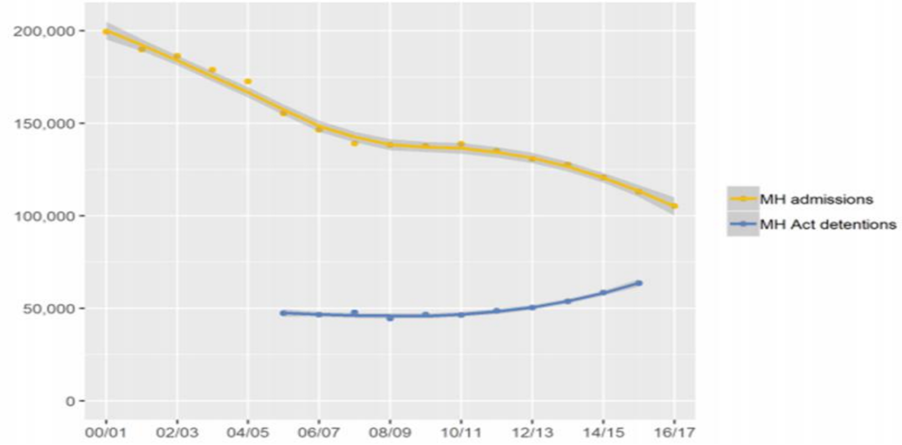


Figure 7:5 – Mental health admissions and MH Act detentions, England 2000/2001 – 2016/2017

Source: The Strategy Unit (2019)

A survey conducted by trainee psychiatrists found that the bed crisis in mental health has reached a 'tipping point', leading to unlawful practices (Buchanan, 2014). Furthermore, the cutting of community services, such as assertive outreach teams, and hesitancy in extending the services of home treatment teams (Docherty & Thornicroft, 2015) has exposed the gaps between what is initially offered and what is available on the ground.

Following the synthesis of evidence, I agree with the observation made by Piat and Lal (2012) that system planners moved ahead in their endeavour to implement SUI through specific policies and tools without sufficient forward planning. It would seem that the current system is not designed to meet the personal recovery needs of service users (Leach, 2008). I would also argue that the current focus of care with a 'one size fits all' approach would appear to have contributed to this predicament. If it is not possible to meet service users' choices and preferences, then it concurs with the observation made by Waldemar et al. (2018) that "*it is challenging to adopt recovery-oriented practices in the inpatient settings*" (p.1178). Even though organisations overtly embrace SUI in ROCP, its application in practice contradicts the real ethos of personal recovery. Tensions between actual practice, mental health ideology and policies are evident in literature (Le Boutillier et al., 2015a; Cleary et al., 2012; Hui & Stickley, 2007) (see Chapter 4, Section 4:4:8). Recovery has cost implications and, without adequate resources, the status quo remains unchanged (Newman et al., 2015; Tait & Lester, 2005). Some authors "*accuse recovery of being either a passing trend or a cash grab—a way to download responsibility from the state to the service user,*" (Morrow & Weisser, 2012, p.34) and some viewed it as a "*neoliberal smoke screen*" (Morrow, 2013, p.323). Based on these observations, the real motives behind these policies have been called into question, as the emphasis on recovery-oriented practice and self-management is seen as a cheaper option than inpatient services (Gilburt, 2015).

Interestingly, Le Boutillier et al. (2015a) highlight that recovery is misused in certain situations for the benefit of meeting an organisation's agenda, rather than that of the service user. Here the policies have anticipated the direction for organisations to travel and expect them to make changes to embed them in practice. This identifies a strategic action (Habermas, 1987) where the 'system' makes efforts to deliver services in as rational and effective a way as possible, with limited resources, which may not agree with the expectation of the society 'life-world'. The next section will discuss organisations' and professionals' approaches to meeting increasing demands on inpatient beds and to limit their usage.

7:8:3 AIMHU as a 'last resort': A deceptive strategic action to appease organisational priorities?

Service users recognise that there is a place for AIMHUs in their recovery journey (Farrell et al., 2014; Currid, 2009), however, the controlled access to AIMHUs that contributes to 'uprooting' and detentions were portrayed as negative experience. It is evident from the literature that prolonged admissions to AIMHUs can jeopardise personal recovery and that short, purposeful admissions with service users' input can be valuable to meet their recovery goals (Clibbens et al., 2018; Nolan et al., 2011). In this sense, admissions to AIMHUs for symptom reduction and crisis stabilisation, in line with least restrictive principles, can be seen as congruent with ROP. I view this as a 'consensual form of social coordination', based on the fact that there is a mutual understanding about the rationale for admission (communicative action). However, findings from my study portray another picture, which indicates that the current focus of care on symptom reduction and crisis stabilisation (Waldermar et al., 2018; Yarborough et al., 2016; Glick et al., 2011) is employed to address the ongoing bed crisis of the organisation (a resource or demand-driven approach). This generates circumstances to use AIMHUs as a 'last resort' choice of care, rather than a proactive or timely treatment option at the onset of a mental health crisis. In other words, the system scarcely anticipates proactive use of AIMHUs to avoid a mental health crisis.

In line with Habermas's theory, this substantiates my earlier argument that the current focus of care adopted by the mental health system implicitly indicates the insidious nature of strategic action to manage the ongoing bed crisis in AIMHUs, instigated due to closure of beds as part of deinstitutionalisation. It benefits organisations and system to manage their bed stock prudently when admissions to AIMHUs are treated as a 'last resort' choice. The organisations are executing their strategic action, as described by Habermas (1987) with the view to achieving their specific goal to manage their limited resources judiciously.

A study by Farrell et al. (2014), conducted in the UK, indicated that service users prefer voluntary admissions as an option, along with a choice of alternative resources, such as crisis houses (a time-limited, non-hospital residential service for individuals in mental health crisis) and crisis cafés (a community-based service that offers out-of-hours assessment and immediate support for individuals in mental health crisis), as they prefer to retain an element of control and influence over their own care. Additionally, Farrell et al. (2014) have also reported that some service users preferred to be admitted sooner, rather than later, as they think a delay in admission to AIMHUs would further deteriorate their mental state and prolong the episode. Furthermore, a recent study (Woodward et al., 2017) with the aim to understand the factors associated with satisfaction with inpatient mental health services, has found that satisfaction was significantly higher when service users were admitted voluntarily, compared to those admitted on an involuntary (detained) basis. It therefore indicates that service users would like to have the choice and option to access the service, as long as the focus of care is on service users' preferences and not on managing an ongoing bed crisis.

As suggested by one of the participants during the consolidation phase, the option of using AIMHUs as part of a list of options and as one of the 'first resort', rather than a 'last resort', along with some alternative services in the community, could help service users and carers. According to The Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults (2016), pressure on beds in AIMHUs is attributed to insufficient support in the community and lack of alternatives to hospitals. Limited evidence of access to support before crisis point in the community has also been identified in previous studies (Paton et al., 2016). This suggests the need for developing more options for service users, including 'planned admissions' as suggested by NICE (2016), where service users have an option to decide from a range of choices. In response to the Crisis Care Concordat (DoH, 2014c), new and emerging crisis care models, such as acute day hospital (non-residential) (Morant et al., 2021); psychiatric decision units (a dedicated space, separate from the accident and emergency department, in which assessment can be conducted and treatment plans developed for service users, where they may remain for up to 24–48 hours) (Goldsmith et al., 2021); and crisis houses and crisis cafés, offer great potential to improve access to services in a timely manner and improve service user satisfaction. Even though I concur with Dalton-Locke et al. (2021) about the need to conduct further evaluation of these models, current evidence suggests that these models are attractive for service users, as well as carers (Clibbens et al., 2018). Hence, I will take this forward as one of the recommendations from my study.

7:8:4 Gatekeeping: a response to conscious strategic action?

The core issue here is the ongoing bed crisis experienced on a regular basis by organisations that are relying on mechanisms, such as gatekeeping assessments, to ameliorate this crisis. It indicates a contradictory scenario, where practice deviates from ideology. In a system that embraces ROP, gatekeeping assessments can be viewed as paradoxical, as the recovery paradigm is based on the notion that service users are equal partners and experts of their illness (Slade, 2009). This is particularly important in my study as it relates to those who have insight about their illness or the mental capacity to be involved in ROCP with professionals. The 'gatekeeping' mechanisms do not appear to indicate the extent of deliberation, consensus and reflection allowed during the process for service users, as it is a process to assess the suitability against the admission criteria set by organisations or the system. As a result, it can arguably constrain the possibility of reaching a coordinated action (communicative action). A comment made by one of my study participants in a carer's role stated: "*I know the daughter I am looking for, you don't*" [Stakeholder Participant-1]. This is suggestive of the tension that emanates as result of disagreements with professionals' views and decisions. The current data on high bed occupancy rates (Figure 7:6) is evidence of pressure on beds in AIMHUs, in addition to numerous recent reports (The Strategy Unit, 2019; Coggan, 2017; The Mental Health Taskforce, 2016) that suggest the same.

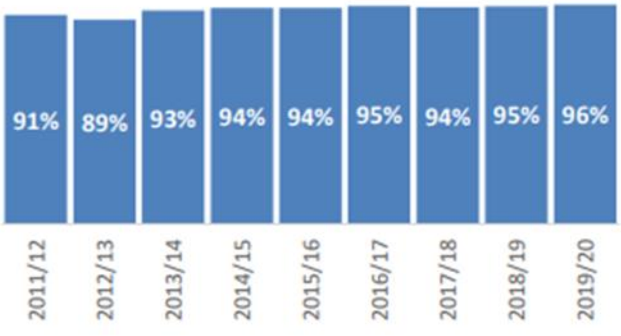


Figure 7:6 – Mental health bed occupancy rate in England

Source: Mental Health Benchmarking Network

Additionally, the lowering number of voluntary admissions and the increasing number of compulsory admissions (Figure 7:5) appears to provide some context to the earlier interpretations where organisations use gatekeeping mechanism to lower the usage of beds on a voluntary basis; in other words, compulsory admissions are on the rise. This means the possibility of accessing beds in AIMHUs on a voluntary basis that is free from coercion (communicative action) is limited, as service users are uprooted and are often detained. It indicates the ‘colonisation of the life-world’ where the system is ‘intruding upon’, and thereby eroding, the life-world by using the powers of the Mental Health Act (Jones, 2020) to detain service users against their will.

This concurs with the study conducted by Wright et al. (2016), which reported that service users were marginalised from decisions on the transition process, due to the lack of inpatient beds and community resources. However, the outcome of Wright et al.’s study has a limitation, as their findings are based on data from a single acute ward as the sole unit research site. In another study, Light et al. (2014) found that service users’ and carers’ were equally concerned with the access to services during a mental health crisis. Generalisation of the findings of this Australian study needs to be cautious, as this study was concerned with the experience during compulsory admission to hospital and has not outlined the predisposing factors that contribute to this issue. A qualitative study (Olasoji et al., 2017) to understand carers’ experiences of services during the mental health crisis of a family member reported that carers spend extensive time on the phone to services and get a disappointing response that their relative is “*not sick enough to access care*” (p.404). Contrary to this, some studies (Chinman et al., 1999) have indicated that this situation takes place as service users do not engage with services or their apprehensions and views are attributed to their mental illness (Rise & Steinsbekk, 2015). However, it is important to see at what stage of the illness the service was offered. A timely access to support and care during a crisis is an important aspect of crisis care pathways (Gilburt, 2015) and the above studies indicate that the experience of carers and service users in the real world can be different. In light of the findings from my study, I argue that timely or proactive admissions could be one of the feasible solutions to address this issue.

7:8:5 Emphasis on clinical recovery: A targeted approach to support the focus of care?

The findings from my study highlight circumstances that trigger situations where service users experience the medical model of care from professionals, which impedes the opportunity for active SUI in formulating ROCP. A medical model in mental health has close links with clinical recovery and is characterised by a hierarchical relationship that disempowers service users, focuses on service users' deficits, rather than their strengths, and maintains professionals as the experts (Chester et al., 2016). The prevalence of the medical model of care is observed in previous studies (Coffey et al., 2019; Bee et al., 2015a; Carlyle et al., 2012). My study links the medical model with constraints in resources, such as limited beds, which 'pushes' professionals to employ this form of practice. The aim of professionals here is to work in line with organisational priorities to free up inpatient beds and to focus excessively on clinical recovery. Professionals increasingly focus on deficits and on pharmacological interventions to accelerate service users' clinical recovery. This is in line with the interests of the organisation, which might not agree with service users' personal recovery goals. It indicates the colonisation of the life-world by the strategic action, for the purpose of the rational use of organisational resources, without reaching consensus and cooperation with service users. Previous studies (Wyder et al., 2017; Rose et al., 2015) have identified that service users' prefer organisations and professionals to adopt recovery-oriented principles in their treatment and to provide opportunities to be part of the decision-making process.

The finding of my study is significant in the light of the current warning from the Royal College of Psychiatrists (2020) about a possible "*tsunami of mental illness after the pandemic*" (p.1), which forecasts further deterioration of the current bed crisis. My study suggests a clear association between how the current focus of care to address the ongoing bed crisis in AIMHUs acts as a predisposing factor that constrains opportunity for active SUI in ROCP. These findings add another dimension to previous findings from studies that suggested that a lack of recovery-focused training (Hornik-Lurie et al., 2018; Zuaboni et al., 2017); professionals' attitudes towards ROP (Kidd et al., 2014b); and service user factors (McKenna et al., 2014), were the predisposing factors that impede ROCP.

7:9 Dimension-2: Weak voice versus strong voice

This dimension will be used to explore PT-2 (Care plan as a tool for recovery?) and PT-3 (Ward rounds as a non-inclusive arena for shared decision making).

7:9:1 Dimension-2: Weak voice versus strong voice (PT-2: Care plan as a tool for recovery?)

PT-2 indicates a context where care plans are used as evidence for SUI in ROCP and nurses are tasked with developing care plans to the standards prescribed by the organisation. Care plans provide an assurance for the organisation and work as proof for involving service users in their care, however, they allow limited scope to influence the decision-making process about treatment. This finding has some far-reaching, practice-related implications. Firstly, my study identifies that care plans are formulated outside the decision-making arenas in the absence of individuals who have the ability to influence treatment decisions. Additionally, reliance on care plans as evidence for SUI can arguably be viewed as weak evidence, as it may not reflect genuine SUI. It can be argued that the approach taken by organisations by entrusting nurses to develop care plans may only help to perpetuate the current rhetoric and symbolic nature of SUI in ROCP. Secondly, the current approach in developing care plans by nurses might have limited therapeutic value and lacks shared ownership. The former will be explained using Fraser's Theory of Public Sphere (1997) and the latter will be explained using the Theory of Capitals propounded by Bourdieu.

7:9:1:1 Care plans formulation: collaboration of mutually disempowered groups

Findings from my study indicated that nurses are entrusted with the responsibility to develop care plans in AIMHUs with service users. Fraser posits that weak publics may discuss issues, however, they have very little chance of influencing decision making, and in AIMHUs, treatment decisions are taken in multidisciplinary ward rounds, which are viewed as strong publics. This is consistent with the findings from a recent study on care planning in AIMHUs conducted by Reid et al. (2018), which states: "*despite developing a collaborative care plan and benefiting from the process, they* [service users] *remained excluded from decisions made about their care*" (p.5). Additionally, my study has identified that there is a lack of buy-in for care plans developed by nurses from the multidisciplinary teams. A theoretical explanation using Fraser's proposition on weak publics can explain this situation. In line with Fraser's theory, the collaboration between nurse and service user can be identified as a weak public, as it does not generate an opportunity to make treatment decisions.

Data from my study contributes a clearer understanding that nurses are not entirely convinced that the care plans they develop have any impact on treatment decisions. This is in line with existing evidence from the CAPITOL project (DoH, 2012b) from a primary care context that reported lack of demonstrable effectiveness, relevance and impact of care plans in health outcomes. It also fits in with the observation made by Tyler et al. (2019) that a single professional's, or individual agent's interventions in ROCP are proved ineffective, as they are often disempowered within a multidisciplinary team and are not able to generate meaningful change.

It has already been established that nurses have limited autonomy in making decisions (Leach, 2008) and care plans developed by nurses are retrospective in nature (Bee et al., 2015a). Furthermore, service users are not convinced by the impact of a care plan compiled by a nurse, as they view doctors as the decision-making authority. According to Rose et al. (2015), both nurses and service users are labelled as disempowered groups within the system. As a result, care plans generated by nurses alone can seldom influence treatment decisions in AIMHUs, which raises the question about the relevance of current practice that entrusts nurses to formulate care plans. Therefore it provides an explanation for Brooks et al.'s (2018) finding that suggests care plans in contemporary practice fail to meet the complexity of service users' needs.

Current findings suggest that care-plan formulation should take place in an arena where decisions can be made and have influence. In other words, it highlights a need for care plans to be part of a multidisciplinary approach. "*Everybody heard the same words at the same time because they were all in the same room"*, this statement from one of the participants (Stakeholder Participant-1) about the benefits of decision made by a multidisciplinary team has a lot of relevance here. The findings from my study also indicate a need to identify how the collaborative work of nurses and service users can effectively contribute towards decision-making processes in AIMHUs. Therefore, the nurse's role and competing demands on nurses in AIMHUs is an area that needs more attention and I will take this forward as one of the recommendations of my study.

7:9:1:2 Weak voice means weak evidence?

My study has identified that care plans are used by organisations as evidence to measure SUI in ROCP and the quality of care records in line with the organisation's prescribed methods. This is consistent with findings from previous studies on care plans in any inpatient settings (Drummond & Simpson, 2017; Keenan et al., 2008). Findings from my study agree with previous studies (Brooks et al., 2018; Bee et al., 2015a) that the involvement of service users in ROCP is analysed based on the quantification of predetermined success criteria set by organisations, rather than on the quality of the process involved in developing the care plan. Currently, SUI in ROCP is assessed as the outcome and not as a process (Bee et al., 2015a). It is noteworthy that there is a lack of consensus as to whether SUI should be measured as an outcome or as a process (Yarborough et al., 2016; Tambuyzer et al., 2014).

Using Fraser's theoretical lens, my study has identified an issue with the current practice of measuring SUI in ROCP as an outcome. This is because the use of care plans developed between nurses and service users as evidence to ascertain SUI in ROCP does not provide a 'live' representation or reflection of SUI in ROCP from a strong public (multidisciplinary ward rounds) where treatment decisions are taken. In other words, these evidences are developed based on what is written in care plans by nurses after meeting with service users (weak public) who have limited ability to make decisions related to service users' care. This means, if McKeown et al. (2017) are right in their observation, that the real state of most care plans is "*somewhat fictional*" (p.453), then it underlines the gravity of the issue of relying on care plans to determine SUI in ROCP. This further highlights the issue raised by my study about the evidence used for SUI in ROCP being weak and it might not provide real-time evidence of the issue. Additionally, reliance on care plans alone might arguably become a stumbling block in making a fundamental shift from the tokenistic state to genuine SUI in ROCP. Studies have identified that service users are rarely consulted on care plans (Simpson et al., 2016) and are not routinely involved in decision making about their care (Coffey et al., 2019). However, observations made by auditors (CQC 2019; 2020) on care plans are rather contradictory (Box 7:1 & Figure 7:7). It is important for regulatory bodies to develop more valid assessments of SUI in ROCP and I will take this forward as one of the recommendations from my study.

"In 2018/19, we recommended that patient involvement was absent or needed to improve in 37% of care plans that we reviewed. Nineteen per cent of care plans showed insufficient or no evidence that a person's diverse needs were considered, and 17% showed insufficient or no evidence that the service had considered the minimum restriction on a patient's liberty (figure 3). In 11% of care plans we reviewed, we found no evidence of patient involvement at all." [CQC, 2019]

"*Over 2019/20 we continued to note overall progress in services enabling patients' involvement in their care plans, and such care plans showing consideration of patients' views.*" [CQC, 2020]

Box 7:1 – CQC observation on SUI in ROCP

Both these statements (Box 7:1) were made in consecutive years and portray a different view to the empirical studies, and, arguably, these views also contain their own contradictions. Therefore, it is imperative to explore ways to measure and capture SUI in ROCP from a multidisciplinary context where decisions are made.

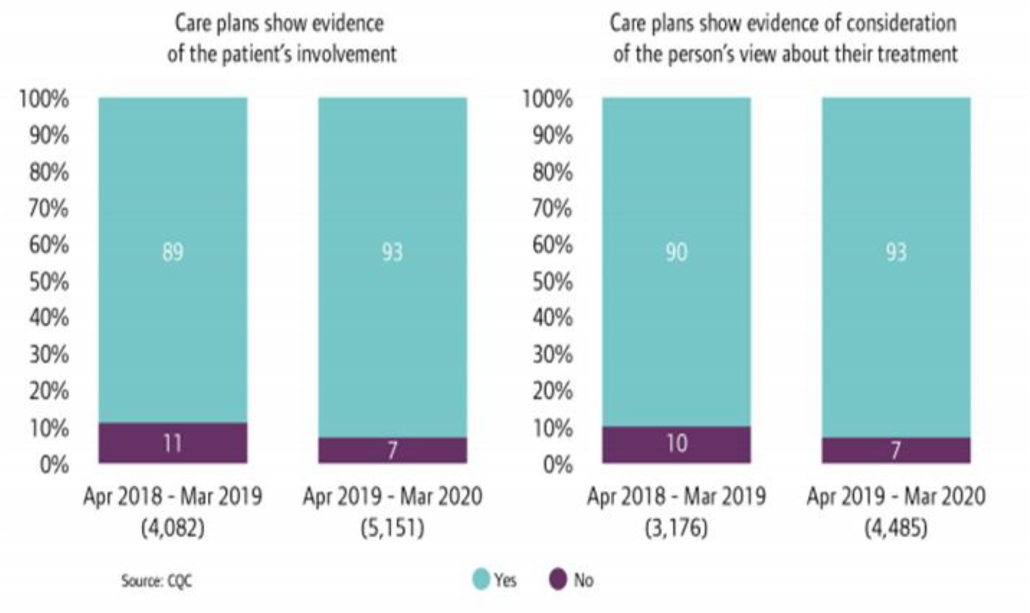


Figure 7:7 – Service users' involvement in care planning, 2018/2019 and 2019/2020

7:9:1:3 Care plan: product has more of a value than the process?

As mentioned before, this section deals with the second aspect of the practice-related implication where care plans have limited therapeutic value and lack shared ownership. My study has identified that nurses view care plans as part of their task and target-oriented activity, which is an 'add on' to the list of competing demands nurses are expected to accomplish. Here nurses see care plans as their task and work towards achieving a target that is set for them by their managers and organisation. Nurses aim to produce a 'perfect piece of work' and have less focus on engaging and developing therapeutic relationships with service users. This has a huge impact, as McCloughen et al. (2011) view therapeutic relationships as the gateway to communication with multidisciplinary teams. It might indicate why there is less buy-in from multidisciplinary teams in regard to care plans. However, my study supports the observation made by previous studies (Reid et al., 2018; Ballantyne, 2016; Rose et al., 2015) that indicate constraints on nurses' time on AIMHUs, due to competing demands on them that make them less available for service users (Ward, 2013). Additionally, it reiterates the need to review the nurses' role in AIMHUs.

A philosophical tension that prevails between SUI and professional accountability (as a record of the evidence for the care provided and to demonstrate their work in line with professional standards) has also been identified in previous studies, but nurses recognise the role of relational skills as a core facilitator of SUI (Bee et al., 2015a). Regardless of this awareness, my study has identified that nurses take the ownership of care plans and distance themselves from service users on paperwork, at an apparent cost to direct, individual time spent with service users. According to McKeown et al. (2017), there are a number of reasons for this, these include: policy; local protocols; manager's directive to maintain up-to-date records; staff fear about disciplinary action; or avoidant behaviour. All these factors correspond with the findings from my study. Constant manual updating of care plans to provide real-time information amid competing demands has been identified as a problem in general health care settings (Ballantyne, 2016).

Findings from my study are consistent with the observations made by previous studies that indicate care plans serve professionals and the system more than service users (Brooks et al., 2018; Drummond & Simpson, 2017). Additionally, the administrative and bureaucratic role of nurses that supersedes any relational work has also been identified in the literature (Coffey et al., 2019; Brooks et al., 2018). Nurses do not believe in the impact of the care plan they develop in service users' treatment. This means nurses view the care plan as an entity (Bourdieu, 1986) that is relevant to their practice, more than service users and any other interventions. Data from my study indicate that it helps nurses to avoid getting into a predicament with their manager. In other words, nurses put their value on the product (care plan) and less on the process of facilitating involvement (relational skills).

On the other hand, data from my study have indicated that service users do not get a sense of ownership of the care plan and do not see the point in working with nurses, as they see the doctors as the decision-making professionals. Additionally, service users do not see any value in a care plan that is formulated without their involvement. Data from my study indicated that service users prefer to 'sit down and talk', which indicates their preference for relational work with nurses, which is also identified in previous studies (Grundy et al., 2016). My study has highlighted that service users' place value on the process (relational work) more than the product (the care plan itself). For a particular resource to function as a form of capital, it must be acknowledged as such by other individuals in a particular social field (Bourdieu, 1986). The findings from my study regarding current practice indicate a lack of shared ownership for care plans and neither nurses nor service users acknowledge the therapeutic use of the care plan, as it does not have the ability to influence the decision-making process. Therefore, it indicates the emphasis on relational work between nurses and service users, an important intervention that is diminishing in AIMHUs, which requires swift attention.

7:9:2 Dimension-2: Weak voices versus strong voice (PT-3: Ward rounds as a non-inclusive arena for shared decision making)

This study has identified that the ward rounds in AIMHUs limit the prospect of meaningful contribution in shared decision making by service users about their care, which leads to disempowerment and marginalising service users from the ROCP process. This concurs with findings from previous studies (Coffey et al., 2019; Grundy et al., 2016; Bee et al., 2015a). I will explore this PT using Fraser's theory on participatory parity as a theoretical basis.

In terms of delivering mental health care, involvement of multiple professionals in care is acknowledged (Storm & Edwards, 2013). As a result, ward rounds can be seen as a public sphere (Fraser, 1989b; Habermas, 1978) where individual professionals meet with service users, along with relevant people, such as carers and other agencies 'to discuss matters of mutual interest' (treatment plan) and to make decisions about treatment. However, in line with Fraser's theory, ward rounds do not always ensure participatory parity. One of the prerequisites for achieving participation parity in a public sphere (ward rounds) is that all participants (professionals, service users and any other participants) in a public sphere should treat others 'as if' they are equals (Fraser, 1989a). This study has identified the ward round as an intimidating, frightening and anxiety-provoking arena, where service users feel that they are being judged and questioned by professionals.

The nature of decisions taken in public spheres depends on the power that can be exerted by the competing parties (Gibson et al., 2012). It highlights the importance of having the ward round as an infrastructure that can safeguard the participatory parity of its participants, especially of service users in this case. This means, for achieving participatory parity in ward rounds, service users' views should be treated as valid and significant, as professionals and ward rounds should be conducive for service users to voice their views during ROCP. This finding has significant impact in terms of promoting active SUI in ROCP within AIMHUs, as Fisher (2016) rightly opined, "*people whose identities are constantly devalued in their interaction with others can become fixed in positions of helplessness*" (p.345). This might explain why service users feel disempowered, which is one of the undesirable outcomes of this PT. Additionally, it reinforces Bee et al.'s (2015a) observation that user involvement models, such as shared decision-making, are less effective than previously envisaged. The mechanisms identified in this PT can be explained through the social inequalities that nullify participatory parity.

7:9:2:1 Ward rounds tainted with cultural or symbolic hierarchy?

A number of mechanisms identified for this PT indicate that the dominance of professionals' opinions limits the prospect of service users' meaningful contribution in the shared decision-making process. Data from my study suggested that professionals find it difficult to balance their advisory expert role with the experiential-based knowledge of service users. Professionals hold a perception that service users are not able to recognise their needs and service users are encouraged to accept professionals' decisions (Tait & Lester, 2005) as professionals perceive themselves as the experts who know what is best for the service user (Mathisen et al., 2016). Previous studies have identified professionals' perceptions that they are paid to make decisions and this professional stance can be a barrier for active SUI (Rutter et al., 2004). Professionals clearly have a different outlook compared to service users, based on their clinical expertise and formal learning.

One of the findings indicated that service users are less informed about the process involved in ward rounds. They are not prepared to engage in discussion with professionals who take the lead in discussion. This finding is significant, as this is reducing service users' prospects of engaging in meaningful discussions about their care. Previous studies have identified that professionals proactively control the agenda for meetings (Diamond et al., 2003). There were similar findings in general health care settings (Mukoro, 2011). It is evident that sharing information is fundamental for the success of the shared decision-making process (Mathisen et al., 2016). In Fraser's terms, this gap in sharing information relevant to ward rounds and treatment indicates an injustice rooted in the social pattern of communication, which Fraser identifies as an act of 'disrespect' (Fraser, 1997, p.14). Previous studies have identified that showing respect has an important role in ROP (Waldmar et al., 2018; Wyder et al., 2017). The significance of preparing service users with relevant information prior to decision making has been highlighted in recent studies (Mathisen et al., 2016; Mukoro, 2011).

Data from my study indicates that professionals also take the responsibility of ensuring service users' safety and endorse measures to remove or minimise risk (symbolic capital). Professionals do not anticipate having discussions about risk and safety with service users and this concurs with the findings from a recent study conducted by Coffey et al. (2019). Here professionals discount the experiential knowledge of service users, however, professionals are accountable for the safe delivery of care. If professionals' views differ from service users' views of their recovery process, it can be difficult to reach a satisfactory agreement in terms of promoting SUI (Rush, 2004). In Fraser's terms, this cultural dominance exhibited by professionals in ward rounds who have their own interpretation of service users' needs, has hints of a paternalistic approach, and a level of disrespect. It implies that the current format of ward rounds can be identified as an arena where the medical model of practice still continues. It therefore explains why and how service users feel marginalised from the decision-making process in ward rounds.

According to Fraser, the form of injustice here is the 'non-recognition' of service users' views and opinions and the remedial measure suggested by Fraser is the politics of recognition. This is where the significance of advocacy services comes into play, as they can shift the dynamics in ward rounds, where they promote service users' views in meetings, represent service users' interests and enable their participation in decision making (Newbigging et al., 2015). This is the transactional aspect of advocacy, where they can address specific issues in relation to services and treatment, however, the evidence for the transformational impact of advocacy (addressing fundamental matters concerning the status of those experiencing mental health problems) is limited (Ridley et al., 2018). This is where peer support workers arguably have an advantage over advocacy services, as they represent the evidence of recovery and can challenge perceptions that service users always require professional help. During the consolidation stage, the prospect of having a PSW presence in the ward round was suggested by one of the study participants and was perceived as a useful resource during stakeholder involvement in the consolidation process.

7:9:2:2 Constraints of choice in AIMHUs: an economic injustice?

As mentioned, the over-reliance on clinical recovery, as opposed to personal recovery, was highlighted as one of the mechanisms identified in this PT, with the focus heavily on pharmacological measures in order to accelerate discharge of service users from AIMHUs. This is to utilise the organisations' resources in an efficient manner by reducing service users' length of stay in AIMHUs as far as possible. Data from my study suggests that service users' roles in negotiating their care and inpatient stay are limited. The current system of health care is not designed to meet the needs and expectations of all stakeholders (Yarborough et al., 2016; Bradshaw, 2008); as a result, disagreements in treatment goals set by professionals and service users during ROCP have been identified in my study. This is consistent with findings from previous studies (Coffey et al., 2019; Leach, 2008).

Fraser's exposition of 'thick needs' and 'thin needs' is relevant here, where professionals focus on clinical recovery to address the problem (problem-oriented care) to accelerate service users' discharge and to minimise the length of inpatient care as a cost-effective option (thin needs). However, the service users' priority is to have more time in AIMHUs for stabilising their recovery process and to have adequate time to prepare for their transition (thick needs). Data from my study identified that service users have less choice and professionals are in a more privileged position, with the autonomy to endorse and allocate available resources. The connection between the paternalistic approach and the lack of resources has been reported in previous studies (Holliday et al., 2005). It therefore identifies tensions and conflicts in choices offered in ward rounds. However, in the contemporary mental health system, confronted with neo-liberal ideology and austerity (Teghtsoonian, 2009), both service users and professionals are bound by limitations. Broer et al. (2014) has identified the feeling of mutual powerlessness between professionals and service users during participation. This indicates a lasting challenge for the AIMHUs and indicates a need for further exploration.

7:9:2:3 Doctor-patient relationship

One of the findings of this study indicates the lack of trusting relationships with professionals; treating medical consultants especially have constrained service users' input in shared decision making during ROCP. Service users are not able to open up with doctors about their preferences and views in ward rounds and it limits their involvement in the deliberation process during ROCP. Service users see doctors as people with authority who endorse treatment plans, but who have limited knowledge about them, and about the care plans that they drew up with nurses. This is significant, as the role of the therapeutic relationship is invaluable in mental health (Newman et al., 2015) and from a service users' perspective it is the bedrock of shared decision making (Eliacin et al., 2015). A number of studies (Zisman-Ilani et al., 2017; Stringer et al., 2008; Schröder et al., 2006) have also highlighted that the relationship with professionals can improve SUI in ROCP.

The ability to work towards a common goal can provide a feeling of equality, but the absence of a relationship and trust can curtail this sense of equality (Dahlqvist et al., 2015). The rhetoric around equal partnership and its practical application remains an unresolved tension (Rush, 2004) and has been referred to as false democracy (McQueen, 2002). It indicates that the paradox of equal partners is persisting in mental health, therefore contradicting the principles of ROP and negating service users' active involvement in ROCP. Parsons (1951) argues that the doctor-patient relationship can be viewed as a social system regulated by social norms that exposes them to social control. However, Fraser does not recognise the impact of interpersonal relationships in developing parity in participation, which I find to be one of the shortcomings of Fraser's theory when applying it in a mental health perspective.

It has been established in previous studies that service users have a 'fleeting relationship' with treating doctors and they see them as a person who only prescribes medication (Rogers et al., 2007). The therapeutic alliance has much in common with the construct of working alliance and the working alliance between treating consultants and service users have digressed from Bordin's (1979) conceptualisation. According to Bordin, a strong working alliance necessitates an established personal bond, agreement on treatment goal and elucidation of treatment task. The 'fleeting relationship' between doctors and service users can be attributed to the short length of stay in AIMHUs and time constraints for doctors (Eliacin et al., 2015).

Recent reports have suggested that a change of model from the sector-based model of care (where a consultant psychiatrist remains medically responsible for service users for their inpatient and community care) to a 'functionalised' model, (where consultant psychiatrists practise in either an inpatient setting or in community mental health teams) has contributed to the deterioration of the therapeutic relationship between the treating doctors and the service users (Razzaque et al., 2020; Kosky et al., 2014). During the consolidation phase, one of the stakeholders (who worked as a consultant with both these models) opined that this change was brought in to benefit the consultants to help minimise their workload and to benefit the organisation; but it disadvantaged service users. Previous studies (Engamba et al., 2019; Schröder et al., 2006), have identified that relational continuity has benefits especially relevant to mental health care, such as: greater trust between service users and doctors; enhanced, shared decision making; service users' satisfaction; treatment outcomes; increased efficiency and consistency. Additionally, Bee et al. (2015a) reported that, "*more congruent decisions between service users and professionals are likely to emanate from trusting and respectful relationships developed over time*" (p.108). It therefore emphasises the significance of the doctor-patient relationship in promoting active SUI in ROCP.

The introduction of the 2007 amendments to the Mental Health Act 1983 (Jones, 2020) allows nurses and allied health professionals to become non-medical responsible clinicians (similar powers to a consultant psychiatrist). Early studies suggest that service users are feeling more listened to by non-medical responsible clinicians. However, the system they work in remains the same, hence more research is needed to understand the impact of these roles in practice.

7:10 Dimension-3: Uni-dimensional approach to SUI versus multi-dimensional approaches to SUI (PT-4: Peer support worker interventions)

This dimension will be used to explain the PT related to the PSW interventions. The findings from this realist study claim that a proactive approach of hiring peer support workers (PSWs) in AIMHUs can create favourable conditions for ROP in AIMHUs. This claim is based on the unique capitals possessed by PSWs that are distinguishable from professionals and this will be critiqued using Bourdieu’s concept of capital. In line with Bourdieu’s concept of capital, data from this study indicates PSWs have certain resources in the form of capitals to minimise inequalities that prevail in mental health practice and to support SUI in ROCP in AIMHUs. Data from my study have supported this claim, as service users in groups led by PSWs were more open and involved, in comparison to meetings that were chaired by professionals (Chapter 5, Section 5:2:8). This is achieved as PSWs can bring in certain capitals that are unique to them, but which are recognisable to service users, and add value to their care in AIMHUs. These results build on existing evidence of the value of the PSW role in mental health. Additionally, these capitals can complement those possessed by professionals for the benefit of service users, when they work as part of a multidisciplinary team. This will be further explored using various types of capitals, as explained by Bourdieu.

7:10:1 ‘A person who walked in their shoes’: a cultural capital

Data from my study have identified an ‘us and them’ divide between service users and professionals, which indicates the existence of two forms of class and is a sign of inequality. Previous studies have also identified this divide (Rose et al., 2015), which indicates the presence of inequality that persists in mental health practice. In line with Bourdieu’s work on multiple forms of capital, inequalities in knowledge and understanding can surface if these various forms of knowledge are not considered as complementary to each other. Mental health care is implemented by multiple professionals from multidisciplinary teams and the fundamental purpose of teamwork is to make decisions and clinical judgements in mutual collaboration (Latvala et al., 1999). These professionals from various disciplines hold different forms of capitals through their formal education or training, status and experience (cultural capital), different to that of PSWs or service users (experiential-based knowledge), compared to the practical knowledge and understanding about mental health of a PSW, earned through lived experience.

Studies have identified that professionals have an inclination to maintain a hierarchical position, based on their acquired knowledge and understanding of mental health recovery over an experiential knowledge base (Rose et al., 2015). A statement made by an anonymous person with mental illness, "*Don't tell me that recovery is not evidence based. I am the evidence.*" (Davidson et al., 2006, p.640) exemplifies the tension that prevails, to give an experiential knowledge base an equal footing with professionals' evidence-based knowledge. Being 'a person who walked in their [service users'] shoes', a PSW can bring a different form of capital to the multidisciplinary team, in the form of the practical knowledge of dealing with mental health needs and personal recovery, that can only be acquired through lived experience of their mental illness and recovery.

7:10:2 Having "*a story to share*": social capital

The data from my study demonstrated that sharing personal experience by PSWs with service users generates knowledge transfer and enables service users to identify with others like them. PSWs 'have a story to share' with service users, which enables them to see something in common between them and it creates a reciprocal relationship that exemplifies the way in which PSWs can use social capital for service users' benefit. The notion of reciprocity was also identified by previous studies (Walsh et al., 2018). The findings from my study have identified that the relationship between PSWs and service users can enhance service users' active involvement in ROCP during their stay in AIMHUs.

7:10:3 Reducing inpatient stay: economic capital

My study identified that the PSWs can motivate and enhance service users' experience in developing ROCP during their stay in an AIMHU, which might reduce the length of their stay. This is consistent with the findings from a previous study that has reported that PSW intervention can reduce the length of hospital stay (Trachtenberg et al., 2013). Some studies (Christie, 2016) have identified that those discharged from AIMHUs with PSW support may also make a more successful transition into the community than those having a traditional discharge with professionals' input. This certainly adds financial benefit to the organisation.

An argument can be raised here as to whether the drive for PSWs is seen as part of a 'neo-liberal smokescreen' for the benefit of the system or organisation. PSWs are paid at a lower rate compared to professionals (Trachtenberg et al., 2013) but provide a valuable service, which substantiates my argument. It also portrays an economic injustice. There is a drive for implementing PSW roles within organisations, but arguably less clarity on their role; ongoing workplace support; how it influences the prospect of career pathway and future employment; and measures taken by organisations/system to support their personal mental health recovery (Walsh et al., 2018). The need for a comprehensive support mechanism for PSWs within organisations is an area that was highlighted during the consolidation stage of this study. I will take this forward as one of the recommendations from my study.

7:10:4 The "*exemplars of recovery*": a symbolic capital

My study has identified that PSWs can help service users to perceive the potential for recovery in mental health, therefore challenging cultures and practices that reinforce stigmatisation, which is considered a social construct (Vuokila-Oikkonen et al., 2002). A wealth of studies have identified stigma and discrimination experienced by service users through condescending conversation and disrespectful and dismissive attitudes (Cutcliffe et al., 2015). The consequence of becoming a service user with mental health problems may not be received as a positive omen for some, as they experience shame and loss of adulthood when admitted to AIMHUs (Newman et al., 2015; Jones & Crossley, 2008).

The findings from my study suggest that PSWs are seen as role models by service users, which indicates the recognition and value they gained by self-managing their recovery. The symbolic capital here is their recognition as 'exemplars of recovery' and service users see them as examples that give them the motivation that recovery is possible. PSWs in this instance act as a symbol of hope for service users, which is a fundamental element of ROP. It highlights the fact that PSWs possess capital that can transform professionals' views about collaborative and respectful relationships, and they help to create recognition among professionals and service users about the potential for recovery in mental health.

7:11 Dimension-5: Power exerted on professionals versus power exerted on organisations by the system (PT-5: Provider-controlled care transition from AIMHUs ‘discharge practice’)

This is the fifth dimension, which I have added as an extension to the original theoretical framework proposed by Gibson et al. (2017) and will be used to address the fifth PT on the discharge practice in the AIMHUs. Discharge indicates a transition of service users from the AIMHUs to the community following a period of inpatient stay. The finding indicates that organisations tacitly entrust professionals to adapt their practice to enable organisations to meet the challenges created by the system in the form of bed crisis, which can lead to undesirable outcomes for service users and professionals. In other words, power is used in a subtle manner by organisations for the purpose of increasing its productivity and efficiency, at the cost of service user and staff satisfaction.

Two questions merit consideration. Firstly, how does it come about that a publicly funded, non-profitable organisation such as the NHS (DoH, 2019) finds itself in a situation, whereby it needs to focus on increasing its productivity and efficiency to meet the demands of the system, which appears to predispose it to delivering a service that is not aligned to the principles of ROP? Secondly, how are professionals drawn into a situation where they are ‘tacitly entrusted’ by organisations to adapt their practice to meet organisations’ demands on beds?

Hitherto, the characteristics of power were seen as a regressive force that indicates a ‘power over’ feature (see Section 7:4:2 on Fraser’s participatory parity and 7:4:3 on Bourdieu’s theory on capitals). The findings from this PT express an implicit or ‘tacit’ reference to a ‘top-down’ interposition by the system on an organisation, and from organisations, on professionals. That is to say, the power that is implied here is not something that is explicitly possessed as a resource by someone. It therefore aligns with Foucault’s notion of the insidious nature of power that is used as a productive agent and in the next section, I will illustrate how findings from my study will fit in with the existing knowledge on discharge practice.

7:11:1 ROCP during discharge practice on AIMHUs

The findings from my study verify existing evidence that indicates ROCP often lacks SUI during discharge practice (Isobel, 2019; Keogh et al., 2015). Contrary to findings from previous studies that indicate a negative and dismissive attitude of professionals towards recovery, recent studies (Gyamfi et al., 2020; Jaeger et al., 2015) have identified that professionals have a positive attitude towards recovery. However, in Jaeger et al's study (2015), the authors did not find any satisfaction, perceived autonomy or hope among service users. It begs the question as to what might be the stumbling block in contemporary discharge practice on AIMHUs that constrains SUI in ROCP.

