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Striking the Right Balance and Supporting Social Aspirations: How Agency and Choice Play out in a Recovery-Oriented Mental Health Service

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ABSTRACT

Introduction: There has been an increasing drive for a transformation of the mental health system towards recovery orientation, with research identifying a series of key recovery principles. It has been argued that these principles remain rhetoric rather than routine practice, and it remains unclear how these are operationalised and promoted within inpatient settings.

Aim: To address the knowledge gap of how staff and service-users enact recovery principles during the daily workings of an inpatient mental health service.

Method: Twenty-one interviews were conducted with staff and service-users at a recovery-oriented inpatient service in the United Kingdom. Data was analysed using framework analysis.

Findings: Analysis of research interview data identified three subcategories grouped under the category of choice. These categories were: a delicate balancing act, acceptability of choices, and social issues impacting choice.

Discussion: Staff were uncertain of their role in promoting choice, resulting in service-users feeling unsupported in their recovery. Staff had to adopt a titrated approach to social inclusion, to protect service-users from discrimination and rejection.

Implications: Mental health professionals need to take a more proactive role in enabling service-users to realise their social aspirations, as well as managing any adverse impacts of stigma and discrimination.

Introduction

Mental health recovery is understood in several ways and remains a debated and controversial concept. Clinical recovery orientates towards recovery in terms of symptomatology, cure and improvements in mental health outcomes (Lieberman et al., 2008). Social recovery considers the role of the community in contributing to ill-health and the need for community approaches to recovery (Onken et al., 2007). Personal recovery is defined as a subjective, ongoing process of personal change (Davidson et al., 2016), leading to a satisfying and fulfilled life, despite symptoms and limitations of mental illness (Anthony, 1993). This concept originated from service-user movements that challenged traditional beliefs about mental health and treatment. Recovery is the process of building a meaningful and satisfying life, even if the individual has ongoing or recurring symptoms or problems associated with a mental illness (Anthony, 1993). Despite a lack of consensus, the discussion of recovery is becoming ever more prominent in mental health treatment. There has been an increasing drive towards the operationalisation of personal recovery in the form of recovery-oriented care (Piat et al., 2017). However, the empirical base regarding recovery-oriented care remains in its infancy (Macpherson et al., 2016).

Recovery-oriented care has featured within mental health policies across many Western countries, such as the United Kingdom (Department of Health, 2011), Australia (Australian Government, 2009) and Canada (Mental Health Commission of Canada, 2012). Le Boutillier et al.'s (2015) paper highlights that wider system acceptance of recovery-oriented care is needed for its implementation at a provider-level. However, the wider mental health system remains medical dominated (Morera et al., 2017), paternalistic (Knaak et al., 2017), focused on cure (Slade et al., 2014), and prioritises reducing hospital beds (Ewbank et al., 2017). The context in which service delivery operates conflicts with the notions of personal recovery (Deegan, 1988); and suggests there are system wide challenges to delivering and achieving recovery-oriented care.

There is ongoing debate as to whether all mental health services can embrace and deliver recovery-oriented care, specifically in services that provide compulsory treatment under mental health legislation (Simpson & Penney, 2011). Research exploring recovery-focused mental health care planning and co-ordination in acute mental health settings in the UK, found that definitions and understandings of recovery differed among mental health professionals and service-users, as did their views on the role of inpatient care

in promoting recovery (Coffey et al., 2019). There was some uncertainty about the relevance of recovery ideas in inpatient settings, and whether those in acute distress, or formally detailed, had the ability to engage in recovery-oriented approaches. Staff reported difficulties in putting the ideas of recovery-orientation into practice, barriers included: time taken completing paperwork, limited resources, the tension between risk management and recovery-oriented care and a primary focus on medical treatment (Coffey et al., 2019; Mhlanga, 2022). The implementation of recovery-oriented care within inpatient settings has been criticised for providing 'imposed recovery'; where recovery is forced upon individuals, compromising choice, autonomy and stifling hope (Young, 2011, p. 397). This debate could stem from the fact that recovery-oriented principles originated from community and outpatient settings (Whitley et al. 2009; Compton et al. 2014); which raises the question of whether these principles can simply be transferred into inpatient care. Inpatient care focuses upon crisis-management, uses coercive treatment, and advocates pharmacological approaches, which have the potential to conflict with key recovery processes, such as choice, self-determination, hope and empowerment. The characteristics of inpatient care may complicate the implementation of personal recovery and therefore consideration of these characteristics and ways to address or overcome these challenges is needed if service providers are going to fulfil the expectation of recovery-oriented care.

