

AN EXPLORATION OF THE COMMISSIONING, DEVELOPMENT AND
IMPLEMENTATION OF EARLY INTERVENTION SERVICES FOR FIRST
EPISODE PSYCHOSIS IN ENGLAND

by

ELIZABETH JAYNE ENGLAND

A thesis submitted to
The University of Birmingham
for the degree of
DOCTOR OF PHILOSOPHY

Primary Care Clinical Sciences
School of Health and Populations Sciences
University of Birmingham
College of Medical and Dental Sciences
July 2012

UNIVERSITY OF
BIRMINGHAM

University of Birmingham Research Archive

e-theses repository

This unpublished thesis/dissertation is copyright of the author and/or third parties. The intellectual property rights of the author or third parties in respect of this work are as defined by The Copyright Designs and Patents Act 1988 or as modified by any successor legislation.

Any use made of information contained in this thesis/dissertation must be in accordance with that legislation and must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the permission of the copyright holder.

Abstract

The aim of this longitudinal, qualitative PhD was to explore the commissioning and implementation of early intervention services for first episode psychosis across a number of sites in England. Methods: After a literature review of policy, implementation, and empirical RCT and cohort studies, 147 semi-structured interviews and six focus groups involving 35 people from different managerial and operational levels of the health service were undertaken between February 2004 and March 2009. May's Normalization Process Theory was used as the underpinning conceptual framework and data were analysed using the Framework Analytical Approach.

Results

The main findings were the importance of partnership working, influenced positively by the role of a facilitator; challenges which arose when commissioning mental health services, alleviated by the involvement of senior managers acting in a mentor role and the 'work' undertaken, from the perspective of Normalization Process Theory. A new service model, called the 'trailblazer' early intervention service was identified, which is not accounted for within Normalization Process Theory.

Conclusion

Further work is needed to define the characteristics and qualities of the mentoring role of

senior managers and the facilitator and explore how best to adapt and extend Normalization Process Theory to incorporate the new 'trailblazer' service model.

Dedication

I would like to acknowledge the inspirational instruction and guidance of Professor Helen Lester and the support given me by Professor Max Birchwood.

Finally, I would like to thank my husband, Richard, for his support and encouragement.

Acknowledgements

I would also like to acknowledge the National Institute for Health Research who provided the funding for me to carry out this work.

CHAPTER ONE: BACKGROUND AND INTRODUCTION TO EARLY INTERVENTION SERVICES FOR FIRST EPISODE PSYCHOSIS

1.0 The structure of this PhD and Chapter One	1
1.1 Aims and objectives	2
1.2 The context of this PhD within the family of EDEN studies and defining the research problem.	3
2.0 Background to early intervention services for first episode psychosis.	4
2.1 What is first episode psychosis?	4
2.2 The five phases of first episode psychosis.	5
2.3 Course and outcomes of first episode psychosis.	5
2.4 The social, financial and personal health costs of schizophrenia and psychosis.	6
2.5 What is the early intervention approach?	7
2.6 Policy support for early intervention in England and implementation of early intervention services.	8
2.7 Critical components of early intervention services.	10
2.8 Bridging the gap	12
2.9 Commissioning of early intervention services.	13
3.0 The rationale for this PhD exploring the commissioning and implementation of early intervention services.	14
4.0 Methodology	15

5.0 Conclusion	16
----------------	----

CHAPTER TWO: LITERATURE REVIEW

1.0 Search strategy	17
1.1 Mesh Terms used	17
1.2 Assessing the quality of the evidence.	18
2.0 Empirical literature: Randomised Controlled Trials	19
2.1 The systematic review	22
2.1.1 Description of studies included in the systematic review.	22
2.1.2 The methodological quality of the studies included in the systematic review.	23
2.1.3 Results of the studies included in the systematic review.	24
2.2 The Randomised Controlled Trials	25
2.2.1 Study settings	26
2.2.2 Recruitment and follow up	27
2.2.3 Intervention and duration	28
2.2.4 Randomisation, allocation and blinding	30
2.2.5 Reporting of outcome data, attrition, missing data	31
2.2.6 Power calculations	32
2.2.7 What were the results?	33
2.2.8 Conclusions reached for empirical studies.	34
3.0 Empirical literature: Cohort studies	36

3.1 Carbone et al., 1999.	39
3.2 Mihalopoulos et al., 1999.	40
3.3 Goldberg et al., 2006.	41
3.4 Harris et al., 2008.	43
3.5 Mihalopoulos et al., 2009.	44
3.6 Discussion	45
4.0 Implementation literature	47
4.1 O’Kearney et al., 2004.	48
4.2 Lester et al., 2008.	49
4.3 Lester et al., 2009.	49
4.4 England et al., 2009.	50
4.5 Discussion of implementation literature.	52
5.0 Mental health policy and early intervention service development in England.	52
5.1 The National Service Framework for Mental Health, 1999.	52
5.2 The NHS Plan (2000) and The Mental Health Policy Implementation Guide (2001).	53
5.3 The Early Psychosis Declaration (2002, 2004).	54
5.4 The National Service Framework for Mental Health-five years on, 2004.	54
5.5 The National Early Intervention Programme, 2004.	55
5.6 The Early Intervention Plan, 2006.	55
5.7 New Horizons, 2009.	56
5.8 Early Intervention Services for young people	56

5.9 Conclusions for policy literature.	57
6.0 Discussion	57

CHAPTER THREE: THE THEORETICAL BASIS FOR THIS PHD

1.0 What are complex interventions?	59
1.1 Can early intervention services be described in this way?	60
1.2 Experimental methods of evaluating complex interventions such as early intervention services.	62
1.3 Resource constraints and timeline of early intervention service development.	63
1.4 Traditional policy implementation evaluation frameworks	64
2.0 Normalization Process Model and Normalization Process Theory- An alternative theoretical approach to the evaluation of complex interventions.	65
2.1 Normalization Process Theory	66
2.2 Concepts underpinning Normalization Process Theory.	67
2.2.1 Practical operationalisation of Normalization Process Theory: The Domains and Outcomes of Normalization Process Theory.	68
2.3 Why Normalization Process Theory was chosen as the key theory in this PhD.	69
3.0 Conclusion	70

CHAPTER FOUR: METHODOLOGY

1.0 Summary of research methods	72
1.1 What is a qualitative approach and why was it chosen for this PhD?	73
2.0 The longitudinal approach	75
3.0 Data collection methods	76
3.1 Focus groups	77
3.2 Round One of the Interviews, July-November 2005. The research participants and sampling.	78
3.2.1 Convenience sampling	78
3.2.2 Judgment sampling	79
3.2.3 Normalization Process Theory and sampling	79
3.2.4 Topic guides	82
3.3 Round Two of the Interviews, May 2006-November 2006. Snowball sampling method and unique case sampling method.	83
3.3.1 Snowball sampling	83
3.3.2 Unique case sampling	84
3.4 Round Three of the interviews, May-September 2007. Snowball sampling method, unique case sampling method and theoretical case sampling method.	85
3.4.1 Theoretical sampling	86
3.5 Round Four of the Interviews, November 2008-March 2009.	87
3.6 Focus Groups	87
3.6.1 Round One of the Focus Groups	87

3.6.2 Round Two of the Focus Groups	89
4.0 Developing the topic guide	89
5.0 Sample sizes	90
6.0 Attrition in qualitative research	91
7.0 Transcription of the data	92
8.0 Trustworthiness of the research	93
8.1 Triangulation	93
8.2 Reflexivity	94
8.3 The doctor as the interviewer	95
9.0 Ethical considerations	96
10.0 'Generalisability'	97
11.0 Methodology and ethical issues	98
12.0 The Framework Analytical Approach to qualitative data analysis and modified Grounded Theory	100
12.1 Grounded Theory	100
12.2 Stages in Grounded Theory	101
12.3 Framework Analysis Method	103
12.3.1 Familiarisation	104
12.3.2 Development of a thematic framework	104
12.3.3 Development of the thematic index	105
12.3.4 Charting	105
12.3.5 Mapping and interpretation	106
13.0 Qualitative analysis of the data: Worked example using five stages of	106

Framework Analysis.	
13.1 Familiarisation	107
13.2 Developing the thematic index	107
13.2.1 Refining the thematic index	111
13.2.2 Application of the refined thematic index	112
13.3 Indexing	115
13.3.1 Analysis of the data with excerpt from refined thematic index	117
13.4 Charting	119
13.5. Mapping	121
14.0 Conclusion	124

CHAPTER FIVE: RESULTS

1.0 Summary of data collected	125
1.1 Round One of the Interviews	125
1.2 Round Two of the Interviews	126
1.3 Round three of the Interviews	127
1.4 Round four of the Interviews	129
1.5 Summary of the Interviews	131
1.6 First round of Focus Groups	131
1.7 Second round of Focus Groups	132
2.0 Findings from this PhD	133
3.0 Theme One: Partnership working	134

3.1 Potential partners	135
3.1.1 Third sector (voluntary sector) partnerships	135
3.1.2 Service users	136
3.1.3 Partnership working with educational services and social care.	136
3.1.4 Partnership working with Child and Adolescent Mental Health Services	138
3.2 Influences on partnership working	139
3.2.1 Resource and funding issues	140
3.2.2 Historical working, philosophy of care and traditional working practices.	141
3.2.3 Organisational perspective on resources and financial issues	141
3.2.4 Geographical issues and services being based in different Trusts	142
3.2.5 Organisational change	143
3.2.6 Concordance between adult and children’s policy frameworks	145
3.3 ‘Bridging the divide’	146
3.3.1 Child and Adolescent Mental Health Services-Early Intervention Service link worker	146
3.3.2 The Early Intervention Service youth focused service model	147
3.3.2.1 Features of the youth focused service model	148
3.4 Facilitators	150
3.4.1 Senior managerial and executive support	150
3.4.2 Joint training and educational initiatives	152
3.4.3 The facilitator	153
4.0 Theme Two: Mental health commissioning	155
4.1 Challenges and barriers	156

4.1.1 Value of mental health	156
4.1.2 Skills and experience of commissioners.	157
4.1.3 Organisational change and re-organisation.	158
4.1.4 Mentorship and support within the organisation.	159
4.2 Consequences and Outcomes	160
4.2.1 Use of Health Act Flexibilities	160
4.2.2 Fragmented service planning	160
4.2.3 Undue provider influence	161
4.3 Facilitators	162
4.3.1 Senior management support	162
5.0 Theme Three: ‘Work’ within the context of Normalization Process Theory	163
5.1 Coherence-sense making work	164
5.1.1 Reconceptualising organisational roles and responsibilities.	164
5.1.2 Perceived benefits and understanding of the evidence base for early intervention services.	165
5.1.3 Contextualising early intervention services within mental health services	166
5.2 Cognitive participation	166
5.3 Collective action	168
5.3.1 Mentorship	168
5.3.2 Meaningful involvement and ownership of early intervention services.	169
5.3.3 Investing in partnerships	170
5.3.4 Managing organisational change	170
5.3.5 Dissemination of success and continuous investment in service.	171

5.4 Outcomes	172
5.5 Reflexive monitoring	174
6.0 Conclusion	175

CHAPTER SIX: DISCUSSION

1.0 The aims and objectives of this PhD	177
1.1 Were the aims and objectives addressed?	178
1.2 Objective One	178
1.3 Objective Two	180
2.0 Limitations	181
2.1 Single researcher	181
2.2 Background of the researcher and perceived legitimacy	181
2.3 Lack of service user and family carer involvement	183
2.4 The large number of interviews	183
2.5 Focus group weaknesses	183
2.6 Temporal issues	185
3.0 The findings of this study	185
3.1 Partnership working	186
3.2 Literature exploring early intervention services and partnership working with wider health and voluntary organisation.	187
3.3 Partnership working with social care.	188
3.4 Partnership working, resources and organisational change.	188

3.5 Partnership working and the role of the ‘facilitator.’	189
3.6 Partnership working and senior managerial or organisational support.	192
3.7 Bridging the divide	193
4.0 Mental health commissioning	195
4.1 The value of mental health commissioning	196
4.2 Organisational support	196
4.3 Commissioners’ experience	198
4.4 Workforce development and leadership	199
4.5 Organisational change	200
5.0 Work as defined by Normalization Process Theory and the conditions needed to normalize early intervention services for first episode psychosis.	200
5.1 How do the findings of this PhD compare with other work in the area of Normalization Process Theory and coherence?	201
5.2 How do the findings of this PhD compare with other work in the area of Normalization Process Theory and Cognitive Participation?	202
5.3 How do the findings of this PhD compare with other work in the area of Normalization Process Theory and Collective Action?	204
5.3.1 Mentorship	204
5.3.2 Management of change	204
5.3.3 Outcomes of collective action	205
6.0 Implications for future research	206
6.1 Expanding methodologies used	206
6.2 Developing the evidence base for early intervention services for	207

first episode psychosis further.

6.3 Evaluation of the gold standard or trailblazer early intervention services.	208
6.4 Evidence and outcomes	208
6.5 Service user and family member involvement	209
6.6 The role of the facilitator and leadership	209
7.0 Conclusion	209

TABLES

Table One: Summary of Randomised Controlled Trials found addressing efficacy of early intervention services for first episode psychosis.	19
Table Two: Cohort studies addressing efficacy of early intervention services for first episode psychosis	37
Table Three: Tentative thematic index November 2005	108
Table Four: Interview excerpt with EIS team lead IV 1	112
Table Five: Refined thematic index May 2006	114
Table Six: Interview excerpt with EIS lead IV 1 R1	117
Table Seven: Interview excerpt with EIS lead IV 15 R1	118
Table Eight: Policy chart with original quote from section 2.6, Chapter Five.	120

FIGURES

Figure One: Flow diagram demonstrating how relevant papers were identified	19
Figure Two: Excerpt from a mapping diagram representing patterns in attitude to implementation of national early intervention service policy locally	123
Figure Three: Partnership working	134
Figure Four: Mental health commissioning	155
Figure Five: Work	163

Appendices

Appendix One-PhD protocol

Appendix Two-Published papers arising from this PhD

Lester, H., Birchwood, M., Tait, L., Shah, S., England, E., Smith, J. 2008. Barriers and facilitators to partnership working between Early Intervention Services and the voluntary and community sector. *Health and Social Care in the Community*, 16(5): 493-500.

England, E., Lester, H., Birchwood, M. 2009. Collaborating to provide early intervention services to persons in England with first-episode psychosis. *Psychiatric Services*, 60(11): 1484-8.

Lester, H., Birchwood, M., Bryan, S. England, E., Rogers, H. N., Sirvastava, N. 2009. Development and implementation of early intervention services for young people with psychosis: case study. *The British Journal of Psychiatry*, 194: 446-450.

Appendix Three-Study information sheet

Appendix Four- Individual topic guides

Appendix Five-Interviewees and focus group participants

LIST OF ABBREVIATIONS

AMHS adult mental health services

ATPS Acute and transient psychotic disorder

BPRS Brief Psychological Rating Scale

CBT Cognitive Behavioural Therapy

CI Confidence interval

CPA Care Programme Approach

CAMHS Child and Adolescent Mental Health Services

CMHT Community Mental Health Services

COAST Croydon Outreach and Assertive Support Team

DCSF Department of Children's, Schools and Families

DH Department of Health

DOSMD Determinants of Severe Mental Illnesses and Disability

DSM-IV-TR The *Diagnostic and Statistical Manual of Mental Disorders Version IV Text Revision*

DUP Duration of untreated psychosis

EE Elizabeth England

EI Early intervention

EIS Early Intervention Service

EISs Early Intervention Services

EPI Early Psychosis Intervention

EPPIC Early Psychosis and Intervention Centre

ER Emergency room

FEP First Episode Psychosis

GAF Global Assessment of Functioning

GP General Practitioner

GPS Global Psychotic Score

GT Grounded Theory

HL Helen Lester

HRSA Hamilton Rating Scale for Anxiety

HRSD Hamilton Rating Scale for Depression

HSCT Health and Social Care Trust

IEPA International Early Psychosis Association

IRAOS Instrument for the assessment of onset and early course of schizophrenia

IRIS Network Initiative to Reduce the Impact of Schizophrenia Network

IT Integrated treatment

ITT Intention to treat

LA Local Authority

LEO (team or study) Lambeth Early Onset (team or study)

LIT Local Implementation Team

MANSA Manchester Short Assessment of Quality of Life

MHA Mental Health Act

MHT Mental Health Trust

MHPIG Mental Health Policy Implementation Guide

MRC Medical Research Council

nGMS New General Medical Services (contract)

NHS National Health Service

NICE National Institute of Clinical Excellence

NIHR National Institute of Health Research

NMHDU National Mental Health Development Unit

NIMHE National Institute for Mental Health in England

NPM Normalization Process Model

NPT Normalization Process Theory

NSF National Service Framework

OASIS Outreach and Support in South London

PACE Personal Assessment and Crisis Evaluation Clinic

PAS Pre-morbid Adjustment Scale

PBC Practice Based Commissioning

PCT Primary Care Trust

PICU Psychiatric Intensive Care Unit

PIF Policy Implementation Framework

QLS Quality of Life Scale

QOF Quality and Outcomes Framework

QOL Quality of Life

RCT Randomised Controlled Trial

REDIRECT Birmingham Early Detection in Untreated Psychosis

RE Realistic evaluation

RR Relative Risk

SAFE Programme Southern Area First Episode Programme

SANS Scale for the assessment of negative symptoms

SAPS Scale for the assessment of positive symptoms

SCAN-2 Schedule for clinical assessment of neuropsychiatry

SDO Service, Delivery and Organisation

SHA Strategic Health Authority

SPA Single point of Access

ST Standard treatment

TAU Treatment as usual

TOC Theories Of Change

UK United Kingdom

VPCR Victoria (Australia) Psychiatric Case Registers

WHO World Health Organisation

WSR Whole systems research

CHAPTER ONE

BACKGROUND AND INTRODUCTION TO EARLY INTERVENTION

SERVICES FOR FIRST EPISODE PSYCHOSIS

1.0 The structure of this PhD and Chapter One

This PhD is divided into six Chapters. Chapter One introduces the field of study, which are early intervention services (EIS) for first episode psychosis (FEP) and chosen area of research, which is the commissioning and implementation of EISs in England. Chapter Two presents the empirical evidence, implementation literature and policy, relevant to EISs for FEP and synthesises and critiques it. Chapter Three describes the theoretical basis underpinning this PhD which is May's Normalization Process Theory (NPT). Chapter Four describes the methodology. Chapter Five presents the findings of this PhD, which are then these discussed in the final chapter of this PhD, Chapter Six.

This first Chapter introduces the aims and objectives of this PhD. Following this, the context of this PhD within the family of EDEN studies is discussed and the research problem defined. A description of the key issues relevant to EIS for FEP are then considered. These include a brief description of the signs and symptoms of FEP; the course and outcomes of FEP; the specific features and critical components of the early intervention (EI) approach; policy support and the rationale for this PhD exploring the commissioning and implementation of EISs in England. Finally the methodology used to achieve the aims and objectives is described.

1.1 Aims and objectives

The aim of this PhD is to undertake an evaluation of the factors influencing the commissioning and implementation of EISs for FEP across a number of sites in England from the perspective of micro (service delivery: EIS), meso (Primary Care Trusts) and macro (Strategic Health Authority) levels of the National Health Service (NHS).

This will be achieved by firstly undertaking a literature review which will summarise, synthesise and critique the different bodies of academic knowledge relevant to the implementation of EIS for FEP. The implementation of EIS for FEP will then be considered from the perspective of May's NPT (2006). NPT is then used to inform the second part of this PhD, which uses longitudinal, qualitative research methods to explore the implementation of EIS for FEP in England.

Objectives

1. To determine the barriers and facilitators influencing EIS commissioning in the EIS literature and related bodies of academic knowledge.
2. To use NPT to inform data collection and explore those factors influencing EIS commissioning and implementation in a number of health and social care organisations in England in a longitudinal, qualitative study.

1.2 The context of this PhD within the family of EDEN studies and defining the research problem

This PhD arose from novel findings in the EDEN study (Lester et al., 2006) and aimed to extend and add value to the ‘family’ of National Institute for Health Research Service Delivery and Organisation Programme (NIHR-SDO) funded EDEN studies. However, it is also a discrete standalone project in its own right. It specifically seeks to explore the barriers and facilitators influencing commissioning and implementation of EISs involving a broad range of healthcare and social care professionals in a wide range of organisational settings, within the NHS using longitudinal, qualitative methods. The need to explore these issues further arose from the original EDEN study and was confirmed by the author (EE) after an extensive review of the literature specific to EISs.

The EDEN study, a largely qualitative study funded by the NIHR SDO Programme (2003-2006), described the evolution and implementation of EISs for FEP, across the Midlands. Using a multiple case study approach (the cases being the EIS), twelve of the fourteen EISs in existence at the time of the study participated. Interviews were undertaken with 106 EIS team leads and members and also with service users. 42 Strategic Health Authority (SHA) Mental Health Leads, Primary Care Trust (PCT) mental health commissioners and Mental Health Trust (MHT) and Health and Social Care Trust (HSCT) chief executives agreed to be interviewed as part of this study. These interviews were undertaken by EE (the researcher submitting this thesis). Issues of access, stigma and engagement of young people were identified as important. Ownership, understanding of the EIS approach and the importance of

leadership within the EIS were identified as facilitators to EIS development. Barriers to EIS development were also created by PCT commissioners' apparent lack of understanding of partnership working issues and their perception that mental health commissioning received lower priority within the PCTs.

It became clear at an early stage that the data from the interviews with SHA and PCT commissioners and mental health leads were novel and required more detailed exploration outside of the scope and funding of the EDEN Study. This led to EE registering to undertake this PhD in evaluating the factors involved in the commissioning and implementation of EISs in January 2005 (PhD protocol can be found in Appendix One). It can therefore be seen that this PhD adds to and extends the findings of the original EDEN study, exploring and developing further critical ideas noted by EE in the original EDEN study.

2.0 Background to Early Intervention Services and first episode psychosis

2.1 What is first episode psychosis?

The *Diagnostic and Statistical Manual of Mental Disorders Version IV Text Revision* (DSM-IV-TR, American Psychiatric Association, 2000) classifies psychosis as caused by 'traditional psychotic illnesses such as severe psychosocial stress, severe depression, bipolar disorder and schizophrenia; psychosis due to general medical conditions, and substance induced psychosis.' (p. 273) Psychosis, more often than not, signals the onset of schizophrenia. People experiencing psychosis may report hallucinations or delusional beliefs, and may exhibit personality changes and thought

disorder. The average incidence (new cases diagnosed per year) of psychosis is approximately 15 per 100,000 (DH, 2001).

2.2 The five phases of first episode psychosis

FEP occurs in five phases, each of which is characterised by ambiguous boundaries. These phases are 1) the premorbid phase 2) the prodrome 3) the acute phase (which is when the symptoms of psychosis begin to emerge and is also known as the critical period) 4) the early recovery phase (which is the first six months following acute treatment) and 5) the late recovery phase which follows the early recovery phase for six to 18 months (Johannessen et al., 1999).

The prodromal phase is the most controversial and uncertain phase of FEP. Preceding the genuine onset of psychotic symptoms, this phase in the past has often only been identified with hindsight. In the prodromal period psychotic symptoms are often vague and easily confused with 'normal' adolescent behaviour such as irritability, mood swings and social withdrawal. The controversies with intervening early in the prodromal period relate to difficulties in making a diagnosis, the risk of misdiagnosis (false positives) and then the potentially inappropriate use of antipsychotic treatment. However, supporters of EI argue that by identifying early signs, young people can be offered treatment quickly enough to produce radically improved outcomes and, perhaps, prevent psychosis from ever developing (Harrison et al., 2001; Yung et al., 2006).

2.3 Course and outcomes of first episode psychosis

It is difficult to fully describe the longitudinal course and outcome of FEP at present as few studies have specifically focussed on long term follow up of individuals with a diagnosis of FEP. EISs were initially introduced in policy and guidance documents in 1999 in the United Kingdom (UK) (DH, 1999), but guidance on implementation of EISs did not appear until 2001 (DH, 2001). Therefore, there has been little time for long term follow up studies for people who have used the services in England. A review of the literature from Australia, Denmark and Canada, where the EI approach has been established longer, suggests that a shorter duration of untreated psychosis (DUP) correlates modestly with decreased severity of positive symptoms, and enhanced social and occupational functioning and quality of life at five years. These studies are discussed and critiqued in detail in Chapter Two.

For those patients with a diagnosis of schizophrenia on presentation, some go on to make a full recovery but many go on to develop a lifelong illness with the potential for huge personal suffering and social cost. Clinical recovery from FEP is variable, with only about 45 percent of individuals recovering after one or more episodes of psychosis (Wunderink et al., 2009). In general, outcomes of schizophrenia have, until recently, been poor, with 15-35 percent of people experiencing relapse in the first year after treatment, rising to 80 percent after five years (Larsen, 1998). Achievement of remission is less likely after each relapse (Wiersma, 1998).