While previous studies on this topic have focused on early discharge (Isobel, 2019); discharge interventions (Steffen et al., 2009); transitional interventions aimed at reducing readmissions (Vigod et al., 2013); and on resources in the form of beds in AIMHUs (Niehaus et al., 2008), data from my study contributes a clear understanding of the challenges encountered by professionals in AIMHUs that trigger early discharge of service users as a means to accelerate 'patient flow' and its impact on ROCP. Additionally, a review conducted by Clibbens et al. (2018) confirms that previous studies were predominantly focusing on the nature of service efficiency and service outcomes with very limited emphasis on recovery or health outcomes for service users. According to Clibbens et al. (2018), the impact of early or crisis discharge from AIMHUs remains under-reported and requires further exploration of its impact on service users. Arguably the overemphasis on service efficiency and service outcomes might have moved the focus of care away from SUI in ROCP at the time of their discharge from AIMHUs. The findings from my study may provide some explanation of the impact of current discharge practice on service users that constrains their active involvement during ROCP at the time of transition (discharge) back to the community.

As mentioned above, contemporary studies on discharge and transitional interventions focus more on reducing the length of stay in AIMHUs. Drawing on Foucault's notion of power, I argue that previous studies on discharge-planning practices might have not adequately explored or demonstrated how power is operated in a subtle and productive way for the benefit of the mental health system as a whole and by the organisations. For this purpose, the next section will use Foucault's notion of bio-power and disciplinary power as an analytical lens to illustrate how the productive form of power might produce outcomes that conflict with ROP.

7:11:2 “*Focus on getting out*”: impact of bio-power?

It is important to note that data from my study has highlighted ‘a focus on getting out, as opposed to dealing with the issues that brought them in the first place’. This raises a critical question about the real beneficiary of early discharge – system, organisation or service users? Foucault’s discourse of the management of population (bio-power) provides an insight into the organisation’s drive for discharge. In this instance, it is clear that organisations are operating with a ‘focus on getting out’, which aligns with the direction set by policy that aims to minimise the need for inpatient beds (costlier option of treatment) by shifting the focus away from inpatient care and focusing more on recovery and self-management in the community (Gilburt, 2015). This radical shift resulting from deinstitutionalisation signals a regulative intervention by experts and administrations in the management of the population. It suggests that the intervention of the system is to modify human life, to make it manageable and productive. As mentioned before, the emphasis on recovery and community-focused care is arguably a ‘neo-liberal smoke screen’ to obscure the reduction of inpatient beds, resulting from the pathway and models adopted by policies.

As illustrated above, the double strategy of policy makers promoting recovery and self-management on the one hand, whilst reducing inpatient beds on the other, summarises the notion of improving productivity and control of the population, which fits in with the bio-power discourse explained by Foucault. In other words, these efforts of managing a population through policies, with a view to increasing productivity by the state through reconfiguring the resource and infrastructure, arguably indicates the presence of bio-power, which has close links with the neo-liberal idea (Kristensen, 2013). It therefore suggests that the current bed crisis is a system-generated situation, with the intention of limiting the expensive option of care that places more burden on state expenditure.

It explains the link between the closure of inpatient beds, which is perceived as an expensive option of treatment (Poole et al., 2014) towards the cheaper version of community resources. It explains why the care from AIMHUs is an increasingly limited resource (Thibeault, 2016). According to Nolan et al. (2011), the reorganisation of the health care system in the UK was heavily focused on administrative efficacy, standardisation and cost-effectiveness, which showed little evidence of having a positive impact on SUI in ROCP. It therefore explains the radical measures taken by policy makers to close inpatient beds and making organisations responsible for regulating the use of their bed stock, which shows how power has infiltrated through to public institutions. Using the Foucauldian lens, this can be viewed as a move to taking charge of life by exerting the power through experts, in this case, the policy makers (Foucault, 1978). It signals that mental health is tainted with the influence of neo-liberal concepts, where the system has a vested interest in meeting its own demands and targets by emphasising a system-centred approach.

As a result, organisations are using proactive measures to manage their limited bed stocks. Services such as complex recovery assessment and consultation service (CRACS) were developed with a view to supporting professionals working in AIMHUs to streamline service users' inpatient stays (Le Burn, 2015). It suggests that attempts are made by organisations to accelerate patient flow through the system to maximise service efficiency. In the next section I will explain how the Foucauldian concept of 'surveillance' permeates organisations.

7:11:3 "*Focus on getting out*": Professionals toeing the line?

My study has demonstrated that professionals are expected to adapt their practice to accelerate the flow of service users through the system. Based on the data from my study, I argue that this is an insidious form of disciplinary power, as explained by Foucault, where professionals are expected to practise in a certain way that aligns with the interests of the organisation. During the consolidation stage consultations with stakeholders, one of the stakeholders indicated that a practice where service users are talked into discharge from hospital by professionals, to accelerate the discharge rate, was a form of 'leeway' to 'toe the line' to meet the demands of the organisation and system. It is understood from previous studies that shorter lengths of stay and early discharge practices are normal occurrences as a troubleshooting mechanism and are no longer a one-off incident or sporadic practice (Nolan et al., 2011). Recent studies have identified that 100% bed occupancy in AIMHUs is now a regular occurrence and is unsustainable (The Strategy Unit, 2019; Clibbens et al., 2018). Contrary to the expectation of policy makers, who envisaged less demand on inpatient beds, the current bed occupancy data outstrips the capacity and need for inpatient beds (Gilburt, 2015).

Initiatives such as the '*Red2Green*' campaign (Quinn et al., 2018), which aims to deliver care to maximise the use of beds where inpatient stay is 'no longer than is clinically necessary', epitomise the 'focus on getting out' in practice. These projects are in place to enable organisations with a visual management system of 'patient flow' through the system, to avoid delays and wasted time in a service users' journey. Moreover, it is a form of surveillance or a panopticon (in Foucault's terms) employed by organisations to maximise service user flow through the system. My study concurs with previous studies (Waldemar et al., 2018; Wyder et al., 2017) and further highlights the presence of a recurring context, where professionals are influenced to accelerate the patient flow. A high level of stress among professionals working in inpatient units has been identified as a consequence of high bed occupancy (Strategy Unit, 2019), which arguably relates to the need for adapting their practice to meet organisational priorities and demands. This situation is eloquently portrayed by Rose et al. (2015) *"Bed management, which involved early discharge, making space and moving clients around provoked a strong emotional response amongst nurse participants as they knew it led to poor interactions with patients"* (p.93).

The 'focus on getting out' (discharge) results from the awareness of an 'invisible gaze' where professionals feel compelled to manage the flow of service users through the system. This indicates the disciplinary power (surveillance) in the form of subtle coercion, where professionals are transformed into agents or tools to act in favour of the organisation, for the purpose of increasing the productivity, but not necessarily improve the lives of individuals.

The data from my study indicates practice where service users are talked into discharge from hospital by professionals, in order to free up inpatient beds. Here, professionals are working as the agents of the organisation and in the interests of the organisation. It indicates an implicit form of 'power over' professionals, which sums up Foucault's account of how power and knowledge are central to the process by which human beings are made subjects. It highlights a context that poses challenges for professionals to use themselves as 'therapeutic self' when professionals are expected to work in line with the organisation's need. Findings from my study highlighted a situation where the demands of the organisation and system limit opportunity for professionals to develop ROCP with service users. This highlights a need to understand how professionals can work with service users to develop ROCP in AIMHUs, when they are under pressure to meet organisational demands. Additionally, the implicit surveillance on professionals can work in favour of the organisation's' priorities, and raises questions about the real autonomy professionals have in arranging comprehensive discharge planning for service users. In the next section I will explain the inescapable nature of power, how it is reproduced and infiltrated in a refined and formalised manner from the organisation, to professionals, and finally, to the recipients of the service.

7:11:4 "*Discharge as a surprise*" for service users

The data from my study suggests that service users do not feel they are prepared adequately for a transition into the community. However, professionals are taking the responsibility for service users' recovery and use their clinical expertise (knowledge). Additionally, professionals may also take a condescending view towards service users, such as 'wasting resources' and perceiving them as 'regulars'; a mechanism that arises from the context of this PT. Foucault's concept of 'medical gaze' (Foucault, 1973) is pertinent here, as data indicates professionals taking a clinical recovery approach and a paternalistic view on service users to find a way to achieve their goal. It indicates a lack of consensus between professionals and service users regarding service users' transition, which explains why service users do not experience involvement in ROCP as part of their discharge from AIMHUs.

Previous studies have identified that "*the impact of services on people's lives is dictated by the degree to which they collaborate with providers and the extent to which care is perceived as helpful, consistent and continuous*" (Nolan et al., 2011, p.360). In order to maximise the benefit of care from AIMHUs, services should place emphasis on the transition from AIMHUs into the community and preparing service users for coping after discharge (Cleary et al., 2006). Data from my study points out the need to have a level of autonomy for professionals to work with service users, without the underlying pressure for discharge (resource-focused) and the need to have adequate resources in the form of inpatient beds. It suggests further study is needed to see whether professional autonomy in discharge practice can improve service users' experiences during the transition from hospital into the community. Additionally, further research is required to see what interventions in AIMHUs can be useful to prepare service users for transition, as previous research conducted on this area was inconclusive (Tyler et al., 2019). Literature in mental health emphasises service users' autonomy and it is pertinent to explore how constraints on resources and professionals' autonomy can impact service users' autonomy.

Some experts are of the opinion that extended usage of beds in AIMHUs is predominantly due to constraints on community-based resources and not due to clinical indication to remain in AIMHUs (The Strategy Unit, 2019). Arguably these reports downplay the service users' view on their stay in AIMHUs and most of these reports are generated by experts. Additionally, it is contradictory and indicates that it may be due to a growing reluctance to purchase placements in the private sector, owing to economic constraints (Poole et al., 2014). While experts and organisations are more concerned with high bed-occupancy rates, the data from my study indicates that service users still view 'discharge as a surprise', leading to outcomes elicited in the PT, such as marginalisation, dissatisfaction, disempowerment and possible readmission. It indicates a gap in the communication between professionals and service users. The busy nature of AIMHUs, competing demands and responsibilities of professionals and the rapid service user turnover impedes the time professionals have to sit down and talk to service users. A rapid change of the three factors I mentioned above is unlikely to happen. Here it is pertinent to address this conundrum using the realist notion of 'what works for whom, and in what circumstances'. This is where the addition of PSWs (with a clear job description and workplace support) into the current workforce as a resource can benefit service users as they have less involvement with day-to-day administrative tasks and have more opportunity to sit down and talk to service users. Therefore, it reiterates the potential for PSW intervention in AIMHUs and this will be one of the recommendations of this study.

In line with realist principles that are focused on the explanation of interventions, this study has contributed a more coherent understanding of the role of the implicit and insidious nature of power that influences discharge-planning practice. Findings of the current study demonstrate new insight, in such a way that power is exerted in its productive dimension that sweeps through various levels (system, organisation, professionals and to service users) and finally triggers mechanisms and outcomes that contradict and challenge the overt application of ROP.

7:12 Chapter summary

This chapter has discussed the findings from this study. A theoretical framework adapted from Gibson et al (2017), ingrained with various theories, has helped the discussion and highlighted the findings from my study. The current position of AIMHUs indicates that "*there is no single solution to this complex issue and several important factors to consider*" (The Strategy Unit, 2019, p.7). The current study has identified that embedding SUI in ROCP will require a multi-contextual approach that entails organisations having adequate resources in the form of inpatient beds to deliver needs-led care (timely admissions and discharges), rather than resource-oriented or demand-driven care; infrastructure that is sympathetic to shared decision making in the ROCP; recognising the value of lived experience and its role within multidisciplinary teams; and to have interventions, such as the formulation of care plans, that are meaningful for service users and professionals alike. This means a single or one-off approach to embed SUI in ROCP in AIMHUs may not produce desirable changes. Until and unless a change in the above-mentioned contexts within the current system happens, it is difficult to envisage how genuine SUI in ROCP can be a reality in practice. The next chapter will provide conclusions and recommendations from my study.

Chapter-8: Conclusion and recommendations

8.1 Introduction

The aim of this chapter is to provide a summary of the research, presenting the findings in light of the research questions posed and to highlight the original contribution to the existing evidence on SUI in ROCP in AIMHUs from this study. This is followed by reflection on the strengths and limitations of the study, recommendations for professional practice, suggestions for future research, and concludes with personal reflections on being a practitioner researcher and using a realist approach.

8:2 Research summary

The purpose of this study was to understand the PTs (what works best, in what circumstances, and to what extent) to embed an active role for service users' involvement in ROCP within the context of AIMHUs. My study relates to those who are deemed to have the mental capacity to make an informed decision to accept an informal admission to AIMHUs and to engage in shared decision making about their treatment plans with professionals. This study was approached from a realist perspective and has used RS as its methodology to articulate five PTs (Table 8:1).

Programme Theory-1: If the focus of care in AIMHUs is totally committed to addressing service users' needs and their recovery goals, rather than focusing exclusively on symptom reduction and crisis stabilisation to mitigate pressure from ongoing bed crises [C], then it predisposes professionals to focus on personal recovery instead of clinical recovery [M]; anticipating timely admissions to AIMHUs, where it is jointly identified between service users and professionals as therapeutically beneficial [M] and diverts from using AIMHU as a last resort [M] might lead to promoting overt application of ROP in AIMHUs [O], reducing the number of compulsory admissions [O], creating a more conducive environment for recovery [O], minimising the 'us and them' divide between professionals and service users [O].
Programme Theory-2: If care plans are to be seen as dynamic and prospective documents to inform service users' views to influence the decision-making process in their treatment, rather than creating a retrospective document that is treated as evidence of commitment to SUI [C], then it requires nurses to engage in relational work with service users to identify their immediate needs and recovery goals for transition from AIMHUs [M]; service users should feel a sense of ownership of their care plan [M] and the care plans should have buy-in from professionals within the multidisciplinary team to focus on addressing those needs pointed out in the care plans [M], which can lead to genuine and active SUI in care planning [O], help prevent care plans being created in silos [O] and can empower service users in the care-planning process [O].
Programme Theory-3: If service users' meaningful involvement in treatment decisions during ward rounds is anticipated, then service users' need to be prepared for ward rounds where they can discuss their needs and recovery goals with the multidisciplinary team [M], where they can engage with mutual respect to have meaningful conversation with the professionals with whom they are already acquainted [M] and have a trusting relationship, especially treating doctors [M], which can lead to genuine SUI in decision making and can promote service user empowerment [O].
Programme Theory-4: If organisations take proactive steps to employ PSWs in AIMHUs with a clear role specification, supervision and workplace support [C], then it creates opportunities to project PSWs as role models and exemplars for recovery in action [M]; sharing of PSWs experiences might help to create a connection with them [M] and can provoke service users' to think about their own personal recovery [M], leading to empowering service users [O], motivating and enhancing service users' experiences; this might lead to reducing their inpatient stay [O] and reducing the 'us and them' gap between the service users and professionals [O].
Programme Theory-5: If professionals' can focus on addressing service users' needs and personal recovery goals without submitting to the tacitly entrusted demand from the organisation to tackle the ongoing bed crisis [C], then it will enable the delivery of interventions that can prepare service users for timely transition to the community [M], this may lead to the overt application of ROP [O], minimising the number of failed discharges [O], and increasing satisfaction with the service [O].

Table 8:1 – Refined programme theories

8:3 Revisiting the research question

1) **What changes to practice work best, in what circumstances, and to what extent, to embed an active role for service users' involvement in recovery-oriented care planning during the acute inpatient care pathway?**

The response to this is addressed and articulated in the key contexts [C] of the PTs that are linked to the agency and structural aspects within AIMHUs. This is in line with realist principles, to inform practices that can work best to embed SUI in ROCP during an acute inpatient care pathway. I will elaborate on them in the following sections:

a) The findings from my study indicate that the current focus of care, based on symptom reduction and crisis stabilisation in AIMHUs, is a 'one size fits all approach' to mitigate pressure from the ongoing bed crisis. There is a tendency to take a problem-oriented or deficit-focused approach, which triggers reliance on clinical recovery that aligns with the medical model of practice. In order to embed SUI in ROCP, the focus of care in AIMHUs should be directed towards addressing service users' needs and their personal recovery goals. This helps to deliver holistic and person-centred care to meet the individual needs of service users.
b) My study points out a need for the reframing of AIMHUs away from being seen as a 'last resort' and to have proactive discussions with service users about the therapeutic benefit of using AIMHUs, which can lead to timely admissions to access interventions from AIMHUs when service users have the agency to work with professionals. This provides opportunities for service users to take an active role in developing ROCP by working alongside professionals.
c) My study identified that care plans do not influence treatment decisions, but are used by organisations to evidence SUI in their care, which might not provide a true reflection of what happens in real practice. In order for the care plans to be a dynamic and prospective document to influence treatment decisions, it requires a cohesive team approach, and service users need to have a sense of ownership of the care plan. ROCP needs to have buy-in from professionals working within the multidisciplinary team, including the treating doctors. Nurses should be able to focus on the relational work with service users to identify their needs and personal recovery goals, and service users need to experience that engaging in care-plan formulation can influence

treatment decisions. This can lead to empowering and actively involving service users in developing ROCP.

d) My study has found that ward rounds in AIMHUs remain an intimidating and anxiety-provoking arena that provides limited scope for service users to contribute towards their treatment decisions during ROCP. In order to increase the scope of service users' meaningful involvement in the treatment decisions during ward rounds, service users should be prepared with an agenda for discussing their needs and expectations; to have a therapeutic space to openly discuss their needs with mutual respect for the professionals with whom they are already acquainted; and to have a trusting relationship with the treating consultants overseeing their care. This allows space for candid discussions and deliberation during the shared decision-making process, thereby providing an active role for service users. It not only promotes empowerment, but also helps them to experience their involvement in developing ROCP.

e) This study has found that the addition of peer support workers (PSWs) to the current workforce within AIMHUs with clear role specification, supervision and workplace support, can create favourable conditions to promote ROP. The opportunity created for sharing PSWs' experiences with service users can generate a sense of connection and can provoke service users to think about their own recovery. PSWs are viewed by others as role models and as exemplars of recovery in action. Their presence can instil hope and empowers service users to become actively involved in the formulation of ROCP with professionals.

f) This study has identified that professionals are tacitly influenced by organisations to resolve the ongoing bed crises by adapting their practice to increase 'patient flow' through the system. In order to embrace the principles of recovery in care planning, professionals need to have the opportunity to focus on addressing service users' needs and personal-recovery goals, without having to put the demands of the organisation and system before service users' needs. This can enable professionals to deliver interventions that can prepare service users for timely transition to the community and allow time to develop a trusting relationship between service users and professionals. Adherence to what is ascribed in the agreed care plan (and not making sudden and surprising deviations from the agreed care plan) by professionals, enables service users to feel that their involvement in ROCP is worthwhile and meaningful.

2) **How is service user involvement in recovery-oriented care planning currently understood and experienced by service users and staff during an acute inpatient care pathway?**

This study has found three features, ‘lost sight’, ‘lost identity’ and ‘lost point’, which illustrate the way in which SUI in ROCP is currently conceptualised by service users and professionals in AIMHUs.

In order to regain its ‘lost sight’, SUI in ROCP should not be seen as a task-oriented exercise, for the purpose of using it as a document for evidence of care that needs to be accomplished within a stipulated time frame. Having a time-bound approach for developing care plans can create a reactive response from nurses, where they see less emphasis on the value of therapeutic engagement for establishing a rapport or trust with service users as part of developing their care plan. Instead, SUI in ROCP should evolve as part of an ongoing process through relational work between service users and nurses, which acts as a scaffold that builds and transfers the ownership of care plans.

In order to reclaim its ‘lost identity’, SUI in ROCP should not be viewed as a target-oriented activity. Maintaining an expectation that all care plans should evidence a ‘perfect piece of work’ to meet the audit standards can trigger a reactive response from nurses to focus more on targets and spend less time on relational work. Instead, care planning should be seen as a ‘journey with staff’ that denotes a work that is in progress, which might be required to change and adapt at various points during the course of that journey, with the care plan as an end product.

In order to retrieve its ‘lost point’, the formulation of care plans should have buy-in from all professionals, including senior clinicians from the MDT, such as the consultant psychiatrist. Care plans should be able to mirror service users’ needs and expectations. Currently treatment plans endorsed and created by MDTs do not always subscribe or align with the actions identified in the care plan. As a result, nurses do not see the point in investing more time in care plans in their already stretched schedules. Similarly, service users also find that care plans do not influence their treatment and find that it has a limited relevance in the decision-making process for their care.

3) **What changes in practice, in what circumstances, and to what extent, can sustain active service user involvement as a dynamic and transparent process in recovery-oriented care planning during an acute inpatient care pathway?**

In order to sustain SUI in ROCP as an active and dynamic process, service users should feel that they have ownership of the care plan and they should feel that their engagement with the care-planning process is meaningful, in such a way that they can influence the decisions about their care. In this way, service users have the opportunity to see 'the point' of developing the care plan as a 'fruitful exercise'. Service users also value and feel involved when they have regular, ongoing therapeutic engagement with nurses to 'sit down and discuss' their preferences and choices as part of care-plan formulation. ROCP should also have buy-in from all professionals within the MDT and the decisions endorsed by the MDT should be based on service users' views and expectations identified in the care plan. Therefore, ROCP requires a cohesive team approach, where all team members have buy-in to the development and updating of care plans. Ward rounds should provide scope for service users to provide a meaningful contribution to the decision-making process. Additionally, having the opportunity to meet and develop therapeutic relationships with the consultants overseeing their care might also help service users to 'open up' in meetings and this can also help to promote SUI in ROCP.

8:4 Original contributions to the knowledge from my study

My study commenced with the understanding that SUI in ROCP in AIMHUs remains tokenistic and symbolic (Coffey et al., 2019) and previous studies have highlighted multiple challenges and reasons. A number of factors that constitute these challenges are identified by various studies. Some studies (Reid et al., 2018; Grundy et al., 2016) have identified that the challenges are practice-related within AIMHUs (micro level), while other studies (Coffey et al., 2019; Pazargadi et al., 2015; Rose et al., 2015) have indicated that the challenges are instigated by professionals who work in AIMHUs. Some of the challenging factors are portrayed in the organisational (meso) level, such as resources (inpatient bed capacity) (Le Boutillier et al., 2015a) and commitment to commissioners (Brooks et al., 2018). There are challenging factors that can constrain the promotion of SUI in ROCP in a wider system (macro level) based on the political and economic agenda (Gilburt, 2015). It is obvious that these studies are focusing on various aspects and levels in which ROCP is operationalised within an open system. Additionally, studies (Zuaboni et al., 2017; Waldemar et al., 2018; Rise & Steinsbekk, 2015) have indicated that infrastructural changes or altering or supplementing existing practices might not produce significant improvement to SUI in ROCP in AIMHUs. This indicates the complexity of this programme under study at various levels. In realist terms, a PT for SUI in ROCP in AIMHUs (what works for whom, in what circumstances, and why) is not clearly articulated. This study was undertaken to understand practices that can embed an active role for those service users who have the personal agency to work with professionals in developing ROCP.

To address this using a realist approach, there is a need to articulate what is currently working (or not working), for whom, and why. This is where this study is extending current knowledge using realist methodology, and to the best of my knowledge, no past attempts have been made to explore this area using a realist approach. My study has identified practices that need to embed an active role for service users to be involved in ROCP, and that this requires multi-contextual approaches or interventions through various levels (macro, meso and micro) of the mental health system. In other words, my study has articulated blockages and contentions that restrain programmes in various levels of the mental health system from producing desirable outcomes. My study has identified that the current focus of care in AIMHUs predominantly appeared to be resource-led in order to cope with limited bed stock in AIMHUs and this needs to be changed to a needs-led approach to embed active SUI to take place during ROCP in AIMHUs.

My study has made an original contribution to current knowledge by articulating realist programme theories (middle-range theories) of practices that can embed an active role for service users with pragmatic conclusions and recommendations at macro, meso and micro levels of the mental health system (open system). These sets of programme theories can provide a foundation for future realist studies about ROP in AIMHUs. Additionally, this study has highlighted significant structural and agency factors that have substantial influence in developing practices that can provide an active role for service users to be involved in developing ROCP with professionals in AIMHUs. I argue that the challenges in AIMHUs (micro level) are likely to continue if the challenges at all levels are not addressed systematically in a way that can encompass various levels of organisational structures and procedures within the mental health system.

8:5 Strengths and limitations of this study

Considering the complexity of this programme under study and the heterogeneous nature of evidence, no single review is able to encompass the entire issue and literature. However, using RS as its methodology, this study was able provide a different dimension by providing an explanation of ‘what works, for whom, in what circumstances’ at various levels within an open system to embed an active role SUI in ROCP, and therefore the review presents the findings in narrative form (PTs). This helps in developing an understanding of practices that might embed an active role for service users to be involved in developing ROCP. This has become particularly important as health professionals try to better understand how service users can be actively involved in ROCP. Additionally, the findings of this study make a valuable contribution to the existing literature and provide a platform for the conduct of further research into SUI in ROCP in AIMHU.

The construction of initial programme theories guided by information from background search, expert opinion and the application of my clinical experience, might however have missed other important contextual elements or features of SUI in ROCP. It is possible that the literature search was not sufficiently specific to identify relevant literature, even though a comprehensive search strategy was used. It is also possible that inappropriate inclusion or exclusion of a study may have occurred, given the complexity of possible sources, terminology and descriptions of interventions. The fact that only English language publications were considered may have also inadvertently excluded some potentially relevant studies. Every attempt was made to obtain the full text of all the articles identified as relevant. The interventions and outcomes of the studies included in this review are heterogeneous, and therefore the review presents the findings in narrative form only. Considering that the topic and literature are very heterogeneous, no single review is able to encompass the entire issue and literature.

The selection, appraisal process and the analysis of evidence would be more rigorous if this had been carried out by at least two reviewers. In this study it was only conducted by myself, mainly due to the nature of the academic study; hence the subjective interpretation of narrative data may have been biased by my own perceptions, influenced by my clinical knowledge and experience. However, self-analysis and reflection of each of the stages of my study against the RAMESES quality and reporting standards (Wong et al., 2013) has helped to maintain fidelity with the realist principles (see Box 8:1).

Quality standards	**Requirement**	**Reflection on fidelity of current study to RAMESES quality standards**
Quality standards for focusing the review	The review question is sufficiently and appropriately focused.	This was achieved as the questions were reviewed by the Experts by Experience group (Section 2:3) and by conducting informal discussions with stakeholders at the theory gleaning stage (Section 3:7:1:2)
Quality standards for constructing and refining a realist programme theory.	An initial realist programme theory is identified and developed.	IPTs were developed using a customised approach (Section 3:7:2). The review has identified five PTs, all of them had clear articulation of Context, Mechanisms and Outcomes.
Quality standards for developing a search strategy.	The search process is such that it would identify data to enable the review team to develop, refine and test programme theory or theories	A clear formal search strategy was developed with an auditable trail (Figure 3:7) and was used iteratively along with interview data. The evolving data from iterative review has enabled refinement of the programme theories.
Quality standards for selection and appraisal of documents.	The selection and appraisal process ensure that sources relevant to the review containing material of sufficient rigour to be included are identified. In particular, the sources identified allow the reviewers to make sense of the topic area; to develop, refine and test theories; and to support inferences about mechanisms	The criteria for qualifying the data for this study was based on relevance and rigour. The data retrieved in this manner has greatly helped to build PT and in its refinement process (Section 4:2).
Quality standards for understanding and applying the underpinning principles of realist reviews.	The review demonstrates understanding and application of realist philosophy and realist logic which underpins a realist analysis.	The research question (Section 1:8), methodology (Section 3:2) and the analytic approach (Section 3:8:8) used in this study are consistent with a realist philosophy.

Box 8:1 – The application of RAMESES quality and reporting standards

Additionally, I acknowledge that the use of a reference group for realist reviews can provide rich information and add great value to the review, as it can increase transparency, ensure consistency and enable reflexive feedback. The nature of this project, bound by academic and ethical regulations, has limited influence on advancing these ideas. However, the stakeholder validation in the consolidation phase has helped, to a certain extent, to engage with stakeholders and to get reflective feedback about the findings that also influenced the recommendations.

The approach adopted to incorporate the main mechanisms (identified by stakeholders in the consolidation stage) from the refined PTs, and applying that in the ‘if-then’ statement, might have missed other important mechanisms; however, addressing the mechanisms and making changes to the context can impact other mechanisms.

I would argue that the use of RS methodology is one of the strengths of this study. This is due to its explanatory nature, context-specific approach, its ability to make sense of complex interventions and its ability to inform policy. The use of RS has enabled a focus on the complex intervention of SUI in ROCP within AIMHUs, and helped to make sense of the generative causation and stratified reality. Hence, the programme theories have helped to identify salient actions and recommendations.

Limitations of this study primarily reflect those inherent in realist synthesis methodology where it is not entirely possible to replicate the study. However, the data extraction forms can enhance the transparency of the decision-making process during the analysis of the data. One of the caveats of the explanatory nature of RS is the descriptive and theory-laden way of presenting the findings as the five programme theories that incorporate the CMO configuration. Although they are descriptive, they are at the same time complex and convoluted, which may be challenging for some audiences to fully engage in. Additionally, the context-specific nature of RS study means that there are limitations in how the findings can be generalised to other areas of practice, but they do, however, provide a sturdy theoretical platform upon which to pursue further research.

This study was conducted within a single organisation and the staff participants were employees of this organisation. The characteristics of this homogenous group of employees from one organisation might have a narrow impact on the findings. However, the use of service user participants and stakeholder participants may have helped in achieving a more balanced view of the programme under study.

Despite the acknowledged limitations of RS as a theory-driven method, realist interviews and the stakeholder validation (consolidation phase) provided an opportunity for verifying and refining the programme theories. Although the results of this study cannot be generalised in line with the tenets of RS (see Chapter 3, Section 3:4:3), they address some of the major themes relating to the potential challenges imposed by contextual elements identified in the study.

I acknowledge that the theoretical framework used to analyse and discuss the findings has used dense, middle-range theories to evaluate my findings and to maximise understanding of the issue. Even though the use of middle-range theories for the discussion of findings has helped in explaining the complexity of the programme under study, and the heterogenous nature of evidence, these theories may appear to present an overly critical stance. It should also be acknowledged that the evidence during the RR, and the interview data, also made some apparently critical observations in response to the rationing and cutting of resources that constrains provision of mental health care. Furthermore, my insider knowledge and observations about ongoing barriers resulting from resource cutting might have inadvertently led to a more pejorative stance and I was aware of this during the course of my study.

8:6 Recommendations for practice

- The use of multidisciplinary meetings as a forum for care-plan formulation can create a cohesive approach and provide equal opportunities to contribute to the care plan, anticipating a shared ownership. Auditors and organisations should explore ways to use the process and real-time experience in care-plan formulation, rather than relying on the contents or quantifiable factors from a care plan. A focus on the nurses' role in supporting relational work is a significant factor that can promote SUI in the care-planning process (Links to PT-2: Section 4:3 & Section 7:9:1).
- The current format and arrangements of ward-round meetings need to be reviewed, as they offer limited opportunity for service users to contribute in a shared decision-making process. Ward rounds should be conducted with professionals who have a clinical responsibility, with a view to minimising numbers in ward rounds. Service users should feel their views are validated by professionals. Professionals should focus on appraising service users of the ward-round process and preparing service users for meetings. Opportunities and access for service users to build therapeutic relationships with the treating doctors is a vital component in engaging service users with the shared decision-making process (Links to PT-3: Section 4:4 & Section 7:9:2).
- Practice in AIMHUs should have an increasing focus on preparing service users for transition into the community and constraints on resources should not dictate or anticipate decisions on discharging service users from AIMHUs, instead it should be

collaborative in nature, where possible. Professionals should focus on a needs-led approach, rather than a resource-oriented, demand-driven approach and professionals therefore require support from the organisation and system to incorporate service users' views and suggestions during the formulation of ROCP (Links to PT-5: Section 5:3 & Section 7:11).

8:7 Recommendations for future research

- Crisis houses offer a community-based alternative to hospital admission during a mental health crisis (Butt et al., 2019). Even though they are a useful and a less costly service model, previous studies identified variations in their effectiveness (Butt et al., 2019; Paton et al., 2016; Sweeney et al., 2014; Siskind et al., 2013). A study exploring if and how these alternative approaches (day hospitals and crisis homes) are more conducive to providing an active role for service users to be involved in ROCP is recommended (Links to PT-1: Section 4:2, Section 6:3 & Section 7:8:3).
- Future research should be conducted on what interventions work, (or not), in what circumstances, for whom, and to what extent, in AIMHUs, to prepare service users for transition from AIMHUs to the community (Links to PT-5: Section 5:3 & Section 7:11:4).
- Future studies are recommended to identify what and how the collaborative work of nurses and service users can best contribute towards decision-making processes about service users' care in AIMHUs.
- My study has answered the research question by developing programme theories based on the premise that service users retain their personal agency (mental capacity) to engage with professionals. A study is recommended to articulate what works (or not), in what circumstances, and to what extent, for those service users who lack personal agency to be involved in developing ROCP.
- Virtual platforms are been utilised frequently as a more feasible and acceptable option to organise meetings. Small-scale studies (including doctoral studies) in future should anticipate utilising the benefits of virtual platforms for organising fully fledged stakeholder reference group at various stages of realist studies.

8:8 Recommendations for policy makers, commissioners and managers

- The focus of care in AIMHUs should be driven according to service users' needs and not as a means to resolve the ongoing bed crisis. It requires a change in practice, to a timely access or admission to an AIMHU, rather than using AIMHUs as a 'last resort', at the point where service users' ability to negotiate treatment with professionals is constrained due to the debilitating symptoms of their mental illness. Adequate alternative resources to AIMHUs are a way forward, but at the same time, inpatient bed stock for each organisation should be reconfigured to meet the requirements of the geographical area, to make it viable for timely admissions, by involving service users in discussions related to admission to AIMHUs (Links to PT-1: Section 4:2 & Section 7:8).
- The current practice of developing and updating care plans as part of a single professional's (key nurse's) responsibility might be an ineffective approach, considering the current nature of AIMHUs and competing demands on nurses. Considering these factors, this study makes recommendations to create pathway guidance for care plans tailored for AIMHUs, by delineating roles for various professionals within the multidisciplinary team, to have a cohesive team approach in the formulation and regular review of care plans with service users (Links to PT-2: Section 4:3 & Section 7:9:1:1).
- This study acknowledges that the competing demands on nurses, increasing acuity on AIMHUs, along with its busy nature, appears to diminish the relational work offered by nurses. Hence this study makes recommendations to reconfigure nurses' roles within AIMHUs and to undertake a staff-establishment review using the Safer Nursing Care Tool to reconfigure and to establish the right staff-patient balance in AIMHUs (Links to PT-2: Section 4:3 & Section 7:9:1:3).
- Hiring PSWs to work as part of a multidisciplinary team in AIMHUs has the potential to promote SUI in ROCP, by inspiring hope and empowering service users. PSWs have practical knowledge and experience in managing their recovery and are in a position to share their knowledge and to establish reciprocal relationships with service users. Their presence in teams could challenge stigma and instigate a more respectful

approach from professionals, which might reduce the ‘us and them’ divide (Links to PT-4: Section 5:2 & Section 7:10).

- This study recommends the presence of PSWs in ward rounds and care-planning meetings, as their presence might create a more user-friendly atmosphere for service users and could minimise the power imbalance in ward rounds (Links to PT-4: Section 5:2, Section 6:6 & Section 7:10).
- Organisations should ensure that PSWs have a clear job specification for their role in AIMHUs and ensure processes or mechanisms are in place to provide adequate work place support and timely supervision (Links to PT-4: Section 5:2 & Section 7:10:3).
- Regulatory bodies, such as CQC, should explore and develop more valid assessments of active and genuine SUI during the development of ROCP (Links to PT-2: Section 4:3 & Section 7:9).
- New ways of working to support professionals from all disciplines to take up the Responsible Clinician’s role (currently in AIMHUs the consultant psychiatrist predominantly undertakes this role, but it is open to other professionals) will offer different approaches, which may be better tailored to service users’ needs. It might be another approach to minimise the power imbalance during treatment decisions (Links to PT-3: Section 4:4 & Section 7:9:2:3).

8:9 Reflection on my PhD journey

My journey as a practitioner researcher was informing and transforming. However, it will never be a full account of my PhD journey if I am not equally open about its challenges. The demands on my time whilst in full-time employment within the NHS were significant and further intensified during the global COVID-19 pandemic. The challenges of finding a work-life-study balance to meet the expectations and deadlines involved in successfully completing my PhD as a part-time student were considerable. English is not my first language, and this added an additional layer of challenge to the project. My motivation during my PhD journey came from the inspiration and encouragement of my family; my deep desire for learning; the opportunity to address an important, ongoing practice-related issue; the prospect of graduating in front of my children, and role modelling the enormous value of lifelong learning to them; and a desire to prove to myself that I could rise to the intellectual challenge.

Being a mental health nurse, I have experienced the benefits of clinical supervision and reflective practice sessions, which have enabled me to develop my skills and knowledge by actively reflecting on my day-to-day practice. During my PhD journey, I’ve maintained a record of personal and academic reflections. This has certainly helped me to trace back and realise how far I’ve travelled in my thinking about this topic and how I’ve developed as a practitioner researcher. My own personal development has been immensely enriched by advancing my research skills, time management, organisational skills and ability to self-manage, my project-management skills and navigating the challenges of the PhD experience. Negotiation with my managers and fellow clinicians at work led to the building of workplace support. This was essential, both in balancing overall workload, and in taking my study forward. Overall, I have found the experience inspiring, creative and rewarding, if exhausting, at times unsettling and laborious.

8:10 Reflexivity

Being a practitioner researcher, I was aware that I wear two virtual hats: that of a clinician and that of a researcher. This constant awareness, reflection and self-critique by the researcher of the researcher’s own contribution and influence in research findings is referred to as ‘reflexivity’ (Teh & Lek, 2018). This is a process that is required from the initial phase, through to the very end of a study, which adds credibility to the findings, rigour and quality of work and is considered as a benchmark in determining the trustworthiness of the study (Dodgson, 2019; Berger, 2015). Throughout my PhD journey, I have made conscious efforts to refrain from projecting my clinical knowledge, and being subjective with preconceived ideas during the research process, as I was aware of the potential risk of researcher’s bias impacting on research findings. For example, during the selection of participants within my organisation, I approached Clinical Lead nurses to assist with participant recruitment, instead of conducting recruitment myself. The use of an Experts by Experience group in developing research questions; informal discussions about my observations of data with fellow clinicians and supervisors; writing a reflective diary; and the stakeholder validation during the consolidation phase are examples of measures I introduced during my PhD to ensure that I remained as objective as possible. However, I agree with Carolan (2003) that personal processes have the ability to influence findings, and on that basis, I do not make a definite claim that the findings from my study have not been affected to some degree.

Reflection on power and power differentials is an area that needs careful consideration, especially where the researcher does not belong to the group of participants under study (Grove, 2017). In my study, this is particularly relevant in relation to the service user participants who took part. In order to maintain their autonomy and avoid coercion, I did not engage in the direct recruitment of participants, as discussed above. During the time of gaining consent from participants, I have indicated that the research questions were developed in collaboration with the Experts by Experience group. Additionally, I gave service users and other participants the option to choose a place where they preferred to be interviewed; this was an effort to empower them with the feeling that they were in their own territory and had the autonomy to express their thoughts freely.

I was cautious about introducing myself as a nurse to my study participants. Some of them have had meetings with me in my clinical capacity as a nurse manager. This led to some participants who saw me as fellow nurse, or as a nurse who worked in AIMHUs, and they started to make references such as "*you know what things happen on our wards*" or "*you know what I am talking about*" without explaining themselves, or expecting me to complete the meaning, or fill in on their behalf. I have reflected on this and realised the drawback is that this can limit the richness of data. As a result, I have focused more on how I introduce myself and asked my participants to respond to questions as if I do not have any prior knowledge about the programme under study. However, it was rewarding to get responses from participants who thanked me for taking the time to study this programme and were keen to know the findings of this study.

From the outset of my PhD journey, I was neither convinced by the notion of 'objectivity' in knowledge creation put forward by positivism, nor content with the view of 'subjectivity' in gaining knowledge of the world proposed by interpretivism. However, my understanding and knowledge of post-positivism was limited. I started contemplating more on post-positivism, following the introduction to realist methodology in the first year of my PhD. As a novice realist researcher, I found the terminology used in realist studies rather challenging and the whole paradigm nebulous. I can relate my process of learning realist methodology to that of an apprentice who learns skills, gains knowledge and earns at the same time. My overall learning was the confidence I gained by applying my learning to practice and mind-mapping my study to be consistent with realist principles. I spent time exclusively on detailed reading of realist methodologies and chose to follow the paper written by Pawson et al. (2004) and the training materials offered by RAMESES II (Wong et al., 2013), which I found invaluable in shaping my understanding about realist methodology. Supplementary reading of papers and studies conducted by leading realist researchers has further extended my knowledge in realist methodology.

Having the subscription of 'JiscMail' (a national academic mailing list service provided by JISC that will enable collaboration and communication with peers, experts and partners, using mailing lists) on the RAMESES website has helped me to tap into the free-flowing exchange of ideas and is an opportunity to collaborate with experts in the realist research community. Additionally, discussions with my supervisors (one of whom is very experienced in realist research) during supervision sessions became a platform that was used to share and constructively challenge my grasp of realist methodology. Along with my growing understanding and awareness about realist methodology, I came to realise that it is the epistemological position that sits most comfortably with me as a researcher. Additionally, the possibility for generative understanding on causality and its recognition and transparency, by stating programmes are not universally successful, and work better in some settings than others, also fascinated me and led me to take a realist approach to my study.

As a logic review, the ability to use multiple sources of literature (including grey literature) has helped to me develop programme theories related to the programme under study and this would have been a challenging task for using evidential hierarchy as prescribed in systematic review. This was especially important, considering the limited number of studies that took place in AIMHUs (Waldemar et al., 2018). However, as the sole researcher, I found the iterative process of the RS very time-consuming. On the other hand, the interview has helped to confirm where the piece of evidence from the RS fits into the CMO configuration. Additionally, the allowance for speculative work during the RS (Pawson et al., 2004) has given me some liberty to use my clinical experience.

8:11 Chapter summary

Studies addressing the role of service users to be involved in developing ROCP in AIMHUs are limited; however, results from previous studies indicate that service users are marginalised from developing ROCP. Programme theories articulated by this study have highlighted these challenges are caused by the complex interaction of multiple contextual elements within a multi-layered open system and have offered pragmatic recommendations to promote and embed an active role for service users in developing ROCP and suggested areas for future studies.

Appendices

Appendix 1: References

Abrahamson, V., Zhang, W., Wilson, P., Farr, W., & Male, I. (2020). Realist Evaluation of Autism ServiCe Delivery (RE-ASCeD): which diagnostic pathways work best, for whom and in what context? Protocol for a rapid realist review. *BMJ open*, *10*(7), e037846. https://doi.org/10.1136/bmjopen-2020-037846

Abrams, R., Park, S., Wong, G., Rastogi, J., Boylan, A. M., Tierney, S., Petrova, M., Dawson, S., & Roberts, N. (2021). Lost in reviews: Looking for the involvement of stakeholders, patients, public and other non-researcher contributors in realist reviews. *Research synthesis methods*, *12*(2), 239–247. https://doi.org/10.1002/jrsm.1459

ACAPS. (2016). Logical reasoning in humanitarian analysis. Brief summary. [Online]. Available from: https://www.acaps.org/sites/acaps/files/resources/files/acaps_technical_brief_logical_reasoning_in_humanitarian_analysis_april_2016.pdf [Accessed on 25 September 2019].

Alvarado, N. (2013). The LoTS (Longer-Term Stroke) care system of care: An evaluation of its local implementation at two community stroke services. (PhD thesis, University of Leeds, Leeds, United Kingdom). Retrieved from: https://etheses.whiterose.ac.uk/5413/

Angus, J. E., & Clark, A. M. (2012). Using critical realism in nursing and health research: promise and challenges. *Nursing inquiry*, *19*(1), 1–3. https://doi.org/10.1111/j.1440-1800.2011.00580.x

Anthony, P., & Crawford, P. (2000). Service user involvement in care planning: the mental health nurse's perspective. *Journal of psychiatric and mental health nursing*, *7*(5), 425–434. https://doi.org/10.1046/j.1365-2850.2000.00332.x

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal,* *16*(4), 11–23. https://doi.org/10.1037/h0095655

Archer, M., Bhaskar, R., & Collier, A. (1998). *Critical Realism: Essential Readings*, London: Routledge.