Recovery, as defined within the service-user movement, appears to transcend any model or theory and instead is about the unique, personal process an individual goes through. Deegan (1989) argued against recovery being reduced to a set of systemised principles. This suggests that attempts to conceptualise and operationalise recovery within policy and practice may already be a deviation from the true meaning of personal recovery. If recovery is so idiosyncratic then this presents a problem for services when attempting to standardise recovery in service delivery. There remains a need for direct evidence generated with people who use and deliver services, of how recovery is operationalised.

Aim

This study aims to explore service user and staff accounts of tensions encountered in the delivery and receipt of an inpatient mental health recovery service where the concept of recovery was advanced, invoked and deployed by participants as an important constituent of the service philosophy. The analysis in this paper aims to address the gap in knowledge of how staff and service-users attempt to enact recovery during the day-to-day workings of an inpatient mental health recovery service.

Materials and methods

Individual semi-structured interviews were conducted, and were subjected to framework analysis (Ritchie & Spencer, 1994). The data and analysis reported in this current paper were collected as part of a larger realist evaluation (Pritchard,

2021, Pawson & Tilley, 1997) to examine how a charity provider operationalised and promoted recovery-oriented care in practice.

Service context

This study was conducted in a 16-bed mental health service that provides locked facilities, daytime psychological intervention, and living skills training to promote recovery for adults with severe mental illness. The service is categorised as a mixed-gender, locked rehabilitation service by the regulating bodies in the UK. The service is a separate property, which has en-suite rooms, gym, multi-faith room, café, lounge and log cabin. Service-users and staff are all responsible for contributing to the decision-making and operation of the service, including making meals, organising activities, cleaning and greeting visitors.

The service was designed after numerous consultations with service-users and carers over a 3-year period. The service's philosophy was to enable service-users to lead an independent life and where possible, support individuals to move successfully into the community. The recovery focused service is designed for those who have been in traditional hospital type settings, or who have tried to live independently but this has not worked, or have previous negative experiences in the mental health system. Service users residing at the service had histories of previous lengthy in-patient stays.

The service is a user-led, not-for-profit inpatient service, delivered by a third sector (charity) organisation; meaning the service is not delivered by the NHS, or an independent healthcare provider. It is the first service of its kind to be delivered by an independent third-sector (charity) organisation within the UK.

Participants

Staff participants were purposively recruited through emailing staff members who had been at the service for at least 6 months. Of the 14 staff members approached, 13 agreed to participate. This included four members of senior management, two mental health nurses, five peer mentors with lived experience of mental ill-health, one recovery practitioner and one administrator.

Service-users were identified and approached by the gatekeeper. The gatekeeper was the Development Consultant who oversaw the delivery and development of the service. The gatekeeper was identified by the service as the most appropriate individual to support with access. The gatekeeper only supported the first contact with potential participants and was not aware of who was involved in the research. All potential participants were provided with information about the study and its voluntary nature. Of the eight service-users approached, all agreed to participate.

Data collection

Interviews were conducted in the family room at the service, or at the charity headquarters and lasted 15–120 min

(average 50 min). A topic guide was used with pre-defined open-ended questions relating to how the service supported service-user recovery, for example "what are the key components of the service's approach to recovery?" "In day-to-day service delivery, what are you doing to promote service-user recovery?". The topic guides were developed as suggested by Manzano (2016) and Westhorp and Manzano (2017) to adhere to realist principles and focused on context of care, resources used, participant responses to resources and outcomes of care delivery. Follow-up questions were used for clarification, or to develop participant responses. Interviews were audio-recorded and transcribed verbatim. The first author conducted and transcribed the interviews, they were independent of the service and had no prior working or therapeutic relationship with participants.

Analysis

Framework analysis was used and involved transcribing, reading, rereading and making notes about initial categories (Ritchie & Spencer, 1993). Before analysis, a framework was created from the reading of background literature relating to the important components of recovery, largely centred on the CHIME framework (Leamy et al., 2011) and material on the service's recovery philosophy. The transcripts were then imported to the analytic software NVivo and the text was divided into meaningful units relevant to the aim and labelled as codes. First, a deductive approach was taken looking for data that fit the frame. This was followed by an inductive approach examining data for new categories, 19 initial descriptive categories being identified from the dataset. These were refined into seven overarching categories which related to the values identified as key to service delivery: the wider context, the staffing group, responsibility, choice, the intended service-user group, the physical environment and the wider organisation. Following the realist focus of this project, for each overarching category subcategories were developed that related to contextual factors that supported or hindered the success of service delivery for example societal stigma, the response of staff and service-users to how the service delivered upon their recovery values, and outcomes, for example, limited access to social opportunities. The analysis was discussed by the authors until consensus was reached. The first author analysed the transcripts and a summary of the categories, including relevant extracts, were provided to the other authors for discussion and refinement. The findings presented in this paper relate to the overarching category - choice.