2.4 The social, financial and personal health costs of schizophrenia and psychosis

Living with FEP has far reaching implications for the individual. Many of the long term problems experienced by these individuals impact on their everyday existence,

including difficulties in developing and maintaining relationships, achieving in education, sustaining a vocation or securing employment, managing finances and maintaining an income and owning a home (Birchwood et al., 1998).

Individuals experiencing psychosis are at significant risk for depression, substance abuse and anxiety disorders. Cognitive deficits are present in both schizophrenia and other psychotic disorders. Stigma, discrimination, poverty and poor physical health are further consequences for those individuals developing a psychotic disorder (Marwaha and Johnson, 2004; Saha et al., 2007).

The financial costs to society are enormous. Work by Mangalore and Knapp (2006) estimated that the total societal cost of schizophrenia was approximately £6.7 billion in 2004/05. The direct cost of treatment and care per annum was about £2 billion. Inpatient care is by far the most costly healthcare component in the overall treatment of schizophrenia. The economic costs of FEP appear to be out of proportion to the relatively low prevalence of psychosis. In addition, a recent paper by Knapp et al. (2011) has reinforced findings from earlier work that shows the EI approach to be a potentially cost saving way of providing care to those in an early stage of psychosis.

2.5 What is the early intervention approach?

EISs differ to traditional English models of care for people with psychosis. In England, until recently, people with severe mental health problems such as psychosis were usually managed either by admission as an inpatient to a psychiatric hospital if very unwell or unable to be managed as an outpatient or as an outpatient by a

Community Mental Health Team (CMHT) or an Assertive Outreach (intensive) service. EISs differ to traditional CMHTs by having smaller caseloads and greater capacity to provide sustained contact and engagement with service users. In comparison to the CMHT model, whose focus has tended to be on providing for the needs of older individuals with chronic relapsing disorders, EISs pay greater attention to engagement and to the distinct needs of young people experiencing the early phases of a psychotic illness (Killaspy, 2006).

‘Early psychosis intervention’ (EPI) refers to an integrated group of approaches to the treatment of psychosis that emphasises the importance of both the timing and types of intervention provided to people experiencing FEP. Early intervention in psychosis has two distinct elements, which distinguish it from standard care 1) early detection and 2) phase specific treatment. Early detection may be defined as either the identification of people thought likely to develop psychosis (described as people displaying prodromal symptoms) or the identification of people with psychotic symptoms who have not yet received adequate treatment.

Phase specific treatments are those treatments (psychological, social or physical) that are especially targeted at people in the prodromal phase to try and prevent progression to psychosis or for people with early or recent onset psychosis to promote earlier recovery (Marshall and Lockwood, 2004). A primary aim of the EIS is a reduction in the DUP (Norman and Malla, 2001; Malla et al., 2004).

2.6 Policy support for early intervention in England and implementation of early intervention services

EISs for FEP have been part of the UK Government's vision for mental health investment and reform for over a decade. *Modernising Mental Health Services: Safe, Sound and Supportive* (DH, 1998) established the guiding principles for further policy development and the new strategy promised extra investment and the development of new and better mental health systems. The *National Service Framework for Mental Health* (DH, 1999) stressed the necessity for prompt assessment of young people with possible psychosis in light of 'the growing evidence that early assessment and treatment can reduce levels of morbidity' (DH, 1999, p. 44). The *National Plan for the NHS* further stated: 'Fifty early intervention teams will be established by 2004 so that ...all young people who experience a first episode of psychosis, such as schizophrenia will receive the early and intensive support they need (DH, 2000, p. 119). The implementation of EISs for FEP is supported by *The Mental Health Policy Implementation Guide* (DH, 2001), which contains guidance on for whom the service is designed for; key components of and core features of the EIS. *The Mental Health Policy Implementation Guide* (DH, 2001) was developed to enable and support Local Implementation Teams (LITs), who were responsible at that time for developing services at a local level, in developing and implementing adult mental health services in their local area. It provided a three-year structure to service development from 2001-2004.

The Mental Health Policy Implementation Guide (DH, 2001) suggested involving a wide range of stakeholders to establish effective and integrated patterns of partnership working across a number of diverse organisational boundaries. It also stated that the most appropriate model of service delivery is one based upon a specialist discrete team which has staff members whose sole or main responsibility is the management

of people in the early phase of psychotic illness; has an adequate skill mix to deliver core interventions; has strong links with other mental health services and good general knowledge of local resources. *The Mental Health Policy Implementation Guide* (DH, 2001) also gives advice on the team composition based on a suggested staffing level and skill mix for a team with a caseload of 120 to 150 people.

The National Plan for the NHS (DH, 2000) target of 50 services for a population of 50 million, assumed an average catchment population for each service of one million. The Nottingham Centre of the Determinants of Severe Mental Illnesses and Disability (DOSMD) found approximately 24 new cases of ‘schizophrenia’ or closely related conditions per 100,000 population per year (Harrison et al., 1996). 85 percent of these cases will be young people in the 14-35 year age range leading to a predicted figure of 7,500 new cases per year in England. Each service will comprise of a number of teams who will manage about 150 new cases per year for three years giving a total caseload of 450 per service. These figures are affected by higher rates of social deprivation, geographical influences and a number of other factors, which must be taken into account when planning services (Joseph and Birchwood, 2005).

2.7 Critical components of early intervention services

Several studies have tried to identify the critical components of the complex interventions carried out by EI programmes. Marshall and colleagues (2004) identified key components of an EIS, which included a focus on FEP; staff whose sole or main responsibility is to the EIS; a holistic approach to care and being able to integrate effectively with wider mental health services such as Child and Adolescent

Mental Health Services (CAMHS).

The *Mental Health Policy Implementation Guide* (DH, 2001) contains guidance on for whom the service is designed for; key components of, and core features of the EIS. It has identified that the appropriate age range for referral to EISs is people aged between 14 and 35 years with a first presentation of psychotic symptoms or in the first three years of psychotic illness and states that EISs should consider a culturally age and gender sensitive approach which is family orientated. EISs should focus on the development of meaningful and sustained engagement based on assertive outreach principles; providing treatment in the least restrictive and stigmatising setting, placing an emphasis on normal social roles and service user's developmental needs, particularly involving education and achieving employment and an emphasise the management of symptoms rather than the diagnosis. EISs should reduce the stigma associated with psychosis and improve professional and lay awareness of the symptoms of psychosis and the need for early assessment. Additional key components include reducing the length of time young people remain undiagnosed and untreated, developing meaningful engagement with service users, providing evidence-based interventions and promoting recovery during the early phase of illness. The Guide particularly specifies that EISs should provide a user centred service available for those from age 14 to 35 years that effectively integrates child, adolescent and adult mental health services and works in partnership with primary care, education, social services, youth and other services.

Further practical guidance is provided by a project group and Expert Reference Group (The Sainsbury Centre for Mental Health, 2003). This guidance identifies ten core

features distilled from the *Mental Health Policy Implementation Guide* (DH, 2001) of an EIS including early detection and assessment; the requirement of a strategy to minimise DUP; comprehensive assessment of the service user and working with diagnostic uncertainty. The guidance suggests that it is appropriate to use low dose atypical antipsychotic medications prescribed according to the National Institute of Clinical Excellence (NICE) guidelines with appropriate medication monitoring and to allocate a key worker, develop a care plan with a recovery focus and involve service users in care planning. Service users should also receive ongoing assessment and planning for anxiety, depression, alcohol and substance abuse and support for financial concerns, healthy lifestyles, vocational and educational needs and housing issues. Importantly the guidance also recommends alternatives be sought to hospital admission in age-appropriate in patient facilities and avoidance of the use of the Mental Health Act (2007) where appropriate, finally the guidance suggests utilising an optimistic partnership approach to care involving primary care, Adult Mental Health Services (AMHS), CAMHS, Social Services, educational services, the third sector and voluntary organisations, Drug and Alcohol services and Criminal justice services.

2.8 Bridging the gap

One of the underlying principles for EI service reform has been to try and ‘bridge the gap’ identified between mental health services for young people and adults through the specialist EIS. It is suggested that this might be achieved by bringing together the individual skills of CAMHS and adult EI practitioners in collaboration to help develop a seamless pathway through mental health services, provide an overall higher

standard of care and ensure a whole systems response to young people with FEP (Singh et al., 2005).

2.9 Commissioning of early intervention services

A joint commissioning approach by PCTs has been recommended in developing EISs. In England, between 2003 and 2006, the commissioning of mental health services is managed by 151 PCTs (six of which are care Trusts). Each PCT covers a separate local area. PCTs receive about 80 percent of the total NHS budget directly from the Department of Health. The role of PCTs is to decide what health services a local community needs and to provide and commission these services. They are also responsible for delivering national health policy at a local level. The finance and much of the agenda of PCTs is effectively determined by directives from the SHA or the Department of Health. SHAs are responsible for larger areas of England and incorporate a number of PCTs. The roles of SHAs include strategic planning of health services, monitoring the performance and standards of PCTs within their area, supporting PCTs in implementing national policies into practice, and ensuring that national priorities are integrated into local health service plans.

Commissioning of social care is however different. Traditionally, mental health services have needed to work closely with their social care counterparts to provide complete care for people with severe and enduring mental health problems as there are significant social as well as physical health needs associated with conditions such as schizophrenia (Smith et al., 2006). Social care needs are distinct from healthcare needs and are provided in the form of 'social care packages' organised through local

councils (NHS Information Centre, 2008). Social care in England is funded through central government funds allocated to local councils; council tax revenue; individuals' contributions to their council care package, and/or to services arranged independently. The voluntary or third sector also provides and subsidises a range of care services. Councils with social services responsibilities (unitary and county councils) commission social care services for the local community.

Integrated or joint commissioning is designed to be innovative, ensure value for money and bring about improved services that are developed in partnership with the local authority who are responsible for commissioning social care. Joint commissioning is able to make use of new powers in the Health Act (1999). These 'flexibilities' allow health and local authorities to pool budgets for specific services, delegate responsibility for commissioning services to a single 'lead' organisation, and integrate the provision of health and social care.

3.0 The rationale for this PhD exploring the commissioning and implementation of early intervention services

A Cochrane review of EISs for FEP (Marshall and Rathbone, 2006) found there was emerging, but inconclusive evidence, to support the EIS for FEP approach and model of care. Despite this uncertain evidence base, current Health Policy in England supports the development of EISs for FEP and a range of services are now being developed and implemented across England. An evaluation of EISs in development has shown under-resourcing for a comprehensive approach to managing the patient and family, widespread variations in service availability and fragmented service

development in some areas (Pelosi and Birchwood, 2003; Pinfold et al., 2005; Singh and Fisher, 2005; Lester et al., 2008) suggesting there may be a range of ‘additional’ factors influencing service implementation. Some of these factors were identified by the author, EE, and are discussed in Section 1.2 of this Chapter.

A recent review of mental health services available for young people has identified that specialist services, which include EISs, are still not available to the majority of young people, with commissioning and management highlighted as specific issues (DCSF, 2007). A review of the literature showed that there were no studies which explored commissioning and implementation of EISs for FEP in England. There is therefore a need for further research and study in this area.

4.0 Methodology

This PhD is a qualitative, exploratory multimethod longitudinal study, nested within the family of EDEN studies (Lester et al., 2006). The aim of the PhD is to evaluate the development and implementation of EISs in the West Midlands and be both explanatory and descriptive in nature. A multimethod approach has ensured a more thorough and holistic evaluation of the findings.

A total of 147 semi-structured interviews and six focus groups involving 35 participants were held between July 2005 and March 2009. Interviews took place on a six monthly basis over a period of two years (July-November 2005; May-November 2006; May-September 2007 and November 2008-March 2009) with senior executives and individuals with a managerial or commissioning aspect to their role from SHAs,

PCTs, MHTs, a Partnership Trust and Health and Social Care Trusts HSCTs, acute hospital Trusts and a number of local authorities. In addition, operational level interviews were carried out with EIS and CAMHS leads and team members.

Six focus groups were carried out with 35 participants from two PCTs, two MHTs, one Partnership Trust and one HSCT. Individuals were invited to participate from different backgrounds within the organisations including individuals with senior executive or managerial content to their role, although all had responsibility for either adult or children's' mental health service development. Transcription and analysis of the interviews and focus groups took place concurrently and emergent findings were used to inform the sampling framework as the PhD progressed.

5.0 Conclusion

This Chapter has laid the foundations and discussed the rationale for this PhD by introducing the research problem and research question- An evaluation of the factors influencing the commissioning and implementation of EISs for FEP. The development of EISs for FEP so far has been described and a brief account of the methodology given. The structure of the PhD is intended to facilitate further exploration of all of these areas in more detail. Chapter Two will now describe the findings of a literature review and critique the evidence base underpinning EISs for FEP.

CHAPTER TWO

LITERATURE REVIEW

1.0 Search strategy

A critical literature review was carried out to identify any studies or literature which specifically addressed the development or implementation of EISs for FEP or those factors which might influence it. The search was carried out using the Cochrane Controlled Trials Register, Medline, CINAHL, Embase, Psychinfo, Counsellit from 1999-2009 and grey literature sources including conference abstracts from 2004-9. Relevant primary care and secondary care journals relating to mental health were also hand searched from 1999-2009 and relevant references sourced. A search was carried out using the Department of Health, NIMHE (National Institute for Mental Health in England) and NMHDU (National Mental Health Development Unit) websites to find relevant policy relating to the implementation of EISs.

1.1 Mesh Terms used

The search was conducted using the MeSH Terms: Early Interventions, Preventive Health Services, Psychotic Disorders, Psychoses, Schizoaffective Disorder, Brief Reactive Psychoses Health Plan Implementations, Health Service, and Community Health Planning Community Health Systems. Exclusion criteria included Children's services, chronic psychosis and ultra high-risk groups. Non-English papers were included in the search. One paper was found in German. The abstract was translated

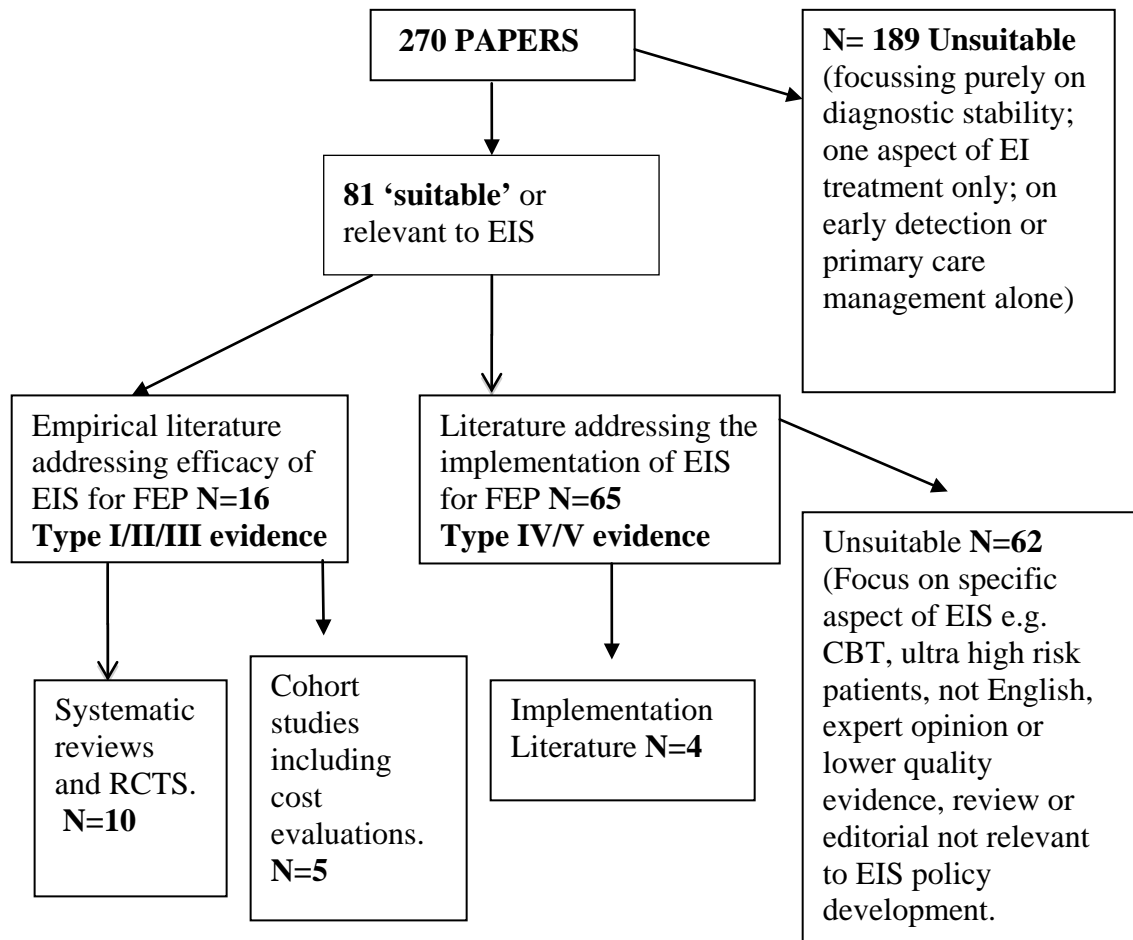
by a colleague on behalf of EE but was not relevant to the aims of the literature review.

1.2 Assessing the quality of the evidence

The search was conducted initially on June 3rd 2004 and thereafter at six monthly intervals up until December 31st 2009 to ensure all relevant and up to date information was captured. Of the 270 papers initially identified in the search strategy, after reading the abstracts, only 81 papers were felt to be relevant. Using the National Service Framework (NSF) Hierarchy of evidence (DH, 1999), the papers were then divided into Type I evidence containing at least one good systematic review, including at least one randomised controlled trial (RCT); Type II evidence containing at least one good RCT; Type III evidence containing at least one well designed intervention study without randomisation; Type IV evidence containing which at least one well designed observational study and lastly Type V evidence which includes expert opinion. Type V evidence was excluded from the main literature review as it generally viewed as being less rigorous and of lower quality in terms of validity than evidence from RCTs. Type V evidence included letters and personal opinions not relevant to the implementation of EIS for FEP. This is shown below in Figure One.

The references and bibliography of the papers, which were included, were all hand searched. This did not identify any further papers. The rest of this Chapter is now divided into four subsections: 2.0 Empirical literature-RCTs; 3.0 Empirical literature-Cohort Studies; 4.0 Implementation literature and 5.0 Policy pertaining to EIS for FEP.

Figure One: Flow diagram demonstrating how relevant papers were identified



2.0 Empirical literature: Randomised Controlled Trials

A total of ten papers presented empirical evidence for the EIS approach to FEP. Nine were RCTs and one, a systematic review. Studies were considered eligible to be in the empirical group of papers if they were RCTs, systematic reviews or well designed controlled trials with pseudo-randomisation. These papers are now summarised in the following table and discussed further:

Table One: Summary of Randomised Controlled Trials found addressing efficacy of early intervention services for first episode psychosis

Paper title	Sample size/ Population	Timeframe	Intervention	Key findings or limitations
Jorgensen et al., 2000. Soc Psychiatry Psychiatr Epidemiol 35: 283-287. OPUS	410 patients, 18-45 years with diagnosis of FEP or schizophrenia like psychosis Mostly urban areas. Denmark	Jan 1998 until Dec 2000. Follow up at 3 months, 1, 2, and 5 years.	Participants randomly allocated to modified assertive community treatment (EIS) or TAU (CMHT).	At 3 months: more patients in EIS group remain in contact than TAU group (no statistical calculation).
Linszen et al., 2001. Schizophrenia Research 51: 55-61.	Part randomized. 76 patients (15-26 years) with FEP and related disorders. Academic medical centre in Amsterdam	Jan 1996 for 15 months. Follow up at 12 months and five years.	Individuals randomised to either an EIS approach to care or a team offering 'best clinical' care at that time.	At 5 years: no control data established so no statistical analysis of results undertaken.
Marshall and Rathbone, 2004. Cochrane Database Systematic Rev (4):CD004718.	3 trials PACE-Melbourne (2001), Linszen-Amsterdam (1997 and 2001) and Zhang-Suzhou(1994).		Systematic review	Insufficient trials identified to draw firm conclusions. It is premature to implement EIS widespread according to the evidence they reviewed.
Craig et al., 2004. British Medical Journal 329: 1067-9. LEO	144 people (16-40 years) with diagnosis of nonaffective psychosis, schizo-affective disorder, delusional disorder. London, England.	January 2000 for 18 months. Follow up at 18 months post randomisation.	Individuals randomised to either TAU or EIS.	No statistically significant differences between the IT group and TAU for recovery. Patient's not all FEP presentation.
Kuipers et al., 2004 Soc Psychiatry Psychiatr Epidemiol 39: 358-	59 patients (18-65 yrs) with a diagnosis of any functional psychosis within the last	April 2000 until July 2001. Follow up at 6 and 9 months.	All new referrals to an EIS (COAST) randomised to either TAU from CMHT or EIS care.	No significant differences in improvement (recovery) between COAST and TAU patients at 9 months

363. COAST	five years. Croydon, England.			follow up. Participants not strictly FEP.
Petersen et al. 2005 British Journal of Psychiatry 187 (48) s98-103. OPUS	As for Jorgensen et al., 2000 above but 547 patients aged 18-45 yrs recruited at this point in the study.	1 year follow up.		In IT group: 'Significant' findings-lower 'psychotic global score' (PGS) and negative PGS; better GAF score; fewer patients with drug or alcohol misuse.
Petersen et al. 2005a British Medical Journal 331:602-8. OPUS	As for Jorgensen et al., 2000 above but 547 patients aged 18-45 years recruited at this point in the study.	2 year follow up.		In IT group: No significant differences in psychotic global score and negative PGS. GAF score significantly better. Satisfaction with EIS significantly better in IT group in year 1 and 2 follow up.
Garety et al., 2006 British Journal of Psychiatry 188:37-45.	144 people aged 16-40 yrs with a diagnosis of non affective psychosis, schizo- affective disorder and delusional disorder London, England.	January 2000 for 18 months. Follow up at 18 months post randomisatio n.	Participants randomly allocated to 'specialised care' an EIS model or standard care.	In IT group: Negative psychotic global scores significantly less, GAF score significantly better and longer vocational activity engagement at 18 months follow up.
Grawe et al, 2006 Acta Psychiatric- a Scandinavi ca 116 (6): 328-336.	50 people with a diagnosis of schizophrenia of less than 2 yrs duration in people aged 18-35 years. Norway	January 1992 and lasted five years. Individuals were followed up after 2 years.	Participants randomly allocated to ST or integrated treatment (IT).	IT patients had significantly better outcomes i.e. no recurrences, persisting psychosis, hospital admissions, suicidal

				behaviours or poor adherence. Some of the sample was recent onset not FEP.
Bertelsen et al., 2008. Archives of General Psychiatry 65:762-771. OPUS	As for Jorgensen et al 2000 above but 547 patients aged 18-45 yrs recruited at this point in the study.	5 year follow up.		No significant differences in psychotic global score or negative psychotic global seen. Patients in the IT group spent statistically significant fewer days in hospital in the five year follow up period.

2.1 The systematic review

Marshall and Lockwood carried out a systematic review of EISs for FEP (Cochrane Review, 2004). The objective of the review was to evaluate the effects of EI inpatients either in the prodrome or early phase of FEP. Whilst they identified a large number of studies in their initial literature review, the majority were excluded for reasons of methodological quality, design or because the studies did not specifically address EISs for FEP. They included three studies: Zhang-Suzhou (Suzhou et al., 1994) Linszen-Amsterdam (Linzen et al., 1997) and (Personal Assessment and Crisis Evaluation) Clinic (PACE)-Melbourne (McGorry et al., 2002). These studies are considered in detail in the following sections.

2.1.1 Description of studies included in the systematic review

PACE-Melbourne compared low dose risperidone and cognitive behavioural therapy (CBT) plus a specialised team, to treatment by the specialised team alone. The

Linszen-Amsterdam study compared family therapy and specialised team management to specialised team management alone and the Zhang-Suzhou study compared family therapy plus standard care to standard care alone. The Zhang-Suzhou trial standard therapy was not, however, comparable to English EISs as it focussed on a low key form of outpatient therapy with little continuity or assertive follow up. A total of 218 participants were included in these three studies. PACE-Melbourne included 59 participants aged 14-30 years and followed participants up at six and 12 months. Linszen-Amsterdam involved 76 participants aged 15-26 years who lived with parents and followed people up at twelve months and five years (this study is discussed separately below) and the Zhang-Suzhou study involved 83 men (no age range given) and followed people up at 18 months. The setting and participants for the Linszen-Amsterdam study are not similar to those people referred to EISs for FEP in England, as they were required to be resident with parents as part of the inclusion criteria and also spend three months as an inpatient. The three studies all used a very broad range of validated outcome measures.