Armond, J. R. & Armond, A. D. (1985) Patients' attitude to multi-disciplinary psychiatric assessments. *British Journal of Clinical and Social Psychiatry*, 3, 36–41.

Armstrong, C., & Thompson, S. (2009). Parity of Participation and the Politics of Status. *European Journal of Political Theory*, *8*(1), 109–122. https://doi.org/10.1177/1474885108096963

Armstrong, C., & Thompson, S. (2009). Parity of Participation and the Politics of Status. *European Journal of Political Theory*, *8*(1), 109–122. https://doi.org/10.1177/1474885108096963

Arnstein, S.R. (1969). A ladder of citizen participation. *Journal of the American Institute of Planners,* 35: 216–224. DOI: 10.1080/01944366908977225

Asad, S., & Chreim, S. (2016). Peer Support Providers' Role Experiences on Interprofessional Mental Health Care Teams: A Qualitative Study. *Community mental health journal*, *52*(7), 767–774. https://doi.org/10.1007/s10597-015-9970-5

Aston, V., & Coffey, M. (2012). Recovery: what mental health nurses and service users say about the concept of recovery. *Journal of psychiatric and mental health nursing*, *19*(3), 257–263. https://doi.org/10.1111/j.1365-2850.2011.01776.x

Australian Government. (2013). National Practice Standards for the Mental Health Workforce. Australia: Australian Government [Online]. Available from: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-wkstd13-toc: [Accessed on 30 October 2021].

Awty, P., Welch, A., & Kuhn, L. (2010). A naturalistic inquiry of registered nurses' perspectives and expectations of psychodynamic therapeutic care in acute psychiatric inpatient facilities. *Archives of psychiatric nursing*, *24*(2), 104–113. https://doi.org/10.1016/j.apnu.2009.05.001

Ballantyne, H. (2016). Developing nursing care plans. *Nursing standard (Royal College of Nursing (Great Britain) : 1987)*, *30*(26), 51–60. https://doi.org/10.7748/ns.30.26.51.s48

Ballesteros-Urpi, A., Slade, M., Manley, D., & Pardo-Hernandez, H. (2019). Conceptual framework for personal recovery in mental health among children and adolescents: a systematic review and narrative synthesis protocol. *BMJ open*, 9(8), e029300. https://doi.org/10.1136/bmjopen-2019-029300

Banonis, B. C. (1989). The lived experience of recovering from addiction: A phenomenological investigation, *Nursing Science Quarterly*, 2(1): 37 – 42.

Barker, P. (2001). The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of psychiatric and mental health nursing*, *8*(3), 233–240. https://doi.org/10.1046/j.1365-2850.2001.00391.x

Basit, T. N. (2003). Manual or electronic? The role of coding in qualitative data analysis. *Educational Research*, 45(2): 143 – 154.

Bee, P. E., Richards, D. A., Loftus, S. J., Baker, J. A., Bailey, L., Lovell, K., Woods, P., & Cox, D. (2006). Mapping nursing activity in acute inpatient mental healthcare settings. *Journal of Mental Health, 15(2)*, 217-226. https://doi.org/10.1080/09638230600608941

Bee, P., Playle, J., Lovell, K., Barnes, P., Gray, R. and Keeley, P. (2008). Service user views and expectations of UK-registered mental health nurses: A systematic review of empirical research. *International Journal of Nursing Studies*, 45(3), 442–457.

Bee, P., Price, O., Baker, J., & Lovell, K. (2015a). Systematic synthesis of barriers and facilitators to service user-led care planning. The British Journal of Psychiatry, 207(2), 104–114

Bee, P., Brooks, H., Fraser, C. and Lovell, K. (2015b). Professional perspectives on service user and carer involvement in mental health care planning: A qualitative study. *International Journal of Nursing Studies*, 52(12),1834–1845.

Beebe L. H. (2010). What community living problems do persons with schizophrenia report during periods of stability?. *Perspectives in psychiatric care*, *46*(1), 48–55. https://doi.org/10.1111/j.1744-6163.2009.00237.x

Bennetts, W., Cross, W., & Bloomer, M. (2011). Understanding consumer participation in mental health: Issues of power and change. *International journal of mental health nursing*, *20*(3), 155–164. https://doi.org/10.1111/j.1447-0349.2010.00719.x

Berg, A., & Hallberg, I. R. (2000). Psychiatric nurses' lived experiences of working with inpatient care on a general team psychiatric ward. *Journal of psychiatric and mental health nursing*, *7*(4), 323–333. https://doi.org/10.1046/j.1365-2850.2000.00307.x

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bergin, M., Wells, J. S., & Owen, S. (2008). Critical realism: a philosophical framework for the study of gender and mental health. *Nursing philosophy: an international journal for healthcare professionals*, *9*(3), 169–179. https://doi.org/10.1111/j.1466-769X.2008.00358.x

Bernard, H. R. and Ryan, G. W. (2010). *Analysing qualitative data: Systematic approaches*. Thousand Oaks: Sage.

Bhaskar, R. (1975). *A realist theory of science*. Leeds: Leeds books.

Bhaskar, R. (1978). *A Realist Theory of Science*. Hertfordshire: The Harvester Press Limited.

Bhaskar, R. (1989). *Reclaiming reality: a critical introduction to contemporary philosophy,* London: Verso.

Bhaskar, R. (1998). Philosophy and Scientific realism. In Archer, M., Bhaskar, R., Collier, A., Lawson, T., & Norrie, A. (Eds), Critical realism: Essential Readings, 16-47. London: Routledge.

Bhaskar, R. (2008). *A realist theory of science*. New York, Routledge.

Bhaskar, R. (2014). Foreword. In Edwards, P. K., O'Mahoney, J. & Vincent, S. (Eds.), Studying organizations using critical realism: A practical guide (pp. 7) Oxford, UK: Oxford University Press.

Blamey, A., & Mackenzie, M. (2007). Theories of Change and Realistic Evaluation: Peas in a Pod or Apples and Oranges? *Evaluation*, *13*(4), 439–455. https://doi.org/10.1177/1356389007082129

Blue, G., Rosol, M., & Fast, V. (2019). Justice as parity of participation. *Journal of the American Planning Association*, 85(3), 363–376. https://doi.org/10.1080/01944363.2019.1619476

Boaz, A., Hanney, S., Borst, R., O'Shea, A., & Kok, M. (2018). How to engage stakeholders in research: design principles to support improvement. *Health research policy and systems*, *16*(1), 60. https://doi.org/10.1186/s12961-018-0337-6.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice,* *16*(3), 252–260. https://doi.org/10.1037/h0085885

Borgstrom, E. (2015). Advance care planning: between tools and relational end-of-life care?. *BMJ supportive & palliative care*, *5*(3), 216–217. https://doi.org/10.1136/bmjspcare-2015-000979

Bourdieu, P. (1986). The forms of capital. In: Richardson, J., *Handbook of Theory and Research for the Sociology of Education.* Westport, CT: Greenwood: 241–58.

Bourdieu, P. (1987). What makes a social class? On the theoretical and practical existence of groups. *Berkeley Journal of Sociology* 32: 1–17.http://www.jstor.org/stable/41035356

Bowers, L. (2005). Reasons for admission and their implications for the nature of acute inpatient psychiatric nursing. *Journal of psychiatric and mental health nursing*, *12*(2), 231–236. https://doi.org/10.1111/j.1365-2850.2004.00825.x

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A. and Warren, J. (2005). The nature and purpose of Acute Psychiatric Wards: The Tompkins Acute Ward Study. *Journal of Mental Health*, 14(6), 625-635. https://doi.org/10.1080/09638230500389105

Boylan, A-M., Tierney, S. and Mahtani, K. (2019). From patients to policymakers: widening stakeholder participation in research. National Institute for Health Research (NIHR). [Online]. Available from: https://www.spcr.nihr.ac.uk/news/blog/from-patients-to-policymakers-widening-stakeholder-participation-in-research [Accessed on 24 March 2021].

Bowersox, N. W., Bohnert, A. S., Ganoczy, D., & Pfeiffer, P. N. (2013). Inpatient psychiatric care experience and its relationship to posthospitalization treatment participation. *Psychiatric services (Washington, D.C.)*, *64*(6), 554–562. https://doi.org/10.1176/appi.ps.002342012

Boynton, P. M. (2005). *The Research Companion: A Practical Guide for the Social and Health Science*. Hove: Psychology press.

Bradshaw, A. (1976). A Critique of Steven Lukes' `Power: A Radical View'. Sociology, 10(1), 121–127. https://doi.org/10.1177/003803857601000109

Bradshaw P. L. (2008). Service user involvement in the NHS in England: genuine user participation or a dogma-driven folly?. *Journal of nursing management*, *16*(6), 673–681. https://doi.org/10.1111/j.1365-2834.2008.00910.x

Brand, S. L., Quinn, C., Pearson, M., Lennox, C., Owens, C., Kirkpatrick, T., Callaghan, L., Stirzaker, A., Michie, S., Maguire, M., Shaw, J., & Byng, R. (2019). Building programme theory to develop more adaptable and scalable complex interventions: Realist formative process evaluation prior to full trial. *Evaluation*, *25*(2), 149–170. https://doi.org/10.1177/1356389018802134

Beresford, P. (2003). User involvement in research: Exploring the challenges. *NT Research*, *8*(1), 36–46. https://doi.org/10.1177/136140960300800106

Broer, T., Nieboer, A. P., & Bal, R. (2014). Mutual powerlessness in client participation practices in mental health care. *Health expectations : an international journal of public participation in health care and health policy*, *17*(2), 208–219. https://doi.org/10.1111/j.1369-7625.2011.00748.x

Brooks, H., Sanders, C., Lovell, K., Fraser, C., & Rogers, A. (2015). Re-inventing care planning in mental health: stakeholder accounts of the imagined implementation of a user/carer involved intervention. *BMC health services research*, *15*, 490. https://doi.org/10.1186/s12913-015-1154-z

Brooks, H. L., Lovell, K., Bee, P., Sanders, C., & Rogers, A. (2018). Is it time to abandon care planning in mental health services? A qualitative study exploring the views of professionals, service users and carers. *Health expectations : an international journal of public participation in health care and health policy*, *21*(3), 597–605. https://doi.org/10.1111/hex.12650

Bryant, A., & Charmaz, K. (2007). *The SAGE Handbook of Grounded Theory*. Los Angeles: Sage.

Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? *Qualitative Research*, *6*(1), 97–113. https://doi.org/10.1177/1468794106058877

Buchbinder, E. (2011). Beyond Checking: Experiences of the Validation Interview. *Qualitative Social Work*, *10*(1), 106–122. https://doi.org/10.1177/1473325010370189

Butt, M. F., Walls, D., & Bhattacharya, R. (2019). Do patients get better? A review of outcomes from a crisis house and home treatment team partnership. *BJPsych bulletin*, *43*(3), 106–111. https://doi.org/10.1192/bjb.2018.105

Byng, R., Norman, I., & Redfern, S. (2005). Using Realistic Evaluation to Evaluate a Practice-level Intervention to Improve Primary Healthcare for Patients with Long-term Mental Illness. *Evaluation*, *11*(1), 69–93. https://doi.org/10.1177/1356389005053198

Byrne, L., Happell, B., & Reid-Searl, K. (2016). Lived experience practitioners and the medical model: world's colliding?. *Journal of mental health (Abingdon, England)*, *25*(3), 217–223. https://doi.org/10.3109/09638237.2015.1101428

Candela, A. G. (2019). Exploring the Function of Member Checking. *The Qualitative Report*, *24*(3), 619-628. https://doi.org/10.46743/2160-3715/2019.3726

Cappleman, R., Bamford, Z., Dixon, C., & Thomas, H. (2015). Experiences of ward rounds among in-patients on an acute mental health ward: a qualitative exploration. *BJPsych bulletin*, *39*(5), 233–236. https://doi.org/10.1192/pb.bp.113.046409

Care Quality Commission. (2015a). *Monitoring the Mental Health Act in 2014/15*. [Online]. Available from: https://www.cqc.org.uk/sites/default/files/20151207_mhareport2014-15_full.pdf [Accessed on 10 October 2016].

Care Quality Commission. (2015b). *Monitoring the Mental Health Act in 2013/14*. [Online] Available from: http://www.cqc.org.uk/sites/default/files/monitoring_the_mha_2013-14_report_web_0303.pdf.pdf [Accessed on 10 October 2016].

Care Quality Commission. (2017a). Involving people in decisions about their care (healthcare service). [Online]. Available from: Involving people in decisions about their care (healthcare services) | Care Quality Commission (cqc.org.uk) [Accessed on 15 June 2021].

Care Quality Commission. (2017b). The state of care in mental health services 2014 to 2017: Findings from CQC's programme of comprehensive inspections of specialist mental health services. [Online]. Available from: https://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf [Accessed on 27 November 2021].

Care Quality Commission. (2019). Monitoring the Mental Health Act in 2018/19. [Online]. Available from: https://webarchive.nationalarchives.gov.uk/20200516222734/https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-201819 [Accessed on 8 January 2021].

Care Quality Commission (2020). Monitoring the Mental Health Act in 2019/20 The Mental Health Act in the COVID-19 pandemic. [Online]. Available from: https://www.cqc.org.uk/sites/default/files/20201127_mhareport1920_report.pdf [Accessed on 8 January 2021].

Care service improvement partnership. (2007). A positive outlook: A good practice toolkit to improve discharge from inpatient mental health care. National institute for mental health in England. P.8-9.

Carlyle, D., Crowe, M., & Deering, D. (2012). Models of care delivery in mental health nursing practice: a mixed method study. *Journal of psychiatric and mental health nursing*, *19*(3), 221–230. https://doi.org/10.1111/j.1365-2850.2011.01784.x

Carolan, M. (2003). Reflexivity: a personal journey during data collection. *Nurse researcher*, *10*(3), 7–14. https://doi.org/10.7748/nr2003.04.10.3.7.c5892

Charmaz, K. (2006). *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis.* London: SAGE Publications Ltd.

Chenail, R. J. (2011). Interviewing the Investigator: Strategies for Addressing Instrumentation and Researcher Bias Concerns in Qualitative Research. The Qualitative Report, 16(1), 255-262. https://doi.org/ 10.46743/2160-3715/2011.1051

Chester, P., Ehrlich, C., Warburton, L., Baker, D., Kendall, E., & Crompton, D. (2016). "What is the work of Recovery Oriented Practice? A systematic literature review". *International journal of mental health nursing*, *25*(4), 270–285. https://doi.org/10.1111/inm.12241

Chinman, M. J., Allende, M., Weingarten, R., Steiner, J., Tworkowski, S., & Davidson, L. (1999). On the road to collaborative treatment planning: consumer and provider perspectives. *The journal of behavioral health services & research*, *26*(2), 211–218. https://doi.org/10.1007/BF02287492

Christie, L. (2016). Peer support roles in mental health services. Insights, 31 [Online]. Available at:

https://www.iriss.org.uk/resources/insights/peer-support-roles-mental-health-services [Accessed on 27 January 2021].

Clark, A. M., Lissel, S. L., & Davis, C. (2008). Complex critical realism: tenets and application in nursing research. *ANS. Advances in nursing science*, *31*(4), E67–E79. https://doi.org/10.1097/01.ANS.0000341421.34457.2a

Cleary, M. (2003). The challenges of mental health care reform for contemporary mental health nursing practice: relationships, power and control. *International journal of mental health nursing*, *12*(2), 139–147. https://doi.org/10.1046/j.1440-0979.2003.00280.x

Cleary, M. (2004). The realities of mental health nursing in acute inpatient environments. *International journal of mental health nursing*, *13*(1), 53–60. https://doi.org/10.1111/j.1447-0349.2004.00308.x

Cleary, M., Hunt, G. E., Walter, G., & Freeman, A. (2006). The patient's view of need and caregiving consequences: a cross-sectional study of inpatients with severe mental illness. *Journal of psychiatric and mental health nursing*, *13*(5), 506–514. https://doi.org/10.1111/j.1365-2850.2006.00972.x

Cleary, M., Hunt, G. E., Horsfall, J., & Deacon, M. (2012). Nurse-patient interaction in acute adult inpatient mental health units: a review and synthesis of qualitative studies. *Issues in mental health nursing*, *33*(2), 66–79. https://doi.org/10.3109/01612840.2011.622428

Cleary, M., Horsfall, J., O'Hara-Aarons, M., & Hunt, G. E. (2013). Mental health nurses' views of recovery within an acute setting. *International journal of mental health nursing*, *22*(3), 205–212. https://doi.org/10.1111/j.1447-0349.2012.00867.x

Clibbens, N., Harrop, D., & Blackett, S. (2018). Early discharge in acute mental health: A rapid literature review. *International journal of mental health nursing*, *27*(5), 1305–1325. https://doi.org/10.1111/inm.12515

Coatsworth-Puspoky, R., Forchuk, C., & Ward-Griffin, C. (2006). Peer support relationships: an unexplored interpersonal process in mental health. *Journal of psychiatric and mental health nursing*, *13*(5), 490–497. https://doi.org/10.1111/j.1365-2850.2006.00970.x

Coffey, M., Hannigan, B., Barlow, S. et al. (2019). Recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings: a cross national comparative mixed methods study. *BMC Psychiatry*, 19,115.

Coggan, A. (2017). 'Royal college warns bed shortage is "national crisis"'. [Online]. Available at: www.hsj.co.uk/humber-nhs-foundation-trust/royal-college-warns-bed-shortage-is-national-crisis/7020046.article [Accessed on 23 August 2017].

Cole, G. E. (1999). Advancing the Development and Application of Theory-based Evaluation in the Practice of Public Health. *American Journal of Evaluation*, *20*(3), 453–470. https://doi.org/10.1177/109821409902000305

Collier, A. (1994). *Critical realism: An introduction to Roy Bhaskar's philosophy*. London: Verso.

Collins, C. S. & Stockton, C. M. (2018). The Central Role of Theory in Qualitative Research, *International Journal of Qualitative Methods*, (17), p1–10. [Online]. Available from: https://journals.sagepub.com/doi/pdf/10.1177/1609406918797475 [Accessed on 28 January 2021].

Concannon, T. W., Meissner, P., Grunbaum, J. A., McElwee, N., Guise, J. M., Santa, J., Conway, P. H., Daudelin, D., Morrato, E. H., & Leslie, L. K. (2012). A new taxonomy for stakeholder engagement in patient-centered outcomes research. *Journal of general internal medicine*, *27*(8), 985–991. https://doi.org/10.1007/s11606-012-2037-1

Cooper, C., Lhussier, M., & Carr, S. (2020). Blurring the boundaries between synthesis and evaluation. A customized realist evaluative synthesis into adolescent risk behaviour prevention. *Research synthesis methods*, *11*(3), 457–470. https://doi.org/10.1002/jrsm.1407

Corner, J. (1991). In search of more complete answers to research questions. Quantitative versus qualitative research methods: is there a way forward?. *Journal of advanced nursing*, *16*(6), 718–727. https://doi.org/10.1111/j.1365-2648.1991.tb01730.x

Corrigan P. W. (2006). Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities. *Psychiatric services (Washington, D.C.)*, *57*(10), 1493–1496. https://doi.org/10.1176/ps.2006.57.10.1493

Coup, A. & Schneider, Z. (2007). Ethical and legal issues in research. In: Schneider, Z., Whitehead, D., Elliott, D., LoBiondo-Wood, G. and Haber, J. eds. *Nursing & Midwifery Research. London:* Mosby Elsevier, pp. 80-101.

Crisp, N., Smith, G., & Nicholson K. (2016). Old problems, new solutions – improving acute psychiatric Care for Adults in England. The commission on acute adult psychiatric care; 2016. [Online]. Available from: http://www.rcpsych.ac.uk/pdf/Old_Problems_New_Solutions_CAAPC_Report_England.pdf [Accessed on 23 July 2020].

Crotty, M. (1998). *The Foundations of Social Research: Meaning and Perspective in the Research Process.* Thousand Oaks: SAGE Publications.

Crotty, M. (2004). *The foundations of social research: meaning and perspective in the research process.* London: SAGE.

Cruickshank, J. (2012). Positioning positivism, critical realism and social constructionism in the health sciences: a philosophical orientation. *Nursing inquiry*, *19*(1), 71–82. https://doi.org/10.1111/j.1440-1800.2011.00558.x

Cunningham, U., De Brún, A., & McAuliffe, E. (2020). Application of the critical incident technique in refining a realist initial programme theory. *BMC medical research methodology*, *20*(1), 131. https://doi.org/10.1186/s12874-020-01016-9

Cunningham, U., Ward, M. E., De Brún, A., & McAuliffe, E. (2018). Team interventions in acute hospital contexts: a systematic search of the literature using realist synthesis. *BMC health services research*, *18*(1), 536. https://doi.org/10.1186/s12913-018-3331-3

Currid, T. (2009). Experiences of stress among nurses in acute mental health settings. *Nursing standard (Royal College of Nursing (Great Britain): 1987)*, *23*(44), 40–46. https://doi.org/10.7748/ns2009.07.23.44.40.c7108

Curtis, L. C., Wells, S. M., Penney, D. J., Ghose, S. S., Mistler, L. A., Mahone, I. H., Delphin-Rittmon, M., del Vecchio, P., & Lesko, S. (2010). Pushing the envelope: shared decision making in mental health. *Psychiatric rehabilitation journal*, *34*(1), 14–22. https://doi.org/10.2975/34.1.2010.14.22

Cusack, E., Killoury, F., & Nugent, L. E. (2017). The professional psychiatric/mental health nurse: skills, competencies and supports required to adopt recovery-orientated policy in practice. *Journal of psychiatric and mental health nursing*, *24*(2-3), 93–104. https://doi.org/10.1111/jpm.12347

Cutcliffe, J. R., Santos, J. C., Kozel, B., Taylor, P., & Lees, D. (2015). Raiders of the Lost Art: A review of published evaluations of inpatient mental health care experiences emanating from the United Kingdom, Portugal, Canada, Switzerland, Germany and Australia. *International journal of mental health nursing*, 24(5), 375–385. https://doi.org/10.1111/inm.12159.

Cypress, B. S. (2017). Rigor or Reliability and Validity in Qualitative Research: Perspectives, Strategies, Reconceptualization, and Recommendations. *Dimensions of critical care nursing: DCCN*, *36*(4), 253–263. https://doi.org/10.1097/DCC.0000000000000253

Dahlqvist Jönsson, P., Schön, U. K., Rosenberg, D., Sandlund, M., & Svedberg, P. (2015). Service users' experiences of participation in decision making in mental health services. *Journal of psychiatric and mental health nursing*, *22*(9), 688–697. https://doi.org/10.1111/jpm.12246

Dalkin, S.M., Greenhalgh, J., Jones, D, Cunningham, B. and Lhussier, M. (2015) What's in a mechanism? Development of a key concept in realist evaluation. *Implementation Science,* 10 (1), 49.

Dalton-Locke, C., Johnson, S., Harju-Seppänen, J., Lyons, N., Sheridan Rains, L., et al. (2021). Emerging models and trends in mental health crisis care in England: a national investigation of crisis care systems. *BMC health services research*, *21*(1), 1174. https://doi.org/10.1186/s12913-021-07181-x

Danermark, B., Ekstrom, M., Jakobsen, L. and Karlsson, J.C. (2002). *Explaining Society: Critical Realism in the Social Sciences.* Trowbridge: Taylor & Francis Books Ltd.

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *11*(2), 123–128. https://doi.org/10.1016/j.wpsyc.2012.05.009

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. Clinical Psychology: Science and Practice, 6(2), 165–187. https://doi.org/10.1093/clipsy.6.2.165

Davidson, L., Lawless, M. S., & Leary, F. (2005). Concepts of recovery: competing or complementary?. *Current opinion in psychiatry*, *18*(6), 664–667. https://doi.org/10.1097/01.yco.0000184418.29082.0e

Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric services (Washington, D.C.)*, *57*(5), 640–645. https://doi.org/10.1176/ps.2006.57.5.640

De las Cuevas, C., Rivero-Santana, A., Perestelo-Pérez, L., Pérez-Ramos, J., & Serrano-Aguilar, P. (2012). Attitudes toward concordance in psychiatry: a comparative, cross-sectional study of psychiatric patients and mental health professionals. *BMC psychiatry*, *12*, 53. https://doi.org/10.1186/1471-244X-12-53

Davies, K., Gray, M., & Webb, S. (2014). Putting the parity into service user participation: An Integrated model of social justice. *International Journal of Social Welfare*, *23(2),* 119-127. https://doi.org/10.1111/ijsw.12049

Dawson, L., River, J., McCloughen, A., & Buus, N. (2021). 'Should it fit? Yes. Does it fit? No': Exploring the organisational processes of introducing a recovery-oriented approach to mental health in Australian private health care. *Health (London, England: 1997)*, *25*(3), 376–394. https://doi.org/10.1177/1363459319889107

Deegan, P. E., & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. *Psychiatric services (Washington, D.C.)*, *57*(11), 1636–1639. https://doi.org/10.1176/ps.2006.57.11.1636

Delaney, K. R., & Johnson, M. E. (2014). Metasynthesis of research on the role of psychiatric inpatient nurses: what is important to staff?. *Journal of the American Psychiatric Nurses Association*, *20*(2), 125–137. https://doi.org/10.1177/1078390314527551

Denzin, N. K. (1989). *The research act: A theoretical introduction to sociological methods*. 3rd edn. New Jersey: Prentice Hall.

Department of Health. (1990). *The NHS and the Community Care Act*. London: HMSO.

Department of Health. (1990). *The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services. HC (90)23/LASSL (90)11.* Joint Health and Social Services Circular: DoH.

Department of Health. (1999). *National Service Framework for Mental Health*. London: HMSO.

Department of Health. (2000). *The NHS Plan. A plan for investment. A plan for reform*. London: HMSO.

Department of Health. (2001). *The Journey to Recovery: The Government's Vision for Mental Health Care*. London: HMSO.

Department of Health. (2002). *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*. London: HMSO.

Department of health. (2003). *Strengthening Accountability – Involving Patients and the Public Practice Guidance: section 11 of the Health and Social Care Act 2001*. London: HMSO.

Department of Health. (2007). *Mental health: new ways of working for everyone; developing and sustaining a capable and flexible workforce*. London: HMSO

Department of Health. (2008). *Refocusing the care Programme approach: policy and positive practice guidance.* London: HMSO.

Department of Health. (2009a). *New Horizons: A Shared Vision for Mental Health*. London: HMSO.

Department of Health. (2009b). *Supporting People with Long Term Conditions. Commissioning Personalised Care Planning: A Guide for Commissioners*. London: HMSO.

Department of Health. (2009c). *Achieving world class productivity in the NHS 2009/10–2013/14.* London: HMSO.

Department of Health. (2011). *No Health Without Mental Health: A Cross government Mental Health Outcomes Strategy for People of All Ages*. London: HMSO.

Department of Health. (2012a). *No decision about me without me*. London: HMSO.

Department of Health. (2012b). *Care Planning in the Treatment of Long-Term Conditions: Final Report of the CAPITOL Project.* [Online]. Available from:

http://hrep.lshtm.ac.uk/publications/Care%20planning_final_Bower%20et%20al_7%20Mar%2013.pdf [Accessed on 30 July 2021].

Department of Health. (2013). *Health Building Note 03-01: Adult acute mental health units*. [Online]. Available from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_03-01_Final.pdf [Accessed on 15 April 2021].

Department of Health. (2014a). *Closing the Gap: Priorities for essential change in mental health*. London: HMSO.

Department of Health. (2014b). *Achieving Better Access to Mental Health Services by 2020*. London: HMSO.

Department of Health. (2014c). *Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis*. London: HMSO.

Department of Health. (2015). *Mental Health Act 1983: Code of Practice*. London: HMSO.

Department of Health. (2018). *Modernising the Mental Health Act Increasing choice, reducing compulsion Final report of the Independent Review of the Mental Health Act 1983*. London. HMSO.

Department of Health. (2019). *The NHS long term plan.* [Online]. Available from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [Accessed on 15 June 2021].

Deverka, P. A., Lavallee, D. C., Desai, P. J., Esmail, L. C., Ramsey, S. D., Veenstra, D. L., & Tunis, S. R. (2012). Stakeholder participation in comparative effectiveness research: defining a framework for effective engagement. *Journal of comparative effectiveness research*, *1*(2), 181–194. https://doi.org/10.2217/cer.12.7

Diamond, B., Parkin, G., Morris, K., Bettinis, J., & Bettesworth, C. (2003). User involvement: Substance or spin? *Journal of Mental Health, 12*(6), 613–626. https://doi.org/10.1080/09638230310001627964

Dilks, S., Tasker, F., & Wren, B. (2013). Conceptualizing the therapist's role in therapy in psychosis. *Psychology and psychotherapy*, *86*(3), 315–333. https://doi.org/10.1111/j.2044-8341.2011.02061.x

Docherty, M., & Thornicroft, G. (2015). Specialist mental health services in England in 2014: overview of funding, access and levels of care. *International journal of mental health systems*, *9*, 34. https://doi.org/10.1186/s13033-015-0023-9

Dodd, S. J. & Epstein, I. (2012). *Practice-based research in social work: A guide for reluctant researchers*. London: Routledge.

Dodgson J. E. (2019). Reflexivity in Qualitative Research. *Journal of human lactation : official journal of International Lactation Consultant Association*, *35*(2), 220–222. https://doi.org/10.1177/0890334419830990

Dowding, K. (2006). Three-Dimensional Power: A Discussion of Steven Lukes' Power: A Radical View. *Political Studies Review*, 4(2), 136–145. https://doi.org/10.1111/j.1478-9299.2006.000100.x

Doyle, S. (2007). Member checking with older women: a framework for negotiating meaning. *Health care for women international*, *28*(10), 888–908. https://doi.org/10.1080/07399330701615325

Drummond, C., & Simpson, A. (2017). 'Who's actually gonna read this?' An evaluation of staff experiences of the value of information contained in written care plans in supporting care in three different dementia care settings. *Journal of psychiatric and mental health nursing*, *24*(6), 377–386. https://doi.org/10.1111/jpm.12380

Dunne, E.A. (2006). The views of adult users of the Public Sector Mental Health Services. The Mental Health Commission. [Online]. Available at: www.mhcirl.ie/File/viewsadultspublic.pdf [Accessed on 11 February 2020].

Eastwood, J. G., Jalaludin, B. B., & Kemp, L. A. (2014). Realist explanatory theory building method for social epidemiology: a protocol for a mixed method multilevel study of neighbourhood context and postnatal depression. *SpringerPlus*, *3*, 12. https://doi.org/10.1186/2193-1801-3-12

Ebenso, B., Manzano, A., Uzochukwu, B., Etiaba, E., Huss, R., Ensor, T., Newell, J., Onwujekwe, O., Ezumah, N., Hicks, J., & Mirzoev, T. (2019). Dealing with context in logic model development: Reflections from a realist evaluation of a community health worker programme in Nigeria. *Evaluation and program planning*, *73*, 97–110. https://doi.org/10.1016/j.evalprogplan.2018.12.002

Elder-Vass D. (2004). *Re-Examining Bhaskar's Three Ontological Domains: The Lessons from Emergence*. Paper presented at IACR Conference, Cambridge August 2004, UK.[Online]. Available at: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.508.2850&rep=rep1&type=pdf [Accessed on 7 September 2018].

Eliacin, J., Salyers, M. P., Kukla, M., & Matthias, M. S. (2015). Patients' understanding of shared decision making in a mental health setting. *Qualitative health research*, *25*(5), 668–678. https://doi.org/10.1177/1049732314551060

Engamba, S. A., Steel, N., Howe, A., & Bachman, M. (2019). Tackling multimorbidity in primary care: is relational continuity the missing ingredient?. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *69*(679), 92–93. https://doi.org/10.3399/bjgp19X701201

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A., & Barry, M. (2012). Shared decision making: a model for clinical practice. *Journal of general internal medicine*, *27*(10), 1361–1367. https://doi.org/10.1007/s11606-012-2077-6

Emmel, N. (2013). *Sampling and Choosing Cases in Qualitative Research: A Realist Approach*. London: SAGE.

Essex, B., Doig, R., & Renshaw, J. (1990). Pilot study of records of shared care for people with mental illnesses. *BMJ (Clinical research ed.)*, *300*(6737), 1442–1446. https://doi.org/10.1136/bmj.300.6737.1442

Evans, D., Hopewell-Kelly, N., Kok, M., & White, J. (2018). Synthesising conceptual frameworks for patient and public involvement in research - a critical appraisal of a meta-narrative review. *BMC medical research methodology*, *18*(1), 116. https://doi.org/10.1186/s12874-018-0572-0

Ewertzon, M., Cronqvist, A., Lützén, K., & Andershed, B. (2012). A lonely life journey bordered with struggle: being a sibling of an individual with psychosis. *Issues in mental health nursing*, *33*(3), 157–164. https://doi.org/10.3109/01612840.2011.633735

Farrelly, S., Brown, G., Rose, D., Doherty, E., Henderson, R. C., Birchwood, M., Marshall, M., Waheed, W., Szmukler, G., & Thornicroft, G. (2014). What service users with psychotic disorders want in a mental health crisis or relapse: thematic analysis of joint crisis plans. *Social psychiatry and psychiatric epidemiology*, *49*(10), 1609–1617. https://doi.org/10.1007/s00127-014-0869-1

Favod, J. (1993) 'Taking Back Control', *Nursing Times,* 89, pp. 68-70.

Fawcett, J. (2000). *Analysis and evaluation of contemporary nursing knowledge: Nursing theories and models*. Philadelphia: Davis.

Fern, E. F. (1982). Focus groups: a review of some contradictory evidence, implications, and suggestions for future research. *Advances in Consumer Research, 10(1),* 121-126.

Fiddler, M., Borglin, G., Galloway, A., Jackson, C., McGowan, L., & Lovell, K. (2010). Once-a-week psychiatric ward round or daily inpatient team meeting? A multidisciplinary mental health team's experience of new ways of working. *International journal of mental health nursing*, *19*(2), 119–127. https://doi.org/10.1111/j.1447-0349.2009.00652.x

Fisher, P. & Freshwater, D. (2014). An Emancipatory Approach to Practice and Qualitative Inquiry in Mental Health: Finding 'Voice in Charles Taylor's Ethic of Identity, *Ethics and Social Welfare*, doi 10.1080/17496535.2014.884611

Fisher, P. (2016). Co-production: what is it and where do we begin?. *Journal of psychiatric and mental health nursing*, *23*(6-7), 345–346. https://doi.org/10.1111/jpm.12281

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology: Theory & Practice, 20*(2), 181–194. https://doi.org/10.1080/13645579.2016.1144401

Foot, C., Gilburt, H., Dunn, P., JabbalJ, J. et al. (2014), People in control of their own health and care. The state of involvement. King's Fund publication. [Online]. Available from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/people-in-control-of-their-own-health-and-care-the-state-of-involvement-november-2014.pdf [Accessed on 22 January 2021].

Forchuk, C., Jewell, J., Tweedell, D., & Steinnagel, L. (2003). Role changes experienced by clinical staff in relation to clients' recovery from psychosis. *Journal of psychiatric and mental health nursing*, *10*(3), 269–276. https://doi.org/10.1046/j.1365-2850.2003.00556.x

Fourie, W. J., McDonald, S., Connor, J., & Bartlett, S. (2005). The role of the registered nurse in an acute mental health inpatient setting in New Zealand: perceptions versus reality. *International journal of mental health nursing*, *14*(2), 134–141. https://doi.org/10.1111/j.1440-0979.2005.00370.x

Foucault, M. (1973). *The birth of the clinic: an archaeology of medical perception*. London: Tavistock

Foucault, M. (1978): *History of Sexuality: An Introduction*. New York: Trans. Hurley, Robert. Random House Inc.

Foucault, M. (1982). The subject and power. *Critical Inquiry*, 8 (4), p777–795.

Foucault, M. (1991). *Discipline and Punish*. London: Penguin.

Foucault, M. (1995). *Discipline and punish: The birth of the prison* (Translated by Sheridan, A.), New York: Vintage Books.

Foucault, M. (2001). *Madness and civilization: history of insanity in the age of reason*. London: Routledge Classic.

Fraser, N. (1985). “What's critical about critical theory? The case of Habermas and gender,” *New German Critique*, 35 (Spring-Summer): 97–131.

Fraser, N. (1989a). Talking about Needs: Interpretive Contests as Political Conflicts in Welfare-State Societies. *The University of Chicago Press Journals,* 99 (2), pp. 291-313.

Fraser, N. (1989b). *Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory*. Minneapolis, MN: University of Minnesota Press.

Fraser, N. (1990). Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy. *Social Text*, 25/26, 56–80. https://doi.org/10.2307/466240

Fraser N. (1997). *Rethinking the public sphere: a contribution to the critique of actually existing democracy.* In: Fraser N, editor. Justice interruptus: critical reflections on the 'Postsocialist' condition. London: Routledge; 1997. p. 69–98.

Fraser, N. (2009). Reframing justice in a globalizing world. *Lua Nova: Revista de Cultura e Política*, 11-39.

Galbraith, J., K. (1983). *The Anatomy of Power*. Boston: Houghton Mifflin.

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology*, *13*, 117. https://doi.org/10.1186/1471-2288-13-117

Gartner, A. J., & Riessman, F. (1982). Self-help and mental health. *Hospital & Community Psychiatry, 33*(8), 631–635.

General Data Protection Regulation (GDPR) (2018)Guide to the General Data Protection Regulation (GDPR) [Online] Available at: https://ico.org.uk/media/for-organisations/guide-to-the-general-data-protection-regulation-gdpr-1-0.pdf [Accessed on 7 August 2018].

General Medical council (GMC). (2019) Good Medical practice. The duties of a doctor registered with the General Medical Council. [Online] Available from: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/duties-of-a-doctor [Accessed on 2 December 2019].

Gerrish, K. and Lacey, A. (2010). *The Research Process in Nursing*. 6th Edn. Oxford: Willey–Blackwell.

Gibbons, P. J. (2017). Collaborative Care Planning: Introduction to an innovative approach to Care Planning in Adult Mental Health. *International Journal of Integrated Care*, 17(5), A479. DOI: http://doi.org/10.5334/ijic.3799

Gibson, A., Britten, N., & Lynch, J. (2012). Theoretical directions for an emancipatory concept of patient and public involvement. *Health (London, England: 1997)*, *16*(5), 531–547. https://doi.org/10.1177/1363459312438563

Gibson, A., Welsman, J., & Britten, N. (2017). Evaluating patient and public involvement in health research: from theoretical model to practical workshop. *Health expectations: an international journal of public participation in health care and health policy*, *20*(5), 826–835. https://doi.org/10.1111/hex.12486

Gilburt, H. (2015). Briefing: Mental Health Under Pressure. London: The King's Fund. [Online]. Available from: https://www.kingsfund.org.uk/publications/mental-health-under-pressure [Accessed on 20 November 2019].

Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC health services research*, *8*, 92. https://doi.org/10.1186/1472-6963-8-92

Gilburt, H., Slade, M., Bird, V. Oduola, S. et al. (2013). Promoting recovery-oriented practice in mental health services: a quasi-experimental mixed-methods study. *BMC Psychiatry* **13,** 167. https://doi.org/10.1186/1471-244X-13-167.

Gillard, S. G., Edwards, C., Gibson, S. L., Owen, K., & Wright, C. (2013). Introducing peer worker roles into UK mental health service teams: a qualitative analysis of the organisational benefits and challenges. *BMC health services research*, *13*, 188. https://doi.org/10.1186/1472-6963-13-188

Glick, I. D., Sharfstein, S. S., & Schwartz, H. I. (2011). Inpatient psychiatric care in the 21st century: the need for reform. *Psychiatric services (Washington, D.C.)*, *62*(2), 206–209. https://doi.org/10.1176/ps.62.2.pss6202_0206

Godin, K., Stapleton, J., Kirkpatrick, S. I., Hanning, R. M., & Leatherdale, S. T. (2015). Applying systematic review search methods to the grey literature: a case study examining guidelines for school-based breakfast programs in Canada. *Systematic reviews*, *4*, 138. https://doi.org/10.1186/s13643-015-0125-0

Goldsmith, L. P., Anderson, K., Clarke, G., Crowe, C., Jarman, H., Johnson, S., Lloyd-Evans, et al. (2021). The psychiatric decision unit as an emerging model in mental health crisis care: a national survey in England. *International journal of mental health nursing*, *30*(4), 955–962. https://doi.org/10.1111/inm.12849

Goodman, D., Ogrinc, G., Davies, L., Baker, G. R., Barnsteiner, J., Foster, T. C., et al. (2016). Explanation and elaboration of the SQUIRE (Standards for Quality Improvement Reporting Excellence) Guidelines, V.2.0: examples of SQUIRE elements in the healthcare improvement literature. *BMJ quality & safety*, *25*(12), e7. https://doi.org/10.1136/bmjqs-2015-004480

Goodwin, V., & Happell, B. (2006). In our own words: consumers' views on the reality of consumer participation in mental health care. *Contemporary nurse*, *21*(1), 4–13. https://doi.org/10.5172/conu.2006.21.1.4

Goodwin, V., & Happell, B. (2008). Psychiatric nurses' attitudes toward consumer and carer participation in care: part 2--barriers to participation. *Policy, politics & nursing practice*, *9*(4), 249–256. https://doi.org/10.1177/1527154408316064

Gould, D. (2012). Service users' experiences of recovery under the 2008 Care Programme Approach - A research study (Executive summary). [Online]. Available from: https://www.nsun.org.uk/Handlers/Download.ashx?IDMF=eca08b2c-708b-4a42-b601-92915b8f0683 [Accessed on 8 November 2019].

Green, M. L., & Ruff, T. R. (2005). Why do residents fail to answer their clinical questions? A qualitative study of barriers to practicing evidence-based medicine. *Academic medicine: journal of the Association of American Medical Colleges*, *80*(2), 176–182. https://doi.org/10.1097/00001888-200502000-00016

Greener, I. (2011). *Designing Social Research-A Guide For The Bewildered*. London: Sage.

Greenhalgh, J., Gooding, K., Gibbons, E., Dalkin, S., Wright, J., Valderas, J., & Black, N. (2018). How do patient reported outcome measures (PROMs) support clinician-patient communication and patient care? A realist synthesis. *Journal of patient-reported outcomes*, *2*, 42. https://doi.org/10.1186/s41687-018-0061-6

Greenhalgh, T., & Papoutsi, C. (2018). Studying complexity in health services research: desperately seeking an overdue paradigm shift. *BMC medicine*, *16*(1), 95. https://doi.org/10.1186/s12916-018-1089-4

Greenhalgh, T., Hinton, L., Finlay, T., Macfarlane, A., Fahy, N., Clyde, B., & Chant, A. (2019). Frameworks for supporting patient and public involvement in research: Systematic review and co-design pilot. *Health expectations: an international journal of public participation in health care and health policy*, *22*(4), 785–801. https://doi.org/10.1111/hex.12888

Greenhalgh, T. (2014). *A realist synthesis of PROMs feedback to improve the care of individual patients* [Online] National Centre for Research Methods. University of Bath. 5 September 2016. Available from: https://www.ncrm.ac.uk/resources/video/?title=A%20realist%20synthesis%20of%20PROMS%20feedback%20to%20improve%20the%20care%20of%20individual%20patients [Accessed on 05 April 2017].

Groot, G., Waldron, T., Carr, T., McMullen, L., Bandura, L. A., Neufeld, S. M., & Duncan, V. (2017). Development of a program theory for shared decision-making: a realist review protocol. *Systematic reviews*, *6*(1), 114. https://doi.org/10.1186/s13643-017-0508-5

Grove, J. (2017). Researching a marginalised group: Reflections on being an outsider. *Counselling and Psychotherapy Research*, 17(3), 176–180. doi:10.1002/capr.12120

Grundy, A. C., Bee, P., Meade, O., Callaghan, P., Beatty, S., Olleveant, N., & Lovell, K. (2016). Bringing meaning to user involvement in mental health care planning: a qualitative exploration of service user perspectives. *Journal of psychiatric and mental health nursing*, *23*(1), 12–21. https://doi.org/10.1111/jpm.12275

Guba, E. and Lincoln, Y. (1989). *Fourth generation evaluation*. Thousand Oaks: Sage.