Ethical considerations

The project received ethical approval from Swansea University's Ethics Committee (Reference 010818a) and NHS Wales Ethics Committee REC 6 (Reference 18/WA/0315). The study was conducted in accordance with the Declaration of Helsinki ethical guidelines (World Medical Association, 2013). Participants were informed of the study's purpose, their right to withdraw at any time,

confidentiality, anonymity, and gave informed consent in writing. In the event that a participant became upset or distressed, interviews would be stopped and the person asked if they would like a break, or to terminate the interview. The service-user would be signposted to support, and the nursing team made aware if any risk to self or others was disclosed. This was not required and all interviews passed without incident.

Findings

In this paper we focus our analysis specifically on the category of choice as a fundamental element of the experience of achieving recovery. Analysis of research interview data identified three subcategories that contributed to the category of choice. These subcategories were: a delicate balancing act, acceptability of choices, and social issues impacting choice.

A delicate balancing act

Staff expressed variation in their understanding of service-users' ability to make decisions for themselves, and this largely related to whether they believed the person had previous experience of making choices and possessed the confidence and skills needed. For service-users with limited experiences of choice, they reported being overwhelmed at the prospect, experienced discomfort when accepting these responsibilities and deflected decisions back to staff.

> we had a very very interesting erm issue with that in the beginning, cause we were like right we are going to let guests (service users) make the choice but they had come from somewhere where they had very little to no choice, to too much choice, and they were so shell-shocked by it they didn't know what to do
>
> (Staff 1)

Staff knew that service users would struggle with choice but nevertheless persevered with this, presumably because they saw it as an unnegotiable element of the recovery vision they had. However, service-users were saying that choice is difficult and they want support to help them to make choices. Service-users also recognised that their reluctance towards choice may be seen negatively by staff.

> in my last unit we never had the choice of what to do so here, I am still trying to get over it, it's quite hard to accept I don't really like choosing what to do, cause I have never had to choose what to do, so I would rather people chose for me I know that's the wrong choice but at the minute, until I am ready
>
> (Service-user 1)

Some staff accounts alluded to an expectation that service-users would be able to make decisions for themselves, and already have the skillset and ability to do this, which was not always the case among the service-users. There was a discrepancy between the actual ability of service-users to make choices for themselves and some staff's expectations; meaning support was not always available when needed. Service-users recognised that they can be helped to build these skills again, but show concern that

being left to make their own decisions without support may mean they are unable to make use of opportunities.

> if you don't come up with the suggestions then nothing gets done and that is the frustrating point... I've been here for 3 months and sometimes feel myself not getting better, and just getting frustrated cause I am hanging out just not doing anything
>
> (Service-user 3)

Service-users discussed wanting support from staff, or other service-users, to make choices. Service-users raised their concerns that one consequence of the absence of resources to draw upon was that their recovery can stall. The promotion of a one-size-fits-all approach to decision-making, as indicated by participants, means that if service-users lacked relevant skills, then there was no alternative.

One particular example that reflected the challenges surrounding choice in practice related to service-users who chose not to engage.

> this is the thing that I sort of wrestle with myself in terms of how much sort of how much persuasion we should be using cause at the moment if someone doesn't feel like doing anything, or a particular thing, then we just go oh ok then fine, and then it ends there
>
> (Staff 3)

Staff opted to back away in response to service-users who chose not to engage, suggesting individuals were left with the responsibility to motivate themselves to engage in their recovery.

Acceptability of choices

Choice was contingent upon service-users being ready and able to make their own decisions. Staff reported being risk-adverse, often only seeing the potential harms in activities, or concluding that the harms outweighed any potential benefits or learning.

> they [service-users] can get frustrated because if they want to do something that we can't encourage, like the pub, they are allowed to but we can't encourage that
>
> (Staff 4)

Staff did not perceive the pub as a suitable activity to support service-users in attending, which appears at odds with what is considered normative in British society. However, rather than going to the pub being viewed as a learning opportunity, or means to connect with others, some staff felt unable to encourage it.