2.1.2 The methodological quality of the studies included in the systematic review

Marshall and Lockwood (2004) comment on the relatively poor methodological quality of the studies. None of the studies presented a power calculation. PACE-Melbourne provided all data on an intention to treat (ITT) basis and randomisation was undertaken by the study coordinator. Linszen-Amsterdam only provided data on an ITT basis at twelve months and no details of randomisation were given. Zhang-Suzhou reported two outcomes on an ITT basis- readmissions and compliance with treatment; but only reported data on mental state and overall functioning on people

not readmitted to hospital therefore rendering the data as unusable. In addition no details were given on the process of randomisation. PACE-Melbourne and Zhang-Suzhou blinded raters to allocation; however, Linszen-Amsterdam did not give details of this. Follow up rates were good with in the PACE-Melbourne and Zhang-Suzhou study. Follow up rates were not clear in the Linszen-Amsterdam study. Overall therefore these methodological issues mean that there was a moderate risk of bias favouring the experimental intervention.

2.1.3 Results of the studies included in the systematic review

PACE-Melbourne reported that at six months participants receiving the intervention were less likely to develop psychosis (RR 0.27, CI 0.08 to 0.89), however this effect was no longer statistically significant at 12 months (RR 0.54, CI 0.23 to 1.30). The data for the Brief Psychological Rating Scale (BPRS, Overall and Gorham, 1962) ratings for anxiety, depression, Global Assessment of Functioning Score (GAF, Hall, 1995) and mania were skewed and had wide confidence intervals with no statistically significant results found. There were no statistically significant differences in Quality of Life (QOL) at 12 months although the data were not skewed. Zhang-Suzhou found that people in the intervention group were significantly less likely to be admitted to hospital when compared to the control group receiving standard treatment (RR 0.28, CI 0.24 to 9.28). Linszen-Amsterdam found no difference in relapse rates at 12 months between the two groups.

Therefore, in summary, there was some evidence to support phase specific treatments such as CBT and family therapy but the methodological quality of the studies was

poor and unusual inclusion criteria, such as the three-month inpatient requirement in the Linszen-Amsterdam study limit the applicability of the findings. In addition, there is a question as to whether any benefits from the EI approach were maintained after a twelve-month period.

2.2 The Randomised Controlled Trials

Of the nine RCTs found, it was possible to group four together as they reported findings at different stages of the same trial, which was called OPUS (Jorgensen et al 2000; Petersen et al. 2005; Petersen et al. 2005a; Bertelsen et al. 2008). In the OPUS study, participants were randomly allocated to either a modified assertive community treatment (EIS) or treatment as usual (TAU) by the CMHT, to determine the effect of integrated treatment (IT) versus usual TAU on the subjective burden of illness, expressed emotion, knowledge of illness and satisfaction with treatment in key relatives of patients with an FEP.

Of the remaining five, two reported different outcomes from the same study called the LEO (Lambeth Early Onset) Team study (Craig et al., 2004; Garety et al., 2006). In the LEO study, individuals were randomised to either an assertive outreach EI approach (the LEO team) or TAU delivered by CMHTs to determine any effect on rates of relapse and readmission to hospital. The three remaining studies included those by Linszen et al. (2001), Kuipers et al. (2004) and Grawe et al. (2006). In Linzen et al.'s study (2001), individuals were randomised to either an EIS approach to care or a team offering 'best clinical' care at that time to see if an assertive early approach improved outcomes including drug taking, medication compliance, and

clinical status as measured by the BSRS. In Kuiper et al.'s study (2004), all new referrals to an EIS called COAST (Croydon Outreach and Assertive Support Team) were randomised to either TAU from a CMHT or EIS care from COAST to determine any impact IT might have on improvement (recovery) rates. Grawe et al (2006) randomised individuals to receive standard treatment (ST) or integrated treatment (IT) to determine if IT improved recurrence rates, persisting psychosis, and number of hospital admissions, suicidal behaviours or medication adherence.

These groupings are important when considering the sizes of the studies as it would not be accurate to report studies from the same trials separately. The combined five studies (OPUS, LEO, COAST, Linzen et al., 2001 and Grawe et al., 2006) included had a total of 813 participants. The OPUS study was the largest with a sample size $n=547$ (Jorgensen et al., 2000; Petersen et al., 2005; Petersen et al., 2005a ; Bertelsen et al., 2008). This sample size was arrived at using a pre-study power calculation. The other trials were small: $n=63$ (Linszen et al., 2001), $n=59$ (Kuipers et al., 2004), $n=144$ (Craig et al.; 2004; Garety et al. 2006) and $n=50$ (Grawe et al. 2006).

2.2.1 Study settings

The OPUS study was conducted in Denmark. Patients were recruited from inpatient and outpatient settings. The intervention took place in the community in home settings, nonmedical community settings, and primary care physicians' offices. The LEO Team study took place in the UK in London (Craig et al., 2004; Garety et al., 2006). Both studies describe the intervention as taking place in community settings, although venues were not specified. One study took place in Amsterdam, again in

community settings with no specified venues (Linszen et al., 2001). The COAST study was set in an EIS in London, England (part of a MHT) and in participants' homes. The final study by Grawe et al. (2006) was set in Norway. TAU patients received regular clinic based case management with antipsychotic drugs, supportive housing and day care, crisis inpatient treatment at one of two psychiatric hospitals, rehabilitation that promoted independent living and work activity, brief psychoeducation, and supportive psychotherapy. 16 of the patients received ST from hospital outpatient services and the remainder from local community general health services. IT patients were treated by a multidisciplinary team and received structured family psychoeducation, cognitive behavioural family communication and problem solving skills training, intensive crisis management provided at home, and individual CBT for residual symptoms and disability.

2.2.2 Recruitment and follow up

Recruitment for the OPUS study began in January 1998 and continued until Dec 2000. Individuals aged 18-45 years with a diagnosis of first episode schizophrenia or schizophrenia like psychosis were included. Follow up took place at three months, one, two, and five years. Recruitment for the LEO Team study took place from January 2000 until October 2001, with patients aged 16-40 years with a diagnosis of non affective psychosis, schizoaffective disorder and delusional disorder presenting to mental health services for the first or second time (Craig et al., 2004; Garety et al., 2006). In the COAST study recruitment began April 2000 until July 2001 with follow up at six and nine months. Individuals aged 18-65 years with a diagnosis of any functional psychosis within the last five years were included. Linszen et al. (2001) did

not define a recruitment period. All patients aged 15-25 years admitted to an Academic Medical Centre in Amsterdam were screened for inclusion. Patients had to be living with parents and have a diagnosis of first episode schizophrenia or related disorder for inclusion. Grawe et al. (2006) recruited patients aged 18-30 years from 1992 for a five-year period. Cases that had experienced the onset of their first psychotic symptoms more than two years previously were excluded. However, a few cases had experienced more than one acute psychotic episode prior to seeking treatment. Individuals were followed up at two years.

2.2.3 Intervention and duration

In the OPUS study, patients received either IT or TAU for two years. Participants in the intervention arm were then transferred to standard care. IT involved an assertive management approach combining psychoeducational family therapy and social skills training delivered in a standardised way (assessed by the Fidelity of Assertive Community Treatment Scale) by trained members of the team. The COAST Service intervention consisted of a multidisciplinary team, which reflected the EIS model laid out in *The Mental Health Policy Implementation Guide* (DH, 2001). Participants were offered a range of individualised interventions and medication and family therapy or support for 18 months. The LEO team (Craig et al., 2004; Garety et al., 2006) again offered a similar multidisciplinary EI approach combining medical therapy, psychological therapy and support for 18 months. Linszen et al.'s study (2001) was described as offering a combined drug and differential transmural intervention programme. Participants receiving the intervention initially received three months of inpatient care, which was accompanied by intensive family and individual

psychoeducation followed by outpatient and care in a day hospital and community care for 15 months. Grawe et al.'s study (2006) has been described above.

A wide range of outcome measures were used in the eight studies. Primary outcome measures in Linszen et al.'s study (2001) consisted of relapse rates (measured using BPRS and Clinicians' notes) and compliance with medication (measured using pill counts and an independent review of clinical contact and prescribing). The OPUS study used DUP, relapse, diagnostic classification stability, employment, social contact and social functioning, substance abuse, criminal behaviour, suicidal behaviour, QOL, family burden and knowledge of schizophrenia as main outcome measures. A number of validated clinical outcome measures were used to assess these.

The LEO Study (Craig et al., 2004) primary outcomes were rates of relapse and recovery (based on operationalised criteria defined by two of the study's authors). Garety et al. (2006), who assessed the LEO service two years later, focussed on clinical and social outcomes and service user satisfaction, again using a wide variety of validated clinical outcome measures. They also measured the number of days spent in hospital. The COAST study used a range of standardised measures administered at baseline and follow up. Grawe et al.'s study (2006) used full and stable recovery as their primary outcome, measured by validated clinical tools. Additional treatment adherence and a composite clinical score rated as 'good' based on the absence of any of the following: hospital admissions; a minor or major psychotic episode; persistent psychotic symptoms; a suicidal attempt, or poor compliance with treatment.

The obvious heterogeneity of outcomes measures and tools used to measure outcomes

presents a problem when trying to compare studies as it is possible that reviewers are not comparing like with like. This also applies to the heterogeneity of interventions and populations used.

2.2.4 Randomisation, allocation and blinding

All nine studies stated that they were RCTs. Only eight gave details of the randomisation process. No details were given by Linszen et al. (2001) regarding how participants were randomised or whether there was any blinding of the raters in the study. The OPUS study described how randomisation took place. There were two sites in the study: Copenhagen and Aarhus. In Copenhagen, randomisation took place independently using a centralised telephone method in the Copenhagen Trial Unit. The allocation sequence was computer generated. In Aarhus, a secretary drew lots from a box. The study authors describe it as difficult to blind the independent raters who carried out the follow up interviews for practical reasons. However, raters at the five-year follow up were blinded to the participant's previous treatment programme (which was checked as reliable). The LEO study (Craig et al., 2004; Garety et al., 2006) randomised patients to intervention or usual treatment using a sequence of sealed opaque envelopes. An independent individual carried out the process of randomisation and allocation. Raters were not blinded. In the COAST study, randomisation and allocation was carried out by an independent administrator using a computer programme and raters were blind to the allocation.

In Grawe et al.'s study (2006), randomisation was undertaken by a secretary who was not part of the clinical service who opened pre-numbered envelopes with treatment

group assignment according to random numbers provided by the central Optimal Treatment Project administration. Blocks were of variable size (8–12), stratified according to sex and with a ratio of IT to ST of 3: 2 to ensure that the majority of cases received the experimental treatment. Ratings of outcome measures at two years were made by an independent rater who was blind to treatment conditions and trained to obtain a 0.8 kappa coefficient of inter-rater reliability on all rating scales. Overall blinding was practically difficult in the studies (due to patients divulging information, being allocated to a whole service and individuals recognising therapeutic language), which might put the results of the study at risk of bias.

2.2.5 Reporting of outcome data, attrition, missing data

Linszen et al. (2001) were unable to establish data at follow up for the control group and only provided descriptive data for relapse at 12 months on an ITT basis. They were able to reinterview 63 of the original 76 patients in the intervention group. The OPUS study provided a patient flowchart through the study and identified that in the intervention group $n=275$ were able to follow up 75 percent of patients at two years and 56 percent at five years. In the control group $n=272$, they were able to follow up 60 percent at two years and 57 percent at five years. Attrition at two years was skewed and further analysis revealed that patients who had not completed high school or who had substance abuse problem at entry to the study were less likely to attend the two-year follow up. They also provided data for the five-year follow up on an ITT basis using data gathered at the two-year follow up. They did however, perform sensitivity analysis of the data using logistic regression analysis to calculate odds ratios for treatment effects.

The COAST study suffered severe attrition in their small study. At six-month follow up 42 percent of patients contributed data. However at nine-month follow up only 33 percent of patient's contributed data. They combine these figures when reporting their findings and performed a regression analysis to assess the significance of treatment by time. This was found to be non significant. The LEO study (Craig et al., 2004; Garety et al., 2006) also suffered severe attrition rates. Of the 144 people included in the study, ($n=71$ for LEO care and $n=73$ for standard care); 55 (77 percent) gave a final interview at 18 months follow up and 94 percent of case notes were reviewed in the intervention group. In the standard treatment group, 44 people participated in a final interview at 18 months and 89 percent of case notes were reviewed. Again regression analysis was employed to assess the impact of attrition on the sensitivity of the results using inverse probability weighting. In Grawe et al's (2006) trial, all participants were followed up at two years.

2.2.6 Power calculations

The OPUS study included clear working around the sample sizes needed using the Pocock formula to detect a 50 percent reduction in psychotic symptoms in the intervention group at the 0.05 level of significance. They do however, comment later in their discussion that this may have been an optimistic expectation. Power calculations showed that 142 patients were required to be required for each arm which was fulfilled. Linszen et al. (2001) do not provide any power calculation therefore the results cannot be interpreted with any confidence. Kuipers et al. (2004) in the COAST study, also do not discuss power calculations but comment a significance level of five percent was used in the study.

The LEO study (Craig et al., 2004; Garety et al., 2006) calculated sample size based on the estimated reduction in relapse rates, their primary outcomes, which required 120 patients to show a reduction from 60 to 40 percent in the experimental group at a power of 80 percent. This was not fulfilled and the study was underpowered. Grawe et al.'s study (2006) used a previous study and calculated that an intermediate sample of 50 individuals was necessary to achieve $P < 0.05$ with 80 percent power on the measures of target symptoms, major exacerbations, and BPRS factors.

2.2.7 What were the results?

Linszen et al. (2001) produced results, which are not useable due to poor methodological quality and of a narrative or descriptive nature. The OPUS study showed at one-year follow up, the number of patients with high psychotic global score and negative psychotic global was significantly less in the intervention group ($p=0.001$ and 0.002 respectively). The Global Assessment of Functioning (GAF, APA, 1994) score was significantly better in the intervention group ($p=0.04$) and significantly fewer patients had drug or alcohol misuse problems ($p=0.03$). At two-year follow up there were no longer significant differences in psychotic global score between groups. Negative psychotic global scores were still significantly less in the intervention group ($p < 0.001$) and GAF scores significantly better in the intervention group ($p=0.03$). Satisfaction with EISs was significantly better in the intervention group ($p=0.001$) in the first year of follow up and also in the second year of follow up ($p < 0.001$). At five-year follow up, there were no significant differences in psychotic or negative psychotic global scores between the groups. There was also no significant differences in the group in mortality (suicide) at five-year follow up. The only

significant difference reported by the authors was that patients in the intervention group spent statistically significant fewer days in hospital in the five-year follow up period compared to the control group ($p=0.05$).

The COAST study by Kuipers et al. (2004) reported that there were no statistically significant differences between the intervention group and standard treatment group at follow up with either clinical symptoms or other outcome measures of global functioning and assessment of needs. The LEO study (Craig et al., 2004; Garety et al., 2006) initially reported that at 18 months, patients in the intervention group were less likely to relapse ($p=0.035$). However, more detailed examination showed that this figure included patients who had previously recovered then relapsed then recovered again at 18 months. When this was reanalysed removing these individuals and only those who had never relapsed in the follow up period included, this was not statistically significant. However, patients in the intervention group were statistically significantly less likely to be readmitted during follow up. The results reported by Garety et al. (2006) showed that the intervention group were significantly more likely to report satisfaction with care ($p=0.005$), better QOL ($p=0.026$) and adherence to medication ($p=0.033$). However, due to the large amounts of missing data, when adjustments were made to the calculations, satisfaction with care was no longer significant ($p=0.223$).

2.2.8 Conclusions reached for empirical studies

The heterogeneity of the outcome measures makes synthesising the findings difficult. In general the results of these five studies are concordant with each other and the

findings of the systematic review discussed above (Marshall and Lockwood, 2004). All of the studies reviewed in the systematic review and the RCTs had substantial issues with methodological quality (with the exception of the OPUS study). These include small sample sizes, high rates of attrition and variable blinding. The variable study settings and age range for inclusion also makes the data more difficult to interpret in an English context. The OPUS study, the LEO study and the COAST study all failed to demonstrate significant clinical or satisfaction benefits from an EIS intervention. The OPUS trial showed that overall there was no effect on clinical outcomes, positive or negative symptoms, global functioning, substance abuse, depression or suicidal behaviour at five-year follow up. Benefits, which had been seen at two years were not sustained. Initially it did show that people in the intervention group might have spent less time in supported accommodation (a secondary outcome in the OPUS study), however, after a Bonferroni correction was applied, this was not statistically significant. This is in contrast to Grawe et al.'s study (2006) who found that there were significantly more minor recurrences of psychotic symptoms in the ST group and patients receiving EISs had generally better outcomes i.e. no recurrences, persisting psychosis, hospital admissions, suicidal behaviours or poor adherence, which reached statistical significance. However, this study had much smaller numbers of participants than the OPUS study and not all participants were FEP patients, which perhaps places greater weight on the OPUS study findings.

In the OPUS study, the authors comment on the expense of EISs and suggest that some of this cost might be mitigated by less use of other health services. The LEO study also failed to find clinical and satisfaction benefits in the intervention group although they did find less readmissions in the intervention group overall and suggest

this may have cost benefits. The LEO study had the significant methodological problem of being underpowered; the initial group allocated to EIS intervention had better prognostic factors and participants were incepted into the study if they were presenting for the first or second time to services with a FEP and had failed to engage before which might have biased the results. The COAST study agreed with LEO and OPUS and found no significant cost or clinical improvement benefits. The authors suggest that this may be because they accepted people who had a FEP any time in the previous five years before recruitment started. This meant individuals might already be improving when incepted into the study.

The RCTs here discussed informed NICE guidance in 2009 but NICE noted that there is still a paucity of high quality evidence regarding the benefit of EISs; however, the Guideline Development Group recognised the ethical rationale for an EIS helping people with serious mental health problems at an early stage to reduce distress and possibly disability.

3.0 Empirical literature: Cohort studies

There were five cohort design studies identified in the literature. Using the NSF Hierarchy of evidence (DH, 1999), none of the studies met the required criteria for being likely to attain 'highly credible' findings (being a well-designed prospective cohort study). Four were cohort studies using historical controls (Mihalopoulos et al., 1999; Carbone et al., 1999; Goldberg et al., 2006; Mihalopoulos et al., 2009) and one was a retrospective cohort study using historical controls (Harris et al., 2008). Both studies by Mihalopoulos et al. (1999, 2009) were originally designed as cost

evaluations of the EPPIC service (Early Psychosis and Intervention Centre) in Australia. They were, however included in this literature review as the authors commented that the effectiveness of the two services must also be compared in order to assess cost effectiveness and relevant outcomes were reported. Four of the five studies all report findings from the EPPIC service in Australia. The five cohort studies will be reviewed now.

Table Two: Cohort studies addressing efficacy of early intervention services for first episode psychosis

Authors	Study design Population/ Country Timeframe	Key findings	Limitations
Mihalopoulos et al., 2009 Schizophrenia Bulletin 35(5): 909-18.	Matched, historical control group. Patients recruited 1993/4. Individuals referred to EPPIC consecutively over one year <i>n=51</i> compared to matched historical cohort treated in pre-EPPIC service (inpatient care) <i>n=51</i> .	At 8 years follow up: Significant differences found between two groups favouring the intervention group with BPRS positive symptoms ($p=0.007$), GAF (0.039) and remission (BPRS criteria) ($p=0.008$).	Underpowered to detect improvement in functional differences between groups. Small sample size. Data obtained from case notes. Lack of full follow up data available.
Harris et al., 2008 Early Intervention in Psychiatry 2: 11-21.	Retrospective cohort study with historical control. Examined records of 7760 individuals with a psychotic disorder (aged 15-29 years) at first contact either with an EPPIC or standard care for suicide/ mortality outcome.	'Survival' functions did not differ significantly between the groups. Possibly survival function greater in intervention group until 4.5 years.	Study >10 years old so findings may be less relevant in terms of current EIS. Methodological limitations-design.

	Melbourne Australia. July 1991 until December 1998.		
Goldberg et al., 2006. Canadian Journal of Psychiatry 51(14):895-903	Cohort study Historical controls (admitted for standard inpatient care) <i>n=159</i> compared to patients managed by an outpatient based EIS <i>n=159</i> recruited 1997- 1999. Ontario, Canada.	No significant differences between two groups on suicide rates or involvement with criminal justice system. Significant differences (favouring the IT group) for aggressive behaviour, average number of admissions over the two year period, visits to ER and involuntary admissions.	Study>10 years old so findings may be less relevant in terms of current EIS. Methodological limitations-design. Small numbers in the study. Recall bias using examination of notes.
Carbone et al., 1999 Acta Psychiatrica Scandinavica. 100: 96-104.	Cohort study with historical control. Notes of 200 people with FEP referred to an inpatient unit for treatment between 1989 and 1991 compared to those of 147 patients with FEP treated in EPPIC from 1992 onwards at 12-month follow up. Outcomes were length of DUP and impact length of DUP had on QOL. Melbourne, Australia.	DUP was significantly longer in the intervention group ($p=0.039$). Overall there was no significant difference between the two groups for QOL score. Subanalysis of DUP showed that a DUP >1 month <6 months had a significant positive impact on QOL ($p=0.049$).	Study>10 years therefore may not be relevant to current EISs. Comparing notes therefore possible recall and observational bias. Methodological issues-design. Small numbers in study.
Mihalopoulos et al., 1999 Acta Psychiatrica Scandinavica 100(1): 47-55.	Cohort study comparing historical matched control group <i>n=51</i> who received high- quality inpatient care but TAU community care to <i>n=51</i> patients who	The authors report clinical improvements but methodological limitations reduce the credibility of these findings.	Not comparing like with like with regard to Australian MHS. Length of follow up only 1 year-EISs in England follow up for 3 years. Methodology poor. Study recruitment

	received IT from EPPIC.		>10 years ago.
--	-------------------------	--	----------------

3.1 Carbone et al. 1999 Study

Carbone et al. (1999) examined two samples of patients who had either received standard care in an inpatient unit in Melbourne, Australia or specialised EI care to determine if specialised EI care reduced the DUP. The control (a retrospective historical control) was a group of patients $n=200$, aged 16-40 years with FEP referred to an inpatient unit for treatment between 1989 and 1992. Patients would then be discharged for relatively limited follow up in the community either by their General Practitioner (GP) or a CMHT. These patients were then compared to a group of patients $n=147$ aged 16-30 years with FEP referred to the EPPIC service. The authors analysed the two groups to check there were no significant differences between them initially and at 12-month follow up. They measured the interrelationship between DUP and QLS, using a validated tool (Heinrichs et al., 1984).

They found that the DUP was highly variable for the control group (affected by a few extreme outliers with exceptionally long DUPs). After correcting for this using a log transformation procedure, the intervention group had a significantly longer DUP than the control group ($p=0.039$). This was not the expected result as the study hypothesis was that an EIS for FEP which focussed on the early detection of cases would mean the intervention group would have had a lower DUP. The authors hypothesised that a focus on early detection might increase referrals to the EIS which would potentially create a ‘waiting list’ phenomenon which would mean by the time individuals were

accepted into the service they had a longer DUP. The authors then evaluated the effect of DUP on QLS. Overall there was no significant difference between the two groups. The authors subanalysed the DUP in four categories which were chosen arbitrarily: <4 weeks DUP; >4 weeks; > 6months and <12 months. They found that in the mid range group (four weeks to six months) there was a marginally significant difference in QLS scores between QLS scores with the EPPIC group faring better (p=0.049). They suggest that this could represent a window where treatment might be better focussed. There were numerous limitations to this study related mainly to the small sample sizes and study design. In conclusion, the study did not show that the EIS reduced the DUP in this group of patients.

3.2 Mihalopoulos et al. 1999

This study was principally an economic evaluation of the EPPIC service using a cohort methodology with a retrospective control sample. 51 patients consecutively referred to the EPPIC EIS were recruited in the first year of the service being set up in 1993. These were compared to a cohort of matched patients treated by a 'pre-EPPIC' service consisting of inpatient care then discharge with no outpatient follow up. At one year follow up several outcomes which were considered to contribute to the costs of the EPPIC service were assessed including QLS, SANS, outpatient utilisation, inpatient utilisation and bed days, medication and wider services used. Costs were calculated for both cohorts as if being treated at the same one year concurrent timeframe in a cost per unit manner. The authors demonstrated an improvement in QLS and SANS score in the intervention group. However, as this study was not powered or results statistically analysed, these findings do not have great reliability.

In addition, the authors failed to measure QLS scores at baseline inception of patients into the study and assumed that their score was 40 (represent a reasonable score seen in similar patients), which reduces the credibility of the findings further. The study did demonstrate that the EPPIC service had cost benefits over the pre-EPPIC model, which was due to fewer inpatient days. EPPIC treated patients outpatient care was actually twice as much as pre-EPPIC patients. It is difficult to transfer these findings to patients receiving care in England. Health service models differ and an alternative to EISs in England would be the CMHT, not inpatient care, as seen in this study.

3.3 Goldberg et al. 2006

Goldberg et al.'s study (2006) was set in Canada. They compared the demographic features and length of, and number of admissions of two groups of patients admitted to hospital with a FEP. Patients included were aged 16-50 years. Data was collected on patients admitted to general hospital acute care psychiatric beds in London and Middlesex, Ontario between 1993-1995 $n=146$ and compared to patients admitted after the EIS was implemented (in 1996/7) between 1997-1999 $n=159$. Data collected included demographic details, educational background, suicide attempts, violence or aggressive behaviour and involvement with the criminal justice system. Indicators for this included number and length of hospital admissions separately for visits to the Emergency Room (ER) or admissions to the Psychiatric Intensive Care Unit (PICU).