Guba, E. and Lincoln, Y. (1994). Competing paradigms in qualitative research. In: Denzin, N. K. and Lincoln, Y. S. ed. *Handbook of qualitative research*. Thousand Oaks: Sage. pp. 105-117.

Guba, E. and Lincoln, Y. (2004). Competing paradigms in qualitative research: Theories and issues. In: Hesse-Biber, S.N., and Leavy, P. eds. *Approaches to Qualitative Research: A reader on theory and practice*. Oxford: Oxford University press. pp. 17-38.

Gyamfi, N., Badu, E., Mprah, W. K., & Mensah, I. (2020). Recovery services and expectation of consumers and mental health professionals in community-based residential facilities of Ghana. *BMC psychiatry*, *20*(1), 355. https://doi.org/10.1186/s12888-020-02768-w

Habermas, J. (1978). *Knowledge and Human Interests*. London: Heinemann Educational.

Habermas, J. (1987). *The Theory of Communicative Action (Volume 2: Lifeworld and System)*. Cambridge: Polity Press.

Hallett, R. E. (2013). Dangers of member checking. In W. Midgley, P. A. Danaher, & M.Baguley (Eds.), *The role of participants in education research: Ethics, epistemologies, and methods*. (pp. 29-39). New York, NY: Routledge.

Hamann, J., Langer, B., Winkler, V., Busch, R., Cohen, R., Leucht, S., & Kissling, W. (2006). Shared decision making for in-patients with schizophrenia. *Acta psychiatrica Scandinavica*, *114*(4), 265–273. https://doi.org/10.1111/j.1600-0447.2006.00798.x

Hamilton, C. B., Hoens, A. M., Backman, C. L., McKinnon, A. M., McQuitty, S., English, K., & Li, L. C. (2018). An empirically based conceptual framework for fostering meaningful patient engagement in research. *Health expectations: an international journal of public participation in health care and health policy*, *21*(1), 396–406. https://doi.org/10.1111/hex.12635

Hammersley, M. (1992). *What's wrong with ethnography?* New York: Routledge.

Hashem, F., Brigden, C., Wilson, P., & Butler, C. (2020). Understanding what works, why and in what circumstances in hospice at home services for end-of-life care: Applying a realist logic of analysis to a systematically searched literature review. *Palliative medicine*, *34*(1), 16–31. https://doi.org/10.1177/0269216319867424.

Hauser, G. A. (1999). *Vernacular voices: The rhetoric of publics and public spheres*. University of South Carolina press, South Carolina, p61.

Health and Care Professional Council. (2018). *Standards of conduct, performance and ethics.* [Online] Available from: https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/ [Accessed on 2 December 2019].

Health Research Authority. (2017a). *UK policy framework for health and social care research.* London: The Stationary Office. [Online]. Available from: https://www.healthandcareresearch.gov.wales/uploads/Policy%20%26%20Strategy/Research%20Governance/uk-policy-framework-health-social-care-research.pdf [Accessed on 19 August 2018].

Health Research Authority. (2017b). *Approvals and amendments.* Health Research Authority [Online]. Available from: https://www.hra.nhs.uk/approvals-amendments/ [Accessed on 19 August 2018].

Hegedüs, A., Kozel, B., Fankhauser, N., Needham, I., & Behrens, J. (2018). Outcomes and feasibility of the short transitional intervention in psychiatry in improving the transition from inpatient treatment to the community: A pilot study. *International journal of mental health nursing*, *27*(2), 571–580. https://doi.org/10.1111/inm.12338

Hengartner, M. P., Klauser, M., Heim, G., Passalacqua, S., Andreae, A., Rössler, W., & von Wyl, A. (2017). Introduction of a Psychosocial Post-Discharge Intervention Program Aimed at Reducing Psychiatric Rehospitalization Rates and at Improving Mental Health and Functioning. *Perspectives in psychiatric care*, *53*(1), 10–15. https://doi.org/10.1111/ppc.12131

Hesse-Biber, S.N., and Leavy, P. (2004). Approaches to Qualitative Research: A reader on theory and practice. Oxford: Oxford University press.

Hewitt, G., Sims, S. J., & Harris, R. G. (2013). The realist approach to evaluation research: an introduction. *International Journal of Therapy and Rehabilitation*, 19(5), 250-260. doi.org/10.12968/ijtr.2012.19.5.250

Hewitt, G., Sims, S., & Harris, R. (2014). Using realist synthesis to understand the mechanisms of interprofessional teamwork in health and social care. *Journal of interprofessional care*, *28*(6), 501–506. https://doi.org/10.3109/13561820.2014.939744

Hickey, G. and Kipping, C. (1998). Exploring the concept of user involvement in mental health through a participation continuum. *Journal of Clinical Nursing,* 7(1), 83–88.

Highet, N., Thompson, M., & McNair, B. (2005). Identifying depression in a family member: the carers' experience. *Journal of affective disorders*, *87*(1), 25–33. https://doi.org/10.1016/j.jad.2005.02.016

Hodgson, R., Jamal, A., & Gayathri, B. (2005). A survey of ward round practice. Psychiatric Bulletin, 29(5), 171-173. doi:10.1192/pb.29.5.171

Holliday, R. C., Antoun, M., & Playford, E. D. (2005). A survey of goal-setting methods used in rehabilitation. *Neurorehabilitation and neural repair*, *19*(3), 227–231. https://doi.org/10.1177/1545968305279206

Holloway, I. and Todres, L. (2010). Grounded Theory. In K. Gerrish & A. Lacey (Eds.), *The research process in Nursing* (pp. 153-163). Oxford: Wiley-Blackwell.

Hopkins, J. E., Loeb, S. J., & Fick, D. M. (2009). Beyond satisfaction, what service users expect of inpatient mental health care: a literature review. *Journal of psychiatric and mental health nursing*, *16*(10), 927–937. https://doi.org/10.1111/j.1365-2850.2009.01501.x

Hornik-Lurie, T., Shalev, A., Haknazar, L., Garber Epstein, P., Ziedenberg-Rehav, L., & Moran, G. S. (2018). Implementing recovery-oriented interventions with staff in a psychiatric hospital: A mixed-methods study. *Journal of psychiatric and mental health nursing*, *25*(9-10), 569–581. https://doi.org/10.1111/jpm.12502

Hudon, C., Chouinard, M. C., Aubrey-Bassler, K., Muhajarine, N., Burge, F., Pluye, P et al. (2017). Case management in primary care among frequent users of healthcare services with chronic conditions: protocol of a realist synthesis. *BMJ open*, *7*(9), e017701. https://doi.org/10.1136/bmjopen-2017-017701

Hui, A., & Stickley, T. (2007). Mental health policy and mental health service user perspectives on involvement: a discourse analysis. *Journal of advanced nursing*, *59*(4), 416–426. https://doi.org/10.1111/j.1365-2648.2007.04341.x

Hussey, J. & Hussey, R. (1997). *Business Research, A Practice Guide for Undergraduate and Postgraduate Students*. Basingstoke: Macmillan Business.

Im, E. O. (2018). Theory Development Strategies for Middle-Range Theories. *ANS. Advances in nursing science*, *41*(3), 275–292. https://doi.org/10.1097/ANS.0000000000000215

Isobel, S. (2019). 'In some ways it all helps but in some ways it doesn't': The complexities of service users' experiences of inpatient mental health care in Australia. *International journal of mental health nursing*, *28*(1), 105–116. https://doi.org/10.1111/inm.12497

Jackson, E. (2013). Choosing a Methodology: Philosophical Underpinning, *Practitioner Research in Higher Educational Journal*, 7(1), 49-62.

Jacobson, N., Trojanowski, L., & Dewa, C. S. (2012). What do peer support workers do? A job description. *BMC health services research*, *12*, 205. https://doi.org/10.1186/1472-6963-12-205

Jaeger, M., Konrad, A., Rueegg, S., & Rabenschlag, F. (2015). Patients' subjective perspective on recovery orientation on an acute psychiatric unit. *Nordic journal of psychiatry*, *69*(3), 188–195. https://doi.org/10.3109/08039488.2014.959561

Jagosh, J., Macaulay, A. C., Pluye, P., Salsberg, J., Bush, P. L., Henderson, J., et al. (2012). Uncovering the benefits of participatory research: implications of a realist review for health research and practice. *The Milbank quarterly*, *90*(2), 311–346. https://doi.org/10.1111/j.1468-0009.2012.00665.x

Jagosh, J. (2019). Realist Synthesis for Public Health: Building an Ontologically Deep Understanding of How Programs Work, For Whom, and In Which Contexts. *Annual review of public health*, *40*, 361–372. https://doi.org/10.1146/annurev-publhealth-031816-044451

Jagosh, J. (2020). Retroductive theorizing in Pawson and Tilley's applied scientific realism. *Journal of Critical Realism*, *19*(2), 121-130. DOI: 10.1080/14767430.2020.1723301

Jagosh, J. (2021). RE. scoping review, [J. Jagosh, personal communication, June 29, 2021]

Jagosh, J., Pluye, P., Wong, G., Cargo, M., Salsberg, J., Bush, P. L., Herbert, C. P., et al. (2014). Critical reflections on realist review: insights from customizing the methodology to the needs of participatory research assessment. *Research synthesis methods*, *5*(2), 131–141. https://doi.org/10.1002/jrsm.1099

Jagosh, J., Pluye, P., Wong, G., Cargo, M., Salsberg, J., Bush, P. L., et al. (2014). Critical reflections on realist review: insights from customizing the methodology to the needs of participatory research assessment. *Research synthesis methods*, *5*(2), 131–141. https://doi.org/10.1002/jrsm.1099

Joint Commissioning Panel for Mental Health. (2013). Guidance for commissioners of acute care – inpatient and crisis home treatment; [Online]. Available from: http://www.jcpmh.info/good-services/acute-care-services/ [Accessed on January2020].

John T. (2017). Setting up recovery clinics and promoting service user involvement. *British journal of nursing (Mark Allen Publishing)*, *26*(12), 671–676. https://doi.org/10.12968/bjon.2017.26.12.671

Jones, A., & Crossley, D. (2008). In the mind of another shame and acute psychiatric inpatient care: an exploratory study. A report on phase one: service users. *Journal of psychiatric and mental health nursing*, *15*(9), 749–757. https://doi.org/10.1111/j.1365-2850.2008.01316.x

Jones, B. G. (2003). 'The Massive Presence of the Past and the Outside'. *Journal of Critical Realism*, 1:2, 35-60. DOI: 10.1558/jocr.v1i2.35

Jones, R. (2020). *Mental Health Act Manual*. 23rd Edn. London: Sweet & Maxwell.

Jørgensen, K., & Rendtorff, J. D. (2018). Patient participation in mental health care - perspectives of healthcare professionals: an integrative review. *Scandinavian journal of caring sciences*, *32*(2), 490–501. https://doi.org/10.1111/scs.12531

Julnes, G., Mark, M. M., & Henry, G. T. (1998). Review: Promoting Realism in Evaluation: Realistic Evaluation and the Broader Context. *Evaluation*, *4*(4), 483–504. https://doi.org/10.1177/13563899822208743

Keenan, G. M., Yakel, E., Tschannen, D., & Mandeville, M. (2008). Documentation and the Nurse Care Planning Process. In R. G. Hughes (Ed.), *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Agency for Healthcare Research and Quality (US).

Keogh, B., Callaghan, P., & Higgins, A. (2015). Managing preconceived expectations: mental health service users experiences of going home from hospital: a grounded theory study. *Journal of psychiatric and mental health nursing*, *22*(9), 715–723. https://doi.org/10.1111/jpm.12265

Kesting, S. (2005). “Countervailing, Conditioned, and Contingent-the Power Theory of John Kenneth Galbraith.” *Journal of Post Keynesian Economics*, 28 (1), 3–23. DOI: 10.1080/01603477.2005.11051470

Kidd, S. A., McKenzie, K., Collins, A., Clark, C., Costa, L., Mihalakakos, G., & Paterson, J. (2014a). Advancing the recovery orientation of hospital care through staff engagement with former clients of inpatient units. *Psychiatric services (Washington, D.C.)*, *65*(2), 221–225. https://doi.org/10.1176/appi.ps.201300054

Kidd, S. A., Mckenzie, K. J., & Virdee, G. (2014b). Mental health reform at a systems level: widening the lens on recovery-oriented care. *Canadian journal of psychiatry. Revue Canadienne de psychiatrie*, *59*(5), 243–249. https://doi.org/10.1177/070674371405900503

Klapowitz, M. D. (2000). Statistical analysis of sensitive topics in group and individual interviews. *Quality and Quantity*, 34, 419-431. https://doi.org/10.1023/A:1004844425448

Klein, A. R., Cnaan, R. A., & Whitecraft, J. (1998). Significance of Peer Social Support With Dually Diagnosed Clients: Findings From a Pilot Study. *Research on Social Work Practice*, *8*(5), 529–551. https://doi.org/10.1177/104973159800800503

Knight, P. T. (2002). *Small-Scale Research: Pragmatic Inquiry in Social Science and the Caring Professions*. London: Sage.

Koelsch, L. E. (2013). Reconceptualizing the Member Check Interview. *International Journal of Qualitative Methods*, 168–179. https://doi.org/10.1177/160940691301200105

Kontos, P.C., Miller K.-L., Mitchell G.J. & Cott C.A. (2011) Dementia care at the intersection of regulation and reflexivity: a critical realist perspective. *Journal of Gerontology*, 66B (1), 119–128.

Kosky, N., Mynors-Wallis, L., Fear, C., & Undrill, G. (2014). Service models in adult psychiatry. College Report-Royal College of Psychiatry. [Online]. Available from: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr188.pdf?sfvrsn=952427c6_2 [Accessed on 21 November 2021].

Kristensen, K. S. (2013). Michel Foucault on Bio-power and Biopolitics. [Online]. Available from: https://helda.helsinki.fi/bitstream/handle/10138/39514/Kristensen%20Masters%20Thesis.pdf?sequence=3 [Accessed on November 2021].

Krueger, R. A. & Casey, M. A. (2000). *Focus Groups: A Practical Guide for Applied Research*, 3rd edn. Thousand Oaks: Sage.

Kuhn, T. (1970). *The Structure of Scientific Revolutions*. 2nd ed. Chicago: University of Chicago Press.

Kumar, R. (2014). Research Methodology. 4th edn. London: SAGE publications.

Lagasnerie, G.D., Paris, V., Mueller, M., & Kumar, A. (2015). Tapering payments in hospitals: Experiences in OECD countries. [Online]. Available from: https://read.oecd-ilibrary.org/social-issues-migration-health/tapering-payments-in-hospitals_5js4h5rlkxxr-en#page9 [Accessed on 15 December 2020].

Laitila, M., Nummelin, J., Kortteisto, T., & Pitkänen, A. (2018). Service users' views regarding user involvement in mental health services: A qualitative study. *Archives of psychiatric nursing*, *32*(5), 695–701. https://doi.org/10.1016/j.apnu.2018.03.009

Lammers, J., & Happell, B. (2004). Mental health reforms and their impact on consumer and carer participation: a perspective from Victoria, Australia. *Issues in mental health nursing*, *25*(3), 261–276. https://doi.org/10.1080/01612840490274769

Latvala, E., Janhonen, S., & Wahlberg, K. E. (1999). Patient initiatives during the assessment and planning of psychiatric nursing in a hospital environment. *Journal of advanced nursing*, *29*(1), 64–71. https://doi.org/10.1046/j.1365-2648.1999.00864.x

Layder, D. (1998). *Sociological practice: Linking theory and research*. London: Sage.

Le Boutillier, C., Chevalier, A., Lawrence, V., Leamy, M., Bird, V. J., Macpherson, R., Williams, J., & Slade, M. (2015a). Staff understanding of recovery-orientated mental health practice: a systematic review and narrative synthesis. *Implementation science : IS*, *10*, 87. https://doi.org/10.1186/s13012-015-0275-4

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric services (Washington, D.C.)*, *62*(12), 1470–1476. https://doi.org/10.1176/appi.ps.001312011

Le Boutillier, C., Slade, M., Lawrence, V., Bird, V. J., Chandler, R., Farkas, M., Harding, C., Larsen, J., Oades, L. G., Roberts, G., Shepherd, G., Thornicroft, G., Williams, J., & Leamy, M. (2015b). Competing priorities: staff perspectives on supporting recovery. *Administration and policy in mental health*, *42*(4), 429–438. https://doi.org/10.1007/s10488-014-0585-x

Le Brun, S. D. (2015). "Speeding up the road to recovery": The Complex Recovery Assessment and Consultation (CRAC) service. *BMJ quality improvement reports*, *4*(1), u206716.w2728. https://doi.org/10.1136/bmjquality.u206716.w2728

Leach, M. J. (2008). Planning: a necessary step in clinical care. *Journal of clinical nursing*, *17*(13), 1728–1734. https://doi.org/10.1111/j.1365-2702.2008.02281.x

Lin, L. C. (2009). Data management and security in qualitative research. *Dimensions of critical care nursing : DCCN*, *28*(3), 132–137. https://doi.org/10.1097/DCC.0b013e31819aeff6

Light, E. M., Robertson, M. D., Boyce, P., Carney, T., Rosen, A., Cleary, M., Hunt, G. E., O'Connor, N., Ryan, C., & Kerridge, I. H. (2014). The lived experience of involuntary community treatment: a qualitative study of mental health consumers and carers. *Australasian psychiatry: bulletin of Royal Australian and New Zealand College of Psychiatrists*, *22*(4), 345–351. https://doi.org/10.1177/1039856214540759

Lilja, M., & S. Vinthagen. 2014. “Sovereign Power, Disciplinary Power and Biopower: Resisting What Power with What Resistance?” *Journal of Political Power,* 7 (1), 107–126. https://doi.org/10.1080/2158379X.2014.889403

Linhorst, D. M., Hamilton, G., Young, E., & Eckert, A. (2002). Opportunities and barriers to empowering people with severe mental illness through participation in treatment planning. *Social work*, *47*(4), 425–434. https://doi.org/10.1093/sw/47.4.425

LoBiondo-Wood, G. and Haber, J. (2006). *Nursing Research- Methods and Critical Appraisal for Evidence – Based Practice*. 6th edn. Missouri: Mosby Elsevier.

Loch A. A. (2014). Discharged from a mental health admission ward: is it safe to go home? A review on the negative outcomes of psychiatric hospitalization. *Psychology research and behavior management*, *7*, 137–145. https://doi.org/10.2147/PRBM.S35061

Lomas J. (2000). Using 'linkage and exchange' to move research into policy at a Canadian foundation. *Health affairs (Project Hope)*, *19*(3), 236–240. https://doi.org/10.1377/hlthaff.19.3.236

Lorien, L., Blunden, S., & Madsen, W. (2020). Implementation of recovery-oriented practice in hospital-based mental health services: A systematic review. *International journal of mental health nursing*, *29*(6), 1035–1048. https://doi.org/10.1111/inm.12794

Lukes, S. M. (1974). *Power: A Radical view*. London. Macmillan.

MacInnes, D. L., & Lewis, M. (2008). The evaluation of a short group programme to reduce self-stigma in people with serious and enduring mental health problems. *Journal of psychiatric and mental health nursing*, 15(1), 59–65. https://doi.org/10.1111/j.1365-2850.2007.01212.x

Mahlke, C. I., Krämer, U. M., Becker, T., & Bock, T. (2014). Peer support in mental health services. *Current opinion in psychiatry*, *27*(4), 276–281. https://doi.org/10.1097/YCO.0000000000000074

Manzano, A. (2016). The craft of interviewing in realist evaluation. *Evaluation*, *22*(3), 342–360. https://doi.org/10.1177/1356389016638615

Marchal, B., van Belle, S., van Olmen, J., Hoerée, T., & Kegels, G. (2012). Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research. *Evaluation*, *18*(2), 192–212. https://doi.org/10.1177/1356389012442444

Masson, J. (2004) ‘The legal context’. In: Fraser, S., Lewis, V., Ding, S., Kellett, M. and Robinson, C. eds. *Doing Research with Children and Young People*. London: Sage.

Mathisen, V., Lorem, G.F., Obstfelder, A. & Måseide, P. (2016), "Whose decision is it anyway? A qualitative study of user participation and how clinicians deal with the patient perspective in mental healthcare", *Mental Health Review Journal*, Vol. 21 (4), 249-260. https://doi.org/10.1108/MHRJ-01-2016-0003

Maxwell, J. (2012). *A Realist Approach for Qualitative Research*. Thousand Oaks: Sage.

Maxwell, J.A. & Mittapalli, K. (2010). *Realism as a stance for mixed methods research. In: SAGE Handbook of Mixed Methods in Social & Behavioral Research*, 2nd edn. (eds A. Tashakkori & C. Teddlie), pp. 145–167. SAGE Publications Inc, Los Angeles, CA.

May, C., & Finch, T. (2009). Implementing, Embedding, and Integrating Practices: An Outline of Normalization Process Theory. *Sociology*, *43*(3), 535–554. https://doi.org/10.1177/0038038509103208

McCarthy, T. (1991). *Ideals and Illusions*, Cambridge, MIT Press.

McCloughen, A., Gillies, D., & O'Brien, L. (2011). Collaboration between mental health consumers and nurses: shared understandings, dissimilar experiences. *International journal of mental health nursing*, *20*(1), 47–55. https://doi.org/10.1111/j.1447-0349.2010.00708.x

McCormack, B., Rycroft-Malone, J., Decorby, K., Hutchinson, A. M., Bucknall, T., Kent, B., Schultz, A., Snelgrove-Clarke, E., Stetler, C., Titler, M., Wallin, L., & Wilson, V. (2013). A realist review of interventions and strategies to promote evidence-informed healthcare: a focus on change agency. *Implementation science : IS*, *8*, 107. https://doi.org/10.1186/1748-5908-8-107

McCormack, B., Dewar, B., Wright, J., Garbett, R., Harvey, G. & Ballantine, K. (2006). A Realist Synthesis of Evidence Relating to Practice Development. Final Report to NHS Education for Scotland and NHS Quality Improvement Scotland. [Online]. Available from: http://www.healthcareimprovementscotland.org/previous_resources/archived/pd_-_evidence_synthisis.aspx [Accessed on 17 August 2018].

McDonald, K. M. (2013). Considering context in quality improvement interventions and implementation: concepts, frameworks, and application. *Academic pediatrics*, *13*(6 Suppl), S45–S53. https://doi.org/10.1016/j.acap.2013.04.013

McEvoy, P., & Richards, D. (2006). A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing*, *11*(1), 66–78. https://doi.org/10.1177/1744987106060192

McGuinness, D., Dowling, M., & Trimble, T. (2013). Experiences of involuntary admission in an approved mental health centre. *Journal of psychiatric and mental health nursing*, *20*(8), 726–734. https://doi.org/10.1111/jpm.12007

McKenna, B., Furness, T., Dhital, D., Ennis, G., Houghton, J., Lupson, C., & Toomey, N. (2014). Recovery-oriented care in acute inpatient mental health settings: an exploratory study. *Issues in mental health nursing*, *35*(7), 526–532. https://doi.org/10.3109/01612840.2014.890684

McKeown, M., Wright, K., & Mercer, D. (2017). Care planning: a neoliberal three card trick. *Journal of psychiatric and mental health nursing*, *24*(6), 451–460. https://doi.org/10.1111/jpm.12356

McNicoll, A. (2013a). Emergency mental health admissions delayed up to 3 weeks due to beds crisis, social workers warn. [Online]. *Community care*. Available from: https://www.communitycare.co.uk/2013/05/31/emergency-mental-health-admissions-delayed-up-to-3-weeks-due-to-beds-crisis-social-workers-warn/ [Accessed on 18 November 2019].

McNicoll, A. (2013b). Patients at risk as 'unsafe' mental health services reach crisis point. [Online]. Available from: https://www.communitycare.co.uk/2013/10/16/patients-at-risk-as-unsafe-mental-health-services-reach-crisis-point-2/ [Accessed on 18 February 2021].

McQueen, D. (2002). Discomfort of patient power. Patients are not doctors' equals. *BMJ (Clinical research ed.)*, *324*(7347), 1214.

Mead, G.H. (1934). *Mind, Self and Society*. Chicago: University of Chicago Press.

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: a theoretical perspective. *Psychiatric rehabilitation journal*, *25*(2), 134–141. https://doi.org/10.1037/h0095032

Medical Research Council. (2000). A framework for development and evaluation of RCTs for complex interventions to improve health. [Online]. Available from: https://mrc.ukri.org/documents/pdf/rcts-for-complex-interventions-to-improve-health/
[Accessed on 30 July 2021].

Mertens, D. M. (2012). What Comes First? The Paradigm or the Approach? *Journal of Mixed Methods Research*, *6*(4), 255–257. https://doi.org/10.1177/1558689812461574

Middleton, P., Stanton, P., & Renouf, N. (2004). Consumer consultants in mental health services: Addressing the challenges. *Journal of Mental Health,* *13*(5), 507–518. https://doi.org/10.1080/09638230400004424

Millar, S. L., Chambers, M., & Giles, M. (2016). Service user involvement in mental health care: an evolutionary concept analysis. *Health expectations: an international journal of public participation in health care and health policy*, *19*(2), 209–221. https://doi.org/10.1111/hex.12353

Miller, E., Stanhope, V., Restrepo-Toro, M., & Tondora, J. (2017). Person-centered planning in mental health: A transatlantic collaboration to tackle implementation barriers. *American journal of psychiatric rehabilitation*, *20*(3), 251–267. https://doi.org/10.1080/15487768.2017.1338045

Milner, G., Jankovic, J., Hoosen, I. & Marrie, D. (2008). Patients and staff understanding of general adult psychiatry ward rounds. *Journal of Mental Health*, 17: 492-7. DOI: 10.1080/09638230701529673

MIND. (2017). One in three people sent home from hospital too early – with no plan for further mental health care. [Online]. Available from: https://www.mind.org.uk/news-campaigns/news/one-in-three-people-sent-home-from-hospital-too-early-with-no-plan-for-further-mental-health-care/ [Accessed on 07 December 2021].

Mingers, J. (2014). *Systems Thinking, Critical Realism and Philosophy: A Confluence of Ideas*. New York: Routledge.

Mladenov, T. (2016). Disability and social justice. *Disability & Society*, 31(9), 1226–1241. https://doi.org/10.1080/09687599.2016.1256273

Modell, S. (2009). In defence of triangulation: A critical realist approach to mixed methods research in management accounting. *Management Accounting Research, 20*, 208-221. https://doi.org/10.1016/j.mar.2009.04.001

Moran G. S. (2018). The mental health consumer movement and peer providers in Israel. *Epidemiology and psychiatric sciences*, *27*(5), 420–426. https://doi.org/10.1017/S2045796018000173

Morant, N., Davidson, M., Wackett, J., Lamb, D., Pinfold, V., Smith, D., Johnson, S., Lloyd-Evans, B., & Osborn, D. (2021). Acute day units for mental health crises: a qualitative study of service user and staff views and experiences. *BMC psychiatry*, *21*(1), 146. https://doi.org/10.1186/s12888-021-03140-2

Morgan, D.L. (2007), Paradigms lost and Pragmatism regained: methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research*, 1(1). 48-76.

Morrow, M. (2013). Recovery: Progressive paradigm or neoliberal smokescreen? In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian Mad Studies*, pp. 323–333. Toronto, ON: Canadian Scholars' Press.

Marrow, M. & Weisser, J. (2012). Towards a Social Justice Framework of Mental Health Recovery, *Studies in Social Justice*, 6 (1), 27-43.DOI: https://doi.org/10.26522/ssj.v6i1.1067

Morse, J. M. (1991). *Qualitative nursing research: A contemporary dialogue*. London: SAGE

Morse, J. M. (2006). The scope of qualitatively derived clinical interventions. *Qualitative health research*, *16*(5), 591–593. https://doi.org/10.1177/1049732306286908

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods*, 13–22. https://doi.org/10.1177/160940690200100202

Mukoro, F. (2011). Care Planning Mini Topic Review. [Online]. Available from: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Care-Planning-Mini-Topic-Review.pdf [Accessed on 30 July 2021].

Mukumbang, F. C., Marchal, B., Van Belle, S., & van Wyk, B. (2020). Using the realist interview approach to maintain theoretical awareness in realist studies. *Qualitative Research*, *20*(4), 485–515. https://doi.org/10.1177/1468794119881985

National Health Service (NHS) England. (2018). Proportion of admissions gate-kept by CRHT teams. [Online]. Available from: https://www.nhs.uk/Scorecard/Pages/IndicatorFacts.aspx?MetricId=9305 [Accessed on 26 November 2019].

National Health Service (NHS) England. (2018). Proportion of admissions gate-kept by CRHT teams. [Online]. Available from: https://www.nhs.uk/Scorecard/Pages/IndicatorFacts.aspx?MetricId=9305 [Accessed on 26 November 2019].

National Institute for Health and Care Excellence (NICE). (2011). *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services*. London: NICE.

National Institute for Health and Care Excellence. (2014) Psychosis and schizophrenia in adults: prevention and management. NICE. [Online]. Available from: https://www.nice.org.uk/guidance/cg178. [Accessed on 24 July 2020].

National Institute for Health and Care Excellence (NICE). (2016). Transition between inpatient mental health settings and community or care home settings. [Online]. Available from: https://www.nice.org.uk/guidance/ng53/evidence/full-guideline-pdf-2606951917 [Accessed on 1 December 2019].

National Institute for Mental Health England (NIMHE) (2005) NIMHE Guiding Statement on Recovery. London: NIMHE.

Naylor, J. and Bell, A. (2010). Mental health and the productivity challenge: Improving quality and value for money. The Kings fund. [Online] Available from: https://www.kingsfund.org.uk/sites/default/files/Mental-health-productivity-Chris-Naylor-Andy-Bell-2-December-2010.pdf [Accessed on 6 December 2019].

Nelson, A. M. (2008). Addressing the threat of evidence-based practice to qualitative inquiry through increasing attention to quality: a discussion paper. *International journal of nursing studies*, *45*(2), 316–322. https://doi.org/10.1016/j.ijnurstu.2007.01.012

Nelson, G. and Prilleltensky I. (2005). *Community psychology: In pursuit of liberation and wellbeing*. London: Palgrave Macmillan.

NESTA, NATIONAL VOICES. (2015). Peer support: what is it and does it work? [Online]. Available from: https://www.scie-socialcareonline.org.uk/peer-support-what-is-it-and-does-it-work/r/a11G000000AvnVRIAZ [Accessed on 13 January 2020].

Newbigging, K., Ridley, J., McKeown, M., Machin, K., & Poursanidou, K. (2015). 'When you haven't got much of a voice': an evaluation of the quality of Independent Mental Health Advocate (IMHA) services in England. *Health & social care in the community*, *23*(3), 313–324. https://doi.org/10.1111/hsc.12153

Newman, D., O'Reilly, P., Lee, S. H., & Kennedy, C. (2015). Mental health service users' experiences of mental health care: an integrative literature review. *Journal of psychiatric and mental health nursing*, *22*(3), 171–182. https://doi.org/10.1111/jpm.12202

NHS England. (2017). Involving people in their own health and care: Statutory guidance for clinical commissioning groups and NHS England. [Online]. Available from: https://www.england.nhs.uk/wp-content/uploads/2017/04/ppp-involving-people-health-care-guidance.pdf [Accessed on 27 November 2021].

Niehaus, D. J., Koen, L., Galal, U., Dhansay, K., Oosthuizen, P. P., Emsley, R. A., & Jordaan, E. (2008). Crisis discharges and readmission risk in acute psychiatric male inpatients. *BMC psychiatry*, *8*, 44. https://doi.org/10.1186/1471-244X-8-44

Nolan, P., Bradley, E., & Brimblecombe, N. (2011). Disengaging from acute inpatient psychiatric care: a description of service users' experiences and views. *Journal of psychiatric and mental health nursing*, *18*(4), 359–367. https://doi.org/10.1111/j.1365-2850.2010.01675.x

Nursing and Midwifery Council (NMC). (2018). The Code Professional standards of practice and behaviour for nurses and midwives.[Online] Available from: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf [Accessed 2 December 2019].

Nutley, S.M., Walter, I., & Davies, H.T. (2007). Using Evidence: How research can inform public services. Bristol: Policy Press.

O'Connor, A. M., Bennett, C. L., Stacey, D., Barry, M., Col, N. F., Eden, K. B., Entwistle, V. A., Fiset, V., Holmes-Rovner, M., Khangura, S., Llewellyn-Thomas, H., & Rovner, D. (2009). Decision aids for people facing health treatment or screening decisions. *The Cochrane database of systematic reviews*, (3), CD001431. https://doi.org/10.1002/14651858.CD001431.pub2

O'Gorman, K. and MacIntosh, R. (2015). Mapping Research Methods. In: O'Gorman, K. and MacIntosh, R. ed. *Research Methods for business and Management*. [Online]. Oxford: Goodfellow Publishers. Available from: https://www.goodfellowpublishers.com/free_files/xChapter%204%20Mapping%20Research%20Methods-ea47945eed5486d42095459f6812d034.pdf [Accessed on 12 March 2018].

Olasoji, M., Maude, P., & McCauley, K. (2017). Not sick enough: Experiences of carers of people with mental illness negotiating care for their relatives with mental health services. *Journal of psychiatric and mental health nursing*, *24*(6), 403–411. https://doi.org/10.1111/jpm.12399

Oliver, C. (2012). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work*, *42*(2), 371–387. https://doi.org/10.1093/bjsw/bcr064

Oliver, S. R., Rees, R. W., Clarke-Jones, L., Milne, R., Oakley, A. R., Gabbay, J., Stein, K., Buchanan, P., & Gyte, G. (2008). A multidimensional conceptual framework for analysing public involvement in health services research. *Health expectations : an international journal of public participation in health care and health policy*, *11*(1), 72–84. https://doi.org/10.1111/j.1369-7625.2007.00476.x

Oltmann, C., & Boughey, C. (2012). Using critical realism as a framework in pharmacy education and social pharmacy research. *Research in social & administrative pharmacy: RSAP*, *8*(4), 333–337. https://doi.org/10.1016/j.sapharm.2011.07.005

Omeni, E., Barnes, M., MacDonald, D., Crawford, M., & Rose, D. (2014). Service user involvement: impact and participation: a survey of service user and staff perspectives. *BMC health services research*, *14*, 491. https://doi.org/10.1186/s12913-014-0491-7

Onwuegbuzie, A. J., & Leech, N. L. (2006). Linking Research Questions to Mixed Methods Data Analysis Procedures 1. *The Qualitative Report*, *11*(3), 474-498. https://doi.org/10.46743/2160-3715/2006.1663

Owen-Smith, A., Bennewith, O., Donovan, J., Evans, J., Hawton, K., Kapur, N., O'Connor, S., & Gunnell, D. (2014). "When you're in the hospital, you're in a sort of bubble." Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. *Crisis*, *35*(3), 154–160. https://doi.org/10.1027/0227-5910/a000246

Palin, A. N. (2005). Ward round practice – a need for urgent attention? *Psychiatric Bulletin*, 29, 353.

Parahoo, K. (2006). *Nursing Research: Principles, Process and Issues*. 2nd edn. Basingstoke: Palgrave Macmillan.

Parsons, T. (1951). *The social system*. Routledge, London.

Paton, F., Wright, K., Ayre, N., Dare, C., Johnson, S., Lloyd-Evans, B., Simpson, A., Webber, M., & Meader, N. (2016). Improving outcomes for people in mental health crisis: a rapid synthesis of the evidence for available models of care. *Health technology assessment (Winchester, England)*, *20*(3), 1–162. https://doi.org/10.3310/hta20030

Patton, M. Q. (2003). Qualitative evaluation checklist. Evaluation checklist project. [Online]. Available from: http://irantvto.ir/uploads/qec.pdf [Accessed on 01 August 2018].

Patton, M.Q. (2002). *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: SAGE.

Pawson, R. (1996). Theorising the interview. The British Journal of Sociology, 47 (2), 295-314. https://doi.org/10.2307/591728

Pawson, R. (2006). *Evidence-based policy: A realist perspective*. London: Sage.

Pawson, R. (2013). *The Science of Evaluation: A Realist Manifesto*. London: Sage.

Pawson, R. (2016). The ersatz realism of critical realism: A reply to Porter. *Evaluation,* 22(1), 49–57.

Pawson, R., & Manzano-Santaella, A. (2012). A realist diagnostic workshop. *Evaluation*, *18*(2), 176–191. https://doi.org/10.1177/1356389012440912

Pawson, R. and Tilley, N. (1997). Realist evaluation. London: Sage publication Ltd.

Pawson, R., Greenhalgh, T., Harvey, G., and Walshe, K. (2004). Realist Synthesis: an introduction. ESRC Research Methods Programme. [Online] Available from: http://www.ccsr.ac.uk/methods/publications/documents/RMPmethods2.pdf [Accessed on 20 September 2017].

Payne, G. & Payne, J. (2004). The Hawthorne effect. In *Key concepts in social research* (pp. 108-111). SAGE Publications.

Pazargadi, M., Fereidooni Moghadam, M., Fallahi Khoshknab, M., Alijani Renani, H., & Molazem, Z. (2015). The Therapeutic Relationship in the Shadow: Nurses' Experiences of Barriers to the Nurse-Patient Relationship in the Psychiatric Ward. *Issues in mental health nursing*, *36*(7), 551–557. https://doi.org/10.3109/01612840.2015.1014585

Peplau, H. E. (1997). Peplau's theory of interpersonal relations. *Nursing science quarterly*, *10*(4), 162–167. https://doi.org/10.1177/089431849701000407

Pfadenhauer, L. M., Gerhardus, A., Mozygemba, K., Lysdahl, K. B., Booth, A., Hofmann, B., Wahlster, P., Polus, S., Burns, J., Brereton, L., & Rehfuess, E. (2017). Making sense of complexity in context and implementation: the Context and Implementation of Complex Interventions (CICI) framework. *Implementation science: IS*, *12*(1), 21. https://doi.org/10.1186/s13012-017-0552-5

Piat, M., & Lal, S. (2012). Service providers' experiences and perspectives on recovery-oriented mental health system reform. *Psychiatric rehabilitation journal*, *35*(4), 289–296. https://doi.org/10.2975/35.4.2012.289.296

Pinxten, W., & Lievens, J. (2014). The importance of economic, social and cultural capital in understanding health inequalities: using a Bourdieu-based approach in research on physical and mental health perceptions. *Sociology of health & illness*, *36*(7), 1095–1110. https://doi.org/10.1111/1467-9566.12154

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S. E., Ryan, R., & Berends, L. (2013). Consumer-providers of care for adult clients of statutory mental health services. *The Cochrane database of systematic reviews*, (3), CD004807. https://doi.org/10.1002/14651858.CD004807.pub

Poggenpoel, M., & Myburgh, C. (2003). The researcher as research instrument in educational research: A possible threat to trustworthiness?(A: research instrument). *Education*, *124*(2), 418-423.

Polit, D.F. & Beck, C.T. (2008) *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. 8th edn. Philadelphia: Lippincott Williams & Wilkins.

Polit, D. F. & Beck, C.T. (2012*). Nursing Research: Generating and Assessing evidence for Nursing Practice*. 9th edn. Philadelphia: Lippincott Williams & Wilkins.

Poole, R., Pearsall, A., & Ryan, T. (2014). Delayed discharges in an urban in-patient mental health service in England. *Psychiatric bulletin (2014)*, *38*(2), 66–70. https://doi.org/10.1192/pb.bp.113.043083

Mays, N., & Pope, C. (2000). Qualitative research in health care. Assessing quality in qualitative research. *BMJ (Clinical research ed.)*, *320*(7226), 50–52. https://doi.org/10.1136/bmj.320.7226.50

Porter, S. (2015a). The uncritical realism of realist evaluation. *Evaluation*, *21*(1), 65–82. https://doi.org/10.1177/1356389014566134

Porter, S. (2015b). Realist evaluation: an immanent critique. *Nursing philosophy: an international journal for healthcare professionals*, *16*(4), 239–251. https://doi.org/10.1111/nup.12100

Price, A., Schroter, S., Snow, R., Hicks, M., Harmston, R., Staniszewska, S., Parker, S., & Richards, T. (2018). Frequency of reporting on patient and public involvement (PPI) in research studies published in a general medical journal: a descriptive study. *BMJ open*, *8*(3), e020452. https://doi.org/10.1136/bmjopen-2017-020452

Procter, S., Allan, T. & Lacey, A. (2010). Sampling. In: Gerrish, K. and Lacey, A. eds. *The Research Process in Nursing*. 6th Edn. Oxford: Willey – Blackwell, pp. 143 – 152.

Puschner, B., Repper, J., Mahlke, C., Nixdorf, R., Basangwa, D., Nakku, J., et al. (2019). Using Peer Support in Developing Empowering Mental Health Services (UPSIDES): Background, Rationale and Methodology. *Annals of global health*, *85*(1), 53. https://doi.org/10.5334/aogh.2435

QSR International Pty Ltd (2015). Nvivo 11. [Downloadable programme]. Windows version. QSR International Pty Ltd. Available from: http://www.qsrinternational.com/nvivo/nvivo-products/nvivo-11-for-windows [Accessed on 31 May 2018].

Quinn, S., Connah, L., Jones, T., Caulfield, M., Boyle, S., Sevillano, R., Jones, C & Davidson, I. (2018). Red2Green: Project to improve flow through mental health inpatient services. [Online]. Available from: https://www.england.nhs.uk/north/wp-content/uploads/sites/5/2018/05/Project-to-improve-flow-through-mental-health-inpatient-services-Red2Green.pdf [Accessed on 24 November 2021].

Quirk, A., & Lelliott, P. (2001). What do we know about life on acute psychiatric wards in the UK? A review of the research evidence. *Social science & medicine (1982)*, *53*(12), 1565–1574. https://doi.org/10.1016/s0277-9536(00)00457-3

Radermacher, H., Sonn, C., Keys, C. and Duckett, P. (2010). Disability and participation: It's about us but still without us! *Journal of Community and Applied Social Psychology*, 20(5), 333–346.

Razzaque, R., Stockmann, T., & Sunthararajah, S. (2020). Models of care, Faculty of General Adult Psychiatry, Royal College of Psychiatrists [Online]. Available from: https://www.rcpsych.ac.uk/docs/default-source/members/faculties/general-adult-psychiatry/general-adult-faculty-report---models-of-care.pdf?sfvrsn=66edf9_4 [Accessed on 21 November 2021].

Reid, R., Escott, P., & Isobel, S. (2018). Collaboration as a process and an outcome: Consumer experiences of collaborating with nurses in care planning in an acute inpatient mental health unit. *International journal of mental health nursing*, *27*(4), 1204–1211. https://doi.org/10.1111/inm.12463

Repper J, Aldridge B, Gilfoyle S, Gillard S, Perkins R, Rennison J. (2013). Peer support workers: Theory and practice. London, UK: Centre for Mental Health and Mental Health Network, NHS Confederation [Online]. Available from: https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/ImROC%20Peer%20Support%20Workers%20Theory%20and%20Practice.pdf [Accessed on 14 November 2021].

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of mental health (Abingdon, England)*, *20*(4), 392–411. https://doi.org/10.3109/09638237.2011.583947

Repper, J., & Perkins, R. (2003). *Social Inclusion and Recovery: A Model for Mental Health Practice.* London: Bailliere Tindall.