Some staff worked to an either-or scenario, where service-users either accepted independence and behaved in the way staff deemed acceptable, or they go to a more secure environment, which could be perceived as threatening by service-users.

> you just have to trust people, and if they are unable to accept that level of independence and trust, then they will have to be discharged to a more secure setting. It all depends on, trust,

partnership, we have to work in partnership with our guests [service-users] but they have to work in partnership with us with the aim of recovery. Recovery is not promoted for somebody with a serious mental illness by combining medication with drugs or drink

> (Staff 5)

Service-users were positioned by some staff as blameworthy, culpable and in some circumstances seen as uncommitted to their recovery.

Service-users were aware that their choices needed to align with what would secure them discharge, and that being in hospital restricted the choices available to them. However, there was variability in the way that service-users positioned and understood choice in regards to their own recovery journey.

> but you've just got to play the game... learn how to get out... I suppose but I'm like I don't know how to play the game... what game are we playing
>
> (Service-user 3)

Some referred to choice as playing the game, which shows awareness of the need to follow rules, at least for now, to enable a future outcome of discharge. This was, however, a learning process for the service-user to identify what was needed to navigate the unwritten rules of mental health care.

> they're not going to let me out there if I'm drinking and drugging are they? So you know... you have to prove yourself and work within the means of that you adhere to do... do all your chores... do all the things you need to do
>
> (Service-user 4)

Some positioned choice as an opportunity to prove themselves, and highlights an understanding of the need to demonstrate their suitability for discharge.

> when you are out of hospital, you are doing your own thing in your house you can go for walks when you are home, you can go out on your own, well you can go out on your own here but you are still in a hospital environment, when you go home you get freedom don't you
>
> (Service-user 5)

Some were aware that choice may be available, but it is a modest choice, one constrained by environment and not likely to be ever like home. These accounts suggest that service-users are very much aware that what is on offer is a limited or modest freedom, constrained by staff and service expectations of what is normative and acceptable.

Social issues impacting choice

Staff evidenced the negative experiences of some service-users:

> with the college course that was a difficult one really cause that's when you realise there still is stigma erm, we had er, we had a guy who did a college course in [location name] and erm they noticed that he had a diagnosis of schizophrenia so he had to have an automatic risk assessment done discussing everything and I just thought this wouldn't happen for everybody whereas his mental illness had nothing to do with what he could've achieved at college and they completed a risk assessment with

him and they never got back to us, they never returned any phone calls, nothing

(Staff 6)

Although mental health services may be encouraging choice, service-users' ability to act upon these choices appeared to be constricted by societal barriers. Services that focus solely on individual-level change, overlook and miss the wider structural inequalities, such as discrimination, social isolation and poverty, that limit opportunities for integration, acceptance and social support.

Staffs' response to service-user experiences of stigma and discrimination was to encourage mental health specific opportunities. Staff attempted to locate local opportunities, activities or work placements that understood mental ill-health:

we [staff] try our hardest to identify placements that understand mental health because there is the issue of rejection and we have had that unfortunately… if we go down to [organisations name] they know they are safe… its run by peer mentors who understand it, there is less chance of rejection, and I think that's the safest way to get back into the scary groups… I know I am more cautious about it

(Staff 2)

Staff opted to protect service-users from rejection, by facilitating opportunities where these experiences were deemed less likely to occur. The avoidance of mainstream services or groups beyond those with mental health awareness, such as college courses and gym classes, in favour of those designed solely for those experiencing mental ill-health, could inadvertently be denying service-users access to valuable and diverse forms of support that aid their recovery. However, it also demonstrates that a more titrated approach to reintegration, such as accessing opportunities with less risk of rejection may be a necessary stepping stone given the presence of societal stigma and discrimination.

Service-users were also aware of societal stigma and expressed a need to humanise their situation, as well as justify and defend their need for community integration and access:

at the end of the day if we are going to be moving back to the community we need to learn how to live in the community so we need that access at the end of the day we are people we are not dangerous animals that can't be let out we need to be let out, we need to do things or else we will just get institutionalised

(Service-user 6)

Service-user accounts highlight that although staff may see them as individuals, this perception may not be exercised in the wider community. Public perceptions and fears may contribute to the difficulties of service-users being able to act upon their preferences, and may contribute to institutionalisation. The concern about the negative effects of limited opportunities to be part of the wider community was something service user participants were aware of and in this example appears to be linked to background expectancies of the mentally ill being dangerous. Participants were seeking choice but also had to weigh this alongside social processes and structures, for example, beliefs about mental illness, that negatively influence recovery journeys.