The analysis showed that in terms of demographic characteristics, the intervention patients were more likely to be younger ($p<0.01$) and male ($p<0.05$). There was no significant difference between the two groups on the number of suicide attempts,

initial behaviour at the index admission although aggressive behaviour was significantly less in subsequent admissions in the intervention group ($p=0.06$). Involvement with criminal justice systems was not significantly different between the two groups. There was a highly significant difference between the two groups in the average number of admissions over the two year period ($p=0.06$). However, the average length of time spent in hospital by both groups was not significantly different. Patients in the intervention group made fewer visits to the ER ($p=0.03$) and had fewer involuntary admissions ($p=0.05$).

Service cost calculations made by the authors suggested a net yearly saving of \$326,284 Canadian dollars per case. In conclusion, the authors found that the EISs reduced the likelihood of aggressive behaviour in subsequent admissions of people with FEP and a reduced likelihood of spending time in hospital or being admitted involuntarily, although this could not be attributed to the EIS alone on subsequent time series analysis. There was a suggestion that costs per case were reduced in the intervention group although this might be offset by the increased costs of developing an EIS (this was not calculated). There were also significant limitations to this study. Data were collected from hospital inpatient notes, which may not always be reliable and is reviewer dependent. The use of historical controls may confound the results as it is difficult to attribute changes to the EIS. A parallel control group would have been more reliable.

3.4 Harris et al. 2008

This study was set in Victoria, Australia and specifically set out to explore the

hypothesis that suicide rates in individuals seen by a specialised EIS would be less than those treated by standard care. The cohort of patients was identified from the Victoria Psychiatric Case Register (VPCR) which captures patient level demographic information and inpatient and outpatient psychiatric contact. Suicide data was obtained by linking the VPCR to a data base of post mortem findings kept by the state coroner. The EPPIC service offered community based assertive phase specific management to people aged 15-29 years in the Victoria area catchment area. Patients were included if they had made first contact with the EIS between the dates of July 1991 and December 1998. The control group was chosen from patients who had received non specialist public adult mental health services. There were several confounding factors affecting the results of this study. The authors were unable to ascertain specific dates of entry and exit to specific treatment programmes across all services reporting to the VPCR and so individuals were assigned to a group if they had spent six days or more with that service to exclude people who might have been referred but not had ongoing care. It would be difficult to ensure that results were specifically due to treatment or care by the specialised service alone.

The authors found that the cumulative suicide rate was 0.7 percent by the end of the first year; 1.5 percent after 3 years; 2.3 percent after five years and 4.2 percent over the entire follow up period. 'Survival' functions did not differ significantly between the groups. However, further analysis using a Kaplan Meier plot suggested that survival probability appeared greater in the intervention group until approximately 4.5 years and thereafter the survival rate appeared worse for the EI treatment group. They concluded that their study failed to find support for their primary hypothesis that exposure to EP treatment would be associated with a decrease in suicide risk over a

period of up to 8.5 years. They suggest that their findings might support the need for longer term follow up by EIS to protect individuals from suicide.

3.5 Mihalopoulos et al. 2009

This study was also set in Victoria, Australia and set out to explore the long term cost effectiveness of a comprehensive model of mental health care for FEP. The study was an extension of a previous economic evaluation of the EPPIC service that assessed the first year costs and outcomes of treatment (Mihalopoulos et al., 1999). The study used a matched, historical control group design with a follow up of approximately eight years. Originally, 51 individuals with FEP were recruited over a one year period in 1993. Complete follow up data were available for 65 of the original 102 participants. Direct public mental health service costs incurred subsequent to the first year of treatment and symptomatic and functional outcomes of 32 participants initially treated for up to two years at EPPIC were compared with a matched cohort of 33 participants initially treated by generic mental health services. Treatment related resource use was measured and valued using Australian published prices. Almost eight years after initial treatment, EPPIC subjects displayed lower levels of positive psychotic symptoms ($P < 0.007$), were more likely to be in remission ($P < 0.008$), and had a more favorable course of illness ($P < 0.011$) than the controls. 56 percent of the EPPIC cohort were in paid employment over the last two years compared with 33 percent of controls ($P < 0.083$). Each EPPIC patient costs on average Australian dollars \$3445 per annum to treat compared with controls, who each cost Australian dollars \$9503 per annum. Specialised early psychosis programmes appeared to be able to deliver a higher recovery rate at one-third the cost of standard public mental health services.

However, residual methodological limitations and a limited sample size indicate that further research is required to verify this finding. The study also suggested that a two year window of specialised intervention may be insufficient to produce a sustained benefit.

3.6 Discussion

The findings of Harris et al. (2008) and Goldberg et al. (2006) concur with those of the RCT OPUS study which found that EISs do not appear to have a statistically significant impact on suicide rates compared to standard or usual care. Both the OPUS study and Harris et al.'s study (2008) findings may suggest that whilst individuals are in receipt of EISs there may be some element of protection against suicide but that any effect is lost once the patient is discharged from the EIS.

Mihalopoulos et al (1999, 2009) and Garety et al.'s study (2006) demonstrated a positive impact of EISs on psychiatric and clinical outcomes (Negative psychotic global scores, BPRS score and GAF) in the intervention group. The OPUS RCT did demonstrate some positive effects at the one and two year follow up on Negative psychotic global scores, which were significantly less in the intervention group and GAF scores, which were significantly better in intervention group. In addition significantly fewer patients in the intervention group had drug or alcohol misuse and satisfaction with EIS was significantly better in intervention group. However, this effect was lost at five-year follow up. The results of the studies by Mihalopoulos et al (1999, 2009) are in marked contrast to those in the OPUS study and Garety et al.'s study, which suggested that whilst individuals are in receipt of EISs there may be

positive impact on clinical symptoms but that any effect is lost once the patient is discharged from the EIS and therefore suggesting that a two-year window of specialised intervention is insufficient to produce a sustained benefit. However, both of the studies by Mihalopoulos et al. (1999, 2009) were not as robust in terms of methodological quality or design and were not originally designed to find outcomes relating to clinical improvement but were cost evaluations. Therefore greater weight must be placed on the OPUS study findings.

Both the RCT and Cohort studies appear to agree that there may be a positive influence on admission rates, particularly involuntary admission rates for people receiving EISs (Zhang et al., 1994; Craig et al., 2004; Goldberg et al., 2006; Mihalopoulos et al., 2009). The total number of days spent in hospital was not significantly different for people treated in EISs or standard care. However, fewer admissions may represent significant benefits to patients and their families as it is likely to be less disruptive and enable better continuity of care for patients with their usual mental health care provider. The main issue with the reliability of this finding in the cohort studies particularly is that follow up rates were generally short (with the exception of Mihalopoulos et al., 2009). Whilst EISs may be cost effective in the short term, there is insufficient high quality evidence supporting this effect in the longer term. Whilst the one study by Mihalopoulos et al. (2009) followed individuals up for eight years, the alternative to the EIS in terms of comparing costs was an historical cohort treated in an inpatient unit. In England, the alternative to EIS care would be the already established CMHTs generally, making this a difficult finding to apply to UK practice.

To conclude, there is insufficient empirical evidence available to suggest that EISs provide incontrovertible evidence of improvements to clinical or satisfaction outcomes to people with a FEP. There is evidence that EISs may offer some protective effect against suicide and improve patient's clinical symptoms whilst people are in receipt of services, but that this is not a long term effect, with the benefits of receiving EIS being lost once patients are discharged. This has implications on the length of time people are followed up by EIS, which in turn could impact on costs of service delivery and care. The findings of this literature review therefore concur with Marshall and Lockwood's systematic review (2004) that it may be premature to implement EIS widespread policies for people with a FEP based on the current available empirical evidence.

4.0 Implementation literature

A total of four papers were found which addressed the implementation of EISs for FEP. Two papers arose in part or in full from this PhD. One paper was first authored by the author of this PhD: England E. et al. 2009 and two were coauthored by E England: Lester et al. 2009 and Lester et al. 2008 (presented in Appendix Two). The fourth paper was unrelated to this PhD by O'Kearney et al. (2004).

4.1 O' Kearney et al. (2004)

O' Kearney et al. (2004) evaluated the sustainability of the Southern Area First Episode (SAFE) programme based in Australia. This study aimed to explore whether an EIS approach (SAFE Team) could be sustained in remote rural regions when the

EIS operated as a specialist within generalist team. The files of 225 individuals seen by three clinical teams over two years after the introduction of the SAFE program were examined with 43 files being deemed suitable for the study as the person was experiencing a FEP. The study team looked for fidelity to the EIS approach delivered by the SAFE team in three areas, measured by client engagement, GP engagement, family engagement, psychiatrist review, drug history and medication protocol usage, physical health check, completion of validated clinical outcome measures, the delivery of psychoeducation to the client and their family, relapse planning, monitoring of psychological outcomes and medication adherence. There was significant variation between teams in delivering EISs particularly around psychoeducation to the individual and their family, relapse planning and monitoring of psychological outcomes. The results suggest that the specialist within generalist team approach can be an effective model of EIS for FEP in some settings for some patients where dedicated specialist teams are not appropriate such as remote rural areas. They also identified that a local EIS champion facilitated the service development and implementation. Limitations include the reliance solely on case note audit, small numbers, a short follow up evaluation time and no consideration overall of clinical outcomes.

4.2 Lester et al. 2008

Lester et al.'s (2008) study involved interviews with EIS managers of 12 services in the West Midlands region and asked them to nominate the names of voluntary and community organisations they had worked with over the preceding twelve months to evaluate partnership working in implementing EISs. The 12 EIS managers nominated

a total of 68 organisations. Only four EISs had a formal arrangement with any voluntary organisation, of which three had integrated team members within the EISs through this partnership arrangement. There were much larger numbers of informal partnerships that had developed. A number of facilitators were identified in the development of partnerships, which included a shared ethos or shared agenda between EIS and the voluntary organisation and joint training initiatives. Barriers described by EISs included differences in organisational culture, lack of capacity within the EIS to undertake partnership work and funding issues, which meant EISs had to prioritise on other areas of their workload such as developing their core services. Limitations of this study are that only one individual was interviewed from each organisation. The authors also comment that the study focussed more on processes and not the outcomes of partnership working.

4.3 Lester et al. 2009

The second paper by Lester et al. (2009) used a multiple case study approach to evaluate the development and implementation of EISs across the West Midlands. Semistructured interviews were undertaken with EIS team leads and managers, mental health leads and commissioners of four SHAs, service users and carers and commissioners of mental health services from thirty PCTs in the West Midlands region. Data were also collected assessing fidelity of the EIS model and team to *The Mental Health Policy Implementation Guide* EIS format (DH, 1999). Key findings from this study were that EISs were seen by service users as an alternative service to traditional mental health services, potentially less stigmatising and more 'youth focussed' in their approach. Service users and carers reported positive experiences of

the EISs and were satisfied with the care they had received. Commissioners reported a number of issues affecting EIS implementation including rurality, a lack of resources and a lack of focus or prioritisation of mental health services within some PCTs. EIS leads reported that the greatest barrier to their team development was lack of funding which led in some cases to modified versions of EISs being developed, deviating away from the *Mental Health Policy Implementation Guide* envisaged format of the team. Study limitations included the qualitative nature of the study with associated difficulties in generalising the findings and the use of key workers to approach service users and the purposive sampling of individuals, which may have led to the exclusion of those individuals who were more critical of the service. In addition, the study took place in only one region (West Midlands) and a relatively small number of individuals in each of the different groups were interviewed.

4.4 England et al. 2009

The paper by England et al. (2009) was published during this PhD and reflected the findings at the point of submission in 2009. This paper aimed to describe barriers and facilitators to commissioning and implementation of EISs from a wide range of stakeholders across the West Midlands. Semistructured interviews and focus groups were carried out with SHA, PCT and organisational leads with a responsibility for mental health commissioning and team leads from EISs and CAMHS from a number of sites within the West Midlands.

147 individuals participated in a semi structured interview and 35 individuals in six focus groups held between July 2005 and March 2009. Key themes identified included

issues around communication between different organisations and within organisations, in particular between EISs and CAMHS, which presented a potential barrier to working as partners. There was also frequently a lack of communication reported within organisations between the different managerial levels and operational levels. However, CAMHS and EIS team members who had participated in joint training and educational initiatives described how an improved awareness of each other's priorities, philosophy of care, and ways of working had helped in breaking down some of these barriers.

One of the most important facilitators at the interface between EISs and CAMHS was senior support either from an individual, such as a senior PCT or SHA executive, or through the involvement of an individual who had greater expertise in the area of mental health and EIS development. Several interviewees described how they had developed a particularly collaborative relationship with CAMHS. With support from their PCT or other Trust, these EIS leaders and teams had created innovative solutions to the problems at the interface between EISs and CAMHS.

A new finding was the development of a different type of service model altogether: the EIS Youth-Focussed model. This service was neither CAMHS, nor AMHS, nor EIS but included elements from all of these teams. It required innovative thinking, senior support, and considerable commitment of resources, time, and energy. Limitations of this study include the generalisability of the findings. During the data collection, relatively few individuals from social care were interviewed and no service users were interviewed, which might also influence the usefulness of the findings.

4.5 Discussion of implementation literature

In summary, there is limited research, which explores implementation of EIS for FEP. Notwithstanding the methodological limitations of these studies, there are some conclusions, which might be drawn including the difficulty and challenges associated with commissioning and implementation of EISs for FEP due to a lack of resources (skills, capacity and funds). EISs may not be able to develop partnerships as easily as envisaged in the policy guidance for a number of reasons, which are not apparent at a national level but often impact locally such as particular geographical circumstances, local funding and resource issues and challenges associated with traditional ways of working within organisations.

5.0 Mental health policy and early intervention service development in England

The aim of this final literature review section is to describe policy documents and contextualise EISs within them chronologically. The search was carried out using the Department of Health, NIMHE and NMHDU websites and rechecking other papers used in the empirical and implementation literature review.

5.1 The National Service Framework for Mental Health, 1999

In 1999, the DH published *The National Service Framework for Adult Mental Health*. It was introduced with the aim of accelerating the modernisation of mental health services in the NHS through a ten year plan for the development and delivery of mental health services for adults of working age. Whilst, the Framework prescribed

standards for each form of service organisation, decision making about local delivery and resourcing were left to individual localities. *The National Service Framework for Mental Health* (DH, 1999) set national standards for mental health services based on the best available evidence and stressed the necessity of prompt assessment of young people at the first sign of a psychotic illness.

5.2 The NHS Plan (2000) and The Mental Health Policy Implementation Guide (2001)

The National Service Framework for Mental Health was followed in 2000 by the publication of *The NHS Plan* (DH). The Government's plan for the National Health Service (NHS) specifically targeted the funding of 50 EIS by 2004. Implementation of mental health aspects of *The NHS Plan*, including EISs, were supported by *The Mental Health Policy Implementation Guide* (DH, 2001) which detailed the purpose, form, structure and function for the development of EISs, set out what an EIS is for, what it is intended to achieve and clarified the management and operational procedures for the development and commissioning of EISs. *The Mental Health Policy Implementation Guide* (DH, 2001) specifically identified that EISs are for people aged between 14 and 35 years with a first presentation of psychotic symptoms for the first three years of their illness. Importantly, this age range included adolescents and young adults.

5.3 Early Psychosis Declaration (2002, 2004)

Further policy development was influenced by the *Early Psychosis Declaration* by the

WHO and International Early Psychosis Association (IEPA) (2002; 2004). In 2001 in the UK, a group of experts, including service users and family members met with representatives of the WHO, the Early Intervention in Psychosis Initiative to Reduce the Impact of Schizophrenia (IRIS) Network and Rethink, a major mental health charity, to agree standards of care that those developing early psychosis and their families should expect. This document was informally called the 'Newcastle Declaration' and was published in 2002. In 2004, the Director of the WHO formally launched the Newcastle Declaration at a UK National EI conference in Bristol, which consolidated support from the WHO and the IEPA.

5.4 The National Service Framework for Mental Health 5 year review (2004)

The National Service Framework for Mental Health five year review (2004) reviewed progress in delivering EISs. There were a number of concerns at this time, that the aspirations of *The National Service Framework for Mental Health* would not be met because of resource constraints leading to a review of the implementation of the NSF, five years after its inception (2004). A number of areas were identified which needed a renewed focus of attention including inpatient care, services for people with 'dual diagnoses', social exclusion in people with mental health problems, the care of people with long term mental disorders and the availability of psychological therapies.

5.5 The National Early Intervention Programme (2004)

The National EI programme three-year strategy was launched in September 2004 to support the development of the many new EISs. Key objectives included supporting

the implementation of the Early Psychosis Declaration, sustaining the policy drive for EI and national prioritisation of EIS development and focussing on research and evaluation of EISs. Key outputs from this programme included the distribution of the Early Psychosis Declaration (2004) and an audit, which comprehensively mapped EISs at that time. This audit of services identified 117 EIS, 86 of which had funding and 63 were operational with case managed patients (as of February 2005). Only three teams met all of the EI fidelity requirements and there were variations in service model, delivery setting and resources across the teams (Pinfold et al. 2007).

5.6 The Early Intervention Recovery Plan (2006)

In England, the NHS business plans and priorities are set out in the *Operating Frameworks*, which operate on a three-year cycle. EIS for FEP formed part of the *Planning and Priorities Framework for 2003-6*. Concerns around PCTs missing the targets for EISs set in the 2003-6 Operating Framework and the issues of variable provision of EIS prompted an EI Recovery Plan (DH, 2006). This was further reinforced by the NHS Operating Framework and the Healthcare Commission, which suggested implementation of EIS as a new PCT commissioning target for 07/08. In 2006, an *EI Recovery Plan* was sent by Duncan Selbie (Director of Performance, DH) to SHA directors of performance and chief executives. Recovery plan trajectories were to deliver 7,500 new patients in receipt of EI services in 2006-07. EISs remained a priority in the *2007/8-2009/10 NHS Operating Framework*.

5.7 New Horizons (2009)

In 2009, the National Service Framework for Mental Health came to the end of its ten year lifespan. Following a public consultation, the new document *New Horizons: A Shared Vision of Mental Health* (DH, 2009) has taken its place. New Horizons is described as cross-government programme of action with the twin aims of improving the mental health and wellbeing of the population and the quality and accessibility of services for people with poor mental health. New Horizons comments on EISs for FEP: 'Early interventions...not only reduce the length and severity of the illness but are also very cost effective.' (DH, 2009, p.24). Early intervention is one of the key themes of the document and it is emphasised that a much wider range of stakeholders will become involved in helping to prevent poor mental health including the education sector, families and carers and the workplace.

5.8 Early intervention services for young people

EISs were discussed in policy for children and young people. Standard nine of *The National Service Framework for Children, Young People and Maternity Services* (DH, 2004, p. 4) which that all children up to their eighteenth birthday should '*have access to timely, integrated, high quality, multidisciplinary mental health services.*' This standard summarises a number of markers of good practice in the management of young people with mental health issues including all staff having sufficient knowledge and training, ensuring continuity of care when transferred to adult services, the development of interagency protocols for referral, support and EI and providing a multiagency approach.

5.9 Conclusions for policy literature

Policy development for EISs for FEP has changed over the past 12 years. Early policies focussed broadly on redesigning and developing more appropriate services for people with mental health problems, improving the quality of care and access to services. This was in response to early emerging research into FEP and also because of increased awareness of the issues from pressure groups and campaigners such as the National Schizophrenia Fellowship (now Rethink) and IRIS. As EISs have become more established, policy development has continued to be influenced by what Bertolote and McGorry (2005, p. 199) termed the ‘early intervention social movement’, referring to national and international political, media, and community support for EISs.

This increasing interest in EI has prompted governments in many developed countries to adopt and prioritise the EI model and commit to a roll out of EIS nationwide despite a lack of solid evidence base. However, questions remain regarding the long term benefits of a focus on EI (Bertelsen et al., 2008; Gafoor et al., 2010). There is still uncertainty about the ideal model and a number of authors have commented that EISs for FEP have been established on the ‘best available’ evidence, rather than an evidence-based approach (Singh et al., 2003).

6.0 Discussion

In summary, the empirical evidence base suggests some limited benefits of EISs. Both the RCT and Cohort studies appear to agree that there may be a positive influence on admission rates, particularly involuntary admission rates for people receiving EISs. The OPUS study and Harris et al.’s study (2008) findings suggest that whilst

individuals are in receipt of EISs there may be some element of protection against suicide. However, overall, there is limited empirical evidence to demonstrate significant clinical effects on clinical outcomes, positive or negative symptoms, global functioning, substance abuse, depression or suicidal behaviour at five year follow up. Benefits, which had been seen at two years in the OPUS study, were not sustained. The conclusions of a systematic review of EIS efficacy were that further high quality RCTs need to be carried out in this area.

There are also limited studies exploring the implementation of EISs. These studies suggest that there are a number of challenges associated with the implementation and commissioning of EISs for FEP due to a lack of resources (skills, capacity and funds). It is unclear at present, which is the best model and method of implementation of EISs.

In conclusion, it appears that EI policy and the widespread implementation of EISs in many countries predates both the clinical evidence base for the effectiveness of EISs and the evidence to support the most effective method of implementation. There are several questions, which remain unanswered regarding both the short and long term benefits of EISs and the most appropriate model of implementation.

Chapter Three will now discuss NPT and complex interventions.

CHAPTER THREE

THE THEORETICAL BASIS FOR THIS PHD

The first part of this chapter describes complex interventions. Consideration is then given to EISs from the perspective of complex interventions. Following this, experimental and theoretical methods of evaluating complex interventions are discussed and reasoning given for the choice of NPT as the key theory underpinning this PhD. The second part of this chapter then describes the Normalization Process Model (NPM) and subsequent NPT. Finally, NPT is discussed as the key theory used in this PhD to evaluate EISs.

1.0 What are complex interventions?

In 2000, the Medical Research Council (MRC) published a discussion document which described a biomedical phased stepwise framework to developing an appropriate study design for researchers undertaking evaluations of complex interventions (MRC Health Services, 2000). This framework, which largely focussed on RCTs, has formed the basis of much discussion and debate around appropriate methods for the evaluation of complex interventions. This document describes complex interventions as widely used in the health service, in public health practice and in other policy areas that have important health consequences (for example, housing, transport or social policy). Using the current most widely used and established definition of complex interventions from the MRC (2000):

Complex interventions are defined as interventions or therapies that may act both independently and interdependently and have been described as ‘the combining of a number of different components in a whole that is more than the sum of its parts. (p. 2)

1.1 Can early intervention services be described in this way?

It has been suggested that any intervention in mental health is ‘perhaps by definition complex given the nature of mental health and illness’ (Faulkner, 2009, p. 1). A diverse range of factors may influence a person’s mental health at any point in time and the associated attributions of how this is experienced by the individual, and the outcomes and consequences are equally variable (Orford et al., 2009).

A number of authors have commented on the complexity inherent in EISs. Malla and Norman (2001) discussed how the content and timing of an EI programme or service contribute to the issues of complexity, posing significant systemic and conceptual challenges. McGorry (2002) stated that there are three essential elements in the management of early psychosis including early recognition and assistance, initial assessment and promoting recovery. The multiple aspects of these three elements of EISs resonate with the updated MRC (2008) description of a complex intervention. EISs have the ‘core features’ of a complex intervention of multiple components, but also reflect the wider dimensions of complexity including the multiple levels of interaction required within EISs with multiple stakeholders, a number of new and potentially more complex behaviours required by those delivering and receiving the intervention, variability in perceived local outcomes and national goals and the

element of 'flexibility' which can be applied to the original *Mental Health Policy Implementation Guide* (DH, 2001) in developing the model. McGorry (2005) identifies several further elements of complexity, which include the lack of a specific test for psychosis creating diagnostic uncertainty and a population with heterogeneous symptoms and stages of illness. This creates a difficult environment in which to develop an intervention.

Edwards and colleagues (2005) reviewed developing EIS models and the context in which they developed, and found multiple different examples of EI programmes which fulfilled the EIS criteria stated by McGorry (2005). They discussed the importance of how the 'evolutionary characteristics' of each service, appeared to have been influenced by local mental health contexts. However, even though each service appeared to be being implemented in different local mental health service economies, structures and organisations, they identified a number of common features including leadership, clinician-researchers fulfilling multiple roles, pre implementation pilot services and studies, and a focus on enhancing local awareness of EI and active dialogue with other FEP services. Edwards et al. (2005) also discussed that although the underlying philosophy of care was universal, there were also many different elements comprising EISs, some of which were variable age ranges for inclusion; different settings geographically such as being based in generic mental health services or being a stand alone specialist service and different models of care. They also commented on current evidence gaps relating to the evaluation of complex interventions and specific interventions for FEP.