Resnick, S. G., & Rosenheck, R. A. (2008). Integrating peer-provided services: a quasi-experimental study of recovery orientation, confidence, and empowerment. *Psychiatric services (Washington, D.C.)*, *59*(11), 1307–1314. https://doi.org/10.1176/ps.2008.59.11.1307

Rhodes, P., & Giles, S. J. (2014). "Risky business": a critical analysis of the role of crisis resolution and home treatment teams. *Journal of mental health (Abingdon, England)*, *23*(3), 130–134. https://doi.org/10.3109/09638237.2014.889284

Richards, H. M., & Schwartz, L. J. (2002). Ethics of qualitative research: are there special issues for health services research?. *Family practice*, *19*(2), 135–139. https://doi.org/10.1093/fampra/19.2.135

Richardson, W.C., & Allegrante, J.P. (2000). Shaping the future of health through global partnerships. In C. E. Coop , C. E. Pearson , & M. R. Schwartz (Eds.), *Critical issues in global health* (pp. 375-383). San Francisco: Josey-Bass.

Ridley, J., Newbigging, K. & Street, C. (2018), "Mental health advocacy outcomes from service user perspectives", *Mental Health Review Journal*, *23(4),* 280-292. https://doi.org/10.1108/MHRJ-10-2017-0049

Rise, M. B., & Steinsbekk, A. (2015). Does implementing a development plan for user participation in a mental hospital change patients' experience? A non-randomized controlled study. *Health expectations: an international journal of public participation in health care and health policy*, *18*(5), 809–825. https://doi.org/10.1111/hex.12105

Ritchie, J. & Spencer, L. (1994). Data analysis for applied policy research. In: Bryman, A. & Burgess, R. (eds). *Analysing Qualitative Data*. London: Routledge, pp. 173-194.

Robson, C. (2011). *Real World Research: A Resource for Users of Social Research Methods in Applied Settings*. 3rd edn. Chichester: Wiley & Sons Ltd.

Roe, D., Hasson-Ohayon, I., Salyers, M. P., & Kravetz, S. (2009). A one year follow-up of illness management and recovery: participants' accounts of its impact and uniqueness. *Psychiatric rehabilitation journal*, *32*(4), 285–291. https://doi.org/10.2975/32.4.2009.285.291

Rogers, J. A., Vergare, M. J., Baron, R. C., & Salzer, M. S. (2007). Barriers to recovery and recommendations for change: the Pennsylvania Consensus Conference on psychiatry's role. *Psychiatric services (Washington, D.C.)*, *58*(8), 1119–1123. https://doi.org/10.1176/ps.2007.58.8.1119

Rose, D. (2014). Patient and public involvement in health research: ethical imperative and/or radical challenge?. *Journal of health psychology*, *19*(1), 149–158. https://doi.org/10.1177/1359105313500249

Rose, D., Evans, J., Laker, C., & Wykes, T. (2015). Life in acute mental health settings: experiences and perceptions of service users and nurses. *Epidemiology and psychiatric sciences*, 24(1), 90–96. https://doi.org/10.1017/S2045796013000693

Royal College of Psychiatrists. (2020). Psychiatrists see alarming rise in patients needing urgent and emergency care and forecast a 'tsunami' of mental illness. [Online]. Available from: https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/05/15/psychiatrists-see-alarming-rise-in-patients-needing-urgent-and-emergency-care [Accessed on 08 December 2021].

Rush, B. (2004). Mental health service user involvement in England: lessons from history. *Journal of psychiatric and mental health nursing*, *11*(3), 313–318. https://doi.org/10.1111/j.1365-2850.2004.00728.x

Rutter, D., Manley, C., Weaver, T., Crawford, M. J., & Fulop, N. (2004). Patients or partners? Case studies of user involvement in the planning and delivery of adult mental health services in London. *Social science & medicine (1982)*, *58*(10), 1973–1984. https://doi.org/10.1016/S0277-9536(03)00401-5

Rycroft-Malone, J., Burton, C. R., Wilkinson, J., Harvey, G., McCormack, B., Baker, R., Dopson, S., Graham, I. D., Staniszewska, S., Thompson, C., Ariss, S., Melville-Richards, L., & Williams, L. (2016). Collective action for implementation: a realist evaluation of organisational collaboration in healthcare. *Implementation science: IS*, *11*, 17. https://doi.org/10.1186/s13012-016-0380-z

Rycroft-Malone, J., Mccormack, B., Decorby K. and Hutchinson, A. M. (2010). Realist Synthesis. In: Gerrish, K and Lacey, A. ed. *The Research Process in Nursing*. 6th edn. Oxford: Blacwell publishing Ltd, pp. 303-320.

Rycroft-Malone, J., Mccormack, B., Hutchinson, A. M., Decorby K., Bucknall, T, K., Kent, B., Schultz, A., Snelgrove-Clarke, E., Stetler, C, B., Titler, M., Wallin, L. and Wilson, V. (2012). Realist synthesis: illustrating the method for implementation research, *Implementation Science*, 7(1), 33.

Sackett, D. L., Richardson, W.S., Rosenberg, W. and Haynes, R.B. (1998). *Evidence Based Medicine: How to Practice and Teach EBM*. Churchill Livingstone, London.

Saldana, J. (2016). *The coding manual for qualitative researchers*. London: Sage.

Salzer, M. S., & Shear, S. L. (2002). Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric rehabilitation journal*, *25*(3), 281–288. https://doi.org/10.1037/h0095014

Sandelowski, M. (1998). The call to experts in qualitative research. *Research in nursing & health*, *21*(5), 467–471. https://doi.org/10.1002/(sici)1098-240x(199810)21:5<467::aid-nur9>3.0.co;2-l

Saunders, M., Lewis, P. and Thornhill, A. (2009). Understanding research philosophies and approaches [Online]. ResearchGate. Available from: file:///C:/Users/Jas/Downloads/Research_Methods_for_Business_Students_C.pdf [Accessed on 8 February 2018].

Sawyer, J. M., Sallnow, L., Kupeli, N., Stone, P. & Sampson, E. L. (2019). Social networks, social capital and end of-life care for people with dementia: a realist review, BMJ open. [Online]. Available from: https://bmjopen.bmj.com/content/9/12/e030703 [Accessed on 16 December 2020].

Sayer. A. (2000). *Realism and social science*. London: Sage

Schiller C. J. (2016). Critical realism in nursing: an emerging approach. *Nursing philosophy : an international journal for healthcare professionals*, *17*(2), 88–102. https://doi.org/10.1111/nup.12107

Schröder, A., Ahlström, G., & Larsson, B. W. (2006). Patients' perceptions of the concept of the quality of care in the psychiatric setting: a phenomenographic study. *Journal of clinical nursing*, *15*(1), 93–102. https://doi.org/10.1111/j.1365-2702.2005.01241.x

Shanley, E., & Jubb-Shanley, M. (2007). The recovery alliance theory of mental health nursing. *Journal of psychiatric and mental health nursing*, *14*(8), 734–743. https://doi.org/10.1111/j.1365-2850.2007.01179.x

Sharac, J., McCrone, P., Sabes-Figuera, R., Csipke, E., Wood, A., & Wykes, T. (2010). Nurse and patient activities and interaction on psychiatric inpatients wards: a literature review. *International journal of nursing studies*, *47*(7), 909–917. https://doi.org/10.1016/j.ijnurstu.2010.03.012

Shearn, K., Allmark, P., Piercy, H., & Hirst, J. (2017). Building Realist Program Theory for Large Complex and Messy Interventions. *International Journal of Qualitative Methods;* 16 (1), 1–11. https://doi.org/10.1177/1609406917741796

Shepherd, G., Boardman, J. & Slade, M. (2008). Making Recovery a Reality. [Online]. Available from: https://www.researchintorecovery.com/files/SCMH%202008%20Making%20recovery%20a%20reality.pdf [Accessed on 17 December 2019].

Simpson, A., Bowers, L. & Miller, C. (2003). The History of the Care Programme Approach in England: Where did it go wrong?. *Journal of Mental Health, 12*(5), pp. 489-504. doi: 10.1080/09638230310001603555

Simpson, A., Hannigan, B., Coffey, M., Barlow, S., Cohen, R., Jones, A., Všetečková, J., Faulkner, A., Thornton, A., & Cartwright, M. (2016). Recovery-focused care planning and coordination in England and Wales: a cross-national mixed methods comparative case study. *BMC psychiatry*, *16*, 147. https://doi.org/10.1186/s12888-016-0858-x

Simpson, E. L., & House, A. O. (2002). Involving users in the delivery and evaluation of mental health services: systematic review. *BMJ (Clinical research ed.)*, *325*(7375), 1265. https://doi.org/10.1136/bmj.325.7375.1265

Siskind, D., Harris, M., Kisely, S., Brogan, J., Pirkis, J., Crompton, D., & Whiteford, H. (2013). A retrospective quasi-experimental study of a community crisis house for patients with severe and persistent mental illness. *The Australian and New Zealand journal of psychiatry*, *47*(7), 667–675. https://doi.org/10.1177/0004867413484369

Slade, M. (2009) *Personal recovery and mental illness a guide for mental health professionals.* New York: Cambridge University Press.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, *13*(1), 12–20. https://doi.org/10.1002/wps.20084

Smith, H. W. (1991). Strategies of Social Research, 3rd Edn. New York: Rinehart & Winston.

Smith, R. (2009). Doing social work research, Maidenhead: Open University Press.

Smith, R. C., & Bartholomew, T. (2006). Will hospitals recover?: The implications of a recovery-orientation. *American Journal of Psychiatric Rehabilitation*, *9*(2), 85-100. https://doi.org/10.1080/15487760600875982

Snape, D. and Spencer, L. (2003). The foundation of qualitative research. In: Richie, J. and Lewis, J. eds. *Qualitative Research Practice*. London: Sage. pp. 02-23.

Solomon P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric rehabilitation journal*, *27*(4), 392–401. https://doi.org/10.2975/27.2004.392.401

South, A., Hanley, B., Gafos, M., Cromarty, B., Stephens, R., Sturgeon, K., Scott, K., Cragg, W. J., Tweed, C. D., Teera, J., & Vale, C. L. (2016). Models and impact of patient and public involvement in studies carried out by the Medical Research Council Clinical Trials Unit at University College London: findings from ten case studies. *Trials*, *17*, 376. https://doi.org/10.1186/s13063-016-1488-9

Stame, N. (2004). Theory-Based Evaluation and Types of Complexity. *Evaluation*, *10*(1), 58–76. https://doi.org/10.1177/1356389004043135

Steffen, S., Kösters, M., Becker, T., & Puschner, B. (2009). Discharge planning in mental health care: a systematic review of the recent literature. *Acta psychiatrica Scandinavica*, 120(1), 1–9. https://doi.org/10.1111/j.1600-0447.2009.01373.x

Stewart, D. W. & Shamdasani, P. N. (1990). *Focus Groups: Theory and Practice*. Newbury Park: Sage.

Stickley T. (2006). Should service user involvement be consigned to history? A critical realist perspective. *Journal of Psychiatric and Mental Health Nursing*, 13(5), 570– 577.

Stomski, N. J., & Morrison, P. (2017). Participation in mental healthcare: a qualitative meta-synthesis. *International journal of mental health systems*, *11*, 67. https://doi.org/10.1186/s13033-017-0174-y

Storm, M., & Davidson, L. (2010). Inpatients' and providers' experiences with user involvement in inpatient care. *The Psychiatric quarterly*, *81*(2), 111–125. https://doi.org/10.1007/s11126-009-9122-6

Storm, M., & Edwards, A. (2013). Models of user involvement in the mental health context: intentions and implementation challenges. *The Psychiatric quarterly*, *84*(3), 313–327. https://doi.org/10.1007/s11126-012-9247-x

Streubert, H. (2011), The conduct of qualitative research: Common essential elements. In: Streubert, H. J. and Carpenter, D. R. eds. *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. 5th edn. Philadelphia: Lippincott Williams & Wilkins.

Streubert, H. J. and Carpenter, D. R. (2011). *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. 5th edn. Philadelphia: Lippincott Williams & Wilkins.

Stringer, B., Van Meijel, B., De Vree, W., & Van der Bijl, J. (2008). User involvement in mental health care: the role of nurses. A literature review. *Journal of psychiatric and mental health nursing*, *15*(8), 678–683. https://doi.org/10.1111/j.1365-2850.2008.01285.x

Sweeney, A., Fahmy, S., Nolan, F., Morant, N., Fox, Z., Lloyd-Evans, B., Osborn, D., et al. (2014). The relationship between therapeutic alliance and service user satisfaction in mental health inpatient wards and crisis house alternatives: a cross-sectional study. *PloS one*, *9*(7), e100153. https://doi.org/10.1371/journal.pone.0100153

Tait, L., & Lester, H. (2005). Encouraging user involvement in mental health services. *Advances in Psychiatric Treatment*, *11(3),* 168-175. https://doi.org/10.1192/apt.11.3.168

Tambuyzer, E., Pieters, G., & Van Audenhove, C. (2014). Patient involvement in mental health care: one size does not fit all. *Health expectations : an international journal of public participation in health care and health policy*, *17*(1), 138–150. https://doi.org/10.1111/j.1369-7625.2011.00743.x

Teghtsoonian K. (2009). Depression and mental health in neoliberal times: a critical analysis of policy and discourse. *Social science & medicine (1982)*, *69*(1), 28–35. https://doi.org/10.1016/j.socscimed.2009.03.037

Teh, Y. Y., & Lek, E. (2018). Culture and reflexivity: Systemic journeys with a British Chinese family. *Journal of Family Therapy*, 40, 520–536. doi:10.1111/1467-6427.12205

The commission to review the provision of acute inpatient psychiatric care for adults, (2016). *Old Problems, New Solutions: Improving Acute Psychiatric Care For Adults In England*. [Online]. Available from: https://nhsproviders.org/media/1750/otdb-independent-commission-on-acute-adult-inpatient-psychiatric-care-final-report.pdf [Accessed on 24 November 2019].

The Independent Mental Health Taskforce. (2016). *The Five Year Forward View For Mental Health*. London: [Online]. Available from: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf [Accessed on 10 January 2017].

The King's Fund. (2021). NHS hospital bed numbers: past, present, future. [Online]. Available from: https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers [Accessed on 08 December 2021].

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer. (2016). Annual Report and 20-year Review. University of Manchester. [Online]. Available from: https://documents.manchester.ac.uk/display.aspx?DocID=37580 [Accessed on 7 December 2021].

The National Survivor User Network. (2014). Service User Involvement in the delivery of mental health services, [Online]. Available from: https://www.together-uk.org/wp-content/uploads/2019/08/Service-User-Involvement-briefing.pdf [Accessed on 15 June 2021].

The RAMESES II Project. (2017). Realist Evaluation and Ethical Considerations. NIHR. [Online]. Available from: https://www.ramesesproject.org/media/RAMESES_II_Realist_evaluation_and_ethical_considerations.pdf [Accessed on 23 March 2021].

The RAMESES II Project. (2017). *REALIST EVALUATION, REALIST SYNTHESIS, REALIST RESEARCH* [Online]. Available from: http://www.ramesesproject.org/media/RAMESES_II_RE_RS_RR_whats_in_a_name.pdf

[Accessed on 02 December 2021].

The Schizophrenia Commission (2012) *The abandoned illness :a report from the schizophrenia Commission.* London: Rethink Mental Illness.

The Strategy Unit. (2019). *Exploring Mental Health Inpatient Capacity*. TSU. [Online]. Available from: https://www.strategyunitwm.nhs.uk/sites/default/files/2019-11/Exploring%20Mental%20Health%20Inpatient%20Capacity%20accross%20Sustainability%20and%20Transformation%20Partnerships%20in%20England%20-%20191030_1.pdf [Accessed on 08 December 2021].

Thibeault, C. (2016). An Interpretation of Nurse-Patient Relationships in Inpatient Psychiatry: Understanding the Mindful Approach. *Global qualitative nursing research*, *3*, 2333393616630465. https://doi.org/10.1177/2333393616630465

Tod, A. (2010). Interviewing. In: Gerrish, K. and Lacey, A. eds. *The Research Process in Nursing*. 6th Edn. Oxford: Willey – Blackwell, pp. 345-357.

Tondora, J., Miller, R., Slade, M. & Davidson, L. (2014). *Partnering for Recovery in Mental Health: A Practical Guide to Person-Centered Planning*. Oxford, UK: John Wiley & Sons.

Trachtenberg, M., Parsonage, M., Shepherd, G. & Boardman, J. (2013). Peer support in mental health care: is it good value for money? London, UK: Centre for Mental Health, [Online]. Available at: https://eprints.lse.ac.uk/60793/1/Trachtenberg_etal_Report-Peer-support-in-mental-health-care-is-it-good-value-for-money_2013.pdf [Accessed on 30 Nov 2021].

Trigg, R. (2001). *Understanding Social Science: A Philosophical Introduction to the Social Science*. 2nd edn. Oxford: Blackwell.

Tritter J. Q. (2009). Revolution or evolution: the challenges of conceptualizing patient and public involvement in a consumerist world. *Health expectations: an international journal of public participation in health care and health policy*, *12*(3), 275–287. https://doi.org/10.1111/j.1369-7625.2009.00564.x

Tse, S., Tang, J. and Kan, A. (2012). Patient involvement in mental health care: culture, communication and caution. Health Expectations: *An International Journal of Public Participation in Health Care and Health Policy*, 18(1), 3-7.

Tunmore, R. & Thomas, B. (2000). Nursing care plans in acute mental health nursing. *Mental Health Practice*, 4, 32–37. doi: 10.7748/mhp2000.11.4.3.32.c1681

Tyler, N., Wright, N., & Waring, J. (2019). Interventions to improve discharge from acute adult mental health inpatient care to the community: systematic review and narrative synthesis. *BMC health services research*, *19*(1), 883. https://doi.org/10.1186/s12913-019-4658-0

United Kingdom Parliament. (1998). *Data Protection Act*. London, The Stationary Office. Also available from: [Online]http://www.legislation.gov.uk/ukpga/1998/29/pdfs/ukpga_19980029_en.pdf [Accessed on 1 May 2017].

United Kingdom Parliament. (2001). *Health and Social Care Act*. London, The Stationary Office.

Valimaki, M. & Leino-Kilpi H. (1998) Preconditions for and consequences of self determination: the psychiatric patient point of view', *Journal of Advance Nursing,* 27, pp 204-212.

Van Heugten, K. (2004). Managing Insider Research: Learning from Experience. *Qualitative Social Work*, *3*(2), 203–219. https://doi.org/10.1177/1473325004043386

Vigod, S. N., Kurdyak, P. A., Dennis, C. L., Leszcz, T., Taylor, V. H., Blumberger, D. M., & Seitz, D. P. (2013). Transitional interventions to reduce early psychiatric readmissions in adults: systematic review. *The British journal of psychiatry : the journal of mental science*, 202(3), 187–194. https://doi.org/10.1192/bjp.bp.112.115030

Vuokila-Oikkonen, P., Janhonen, S., & Nikkonen, M. (2002). Patient initiatives in psychiatric care concerning shame in the discussion in co-operative team meetings. *Journal of psychiatric and mental health nursing*, *9*(1), 23–32. https://doi.org/10.1046/j.1365-2850.2002.00406.x

Wagstaff, K., & Solts, B. (2003). Inpatient experiences of ward rounds in acute psychiatric settings. *Nursing times*, *99*(5), 34–36.

Wainwright, S. P. (1997). A new paradigm for nursing: the potential of realism. *Journal of advanced nursing*, *26*(6), 1262–1271. https://doi.org/10.1111/j.1365-2648.1997.tb00821.x

Waldemar, A. K., Arnfred, S. M., Petersen, L., & Korsbek, L. (2016). Recovery-Oriented Practice in Mental Health Inpatient Settings: A Literature Review. *Psychiatric services (Washington, D.C.)*, *67*(6), 596–602. https://doi.org/10.1176/appi.ps.201400469

Waldemar, A. K., Esbensen, B. A., Korsbek, L., Petersen, L., & Arnfred, S. (2018). Recovery orientation in mental health inpatient settings: Inpatient experiences?. *International journal of mental health nursing*, *27*(3), 1177–1187. https://doi.org/10.1111/inm.12434

Waldemar, A. K., Esbensen, B. A., Korsbek, L., Petersen, L., & Arnfred, S. (2019). Recovery-oriented practice: Participant observations of the interactions between patients and health professionals in mental health inpatient settings. *International journal of mental health nursing*, *28*(1), 318–329. https://doi.org/10.1111/inm.12537

Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: a metasynthesis of qualitative findings. *Psychiatric rehabilitation journal*, *36*(1), 28–34. https://doi.org/10.1037/h0094744

Walker, L.O. & Avant, K.C. (2005). *Strategies for Theory Construction in Nursing*, 4th edn. Pearson Prentice Hall, Upper Saddle River, NJ.

Walsh, P. E., McMillan, S. S., Stewart, V., & Wheeler, A. J. (2018). Understanding paid peer support in mental health. *Disability & Society*, 33(4), 579–597. https://doi.org/10.1080/09687599.2018.1441705

Ward, L. (2013). Ready, aim fire! Mental health nurses under siege in acute inpatient facilities. *Issues in mental health nursing*, *34*(4), 281–287. https://doi.org/10.3109/01612840.2012.742603

Warrender, D. (2016). Sparking the Process: Recovery in an Acute Mental Health Ward. [Online]. Available from: https://www.scottishrecovery.net/resource/sparking-the-process-recovery-in-an-acute-mental-health-ward/ [Accessed on 26 November 2019].

White, R. & Karim, B. (2005). Patients' views of the ward round: A survey. Psychiatric Bulletin, 29, 207–209.

Whiteford H. A. (1998). Renewing Australia's mental health strategy. *The Medical journal of Australia*, *169*(8), 432–434. https://doi.org/10.5694/j.1326-5377.1999.tb127828.x

Whitehead, D. (2007). An overview of research theory and process. In: Schneider, Z., Whitehead, D., Elliott., Lobiondo-Wood. and Haber, J. eds. *Nursing & midwifery research: Methods and Appraisal for Evidence-Based Practice*. 3rd edn. Sydney: Mosby Elsevier, pp. 20-32.

Whittemore, R. & Grey, M. (2006). Data-Collection Methods. In: Lobiondo-Wood, G. and Haber, J. eds. *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice.* 6th Edn. Missouri: Mosby Elsevier, pp. 317-334.

Willig, C. (1998). Social constructionism and revolutionary socialism: A contradiction in terms? In: *Social Constructionism, Discourse and Realism.* Edn Parker. London: Sage, pp. 91-104

Williams, L., Rycroft-Malone, J., & Burton, C. R. (2017). Bringing critical realism to nursing practice: Roy Bhaskar's contribution. *Nursing philosophy: an international journal for healthcare professionals*, *18*(2), 10.1111/nup.12130. https://doi.org/10.1111/nup.12130

Williams, L., Rycroft-Malone, J. and Burton, C.R., Edwards, S., Fisher, D., Hall, B., McCormack, B., Nutley, S. M., Seddon, D., Williams, R. (2016). Improving skills and care standards in the support workforce for older people: a realist synthesis of workforce development intervention. *BMJ Open*, 6. 1-11.

Rycroft-Malone, J., Burton, C. R., Williams, L., Edwards, S., Fisher, D., Hall, B., McCormack, B., Nutley, S., Seddon, D., & Williams, R. (2016). *Improving skills and care standards in the support workforce for older people: a realist synthesis of workforce development interventions*. NIHR Journals Library.

Willing, C. (1999). Beyond appearances: a critical realists approach to social constructionism. In: Nightingale, D. J. and Cromby, J. eds. *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*. Maidenhead: Open University Press.

Wilson, H. S., & Hutchinson, S. A. (1991). Triangulation of Qualitative Methods: Heideggerian Hermeneutics and Grounded Theory. *Qualitative Health Research*, *1*(2), 263–276. https://doi.org/10.1177/104973239100100206

Wilson, P., Mathie, E., Keenan, J., McNeilly, E., Goodman, C., Howe, A., Poland, F., Staniszewska, S., Kendall, S., Munday, D., Cowe, M., & Peckham, S. (2015). *ReseArch with Patient and Public invOlvement: a RealisT evaluation – the RAPPORT study*. NIHR Journals Library.

Wong, G. (2018). Getting to grips with context and complexity - the case for realist approaches. *Gaceta sanitaria*, *32*(2), 109–110. https://doi.org/10.1016/j.gaceta.2017.05.010

Wong,G., Westhorp, G., Pawson, R. and Greenhalgh. (2013). Realist synthesis RAMESES Training Material. RAMESES project. [Online]. Available from: http://www.ramesesproject.org/media/Realist_reviews_training_materials.pdf [Accessed on 02 November 2017].

Woodward, S., Berry, K., & Bucci, S. (2017). A systematic review of factors associated with service user satisfaction with psychiatric inpatient services. *Journal of psychiatric research*, *92*, 81–93. https://doi.org/10.1016/j.jpsychires.2017.03.020

World Health Organisation (WHO). (2013). *Mental Health Action Plan 2013 – 2020.*[Online] Available from: http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf?ua=1 [Accessed on 24 September2016].

Wright, N., Rowley, E., Chopra, A., Gregoriou, K., & Waring, J. (2016). From admission to discharge in mental health services: a qualitative analysis of service user involvement. *Health expectations : an international journal of public participation in health care and health policy*, *19*(2), 367–376. https://doi.org/10.1111/hex.12361

Wyder, M., Ehrlich, C., Crompton, D., McArthur, L., Delaforce, C., Dziopa, F., Ramon, S., & Powell, E. (2017). Nurses experiences of delivering care in acute inpatient mental health settings: A narrative synthesis of the literature. *International journal of mental health nursing*, *26*(6), 527–540. https://doi.org/10.1111/inm.12315

Yarborough, B. J., Yarborough, M. T., Janoff, S. L., & Green, C. A. (2016). Getting by, getting back, and getting on: Matching mental health services to consumers' recovery goals. *Psychiatric rehabilitation journal*, *39*(2), 97–104. https://doi.org/10.1037/prj0000160

Yeung, H. W. (1997). Critical realism and realist research in human geography: a method or a philosophy in search of a method? *Progress in Human Geography*, *21*(1), 51–74. https://doi.org/10.1191/030913297668207944

Zisman-Ilani, Y., Barnett, E., Harik, J., Pavlo, A., & O'Connell, M. (2017). Expanding the concept of shared decision making for mental health: Systematic search and scoping review of interventions. *Mental Health Review Journal, 22*(3), 191–213. https://doi.org/10.1108/MHRJ-01-2017-0002

Zuaboni, G., Hahn, S., Wolfensberger, P., Schwarze, T., & Richter, D. (2017). Impact of a Mental Health Nursing Training-Programme on the Perceived Recovery-Orientation of Patients and Nurses on Acute Psychiatric Wards: Results of a Pilot Study. *Issues in mental health nursing*, *38*(11), 907–914. https://doi.org/10.1080/01612840.2017.1359350

Appendix 2: Publication on Recovery clinics

Setting up recovery clinics and promoting service user involvement

Thomas John

ABSTRACT

Service user involvement in mental health has gained considerable momentum. Evidence from the literature suggests that it remains largely theoretical rather than being put into practice. The current nature of acute inpatient mental health units creates various challenges for nurses to put this concept into practice. Recovery clinics were introduced to bridge this gap and to promote service user involvement practice within the current care delivery model at Kent and Medway NHS and Social Care Partnership Trust. It has shaped new ways of working for nurses with a person-centred approach as its philosophy. Service users and nurses were involved in implementing a needs-led and bottom-up initiative using Kotter's change model. Initial results suggest that it has been successful in meeting its objectives evidenced through increased meaningful interactions and involvement in care by

service users and carers. The clinics have gained wide recognition and have highlighted a need for further research into care delivery models to promote service user involvement in these units.

Key words: Mental health services ▪ Patient participation ▪ Empathy
▪ Organisational culture ▪ Recovery clinics ▪ Service user involvement

In recent years, service user involvement in mental health has gained considerable momentum, and this is widely supported by various groups. This is evident in Government reports (Department of Health (DH),1991; 1992; 1994; 1999; 2000; 2001; 2003; 2009; 2012), professional bodies

such as the General Medical Council (2013) and Nursing and Midwifery Council (2015) and voluntary organisations (e.g. Schizophrenia Commission, 2012). It is a recurrent theme that appears in Care Quality Commission (CQC) (2015a; 2015b; 2016) reports that show the importance it places on user involvement practice. User involvement and empowerment is the second guiding principle of the Mental Health Act Code of Practice (DH, 2015). These developments have helped the wider NHS to reflects on current practice and identify a need to move away from the paternalistic approach, which was prevalent in the NHS (Coulter, 1999) towards a service user involvement approach. There is a drive within Kent and Medway NHS and Social Care Partnership Trust to incorporate service user involvement in all areas of care. 'Involving you in planning your care' was one of the five commitments the organisation made in the Customer Care Charter that was

published in 2012 (Kent and Medway NHS and Social Care Partnership Trust, 2012).The introduction of recovery clinics was an innovation by frontline staff in acute inpatient units, using available resources in a creative way.The clinic provides a protected time for service users with the mental capacity to engage in meaningful conversations with nurses regarding their treatment. This has shaped new ways of working for nurses in acute inpatient mental health units (AIMHUs) with the aim of promoting service user involvement in their care.This article describes the background for this innovation, the process of implementation of the recovery clinics using Kotter's (1996) eight-step change model, and an account of the sustainability of this initiative.

Background

Service user involvement is one of the most important factors in recovery-oriented practice, where service users are considered to be the experts in their illness (Slade, 2009). Service user involvement is the primary step that is required to implement a recovery-oriented practice; however, evidence from the literature suggests that this concept remains largely rhetoric (Connor and Wilson, 2006; Wilson et al, 2015). The momentum for service user involvement described in the literature is not reflected in current acute inpatient practice owing to various challenges to the NHS, as described below. In the NHS, a gradual transition from a paternalistic approach towards a user involvement approach is happening (Goulter et al, 2015) despite few changes in staffing infrastructure, the care delivery system or model. Regardless of the wealth of literature about user involvement, clear guidance on how to facilitate user involvement in various contexts and in practice is not often explicit in the literature (Radermacher et al, 2010), and Tambuyzer et al (2014) highlighted the need to have practical ways to shape patient involvement.

The barriers to user involvement in mental health practice have been clearly identified in the literature: organisational culture, professional culture and wider society, limited resources, poor information provision, debilitating mental state, conflicting responsibilities and duties and negative staff attitudes (Hickey and Kipping, 1998; Anthony and Crawford, 2000; van der Ham et al, 2014). However, an understanding of the current nature of AIMHUs is pivotal to appraise the challenges to user involvement practice in these units. The report produced by the Independent Mental Health Taskforce (2016) states that: 'Adult mental health services are under intense pressure.' Independent Mental Health Taskforce, 2016: 30

Furthermore, this report revealed that: 'Many acute wards are not always safe, therapeutic or conducive to recovery.' Independent Mental Health Taskforce, 2016: 9

This substantiates the observations made about AIMHUs as being complex, chaotic, unpredictable and dangerous sites (Horsfall et al, 2010; Cleary et al, 2012; Ward, 2013).This raises questions about the therapeutic environment of these units.

There are many factors that have contributed to the complex nature of AIMHUs. The emphasis on care in the community for the last two decades (Ward, 2013) has led to considerable reduction of AIMHU beds by 39% in the years 1998–2012 (The Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults, 2015). This has increased the admission rate and the bed

occupancy rate in these units (Independent Mental Health Taskforce, 2016). It led to a reduction in the duration of inpatient treatment (Cleary et al, 2005) and an increase in the threshold for admissions to AIMHUs (Brooker et al, 2007). Service users who are admitted to AIMHUs are acutely ill compared to admissions in the past (Lay et al, 2007), as admissions to these units are taking place at a later stage of the illness when safe provision of mental health care is no longer an option in the community (Bowers et al, 2005; Delaney and Johnson, 2012).These situations explain the increasing use of Mental Health Act assessments and detentions which is evident from recent CQC reports (CQC, 2015a; 2015b; 2016).These changes in the mental healthcare system can explain the mounting challenges faced by staff in AIMHUs. Despite the challenges mentioned that are outside nurses' remit, there are a number of internal challenges, such as working with disturbed and challenging patients on the ward, patients requiring high levels of observation, unpredictability of patient needs, coping with staff shortages and unplanned staff absences, high usage of non-permanent staff, high staff turnover, increasing numbers of inexperienced staff and meeting the national and
organisational targets.

These have an effect on the ability of inpatient nurses to spend therapeutic time with service users. This is evident from an observation made by Jones and Coffey (2012) that interpersonal work, which is the fundamental aspect of mental health nursing, is diminishing. The increasing amount of paperwork and the necessity of relying on computer-based activities to evidence their work takes nurses away from patients. Bee et al (2006) reported that containment of difficult behaviour is the most common nursing care activity in these settings. The need to balance the care between containment of difficult behaviour and managing high-risk patients (Mullen, 2009) poses further challenges to inpatient nurses. Ward (2013) identify the complex mix of patients as the most stressful part of mental health nursing, which is a common feature in AIMHUs. A descriptive observational study conducted by Goulter et al (2015) revealed that 32% of nurses' time was spent on direct care, 52% on indirect care and 17% on service-related activities. The results from this study echoed previous studies (Borg and Kristiansen, 2004; Stenhouse, 2011), which therefore suggests a need for nurses to make themselves available for therapeutic interventions. All these challenges play a vital role in making nurses unavailable for service users. In the Guardian, Carroll (2015) wrote:

'Please do not drown us in a sea of targets, statistics and paperwork. Please do not take away our time to be compassionate.'

Carroll, 2015

This is an open and honest response of a nurse's frustration in relation to their inability to spend therapeutic time with service users. All these challenges are suggestive of limited time available for nurses in AIMHUs as a result of tasks and activities that are factored in as part of their expected role and which impact on direct care time.

There are other factors that lie outside of nurses' control that also affect the quality and quantity of therapeutic time (Rydon, 2005; Nolan et al, 2007; Horsfall et al, 2010). Despite facing these increasing challenges, the operational model for nurses in AIMHUs remains unchanged and is not conducive to meeting current demands (Bowers et al, 2009). This raises an important question about the ability of the current model (Carlyle et al, 2012) the NHS uses to promote user involvement practices. It is necessary to consider new models to meet these challenges as the current model supports a medical model of care (Mind, 2004; McCulloch et al, 2005; Carlyle et al, 2012). Furthermore, the traditional role, which is preoccupied with tasks and containment, should be replaced with more therapeutic roles for inpatient nurses (Baguley et al, 2007). Promoting user involvement practice requires adequate time, support and commitment (Anthony and Crawford, 2000; Radermacher et al, 2010), however, it is a vital part of the recovery process (Thomson and Hamilton, 2012). Nurses on the AIMHU where the recovery clinics were implemented felt that time constraints and persistent interruptions during therapeutic sessions were a real set-back. Leese et al (2014) also highlighted time constraints as a major barrier in these units for accomplishing therapeutic time.

Implementation

Because of these challenges, the concept of recovery clinics was taken forward in the Trust. It originated as a result of outcomes from service user feedback, clinical supervision and practice reflection sessions. Kotter's eight-step change model (1996) was used as a framework for the implementation of recovery clinics. The steps are:

- Create a sense of urgency
- Form a strong coalition
- Create a vision for change
- Communicate the vision
- Remove obstacles
- Create short-term wins
- Build on change
- Embed the change into the culture.

This model was chosen as it advocates a subtle and gradual change process that allows the team to become familiar with new situations.

Create a sense of urgency

The prospect of having protected time for individual nurses to spend time with service users to promote their involvement in care was discussed during a team meeting. This sparked enthusiasm among team members; however, there was some ambivalence and concern about its application and sustainability. This is because of the previous experience the team had had of protected time for therapeutic work on this unit, which was not successful. Protected time had been implemented for the whole unit, where staff focused on one-to-one therapeutic time with service users. However, when staff encountered internal challenges, the whole unit became distracted and was unable to meet the objective of providing protected time. Baker et al (2014) reported that quality improvement initiatives to improve acute inpatient care in the last 15 years have not delivered the expected outcomes.

The team also reviewed some evidence on the success of protected time when it was assigned to individual staff for facilitating specific roles, such as the carers' champion role and physical health nurse role in these units. They recognised that these nurses have protected time to carry out these tasks, and the amount of disruption is minimal. In recent internal and external audits that took place in the unit, the need for increased user involvement in care plans was highlighted. Therefore this was seen as an additional reason to progress the idea.

The proposal was discussed with service users on the unit and their responses were very encouraging and supportive. They proposed this space be called recovery clinics rather than nurse clinics, which was the original title of this initiative. These suggestions were taken to the local clinical management team who supported the initiative and suggested presenting it in a governance meeting. The fundamental proposal was to use the available staff resources in a creative and productive way that would not incur any financial costs. Discussions with service users, team and local management became instrumental in creating a sense of urgency for the need to promote service user involvement in their care at the area of practice.

Form a strong coalition

Members of the team who acknowledged the need to change expressed their commitment by becoming part of a steering group in implementing the recovery clinics. Despite encouragement, there was reluctance from service users on the unit at that time to represent themselves in the steering group. The rapid turnover of service users also posed a stumbling block. The group was clear about the objectives of recovery clinics (Box 1) and agreed to meet frequently to assess developments. The discussion included staffing resource, identifying an appropriate area for the clinics and evaluation methods. The members of the group were unanimous that the service users should have the right to choose an area for discussion pertaining to their recovery. There was also a consensus within the group members that the recovery clinics should not be seen as a fast track for discharge from the unit. It was also agreed that the outcome of the clinics would be measured by maintaining a register to assess the number of service users using this opportunity and the individual time they spend with nurses during clinics. It was anticipated that service users would have an opportunity to provide feedback on their experience.

Create a vision for change

After a couple of sessions the steering group were able to develop a project proposal that outlined the scope of the recovery clinics. Its vision was to create new ways of working for nurses in an acute inpatient unit to promote service user involvement in their care by spending meaningful time with service users. The clinics would be facilitated outside the immediate ward environment by a qualified member of staff with a person-centred approach as their philosophy. One of the main roles of the nurse during the clinic was to be an active listener. The clinic aimed to provide ample opportunity to work in partnership with service users by sharing information, encouraging their involvement and formulating interventions collaboratively to promote recovery. Each individual session was planned to be 60 minutes as recommended by the National Institute for Health and Care Excellence (NICE) (2011). The clinics were scheduled to take place from 10 am to 5 pm and accommodate up to six service users per day.

Communicate the vision

The scope, implications and expected outcomes of the clinics were communicated to all staff members, service users and wider teams using a presentation and posters. One of the service users said: ‘This should happen in all our hospitals’. A presentation was compiled with support from service users and was shared with everyone from individual staff members to the senior management team. The responses received were very supportive and encouraging. During this phase, service users expressed their desire to have more frequent sessions on the unit.

Remove obstacles

At the beginning of the journey towards implementing recovery clinics, a number of constraining forces were identified such as staff reluctance and availability, financial limitations, an appropriate environment and availability of staff trained in delivering psychosocial interventions.

Another issue was to identify a process for assessing the success of clinics. It was identified that staff availability can be ensured by allocating staff members on the duty rota in advance. It was decided that the clinics would be facilitated by the staff that were in the steering group to reassure the team that this is feasible.

The financial cost was greatly reduced by providing protected time for staff members by amending the shift timings to facilitate clinics.

To avoid a busy ward environment, it was necessary to identify a space outside the immediate ward context. This is where the group required support and involvement from the management team. An appropriate room was identified and was refurbished with new furniture to use as a therapeutic space to facilitate the clinics.

Staff members trained in delivering psychosocial interventions were able to share their expertise with other team members to help them facilitate the clinics. The initiative also highlighted the need to have more staff trained in delivering psychosocial interventions and has resulted in enrolling more staff to universities; however, it can take up to a year for successful completion of the course. Baker et al (2014) reported that adequate access to psychosocial interventions in AIMHUs is vital. As an interim measure, psychosocial interventions training sessions were arranged locally for staff in collaboration with a local university to address immediate requirements. Regular clinical supervision for staff who facilitate clinics was also ensured to support these nurses.

Aston and Coffey (2012) suggested that the quality of the relationship between service users and nurses is more important than the level of expertise. In essence, the obstacles were removed largely by using the available resources and by making changes in a subtle and creative way.

Create short-term wins

The clinics were launched jointly by a service user and staff representative on 30 April 2013.The enthusiasm and comments of service users were testament to the expectation they had from recovery clinics. A service user who attended the clinic said:

'I've been here few times but this is the first time I felt that I got someone to talk to and got time to listen.'

The communication department of the organisation produced a report on the initiative. A peer review carried out by another NHS organisation made complimentary reference to the recovery clinic in its report as an excellent model.

Build on change

A review of the data collected after 3 months from the start of the clinics showed encouraging evidence of user involvement opportunity for service users and carers on the unit. Data collected using agreed evaluation methods quantified a significant increase in therapeutic time where service users were involved in discussions about their care and problem- solving activities. Furthermore, there was a noticeable decline in comments such as 'can't speak to anyone', 'lack of involvement in care' in discharge questionnaires and in community meetings on the unit. These results were presented in the acute service line leadership forum of the organisation where there was a unanimous consensus to implement recovery clinics in other AIMHUs in the organisation. Subsequently, the members of the steering group were able to present this at the nursing conference hosted by the organisation. The story of this initiative was published on the organisation's staff zone web page with the title 'Recovery clinic proves a win-win for service users and staff.' The recovery clinics were highly commended in the National Positive Practice Mental Health Awards (Picker Institute Europe, 2014), which was a great recognition for this joint initiative and a poignant moment marking a milestone.

Embed the change into the culture

As a result of this success, recovery clinics were introduced in other acute units of the organisation. The members of the steering group were able to visit other teams to support their implementation. Service users groups, carers groups and other external teams were informed about this new opportunity on the unit. Reference to the clinics during shift handovers and multidisciplinary team meetings where service users who might benefit from clinics were identified was suggestive of its acceptance into the organisational culture. Provisions were made in the electronic duty roster for allocating staff exclusively to facilitate recovery clinics. Nursing students, during their placement, started joining their mentors in the clinics and reported their time there as a new learning opportunity.

Sustainability

The sustainability of initiatives that have an impact on the role and practice of nurses in AIMHUs has been a subject of debate. However, data reflecting nurse's views and involvement in such initiatives are limited (Cleary et al, 2005). Recommendations for change in practice and criticism are often raised by individuals who do not work in AIMHUs (Horsfall et al, 2010). According to Baker et al (2014), many quality improvement initiatives in AIMHUs in past years were ineffective. It would be interesting to look at the involvement of service users and frontline staff in developing and implementing these initiatives that Baker et al's (2014) study refers to. Furthermore, it can be argued that such failures can create an unconstructive perception among staff towards future initiatives. The achievements of this initiative support the findings from a study conducted by Stewart et al (2012), which suggest small changes to the allocation of staff resources can give rise to considerable improvements to inpatient service delivery and patient experience.

The sustainability of these clinics was one of the issues raised by nurses, service users and management at the initial stages of this initiative. The concept of recovery clinics was a needs-led and bottom-up initiative, originated as an integrated response to service user voices and nurse desire, which remains a backbone of its sustainability. Since its launch, service users, carers, nurses and clinicians from other disciplines have embraced recovery clinics as a space for nurses to promote user involvement and to provide therapeutic interventions. One of the senior nurses stated that:

‘It is like a breath of fresh air, it really energises you career wise and your practice as a nurse.’

The nurses who facilitate these clinics spend more meaningful time with service users, have increased job satisfaction and feel proud to work in a service with an enhanced reputation. The CQC has appraised this initiative in its report (CQC, 2015c) as an example of positive innovation in acute inpatient practice.

Conclusion

The concept of service user involvement has gained wide acknowledgement and momentum from various groups in society. However, its application in AIMHUs creates various challenges for nurses. These challenges are mainly owing to the current nature of AIMHUs. Consequently, it is limiting opportunities for nurses to spend meaningful time with service users and to involve them in their care that creates a theory– practice gap. Recovery clinics were introduced to bridge this gap and to embed a user involvement practice within the current care delivery model in an AIMHU. Service users and nurses were involved in implementing this initiative using Kotter’s change model and played a vital role in its success. Evolving results (both qualitative and quantitative) suggest that it has been successful in meeting its objectives evidenced by increased meaningful interactions and involvement in care by service users and carers. The success of the clinics has reiterated that nurses require protected time in AIMHUs to promote service user involvement practice. They have also provided insight into how service users’ involvement in care can be improved in AIMHUs. Recovery clinics have gained both internal and external recognition; however, the positive response from service users, carers and nurses is the most important factor. This intervention has highlighted a need for further research into care-delivery models and practices that are compatible with the current nature of AIMHUs to embed active service user involvement in care planning.