Discussion

The focus on choice within this paper fits with previous research by Leamy et al. (2011) as it is an important element of recovery (Ellison et al., 2018). Little was known about how staff and service-users attempt to enact choice within the daily operation of an inpatient service delivery, therefore the findings from this paper address this gap in knowledge and highlight the operational complexities surrounding service-user choice within practice. Our findings show that despite choice being something both staff and service-users recognise as necessary for recovery, achieving this in practice was complex, requiring collaborative, creative and innovative strategies to address barriers when they arise.

Staff participants were uncertain of their role in promoting choice. An implication of this uncertainty, is that this is another example of the liminal space staff occupy within mental health practice; this needs to be addressed by a more assertive stance in relation to person-centred practice (Terry, 2020). Front-line workers experienced tension when balancing service-users' needs for support against a recovery concept that promotes self-management and autonomy, with the latter often being prioritised by staff. Another part of this tension is that staff are often concerned about being blamed for errors that raise safety or risk concerns. It seems at odds that staff hold expectations that service-users should be autonomous, and not be worried about safety. Despite the clear need for flexibility, some staff expressed the assumption that all service-users had the capabilities and skills to make choices and needed to do this without support. The process of 'responsibilising' service-users promotes neoliberal ideas of individualised responsibility and self-governance that views everyone as a self-directing and autonomous individual (Cradock, 2007), irrespective of context (Esposito & Perez, 2014). This study highlights that people recovering from mental illnesses need flexible support to develop the skills to become independent and make choices for themselves. Our findings show that a blanket, one-size-fits-all approach to the concept of choice, that promotes self-reliance and self-management was not always suitable, and meant opportunities for service-users to learn how to make choices were lost. Staff need to find a balance between providing the space for service-users to make choices for themselves and providing the support and resources for service-users to be able to do so. At times, staff were unsure of how to strike this balance, which indicates the need for further training or policy clarification on how they are expected to promote independence, without conflating it with self-reliance. To support recovery, staff not only need the skills and knowledge to tailor interventions to meet the needs of individuals, but they need to feel empowered to be creative and flexible, and free from overly rigid interpretations of how choice as an element of recovery, should be promoted in practice.

Service-users were expected to make decisions, demonstrate self-care and manage their own risk, through the promotion of individualism and autonomy; however, these concepts were often interwoven with views of what choices were considered acceptable or 'right', reflecting a potential for judgement and blame. Service-users were very aware that selecting the 'right' or acceptable choice was closely associated with prospects for discharge. Opportunities, such as the pub or non-engagement, were not viewed as a learning opportunity, as some staff felt unable to encourage such choices. Whilst this could be attributable to the professional responsibility of staff to ensure service-user, staff and public safety, staff appeared risk-adverse to potential harmful situations (Chen et al., 2013). The conflicting tensions between ensuring a safe but enabling service on the one hand and meeting the needs of service users to have experiences that might challenge or strain their safety on the other, meant that those who failed to show improvement or movement towards recovery were considered a poor fit for that service. The notion that a tension exists between recovery-oriented care and risk management, largely in inpatient and acute settings, has been demonstrated elsewhere within UK literature (Coffey et al., 2019, Mhlanga, 2022). Constructing choice in this way could render those, unable or unwilling to conform, marginalised and excluded by the very services who aim to support them. This approach fails to account for the reality that some individuals may need to learn how to make decisions that are supportive of their recovery, and may require the guidance of staff. The approach also does not take account of the need to learn the 'rules' that are sometimes taken-for-granted by staff, but remain unknown to service-users. It places service-users in an impossible situation, expected to adhere to sets of rules that are unstated and penalised for transgressing those same rules despite these not being clearly delineated. Recovery values promote that people may have to learn along the way, which includes making mistakes, or having occasional faulty judgement. Using acceptability of choices and readiness as rigid markers of suitability, could devalue and work against the principles that underpin recovery, where individuals with a mental illness must be willing to try and fail and try again (Deegan, 1988).