The outcomes of EISs are another area that has become increasingly complicated, as

services have developed. Originally the Planning and Priorities Framework (DH, 2002) stated service outcomes were: ‘Number of 14-35 year olds with newly diagnosed cases of first episode psychosis receiving early intervention in psychosis services.’ (p. 16) However, after the EIS Recovery Plan (DH, 2006) was introduced, whilst these numerical outcomes are still apparent, they are much more complex with each PCT required to deliver its locally agreed share of the 7,500 people to be taken on as new cases by EISs. The EIS Recovery Plan suggests this is calculated using a complex formula (Community Mental Health Activities Collection 2009/10; Care Quality Commission special data collection [financial year 2009/10]).

The updated MRC guidance (2008) identifies multiple outcomes as one of the several dimensions of complexity in a complex intervention evaluation: ‘it may be to do with the range of possible outcomes, or their variability in the target population.’ (p. 6) Therefore, there is evidence to suggest that EISs are a complex intervention and whilst the function of services tends to remain constant, there are multiple variables, which contribute to the service complexity.

1.2 Experimental methods of evaluating complex interventions such as early intervention services

Oakley and colleagues (2006) suggested that there are two key questions when evaluating complex interventions, which are ‘Does it work?’ and ‘Does it work in everyday practice?’ (p. 413) It is important for a study to aim to develop an understanding of the whole range of effects, how these effects vary between the participants and recipients of the intervention, how they vary between sites, over time,

the possible underlying causes of the variations and what the active ingredients of the intervention are and how they exert their effects. Since many public programmes contain social or human service goals, the quantification of their outputs and outcomes becomes a difficult task (Campbell et al., 2000).

They, and a number of other authors, suggest that not all of these questions can be adequately answered using the experimental paradigm (Michie et al., 2004). In support of the qualitative approach to the evaluation of complex interventions, Ritchie and Lewis (2004) suggested that at the deeper level of analysis for emergent themes, qualitative research can help us understand why particular outcomes come about. It can also examine and test the theoretical basis of an intervention and question or affirm the principles on which the tasks and processes have been based.

However, for a number of researchers the updated MRC guidance has failed to develop and incorporate some of the wider theoretical issues. Anderson (2008) described the lack of inclusion in the updated MRC guidelines (2008) of more recent developments in the methodology of evaluation. These include an approach to evaluation based on the science of complex systems and acknowledgment of theory-driven evaluation approaches (Durie et al., 2007; Shiell et al., 2008). It was therefore considered that an experimental approach using formal RCT methodology might not be the most appropriate approach.

1.3 Resource constraints and timeline of early intervention service development

A number of authors described the realities of evaluating complex interventions and the difficulties in relating this to the MRC guidance (2000). They describe a number of constraints placed on the researcher arising from the source of the intervention, for example project funding over the methodology used, political influences and ethical or moral considerations. Additionally, the actual researcher usually has little or no influence over the actual development and implementation of the intervention itself (Belsky et al., 2006; Rutter, 2006). When this PhD began, EISs were already being developed and implemented, which impacted on the methodology and theory choice, making experimental methods less appropriate and NPT a more practical choice. An RCT could not be used to evaluate the commissioning and implementation of EISs as it would not be possible to influence EIS implementation in the West Midlands to allow any randomisation or comparison to existing services. In addition, the aim of this PhD was to explore the mechanisms underpinning service development and implementation, not to quantify the intervention.

1.4 Traditional policy implementation evaluation frameworks

Traditionally, policy implementation has been evaluated using a number of different theoretical frameworks, which can be broadly categorised as top-down or bottom-up theories (vertical), and horizontal model theories (Hill and Hupe, 2002). Vertical theories assert that policy implementation is achieved through the coordination mechanisms involving higher level governmental bodies using their formal authority and a variety of informal tools, usually connected to their formal supervisory role, to mandate or encourage lower tier bodies to coordinate their activities. However, it has long been acknowledged that those individuals at the lower end of the implementation

process (in health care usually those who are delivering the service) can influence policy processes and outcomes, with public policy changed, adapted or even designed at this level. Bottom-up conceptions of the policy process emphasise that policy on coordination is, and on occasions should be, left deliberately ambiguous at the higher tiers of bureaucracy, with the intention that it should be ‘worked out’ at the service level by those actually delivering the policy.

O’Toole (2006) has suggested that these traditional top-down and bottom-up frameworks may not adequately address the reality of public policy implementation as they do not take into account societal and contextual barriers to implementation and fail to engage with policy makers adequately. May and Finch (2009) suggested that NPT might overcome some of these challenges as it has the capacity to explore the wider factors influencing policy implementation (or normalization) and can also deal with issues relating to changes in policy implementation or normalization over time. They cite the example of the typewriter and discuss how at one stage typewriters were the ‘norm’ within office settings but have now been superseded or ‘de-normalized’ over time by computers. This is relevant to this PhD as it is a longitudinal study exploring implementation over a two-year period.

2.0 Normalization Process Model and Normalization Process Theory: An alternative theoretical approach to the evaluation of complex interventions

Normalization Process Model (NPM), developed by May et al. (2006) explains how in healthcare, new technologies can become routinely embedded, and taken-for-granted in everyday work, in the light of increasing corporate organisation and

regulation. May et al. (2006) suggest that the model assists in explaining the processes by which complex interventions become routinely embedded in health care practice and offers a framework for process evaluation and also for comparative studies of complex interventions. It focusses on the factors that promote or inhibit the routine embedding of complex interventions in health care practice. NPM proposes that evaluating the implementation of complex interventions requires attention to both the measurement of outcomes and effectiveness, and also to the social relations and processes related to the work that leads to those outcomes.

2.1 Normalization Process Theory

May and colleagues undertook further work on the NPM. They drew on work undertaken by Greenhalgh et al. (2004) and to perceived gaps in the tools available to explain the failure of telemedicine systems to become routinely incorporated in clinical settings (May et al., 2000). Reviews of relevant theory published at that time described the lack of strong theoretical basis for the planning and evaluating of implementation programmes and called for the use of theories to generate testable hypotheses linking tailored strategies with factors that promote or inhibit implementation (Ashford, 2002; Grol et al., 2007). Greenhalgh et al.'s work (2004) reflected a number of studies of organisational theory and models of the capacity of organisations to innovate and deploy new systems of practice (Singleton and Michael, 1993; Rogers, 1995; Kaplan et al., 2001). NPT is a general sociological theory that fits well with macro approaches to innovation like Roger's diffusion of innovations theory (1995). NPT has now superseded the more limited NPM.

NPT considers complex interventions' 'workability', clinical and cost effectiveness (the focus of Health Technology Assessment research), their capacity for successful 'integration' into existing or new configurations of health services (the focus of research on Service Delivery and Organisation), and professional practice (the focus of Quality Improvement research). For the purposes of the theory, May and colleagues (2006) describe 'Normalization' as the 'embedding of a technique, technology or organizational change as a routine element of clinical practice.' (p. 2)

2.2 Concepts underpinning Normalization Process Theory

May and Finch (2009) describe NPT as:

A middle range theory that can underpin process evaluation of complex interventions in healthcare' and 'Normalization Process Theory...how and why things become, or don't become, routine and normal components of everyday work... helps us to understand how practices are embedded and integrated into their social contexts.' (p. 536)

Middle Range Theory is a term developed in sociology by Robert K. Merton in the late 1940s as a way of connecting high-level social theory such as Hermeneutics with empirically observable patterns. A theory is a set of conceptual tools that enable us to describe, explain, and make claims about aspects of the world we live in (Merton, 1967). NPT explains the processes by which complex interventions become routinely embedded in health care practice and offers a framework for process evaluation and comparative studies of complex interventions. It is concerned with the social

organisation of the work (implementation), of making practices routine elements of everyday life (embedding), and of sustaining embedded practices in their social contexts (integrations). It focusses on the factors that promote or inhibit the routine embedding of complex interventions in health care practice.

NPT allows accurate descriptions by systematically establishing and differentiating the phenomena with which it is concerned by defining actors, objects and contexts, and the processes that govern them. It provides a rational foundation for explanations of observed events and processes related to the implementation of new technologies and complex interventions in health care systems. NPT offers a systematic explanation of the operation of those processes and conditions by referring to patterns of action that can be empirically shown to affect their outcomes, and by defining the causal mechanisms and relations that underpin these (May et al., 2009).

More specifically, NPT provides a tool that assists process evaluation in two ways by firstly identifying and describing factors that have been shown to be important in promoting or inhibiting the implementation of complex interventions; then secondly, by providing a basis for assessing the probability that a complex intervention will become routinely incorporated in practice.

2.2.1 Practical operationalisation of Normalization Process Theory: The Domains and Outcomes of Normalization Process Theory

Practical operationalisation of NPT always begins with the question: ‘What is the work?’ This is addressed using four key concepts or domains: coherence, cognitive

participation, collective action and reflexive monitoring (May et al., 2009). Coherence is the sense making work that people do individually and collectively when they are faced with the problem of operationalising some set of practices, policy or service. Cognitive participation is the relational or interpersonal work that people do to build and sustain a community of practice around a new technology or complex intervention. Collective action is the operational work that people do to enact a set of practices, whether these represent a new technology or complex healthcare intervention. It is concerned with those factors, beliefs and behaviours that promote or inhibit the participation and enactment of a practice. Normalization is only one possible outcome of collective action. Others include: 'adoption', where a complex intervention is taken up but does not become routinely embedded in everyday work; and 'rejection', where users disregard, subvert, or otherwise refuse a complex intervention. Thus normalization is not automatically the outcome of the initiation of a new or changed set of practices. 'De-normalization' may also occur during the lifetime of a complex intervention when a previously normalized intervention is superseded, disturbed, disrupted, or atrophied. Thus normalization is neither an automatic outcome nor a permanent state. Reflexive monitoring is the fourth domain of NPT and refers to the appraisal work that people do to assess and understand the ways that a new set of practices affects them and others around them, those factors, beliefs and behaviours that promote or inhibit the appraisal of a practice.

2.3 Why Normalization Process Theory was chosen as the key theory in this PhD

There were several underlying reasons why NPT was considered as the key theory in relation to the methodology of this PhD. As Kern (2004) and May et al. (2010)

discuss, evaluation of the implementation of complex interventions is challenging due to the multifaceted relationships between the different elements of the intervention. These relationships are generally characterised by a relatively small number of possibilities that are held in place by ‘normative’ frameworks and structural constraints (permission of others and material resources.) This means that in practice, normative and structural constraints have an important influence on implementation. NPT is therefore a good fit in terms of a theoretical model for exploring complex interventions such as EIS because it has a particular focus on the normative and structural constraints of implementation (May et al., 2010).

Secondly, traditional theories have tended to explore why policy is not implemented as intended – what factors have caused a misfit between those implementing the policy and the intended outcomes. This is often called the ‘implementation gap’ (Hill and Hupe, 2002). May and Finch (2009) suggests an alternative approach might be to look at the processes involved in reaching the ‘fit’. This might involve looking at individual and collaborative efforts or work undertaken in implementing policy at different levels of organisation and the changing social contexts. NPT is a dynamic, reflexive theory that fits well with the approach taken in this PhD to explore not implementation ‘gaps’ but process. NPT has also been used previously in healthcare implementation evaluations including those focussing on new mental health developments (May et al., 2001; Gask et al., 2008). NPT also incorporates context as an important part of its theoretical basis and includes a focus on a wide range of variables including political, social, cultural, administrative and economic contexts (Finch et al., 2007). Therefore in summary, NPT was chosen as it appears to be a dynamic and reflexive theory suitable for evaluating complex policy.

3.0 Conclusion

This chapter has aimed to define complex interventions, describe the dimensions of complexity and give an account of the main experimental and theoretical models of complex intervention evaluation. EIS have been shown to fulfil the criteria for a complex intervention.

May and colleagues (2007) state that NPT provides a framework to describe how new technologies, ways of acting and ways of working become embedded in everyday practice. Their model considers complex interventions' 'workability', capacity for successful 'integration' into existing or new configurations of health services and professional practice and considers the context into which the intervention is being implemented. The features of workability, integration, collective investment and professional practice of NPT are a good fit with the aims and objectives of this PhD.

Chapter Four will now discuss the methodology of this PhD.

CHAPTER FOUR

METHODOLOGY AND RESEARCH METHODS

The aim of this chapter is to describe the research methods and methodology of this PhD. The chapter is presented in two parts. The first part will describe the research methods, features of qualitative methods relevant to this PhD and the longitudinal approach to data collection. This is followed by a description of the data collection methods used including semi-structured interviews and focus groups and the different methods of sampling. This will include a description of where and how individuals were recruited, and how they were followed up (more detailed information is then given in Chapter Five). To conclude this part of the chapter, issues affecting the research methods such as topic guide development, sample sizes, attrition in qualitative research, transcription of the data and trustworthiness of the research will be discussed. The second part of this chapter will focus on how the data was analysed using Framework analysis.

1.0 Summary of research methods

In total, 147 semi-structured interviews were carried out on a six monthly basis from July-November 2005; May-November 2006; May-September 2007 and November 2008-March 2009 exploring the views of key stakeholders comprising the mental health leads in the three West Midlands SHAs, clinical and commissioning leads for mental health in each of the 14 PCTs involved in this PhD and EIS team leads in each EIS locality. Individually constructed topic guides were developed to guide the

interviews to reflect the diverse characteristics of each of the different groups and explore a range of relevant views and opinions, according to the different priorities of each group. Six focus groups also took place at the end of the first and second years of data collection involving a total of 35 individuals comprising EIS leads and team members, PCT mental health commissioners, managerial and senior level executives within the PCT and other provider organisations including a MHT and CAMHS leads and team members. Transcription and analysis of the interviews and focus groups took place concurrently and emergent findings were used to inform the sampling framework as the PhD progressed.

1.1 What is a qualitative approach and why was it chosen for this PhD?

Qualitative research, broadly defined, means ‘any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification’ (Strauss and Corbin, 1990, p.17). Patton highlights the inductive, flexible nature of qualitative research which reflects ‘real-life’ by describing the findings of qualitative research as ‘arriving from real-world settings where the ‘phenomenon of interest’ unfold naturally’ (Patton, 2002, p.39).

The significance of qualitative research is the focus on describing and understanding complex phenomena and investigating the relationships and patterns among factors or the context in which the activity happens. Perhaps one of the most important reasons for using qualitative methods is their ability to focus on the personal accounts of the individuals and their attitudes and behavior.

Qualitative methods were appropriate for this PhD because the implementation of EISs is an ‘under-explored’ area with further trials necessary according to Marshall and Lockwood (2004, p.2). The aims and objectives of this PhD also required a methodology that was flexible and able to explore complex behaviours. In this PhD, EISs might also be considered as a ‘real life’ intervention making qualitative methods particularly relevant.

Qualitative methods are also valuable when the focus of the research is on how and why an intervention or policy succeeds or fails; where the general context of the study locale will influence the outcome and where the researchers asking the questions have no control over events (Denzin and Lincoln, 1998). This lack of control over events resonates with this PhD as EISs were already being implemented when the PhD began in 2004 making it difficult to use an experimental methodology.

In addition, qualitative research methods are appropriate when considering the underlying theory of this PhD, May’s NPT and the aims and objectives. May and Finch (2009) specifically identify three ways NPT may be useful. Firstly they suggest that NPT can inspire the researcher to undertake research on how a technology or way of working is ‘normalized’ within a specific organisation or setting. Secondly, it can be used to discover how new technologies or ways of working are actually being implemented, how they are being introduced and how they are being rolled-out. Finally, they suggest that NPT can provide a focus on technologies or ways of working that have been recently introduced and are still going through a process of normalization, to focus on how well they are being embedded.

2.0 The longitudinal approach

Longitudinal approaches are well established in social research. Constructionist approaches to social research such as discourse analysis have, for example, used longitudinal methods for decades to look at how people construct concepts and views of the social world and how these change over time (Coupland and Nussbaum, 1993). More recently, researchers and managers have begun to recognise the role which longitudinal qualitative research can play in exploring policies, programmes and interventions (Paliokas and Rist, 1998).

Longitudinal qualitative studies seek to provide a deeper understanding of the factors accounting for change and of how and why the attitudes, behaviours or status of respondents have changed or remained static. Qualitative longitudinal research examines the investigation and interpretation of change over time and process in social contexts and is therefore particularly relevant to this PhD (Holland et al., 2006). Such data can also provide an opportunity for the researcher to explore objectives beyond the scope of the original intent and provide a more informed study and richer dataset (Patton, 2002).

Longitudinal research has certain key characteristics including the fact that the data are collected for each item or variable for two or more distinct periods; the subjects or cases analysed are the same, or at least comparable, from one period to the next; and the analysis involves some comparison of data between or among periods (Menard, 1991). Data collection over a given period of time can be retrospective (asking participants to reflect back upon their experiences and attitudes) or contemporary (that

is collecting data at different times about the current situation). The contemporary longitudinal study involves repeat follow-ups of a single sample, panel or cohort and is the favoured approach (Mingione, 1999). Although retrospective data collection is an important part of any study, longitudinal research usually focusses on short-term retrospection because of the deterioration of reliability and validity when asking respondents to reflect back over long time scales (Hakim, 1987).

This PhD used a modified prospective approach to gather information. Individuals were contacted and invited to participate in the PhD at four sequential points in time: July-November 2005; May-November 2006; May-September 2007 and November 2008-March 2009. The main factors influencing the length of time between interview points was that there had to be sufficient time between interviews to allow service development to take place but not so long that events would be distorted or forgotten.

3.0 Data collection methods

In this PhD data were collected using in-depth semi-structured interviews and focus groups. Interviews allow the researcher to capture a wide range of stakeholders' opinion and perspectives. The use of interviews as a data collection method begins with the assumption that the participants' perspectives are meaningful, knowable, and able to be made explicit, and that their perspectives affect the success of the project. Interviews, rather than surveys, enhance interpersonal contact, which is important in developing trust between the researcher and interviewee.

The EDEN study (2003-6) used a multiple case study approach where the cases were

all fourteen of the EISs in existence in the West Midlands at the time of the study. Initially this approach was considered for this PhD but a number of difficulties presented themselves including the complexities of the commissioning process and how this might impact on the boundaries of the 'case' or unit of analysis and the aim of this PhD. In addition, using the EISs already described in the EDEN study or the PCTs alone might mean unique cases and outliers were not included as they were identified by theoretical sampling at later stages in the study and included services outside the West Midlands.

3.1 Focus groups

Six focus groups also took place at the end of the first and second years of data collection involving managers; commissioners; EIS and CAMHS leads and team members within two PCTs, two MHTs, a Partnership Trust (provider organisation) and a HSCT.

Focus groups were chosen both for practical reasons and to generate richer data by the inclusion of those executive and management individuals, and EIS and CAMHS team members who did not participate in the semi-structured interviews. This reflects the key characteristic of focus groups, which is the insight and data produced by the interaction between participants (Morgan, 1997). Powell et al. (1996) define a focus group as: 'A group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research.' (p.499) The main purpose of focus group research is to draw upon respondents' attitudes, feelings, beliefs, experiences and reactions in a way in which

would not be feasible using other methods, for example observation, one-to-one interviewing, or questionnaire surveys. These attitudes, feelings and beliefs may be partially independent of a group or its social setting, but are more likely to be revealed via the social gathering and the interaction which being in a focus group entails. Focus groups are also particularly useful when there are power differences between the participants and decision-makers or professionals, as was envisaged in this PhD by the involvement of individuals from different levels of hierarchy within the organisations, as this can generate unique data based on the synergy of the group interaction (Morgan and Kreuger, 1993). In addition, the use of two research methods (semi-structured interviews and focus groups) enabled triangulation of the data to increase the validity of the results.

3.2 Round One of the Interviews, July-November 2005. The research participants, convenience and judgment sampling.

A combination of convenience and judgment sampling was used for the first round of interviews, which took place between July 2005 and November 2005. It was necessary to initially use a convenience sampling approach combined with judgment sampling, as the total population of potential key informants (individuals involved in commissioning and implementation of EISs in the West Midlands identified from the EDEN study) was small.

3.2.1 Convenience sampling

Convenience sampling is a non-probability sampling technique where subjects are

selected because of their convenient accessibility and proximity to the researcher. The convenience aspect of this was that interviewees identified from the EDEN study were readily available as a sampling framework. The drawback of this approach is that not all of the individuals in the West Midlands who had been involved in the commissioning and implementation of EISs may have been identified.

An alternative approach which might have proved more time consuming but yielded a more complete sample would have been to identify every organisation in the West Midlands responsible for commissioning and implementing EISs and purposively sample relevant individuals. This option was explored but was difficult as organisational structures and job titles varied greatly between organisations making it extremely difficult to identify who precisely had a responsibility for commissioning and implementation of EISs.

3.2.2 Judgment sampling

Judgment sampling methods involved using the researcher's personal knowledge and experience of the research area, geographical and organisational areas involved and the literature in this field. This enabled as broad a range as possible of individuals to be involved in the PhD from the limited population and also the inclusion of any individuals who were outliers or 'unique cases' (those who had a special experience).

3.2.3 Normalization Process Theory and sampling

NPT also informed decision-making about the initial research sample. NPT

encourages the researcher to think about a large range of potential ‘actors’ whose day-to-day routines, work or life is in some way impacted upon by the new technology or way of working. A key part of NPT is that it advocates a broad approach to sampling and encourages the researcher to focus beyond the ‘usual suspects’ of healthcare research, and focus on others who are vital to the normalization of a new technology or way of working who may be less visible and often omitted from implementation studies. NPT also encourages a focus on a large range of potential situations, sites and contexts (May et al., 2007).

Murray et al. (2010) comment on NPT’s emphasis on ‘context’ and describe this as positively influencing research. They suggest that a focus on ‘situational context’, involves evaluation of the wider system and circumstances into which the complex intervention is being implemented. Considering ‘context’ can then influence other aspects of research design such as the population being sampled and the different sites where research might take place.

In this PhD, although the initial sample was composed mainly of those who were obviously involved in commissioning and implementing EISs, later, theoretical sampling in rounds two, three and four of interviews, was used to broaden the sample and included a range of individuals in many job roles including youth workers, occupational therapists and non-clinical managers.

An initial group of potential participants were identified by carefully reading all of the 162 EDEN study interview transcripts, which combined with personal knowledge of EISs in the West Midlands, gave rise to a number of possible interviewees or

contacts. An example of the process undertaken is shown in the excerpt below, where the highlighted words (in italics) represent potential contacts. The context here is that the interviewee, an EIS team lead, was questioned about the development of EISs in other local Trusts. She responded:

“The main thing is the commissioning by the other PCTs *the North and South*, to commit to developing an early intervention service ...” EIS team lead IV from EDEN Study August 2005

For this PhD, knowing the location of the interviewee enabled identification of potential contacts in the other two PCTs-the North and South PCTs. This process yielded a total of 51 potential interviewees. These individuals were based in a variety of organisations and service settings and comprised managers and clinicians based within 12 EISs established in the West Midlands at that time (2004); PCT and SHA mental health leads; commissioners, managers and executives responsible in a number of PCTs; directors of AMHS from two local authorities and a number of EIS team leads and team members.

Individuals were contacted by letter which included a study information sheet (see Appendix Three) inviting them to participate in an interview. This was followed up by a telephone call one week later. Informed consent was obtained and then interviews were carried out by EE at a time and place of the respondents' choice. Practically this was usually the individual's place of work and was a PCT headquarters, NHS or local authority building. Interviews with EIS team leads often took place at the EIS team site. It should be emphasised that considerable time and

effort was spent on identifying the large number of individuals in this study, contacting them, following them up and carrying out the interviews and focus groups. EE carried out all of the interviews and focus groups.

3.2.4 Topic guides

Individual topic guides were constructed for each potential group (Appendix Four). Core topics comprised the role and responsibilities relating to the EIS and on a wider level involvement in the local and strategic planning of the EIS; challenges associated with implementing and establishing the EIS; knowledge and experience of budgetary issues and finances and the commissioning process. Other topics developed aimed to explore the different constructs of NPT in implementing EISs comprised cognitive participation, coherence, collective action and reflective monitoring (see Section 2.2.1, page 68, Chapter Three).

All interviews were audiotaped and field notes were taken. Analysis of the data took place concurrently with the interviews and proceeded in an iterative manner that allowed a progressive focus on key themes. Disconfirming evidence was actively sought throughout and all interviewees were sent a copy of the preliminary analysis for comment. Topic guides were subsequently refined to take into account emerging themes and the longitudinal nature of this PhD. All interviewees were asked, at the time of interview, if they could be recontacted for a further interview and if they were able to identify any individuals who would be suitable for participation in an interview in round two or the focus groups using the snowballing methodology (see Section 3.3.1 below).

3.3 Round Two of the Interviews, May-November 2006. Snowball sampling method and unique case sampling method.

For round two of the interviews, all interviewees from round one were recontacted and invited to participate again. However, at this time there was significant reorganisation of the PCTs and SHAs (from June to October 2006). A number of PCTs merged, as did the three SHAs into one organisation. This impacted on the number of individuals who could be recruited for a second interview.

3.3.1 Snowball sampling

Contacts had also been suggested by interviewees in round one (snowball sampling). These contacts were colleagues within their own teams, colleagues in other health care organisations (including commissioners from a number of newly merged PCTs both within and outside of the West Midlands) and social care leads (in local authorities outside of the original EDEN study boundaries).