Declaration of interest: none

Acknowledgements: The author is very grateful to all AIMHU staff, service users, carers and management of the Kent and Medway NHS Trust, for their enormous support, encouragement and suggestions with the implementation of recovery clinics. Also thanks to Dr John Crowley for his supervision of this project.

Anthony P, Crawford P (2000) Service user involvement in care planning: the mental health nurse's perspective. J Psychiatr Ment Health Nurs 7(5): 425–34 Aston V, Coffey M (2012) Recovery: what mental health nurses and service
users say about the concept of recovery. J Psychiatr Ment Health Nurs 19(3): 257–63. https://doi.org/10.1111/j.1365-2850.2011.01776.x

Baguley I, Alexander J, Middleton H, Hope R (2007) New ways of working in acute inpatient care: a case for change. Journal of Mental Health Training, Education and Practice 2(2): 43-52. https://doi. org/10.1108/17556228200700013

Baker J, Sanderson A, Challen K (2014) Acute inpatient care in the UK. Part 1: recovery–oriented wards. Mental Health Practice 17(10): 18-24. https:// dx.doi.org/10.7748/mhp.17.10.18.e883

Bee P, Richards D, Loftus S et al (2006) Mapping nursing activity in acute inpatient mental health settings. Journal of Mental Health 15(2): 217-26. https://doi.org/10.1080/09638230600608941

Borg M, Kristiansen K (2004) Recovery-oriented professionals: helping relationships in mental health services. Journal of Mental Health 13(5): 493– 505. https://doi.org/10.1080/09638230400006809

Bowers L, Simpson A, Alexander J, Hackney D, Nijman H, Grange A,Warren J (2005) The nature and purpose of acute psychiatric wards: the Tompkins acute ward study. Journal of Mental Health 14(6): 625-35. https://doi. org/10.1080/09638230500389105

Bowers L, Brennan G,Winship G,Theororidou C (2009) Talking with Acutely Psychotic People: Communication Skills for Nurses and Others Spending Time with People who are Very Mentally Ill. City University, London

Brooker C, Ricketts T, Bennett S, Lemme F (2007) Admission decisions following contact with an emergency mental health assessment and intervention service. J Clin Nurs 16(7): 1313–22. https://dx.org/10.1111/ j.1365-2702.2007.01302.x

Care Quality Commission (2015a) Monitoring the Mental Health Act in 2013/14. https://tinyurl.com/y9j2ydyz (accessed 5 June 2017)

Care Quality Commission (2015b) Monitoring the Mental Health Act in 2014/15. http://tinyurl.com/yb3eovby (accessed 5 June 2017)

Care Quality Commission (2015c) Kent and Medway NHS and Social Care Partnership Trust: Quality Report: 14. http://tinyurl.com/y6umboek (accessed 13 June 2017)

Care Quality Commission (2016) Monitoring the Mental Health Act in 2015/16.
http://tinyurl.com/ydfqzhy5 (accessed 5 June 2017)

Carlyle D, Crowe M, Deering D (2012) Models of care delivery in mental health nursing practice: a mixed method study. J Psychiatr Ment Health Nurs 19(3): 221–30. https://doi.org/10.1111/j.1365-2850.2011.01784.x

Carroll E (2015) Working as a mental health nurse in today's NHS drained me of compassion. Guardian 17 August. http://tinyurl.com/y87l2tn5 (accessed 31 May 2017)

Cleary M,Walter G, Hunt G (2005) The experience and views of mental health nurses regarding nursing care delivery in an integrated, inpatient setting. Int J Ment Health Nurs 14(2): 72–7. https://doi.org/10.1111/ j.1440-0979.2005.00362.x

Cleary M, Hunt GE, Horsfall J, Deacon M (2012) Nurse-patient interaction in acute adult inpatient mental health units: a review and synthesis of qualitative studies. Issues Ment Health Nurs 33(2): 66–79. https://doi.org/10
.3109/01612840.2011.622428

The Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults (2015) Improving acute Inpatient Psychiatric Care for Adults in England. http://tinyurl.com/yb2o3yk2 (accessed 8 June 2017)

Connor S,Wilson R (2006) It's important that they learn from us for mental health to progress. Journal of Mental Health 15(4): 461–74

Coulter A (1999) Paternalism or partnership? BMJ 319(7212): 719–20 Delaney KR, Johnson ME (2012) Safety and inpatient psychiatric treatment:
moving the science forward. J Am Psychiatr Nurses Assoc 18(2): 79–80. https://doi.org/10.1177/1078390312441369

Department of Health (1991) The Patient's Charter. DH, London. Department of Health (1992) The Health of the Nation. HMSO, London

Department of Health (1994) Working in Partnership? A Collaborative Approach to care. Report of the Mental Health Nursing review team. HMSO, London

Department of Health (2000) The NHS Plan: A Plan for Investment, A Plan for Reform. https://tinyurl.com/cwuknoz (accessed 6 June 2017)

Department of Health (2001) Involving Patients and the Public. A Discussion Document. https://tinyurl.com/yc2vfr8w (accessed 6 June 2017)

Department of Health (2003) Strengthening Accountability—Involving Patients and the Public Practice Guidance: section 11 of the Health and Social Care Act 2001. https://tinyurl.com/yb5hujqj (accessed 6 June 2017)

Department of Health (2009) Supporting People with Long Term Conditions.
Commissioning Personalised Care Planning: A Guide for Commissioners. https:// tinyurl.com/yb246cl7 (accessed 6 June 2017)

Department of Health (2012) Liberating the NHS: No Decision About Me Without Me: Further Consultation on Proposals to Secure Shared Decision- making https://tinyurl.com/yb9u8uu9 (accessed 13 June 2017)

Department of Health (2015) Mental Health Act 1983: Code of Practice. http:// tinyurl.com/o43x972 (accessed 5 June 2017)

General Medical Council (2013) Good Medical Practice. http://tinyurl.com/ yk5c9vu (accessed 5 June 2017)

Goulter N, Kavanagh DJ, Gardner G (2015) What keeps nurses busy in the mental health setting? J Psychiatr Ment Health Nurs 22(6): 449–56. https:// doi.org/10.1111/jpm.12173

Hickey G, Kipping C (1998) Exploring the concept of user involvement in mental health through a participation continuum. J Clin Nurs 7(1): 83–8

Horsfall J, Cleary M, Hunt GE (2010) Acute inpatient units in a comprehensive (integrated) mental health system: a review of the literature. Issues Ment Health Nurs 31(4): 273–8. https://doi. org/10.3109/01612840903295944

Independent Mental Health Taskforce (2016) The FiveYear Forward View For Mental Health. http://tinyurl.com/gvc4or3 (accessed 5 June 2017)

Jones M, Coffey M (2012) Voice hearing: a secondary analysis of talk by people who hear voices. Int J Ment Health Nurs 21(1): 50–9. https://doi. org/10.1111/j.1447-0349.2011.00761.x

Kent and Medway NHS and Social Care Partnership Trust (2012) KMPT Launch new Customer Care Charter. http://tinyurl.com/ycbkr5xk (accessed 8 June 2017)

Kotter JP (1996) Leading Change. Harvard Business School Press, Boston Lay B, Nordt C, Rössler W (2007) Trends in psychiatric hospitalisation of

people with schizophrenia: a register-based investigation over the last three decades. Schizophr Res 97(1–3): 68–78. https://doi.org/10.1016/j. schres.2007.07.006

Leese D, Smithies L, Green J (2014) Recovery-focused practice in mental health. Nurs Times 110(12): 20–2

McCulloch A, Ryrie I,Williamson T, John T (2005) Has the medical model a future? Mental Health Review Journal 10(1): 07-15. https://doi. org/10.1108/13619322200500003

Mind (2004) Mind’s Campaign to Improve Hospital Conditions for Mental Health Patients. https://tinyurl.com/yct5kcop (accessed 5 June 2017)

Morrow E, Robert G, Maben J, Griffiths P for NHS Institute for Innovation and Improvement (2010) Improving Healthcare Quality at Scale and Pace Lessons from The Productive Ward: Releasing Time to Care TM Programme. https://tinyurl.com/yarkrg5m (accessed 8 June 2017)

Mullen A (2009) Mental health nurses establishing psychosocial interventions within acute inpatient settings. Int J Ment Health Nurs 18(2): 83–90. https://doi.org/10.1111/j.1447-0349.2008.00578.x

National Institute for Health and Care Excellence (2011) Service user experience in adult mental health: improving the experience of care for people using adult

NHS mental health services. Clinical guideline 136. https://tinyurl.com/ ya4tq4xm (accessed 5 June 2017)

NHS Institute for Innovation and Improvement (2009) The Productive Mental Health Ward: Releasing Time to Care. http://tinyurl.com/y8ghcpnq (accessed 13 June 2017)

Nolan P, Haque S, Doran M (2007) A comparative cross-sectional questionnaire survey of the work of UK and US mental health nurses. International Journal of Nursing Studies 44(3): 377-85

Nursing and Midwifery Council (2015) The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives. https://tinyurl.com/zy7syuo (accessed 5 June 2017)

Picker Institute Europe (2014) The National Positive Practice in Mental Health Awards Recovery Clinics—Kent and Medway Partnership NHSTrust. https:// tinyurl.com/y9oejlgo (accessed 6 June 2017)

Radermacher H, Sonn C, Keys C, Duckett P (2010). Disability and participation: It's about us but still without us! Journal of Community and Applied Social Psychology 20(5): 333–46

Rydon SE (2005) The attitudes, knowledge and skills needed in mental health nurses: the perspective of users of mental health services. Int J Ment Health Nurs 14(2): 78–87. https://doi.org/10.1111/j.1440-0979.2005.00363.x

Schizophrenia Commission (2012) The Abandoned Illness. http://tinyurl.com/ ycm5crls (accessed 5 June 2017)

Slade M (2009) Personal Recovery and Mental Illness: A Guide for Mental Health Professionals. Cambridge University Press, New York

Stenhouse RC (2011) 'They all said you could come and speak to us': patients' expectations and experiences of help on an acute psychiatric inpatient ward. J Psychiatr Ment Health Nurs 18(1): 74–80. https://doi.org/10.1111/ j.1365-2850.2010.01645.x

Stewart MW,Wilson M, Bergquist K,Thorburn J (2012) Care coordinators: a controlled evaluation of an inpatient mental health service innovation. Int J Ment Health Nurs 21(1): 82–91. https://doi.org/10.1111/j.1447- 0349.2011.00771.x

Tambuyzer E, Pieters G,Van Audenhove C (2014) Patient involvement in mental health care: one size does not fit all. Health Expect 17(1): 138–50. https://doi.org/10.1111/j.1369-7625.2011.00743.x

Thomson LDA, Hamilton R (2012) Attitudes of mental health staff to protected therapeutic time in adult psychiatric wards. J Psychiatr Ment Health Nurs 19(10): 911–5. https://doi.org/10.1111/j.1365- 2850.2011.01871.x

van der Ham AJ, Shields LS, van der Horst R, Broerse JEW, van Tulder MW (2014) Facilitators and barriers to service user involvement in mental health guidelines: lessons from the Netherlands. Adm Policy Ment Health 41(6): 712–23. https://doi.org/10.1007/s10488-013-0521-5

Ward L (2013) Ready, aim fire! Mental health nurses under siege in acute inpatient facilities. Issues Ment Health Nurs 34(4): 281–7. https://doi.org/10
.3109/01612840.2012.742603

Wilson P, Mathie E, Keenan J et al (2015) ReseArch with Patient and Public invOlvement: a RealisT evaluation—the RAPPORT study. Health Services and Delivery Research 3(38) https://doi.org/10.3310/ hsdr03380

Worthington A, Rooney P, Hannan R (2013) The Triangle of Care Carers Included: A Guide to Best Practice in Mental Health Care in England. 2nd edn. https://tinyurl.com/yb7dz3lm (accessed 8 June 2017)

KEY POINTS

- Kotter's eight-step model was used to implement recovery clinics in acute inpatient mental health units
- Service user involvement was considered an important factor in the process
- Promoting service user involvement requires adequate time, support and commitment

CPD reflective questions

- Think about user involvement in your area of practice. How is it currently experienced by both service users and staff?
- Reflecting on your own practice, how do you encourage user involvement?
- In what ways could you, or your organisation, promote greater user involvement in your clinical area? Reflect on the barriers to involvement, and ways in which these could be overcome

Appendix 3: Quality standards for focusing reviews

	Inadequate	Adequate	Good	Excellent
The review question is sufficiently and appropriately focussed.	The review question is too broad to be answerable within the time and resources allocated. There is no evidence that progressive focussing occurred as the review was undertaken.	Attempts are made by the review team to progressively focus the review topic in a way that takes account of the priorities of the review and the realities of time and resource constraints. Attempts are documented so that they can be described in publications as appropriate.	Adequate plus: The focussing process is iterative. Commissioners of the review are involved in decision-making about focussing. Decisions made about which avenues are pursued and which are left open for further inquiry are recorded and made available to users of the review.	Good plus: The review team draws on external stakeholder expertise to drive the focussing process in order to achieve maximal end-user relevance.

Source: RAMESES training materials (Wong et al., 2013)
https://www.ramesesproject.org/media/Realist_reviews_training_materials.pdf

Appendix 4: Quality standards for constructing and refining a realist programme theory

	Inadequate	Adequate	Good	Excellent
An initial realist program theory is identified and developed.	A realist program theory is not offered or A program theory is offered but is not converted to a realist program theory at any stage of the review.	An initial program theory is identified and described in realist terms (that is, in terms of the relationship between contexts, mechanisms and outcomes). The refined theory is consistent with the evidence provided.	Adequate plus: An initial realist program theory is identified and described at the outset. The theory is refined iteratively as the review progresses.	Good plus: The relationship between the program theory and relevant substantive theory is identified. Implications of the final theory for practice, and for refinements to substantive theory where appropriate, are described. The final realist program theory comprises multiple context-mechanism-outcome configurations (describing the ways different mechanisms fire in different contexts to generate different outcomes) and an explanation of the pattern of CMOs.

Source: RAMESES training materials.

https://www.ramesesproject.org/media/Realist_reviews_training_materials.pdf

Appendix 5: Quality standards for selecting and appraising documents

	Inadequate	Adequate	Good	Excellent
The selection and appraisal process ensures that sources relevant to the review containing material of sufficient rigour to be included are identified. In particular, the sources identified allow the reviewers to make sense of the topic area; to develop, refine and test theories; and to support inferences about mechanisms.	The selection and appraisal process does not support a rigorous and complete realist review. For example: • Selection is overly driven by methodological hierarchies (e.g. the restriction of the sources to RCTs to the exclusion of other forms of evidence) • Sources are appraised using a technical checklist for a particular method (e.g. assessment of quality for an RCT) rather than by making a defensible judgement on the relevance and rigour of the source • Selection and appraisal processes are overly restrictive and exclude materials that may be useful for a realist analysis • Selection and appraisal processes are not sensitive enough to exclude irrelevant materials	Selection of a document for inclusion into the review is based on what it can contribute to the process of theory development, refinement and/or testing (i.e. relevance). Appraisals of rigour judge the plausibility and coherence of the method used to generate data.	Adequate plus: During the appraisal process limitations of the method used to generate data are identified and taken into consideration during analysis and synthesis.	Good plus: Selection and appraisal demonstrate sophisticated judgements of relevance and rigour within the domain.

Source: RAMESES training materials
https://www.ramesesproject.org/media/Realist_reviews_training_materials.pdf

Appendix 6: Quality standards for understanding and applying the underpinning principles of realist review

	Inadequate	**Adequate**	**Good**	**Excellent**
The review demonstrates understanding and application of realist philosophy and realist logic which underpins a realist analysis.	Significant misunderstandings of realist philosophy and/or logic of analysis are evident. Common examples include: •program/intervention activities or strategies are confused with mechanisms • no attempts are made to uncover mechanisms • outcomes are assumed to be caused by the program/intervention • relationship(s) between an outcome, its causal mechanism(s) and context(s) are not explained • some theory is provided but this is not explicitly linked to outcome(s).	Some misunderstandings of realist philosophy and/or logic of analysis exist, but the overall approach is consistent enough that a recognisably realist analysis results from the process.	The review's assumptions and analytic approach are consistent with a realist philosophy at all stages of the review. Where necessary a realist program theory is developed and tested.	Good plus: Review methods, strategies or innovations used to address problems or difficulties within the review are consistent with a realist philosophy of science.

Source: RAMESES training materials

https://www.ramesesproject.org/media/Realist_reviews_training_materials.pdf

Appendix 7: Quality standards for developing a search strategy

	Inadequate	**Adequate**	**Good**	**Excellent**
The search process is such that it would identify data to enable the review team to develop, refine and test program theory or theories	The search is incapable of supporting a rigorous realist review. Common errors include: • The search is driven by a methodological hierarchy of evidence (e.g. privileging RCTs) rather than the need to identify data to develop, refine or test program theory/ies • The search process is not informed by the objectives and focus of the review • The database(s) selected are narrow in the subject matter that they contain (e.g. limited to specific topics rather than extending to social science, psychology etc.) • Searching is undertaken once only at the outset of the review and there is no iterative component.	Searches are driven by the objectives and focus of the review. The search strategy is piloted and refined to check that it is fit for purpose. Documents are sought from a wide range of sources which are likely to contain relevant data for theory development, refinement and testing. There is no restriction on the study or documentation type that is searched for	Adequate plus: further searches are undertaken in light of greater understanding of the topic area. These searches are designed to find additional data that would enable further theory development, refinement or testing.	Good plus: the searching deliberately seeks out data from situations outside the program under study where it can be reasonably inferred that the same mechanisms(s) might be in operation.

Source: RAMESES training materials (Wong et al. 2013).

Appendix 8: Data extraction & appraisal form for RR

Document Title	
Author/s & year of publication	
Type of paper & methods used	
Abstract	
Contextual factors	
Mechanisms identified	
Page no from which evidence is taken	
Strengths of the study	
Limitations of the study	
Linking to substantive theories	
Comments	

Appendix 9: Interview schedule for service user participants

This research is about service user involvement in recovery-oriented care planning in acute inpatient units

1. What do you think service user involvement in their care planning means?

2. Have you had personal experience of being involved in your care planning?

3. Can you share any good experiences of being involved in your care planning?
    - What made it a good experience?
    - Could it have been improved at all?

4. Can you share any experiences when your involvement in your care planning wasn't so good?

5. What do you think are the big issues that make it less easy to involve people in their care planning?

6. How could staff make it easier for service user involvement in care planning?
    - What do they need to do differently?
    - When are the best opportunities for you to be involved in your care planning?

7. What is your opinion about inpatient staff involving carers to formulate care plans when service user is seen to lack capacity to be involved in this process?

8. Is there anything else about service user involvement in their care planning you would like to say that I have not covered?

Appendix 10: Interview schedule for mental health staff participants

1. Let’s start by exploring service user involvement in recovery-oriented care planning – what does this mean to you?

2. Is service user involvement in care planning encouraged in your workplace? How does this work in practice?

3. Are there particular issues in involving acutely ill service users in care planning? Have you found ways or can you give examples of how this has been managed?

4. Are there any downsides to active service user involvement in care planning?

5. How can these benefits be maximised and service user involvement in care planning be normal, everyday practice?

    - Are there specific things staff needs to do differently?

    - Are there specific meetings that would be most suitable for involving service users in their care plans?

    - What role do you think service users have in enabling involvement in care planning?

6. What are the challenges to service user involvement in recovery-oriented care planning? Prompts if needed:

    - Realistic goals?
    - Disagreements over goals and actions?
    - The inpatient environment?

7. Is there anything else you’d like to say about service user involvement in their care plans?

Appendix 11: Interview schedule for national / regional stakeholders

1. From your experience and work, can you think of examples where service user involvement in recovery-oriented care planning as an acute inpatient has worked well?
    - Why do you think it worked well?
    - Are there general principles that can be applied to all acute inpatient units?
2. Why do you think service user involvement in recovery-oriented care planning as an acute inpatient is important?
    - How can we best evaluate/measure outcomes of service user involvement in care planning as an acute inpatient?
3. What do you think are the main barriers to service user involvement in care planning as an acute inpatient?
4. If you could change one thing to enable service user involvement in care planning as an acute inpatient, what would that be?
5. Is there anything else about service user involvement in their care planning you would like to say that I have not covered?

Appendix 12: Information Sheet for Service Users (Focus group and interview)

Study Title:

Enhancing Service User Involvement in recovery-oriented care planning during acute inpatient care pathway.

Introduction

I am a PhD student at the University of Kent and I am undertaking a study to understand how service users can be involved in their care planning during an acute inpatient stay. You are being invited to take part in this study because I value your views and opinions based on your personal experience that can contribute towards this study. This information sheet explains why it is being done and what it would involve for you. Please do contact me if you have any questions. My contact details are provided at the end of this sheet.

Purpose of the study

Service user involvement in care planning is important in mental health care and is seen as a key contribution to recovery oriented care. It is currently being promoted and advocated through various means such as local and national policies, studies, guidelines and by voluntary organisations. However studies and reports indicate that service users are not commonly involved in care planning. This study will concentrate on understanding practices and interventions that can bridge this gap in order to embed service user involvement in care planning during an acute inpatient stay.

Why have I been invited?

I would like to find out from people like you who have received inpatient care and to hear your experiences of involvement in the care-planning process. In addition to this, I would like to take this opportunity to understand your views and opinions about practices that can enhance service user involvement in care planning during acute inpatient care.

What will happen?

1. Taking part in a focus group.

I am asking whether you would be willing to take part in a focus group which will involve a maximum of 10 service users who have also received acute inpatient care. A focus group is a small group of people who, with the guidance of a researcher, will discuss their experience on a specific topic. The aim of this focus group is to discuss questions raised in this study about service user involvement in care planning and to understand views of this group about practices that can enhance service user involvement in care planning during an acute inpatient stay. The focus group will not take longer than 60 minutes. With the group's consent, the discussion will be recorded and transcribed.

2. Taking part in an interview

As an expert by experience your views on this subject is immensely valuable to this study. If you have difficulties in attending scheduled focus groups in your area, or would prefer to talk one to one rather than in a group, I would still like to give you an opportunity to share your views and opinions on this topic. After consulting with you, I will arrange a convenient time and place for a face-to-face interview. The aim will be to discuss questions raised in this study about service user involvement in care planning and to understand your views about practices that can enhance service user involvement in care planning during acute inpatient care. The interview will not take more than 60 minutes. With your consent, the interview will be recorded and transcribed.

Do I have to take part?

It is entirely up to you whether you take part in this study. You can choose to do either the focus group or the interview. It may be more convenient for you to have an interview over the phone at a time suitable to you; it's your choice. If you decide to take part but change your mind, you are free to do so and you can stop at any time. Taking part in this study will have no effect on the care you receive.

Will my taking part in this study be kept confidential?

All information collected about you will be strictly confidential, and we will protect your identity. In the transcripts your name will be replaced by an anonymised code. The transcripts will be stored on a password protected network at the University and will only ever be accessed by the research team. Once the study is finished, all the recordings and any personal data collected about you will be deleted, and anonymised data will be destroyed after five years. You will not be identifiable in any written reports. Things you say during the interview may be directly quoted in written reports and publications, but your name or anything else that could make you identifiable will be removed. If you would like, a draft of the report to read through before it is made public to make sure you are satisfied with the level of anonymity, then this can be arranged.

Confidentiality during focus groups

The researcher will not tell anyone that you have taken part in the focus group, although there is of course a possibility that another member of the group might recognise you. We will also not name you in any of our reports or publications. While the researcher will maintain confidentiality, he cannot promise this on behalf of other participants. As a result, all participants in the focus group will be asked to respect the confidentiality of their fellow participants.

Benefits and risks of taking part in this study

I will ensure that there are no risks to you by taking part in the study. Furthermore, any sensitive information you give me regarding yourself, or other health and care workers will not be shared with anyone. Rarely, researchers hear something that may indicate a risk to the participant or others. In these circumstances the researcher may be obliged to share this with those caring for the participant, but the researcher would keep the participant fully informed about this. Your input into the study will be a vital part of planning improvements to your service and to improving the quality of care to other people in your area. Your information will also give me a better idea of how we can improve health and care services across the country. You will receive a £20 shopping voucher, to thank you for taking part in this study and your travel expenses (public transport tariff or mileage basis for private transport) for taking part in this study will be reimbursed.

What will happen to the results of the study?

Any information you give, will be made completely confidential and anonymous. The results of the study will be used to improve the care provided at your service. I will work directly with local care teams on making improvements based on the results of the study. The results will also be published in journals and conferences to share the learning from the study with others.

Who has reviewed the study?

All research in the National Health Service is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed by the London - Camberwell & St. Giles Research Ethics Committee.

Who can I contact if I have any further questions?

If you have any further questions or concerns about the study, please do not hesitate to contact:

Thomas John,

Post graduate Research student

Centre for Health Service Studies

Phone: 07867142045

Email: tj205@kent.ac.uk

Who can I contact if I want to make a complaint about the study?

If you are unhappy about any aspects of the study and wish to make a formal complaint, you can do this through contacting

Professor Jenny Billings

Phone: 01227 823052; Email: j.r.billings@kent.ac.uk.

Alternatively you can also contact seAp advocacy on 0330 440 9000

Email: info@seap.org.uk

Web: http://www.seap.org.uk/services/nhs-complaints-advocacy/

Thank you for your time

Appendix 13: Information Sheet for mental health staff (Focus group and interview)

Study Title:

Enhancing service user involvement in recovery-oriented care planning during acute inpatient care pathway.

Introduction

I am a Post Graduate student researcher at the University of Kent and I am undertaking a study to understand how service users can be involved in their care planning during an acute inpatient stay. You are being invited to take part in this study because I value your views and opinions based on your professional and personal experience that can contribute towards this study. This information sheet explains why it is being done and what it would involve for you. Please do contact me if you have any questions. My contact details are at the end of this sheet.

Purpose of the study

Service user involvement in care planning is important in mental health care and is seen as a key contribution to recovery-oriented care. It is currently being promoted and advocated through various means such as local and national policies, studies, guidelines and by voluntary organisations. However, studies and reports indicate that service users are not commonly involved in care planning. It is acknowledged that acute inpatient units present particular, more pronounced, challenges for service user involvement compared to other domains of mental health practice. This study will concentrate on understanding practices and interventions that can bridge this gap in order to embed service user involvement in care planning during an acute inpatient stay.

Why have I been invited?

I would like to find out from people like you, who deliver acute inpatient care, about practice related challenges you encounter on a day to day basis. In addition to this, I would like to take this opportunity to understand your views and opinions about practices that can enhance service user involvement in care planning, during acute inpatient care.

What will happen?

1. Taking part in a focus group.

I am asking whether you would be willing to take part in a focus group, which will involve a maximum of 10 mental health staff who had experience in delivering acute inpatient care. A focus group is a small group of people who, with the guidance of a researcher, will discuss their experience on a specific topic. The aim of this focus group is to discuss questions raised in this study about service user involvement in care planning and to understand views of this group about practices that can enhance service user involvement in care planning during acute inpatient stay. The focus group will not take longer than 90 minutes. With the group's consent, the discussion will be recorded and transcribed.

2. Taking part in an interview

As mental health staff who have experience in delivering acute inpatient care, your views on this subject are immensely valuable to this study. If you have difficulties in attending scheduled focus groups in your area, or would prefer to talk one to one rather than in a group, I would still like to give you an opportunity to share your views and opinions on this topic. After consulting with you, I will arrange a convenient time and place for a face-to-face interview. The aim will be to discuss questions raised in this study about service user involvement in care planning and to understand your views about practices that can enhance service user involvement in care planning during acute inpatient care. The interview will not take more than 60 minutes. With your consent, the interview will be recorded and transcribed.

Do I have to take part?

It is entirely up to you whether or not you take part in this study. You can choose to do either the focus group or the interview; it's your choice. If you decide to take part but change your mind, you are free to do so and you can stop at any time. Taking part in this study will provide an experience to be involved in a research study. Professional bodies such as the General Medical Council (GMC), Nursing & Midwifery Council (NMC) and Health and Care Professions Council (HCPC) supports and encourages to promotes research activities by their registrants to develop evidence based knowledge for improving the care we provide. Taking part in this study will not impact on employee relationships with the Trust.

Will my taking part in this study be kept confidential?

All information collected about you will be strictly confidential, and we will protect your identity. In the transcripts your name will be replaced by an anonymised code. The transcripts will be stored on a password protected network at the University and will only ever be accessed by the research team. Once the study is finished, all the recordings and any personal data collected about you will be deleted, and anonymised data will be destroyed after five years. You will not be identifiable in any written reports. Things you say during the interview may be directly quoted in written reports and publications, but your name or anything else that could make you identifiable will be removed. If you would like a draft of the report to read through before it is made public; to make sure you are satisfied with the level of anonymity, then this can be arranged.

Confidentiality during focus groups

The researcher will not tell anyone that you have taken part in the focus group, although there is of course a possibility that another member of the group might recognise you. We will also not name you in any of our reports or publications. While the researcher will maintain confidentiality, he cannot promise this on behalf of other participants. As a result, all participants in the focus group will be asked to respect the confidentiality of their fellow participants.

Benefits and risks of taking part in this study

I will ensure that there are no risks to you by taking part in the study. Furthermore, any sensitive information you give me regarding yourself or other health and care workers will not be shared with anyone. Rarely, researchers hear practices that may put service users or others at risk. In these circumstances the researcher may be obliged to share this with the line manager of the participant, but the researcher would keep the participant fully informed about this. Your input into the study will be a vital part of planning improvements to your service and to improving the quality of care you deliver to service users in your area of practice. Your information will also give me a better idea of how we can improve health and care services across the country.

What will happen to the results of the study?

Any information you give, will be made completely confidential and anonymous. The results of the study will be used to improve the care provided at your service. I will work directly with local care teams on making improvements based on the results of the study. The results will also be published in journals and discussed at conferences, in order to share the learning from the study with others.

Who has reviewed the study?

All research in the National Health Service is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed by the London - Camberwell & St. Giles Research Ethics Committee.

Who can I contact if I have any further questions?

If you have any further questions or concerns about the study, please do not hesitate to contact:

Thomas John,

Post graduate Research student

Centre for Health Service Studies

Phone: 07867142045

Email: tj205@kent.ac.uk

Who can I contact if I want to make a complaint about the study?

If you are unhappy about any aspects of the study and wish to make a formal complaint, you can do this through contacting

Professor Jenny Billings

Phone: 01227 823052

Email: j.r.billings@kent.ac.uk.

Alternatively, you can also contact seAp advocacy on 0330 440 9000

Email: info@seap.org.uk

Web: http://www.seap.org.uk/services/nhs-complaints-advocacy/

Thank you for your time

Appendix 14: Information Sheet for national/regional stakeholders' interview

Study Title: Enhancing Service User Involvement in recovery-oriented care planning during acute inpatient care pathway.

Introduction

I am a Post Graduate student researcher at the University of Kent and I am undertaking a study to understand how service users can be involved in their care planning during an acute inpatient stay. You are being invited to take part in this study because I value your views and opinions based on your personal and professional experience that can contribute towards this study. This information sheet explains why it is being done and what it would involve for you. Please do contact me if you have any questions. My contact details are at the end of this sheet.

Purpose of the study

Service user involvement in care planning is important in mental health care and is seen as a key contribution to recovery oriented care. It has been promoted and advocated through various means, such as local and national policies, studies, guidelines and by voluntary organisations. However studies and reports indicate that service users are not commonly involved in care planning. This study will concentrate on understanding practices and interventions that can bridge this gap, in order to embed service user involvement in care planning during an acute inpatient stay.

Why have I been invited?

I would like to find out from people like you who can provide expert opinion and observation, about service user involvement in care planning, in acute inpatient units. In addition to this, I would also like to take this opportunity to understand your views and opinions about practices that can enhance service user involvement in care planning during acute inpatient care.

What will happen?

1. Taking part in an interview

As an expert in this area, your views on this subject are immensely valuable to this study. If you agree to take part, I'll arrange a face-to face or telephone interview with you, whichever is most convenient. The aim will be to discuss questions raised in this study about service user involvement in care planning and to understand your views about practices that can enhance service user involvement in care planning, during acute inpatient care. The interview will not take more than 60 minutes. With your consent, the interview will be recorded and transcribed.

Do I have to take part?

Taking part is voluntary so it is entirely up to you whether or not you take part in this study. If you decide to take part but change your mind, you are free to do so and you can discontinue at any time.

Will my taking part in this study be kept confidential?

All information collected about you will be strictly confidential in accordance with the Data Protection Act (1998). Any identifiable details will be stored separately from the answers you give during the interview and we will protect your identity. You will not be identifiable in any written reports. Things you say during the interview may be directly quoted in written reports and publications, but your name or anything else that could make you identifiable, will be removed. In the transcripts, your name will be replaced by an anonymised code. The transcripts will be stored on a password protected network at the University and will only ever be accessed by the research team. Once the study is finished, all the recordings and any personal data collected about you, will be deleted, and anonymised data will be destroyed after five years. If you would like, a draft of the report to read through before it is made public; to make sure you are satisfied with the level of anonymity, then this can be arranged.

Benefits and risks of taking part in this study

The information you provide will help to increase the understanding of enhancing service user involvement in care planning during acute inpatient care pathway. I will ensure that there are no risks to you by taking part in the study. Your input into the study will be a vital part of planning improvements to your service and to improving the quality of care-planning process. Your information will also give me a better idea of how we can improve health and care services across the country.

What will happen to the results of the study?

Any information you give, will be made completely confidential and anonymous. The results of the study will be used to improve the care provided at your service. I will work directly with local care teams on making improvements based on the results of the study. The results of this study are likely to be published in academic journals and presented in conferences, to share the learning from the study with others.

Who has reviewed the study?

All research in the National Health Service is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed by the London - Camberwell & St. Giles Research Ethics Committee.

Who can I contact if I have any further questions?

If you have any further questions or concerns about the study, please do not hesitate to contact:

Thomas John,

Post graduate Research student

Centre for Health Service Studies

Phone: 07867142045

Email: tj205@kent.ac.uk

Who can I contact if I want to make a complaint about the study?

If you are unhappy about any aspects of the study and wish to make a formal complaint, you can do this through contacting

Professor Jenny Billings

Phone: 01227 823052

Email: j.r.billings@kent.ac.uk.

Alternatively, you can also contact seAp advocacy on 0330 440 9000

Email: info@seap.org.uk

Web: http://www.seap.org.uk/services/nhs-complaints-advocacy/

Thank you for your time

Appendix 15: Contact form for service users

Project Title: Enhancing Service User Involvement in recovery-oriented care planning during acute inpatient care pathway.

Name (please print) …………………………………………………………….

Preferred contact method - Post, telephone, email (please circle)

Preferred telephone number………………………………………………………………………

Preferred times to be contacted…………………………………………………………

Preferred email address (optional)……………………………………………………………………………..

Preferred contact address (optional)………………………………………………………………….

Please leave completed form with your Care co-ordinators.

Appendix 16: Contact form for mental health staff

Name (please print) ………………………………………………………………………

Preferred contact method - Post, telephone, email (please circle)

Preferred telephone number………………………………………………………………………………

Preferred times to be contacted………………………………………………………

Preferred email address (optional)……………………………………………………………………….

Preferred contact address (optional)……………………………………………………………….

Please leave completed form with team administration staff.

Appendix 17: Introductory letter for Stakeholders

Thomas John

Post Graduate Research student

Centre for Health Service Studies (CHSS)

University of Kent

Canterbury

Kent, CT2 7NF

tj205@kent.ac.uk

Reference: Participation in research study

Dear Sir/Madam,

I am a PhD student at the University of Kent and I am undertaking a study to understand how service users can be actively involved in recovery-oriented care planning during an acute inpatient stay. During a subject related discussion, some of the experts in this area have pointed out you, as a credible resource that I can approach regarding this topic. As one of the experts in this area, I believe, your experience and knowledge can greatly contribute to this study. As part of data collection for this study, with your consent, I would like to arrange a face-to-face interview with you which will not take more than 30 minutes. Please refer to the information sheet that I have attached with this mail.

Thanks for your time and I look forward hearing from you.

Kind regards

Thomas John

Appendix 18: Service User Consent Form (Focus group / interview)

Project Title: Enhancing Service User Involvement in recovery-oriented care planning during acute inpatient care pathway.

Participant ID:

Please initial if you agree:

☐ I have read the attached information sheet

☐ I understand that my participation is voluntary and that I can stop taking part in this study at any time.

☐ I have asked and been given answers to questions about this study to make sure that I fully understand.

☐ I understand that I do not have to answer any question(s) that I do not feel comfortable with.

☐ I understand that by participating in an interview that I am consenting to have my comments recorded.

☐ I understand that any comments I make may be reported but I will not be identifiable in any report.

☐ I understand that the health care I receive will not be affected by my decision to participate.

☐ I understand that all information gathered during the interview will be kept confidential and will be safely stored on a password protected network with restricted access and in the offices of the Centre for Health Services Studies (CHSS) at the University of Kent.

☐ I understand that I need to respect the privacy of other participants in the focus group and to maintain confidentiality of the focus group discussion.

☐ I understand that my signature below means I have given permission to participate in this study.

Name ……………………………………Signature ……………………………..Date …………

Researcher's Name……………………Signature ……………………………..Date …………

Appendix 19: Mental Health staff consent Form (Focus group / interview)

Project Title: Enhancing Service User Involvement in recovery-oriented care planning during acute inpatient care pathway.

Participant ID:

Please initial if you agree:

☐ I have read the attached information sheet

☐ I understand that my participation is voluntary and that I can stop taking part in this study at any time.

☐ I have asked and been given answers to questions about this study to make sure that I fully understand.

☐ I understand that I do not have to answer any question(s) that I do not feel comfortable with.

☐ I understand that by participating in an interview that I am consenting to have my comments recorded.

☐ I understand that any comments I make may be reported but I will not be identifiable in any report.

☐ I understand that the health care I receive will not be affected by my decision to participate.

☐ I understand that all information gathered during the interview will be kept confidential and will be safely stored on a password protected network with restricted access and in the offices of the Centre for Health Services Studies (CHSS) at the University of Kent.

☐ I understand that I need to respect the privacy of other participants in the focus group and to maintain confidentiality of the focus group discussion.

☐ I understand that my signature below means I have given permission to participate in this study.

Name ……………………………… Signature ……………………………. Date ………..

Researcher's Name…………………… Signature ……………………………. Date ………..

Appendix 20: Stakeholders’ consent Form (interview [Face-to-face / Telephone])

Project Title: Enhancing Service User Involvement in recovery-oriented care planning during acute inpatient care pathway.

Participant ID:

Please initial if you agree:

☐ I have read the attached information sheet

☐ I understand that my participation is voluntary and that I can stop taking part in this study at any time. Any information I have offered up to this point will not be included in the study.

☐ I have asked and been given answers to questions about this study to make sure that I fully understand.

☐ I understand that I do not have to answer any question(s) that I do not feel comfortable with.

☐ I understand that by participating in an interview that I am consenting to have my comments recorded.

☐ I understand that any comments I make may be reported but I will not be identifiable in any report.

☐ I understand that the health care I receive will not be affected by my decision to participate.

☐ I understand that all information gathered during the interview will be kept confidential and will be safely stored on a password protected network with restricted access and in the offices of the Centre for Health Services Studies (CHSS) at the University of Kent.

☐ I understand that my signature below means I have given permission to participate in this study.

Name …………………………………… Signature …………………………… Date ………..

Researcher's Name……………………. Signature …………………………… Date ………..

Appendix 21: Principles of Stakeholder involvement

Organisational

1) Clarify the objectives of stakeholder engagement

The objectives might be one or more of accessing knowledge and skills; supporting interpretation of the results and drafting recommendations; supporting future influence and impact on policy and practice; increasing recruitment/enabling research; supporting transferability. The objectives need to be shared then among all parties.

2) Embed stakeholder engagement in a framework or model of research use

There are a number of models and frameworks designed to show how stakeholders might be engaged in a way that helps increase the chances of research being used in policy and practice, for example, the linkage and exchange model [9]

3) Identify the necessary resources for stakeholder engagement

Resources to consider are budget, time, skills and competences to manage engagement

4) Put in place plans for organisational learning and rewarding of effective stakeholder engagement, for example, through appropriate evaluation of stakeholder engagement

5) Recognise that some stakeholders have the potential to play a key role

Identify those stakeholders who are particularly interested in being engaged and those who are likely to be influential. Depending on the objective of stakeholder engagement, they may provide the most useful input, and are most likely to play a key role in using the results; their engagement should be especially encouraged

Values

6) Foster shared commitment to the values and objectives of stakeholder engagement in the project team

Ideally, make sure the commitment is there from the outset [6]

7) Share understanding that stakeholder engagement is often about more than individuals

Consideration needs to be given to stakeholders' roles where they act as representatives – their power and influence within organisations and networks they represent and how these change over time

8) Encourage individual stakeholders and their organisations to value engagement

Support and build capacity for stakeholders and their organisations to engage

9) Recognise potential tension between productivity and inclusion

Engagement may lead to greater relevance and impact, but may have implications for productivity in meeting project objectives (for example, in a timely fashion). Engaging stakeholders, taking into account their needs and inputs and adjusting elements of the research project based on their feedback takes time and can slow down the research process

10) Generate a shared commitment to sustained and continuous stakeholder engagement

Project teams and stakeholders see the value of links between research producers and research users to build ongoing collaborations in order to meet the objectives

Practices

11) Plan stakeholder engagement activity as part of the research programme of work

This should be built into the project protocol or plan (see Pokhrel et al. [34])

12) Build flexibility within the research process to accommodate engagement and the outcomes of engagement

It will also be important to build in mechanisms to allow researchers to have the independence to articulate what is out of scope

13) Consider how input from stakeholders can be gathered systematically to meet objectives

The importance of some face-to-face contact and interactions should be considered

14) Consider how input from stakeholders can be collated, analysed and used

This important aspect of stakeholder engagement needs to be considered earlier than often happens

15) Recognising identification and involvement of stakeholders is an iterative and ongoing process

Ongoing interaction will be fostered by taking the time and creating the structures to build trustful relationships

Appendix 22: Approval letter from Health Research Authority

NHS
Health Research Authority

Mr Thomas John
Inpatient Quality & Development lead
Kent & Medway NHS and Social Care Partnership Trust Priority House
Hermitage Lane Maidstone, Kent ME16 9PH
Email: hra.approval@nhs.net

29 November 2017
Dear Mr John

Letter of HRA Approval

Study title:	Enhancing service user involvement in care planning during acute inpatient
IRAS project ID:	230887
Protocol number:	ResGov 378
REC reference:	17/LO/1681
Sponsor	University of Kent

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read *Appendix B* carefully, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from the HRA website.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators",* issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.

- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through IRAS.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

procedure. If you wish to make your views known please use the feedback form available on the HRA website.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details on the HRA website.

Your IRAS project ID is 230887. Please quote this on all correspondence. Yours sincerely

Michael Pate Assessor

Email: hra.approval@nhs.net

Copy to: *Ms Nicole Palmer – University of Kent – Sponsor contact*

Ms Sarah Dickens - Kent and Medway NHS and Social Care Partnership Trust – Lead NHS R&D contact.