Choice is a function of agency, and this study evidences how individual agency is limited by structural issues, such as discrimination, access to material and emotional resources, and availability of social support. Whilst it is acknowledged that choice is not infinite for anyone, and limited options exists for us all, this study shows the constraints for participants due to concerns about negative societal perceptions of mental illness. This study adds to the literature as it unpacks how choice is being promoted within an inpatient setting, but also shows how the society in which individuals live can impact not only recovery, but service delivery and the ability for choice to truly be achieved in practice. Approaches that focus exclusively on change within the service-user, directly contrast with our understanding that social processes have a greater impact on psychosocial outcomes among vulnerable populations when compared to changes that an individual can make themselves (Ungar et al., 2013). The enduring stigma of mental ill-health and the denial of opportunities has the potential to cause significant harm to individuals with severe mental illness, and staff may be unintentionally reinforcing this through confining opportunities to those within the mental health sphere.

Service-users experienced patterns of disadvantage when attempting to socially integrate, which constitutes structural violence, a form of inequity and injustice embedded in institutional and social structures in society (Farmer, 2004). Exclusively referring service-users to resources only intended for those with mental ill-health may be a form of ghettoisation (Stewart, 2019). Although this may not be a conscious attempt to ghettoise service-users, it can foster that mentality, and limit the agency of service users to engage with mainstream society. Our findings support that choice and recovery involve a journey of both personal change and social engagement (Tew et al., 2012). It is essential that service-users are understood within the social context in which they live, and developing accepting and enabling social environments within which recovery can be supported are essential. Our findings raise the question of whether inpatient services and staff should be doing more outreach and engagement work with communities to support the integration of people using services to fulfil their choices.

This paper raises the question of how recovery oriented a locked environment can truly be. Policies promoting recovery-oriented care present a one-size fits all approach to this model of service delivery, and fail to capture the nuances of inpatient care. The origins of recovery-oriented principles came from outpatient and community settings (Compton et al. 2014), and this paper has demonstrated that these cannot be simply transferred to locked services. This paper has demonstrated that the operationalisation and purpose of inpatient care sits in conflict with key recovery processes (Coffey et al., 2019; Mhlanga, 2022). It is of importance that key stakeholders, such as service-users, policy-makers, service providers and healthcare professionals discuss the limits of what can be achieved within the confines of a locked service. There needs to be transparency around the challenges and frustration that staff and service-users may experience when attempting to reach the ideals of recovery-oriented care within inpatient settings. Whilst we can strive for the ideals of recovery-oriented care, we must be transparent about what can truly be achieved within locked services.

Strengths and limitations

A strength of this study was that interviews were conducted with service-users whilst they were staying at the service and were not subject to recall bias. However, this might impose limitations to the validity of the interviews, as both staff and service-users were talking about a service they were still working for, or were accessing care from, meaning individuals may have been selective about what was shared. There was a large variation in the length of interviews from 15–120 min, which may have had some effect on the findings, as some more verbose participants could had more impact than others. However, this was mitigated by ensuring that service-user and staff data

were analysed separately first, to ensure that key categories from both participant groups were captured, before bringing the full dataset together. The interview data was rich, and the framework approach provided a time-consuming, yet structured method of organising, analysing and comparing data across participant groups. A study limitation is the small sample size from one newly established, third-sector (charity) service within the social context of the UK, reducing generalisability to other social contexts and services.

Conclusion

Choice is an interactional and negotiated process which both staff and service-users engage with, and together, must learn what can be achieved, and how to overcome barriers that exist. There may be differences in how the challenges of choice are viewed; for example, service-users may feel constrained by services and legal impositions, whereas, staff may be overly paternalistic, or prone to blaming service-users. However, it is important that this learning process is collaborative so staff and service-users both discover what constraints exist when attempting to facilitate opportunities for promoting choice, generating recovery journeys, and appropriate strategies to address these barriers are identified.

This study identifies the challenges staff and service-users experience when trying to operationalise choice, an aspect of recovery-oriented care, within an inpatient setting. Staff expressed experiencing various tensions when promoting choice, such as ensuring a safe and enabling service against service-users having experiences that might challenge that safety, and balancing individuals need for support against a recovery concept that promotes self-management and self-reliance. There was uncertainty on how to strike the right balance, but what was evident was the need for staff and service-users to learn what could be achieved and what barriers existed. Mental health professionals can adopt a more assertive and person-centred approach to enable people disabled by years of institutional care to take the first tentative steps in expressing and enacting choice as they commence their recovery journey. This research highlights how social factors can play a central role in recovery. Unless inpatient services shift their attention to start addressing social barriers to recovery, factors such as stigma and social exclusion will continue to prevent service-users from participating as equal and full citizens, and personal recovery and recovery-orientated care will remain rhetoric.

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