Vogt (1999) defined snowball sampling as: ‘A technique for finding research subjects. One subject gives the researcher the name of another subject, who in turn provides the name of a third, and so on.’ (p.348) In its simplest formulation snowball sampling consists of identifying respondents who are then used to refer researchers on to other respondents. Snowball sampling contradicts many of the assumptions underpinning conventional notions of sampling, particularly those held in quantitative research methods, but has a number of advantages for sampling populations such as the deprived, the socially stigmatised and elites such as the individuals participating in

this PhD (Faugier and Sargeant, 1997).

A total of four EISs outside of the original study area were identified through wider reading and expert opinion as ‘unique cases’, which required further exploration. Two of the unique EISs were identified through personal discussion with an expert in EISs (an EIS Director and member of the IRIS network) who identified that these two EISs were unique in their particular model of working. An additional unique EIS was identified through reading around the subject of EI in the literature, which reported that this particular EIS was being decommissioned. The fourth EIS was identified by a number of EIS team leads and team members during interviews as being a particularly successful model of EI working, which they had visited. From these unique cases, four EIS leads were contacted and four team members.

3.3.2 Unique case sampling

Unique case sampling involves learning from highly unusual manifestations of the phenomenon of interest. Examining cases that in some way are different to the regular patterns seen may improve researchers’ understanding of the regular patterns of behaviour that are normally observed. Patton (2002) describes this as ‘Learning from unusual manifestations of the phenomenon of interest, for example, outstanding successes/notable failures; top of the class/dropouts; exotic events; crises.’ (p.243)

In this PhD, four EISs were identified as unique. Two services were described in terms of their ‘outstanding successes’ in clinical outcomes in FEP and ability to reduce DUP; one service was unique in that it had recently been decommissioned and

so possibly represented an example of failure to implement EIS policy and one service was unique in that it had developed into a completely different model of care to that outlined in the *Mental Health Policy Implementation Guide* (DH, 2001).

As before individuals were contacted by letter, including a study information sheet, inviting them to participate in an interview and then this was followed up by a telephone call one week later. Again informed consent was obtained and interviews were then carried out by EE at a time and place of the respondents' choice. In these four unique cases, all interviews took place at the EIS site, which included non-health or local authority related buildings in the middle of the city and the outpatient department of a mental health hospital. Other interviews took place in a variety of NHS and local authority buildings. Again after the interviews all interviewees were asked for potential contacts. Analysis of the data took place concurrently at the time of the interviews.

3.4 Round Three of the Interviews, May-September, 2007. Snowball sampling, unique case sampling and theoretical case sampling.

In the third round of interviews, contact was made with individuals who had participated in round one of the interviews (but who had not participated in round two of the interviews). A further seven people agreed to participate. Contact was also made with the people who had participated in round two of the interviews. In addition, individuals were suggested by round two interviewees as potential contacts (snowballing methodology). No individuals were identified through unique case sampling at this point. Individuals were also identified using theoretical sampling

methods.

Analysis of the interviews from round two and three (concurrently carried out with the interviews) showed an important theme developing which focussed on the interaction and relationship between EISs and CAMHS. This will be discussed further in Chapter Five. Therefore as round three continued, it was considered important that interviewees should be specifically asked about the nature and quality of partnership working with CAMHS and who would be an appropriate contact in CAMHS (theoretical sampling).

3.4.1 Theoretical sampling

Theoretical sampling involves building interpretative theories from the emerging data (which is being analysed concurrently to data collection) and selecting a new sample to examine and elaborate on this theory. Patton (2002) describes this process as ‘selecting incidents, slices of life, time periods, or people on the basis of their potential manifestation or representation of important theoretical constructs.’ (p.28) Theoretical sampling can increase the quality of the data gathered in each interview. Morse (2000) describes this as ‘an inverse relationship between the amount of usable data obtained from each participant and the number of participants,’ (p.4) meaning the greater the amount of usable data a researcher is able to gather from a single participant, the fewer participants will be required.

Using theoretical sampling methodology, nineteen CAMHS team leads, PCT executives and commissioners with a responsibility for developing or commissioning

children's mental health services were identified (all based in the West Midlands).

3.5 Round Four of the interviews, November 2008-March 2009.

Using the same methodology, contact was made again with as many of those who had already been interviewed in rounds one, two and three as possible. In addition to the individuals identified from previous rounds of interviews, potential interviewees were also identified using snowball and theoretical sampling methodology.

3.6 Focus groups

Focus groups were held at the end of November 2006 until May 2007 and from March until July 2008.

3.6.1 Round one of the Focus Groups

Potential participants for the focus groups were considered during rounds one and two of the interviews. Individuals were identified from those people who had already participated in a semi-structured interview or by snowball sampling, with names suggested by interviewees. The initial criteria for individuals to participate in focus groups were defined by their job description and it was envisaged that focus groups would be held with individuals within the same job area but across different organisations. However, this proved very difficult to organise and pragmatically, each group of individuals identified for each focus group generally came from either the same organisation or 'related' organisations. For example, not all SHAs and PCTs

had appointed mental health leads, there were time constraints in freeing people to participate and there was a reluctance for some individuals to participate in a focus group with their senior or direct line manager and in participating in focus groups with individuals from other organisations. Therefore, the recruitment strategy was amended and it was decided that the focus group participants' defining characteristic would be the Trust or area they worked in. This strategy proved more successful and focus groups with a wide range of individuals with different levels of seniority and job descriptions from within a single Trust participated.

Individuals were invited to participate in the focus groups being held at the end of year one and were identified using purposive sampling. The characteristic of interest was the Trust or organisation within which the individual worked. The sample frame was individuals who had participated in round one and two of the interviews.

Changing the criteria for participation in the focus groups, however, also created a number of issues. At times, there was a lack of spontaneity in responses, which appeared to be partly related to having senior managers and more junior staff within the groups. In addition, having individuals from one organisation in a focus group limited the dialogue, which might have developed in terms of cross boundary organisational working.

Focus group one (November 2006 until May 2007) involved individuals from a Partnership Trust including AMHS (senior) executives. Focus group two involved individuals from an acute MHT including AMHS (senior) executives (non clinical), AMHS managers (clinical role) and EIS leads. The third focus group to take place

between November 2006 and May 2007 involved individuals from one of the PCTs in the West Midlands and included AMHS senior executives, CAMHS senior executives (non clinical) and AMHS commissioners. The focus groups all took place at the organisation headquarters or main offices at the request of the individuals participating.

3.6.2 Round Two of the Focus Groups

Again, potential participants were considered for the second round of focus groups throughout the time round three of the interviews were carried out. Individuals from rounds one and two of the interviews and the first round of focus groups were also considered to develop the longitudinal approach to data collection. During this time, it became apparent in the interviews that a significant emerging issue was the interface between EISs and other mental health services, in particular CAMHS. Therefore, potential participants in the focus groups were extended to include representatives from CAMHS.

Focus group four comprised senior AMHS and CAMHS executives, commissioners and managers from a PCT. Focus group five comprised EIS team leads, managers and team members from a MHT. Focus group six comprised EIS team leads and members, CAMHS clinical and non-clinical leads and AMHS commissioners and executives from a HSCT. The number of focus groups held was limited by the pragmatic constraints of a single researcher collecting data in this PhD.

4.0 Developing the topic guide

The topic guide was developed following a specific process suggested by Kvale (2007). Initially the aims and objectives of the PhD were considered in order to identify the information required from respondents. This was then supplemented with relevant information based on the literature review and the theory underpinning this PhD-NPT. May et al. (2010) suggest that NPT can help guide some of the specific, practical, choices made when developing the topic guide by incorporating the specific ideas of the theory (the four constructs discussed in Section 2.2.1, page 68, Chapter Three) relevant to the specific phenomena being studied. For example a question reflecting the domain of ‘coherence’ might focus on asking individuals to describe what they thought when they first heard about EIS policy, how they felt it related to their current work practices and what the view of the unit they were working in was. Questions asking individuals about ‘contextual integration’ might focus on discussing local and national policy or Government documents, decisions or guidelines on EISs.

Several authors including May et al. (2010) identify that questions should be framed as a list of topics in the everyday language of the people you are interviewing, perhaps particularly important when asking about the constructs of NPT. The topic guide was revisited and developed as the PhD progressed and emergent findings used to modify the topic guide.

5.0 Sample sizes

Questions about appropriate sample sizes are addressed by Glaser and Strauss (1967) and later by Strauss and Corbin (1990) amongst others. They discuss the correct sample size in relation to ‘theoretical saturation’ (Glaser and Strauss, 1967; Corbin

and Strauss, 1998). Theoretical saturation occurs when no new or relevant data seem to emerge regarding a category; the category is well developed in terms of its properties and dimensions demonstrating variation, and the relationships among categories are well established and validated (Strauss and Corbin, 1998). In this PhD, semi-structured interviews were carried out over four particular points in time, however, theoretical saturation was being approached in the last round of interviews. Potentially there was scope to continue interviewing outside the West Midlands (other than those individuals identified as unique cases or deviant cases) but this was beyond the remit of this PhD.

6.0 Attrition in qualitative research

Attrition occurs when cases are lost from a sample over time or over a series of sequential processes. Sample attrition can be a major issue for qualitative longitudinal research particularly as the smaller sample sizes involved may mean that the loss of one or two sample members can adversely affect the overall balance of the sample. However, Molloy and Woodfield (2002) suggest that this might be ameliorated by development of 'relationships' built up between respondents and the researcher at first or second interviews. Another method of reducing attrition can be by sample tracking. This increases the chances that sample members will be traceable at a later period, by collecting 'tracking' information at the end of the initial interview. This involves asking questions about where respondents might be at the point in time when later fieldwork is to be carried out, where they spend most of their time and collecting addresses and telephone numbers.

There was some attrition in this PhD. Some individuals felt they could not add anything further and others simply declined to participate further, and potentially had 'interview fatigue'. Attrition also occurred due to the changes which took place within the NHS in 2006, which meant several individuals' posts became vacant. There was scope to re-contact individuals in these roles as this was a longitudinal PhD and this was done. It was possible that some individuals agreed to be re-interviewed because of the relationship described by Molloy and Woodfield (2002). There was also the sense that some individuals agreed to participate because of an 'altruistic perspective' and that they wanted to participate in health service research.

7.0 Transcription of the data

Typically transcription takes several hours for each interview and may be undertaken by the researcher or academic secretary. Oliver et al. (2005) consider transcription to be a powerful act of representation (of those being interviewed) and encourage the qualitative researcher to undertake transcription themselves to enable them to stay true to the meaning of the words as said by the respondent, referring to how the process of transcription can affect how data are conceptualised by the researcher. The process of transcribing a recording may give the researcher insight in how aspects of the data relate to the research questions posed.

In this PhD, it was not practical for the researcher, EE, to transcribe the tapes due to the large volume of information created by undertaking 147 semi-structured interviews and six focus groups. However, EE listened to all of the interview recordings several times and also read them concurrently with the transcriptions to

ensure accuracy, that no nuances of tone or inferred meanings were missed and to facilitate familiarity with the data and reduce any misrepresentation. Using a secretary to produce the transcripts raises a number of ethical issues as there is the possibility of endangering participant confidentiality, and revealing personal or intimate information about the individual, particularly when combined with other sensitive information revealed in the interview.

In addition, a research diary was kept to allow ongoing reflection on different aspects the research and the role of the researcher within the construction of research knowledge. Also observational notes or field notes were made as a descriptive reminder of an event during an interview, chance encounter or observation. These were then used to complement the transcriptions when they were being analysed to serve as a way of minimising transcriber bias.

8.0 Trustworthiness of the research

The following section discusses methods that can be used to increase the trustworthiness of qualitative research, particularly reliability and validity, triangulation, reflexivity and generalisability and how these were addressed in this PhD. Cook and Campbell (1979) define validity in the context of qualitative research as the ‘best available approximation to the truth or falsity of a given inference, proposition or conclusion.’ (p.37)

8.1 Triangulation

Triangulation is typically a strategy for improving the validity and reliability of research or evaluation of findings. Mathison (1988) elaborates this stating 'Triangulation has risen as an important methodological issue in naturalistic and qualitative approaches to evaluation [in order to] control bias and establish valid propositions.' (p.13) Patton (2002, p.247) advocates the use of triangulation by stating 'triangulation strengthens a study by combining methods. This can mean using several kinds of methods or data, including using both quantitative and qualitative approaches.'

In this PhD, methodological triangulation was used with a combination of focus groups and semi-structured interviews. Disconfirming evidence was sought throughout the process of analysis and theories refined as a result. The benefit of a longitudinal approach with a number of rounds of interviews and focus groups was that disconfirming evidence identified could be incorporated into the topic guide for the next round of interviews to gain greater insight into the issue of concern. Emergent themes were discussed and clarified with a skilled researcher at regular meetings (HL) who had read approximately half of the transcripts.

8.2 Reflexivity

A further method of enhancing the validity and reliability of the findings of qualitative research is that of reflexivity. Ely (1991) comments 'Doing qualitative research is by nature a reflective and recursive process.' (p.179) Ruby (1980) discusses reflexivity describing it as a sensitivity to the ways in which the researcher and the research process have shaped the collected data, including the role of prior

assumptions and experience.

Reflexivity can be considered from several different perspectives including that of the study participant, the background and role of the researcher and the researcher's epistemological stance (chosen paradigm). The approach in this PhD, based on May's NPT, is that individuals generate multiple social constructs or processes (new or modified ways of thinking, enacting, and organising work in operationalising new policies in healthcare and other institutional settings) which can be understood and explained through the set of sociological tools provided by NPT and can lead to actions and behaviours that create problems or facilitate the implementation process.

8.3 The doctor as the interviewer

It was decided a priori to ensure that all participants in this PhD were aware of the interviewer's dual role of researcher and practising General Practitioner (GP). Participants were informed of this by means of a study information sheet and also by telephone and on introduction at the beginning of the interviews and focus groups. Richard and Schwartz (2002) comment on the potential power imbalance that can develop when the researcher is also a practising health professional. All participants were made aware of the researcher's background, which proved both a barrier and facilitator in the data collection process. Many individuals who initially expressed a reluctance to participate appeared more interested in being involved when they became aware that the researcher was a 'fellow' healthcare professional and the title of 'Doctor' proved helpful when trying to organise dates and times with executives and managers for focus groups and in gaining access to some of the PCT and SHA

executive elites. However, there were also drawbacks associated with being a doctor. Occasionally in focus groups, some participants appeared inhibited by the GP role. It was also an issue with some PCT executives who felt that at times when they discussed some issues relating to primary care and early intervention they might be perceived as criticising the researcher personally.

By far the most difficult individuals to access were social care staff. Initially there was some difficulty in identifying the person who was responsible for EISs and adult mental health services. Joint commissioners who were interviewed were able to give the names of those individuals who line managed them from the perspective of the social care strand of their role but identification of further interviewees proved challenging. This was partly because the researcher was initially less familiar with the structure and hierarchy of social services, and also because individuals who were invited to participate in the interviews tended to view EIS development as the PCT's or provider Trust's responsibility.

9.0 Ethical considerations

Munhall (2001) describes one of the most critical aims of the dual clinician-researcher as describing the experiences of others from interviews and focus groups in the 'most faithful way possible.' (p.537) The ethical obligation is to describe and report in the most authentic way, how that individual's experience unfolded even if it is contrary to the study's aims. Researchers need to be alert to nuances, which might change the nature of the findings and also impact on the study participants Warwick (1982).

Field and Morse (1985) comment on how the development of a trusting relationship can be important in the acquisition of knowledge but can also lead to ethical dilemmas. Whilst many individuals consent to join a study because of the anonymity afforded to them by the consent form, often once a relationship has been established the confidentiality of the exchanges can be affected and participants may wish to divulge 'off the record' comments. This is difficult as the researcher can only use information which is obtained during the consented process of the interview.

One particular area relating to anonymity in this PhD related to protecting certain individuals' identity particularly when there was only one person holding an easily identifiable role within the Trust or SHA. For example, there was only one individual who held the role of 'Lead for Mental Health within the South West SHA.' This individual would be readily identified if specific job descriptions were used. The second potential method of inadvertently exposing participants' identities may be related to the content of the quotes presented in the findings. Quotes where participants discuss specific issues, which could only relate to a certain place, time or person needed to be altered to conceal the identity of the interviewee (Harrison, 2000).

10.0 'Generalisability'

One important aim of most studies is the application of research findings to inform future practice and knowledge. Gorbich (1999) said generalisability involves 'the usefulness of one set of findings in explaining other similar situation...and is central to the definition and creation of valid public knowledge.' (p.66) Generalisability is

sometimes equated with terms of ‘transferability’ and ‘external validity’ (Tashakkori and Teddlie, 2003). However, a familiar criticism of qualitative methodology questions the value of its dependence on small samples, which is believed to render it incapable of such generalising conclusions (Yin, 1994). There is one school of thought within qualitative research that rejects generalisability as a goal. Denzin (1983) suggests ‘every instance of social interaction, if thickly described, represents a slice from the life world’ (p.133) and is thus a proper subject matter. Lincoln and Guba (1985) say: ‘The only generalisation is: there is no generalisation.’ (p.110)

On the other hand, a number of qualitative researchers argue that qualitative research can be generalised to some extent. Silverman (2000) defines generalisability as that characteristic of research which permits ‘generalising from particular cases to populations.’ (p.109) Giddens (1984) and Hammersley (1992) argue that it is possible to establish the representativeness of a case on the basis of comparisons with a larger sample of similar cases.

Perhaps most relevant to this PhD is the perspective suggested by Fitzpatrick and Boulton (1994) and Black (1994) who both suggest that rather than focus on the generalisability of qualitative research, the potential and strengths of qualitative research are to sensitise policymakers and practitioners to the perceptions of health service users and professionals.

11.0 Methodology and ethical issues

Tully et al. (2009) suggest considering the methodology of research studies under ethical review and highlight a number of areas requiring consideration including poor design, trivial or foolish research and over-researching small populations. They argue that poor design and trivial or foolish studies can waste people's time and can contaminate the field for future research. In this PhD, the researcher undertook a thorough literature review and also consulted with peers and senior experienced researchers in the field of early intervention to ensure that this PhD would not duplicate existing work or over-research the relatively small sampling frame.

In addition, the researcher was aware that focus groups and interviews can be time consuming and inconvenience individuals and potentially also reduce the amount of time available for actual patient care or their commissioning. This was minimised by offering interview dates and times that were flexible and potentially out of conventional working hours and that the topic guide was as relevant as could be and not overly burdensome.

Issues of informed consent were considered. Inquiries involving human subjects including NHS staff should be based as far as practicable on the freely given informed consent of subjects. In voluntary inquiries, subjects should not be under the impression that they are required to participate. They should be aware of their entitlement to refuse at any stage for whatever reason and to withdraw data just supplied. The researcher ensured all information sheets contained appropriate information reflecting this and that individuals were thoroughly consented individuals prior to any interviews or focus groups (NRES website, 2007).

Finally, one of the most important but difficult responsibilities of social researchers is that of alerting potential users of their data to the limits of the reliability and applicability of that data. The twin dangers of either overstating or understating the validity or degree to which the data can be generalised are nearly always present according to Li and Seale (2007).

The second part of this chapter will now focus on how the data was analysed using Framework analysis.

12.0 The Framework Analytical Approach to qualitative data analysis and modified Grounded Theory.

Framework analysis is a qualitative method particularly suitable for applied policy research. Framework analysis was developed by the Social and Community Planning Research Institute situated in London, England by two qualitative researchers, Jane Ritchie and Liz Spencer in 1994. They describe it as a modified form of grounded theory (Ritchie and Spencer, 1994).

12.1 Grounded Theory

Grounded theory (GT) was developed by the sociologists Anselm Strauss and Barney Glaser (1967) as a way of formalising the ‘operations’ or ‘process’ needed to develop theory from empirical data. Proponents of GT urge researchers to use the method flexibly and as a guiding framework (Glaser and Strauss, 1967; Charmaz, 2006). The basic tenet of GT is to allow free discovery of theory and to limit any preconceptions.

GT is the inductive process of identifying analytical categories as they emerge from the data by developing hypotheses 'from the ground' or 'research field' upwards rather than defining them a priori.

An important feature of GT is theoretical sensitivity, which refers to a personal quality of the researcher and relates to understanding the meaning and subtlety of data. Theoretical sensitivity has been described by Glaser (1978) as the process of developing the insight with which a researcher comes to the research situation. Such insight should be conceptual rather than concrete. It is often referred to as a creative aspect of GT and involves the researcher working in the area to obtain experience and expertise. By gaining theoretical sensitivity the researcher will be able to recognise important data and formulate conceptually dense theory.

12.2 Stages in Grounded Theory

There are four stages in data analysis using GT: coding, concepts, categories and theory. Coding involves identifying 'anchors' which allow the key points of data to be gathered. Collections of codes of similar content are then grouped together as concepts. Broad groups of similar concepts are then used to generate a theory. The theory is a collection of explanations that explain the subject of the research.

The initial stage of data analysis is coding. There are three or four types of coding. The number of codes can vary depending on whether the researcher is using GT as described originally by Glaser and Strauss in 1967 or later versions of GT, developed and added to by Glaser and Strauss, and Strauss and Corbin (1990). Original codes

included open coding, selective coding and theoretical coding. Axial coding, explained below, was added to GT coding by Strauss and Corbin in 1990.

The first level of coding is open coding or substantive coding, where written data from field notes or transcripts are analysed and considered line by line, which produces a large number of concepts from the data. As further data are coded, concepts are compared and may merge into new concepts, which are eventually renamed and modified.

Axial coding, proposed by Strauss and Corbin (1990) is a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories. They proposed a 'coding paradigm' that involved 'conditions, context, action/interactional strategies and consequences.' (Strauss and Corbin, 1990, p.96)

The next stage is the researcher selecting the 'core variable' or what is thought to be the core, the 'tentative core'. The core explains the behavior of the participants in resolving their main concern. After the core variable has been chosen, the researcher then applies selective coding to the data, with the core as a guide. At the same time, the researcher selectively samples new data with the core in mind, which is called theoretical sampling. Selective coding can involve going over old field notes or memos that have already been coded at an earlier stage or by coding newly gathered data.

Theoretical codes integrate the theory by weaving the fractured concepts into

hypotheses that work together in a theory explaining the main concern of the participants. Theoretical coding means that the researcher applies a theoretical model to the data. It is important that this model has emerged during the comparative process of GT. This procedure is continued until 'theoretical saturation' is reached meaning no new significant categories or concepts are emerging. The procedure of grounded theory analysis is not linear, rather it is cumulative and often the researcher revisits the data when new concepts emerge. This completes the '*grounding*' of the theory.

12.3 Framework Analysis Method

Framework analysis differs to GT in that it is said to be better adapted to research that has specific questions (such as applied policy research), a limited time frame, a pre-designed sample (e.g. professional participants) and a priori issues (e.g. organisational and integration issues) that need to be dealt with. Although framework analysis may generate theories, the prime concern is to describe and interpret what is happening in a particular setting (Ritchie and Spencer, 1994). This is perhaps relevant to this PhD in that there were a number of constraints in deciding on the methodology and research methods due to factors such as EIS policy already being implemented and the fact that EISs are a national priority, therefore manipulation of the team structures or commissioning bodies would not be possible. Mays and Pope (2000) suggested that when the objectives of the investigation are typically set in advance and shaped by the information requirements of the funding body, then Framework analysis might be the most suitable approach.

Framework analysis is a generic method, providing a versatile means for qualitative

analysis, rather than being a highly specific technique. It provides a procedural structure to which the researcher can apply their own data. As such it can be applied to a wide variety of qualitative methods of data collection with differing aims and objectives. Whilst incorporating systematic, comprehensive methods, it also allows a flexibility and adaptive process of analysis. This method allows full review of all the material collected and enables easy retrieval of this material to facilitate between and in case analysis. Perhaps most importantly, the transparent and structured approach used in this method allows individuals, other than the primary analyst, to be able to easily access the data.

There are five key stages to analysing data using this process, which include familiarisation, identification of a thematic framework, indexing, charting and mapping and interpretation of the data.

12.3.1 Familiarisation

During familiarisation, the analyst is said to immerse themselves in the data. The aim is to gain an understanding of the richness, depth and diversity of the data and begin the process of abstraction and conceptualisation. Whilst reviewing the material the analyst keeps contemporaneous notes on recurrent themes and issues which appear to be emerging and important.

12.3.2 Development of a thematic framework

Once all the material has been reviewed, the analyst then attempts to identify the key

concepts and themes emerging. This is developed within a framework. This process results in a thematic framework of the data that can be used to filter and classify the data. This stage of the process reflects the open coding of GT. It is important at this stage to ensure that the researcher keeps an open mind and does not impose their a priori thoughts and issues on the data. Ritchie and Spencer (1994) stress that the thematic framework is only tentative and there are further chances of refining it at subsequent stages of analysis. A further consideration at this stage is that the aims and objectives of the research, especially in applied social policy research, are being addressed and remain the focus of the work (Ritchie and Spencer, 1994)

12.3.3 Development of the thematic index

The tentative thematic index, once refined, is then given numerical coding values and applied to each transcript. This is called indexing. The thematic index is systematically applied to all of the data. The data is then re-arranged according to the emergent themes identified, a process known as charting. This reflects the axial coding of GT.