Appendix 23: Distress management protocol for research focus group / interview

Distress	- The researcher observes first sign of distress observed on participant or - Participant exhibit behaviours suggestive that the discussion during focus group or interview is too stressful
Stage1 Response	- Discussion or interview will be stopped - Researcher will attend to participant and offer immediate support - Researcher will escort participant to a quiet room - Researcher will offer time and a drink - Researcher will ask the participant whether they would like to talk about what is distressing them and also reassure and remind the participant that they do not need to continue with the discussion or interview.
Review	- If the participant feels that they can proceed with the discussion or interview; discussion/interview will be resumed. Or - If the participant is unable to proceed with the discussion/interview, the researcher will apply stage 2 response.
Stage2 Response	- If the participant finds it difficult to be in focus group discussion the researcher will remind the participant about the option about the interview that can be rescheduled. - If a participant finds it difficult to proceed either with focus group or with interview and express their wish to discontinue then the participant will be reassured it is absolutely fine to discontinue with the focus group / interview

	- Participant will be encouraged to make contact with their care co-ordinator or offer, with the participant’s consent, for the researcher to do so - With participant consent contact the care co-ordinator of the participant - Offer reassurance to participant and follow up courtesy call - Provide token of appreciation of their time as described in the participant information sheet - Researcher will also offer contact details for free telephone helpline support such as: - Mental Health Helpline (08001070160) - Samaritans (116 123), - SANE (0300 304 7000) (www.sane.org.uk) - MIND (03001233393) Text- 86463, www.mind.org.uk - In case of mental health staff, researcher will offer staff support line number (03000411411) for psychological support.
Follow up	- Researcher to make follow up courtesy call if participant consents) Or - Encourage the participant to call either if he/she experiences increased distress in the hours/days following the focus group or interview

Appendix 24: Papers included in the synthesis and appraisal of evidence

SL No	Authors & Year	Title	Source	Findings	Strengths	Limitations	Contribution to Programme theory
1	McKenna, B., Furness, T., Dhital, D & Ennis, G et al. (2014)	Recovery-Oriented Care in Acute Inpatient Mental Health Settings: An Exploratory Study	Database	The results of this study indicate that regardless of how the National policy of recovery-oriented care may be applied in the near future, mental health nurses are challenged more by the structure of the health service than the comprehension of recovery-oriented care as a new paradigm of mental health service delivery. Additionally, this study describes the extent to which mental health nurses pragmatically apply a recovery-oriented model of care in acute inpatient mental health units that are not overtly recovery-oriented.	Involves care in AIMHUs. Qualitative study that has used exploratory research design. Purposive sampling of nurses from AIMHUs in a one-off focus group and data analysis using NVivo.	Data may not represent the model of care used by mental health nurses across other areas of the service, single site study and the results of this study are limited without the opinions of consumers within the MDT. Additionally, focus group questions were leading, rather than facilitating an open-ended group discussion on recovery at the discretion of Participants.	PTA-1: Controlled access to AIMHUs. “As such, knowledge about ***current models of care*** that may fit within the domains of recovery, and pragmatic descriptions of how to practice recovery-oriented care in acute inpatient settings, remains scant” [527]. “There was a challenge to maintain this focus in the context of high acuity and rapid turnover in the inpatient environment.” [531]. ***“we are here to get them back on track,*** but with the time element, it’s very fast. The turnover is quick here, in-out, in-out.” [531].
2	Waldemar, A., Arnfred, S.M., Petersen, L. & Korsbek, L. (2016)	Recovery-Oriented Practice in Mental Health Inpatient Settings: A Literature Review	Database	The results highlight the limited number of studies of recovery-oriented practice in mental health inpatient settings and the limited extent to which such an approach is integrated into these settings. Findings raise the question of whether recovery-oriented practice can or should be an approach used in these	The review was focused on recovery-oriented practice in acute inpatient setting.	The results are based on secondary analysis of results and conclusions, not on primary data. Search strategy may have inadvertently omitted relevant studies.	PTA-1: Controlled access to AIMHUs. PTA-2: care plan PTA-3: SDM in ward rounds PTA-5 Discharge practices Instead of focusing merely on ***rapid stabilization and symptom relief*** as a clinical outcome [p596].

				settings, which are primarily aimed at stabilization and symptom relief.			Implementation has proven to be somewhat challenging and we know little about the current state of integrating such a practice into mental health inpatient settings. [p536]. Descriptions of ***poor communication and lack of collaboration and patient involvement*** by both inpatients and staff members were found. patients ***felt excluded from planning their care and creating their treatment plans*** [p599]. Implementation of recovery-oriented practice is affected when the demands of the organizational system take precedence over an approach that supports personal recovery [P601]. Low capacity and contradictory structures in the organization create competing demands, which take priority over the individual needs of the patient, thereby reinforcing traditional crisis-driven care that ultimately challenges the values and principles of recovery-oriented practice. This raises a central question of whether recovery-oriented practice can or should be an integrated part of inpatient mental health settings,

							which are primarily aimed at stabilization and symptom relief [p601].
3	Waldemar, A., Esbensen, B. A., Korsbek, L. Patersen L. et al. (2018).	Recovery orientation in mental health inpatient settings: Inpatient experiences?	Database	The review reported unchanged care issues of too much control, lack of personal contact, and medical treatment predominance. The experiences of inpatients do not reflect the principles of a recovery-oriented practice. Participants reported being subject to practices that left them with limited information, choice, influence, and dialogue with health professionals, yet they also found acceptance, safety, retreat, and companionship with others in the ward. The findings indicate that inpatients seem to comply with the medical treatment paradigm, some even perceiving it as mandatory, and accepting their limited choice and influence on treatment, but they also call for respectful one-to-one dialogues with health professionals. [327]	Qualitative study using semi-structured interviews with inpatients from adult inpatient unit during inpatient stay**.** The interview schedule was based on the Recovery Self-Assessment (RSA). This has helped to secure transparency and conceptual accuracy in terms of the definition of the concept of recovery-oriented practice used in this study. Researchers representing different professions with clinical and research experience in the	Memory difficulties could have had an impact on their response	PTA-1: Controlled access to AIMHUs PTA-2: care plan PTA-3: SDM in Ward rounds PTA-4- Peer support role/intervention PTA-5 Discharge practices organizational structures – for example ***capacity, resources, and procedures*** – seem to reinforce the ***emphasis on illness*** and measurable outcomes rather than personal recovery (Chester et al. 2016) [p1178]. PT 1&5 Spending time with them crucial for the development of trust and the ***willingness to open up -and to have confidence*** in them. However, time was considered limited, and many said that the ***health professionals rarely had time for personal talk*** or informal activities with inpatients. [p1182].PT-3 + 'lack of connectedness'[p1184] Balancing the role of advisory experts.

					field added strength that yields different perspectives during the data analysis.		Negative attitude towards patients and difficulty in trusting them. PT-3&5. The participants described having ***limited influence on the course of their treatment and admission*** + medication as a very central aspect of admission [p 1183]. PT-1 ***Medication as a very central aspect of admission***, the primary purpose of the admission was, according to the participants, to receive medication, for example trying something new or having the current regulated. [p1183]. - PT-1, 3&5. The concept that continues to favour more traditional notions of mental health treatment as ***focused primarily on medical symptom relief***. PT-1&PT-5 The hospital also employed people in recovery as '***recovery mentors'*** in the inpatient wards as peers to work with inpatients and ***reinforce a recovery-oriented approach in the clinical practice*** [p1178] PT-4.
4	Waldemar, A., Esbensen, B. A., Korsbek, L. Patersen L. et al. (2019).	Recovery-oriented practice: Participant observations of the	Hand searched	The results suggest that recovery-oriented values such as equal collaboration, choice and patients' personal preferences are reflected	Qualitative study using semi-structured interviews with inpatients from adult inpatient	Researchers might have missed capturing all staff – patient interactions. Peer support worker's intervention was observed but might have missed the	At planned consultations between patients and health professionals, the patients' views and needs were addressed, but ultimately, it was the health professionals' decisions

		interactions between patients and health professionals in mental health inpatient settings		rhetorically in the interactions between patients and health professionals. However, they are negotiated within organizational logics and often overruled by competing demands. Results support the impact of economical and operational procedures in the form of competing demands, and that, for instance, procedures in the included wards allow for important decisions to be made without consulting the patients despite intentions of delivering a recovery-oriented practice.	unit during inpatient stay**.** The interview schedule was based on the Recovery Self-Assessment (RSA). This has helped to secure transparency and conceptual accuracy in terms of the definition of the concept of recovery-oriented practice used in this study. Researchers representing different professions with clinical and research experience in the field added strength that yields different perspectives during the data analysis.	impact of the 'companionship' offered by peer workers. This might have limited the opportunity to shed light on peer support role in in patients.	that informed the planning. Sometimes, these decisions had been made among the professionals before the consultation [p324] PT-3. ***Bed capacity was continuously an issue*** on both wards, forcing the health professionals to ***maintain a high discharge rate***. For instance, the ***health professionals would try to accelerate the patients' treatment to make them ready for discharge*** or transferral. This could involve a somewhat intense persuasion of patients to go home for overnight leave or early discharge, and patients were observed being suddenly discharged without warning to make room for new patients [p325] PT-5. Inpatient settings are often characterized as under resourced dealing with progressively shorter admissions and quick turnovers, favouring fast stabilization and crisis management. Treatment is often described as directed towards fast diagnostic assessment and medical stabilization prior to the earliest possible discharge. [p326] PT-1&5.

5	Gilburt, H, Slade, M Bird, V & Oduola, S et al. (2013).	Promoting recovery-oriented practice in mental health services: a quasi-experimental mixed-methods study	Database	The findings of this study support the use of training approaches as a mechanism for knowledge transfer can provide an important mechanism for instigating change in promoting recovery-orientated practice.	Findings can be related to the current practices of providers. Furthermore the use of a mixed methods design combining an overarching measure of impact with the experiences and insights of staff at the focus of the intervention provides important knowledge about of the process of implementation generalizable to other organisations.	Randomised controlled trial we were unable to control for differences between the control and intervention groups at baseline and the lack of blinding may have led to the introduction of bias	Successful implementation of recovery requires a service transformation towards mental health systems with ***a different values base*** [P2] PT-1. ***Recovery orientated approaches were often seen as conflicting with the overarching roles of the service***. [P7] PT-5. Care plans provide an important measure of intent and action but our research suggests that this may have limitations in recording the implementation of recovery-orientated practice. [p8] PT2. Purveyors of the medical model were least likely to be recovery-focused while those adhering to social models of illness were most likely. Doctors were seen as least recovery–focused. [p6] PT-3. Recovery approach was being implemented for political reasons, to meet government targets, as a tool for reducing costs, and like previous initiatives, may soon be de-prioritised. [P7] PT-1. Organisations should be cautious in relying on training programmes which alone are unlikely to be sufficient to create widespread

							and sustained change. Most importantly, implementation needs to move beyond the frontline workforce. [p-9] PT-1,3&5.
6	Chester, P., Ehrlich, C., Warburton, L. & Baker, D et al. (2016).	"What is the work of Recovery Oriented Practice? A systematic literature review"	Database	The study has identified three main themes accounted for the work that health professionals needed to undertake to deliver ROP. They are (i) alleviating stigma, (ii) responding effectively to the complex health and social care needs of service users and (iii) managing challenges associated with the work of ROP. This study has found that these challenges are produced by the context in which professionals deliver care and the processes and conventions (e.g., medical oriented service delivery) that occur inside those contexts.	This study has used the lens of NPT for analysing literature and was able to explore how the characteristics of the work of ROP and highlighted the challenges and barriers to its integration into existing practices**.**	The search was limited to the practice of qualified health professional workforce and not the entire workforce. This study acknowledges the contribution of lived experience workforce. Limited literature due to the strict inclusion criteria set by systematic review.	"re-connecting with others and moving beyond diagnostic label" [p271&273] PT-4 Strategies that support personal and social recovery are foundational to the work of ROP and are underpinned by values of person-centeredness, collaboration, empowerment and a focus on the strengths rather than the deficits of the person (Davidson et al. 2009). [p271] PT-1 ROP requires professionals to separate the person from their illness and deliver services in person-centred ways based on respectful relationships (Lammie et al. 2010; Schwartz et al. 2013; Tennille et al. 2010). [p279]PT-1,2,3&5. A *'one-size fits all' approach* to mental health fails to adequately address the combinations of multi-morbidity, chronicity and issues pertaining to social disadvantage that characterize the lives of consumers. [P279]PT-1&5.

							The shift from authoritarian to egalitarian working relationship between professional and consumer means that the transition to ROP requires professionals to work more closely with the complexity and non-linearity that defines the daily lives of people with SMI. [P279] PT-3. ROP requires professionals to distance themselves from deficit-focused illness perspectives and work with consumers’ strengths. [P279] PT-1. The relationship between professionals and consumers operates in a cyclical manner, such that practices that afford professionals more time to listen closely to, and understand consumers, increases their ability to support recovery. [P279] PT-3. When the organizational context does not provide the resources required to practice in recovery-oriented ways, then the work of ROP is thwarted, Policy upheaval and uncertainty threatens the integration of ROP into medically oriented service contexts. Funding cuts negatively influence health professionals’ ability to

							deliver ROP due to precarious employment [P279] PT-5 Professional's fear that consumers prefer to stay ill rather than engage with recovery and feel anxious about working in recovery-oriented ways when they believe that consumers are at increased risk of suicide or other disturbing incidents of self-harm. [P280] PT-3. Revolving door patients [p281] PT-5. Service users prefer being able to speak freely without fearing the consequences of what they say to professionals and feel relieved when they don't have to change their message to suit the health professionals' expectations. It is important for consumers to feel valued and accepted and have their perspectives and opinions considered, irrespective of whether professionals agree with them[P282] PT-3.
7	Aston, V & Coffey, M. (2012).	Recovery: what mental health nurses and service users	Database	The main findings of the study are that recovery is a difficult-to-define concept and	Participant group that contains service users and nurses comprised of	The main limitation of the study is that the sample is small and findings cannot be generalized.	The nurses highlighted the difficulties they experienced in adopting the idea of recovery with the reality of the everyday ***pressures and task-oriented***

		say about the concept of recovery		remains a challenge for both this group of service users and nurses.	varying ages and experiences, and were able to express views that were consistent with wider knowledge of recovery.		***routines of inpatient settings***. This study suggests patient dependency and increasing intensity and diversity make it difficult to maintain a safe and therapeutic setting, ***limiting the time available for nurse–patient interaction.*** The difficulty here is how a recovery concept can be applied within the current environment of acute inpatient settings, which may be providing little more than ‘custodial care’/ It has been suggested that rather than nurses having limited skills in engagement and nurse– patient interactions, it is instead a ***consequence of working in a demanding and medically dominated arena*** [p261] PT-2. The ***move from medically oriented services to viewing mental illness as more than a biological phenomenon*** with access to a broader range of interventions. Mental health services ***need to focus more on personal outcomes rather than organizational performance outcomes and have a clear vision*** of what their

							expectation of recovery is for mental health. [p262] PT-1,2 &5.
8	Cusack, E., Killoury, F. & Nugent, L.E. (2017)	The professional psychiatric/mental health nurse: skills, competencies and supports required to adopt recovery-orientated policy in practice	Hand searched	The medical profession uses a symptom-focused approach to mental healthcare delivery. Nurses viewed this as a primary inhibitor to development and implementation of recovery-orientated practice. The findings demonstrate that the title of psychiatric nurse is still associated with an illness model. The qualitative data from our study point to the need to find a way to embed a recovery-orientated approach of working at a **societal, cultural and organizational level** in order for it to be fully supported and implemented consistently by healthcare staff. A lack of meaningful engagement of nursing staff with service users and carers was identified in this study. In the absence of this partnership working nurse's capability to have meaningful and genuine influence to successfully facilitate the recovery approach can be reduced. [p101]	The descriptive account by various professionals.	The authors acknowledge that this study is descriptive in nature and the findings are only relevant to the population studied and therefore may not be generalizable. Despite this limitation it is important to consider that the participants in this study work in several mental healthcare settings over a large geographical area and thus the findings may have universal application.	Major factors perceived that would assist them in working in a recovery-oriented way. The first indicated a need to increase opportunities for recovery education and training. Secondly, a need for an organisational culture and structures to support a recovery-orientated approach. Thirdly, a large number of responses indicated that ensuring recovery involves working as a member of a MDT with a focus on establishing collaborative partnerships with key community and peer support agencies. [p99] All PTs The primary inhibitor found to adopting the recovery approach was the ***medical format of documentation*** used within the mental health services. [p100] PT-2 The integration of ***a strengths-based approach*** is critical in all assessment processes to assist and enable the individual achieve insight and build resilience for the recovery journey.

							[p101] PT-1. The approach to ***recovery needs to be organizationally mandated*** where all organizational policies and protocols are recovery proofed to influence practice. [p101] PT-1, 2, 3 &5. The concept of shared decision making should continue to be employed as such but also between medical, nursing and allied health professions in relation to completing comprehensive clinical assessments and determining appropriate recovery-focused care. [p102] PT-2&3.
9	Cutcliffe, J., Santos, J.C Kozel, B. & Taylor, P et al. (2015).	Raiders of the Lost Art: A review of published evaluations of inpatient mental health care experiences emanating from the United Kingdom, Portugal, Canada,	Database	There is a major disconnect between what is espoused in mental health policy documents (e.g. Recovery focused) and what is often happening in practice. The findings suggest that a mental health care inpatient experience is often devoid of warm therapeutic relationships, respectful interactions, information or choice about treatment and any kind of formal/informal 'talk therapy'.	The published evaluations of mental health care, authored by service user groups and practitioners/ academics, emanating from the United Kingdom, Portugal, Canada, Switzerland,	Methodological challenges in research design, questions concerning the underpinning philosophy (e.g. one of emancipation or more regulation/control), epistemological issues, and potential validity issues (see, for example, Beresford 2002) all conspire to the extent that the findings in this paper	'Engagement held as 'sacrosanct' SUs prefers a mental health care experience personified by personal (human-to-human) contacts, where SUs feel they are being listened to, understood and responded to empathically. [p376] PT-2. 'the nascent literature in this area also indicates a significant ***disconnect between SU perceptions' of their needs and the nature of the help they would***

		Switzerland, Germany and Australia		Instead such care experiences are personified by: coercion, disinterest, inhumane practices, custodial and controlling practitioners and a gross over use of pharmacological 'treatments. The limited literature pertaining to attempts to improve the clinical situation depicted in the findings above, suggests that **the problem has been caused by a combination of rather than a singular variable**; and this has major implications for what remedial actions might be applicable.	Germany and Australia**.**	should be viewed through a cautionary 'lens'.	***like to receive and what they often actually encounter***' [p376] PT-1,3 &5. lack of interaction with staff, over use of medication, and ***no/little involvement or 'say' in their care***. [p377] PT-1,2,3&5. '***anti-therapeutic environment'*** [p377] PT-1. ***Interpersonal relationships with the psychiatric unit staff have been found to directly account for how SUs perceive treatment*** [p379]PT-2&3. SUs felt invalidated when they were 'not being listened to, and when their distress was not taken seriously). In this way, collaborations with the treatment team were perceived to be lacking in particular during discharge planning'. [p379] PT 3&5. SUs report that ***inpatient services can be difficult or daunting to access*** and navigate, and that ***people may be excluded from service if they are not deemed to be in an acute state of need.*** [p379] PT-1.

10	Clibbens, N., Harrop, D & Blackett, S. (2018).	Early discharge in acute mental health: A rapid literature review	Hand searched	The impact of early discharge on health and recovery are underreported. Most studies reported service outcomes, whereas health outcomes were underreported. Overall, the review found the evidence for early discharge provided a limited picture of the components of an early discharge intervention, its outcomes, or people's experiences of it.	The findings draw on quantitative, qualitative, and mixed-method data; the findings are presented using a descriptive approach. All papers having been double screened to determine their eligibility for inclusion in the review and this has reduced the risk of bias in study.	The reviewers were not blinded to the authors of the studies that were screened. Comparison between studies was complex due to international differences in early discharge service design and the range of methodologies included in the review. Methodological weaknesses in the included studies mean that only tentative conclusions can be reached about early discharge in acute mental health.	Economic pressures alongside a drive for recovery-orientated care in the least restrictive contexts have led to ***increasing pressure to discharge people from hospital*** early. [p1305] PT-5. Professionals and service users were positive about early discharge and ***service users asked for peer support***[p1305] PT-4 Practice experts have suggested that ***hospital avoidance interventions*** alone will not reduce pressure on beds [p1306]PT-1 CRHTs in the UK function as a gateway for all acute mental health admissions; ***professional staff deliver*** ***this through their gatekeeping role. Where more than 50% of admissions involved a professional gatekeeper***, rates of early discharge more than doubled [p1317] PT1. Service users described ***peer support workers as providing understanding, trust, reassurance, continuity of care, positive role modelling,*** and better links between hospital and home. Peer support helped them

							to feel normal and not different, to understand themselves more, and to believe in their ability to meet goals, and this ***resulted in an improved experience of the discharge process*** [p1318] PT-4. Despite limited evidence that peer support is an effective intervention, people ask for it and ***describe it as helpful.*** Peer-supported early discharge is not routinely available; however, people describe the availability of peer support on the wards. The development of a peer-supported early discharge intervention delivered on the wards may ***provide a way to meet this need, particularly as part of an integrated early discharge pathway*** [p1321]PT-4 There is an economic argument for reducing length of hospital stay, [p1319]PT-5. The studies reviewed tended to ***focus on psychiatric reasons for admission over other psychosocial factors***. [p1320] PT-1.
11	Cleary, M., Horsfall, J., O'Hara-Aarons, M. &	Mental health nurses' perceptions of good work in	Database	This paper reports on a study of acute mental health nurses' views on what constitutes 'good' nursing work and how optimistic	Relatively large sample size of nurses who are currently working in the	Data were collected from a single health service and Interviews were not audio recorded, so the data were notes taken at interview.	The nursing literature highlights the frustration of nurses being unable to do what they should be doing [p.471] PT-2 The contradictions between

	Jackson, D. (2012).	an acute setting		they considered themselves. Clearly, professional interactions and relationships with both colleagues and patients were central to participants' experiences of 'good' nursing work.	acute mental health inpatient services		actual practice in acute inpatient mental health units and mental health ideology [p.471] PT-1,3&5. The sense of teamwork here makes it easy to contribute to the therapeutic relationship with patients' [p473] PT-2&3. The non-consenting, involuntary patient legal status fundamentally shapes the nursing work of acute inpatient nurses. Dangerousness to self or others, assessment and observation for diagnostic purposes, and treatment by medication, particularly to ameliorate positive psychotic symptoms, are common reasons as to why patients are admitted to these facilities + To some extent, this is in accordance with national policy agendas for acute inpatient units, which advocate short hospital stays, rapid patient improvement, and an ethos of least restrictive care which undoubtedly contributes to the perception that mental nursing work is reactive. [p475] PT-1&2. establishment of a therapeutic relationship between nurse and patient, and took considerable one-on-one time to achieve, yet what these findings reveal is that

							these mental health nurses derived considerable professional satisfaction. [p476] PT-2
12	Brooks, H.L., Lovell, K. Bee, P. & Sanders, C. et al. (2018)	Is it time to abandon care planning in mental health services? A qualitative study exploring the views of professionals, service users and carers	Database	Care plans and care planning were characterized by a failure to meet the complexity of mental health needs, and care planning processes were seen to prioritise organisational agendas and risk prevention which distanced care planning from the everyday lives of service users. Care plans were of most relevance to professionals and mostly inconsequential to the everyday lives of service users. This study reports that that the focus on quality indicators along with the inclusion of organizational risk assessments within current care planning structures also detracts from meeting the expectations or expressed needs of service users. This study adds to existing literature through demonstrating that the unintended outcomes of quality indicators are manifest within mental health-care planning systems with the consequence that the intended focus of care plans, responding	in-depth semi-structured interviews employed in this study and the ability to compare data across multiple stakeholder groups.	The data reflect the experiences of stakeholders at one point in time and do not purport to reflect the experiences of all mental health service users, carers and professionals.	The use of quality indicators is driven by demands for transparency and accountability with organizations placing emphasis on the need for measurement and evaluation of performance. The increased significance of such indicators within health services has produced unintended consequences. Other negative consequences include overtreatment and "tunnel vision" whereby professionals focus on problem areas inherent in quality indicators [p598] PT-2. service users and carers themselves attach priority value to relational aspects of care planning compared to professionals who focus instead on service-led outcomes [p598] PT-2, 3 & 5. care planning processes prioritized organizational and risk agendas which further distanced and alienated the process of care planning from the everyday lives of service users, saw little value in engaging in the delivery of management

				to needs in a holistic and patient-centred way, is thwarted and preference is given instead to feeding organizational imperatives for measuring performance			plans they did not want nor had control over in the first place [p600] PT-2,3&5. Service users also talked about the problems of a ***system that failed to adopt an holistic approach to planning which reflected their real-life priorities and ability to leverage resources*** which could be of assistance. [p.600] PT-1 Professionals felt that IT systems restricted service user involvement in the care planning process; documents were described as "utilitarian" and were not considered user-friendly. Additionally, systems did not lend themselves to remote working. [p600] PT-1 limited resources both within and outside health services impacted on multidisciplinary and holistic approaches to care planning and meant there was often little tangible benefit to service users and carers of engaging with the care planning process. [p601] PT-1,2,3&5. Professionals reported constant ***pressure from the imperative of organizational targets that impacted directly on the quality of developing care plans*** and subsequent patient care. [p600] PT-2.

							Targets provided sufficient evidence for managers about performance levels within care teams. However, this often did not reflect what happened in practice. Care coordinators reported copying across previous care plans without reviewing them to ***make the system believe that care plans were in date***. In some cases, this approach was being actively ***encouraged by managers to relieve system pressures.*** [p602]PT-2 There was a ***focus during appointments on agendas prioritized by the organization*** such as risk assessments rather than working towards longer term recovery goals [p602] PT-2,3 & 5. Quality indicators along with the inclusion of organizational risk assessments within current care planning structures also detracts from meeting the expectations or expressed needs of service users. [p603]. This study adds to existing literature through demonstrating that the unintended outcomes of

							quality indicators are manifest within mental health-care planning systems with the consequence that the intended focus of care plans, responding to needs in a holistic and patient-centred way, is thwarted and preference is given instead to feeding organizational imperatives for measuring performance. [p603] PT-2. Using a ***peer workforce*** to complement that provided by health professionals may be useful to take ***care planning in a different, more user-focused direction away from the organizational constraints, paternalistic culture and clinical norms of surveillance and control associated with statutory services***. [p603] PT-4.
13	Bee, P., Brooks, H., Fraser, C. & Lovell. K. (2015a**)**	Professional perspectives on service user and carer involvement in mental health care planning: A qualitative study	Database	Emergent themes identified care-planning as a meaningful platform for user/carer involvement but revealed philosophical tensions between user involvement and Professional accountability. Professionals emphasised their individual, relational skills as a core facilitator of involvement, highlighting some important	The focus groups and in-depth interviews with a broad range of mental health professionals. allowed to raise issues that were important to them and which may not	The views of professionals from only two Trusts were included in this study.	Involving service users and carers in mental health care planning and promoting ***shared decision making are central tenets*** of contemporary mental health policy. [PT-3]. Small scale studies suggest that involving service users and carers in the planning and delivery of care can

				deficiencies in conventional staff training programmes. Although internationally accepted on philosophical grounds, user-involved care-planning is poorly defined and lacks effective implementation support. Its full realisation demands greater recognition of both the historical and contemporary contexts in which statutory mental healthcare occurs. Our data suggests that, whilst not contended on philosophical grounds, the pace of the international user involvement movement has not yet been matched with effective implementation support. The emergence of service user insight as a key influence on care planning practice is an important finding. Reduced insight has long been accepted as a reason for the adoption of more paternalistic approaches to care and as a potential limiter of participatory decision making.	have arisen during a quantitative, questionnaire-based study. Professionals from a number of different clinical areas who had a broad range of different experiences of health settings. The data presented in this paper represent necessarily partial views (e.g. only mental health professionals) which were considered important and under-represented in previous literature.		have positive effects on service and individual outcomes; ***reducing rates of enforced admission and treatment for people with severe mental illness***; increasing user esteem, and empowering individuals to regain control over their own recovery and care ‘p1835] PT-1. Although substantial evidence suggests that users are sufficiently motivated to collaborate in care-planning, substantial barriers continue to be created through ***poor information exchange and insufficient opportunities for participatory decision making.*** [p1835], PT-2&3. Distinguishing features of mental health services are acknowledged to include a longstanding history founded on aspects of containment and compulsion and an ***entrenched stigmatisation of service users.*** Nonetheless, initial concerns that effective involvement might be barred by illness severity, or undermined by treatment refusal, have rarely been realised in practice [p1836] PT-4. Although contemporary health services are progressively utilising a wider range of user involvement strategies, professional opinion is

							still alleged to dominate the majority of nursing practice [p1836] PT-2. ***Marked tensions were identified between contemporary care philosophies*** advocating patient empowerment and longstanding socio-medical constructs of mental health services founded on aspects of safety and containment [p1838] PT-1. necessitate a marked shift in organisational ethos + ***exacerbating existing power differentials between service users and professionals and sanctioning professionals to have the 'final say'***. [p1838] PT-2,3&5. user capacity demanding a high level of fluidity in care planning implementation and design. [p1838] PT-1 ***Insight was deemed a key factor limiting joint deliberation*** & maximising user involvement during periods when ***individuals were well***. For the majority however, lack of insight was viewed as a direct contradiction to the philosophy of user involved care planning. [p1838] PT-1.

							Sustained by ***ill-conceived notions of the feasibility of user involvement,*** and a potential mismatch between the rhetoric of service leaders and the organisational culture and workload pressures faced by front line staff. Translational gaps were most likely to occur where staff ***were overburdened with administrative responsibilities***, [p-1839]. PT-2,3&5. greatest barrier reported by health professionals to involving service users and carers in care planning was increasing time and ***workload pressures*** & relegation of user involved care planning in favour of the administrative efficiency promoted and prioritised under a ***target driven culture*** [p1839] PT-2. The qualitative ***nature of the relationships established between professionals and users was posited as a key determinant of successful user involvement, and one capable of overcoming a lack of wider organisational support*** [p1839] PT-2, 3 &4. Acknowledgement of the ***entrenched stigmatisation of***

							service users and/or debate regarding nurses' ***failings to deliver compassionate*** care provide two potential rationales for the observed service gaps. [p1840] PT-2&4. By failing to provide ***adequate systems transformation***, the rhetoric of user and carer involvement has historically fallen to individuals, whether users and providers, capable of functioning as localised 'involvement champions [p1841] PT-1,2&5.
14	Bee, P., Owen, P., Baker, J. & Lovell, K. (2015b)	Systematic synthesis of barriers and facilitators to service user-led care planning	Database	Synthesis of data from 117 studies suggests that service user involvement fails because the patients' frame of reference diverges from that of providers. Service users and carers attributed highest value to the relational aspects of care planning. Health professionals inconsistently acknowledged the quality of the care planning process, tending instead to define service user involvement in terms of quantifiable service-led outcomes. Service user-involved care planning is typically operationalised as a series of practice-based activities	The wealth and consistency of data reviewed and the systematic approach to its synthesis raises confidence in the validity of these findings.	Evidence search might be tempered by significant methodological and clinical heterogeneity in the primary studies. Meta-analysis of quantitative satisfaction data was not performed in this study. The existing evidence tends towards the views of service users rather than carers or providers.	Potential for regional and national variation in the level and organisational context of service user involvement is acknowledged. Within the UK, for example, discrete differences exist in the statutory requirements for service user involvement in care planning between England and Wales. In-depth qualitative data suggest that the primary driver for this involvement is the desire of service users and carers to move away from traditional, paternalistic models

				compliant with auditor standards. Meaningful involvement demands new patient-centred definitions of care planning quality. New organisational initiatives should validate time spent with service users and display more tangible and flexible commitments to meeting their needs.			of care towards more patient-centred approaches capable of prioritising and responding to individual need [p106] PT-1,23&5. service users and carers express a preference for – and portray a greater readiness to participate in – ***strength-based approaches based on concepts of recovery and hope*** [p106] PT-1&3. Service users often receive ***insufficient information and support to contribute meaningfully to decisions*** about their care. [p107] PT-3. many lack confidence during care-planning consultations and that some may express uncertainty regarding their own ability to contribute meaningfully to their care. [p108] PT-3. SDM perceived equality between Them [p108] PT-3. Consensus across these studies suggests that too few people had received a copy of their care plan or had prospectively influenced its development in a meaningful way [p108] PT-2 More congruent decisions between service users and

							professionals are likely to emanate from trusting and respectful relationships/ Pre-empting care planning meetings with informal discussion, and documenting only plans that have been prospectively endorsed by service users, has been shown to reduce perceptions of coercion and promote a greater sense of user control. [p108] PT-2&3. The predominant factor eroding service user and carer confidence may be a perceived power differential between themselves and mental health professionals [p108] PT-4. Psychiatrists may be more likely to endorse shared decision-making where they ***perceive service users to have greater insight, higher levels of alliance or treatment adherence***[p109]PT-2,3&5. perspectives of people using in-patient services indicate that some may indeed refuse participation, either because they lack motivation, or because ***prior experience*** suggests that the process will be tokenistic[p109] PT-2.

							perceive some service providers as displaying ***critical condescension towards*** them ***emanating directly from concepts of stigma or blame.*** [p109] PT-2,3&5. some mental health professionals may deliberately seek to ***retain relational power*** by presenting themselves as ***the most knowledgeable group*** [p109] PT-2,3&5. The potential for professionals' views to be ***influenced by stigma*** is supported [p109] PT-4. ***Increasing opportunities for service users to identify and communicate their needs effectively*** thus hold promise as an effective means by which to ***enhance satisfaction with mental health services and specifically with user-involved care***. [p109] PT-1,2,3&5. meaningful service user involvement is likely to ***depend upon the reorientation of the attitudes*** and practices of ***more than one stakeholder group*** [p109] PT-1&2. **The majority of decisions rest with a** **psychiatrist,** has specifically been implicated in preventing other **mental health professionals from**

							practising in an empowering way [p110]PT-2,3,4&5. Care planning ***inevitably necessitates interactions between different stakeholder groups*** and the ***context and quality of these interactions*** may directly affect the way in which the ***meaning of the event is construed***. [p110] PT-2&3. insufficient Notification of care planning meetings, poor documentation of care planning outcomes, and a lack of warning regarding treatment changes or scheduled review/ feel intimidated or ignored during care planning meetings. [p110] PT-3. Secondary services have arguably reduced care planning to a linear, ***task-focused event***. / user-involved care planning has over time been diluted to a series of practice-based activities designed to comply with auditor standards, rather than ***enhancing the quality of the experience*** [p110] PT-2 Subsequent and substantial barriers are created through poor information

							exchange and ***insufficient opportunities for care negotiation.*** [p110] PT-3 Different variants of care planning are likely to be conceptualised very differently by service users, whose ***motivation and capacity*** for involvement will ultimately depend upon the extent to which clinical ***practice is judged to complement their own recovery-based needs***. Future interventions aimed at enhancing interindividual relationships for care planning will thus also need to consider in detail the values, ***priorities and care philosophies upheld by the organisational context*** in which care occurs. [p111] PT-1,2&3. Service user-involved care planning aligns closely with the UK's personalisation agenda advocated by adult social care. ***The success of this agenda relies heavily upon system transformation to ensure that both staff and service users are equipped to engage in informed decision-making against the backdrop of fluctuating mental health symptoms and a traditionally risk-averse***

							organisational culture. [p111] PT-1,2.3,4&5. Staff must be enabled to, and feel validated in, spending time with service users so that the pace of consultation and service users' understanding of and contribution to the care planning process are not governed solely by administrative efficiency. [p111] PT-2. Dissatisfaction with user involved care planning supports the notion that traditional methods of communication between professionals and their clients have failed. Future commitments to addressing service users' and carers' needs are likely to include the increased provision of service user-centred materials and resources, and a more flexible strategy for engaging service users and carers in clinically led consultations, possibly through remote communication links with multidisciplinary teams. [p111] PT-2,3&5.
15	Wyder, M., Ehrlich, C., Crompton, D. & McArthur,	Nurses experiences of delivering care in acute	Database	This study has identified three overarching domains, namely the complexity of the nursing role, constraints in which nurses		One of the main limitations of this review is that we have focused our attention on the experiences of	Recovery-oriented and person-centred care whereby control is clearly placed ***in the hands of consumers rather than in***

	L. et al. (2017).	inpatient mental health settings: A narrative synthesis of the literature		operate and facilitating factors to good care.		nursing staff and their understanding of their practice.	***those of mental health professionals***. [p527] PT-1,2,3&.5. Some of the challenges include brief periods of stay, acuity of illness, managing the safety of all consumers and ***admission on an involuntary basis*** [p527] PT-1. Some have argued that ***financial pressure, reduced length of stay in hospital and a focus on safety and crisis stabilization*** also limit opportunities to provide care which enhances sustained recovery (Glick et al. 2011). . It was noted that when clinical care became too task-focused, at the expense of developing therapeutic and person-centre relationships with consumers, there was potential for care provision to be antithetical to the way nurses wanted to practice [p533] PT-2 It was also noted that even when nurses were able to develop person-centred plans to support discharge, at times these could be thwarted when ***medical staff changed direction of care, or when pressure for beds meant that consumers were discharged prior to completing the agreed care plan*** [p534] PT-2&5.

							Increasingly, nurses were required to balance ***restrictive practices such as involuntary hospital admissions*** [p534] PT-1. Administrative ***tasks*** that nurses were required to perform / unsupportive organisational culture [p534] PT-2. ***Pressure from the system to transfer consumers quickly out of the acute care system*** further hindered nurses' capacity to provide person-centred care [p535] PT-2&5. There was a perception that because of a ***decrease in the number of suitable beds, there was an increased acuity of the mental state of consumers on admission***. [p535] PT-1 Frequent readmissions as consumers were discharged sooner. The reduction in ***the length of stay was described as decreasing the opportunity for nursing staff*** to engage with their consumers and for consumers to participate in therapies/ the ***strong medical***

							focus did not always allow nurses to attend to recovery-oriented aspects of their role/ ***lacked autonomy in care decisions***, [p535] PT-2&5. it is important that there is a shift of ***power back to the consumer as soon as the acuity of the illness reduces*** [p536]. PT-5 These enabling systems and contexts are essential if nursing staff are going to be able to deliver sustained person-centred and recovery-oriented care. [p538].
16	Yarborough, B. J. H., Yarborough, M. T., Janoff, S. L. & Green, C. A. (2016)	Getting By, Getting Back, and Getting On: Matching Mental Health Services to Consumers' Recovery Goals	Database	Three primary and 2 cross-cutting themes emerged. "Getting by" meant coping and meeting basic needs. "Getting back" meant learning to live with mental illness. "Getting on" meant living a life where mental illness was no longer prominent. Regaining control and recouping losses were cross-cutting themes. Person-centered care must accommodate changing consumer priorities, services must be flexible and responsive, and outcomes need	This study has used a modified, grounded theory analytic approach and constant comparative analysis, study investigators and interviewers reviewed transcripts and investigator triangulation enhance rigor	Study sample of members of an integrated health plan differs from samples gathered. Participants were more likely to be married and to have higher education and income levels than those in public settings, and characteristics such as social support and socioeconomic standing may influence individuals' perceptions of recovery and opportunities for engaging in activities associated with recovery	focusing on symptom reduction through effective mental health treatment with the goal of symptom remission, measured as an outcome. [PT-1&5]. Our findings suggest that clinicians should encourage ***and instil hope for recovery while understanding that recovery will mean different things*** to different people and different things to the same person over time. [p101] PT-4. Desirable services will likely be used during symptom exacerbations and ***need to be***

				to match consumers' objectives. Clinicians can assist in (a) identifying recovery goals, (b) monitoring progress toward and recognizing movement away from goals, (c) tailoring support to different phases/stages, and (d) supporting transitions between phases/stages.		public-sector settings. Most participants in our sample were White (94%) and non-Hispanic, and conceptualizations of recovery are likely to differ across cultures.	***accessible, ondemand, and consumer-driven***, providing minimally necessary care within the ***context of continuous therapeutic relationships with clinicians who know the course and history of a person's illness*** and treatment. [p101]. PT-1 & 3. Such care might minimize reliance on and reduce unnecessary medication & allowing re-entry when necessary. [P101/2] PT-1. Services and a mental health system that are narrowly focused on symptom ***reduction fail to meet consumers' recovery goals.*** [p102] PT-1&5. A person-centered, responsive mental health service system would anticipate realigning services, adapting to recovery goals and changing service needs rather than requiring consumers to adapt their priorities to a limited set of available Services [p102] PT-1.
17	Glick, I. D., Sharfstein, S. S. & Schwartz, H. I. (2011)	Inpatient Psychiatric Care in the 21st Century: The Need for Reform		focuses on the need to reconsider the current model of inpatient hospitalization in order to maximize positive outcomes and emphasize appropriate transition	Observations of experienced clinicians.	Position paper	The sole ***focus of psychiatric inpatient treatment has become safety and crisis stabilization*** / diminished role for institutional care is consistent with recovery, ultrashort hospitalizations ***may***

				to the community and less intensive levels of care.			***diminish opportunities for a sustained recovery*** [p206] PT-1&5. However, admission requirements that focus on dangerousness as the ***only criterion for medical necessity of an inpatient stay ignore the realities of mental illness***. [p207] PT-1 ***Ultrashort stays have severely eroded the interpersonal connectedness of staff, patients, and families.*** At the same time, the emphasis on safety has deconstructed the physical environment of many hospital psychiatric units, lending them a prisonlike atmosphere. The overall effect is a dehumanized physical, psychological, and social environment for patients when they are in most acute need. We believe that ***ultrashort inpatient hospitalization may do more harm than good***. [p207] PT-5. The ***evidence base for various approaches to inpatient psychiatric care is sadly lacking***. In the ***absence of an evidence base for ultrashort hospitalization, we have an ethical obligation to promote what we consider to be best pract***ice. Health system

							reform means just that—reform of the system itself. In the inpatient psychiatric setting, ***it should start with providing treatment that is nuanced and, in the spirit of recovery***, intended to make an effective impact (beyond the assurance of safety) on the life course of the patient with severe psychiatric illness.
18	Kidd, S. A., McKenzie, K. J. & Virdee, G. (2014a).	Mental Health Reform at a Systems Level: Widening the Lens on Recovery-Oriented Care	Database	This review makes the argument that until an evidence base is developed for recovery-oriented practices on hospital wards, the effort to advance recovery-oriented systems will stagnate. Relative to some other fields of medicine, evidence surrounding the question of recovery-oriented care on psychiatric wards and how it may be implemented is underdeveloped. ***Problems and barriers to change*** Desire to have their needs heard and respected, being treated in a manner that is person-centred and ethical, and their highlighting of wards as being typically characterized by poor access to information and compulsory aspects of care.		Limitations of SR but not declared by authors.	there are **some major challenges at the systems level in realizing the mandates and objectives for recovery-oriented reform** as set out by system planners and administrators / the most obvious impediment to the implementation of mental health ***reform at a systems level is the lack of clear, evidence-based, and practical direction for hospitals***. [p244] PT-1&5. (Reason for RS) ***"An argument is made that until a base of evidence is developed for recovery-oriented practices on hospital wards, the effort to advance recovery-oriented systems will stagnate***." [p244] very ***limited individualized care planning***, ***patient engagement, and shared decision making***, all within the context ***of increasingly shorter stay and high-acuity***

								settings that emphasize risk management and stabilization. [p245] PT-1,2,3&5. Job ***dis-satisfaction for nurses*** [p245] PT-2. At a ***pivotal point of clinical engagement, many patients are exposed to historical models of care***, with very little guidance to be found in the research literature as to how such settings may be improved. [p246] PT-1&5. the development of transition-focused interventions, several of which embed recovery principles in the use of peer support and the emphasis on community engagement [p247] PT-4&5. should people with mental illness perceive **inpatient care as being less highly aversive**, they ***may access hospitals earlier in the progression of acuity, rather than as a last resort when a full-blown crisis requires emergency hospitalization owing to safety concerns.*** Such a scenario may lead to more effective clinical engagement, briefer periods of hospitalization, and more effective transitions back into the community. Therein lies the recovery-oriented system of care—one that better reflects