12.3.4 Charting

Ritchie and Spencer (1994) describe how the analyst will have built up a picture of the data as a whole by considering the range of attitudes and experience for each issue or them, by this stage of the analysis. Data are then 'lifted' from their original context and rearranged within the appropriate thematic reference. Charts are devised with headings and subheadings drawn from the thematic index, a priori research questions

and how the analyst wants to write up the study. Charts may be thematically presented (where a theme is applied across all respondents) or by case (where each respondent's data is applied across each theme). In Framework analysis, the data within the chart are not cut and pasted from the text but distilled and summarised keeping the original text reference so the process of abstraction can be examined and replicated. Illustrative quotations for later use can also be included at this stage.

14.3.5 Mapping and interpretation

Mapping is the final stage of the process where attempts are made to interpret the data and identify where associations can be made between themes and explanations generated. Ritchie and Spencer (1994) discuss how there are six potential ways that a researcher can approach the data at this stage, depending on their original research question and the themes and associations that have emerged from the data. The first three include defining concepts (identifying systematically key dimensions and themes), mapping the range and nature of phenomena (identifying the form and nature of phenomena) and creating typologies (linking two or more dimensions to give a range of cases). The second three include finding associations (identifying patterns of responses), providing explanations and developing strategies (explaining attitudes, experiences or behaviour which can then be used to inform policy decisions). This stage reflects the selective coding and the development of core categories of GT. Again; the researcher uses the constant comparative approach to the data.

13.0 Qualitative analysis of the data: Worked example using five stages of Framework analysis

These data are included here to increase the transparency of the analysis methodology rather than in the results chapter.

13.1 Familiarisation

Analysis of the data took place concurrently with data collection. Initially the researcher EE familiarised herself with the data by listening to the audiotapes and reading and re-reading the transcripts. The researcher also read all of the transcripts with the field notes and listened to the recordings at the same time as reading the transcripts to ensure they had been transcribed accurately and that the transcribed version reflected as much of the original meaning as possible. In addition, the researcher kept notes of what were considered to be important or overarching themes that seemed to be emerging from the interviews and focus groups. Emergent themes were discussed and clarified with a skilled researcher on a regular basis. Regular review and discussion of evolving themes with the skilled senior researcher (HL) contributed to the data synthesis and interpretation. HL (PhD supervisor) read approximately half of the transcripts.

13.2 Developing the thematic index

The second stage of analysing the data using Framework analysis involved constructing the thematic index. Several transcripts were selected using the approach recommended by Ritchie and Spencer (1994) who suggest that the researcher selects a range of transcripts representative of the methods used; the researchers involved; the

diversity of people and circumstances studied; the time period of the data collection and the extent to which the research agenda was modified or evolved during this time.

The next stage involved constructing a ‘tentative index’ or ‘initial’ thematic index. Transcripts were chosen that were representative of the range of methods used; the diversity of people and circumstances studied; the time period over which the material was collected and the extent to which the research agenda was modified or evolved during this time. This version of the thematic index was largely descriptive and, as expected, extensive with an element of duplication in a number of sections. Double coding was applied when this occurred. The ‘tentative’ thematic index is shown below in Table Three:

Table Three: Tentative thematic index November 2005

1.0 Barriers to EIS implementation	
1.1	Differing national policy for adult and children’s services
1.1.a	Lack of strategic approach at policy level to unite adult and children’s services
1.1.b	Comprehensive CAMHS and the single point of access
1.1.c	Impact on service organisation and priorities
1.1.d	Different targets
1.1.e	Duplication of service development
1.1.f	Ad hoc service development
1.1.g	Lack of planning at CAMHS-EIS interface: transitions 1
1.1.h	Need for an adolescent policy at national level
1.1.i	Age ranges of services and boundaries
1.2	Tension between national and local policy
1.2.a	Duplication of services

1.2.b 1.2.c	Ad hoc service developments Effect on interface between services
1.3	Different funding streams for adult and children's services
1.3.a 1.3.b 1.3.c 1.3.d 1.3.e 1.3.f	CAMHS investment compared to AMHS Transparency of budgets Combining budgets Effects on staff capacity and resources Impact on priority setting Funding for EISs through adult route
1.4	Relationships and communication
1.4.a 1.4.b 1.4.c 1.4.d 1.4.e 1.4.f 1.4.g 1.4.h	Inter-organisational at operational and PCT level Inter-organisational within the PCT Inter-organisational at meso and macro level e.g. PCT and SHA Intra organisational at meso level e.g. PCT, Acute Trusts, provider organisations Geographical disparity and situations/ locations of each organisation Health service reorganisation Historical and cultural boundaries Organisational ethos and philosophical approach to care
1.5	Organisational barriers
1.5.a	Partner non statutory organisation skills and capacity, aims, goals and objectives in mental health
1.6	Commissioning process
1.6.a 1.6.a.i 1.6.a.ii 1.6.a.iii 1.6.a.iv 1.6.a.v 1.6.a.vi 1.6.a.vii 1.6.b 1.6.b.i 1.6.c 1.6.c.i 1.6.c.ii 1.6.c.iii 1.6.c.iv	Decision making Service reorganisation Seconded, post vacancy Complexity at organisational and service level Conflict between organisational and operational priorities and needs Low strategic focus, 'silo's' Impact of different Trusts Understanding of EISs Experience level amongst commissioners Intra and inter-organisational mentorship and support Mental Health commissioning Marginalised Core-business Investment and fire-fighting PBC problems

2.0	
Facilitators to EIS implementation	
2.1	Youth focussed approach
2.1.a	Access
2.1.b	Location
2.1.c	Non-traditional health settings
2.1.c	Person centred
2.1.d	Vocationally orientated, recovery
2.1.e	Flexibility
2.1.f.	Complexity
2.1.g	Multiple Partnership Working
2.1.h	Inter-agency working
2.1.i	Joint funding
2.1.j	Clinical Governance
2.1.k	Communication Structures
2.1.l	Age specific
2.1.m	Multiple statutory and non-statutory services
2.2	Role of the ‘facilitator’
2.2.a	Engaging
2.2.b	Supportive
2.2.c	Developmental
2.2.d	Practical and useful
2.2.e	Normalising
2.2.f	Seniority
2.2.g	Practical experience
2.2.h	Service champion
2.2.i	Can provide a more national strategic viewpoint
2.2.j	Enhance intra and inter-organisation communication
2.3	Senior and structured support
2.3.a	Enhanced clarity and understanding of roles and responsibilities
2.3.b	Clear strategic direction for planning
2.3.b	Medical model influence if support within health services structure
2.3.d	Joint learning and training or structured communication and knowledge transfer
3.0	Features of a youth focussed service
3.1	Access, location, non-traditional health settings

3.2	Person centred, vocational and recovery models used
3.3	Flexible
3.4	Complex- multiple partnerships
3.5	Joint working patterns
3.6	Funding issues
3.7	Normalising
4.0	Models of working and service models developed for EISs
4.1	Transitions
4.2	CAMHS
4.3	Knowledge
4.4	Protocols
4.5	Generic link worker
4.6	Specific EIS/ CAMHS link worker
4.7	CMHTs
4.8	PHCTs
4.9	Stand alone or hub
4.10	Hub and spoke
4.11	Outreach model
5.0	Implementation of services
5.1	Traditional models of top-down/ bottom-up
5.2	Role of PCT
5.3	Role of SHA
5.4	Focus on national targets and policy
5.5	Prioritising resources
5.6	Approaches, skills and experience of commissioning
5.7	Knowledge of commissioning
5.8	Horizontal methods-negotiation
5.9	Role of the ‘facilitator’
5.10	Collaborative working
5.11	Actions and ‘work’ needed to practically implement EIS

13.2.1 Refining the thematic index

The aim of the next stage of data analysis was to refine and further develop the tentative thematic framework so it reflected emergent and analytical themes. As Ritchie and Spencer (1994) suggest, the researcher kept revisiting the aims and

objectives of the research to ensure that the analysis remained appropriately focussed on the research question. Refining the tentative index involved application of the index to an additional number of transcripts. This involved the researcher making judgments about meanings, relevance and importance of themes and codes and connections between the ideas. This resulted in a much smaller, more focussed thematic framework.

13.2.2 Application of the refined thematic index

A quotation from the results chapter, Section 3.2.6, page 146, Chapter Five is presented here.

‘We do not need more nurses, we need other staff like an OT or psychologist. There’s certainly resistance to this coming down from management because what we need doesn’t conform to what we’re supposed to have so we won’t be PIG-compliant, like it’s some holy grail.’ EIS lead IV 1

An example of the application of the thematic index to an interview excerpt, containing the quotation is shown below in Table Four:

Table Four: Interview excerpt with EIS team lead IV 1

Person speaking	Question/ answer	Thematic index areas
EE	What is your background in terms of early intervention?	

IV1	...in the last six or seven years really and throughout my history I've undertaken bits of mental health work in various guises. Setting up different services and so on. I haven't led a team though so this is a first.	5.1.d Low operational experience or new service development
EE	You were talking a bit about a particular model earlier and how that has led to delays in developing EISs in this Trust. Could you talk a little bit more about that?	
IV1	The powers that be think it is a very manpower intensive model, and their take on early intervention is almost that it should be delivered as a brief intervention, which is obviously not my take on it. Um...problem is the Trust's in a precarious position financially at present and they say they cannot afford this model and so...So I am trying to develop this service but it is very difficult and there are lots of conversations with the commissioner who has a different perspective.	1.6.a.vii Understanding of EISs 5.1.b Resource priorities 1.6.a.iv Conflict between organisational and operational priorities and needs
EE	Could you give me an example of where tensions or differences have occurred?	
IV1	An example-well based on the PIG, I have appointed four practitioners...three are CPNs, one is an OT. I wanted a psychologist but management wouldn't allow that. We do not need more nurses, we need other staff like an OT or psychologist. There's certainly resistance to this coming down from management because what we need doesn't conform to what we're supposed to have so we won't be PIG-compliant, like it's some holy grail.	1.6.a.iv Conflict between organisational and operational priorities and needs 5.1.a.iv Focus on national targets rather than local development/ need 5.1.e Distance from service and low ownership

After all of the initial interviews had been read, a more detailed, refined thematic index was constructed, shown below in Table Five:

Table Five: Refined thematic index May 2006

<p>THEME ONE: NATIONAL POLICY IMPLEMENTATION VERSUS LOCAL ISSUES</p>
<p>1.0 National policy versus local issues 1.1 Lack of strategic approach at policy level to unite adult and children’s services 1.2 Different operational processes 1.3 Achieving different targets, levers, incentives, priorities, investment levels 1.4 Funding (CAMHS and AMHS) different 1.5 Ad hoc service development and lack of strategic planning 1.6 National policy versus local need/priorities</p>
<p>THEME TWO: PARTNERSHIPS</p>
<p>2.0 Relationships and communication 2.1 Inter-organisational 2.2 Intra-organisational at meso level e.g. PCT, Social Care, Acute Trusts 2.3 Geographical disparity and situations/locations of each organisation 2.4 Health service reorganisation 2.5 Historical and cultural boundaries 2.6 Organisational ethos and philosophical approach to care</p>
<p>3.0 Youth focussed approach 3.1 Access 3.2 Location 3.3 Non traditional health settings 3.4 Vocational, recovery 3.5 Flexibility 3.6 Inter-agency working 3.7 Funding 3.8 Communication structures</p>
<p>4.0 Role of the ‘facilitator’ 4.1 Engaging 4.2 Supportive 4.3 Developmental 4.4 Practical and useful 4.5 Seniority 4.6 Practical experience 4.7 Service champion 4.8 Enhance communication</p>
<p>5.0 Senior and structured support 5.1 Enhanced clarity and understanding of roles and responsibilities 5.2 Clear strategic direction for planning 5.3 Medical model influence if support within health service structures 5.4 Joint learning and training or structured communication processes/knowledge transfer</p>

<p>6.0 Models of working and service models developed for EISs</p> <p>6.1 Generic link worker 6.2 Specific EIS Link worker 6.3 Youth Focussed service 6.4 Consultant collaborative care 6.5 EIS outreach model 6.6 Structure of working 6.7 Stand alone team 6.8 Hub and Spoke team</p>
<p>THEME THREE: MENTAL HEALTH COMMISSIONING</p>
<p>7.0 Commissioning process</p> <p>7.1 Service reorganisation 7.2 Secondees, post vacancy 7.3 Experience level amongst commissioners 7.4 Intra and inter-organisational mentorship and support. 7.5 Mental Health commissioning</p>
<p>THEME FOUR: WORK</p>
<p>8.0 Implementation of services ‘work’</p> <p>8.1 Resource priorities 8.2 Approaches to commissioning and service development 8.3 Lack of clarity of role and responsibilities 8.4 Knowledge of resources and organisations 8.5 Increased ownership of project 8.6 Joint training-workshops, educational or developmental groups. 8.7 Collaborative working 8.8 Joint policy development 8.9 Joint service level agreements 8.10 Role of the facilitator 8.11 Networking, connecting 8.12 Consultancy 8.13 Mentoring</p>

13.3 Indexing

The third stage involved indexing the data. This meant applying the refined (and much reduced) thematic index to the data in a systematic fashion. This process involved making judgments about the sense and meaning of different passages within

the text. Some passages contained more than one code when it was considered there were multiple meanings or ways of interpreting the data. The thematic index was recorded numerically, as suggested by Ritchie and Spencer (1994) allowing codes to be applied to the transcripts (in the margin). This meant that the process was visible and accessible to others.

Qualitative data analysis tools such as NVivo are ideal assisting in such a task as the process of indexing. As this was a PhD, the researcher used NVivo for some of the data to gain experience of the system. However, this was more time consuming than manual analysis. Welsh (2002) suggested that the benefits of a computer assisted analysis approach include the use of search tools to find out what has not been coded, as well as what has been coded. This can be very useful in testing the consistency and comprehensiveness of the coding but is not accessible in manual coding. Welsh (2002) also suggests that coding can also be adjusted, amended and reorganised more easily. However, Welsh also identifies that as time passes, using a computer assisted analysis tool can result in the researcher becoming distanced from the data, as was found in this PhD, and can become more of a counting, non-analytical exercise.

Therefore the analysis was completed manually. In the end, approximately 50 percent of the transcripts were analysed using NVivo. An example of indexing as part of the analysis of the data is demonstrated below using one small part of the refined thematic index (taken from Table Five) and two short excerpts from the interview with an EIS lead used earlier in this chapter (Table Six) and a second excerpt from an interview with another EIS lead (Table Seven).

13.3.1 Analysis of the data with excerpt from refined thematic index (Taken from Table Five)

<p>1.0 National policy versus local issues</p> <p>1.1 Lack of strategic approach at policy level to unite adult and children’s services</p> <p>1.2 Different operational processes</p> <p>1.3 Achieving different targets, levers, incentives, priorities, investment levels</p> <p>1.4 Funding (CAMHS and AMHS) different</p> <p>1.5 Ad hoc service development and lack of strategic planning</p> <p>1.6 National policy versus local need/priorities</p>
--

Key

IV 1 Interview number 1 as identifier

R1 Round 1 of the interviews as timeline

Table Six: Interview excerpt with EIS lead IV 1 R1

Person speaking	Question/ answer	Indexing
EE	Could you give me an example of where tensions or differences have occurred?	
IV1	An example-well based on the PIG, I have appointed four practitioners...three are CPNs, one is an OT. I wanted a psychologist but management wouldn’t allow that. We do not need more nurses, we need other staff like an OT or psychologist. There’s certainly resistance to this coming down from management because what we need	1.6 National policy versus local need/ priorities

	doesn't conform to what we're supposed to have so we won't be PIG-compliant, like it's some holy grail.	
EE	Do you think the PIG has been a useful document then? Does it help with things like how you work with other teams and so on? I'm thinking CAMHS specifically.	
IV1	Not sure really, they don't particularly say much do they about working together? I don't really think the system is set up for us to work together that well at the end of the day. You know, things like how we assess people, medication, RMO responsibility and so on...we don't really work to the same agenda	1.1 Lack of strategic approach at policy level to unite adult and children's services 1.2 Different operational processes

Table Seven: Interview excerpt with EIS lead IV 15 R1

Person speaking	Question/ answer	Indexing
EE	You were talking about CAMHS and how your protocol...could you tell me some more about that and whether you found things like the mental health PIG useful?	
IV15	Mmm... ok well things are working well now but in my opinion national policy and guidance is not particularly aimed at bringing Adult and Children's services together . 'Every child matters'...yes that's important to both of us but the interpretation of 'early intervention' differs greatly in meaning. For them [CAMHS] it is general early intervention not specifically for psychosis , which can create problems when you are looking at working together in a team for first episode psychosis and with	1.1 Lack of strategic approach at policy level to unite adult and children's services 1.2 Different operational processes 1.3 Achieving different targets, levers, incentives, priorities, investment levels

	funding and so forth. Perhaps more clarity at a higher level would resolve some of these anomalies.'	
EE	Have there been any other issues in terms of national policy and guidance and local issues?	
IV15	I suppose the biggest issue for us is that we are a very distinct area geographically and have struggled with capacity in terms of how we deliver an early intervention service that meets the PIG requirements, yet works across our locality. We have a huge area-one part very rural, the other urban with two universities and this has presented problems.	1.6 National policy versus local need/priorities

13.4 Charting

The researcher then developed the charts. This researcher had reviewed the data as a whole and built up a picture of the range of attitudes and experience for each issue or theme. The researcher then 'lifted' sections of data out of their original context and grouped and re-arranged them within a 'chart' according to the appropriate thematic reference. Charts were devised with headings and subheadings drawn from the thematic framework. Charts were constructed thematically (discussed in 14.3.3 above) and sequentially (respondents were grouped on charts according to the time they were interviewed or participated in a focus group), to represent the longitudinal nature of this PhD and facilitate reviewing and analysing how themes and ideas changed over time. Four charts were devised including National policy versus local issues; Partnership working, Commissioning mental health and 'work' within the context of NPT. Charts did not change over time.

Each individual who had participated in this PhD was individually charted and a summary of each person’s views recorded and interpreted. A consistent order was kept for each chart to allow for comparisons between and within cases. The original quote in Section 3.2.6, page 146, Chapter Five was placed in the Policy chart, as demonstrated in the below.

Table Eight: Policy chart with original quote from Section 3.2.6, page 146, Chapter Five.

	POLICY CHART	
Subject heading	1.1 Lack of strategic approach at policy level to unite adult and children’s services	1.6 National policy versus local need/ priorities
Interviewee		
EIS lead IV 15	<p>‘National policy and guidance is not particularly aimed at bringing Adult and Children’s services together. ‘Every child matters’...yes that’s important to both of us but the interpretation of ‘early intervention’ differs greatly in meaning. For them [CAMHS] it is general early intervention not specifically for psychosis, which can create problems when you are looking at working together in a team for first episode psychosis and with funding and so forth. Perhaps more clarity at a higher level would resolve some of these anomalies.’</p> <p><i>Different policy for adults and children might be a barrier to partnership working?</i></p> <p><i>Leadership might overcome</i></p>	

	<i>this barrier (as unlikely to be able to merge all policy)</i>	
EIS lead IV 1		<p>‘We do not need more nurses, we need other staff like an OT or psychologist. There’s certainly resistance to this coming down from management because what we need doesn’t conform to what we’re supposed to have so we won’t be PIG-compliant, like it’s some holy grail...’</p> <p><i>Operational level interviewee feels that the next layer of management is too distant and remote from operational level.</i></p>
AMHS commissioner (Mental Health Trust) FG 1	<p>‘Typically, the priority with CAMHS wasn’t around that [referring to transitions] but around service developments for ADHD and autistic spectrum disorders, more so than EI. Possibly because of targets and things related to that I suppose.’</p> <p><i>Different targets and policies means collaboration might be more difficult as aims and priorities of organisations differ.</i></p>	<p>‘The NSF has been driven by the NHS and hasn’t been embraced by the social care providers and our social colleagues as much as we’d like. One of the tensions I’ve still got is getting my social care colleagues to step up and take their part in costs associated in enacting the NSF appropriately..’</p> <p><i>Is it that the NSF is a predominantly medical document, excluding social care or social care excluding self (i.e. ignoring NSF)?</i></p> <p>Mapped to partnership working and funding</p>

13.5 Mapping

The final part of Framework analysis involved mapping the data. Throughout the process of analysis, the researcher has contemporaneously noted any associations or patterns emerging. As the original research question was: ‘to determine the barriers

and facilitators influencing EIS commissioning,’ (Section 1.1, page 2, Chapter One) the researcher approached the data and charts with the aim of defining key concepts relevant to the process of implementation and providing explanations of behaviours, attitudes and experiences. Ritchie and Spencer (1994) acknowledge that mapping is ‘... part of the analytical process [that] is the most difficult to describe’ (p.186).

In the mapping diagram below in Figure Two, the original quote in Section 3.2.6, page 146, Chapter Five is contextualised using additional sources of data such as a memo excerpt. Figure Two represents an excerpt of a mapping diagram used to explore respondents positive and negative attitudes to national policy implementation at a local level and to demonstrate the range of beliefs of the different individuals involved.

Memo excerpt: IV with CAMHS commissioner

‘Alignment of national guidance and funding different; planning cycle and performance management mainly council led, different to health. Foundation Trust status applied for which is a big drive to hit all targets etc. Consideration of impact of EISs on CMHTs etc in locality.’

Figure Two: Excerpt from a mapping diagram representing patterns in attitude to implementation of national early intervention services policy locally.

(The original quote from Section 3.2.6, page 146, Chapter Five, can be found on this map shown in bold).

Positive comments

Makes job easier if national targets, goals and aims as greater consistency across the patch:
'Look as long as they [EIS] are performing and delivering as per the requirements laid out, then I am not getting involved. That is the beauty of national guidance and policy' SHA mental health lead IV 8 R1

Good as prioritises mental health which means there is an argument for funding and resources to be redirected:
'I don't see targets as the enemy! Basically having a target in an area makes it happen so no targets means less priority, funding and focus. So for something like early intervention, I think targets are brilliant.' AMHS commissioner IV 8 R3
'So it's a Cinderella service I think in terms of Government policy but having said that, having no policy at all would mean I would have to fight even harder to get in the queue for investment!'
From PCT perspective: Targets useful in MH for getting money/resources

SHA leads	EIS Team	Senior AMHS Executives	AMHS Commissioners	CAMHS Executives	Senior CAMHS Commissioners
-----------	----------	------------------------	--------------------	------------------	----------------------------

Alignment of national guidance and funding different memo from IV with AMHS Commissioner

Doesn't address nuances such as who will pay for CAMHS/ transition age beds
'For me it [referring to MHPIG] isn't specific enough or relevant enough to actually be useful.' CAMHS commissioner IV

National policy doesn't take into account current changes in health services with significant organisational change: *'It doesn't take into account that mental health services are developing at different paces in each of the trusts, each with different local thinking and problems relating to local issues like change of management structures etc.'* SHA mental health lead IV 9 R2

National top down guidance can mean local interpretation difficult and not always relevant to those actually delivering service on the ground: *'We do not need more nurses, we need other staff like an OT or psychologist. There's certainly resistance to this coming down from management because what we need doesn't conform to what we're supposed to have so we won't be PIG-compliant, like it's some holy grail...'* EIS lead IV 1

Different policy for adults and children might be a barrier to partnership working? *'National policy and guidance is not particularly aimed at bringing Adult and Children's services together. 'Every child matters'...yes that's important to both of us but the interpretation of 'early intervention' differs greatly in meaning. For them [CAMHS] it is general early intervention not specifically for psychosis, which can create problems when you are looking at working together in a team for first episode psychosis and with funding and so forth. Perhaps more clarity at a higher level would resolve some of these anomalies.'* EIS lead IV 1

Negative comments

14.0 Conclusion

The aim of this chapter was to describe the research methods and methodology of this PhD. The first part of the chapter described the research methods, features of qualitative methods relevant to this PhD and the longitudinal approach to data collection. This was followed by a description of the data collection methods used including semi-structured interviews and focus groups and the different methods of sampling including convenience, snowballing, theoretical and unique case sampling. A discussion of the different issues affecting the research methods of this PhD such as topic guide development, sample sizes, attrition in qualitative research, transcription of the data and trustworthiness of the research was then presented. The second part of this chapter focussed on describing how the data was analysed using Framework analysis, a modified form of Grounded Theory.

Chapter Five will now present the main findings that emerged from this PhD and demonstrate evidence as it emerged from the five stages of Framework analysis described.

CHAPTER FIVE

RESULTS

1.0 Summary of data collected

147 semi-structured interviews and six focus groups (see Appendix Five) involving 35 participants were held between February 2004 and March 2009. The focus groups were carried out with participants from two PCTs, two MHTs, one Partnership Trust and one HSCT. Individuals were invited to participate from different backgrounds within the organisations including individuals with senior executive or managerial content to their role, although all had responsibility for either adult or children's mental health service development.