							policy mandates and practice recommendations. [p247] PT-1. recovery-oriented system change was viewed as something to be left to direct service providers to address,
19	Kidd, S. A., McKenzie, K., Collins, A. & Clark, C et al. (2014b).	Advancing the recovery orientation of hospital care through staff engagement with former clients of inpatient units.	Database	This study supports the use of a consumer engagement approach in psychiatric inpatient units, settings that so far have been largely overlooked in recovery-oriented care dialogues. The hypothesis that the speaker series would have an impact on the attitudes and knowledge of staff with respect to the recovery model was supported.	The finding was evident from both Quantitative and qualitative data.	There were several limitations to the design of this study. First, the study was unable to use a paired-sample strategy because of staff concerns about anonymity. Second, we are unable to comment upon the generalizability of these findings beyond the context of inpatient care in a single hospital. Third, the lower baseline score on the RKI for the intervention group may have contributed to the significance of the findings.	Several studies have examined the ***challenges involved in implementing recovery-oriented care on inpatient*** units. Examination of client perspectives have highlighted that **effective engagement by inpatient staff can have a major impact**. [p221] PT-2 &3. wards have difficulty applying recovery principles to their work for at least three reasons. 1. ***Delivering care driven by the agenda of a vulnerable, distressed patient who may be detained against his or her will*** may seem to run counter to ward practices that increasingly emphasize risk management and clinician-driven decision making ***in short-stay frameworks*** 2. It is seldom applied because

							clinicians are not educated to develop the skills and perspectives necessary to support such an orientation. 3. The very nature of the staffing experience on inpatient units represents a challenge, given that staff often have ***exposure to clients only when they are in crisis and not when they are engaged in work***, in school, and in the community. This limited exposure has an impact on their expectations for clients and can undermine their belief in recovery-based care [p222]. PT-1,2&3. “working all day and you don’t see anything come of it.” [p224] PT-2 &3. “a boost of hope and energy to come up with new and innovative ideas on how to maybe change [our] practice and thinking.” “spurred reflection” [p224] PT-4. Staff also highlighted the many constraints, particularly those related to documentation, that

							challenge their ability to better engage their clients. [p224] PT-2. they successfully engaged staff at a "human level," in effect recalibrating a relationship that had been characterized by a marked power differential. [p224] PT-4.
20	McCloughen, A., Gillies, D. and O'Brien, L. (2011)	Collaboration between mental health consumers and nurses: Shared understanding, dissimilar experiences	Database	The study found that although consumers and nurses conceptualized collaboration in similar ways, their lived experiences were disparate. A key finding of the study was that mutual recognition of each other's knowledge and expertise is needed for successful collaboration. The study reinforced the need for consumers and nurses to establish common ground on which to collaborate and to articulate the behaviours and expectations of working collaboratively.	Rich data from focus groups with service users and nurses. Contextual factors and professionals/ nurses' role in decision making explored.	Generalizability of the findings of this study might be limited. Additionally, self-selection for focus groups, the selection of 'well' consumers, and a low survey response rate might be indicative of a particular predisposition to or preconceptions of collaboration, and therefore, biased data.	*"A sense of powerlessness was also revealed by nurses in this study, in that they perceived a lack of control within a framework of systems and processes in which they worked. Where decision-making power was held by others external to the nurse–consumer relationship, for example, when other members of the multi-disciplinary team held greater influence over clinical treatment and management decisions, including granting of leave and medication titration, nurses felt they were unable to collaborate effectively with consumers on treatment decisions"* [p53] PT-3 [M-4] *They also found that trying to negotiate with nurses on particular issues was pointless, because nurses appeared to have little or no authority to make care or*

							treatment decisions or changes. [p.51] PT-3 [M-5].
21	Wright, N., Rowley, E., Chopra, A., Gregoriou, K. and Waring, J. (2016).	From admission to discharge in mental health services: a qualitative analysis of service user involvement	Database	Study identified loss of the service user voice at the key transition points into and out of acute inpatient care. Due to the lack of resources (inpatient beds and community care follow-up), the role service users could play was diminished. In their narratives, clinical staff associated the person with the process and used language which dehumanized the individual.	This study has illuminated some interesting and pertinent issues relating to service user involvement at the interface of community and inpatient mental health care.	This study was conducted on a single research site. The interactive nature of focus groups is both a strength and limitation of the method.	"*Service users can experience stigma and discrimination from the negative attitudes of mental health staff. Within the literature, particular prominence is given to those with comorbid substance misuse issues and those diagnosed with personality disorder. More negative attitudes are expressed when individuals are perceived to be 'not ill' and therefore wasting precious resources or being in some way responsible for their predicament*" [p.102] PT-1 M-1. "*If service users agreed to admission or identified that a period of respite in hospital would be helpful, facilitating this was difficult. Community staff reported that 'informal' admissions (where the service user requests or agrees to go into hospital voluntarily rather than being compelled by law) were virtually impossible unless there was personal contact with the inpatient consultant and you were prepared to do some 'wheeling and dealing"* [p.371] PT-1 M-2 "Pressure from above to free the beds up" [p.372]. PT-1 M-3. "*I was pulled in for what I thought was routine psychiatric*

							appointment with Dr X and I was told ‘I want to send you home today’. Out of nowhere... so I didn’t take it well. I didn’t feel ready to go out... He said he was going to be honest because I deserved it. He had pressure from above to free the beds up and I said to him ‘so you don’t think I am well enough to go home but it’s just you need a few beds’ and so I was not very happy” [p.372], PT-5.
22	The Joint Commissioning Panel for Mental Health (2013)	Guidance for commissioners of acute care – inpatient and crisis home treatment	Google	This guide is about commissioning services for people with acute mental health needs. It explains the purpose, characteristics and components of acute care so that commissioners can commission good quality services that are therapeutic, safe and support recovery.	Report by the Royal College of General Practitioners and the Royal College of Psychiatrists	Report furnished by professional group.	“*Inpatient wards have an important place within the acute care pathway and should have a focus on enabling patients to get as well as possible, as quickly as possible*” [p.17] PT-1.
23	Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A. and Warren, J. (2005).	The Nature and Purpose of Acute Psychiatric Wards: The Tompkins Acute Ward Study.	Personal library	Patients are admitted because they appear likely to harm themselves or others, and because they are suffering from a severe mental illness, and/or because they or their family/community require respite, and/or because they have insufficient support and supervision available to them in the community. The tasks of acute inpatient care are to keep	Rich data from interviews conducted with multidisciplinary staff (13 Ward Managers, 14 F Grade nurses, 11 Occupational Therapists and 9 Consultant Psychiatrists), on rationales for	Methodological limitations for semi-structured interviews	“*Admission was a ‘last resort’, and that community psychiatric services and teams were strongly geared towards keeping people out of hospital and treating them in the community as far as possible. This was considered to be the function of Community Mental Health Teams, Home Treatment Teams, and Assertive Community Treatment Teams. Over occupancy of ward beds was another factor*

				patients safe, assess their problems, treat their mental illness, meet their basic care needs and provide physical healthcare.	admission, their care and treatment philosophy, and the roles of different professionals.		*leading to only the most severe and emergency cases gaining admission. However, as one respondent remarked, this huge emphasis on keeping people out meant that when an admission did have to occur, it could be seen in a negative light, as a failure"*
24	Stomski, N. and Morrison, P. (2017)	Participation in mental healthcare: a qualitative meta-synthesis	Database	The findings of this meta-synthesis demonstrate that service user participation in mental healthcare remains a policy aspiration, which generally has not been translated into clinical practice. The synthesis resulted in the identification of six principal themes, which articulate key processes that facilitate service user participation in mental healthcare. These themes included: exercising influence; tokenism; sharing knowledge; lacking capacity; respect; and empathy.	The views of service users, health professionals, and managers, provides rich data, hence includes the perspectives of all-important stakeholders. Therefore the findings capture the essential processes influencing participation in mental healthcare.	Examining patterns throughout this meta-analysis diverse participant groups typically omit detailed interrogation of the complex experiences within each group.	Service users often qualified their ability to exercise influence by noting that they did not desire absolute control, but instead wanted to share responsibility with health professionals in making decisions. However, service users said that health professionals frequently denied them the ability to influence decisions. [p.3] PT-3, O-2
25	Borgstrom, E.	Advance care planning: between tools and relational end-of-life care?	Hand searched		Editorial		Staff felt pressured to document specific details in limited time and non-private spaces, and with patients who may be perceived as uncooperative, as part of a commitment to 'best practice'. Consequently, some people have

							begun to question the validity of the approach and its usefulness in providing care. The requirement of modern healthcare provider organisations to demonstrate quality assurance to their own governing bodies as well as statutory regulators. It is possible that documents designed to facilitate audit of clinical practice come to subsume the very process that they record, becoming prioritised over and above person-centred practice in the minds of healthcare professionals. Previous research has noted that good intentions and positive care philosophies often unwittingly get subsumed in the routines and structures of organisations. [p.216] PT-2 [C].
26	Fourie, W., McDonald, S., Connor, J. & Bartlett, S. (2005)	The role of the registered nurse in an acute mental health inpatient setting in New Zealand: Perceptions versus reality.	Database	A key finding of this study was that many of the nursing roles related to delivering care from a crisis management perspective, which covers aspects such as assessment, stabilization of symptoms and discharge planning. Participants also believed that the therapeutic	The study was carried out in an acute care inpatient unit at a large mental health service using a qualitative descriptive	Methodological limitations and researcher bias/hawthorn effect during observations	“Nurses were caught in a conundrum regarding their practice; where organizational documentation requirements conflicted with the nurses need to deliver patient care: You would choose the documentation . . . because it is the paperwork that we can be held accountable for, not the patient contact. Nowhere

				relationship was a fundamental role in inpatient care. The findings suggest that nurses believe that practice is driven more by the needs of the organization than the patient.	exploratory approach.		in the unit manual protocols does it say that we must have contact with patients and develop a therapeutic relationship, yet this is what we believe our job is about" [p.139] PT-2 M-1.
27	McNicoll, A 2013)	Emergency mental health admissions delayed up to 3 weeks due to beds crisis, social workers warn	Google search	Mentally ill people assessed by professionals as needing urgent hospital care are having to wait up to three weeks for admission due to a shortage of NHS mental health beds, a survey of approved mental health professionals (AMHPs) has revealed	Approved Mental Health Practitioners survey	Not stated	"Delays to admission were considered by all respondents to result in increased risk to both the individual and others," said the survey, which also found that two-thirds of AMHP leads had delayed Mental Health Act assessments due to bed shortages. Around 2,000 mental health beds were closed in 2011/12, according to a 'rough' estimate in NHS figures released in February. The survey, of over 100 AMHP leads from across England, also revealed that 90% of AMHPs had seen patients forced to travel out-of-area due to bed shortages – an issue raised by a recent Community Care investigation. PT-1& 5.
28	National Health Service (NHS) England. (2018).	Proportion of admissions gate-kept by CRHT teams.	Hand searched	The percentage of inpatient admissions where alternatives to inpatient admission were properly considered beforehand. Ideally this should be 100%.	Policy document	Not stated	Gatekeeping involves assessing the service user before admission to hospital to consider whether there are alternatives to admission and the CRHT (or equivalent) involvement in the decision-making processes that result in admission. An admission has been

							gate kept by the CRHT if they have assessed the service user before admission and if they were involved in the decision-making process which resulted in admission. PT-1, M-1.
29	Olasoji M, Maude P, McCauley K. (2017).	Not sick enough: Experiences of carers of people with mental illness negotiating care for their relatives with mental health services.	Database	Accessing mental health services was described by most carers as being particularly difficult. This is especially in the area of emergency psychiatric services. Carers were often denied ac-cess due to their relative's illness being classified as "not in crisis" or not suitable for admission. This often led to feelings of frustration, distress and great anxiety. The criteria for in-patient admission of acutely unwell mental health patients still remains quite shrouded in mystery to carers in this study.	Descriptive qualitative design with five focus groups provided rich data from carers.	The demographics of the participants for the study were mainly from a particular area of mental health service, and the sample size (n = 19) could be considered as a limitation to the study.	Carers often spent a great deal of time on the phone to services only to be told that their relative was "not sick enough" to access care or that no response would occur without another service also being involved [p.404] PT-1, M-1.
30	Simpson, A., Hannigan, B., Coffey, M., Barlow, S., Cohen, R., Jones, A., Všetečková, J., Faulkner, A., Thornton, A., & Cartwright, M. (2016).	Recovery-focused care planning and coordination in England and Wales: a cross-national mixed method comparative case study	Database	Care plans were described as administratively burdensome and were rarely consulted. Carers reported varying levels of involvement. Risk assessments were central to clinical concerns but were rarely discussed with service users. Service users valued therapeutic relationships with care coordinators and	Cross-national, multi-site mixed methods study	There was a moderate level of missing data for the RSA scale completed by service users, possibly due to some of the difficult language used. There may have been an element of self-selection or inherent biases not immediately apparent to the researchers.	In the face of competing macro and meso-level pressures, at the micro-level we heard of care plans being developed and then forgotten about by service users and practitioners unsure or unable to make active, day-to-day, use of them. Frequently, service user participants were unable to talk knowingly about the way their care plans were produced, or subsequently used. [p15].

				others, and saw these as central to recovery. there exists a gap between the macro-level national policy aspirations for recovery focused, personalised care planning and coordination and the meso/micro-level 'street-level' practices and everyday experiences of service users, carers and care coordinators. Of particular concern was evidence of a perhaps widening discrepancy between policy and practice and the indications of an emergent cynicism amongst participants as recovery concepts and ideals are subverted by higher-order organisational needs, directives and ends. There is a serious risk that the hope and optimism that recovery approaches can offer mental health services is being dampened and perhaps snuffed out by the 're-conceptualisation of recovery' at a macrolevel.			Across all sites we found evidence that austerity, as an explicit macro-level response to economic collapse, was being felt. The form is a prompt for them to make sure they've covered everything rather than a personalised summary for me…"
31	Coffey, M., Hannigan, B., Barlow, S., Cartwright, M., Cohen, R., Faulkner, A., Jones, A.	Recovery-focused mental health care planning and co-ordination in acute	Database	There is positive practice within acute inpatient wards, with evidence of commitment to safe, respectful, compassionate care. Recovery ideas were evident but there remained ambivalence on their relevance to inpatient care.	This was a cross-national, multi-site mixed methods study. The interview data is rich and	Samples were not randomly selected.	In all sites some service users report that they were not involved in the planning of their care, were unaware of the content of their care plans or had not received copies, or did not feel a **sense of**

	and Simpson, A. (2019)	inpatient mental health settings: a cross national comparative mixed methods study.		Service users were aware of efforts taken to keep them safe, but despite measures described by staff, they did not feel routinely involved in care planning or risk management decisions.	the framework method provided a time-consuming but structured and visible method of organising, analysing and comparing that data within and across sites. The involvement of service users and carers throughout the study as researchers and advisors has also provided added value to the study through additional viewpoints and interpretations.		**care plan ownership.** [p.11] PT-2 M-3. Rapidly arranged discharges caused some concern with little time then available for considered planning, one service user recalled being 'pulled in out of the blue' to be told 'right, you can go' [p.12] PT-2, M-4 & M-5. Sometimes you've got a load of people in there and you sort of feel a bit like you're on stage, you know like the spotlights on you, sort of thing. But yeah. I've had problems with ward rounds but more recently things have been OK, I've been able to sort of express myself more." [p.12] PT-3, C. The information needs of service users could be better met by helping them prepare for ward rounds, including determining expectations and the agenda. In addition, it was suggested to us that service users be given summaries of ward round outcomes. [p.14] PT-3, M-2.
32	Dunne E.A. (2006).	The views of adult users of the Public Sector Mental Health Services. The Mental	Hand searched	Services are difficult to access and service users may avoid or delay contact to a critical degree because of the stigma associated with mental illness. There is an over-reliance on medication as the only treatment	The research focus was on the organisational aspects of the publicly funded mental health	Methodological limitations	*"They don't know you in the first place. He [consultant] never knew me. He never asked me any questions to find out who I was. So how could he diagnose me*?" [p.36].

		Health Commission.		both initially and for the long-term. Communication between service users and their consultants is often unsatisfactory. Consultation time is too short for a service user to have any in depth discussion with their clinician should they wish to do so. The reasons for this need to be explored with consultants and the causes addressed. The organisation of inpatient services is often anti-therapeutic, Consultants and nursing staff spend too little time interacting therapeutically with service users. Preparation for discharge is not a standard feature of the service and may not even be a routine feature within any given facility. The transition to home would be made easier and the likelihood of relapse would be reduced if the concerns of service users were addressed before discharge. Day centres tend to offer a greater variety of activities and are noted for their more relaxed atmosphere and for the active therapeutic involvement of their staff. These centres provide a	Service. Focus groups and the semi-structured narrative interview were used to ensure that service users' experience when availing of services, and their views on how the services might be further developed were recorded.		"*…the same doctor that you might build up…some kind of relationship with…they changed so often. I had this new doctor …and all he did was prescribe. He didn't listen to me…just prescribed the same drugs that I was on before which were really causing me terrible trouble…*" [p.39]. "*Doctors normally see you on Monday or Friday. And I would suggest that they try and see patients more… if they could at all you know. They're not able to see you, they haven't got the time…but it is needed, it is needed. It's the doctor you want to see...*" [p.62] PT-3, M-1.

				good template for community based mental health Care.			
33	Isobel, S (2019)	In some ways it all helps but in some ways it doesn't': The complexities of service users' experiences of inpatient mental health care in Australia	Hand searched	Findings highlight the complexity of experiences of care including how an admission can seemingly facilitate clinical recovery while not being recovery-oriented.	The single approach design focused on structured interviews with inpatient service users about their experiences of care and treatment, guided by the tool and with particular emphasis on the quality of the interactions with clinicians, experiences of medications and treatments as well as emotional safety, pathways of appeal and relevance of care.	The study was undertaken by individuals in clinical and managerial positions and did not engage service users in the design or delivery.	While many participants felt that they had choice or input into their care, others strongly felt that they did not. Tribunal processes and case reviews where service users were present were identified as potential moments where participants experienced feelings of disempowerment and judgement. Many were intimidated to express their wishes, and others felt that they were not listened to. [p.109] PT-3, O. Power was noted to be held by the medical staff yet participants also felt that the doctors knew them the least. Subsequently, there was little that they felt they could do to influence decisions that were made. The interactional work of mental health nursing has been eroded by a focus on medical interventions and tasks, creating a dichotomy of philosophy that cannot easily be translated into practice. "I'm not here by choice. I can say what I think but I don't have the

							final say and there is not much I can do. The way I behave is the only thing I can control" [p.110] A sense of separation between staff and service users was noted, although this did not include all individual staff but rather an overall dynamic of power.
34	Reid, R., Escott, P. & Isobel, S. (2018).	Collaboration as a process and an outcome: Consumer experiences of collaborating with nurses in care planning in an acute inpatient mental health unit	Database	Consumers highlighted the importance of the process of developing their care plan with a nurse as being as helpful for recovery as the goals and strategies themselves. The findings provide insights into consumers' experiences of care planning in an acute inpatient unit, the components of care that support recovery and highlight specific areas for mental health nursing practice improvement in collaboration.	A qualitative study explores inpatient mental health consumer perceptions of how collaborative care planning with mental health nurses impacts personal recovery. Semi-structured interviews were conducted with consumers close to discharge from one unit in Sydney, Australia.	This study focused on a single unit only that had its own processes and cultures of care. The findings may not be directly applicable to other units and their approaches to care planning.	*"I put it in front of my psychiatrist and he kind of gave it a cursory glance and then asked me a few questions that would've been easily answered if he read it. So, he really – I mean he didn't even pick it up to pull it that couple of inches closer and angle it so he could read it. He just glanced at it and then asked me a couple of questions... Yeah, I felt like me individually and me with the nurses' input had spent a fair bit of time on it and on making it clear and on – and not – for me it was a personal document that kind of structured my goals a bit and the interventions towards that. But it was also to show the treating team what my plans were for maintaining my health and they didn't seem interested at all"* [p 1208] PT-2. C During the process of collaborating, some had also started to question what the purpose was and whether

							the process had any real meaning for their care. it’s (the plan) kept simple and well directed but if it’s not used then it’s kind of a pointless exercise filling it out and spending that time thinking about things and how you’re going to maintain and achieve those goals’ [p.1207]. PT-2, M-4&5.
35	Berg, A., & Hallberg, I. R. (2000).	Psychiatric nurses’ lived experiences of working with inpatient care on a general team psychiatric ward.		The result indicates the need for a stable and predictable organizational structure if nurses are to manage the demanding nurse–patient relationships that everyday caregiving requires.	Semi- structured interview with 22 psychiatric nurses lived experiences of working with inpatient care on a team psychiatric ward provided rich data and the transcribed texts were analysed by means of latent content analysis.	Findings are limited to the nurses	It was revealed that the physicians or the psychotherapist ‘had to be’ asked about the care and were the ones who made the decisions and this was done sometimes over the nurses’ heads. [p.330] PT-2, M-4. The team organization as well as the nurses’ role in the team stood out as being unclear. Thus, the way in which nurses’ function and the way in which their relationships with the patients develop must be interpreted in the context of the organizational structure and climate in which they exist.
36	Bennetts, W., Cross, W., & Bloomer, M. (2011).	Understanding consumer participation in mental	Database	Power and change were the primary themes. Power and the overwhelming consensus that the medical model and those	Semi structured interviews were conducted with seven	Methodological limitaions	Managers recognized the negative culture existing in some parts of mental health services as one that

		health: Issues of power and change.		working within it hold the most power was strongly represented in this study. Staff attitudes, the under resourcing of consumer consultants, and the somewhat tokenistic approach taken to consumer participation were identified as significant barriers to the ongoing development of consumer participation.	participants in this qualitative, interpretive study. The thematic analysis revealed the complexities around defining consumer participation and demonstrated the difficulties and possible reasons as to why there is no real clarity between managers, service providers, and consumers as to what consumer participation should look like. of the participants by allowing their interpretations of their experiences to be explored and discussed.		is far from accepting of consumer participation and consumer-led health care [PT-4] One manager used the term being ‘dumbed down’ to describe the long-term relationship between the medical profession and consumers p.160]. The participants identified nurses and psychiatrists as those with the most negative attitudes towards consumer participation, and interestingly, they also regarded these as having the strongest orientation towards the med1ical model. Bleecher (2009) linked this orientation to the medical model to a decreased focus on the person in favour of a focus on the illness. The medical model is one that focuses on the biology of mental illness, rather than the person, and dominates mental health-care delivery (Bleecher 2009). For managers, the issue was that the system and the traditional views of psychiatry are not very consumer focused, and tend to be exclusive rather than inclusive. Managers felt that those working from a medical model are inclined

							to find consumer participation challenging and threatening [p160] PT-1,2,3&5. (The power sits) with the doctor; medical model. As I say, it's very infrequently will a consumer come in and actually discuss their needs. The medical agenda still comes first [p160] PT-3, M-6.
37	Rose, D., Evans, J., Laker, C., & Wykes, T. (2015).	Life in acute mental health settings: experiences and perceptions of service users and nurses	Database	The main themes were nurse/patient interaction and coercion. Service users and nurses conceptualised these differently. Service users found nurses inaccessible and uncaring, whereas nurses also felt powerless because their working life was dominated by administration. Nurses saw coercive situations as a reasonable response to factors 'internal' to the patient whereas for service users they were driven to extreme behaviour by the environment of the ward and coercive interventions were unnecessary and heavy handed.	Using a participatory methodology, participants spoke freely of their concerns in a way we think might have been inhibited had the researchers been conventional academics or clinicians	Lack of generalisability	There is a dichotomy in our data. There is a social psychological element hinging on an 'us and them' dichotomy described by both sets of participants. [p.94] PT-1, O-4. Inpatient wards were routinely described as unsafe, fearful places where users felt unprotected by staff.
38	Hornik-Lurie, T., Shalev, A., Haknazar, L., Garber Epstein, P., Ziedenberg-Rehav, L. &	Implementing recovery-oriented interventions with staff in a psychiatric hospital: A	Database	Findings support the need for broader staff training in recovery-oriented interventions. Recruiting the support of the hospital administration for recovery-oriented intervention	This study used a concurrent triangulation mixed-methods design. Using a mixed-methods study design	A source of potential bias is related to the relatively low Cronbach's alpha α = 0.342 of the roles of self-definition and peers in recovery, the third factor	Staff noted increased awareness about the way they discussed patients in meetings, moderating the negative remarks that were sometimes made (Number 4): "You notice that you stop making jokes

	Moran, G. S. (2018).	mixed-methods study.		programmes is key, both ethically and structurally.	provided empirical validation, complemented with in-depth understanding, of how the outcomes and challenges played out in the daily practice of recovery orientation in inpatient wards. Seventy-two mental health practitioners from various disciplines completed self-report questionnaires. A disproportionate sampling strategy was used to distinguish staff who had undertaken recovery-oriented intervention training from those who had not.	in the Recovery Knowledge Inventory. Thus, results related to this subscale should be interpreted with caution, due to the lower reliability of the scale.	[about patients] like you did before." [p.577]. PT-4, M-3. Lack of role clarity [p.576], staff were concerned that their role was not clear enough [p.577] PT-4, C. Direct contribution in staff meetings. • Peer specialists offer new perspectives • Peer specialists impact decisions on treatment Indirect contribution to staff • Authentic exchange with staff • Increased awareness about language and communication about patients [p.576], PT-4, C+ M-3.

39	Keogh, B., Callaghan, P. & Higgins, A. (2015).	Managing preconceived expectations: Mental health service users experiences of going home from hospital: A grounded theory study.	Hand searched	While there is a move to develop recovery-orientated mental health services, key indicators of recovery-oriented practices were often absent from service users' experiences of service provision.	GT methodology is the articulation of participant's main concern of mental health service users' experiences of going home from the hospital	Methodological and researcher bias.	Although there has been a move to adopt recovery-orientated services, key indicators of recovery were often absent for service users being admitted and subsequently discharged. [p.716] PT-5, C. In this study, the experience of being diagnosed (labelled) and admitted to hospital had a far-reaching negative impact that altered the participants' sense of self and their perception of themselves as valid individuals. [p721]. PT-3 Mental health nurses and other professionals need to be aware of the impact that psychiatric hospitalization has on service users sense of self. In addition, they need to acknowledge that stigma continues to be a problem for people with mental health problems and that service users Managing preconceived expectations need to be prepared to address some of these issues when they are discharged from the hospital. [p.721] PT-4&5].
40	Niehaus, D. J. H., Koen, L.,	Crisis discharges	Hand searched	Patients discharged as usual had a far lower risk of	A major strength of this study was	Admission data prior to the implementation of the	It has therefore been postulated that too

	Galal, U. et al. (2008).	and readmission risk in acute psychiatric male inpatients.		readmission than those discharged due to bed pressures (i.e. crisis discharge).	that all admissions were from one hospital and data/participants were evaluated in a standardized fashion. This yielded a sizeable study sample that was followed up over a long period, comparing very favourably to sample sizes and study period of other studies	crisis discharge policy, which could have strengthened this study substantially, was not available. Additionally, readmissions would have been missed if patients were admitted to a private or other psychiatric hospital, but this would have introduced a positive bias to the results.	short a LOS does not allow for a resolution of the patient's clinical condition nor allow adequate preparation for the patient's discharge, thereby contributing to a revolving door effect [p.5] PT-5, O-1 the clinical management of Frequently admitted patients may be adversely affected through demotivation of staff and therapeutic nihilism [27] if readmitted patients are viewed as 'regulars' who have familiar, unchanging repetitive issues and patterns of admissions within an already struggling and short-staffed mental health system. [p.6] PT-5, M-2.
41	Walsh, P. E., McMillan, S. S., Stewart, V., & Wheeler, A. J. (2018).	Understanding paid peer support in mental health.	Hand searched	These findings provide an expanded understanding of the role of paid peer support as part of the recovery process in mental health service delivery. The effective use of paid peer support workers can be enhanced through attention to the issues identified.	Focus groups and interviews were conducted with 32 participants to identify elements of paid peer support work in two organizations in Queensland, Australia. Participants included peer-supported	Study participants were from only two consumer-operated services in one Australian state and therefore the findings cannot be generalized to other services or settings. The study used self-reported data which could be influenced by interviewer bias.	Peer skills such as an ability to navigate mental health systems (Adame and Leitner 2008) and **relationship-building through disclosure** (Cabral et al. 2014), empathy and active listening (Castellano 2012), respect and encouragement (Jacobson, Trojanowski, and Dewa 2012) are essential. **Role modelling is an important element** of peer work and can **provide inspiring examples** of how to move

					consumers, paid peer support workers, managers and other key stakeholders. Through a grounded theory analysis, eight categories of paid peer support were identified.	A more important limitation of this study is that it was not able to examine consumer outcomes from paid peer support involvement or compare outcomes from these services with other service types.	forwards and an opportunity to educate other non-peer staff (Cabral et al. 2014), **providing hope for future recovery** (Gillard et al. 2014) and challenging stigma (Migdole et al. 2011). [p.582]. PT-4, M-1, M-2&M-3 + O-1. peer support workers have emphasized that there is, within many settings, **role ambiguity** [p.582]. PT-4, C. There is a particular emphasis on addressing, to a certain degree, 'role ambiguity' within the organization (Asad and Chreim 2016. [p.592]-PT-4, C. Supervision and workplace support were viewed as essential within peer support work. Participants identified that informal supervision, co-supervision, manager supervision, external supervision and team meetings were offered at work. For one organization, active supervision was identified as more important than training, although this was occurring on an informal basis. [p589], PT-4, C.

42	Jacobson, N., Trojanowski, L., & Dewa, C. S. (2012).	What do peer support workers do? A job description	Hand picked	Peers engage in direct work with clients and in indirect work that supports their work with clients. The main types of direct work are advocacy, connecting to resources, experiential sharing, building community, relationship building, group facilitation, skill building/mentoring/goal setting, and socialization/self-esteem building. The main types of indirect work are group planning and development, administration, team communication, supervision/training, receiving support, education/awareness building, and information gathering and verification. In addition, peers also do work aimed at building relationships with staff and work aimed at legitimizing the peer role. Experience, approach, presence, role modelling, collaboration, challenge, and compromise can be seen as the tangible enactments of peers' philosophy of work.	The findings from this study should be useful in providing some of the descriptive detail other investigators have identified as necessary to improving the specification of the peer role.	One of its major limitations is the extent of its generalizability in either its qualitative or quantitative components. The experiences of the participants for this evaluation may not necessarily be representative of those of other similar programs.	To address two issues the literature identifies as problematic for peer support: a lack of clarity in peer role expectations and a need for peers to be better integrated into their workplace teams The fact that they have had these experiences means that they are able to understand clients in a way that is real and empathetic. Because of their own experiences, they are able to make meaningful connections with clients. [p.8] M1 The physical presence of peers allows clients greater freedom and more access to valued resources than they would otherwise enjoy[p-8] PT-4 C. Role modelling Peers serve as symbols and examples to both clients and other staff. They provide "someone to look up to" for clients who are seeking ways of living that will help them to meet their goals. For staff, they stand as exemplars of "recovery in action," and their skills and knowledge serve as examples to staff looking for a new way in which to work. [p8] PT-4, M2.

							d to “pick their battles”—judging when to respond to discriminatory words or actions (directed against clients or themselves) PT-4, [O-3].
43	Gillard, S. G., Edwards, C., Gibson, S. L., Owen, K., & Wright, C. (2013).	Introducing peer worker roles into UK mental health service teams: a qualitative analysis of the organisational benefits and challenges.	Hand searched	This research is indicative of potential benefits for mental health service teams of introducing Peer Worker roles. Analysis also suggests that if the emergence of a distinctive body of peer practice is not adequately considered and supported, as integral to the development of new Peer Worker roles, there is a risk that the potential impact of any emerging role will be constrained and diluted.	The robustness of our analysis was enhanced by the input of two service user researchers. Crosschecking of the analysis by two researchers who were independent of the primary study, but who as service user researchers worked from a complementary standpoint was a strength of our approach, increasing the rigour of the methodological process and the explanatory power of the analysis.	Potential weaknesses in secondary analyses of qualitative data have been identified where there is not a good fit between data collected in the primary study and the questions asked of the data in the secondary analysis. There was a relative lack of data from service user participants (compared to Peer Workers, nonpeer staff and managers, from most of whom data was collected).	A before-and -after study and a cross sectional survey, both from the US, found significant improvement in individual empowerment associated with receiving peer based support [p2] PT-4, O-1. Non-peer staff, managers and service users all thought Peer Workers brought insight to the team that would otherwise be lacking [p.9] PT-4, M-3. This data is suggestive of an emerging body of practice characterising the Peer Worker role, incorporating a number of key elements: demonstration or role modelling of personal recovery to current service users; bringing insight and knowledge to the staff team (enhancing the team’s skills mix); creating a more engaging, relaxed environment that feels safe and is conducive to talking and listening. [p.9], M-2&3. Existing Peer Workers had been motivated to take on the role as an opportunity to use their personal experiences to help others who

							shared similar problems [p.10], M-1.
44	Repper, J., & Carter, T. (2011).	A review of the literature on peer support in mental health services.	Hand searched	PSWs have the potential to drive through recovery-focused changes in services.	Study has identified some of the benefits and challenges resented in the employment of PSWs in statutory services as well as attempting to define peer support in statutory services.	Limitations include the lack of a framework to critically analyse the included articles. Furthermore, due to the wide scoping aims of the review, the findings had to be on a more general level, although this allowed for a wide variety of themes to be covered, each theme in itself (effectiveness and challenges) could be reviewed exclusively in detail.	Peer support has been implemented outside the UK and is showing great promise in facilitating recovery. The literature demonstrates that PSWs can lead to a reduction in admissions among those with whom they work. [p392] O-1 & O-2. Peers use their own experience of overcoming mental distress to support others who are currently in crisis or struggling. This shift in emphasis from reciprocal relationship to a less symmetrical relationship of ‘giver’ and ‘receiver’ of care appears to underpin the differing role of peer support in naturally occurring and mutual support groups and PSWs employed in mental health systems [395], M-1. the experiential knowledge provided by PSWs created a ‘comradery’ and a ‘bond’, which made them feel that their challenges were better understood [397] PT-4, M-1. An evaluation of a model of discharge

							involving peer support reported that peer support used as part of the discharge process significantly reduces readmission rates and increases discharge rates [p.396], PT-4, O-2. Participants involved in peer support were less likely to identify stigma as an obstacle for getting work and were more likely to have employment. This makes sense as peers embody the possibility of acceptance and success, so that they can challenge the barriers created by self-stigmatisation: anticipation of discrimination [p.397], PT-4, M-3. A raised empowerment score has been reported in several studies of peer support attributed improvements in empowerment to the new ways of the thinking and behaving that occur when engaging in reciprocal peer support relationships. In a qualitative study of consumer views, Ochocka, Nelson, Janzen, and Trainor (2006) reported that participation in peer support as both a provider and recipient resulted in an increased sense of independence and empowerment. [p.396], PT4, O-1.

							One of the essential benefits gained from peer support is the sense of hope – a belief in a better future – created through meeting people who are recovering, people who have found ways through their difficulties and challenges [p.397], O-1.
45	Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012).	Peer support among persons with severe mental illnesses: a review of evidence and experience.	Hand picked	This study provide evidence that peer staff providing conventional mental health services can be effective in engaging people into care, reducing the use of emergency rooms and hospitals, and reducing substance use among persons with co-occurring substance use disorders. When providing peer support that involves positive self-disclosure, role modelling, and conditional regard, peer staff have also been found to increase participants' sense of hope, control, and ability to effect changes in their lives; increase their self-care, sense of community belonging, and satisfaction with various life domains; and decrease participants' level of depression and psychosis.	Mental Health policy paper.	Not available	Three basic contributions of peer support that would seem to be unique to, or at least especially well-suited for, peer staff. The first is the instillation of hope through positive self-disclosure, demonstrating to the service recipient that it is possible to go from being controlled by the illness to gaining some control over the illness, from being a victim to being the hero of one's own life journey (23,25). The second expands this role modelling function to include self-care of one's illness and exploring new ways of using experiential knowledge, or "street smarts". The third aspect of peer support focuses on the nature of the relationship between peer provider and recipient, which is thought to be essential for the first two components to be effective. This relationship is characterized by trust, acceptance,

							understanding, and the use of empathy; empathy which in this case is paired with “conditional regard” – otherwise described as a peer provider’s ability to “read” a client based on having been in the same shoes he or she is in now. [p.124], PT-4, M-1&2. A clear job description and role clarification – fully endorsed by key stakeholders (including program administrators, supervisors, and potential co-workers) – with relevant competencies, and a clear policy for evaluating competencies and job performance. [p.127]. PT-4, C. implementing peer support services in mental health settings is messy and complicated work that brings about significant culture change in these institutions [p.127], PT-4, M-3.
46	Trachtenberg, M., Parsonage, M., Shepherd, G. & Boardman, J. (2013).	Peer support in mental health care: is it good value for money?	Handpicked/ Google search	The overall conclusion suggested by these figures is that peer support workers bring about significant reductions in hospital bed use among the patients they support, leading to financial savings which are well in excess of additional pay costs. On the basis of this evidence, the use of peer support workers is justified	This study searched the literature on peer support workers for studies with quantitative data on the relationship between the employment of	A specific limitation relating to the financial analysis is that the impact of peer support workers on mental health service costs has been assessed solely in relation to hospital inpatient bed use. Other services may (or	Identified six studies in the research literature which give some evidence on the relationship between peer support and inpatient bed use [p.2]—PT4, O-2

				on value for money grounds. This conclusion stands even without taking into account the evidence for a positive impact on outcomes relating to the mental health and quality of life of service users.	peers and psychiatric hospital bed use. This study also used the Cochrane guidelines to assess these studies for risk of bias and to determine their overall quality, although not all of the studies considered were randomised controlled trials.	may not) also be affected. Finally, of these six studies, five come from the US and one from Australia. This raises the question of the extent to which contextual factors may limit the application of the results to the UK. This is clearly a valid concern, but the general conclusion still looks robust. For example, even if the average saving from lower bed use in six studies is halved, the financial benefits would still exceed the costs.	
47	MIND (2017)	Mind survey of 1,221 people (2017)	Hand searched	One in three people sent home from hospital too early – with no plan for further mental health care. One in five (21 per cent) were given no notice at all that they were going home. This even happens when people have been in hospital for a long time - one in three people (33 per cent) in hospital for more than a month were given less than 48 hours' notice that they were being discharged or no notice at all.	Not available	Not available	Research released today by mental health charity Mind reveals serious problems with the planning around discharging people from mental health hospitals. [PT-5]. One in three people (38 per cent) felt they were discharged from hospital sooner than they should have been PT-5, M-1.

				Two out of five people (37 per cent) said there was no plan for further care and support, contrary to guidelines. Less than half of people (44 per cent) said managing their mental health or self-care was considered in plans for leaving hospital. Only half of people (51 per cent) said their accommodation needs were considered in any plans, and less than a third (29 per cent) said that money and benefits were considered.			
48	Sharac, J., McCrone, P., Sabes-Figuera, R., Csipke, E., Wood, A. and Wykes, T. (2010).	Nurse and patient activities and interaction on psychiatric inpatients wards: A literature review.	Database	The amount of time spent delivering 'therapy' is probably in the region of 4–20%, (iv) relatively little patient time is spent in contact with staff and much is spent in isolation. There is also evidence to suggest that staff time with patients is reducing over time (Higgins et al., 1999) and that increasing staff numbers may not result in more time spent with patients	A search strategy was employed to systematically identify published studies relevant to the literature review. Studies published over a 35-year period from seven countries revealed quite consistent and clear findings.	The number of studies (13) identified was relatively low.	Given the reduction in acute beds, priority naturally goes to those patients who are more severely mentally ill, particularly those who have been involuntary admitted or have major social problems (Ryrie et al., 1997). Nurses report that they feel pressure to discharge patients who may not have yet fully recovered in order to free up beds. [p.910]. PT-1&5 [M-4] The lack of structured activities and patient contact [p.916], PT-5, M-1.
49	Nolan, P., Bradley, E. & Brimblecombe, N. (2011).	Disengaging from acute inpatient psychiatric	Database	Inpatient interventions should aim to build on relationships by focusing predominantly	The study involved all four acute care wards in a large NHS	Methodological limitation.	**None recalled at the time of admission being offered a choice, nor any reference to other possible options**. Thirty-two

		care: A description of service users' experiences and views.		on preparing the person for life after discharge and the multiple difficulties they may encounter.	Mental Health Foundation Trust in the West Midlands. All service users admitted over a 9-month period were invited to participate, the only eligibility criteria being that they had received inpatient care for a minimum of 2 weeks and agreed to be interviewed in two phases.		respondents reported satisfaction with some aspects of acute care particularly with respect to the provision of respite, taking the pressure off their relatives, reducing their fear and uncertainty and relishing the opportunity of having their mental health reviewed. [p.362], PT-1 [O] Inpatient interventions should aim to build on relationships by focusing predominantly on preparing the person for life after discharge and the multiple difficulties they may encounter. More focused interventions could have helped some in the preparation for discharge and could have minimized the distress experienced. [p.359], PT-5, M-1.
50	Fiddler, M., Borglin, G., Galloway, A., Jackson, C., McGowan, L., & Lovell, K. (2010).	Once-a-week psychiatric ward round or daily inpatient team meeting? A multidisciplinary mental health team's experience of new ways of working.	Hand searched	Evidence indicates that while service users are dissatisfied with current ward round practices, studies of how professionals experience this practice are sparse. This study found that staff views on ward rounds are more complex than had been earlier understood, but new ways of working can be implemented, if the impact of tradition, the process of change,	The study has allowed emphasis to be placed on the meanings and interpretations of those being researched and on ward rounds.	The results were based on 21 interviews, and the final number of participants was decided upon during data collection to ensure redundancy	Evidence suggesting that 'traditional' ward rounds might serve the interests of professionals rather than patients [p120] PT-3, [C] Competing agendas were interpreted to reflect an inherent tension within the working practice of the traditional ward round ward round, meetings were in general viewed as severely overcrowded in terms of the

				and the time to bed down are taken into account.			number of professionals attending. he assumption that a more flexible approach to ward rounds, which has the potential to facilitate greater involvement of inpatient [p.124].
51	Hodgson, R., Jamal, A., & Gayathri, B. (2005).	A survey of ward round practice	Hand picked	The recurrent themes were that ward rounds were an effective use of professional time but were often daunting for patients. The lack of representation at ward rounds for certain professional groups may adversely affect the range of opinions and therapies for patients. Changes could be made to incorporate the views of users, which would make ward rounds more productive for users and professionals.	Two common themes emerged which were: time pressures (12) and empathy with patients for the potential anxiety provoking nature of the ward round (10).	Study only involved professionals.	Approximately one-third of patients found the ward round provoked anxiety. A quarter of patients held an unfavourable view of the ward round but this did not relate to diagnosis, previous admission or demographic details. They noted that the simple measure of introducing each professional and stating their role significantly reduced anxiety [p171] P-3.
52	Milner G, Jankovic J, Hoosen I, Marrie D. (2008).	Patients and staff understanding of general adult psychiatry ward rounds.	Hand picked	Adequate preparation and education for patients and staff regarding the structure and purpose of the general adult psychiatric ward round would improve not only the patient experience but also the outcomes of the ward round for patients and staff.	A semi-structured questionnaire was designed specifically for this survey. The questionnaire was given to a group of psychiatric inpatients on two acute adult wards in Solihull Hospital The results	The main limitations of this study are a relatively small size, a potential selection bias and heterogeneity of the sample	‘‘Information beforehand about what and who to expect’’ would help them prepare better for the ward round, ‘‘Staff talking to patients before the ward round’’ ‘‘Intimidating, uncomfortable for patients’’, 10 (21%) that there are ‘‘Too many people in the wards round seeing the patient’’ [p496] PT-3. If patients and staff are all aware of the purpose and process of the ward round then inevitably this

					demonstrated that 57% of patients and 49% of staff had no explanation of the purpose of the ward round and that 60% of patients and 32% of staff were not aware of the ward round process.		will lead to realistic expectations and hopefully improved experience and better satisfaction. [p497], PT-3, M-2.