1.1 Round One of the Interviews

51 individuals were invited to participate in round one of the interviews. 41 agreed to participate comprising 25 PCT commissioners or executives, three SHA Mental Health leads, two Directors or leads from two local authorities and 11 EIS team leads. Ten people declined with two PCT commissioners citing lack of time, one EIS team lead was unable to participate as the team was still at an embryonic stage of development, four of the EIS team members were no longer in post and three EIS team members preferred not to participate at this stage as their team lead was participating.

1.2 Round Two of the Interviews

For round two of the interviews, all interviewees from round one were recontacted and invited to participate again. Only 13 individuals from round one of the interviews agreed to participate in a second interview comprising four EIS team leads, eight PCT commissioners and managers and one social care lead. Nine individuals formally declined comprising two PCT managers who stated they had just started in post and would not be able to give any useful information, two PCT managers were off work on sickness absence, two EIS team leads declined to participate again stating that they were too busy, two were on secondment and one post had an acting lead who did not wish to participate. The remaining 19 potential interviewees did not respond to the invitation of follow up. Therefore a total of 13 individuals from round one of the interviews were re-interviewed.

Fifteen contacts had been suggested by interviewees in round one (snowball sampling) including colleagues within their own teams and colleagues in other health care organisations including commissioners and managers from eight of the newly merged PCTs within the West Midlands, two commissioners from outside the West Midlands, one of whom was a commissioner for Children's mental health services, two EIS team leads from within the West Midlands and three social care leads based in local authorities outside of the original EDEN study boundaries in the West Midlands. These individuals were contacted and 11 people agreed to participate including six PCT commissioners and managers, three social care leads for mental health and two EIS team leads. Four individuals declined to participate with two West Midlands based commissioners citing a lack of time, one post became vacant (PCT

commissioner for children's services outside of the West Midlands) and one individual (commissioner for AMHS outside of the West Midlands) did not reply despite repeated contacts.

The third group of individuals identified to participate in round two of the interviews comprised eight individuals (four EIS team leads and four team members) from four 'unique' EISs. These services were unique for different reasons. Two unique EIS were identified using snowballing sampling methodology, through personal discussion with an expert in EIS (an EIS Director and member of the IRIS network) who identified that these two EISs were unique in their particular model of working; an additional unique EIS was identified through reading around the subject of EI in the literature, which reported that this particular EIS was being decommissioned (theoretical sampling) and the fourth EIS was identified by a number of EIS team leads and team members during interviews as being a particularly successful model of EI working, which they had visited (snowballing sampling). All of the individuals within these unique EISs agreed to participate.

Therefore a total of 32 individuals participated in round two of the interviews of which 13 participants were from round one of the interviews, 11 were identified by the snowballing sampling method and eight individuals identified as they were 'unique cases'. Individuals were contacted using the same methods as before in round one and given the same information and follow up.

1.3 Round Three of the interviews

In the third round of interviews, contact was made again with as many of those individuals who had participated in rounds one and two of the interviews as possible. Twenty-eight people from round one were contacted and seven individuals agreed to participate (four PCT commissioners, three EIS team leads). All 32 people from round two were contacted, which included those individuals from round one who had participated in a second interview. Twelve people agreed to participate from the second round of interviews, five of whom were solely from round two of the interviews (four PCT executives and one EIS team leads and members) and seven of whom had participated in two interviews already (in rounds one and two-three EIS team leads, one EIS team member and three PCT commissioners). Forty-eight people did not respond to the invitation or follow up telephone call and could not be contacted.

Nine individuals were suggested by round two interviewees as potential contacts (snowballing methodology) including two SHA mental health leads (one from the original West Midlands, one from outside), one EIS team lead, four CAMHS leads, two PCT executives (from a PCT within the West Midlands and one from a PCT outside the West Midlands). All agreed to participate.

A group of 19 individuals were identified using theoretical sampling methods for round three of the interviews including eight CAMHS team leads and 11 PCT executives and commissioners with a responsibility for developing or commissioning children's mental health services (all based in the West Midlands). Fourteen agreed to participate in an interview which included all eight CAMHS team leads and six PCT commissioners and managers with a responsibility for commissioning CAMHS. Five

individuals did not respond to the invitation or follow up.

To summarise, for round three of the interviews, 88 people were contacted with 28 people from round one of the interviews (not including the 13 people who participated in round two of the interviews), 32 people from round two of the interviews (which included the 13 people from round one), nine people through using snowballing sampling methodology and 19 people through theoretical sampling methodology. Forty-two people agreed to participate in an interview for round three including seven 'new' people from round one of the interviews, five 'new' people from round two of the interviews, nine people from snowball sampling methodology and 14 from theoretical sampling. Therefore in round three of the interviews, there were a total of 19 people who had participated in this PhD before who were re-interviewed, and 23 new interviewees.

1.4 Round Four of the Interviews

Twenty-one individuals from round one were re-contacted (not including those individuals who had participated in rounds two and three of the interviews). Five individuals responded and agreed to participate. These included three PCT commissioners for AMHS and two EIS team leads. Twenty individuals who had participated in round two of the interviews were also contacted (not including five people who had participated in an interview at round three). No further individuals agreed to participate at this stage. Forty-two people from round three of the interviews were contacted (which included the individuals who had previously participated in interviews in rounds one and two) and a total of 13 people agreed to participate in an

interview. Three of these individuals had previously participated in all the other rounds of interviews. Ten had participated in round three of the interviews only.

In addition to the individuals identified from the three previous rounds of interviews, 18 people were identified using snowballing sampling methodology including three EIS team members, nine PCT commissioners or executives, two CAMHS commissioners and four CAMHS leads and team members. Six people agreed to participate including one EIS team members, one CAMHS commissioner, three PCT executives and one CAMHS team lead agreed to participate. One CAMHS commissioner declined as she did not have time, two EIS team leads declined as they were busy, one commissioner's post became vacant at this point in the PhD and eight PCT commissioners, CAMHS team leads and members did not respond.

Using theoretical sampling methodology, 24 contacts were identified including 14 individuals from four CAMHS teams (outside of the West Midlands), one SHA mental health lead, six EIS team leads and members and three social care mental health leads for both children's and adult services. Eight people agreed to participate including one SHA mental health lead, three EIS team leads and members, two social care leads and two CAMHS team leads and members. One social care lead declined to participate and commented that she did not feel this was a relevant study for social care services. Five CAMHS team leads and members declined as they were new to the role and felt they would not be able to add any useful information. Ten people were not contactable.

In summary for round four of the interviews, a total of 125 people were contacted: 21

from round one of the interviews; 20 from round two, 42 from round three, 18 people using snowballing sampling methodology and 24 people using theoretical sampling methodology. In total, 32 people were interviewed, five from round one (who had not participated in any other interviews), none from round two 'exclusively,' 13 people from round three (three people from rounds one, two and three and ten people from round three alone), six people identified using snowball sampling methodology and eight people identified using theoretical sampling methodology

1.5 Summary of the Interviews

In summary, a total of 147 individuals participated in semi-structured interviews comprising 56 PCT commissioners and managers responsible for AMHS, 14 CAMHS commissioners, six SHA MH leads, eight local authority directors or mental health leads, 46 EIS team leads and members and 17 CAMHS leads and team members. These participants worked in a total of 37 separate PCTs (including seven new PCTs in the West Midlands after the merger in 2006 and four PCTs outside of the West Midlands), five SHAs (three from before the SHA reorganisation in 2006, one which developed as a result of the merger in the West Midlands and one outside of the West Midlands), four local authorities (two outside of the West Midlands), 18 EISs (14 of which were from the original EDEN study in the West Midlands) and ten CAMHS teams (with four based outside of the West Midlands). Forty people participated in two interviews, seven people in three interviews (four EIS team leads and three AMHS commissioners) and three people in all four interviews (all EIS team leads).

1.6 First round of Focus Groups

Thirty individuals were invited to participate in the focus groups held at the end of year one. These individuals were identified using purposive sampling, based on the employing organisation. The sampling frame was individuals who had participated in round one and two of the interviews. Fifteen individuals agreed to participate. Numerous reasons for non-participation were cited with the main two reasons being a lack of time and individuals changing roles before the focus group (leaving the Trust for example). Focus groups were held just after the re-organisation of the SHAs (July 2006) and PCTs (October 2006) and a number of SHAs had not yet confirmed their mental health leads. PCTs were also in a state of flux and many individuals who were invited felt they would not be able to participate in a focus group as they had only just started in the role of mental health commissioner and would have little to contribute. Again, several positions of mental health commissioner were not filled at this stage.

1.7 Second round of Focus Groups

A total of 36 people were approached to participate in the second round of focus groups including all 15 individuals from the previous focus groups. Nineteen people were identified from interviews that had taken place in the preceding year. Two people were approached separately from those individuals identified in the first round of focus groups who had expressed a wish to participate in the second round of focus groups. Twenty people agreed to participate. No individual agreed to participate in a second focus group. The majority of individuals did not respond to the invitation. Several people from the previous focus groups declined as they felt they would not have anything new to contribute and also a number of people were in the process of changing posts or the posts were currently vacant. Only one person from the group of

19 people identified from interviews that had taken place the previous year declined to participate. Both of the individuals who had asked to participate in this round of focus groups rather than the previous year's focus groups agreed to participate. 18 of the 20 individuals who participated in the second round of focus groups also participated in a semi-structured interview. Four of these people (two EIS team leads and two commissioners) had participated in two semi-structured interviews.

In summary, 66 people in total were invited to participate in the focus groups with 30 people invited to participate in focus groups held at the end of the first year of data collection, and 36 in the second round. Fifteen individuals agreed to participate in the first round of interviews and 20 in the second round.

2.0 Findings from this PhD

Three major themes and 11 sub themes emerged from the qualitative data analysis.

The three main themes were:

1. Partnership working.
2. Mental Health Commissioning.
3. 'Work' within the context of NPT.

Quotes have been presented in the results section verbatim to allow the reader to make some judgment about the validity of the interpretations and have been chosen on grounds of representativeness (Murphy et al., 1998). Longitudinal presentation of quotes has been included wherever possible. However, one of the limitations of this

PhD was that there was a high rate of attrition (discussed in Section 6.0, Chapter Four) due to significant organisational changes. This meant that whilst the topic or theme might be discussed in a longitudinal fashion, it was often not possible to attribute comments about the topic to the same person.

Key to quotes:

EIS-early intervention service

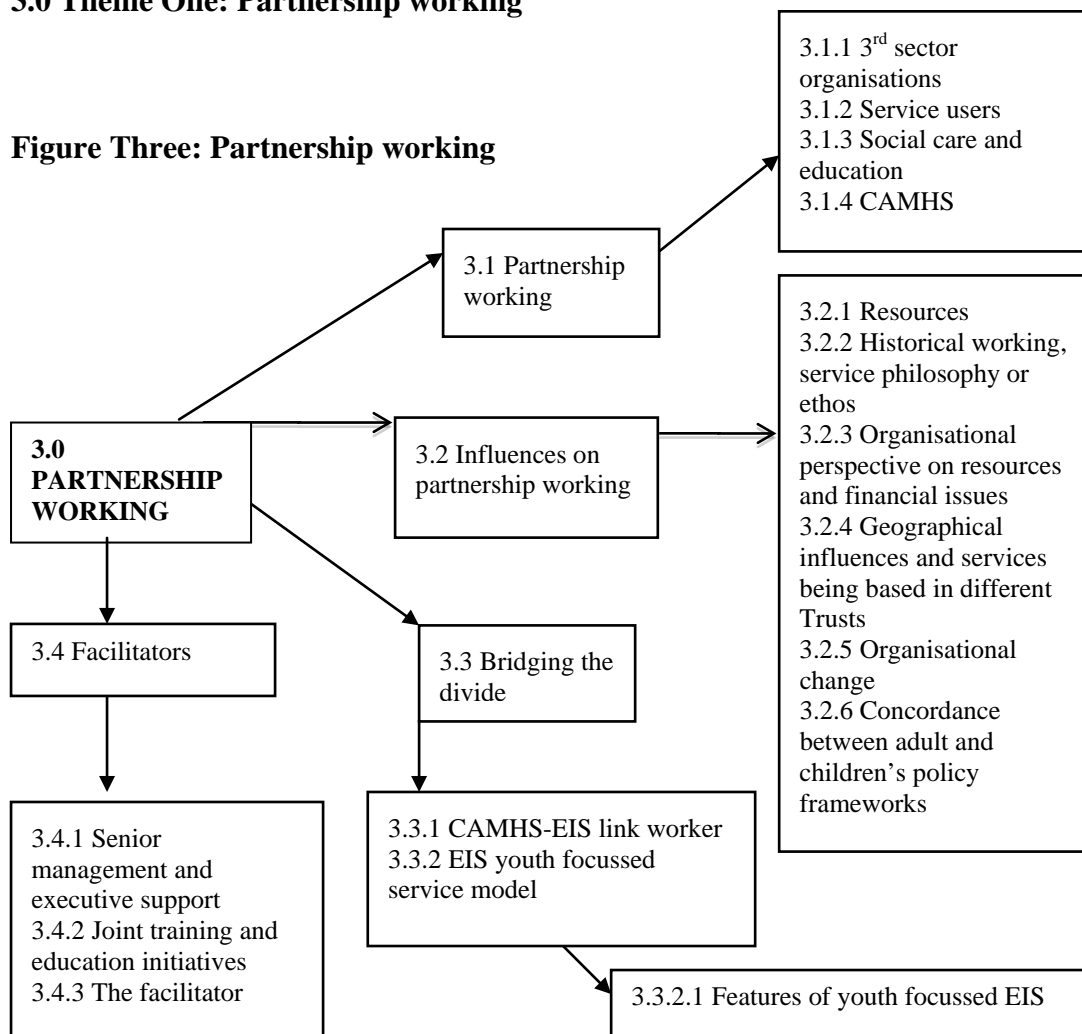
IV 1-interview number 1

FG 3-focus group 3

R1/ R2/ R3/ R4-quote taken from round 1,2,3,4

3.0 Theme One: Partnership working

Figure Three: Partnership working



Interviewees in all of the different groups were asked a range of questions about developing EISs and partnership working reflecting the *Mental Health Policy Implementation Guide* (2001) and *National Service Framework for Mental Health* (1999) which emphasised interagency collaboration and multi agency working.

3.1 Potential partners

3.1.1 Third sector (voluntary sector) partnerships

Partnerships which were discussed more frequently, perhaps because they appeared to have been developed most successfully and straightforwardly, were those with third sector organisations and vocational and employment services. Reasons for developing these particular partnerships were to provide a holistic EIS, reduce stigma in accessing services, make EISs less formal and more responsive to younger people's needs and develop a youth focussed approach to services. One EIS team lead suggested that these partnerships were easier to develop because of their similar philosophy and ethos in the way they worked, which was comparable to the philosophy and ethos of EISs. Another EIS team member described what appeared to be greater willingness on the part of the third sector organisations to become involved with EISs. The quote below is from an EIS team member who belonged to an EIS, which appeared to have been '*normalized*' according to NPT (see Section 2.2.1, page 68, Chapter Three).

'Substance misuse, educational or vocational, you know those services. If you've got family issues, criminal justice issues, you know you've got a young person with

multiplicity of problems that's what we try and look at and work with the other services to provide a 'whole person approach'. EIS team lead IV 41 R1

3.1.2 Service users

At the time of the first interviews and focus groups, no EIS team lead or team member interviewed had specifically involved any service users in developing EISs. Two EIS team leads suggested that this was because EISs were not sufficiently developed or established enough at the time of their interview for partnership working.

'We haven't really had much opportunity to get service users involved yet as we aren't really at that stage of development, service wise.' EIS team lead IV 15 R2

However, the same individuals interviewed at a later stage were still unable to describe effective partnership working with service users in developing EISs.

'I have to be honest...we did try and set up a sort of users group to inform how we developed the service but it is very difficult getting them involved [referring to service users]...they're young people with better things to do!' EIS team lead IV 15 R3

3.1.3 Partnership working with educational services and social care

Several interviewees discussed the concept of 'traditional' partnerships and how different organisational working practices and historical ways of working influenced the EIS's ability to develop more formal partnership working. These were particularly

important in three areas: education, social services and CAMHS (see Section 3.1.4 of this Chapter below).

The partnerships between social services and other organisations appeared to be traditionally different to those with health services. Social services appeared to partner other local authority provided services such as education more naturally. At an operational level, three EIS team leads commented on difficulties with social workers actually being recruited or working as part of the EIS.

‘There are a lot of issues-for example we are on different pay scales, we have different career trajectories and so on. We all tend to get a different deal! It’s not just social care and health that are different; it’s complicated by the other groups such as education that we have to liaise with.’ Social care executive IV 49 R2

Of the eight social care interviewees, all commented on how social service partnerships appeared to be different to healthcare with social services more naturally partnering other local authority provided services such as education.

‘There’s no commitment in our organisations to drawing the areas together but it’s more likely social services and education will be pooled together because they’re county council, they will come together first.’ Social service AMHS lead IV 50 R2

Only a small number of the EIS team leads or team members at the time of interview had successfully established any formal partnership working with schools and colleges. Most EIS team leads or team members were aware that the EIS needed to

develop this area but were not sure how they should develop the interface with educational services. The two sequential quotes below are from an EIS team lead where the EIS appeared to have been ‘*adopted*’ (according to NPT, Section 2.2.1, page 68, Chapter Three).

‘I find there’s quite a lot around education – we’ve got young people in college and their behaviour is not always tolerated but we haven’t made great headway in linking into mainstream education and going into schools and colleges and so on.’ EIS team member IV 59 R2

This person was re-interviewed a year later and again asked about partnership working. Their comments perhaps show how over time partnership working could become more established through increasing the control and autonomy of those providing EISs and organisational support.

‘Initially, I think working with education and CAMHS was undermined by the failure to overcome long-standing problems between commissioners and providers in our patch. The new commissioner though seems to be taking a different approach. This new approach-where service providers like ourselves are trusted more to take a greater leadership role-is an important element of partnership development.’ EIS team lead IV 59 R3

3.1.4 Partnership working with Child and Adolescent Mental Health Services

Partnership development at the EIS-CAMHS interface was a particularly important

issue identified by many interviewees. Comments tended to reflect those of the third sector, education and social care, in that some EIS team leads perceived CAMHS ‘traditional’ working practices as a barrier to partnership working. An additional issue identified by both CAMHS and EIS interviewees was that of the perceived specialist nature of each of their services. A CAMHS interviewee did not feel that EISs were likely to impact on the ways CAMHS worked because it was a ‘specialist’ service; whilst an EIS team lead felt that Children or young people’s mental health was sometimes perceived as too complex for anyone other than a CAMHS-trained professional to work in. The quotation below is from an EIS team lead that belonged to an EIS which appeared to have been ‘normalized’ according to NPT (see Section 2.2.1, page 68, Chapter Three).

‘I think it’s interesting how early intervention is seen very differently by CAMHS. I think it gets a bit of a battering every time it comes on the agenda because they don’t really think that for our clients it is necessarily the most appropriate way of treating them. Generally it has been recognised that co-ordination of services for older children or adolescents has been less than satisfactory but it is difficult to try and change the status quo, particularly from the ‘adult provider’ end of services.’ EIS team lead IV 51 R2

3.2 Influences on partnership working

A number of barriers and facilitators were identified which appeared to affect the development of partnerships, and the quality of those partnerships. At an operational level (individual services), issues included available resources (capacity, skills and

finances), historical working practices and ‘philosophical’ perspective of services. At an organisational level (individual Trusts), resources available were again discussed. Services being based in different organisations or Trusts and organisational change were also identified as possible barriers to partnership working.

3.2.1 Resource and funding issues

A perceived lack of resources was cited by the majority of respondents at the operational level as a significant barrier to developing partnership working. ‘Resources’ could be monetary/financial or capacity in terms of time and staff and skill base. The quote below is from the EIS team lead of one of the ‘unique’ services (see Section 3.3.2, page 84, Chapter Four). The service was unique in that it was ‘*de-commissioned*’ or ‘*de-normalized*’ according to NPT, Section 2.2.1, page 68, Chapter Three).

‘We have had real difficulties with social services and accessing them and working alongside them is nigh on impossible because they are so over budget to the point where they can’t even manage the basics...so no there isn’t much of a partnership there.’ EIS team lead IV 52 R2

In later interviews, the specific area of inpatient beds for young people aged between 15 and 18 years was identified as a resource issue by CAMHS interviewees. No EIS interviewees commented on this area. Some CAMHS interviewees commented on concerns they had about whose responsibility it was to fund these beds and the lack of current capacity in terms of available beds.

'Issues for us centred particularly on inpatient beds. Would we need specific 'transitional' beds? Who would fund the inpatient care- CAMHS or Adults? CAMHS team lead IV 74 R3

3.2.2 Historical working, philosophy of care and traditional working practices.

EIS respondents often discussed the 'ethos' underpinning the EISs work, which appeared to be an assertive outreach early treatment model. This was an area where disagreements arose with other services, including social care, primary care and other mental health teams, some of which appeared to have a different philosophical model of practice. For example, a CAMHS worker suggested that CAMHS work to a more family focussed, child friendly model, often with a reluctance to make a diagnosis of psychosis, preferring to use a 'watch and wait' approach. The CAMHS worker felt this model did not particularly sit well with the assertive outreach, early treatment model promoted by EISs.

'We've got some people who are coming up to being with us for 3 years and we are looking to get them out of EI and into mainstream mental health care but it is proving difficult. The CMHTs aren't really interested. They say they deal with long term enduring mental illness and say that we should get them back to the GP but you can't always do that if someone still needs follow up from a mental health perspective. The GPs won't deal with that.' EIS team lead IV 14 R3

3.2.3 Organisational perspective on resources and financial issues.

At an organisational level, several PCT and social care executives commented on the impact finances could have on developing effective partnerships. In some health services such as CAMHS, financial issues appeared to be linked to how much emphasis or priority was placed on partnership development. Finance and resource issues were a frequently mentioned topic in all of the focus groups, although usually commented on by commissioners and operational level participants rather than senior executives and managers:

[Talking about joint working with EISs] *Pan *** CAMHS planning officer: 'We're not at that stage yet. I mean we have to be very secure in our finances when we go down that road and there is still a lot of financial pressure within the children's services in *** [name removed].'* CAMHS commissioner IV 83 R3

3.2.4 Geographical issues and services being based in different Trusts

Initially respondents discussed how services being based in different Trusts and organisations could affect partnership working. This appeared to impact on decision-making, communication, service continuity and more strategic service planning and development. For example, several CAMHS services were provided by acute Trusts, children's Trusts or MHTs, EISs were mostly provided by MHTs or Partnership Trusts, primary care services were managed largely by the PCTs and social care services were based within local authorities. The quote below was from a PCT executive from a Trust responsible for commissioning an EIS which appeared to have been '*adopted*' according to NPT (Section 2.2.1, Chapter Three).

'Okay well the collaboration [between CAMHS and the EIS] initially is going to be fairly conservative and rather limited because, well you know big structures like adult mental health services and CAMHS, they're different. As you know CAMHS are based in the Children's Hospital and adults in the Mental Health Trust, so you know organisationally as well as professionally we've really got very different backgrounds.' PCT AMHS senior executive FG 3

EISs and CAMHS being in separate teams, organisations and Trusts appeared to impact on communication and information sharing, particularly in the area of transparency of budgets affecting service planning.

'One of the barriers to actually developing any proper transition practices or that sort of thing is the fact that adult and children's mental health services are in different Trusts which makes life very difficult-it's not easy to get two different organisations to join up like that or have any sort of sensible conversation about funding, sharing staff and so on.' Joint commissioner for children's services IV 82 R3

3.2.5 Organisational change

Several interviewees and focus group participants discussed how changes within the different Trusts and organisations, especially the major reorganisation of the SHAs and PCTs that took place from July-October 2006, had an impact on their ability to develop successful partnership working. In some cases partnership development could not take place as some posts remained vacant including EIS team lead posts and commissioner posts. Many respondents identified how this time was difficult for

service implementation and development, affecting communication between different groups and presenting new organisational challenges to be overcome.

'We don't have a mental health commissioner at the minute. The commissioners in post are all sort of operating in a time warp and because of delays in appointing new chief executives and the subsequent layers, no-one really knows if they are going to be in the new structure so no-one will make any firm decisions-it might reflect badly on them if it goes wrong or they just don't know what the service configuration is going to be. Also a lot of good people have left and got posts elsewhere to avoid all this uncertainty.' PCT Director for AMHS IV 42 R2

The issue of the impact of organisational change was still discussed in the final round of interviews and focus groups. The quote below is from a manager working within a HSCT responsible for providing EISs. This commissioner was responsible worked for the Trust which had a unique EIS in that it was '*decommissioned*' or '*denormalized*' (according to NPT, Section 2.2.1, Chapter Three). Unique EISs were discussed in Section 3.3.2, page 84, Chapter Four).

'One of the difficulties is that our mental health commissioner was a secondee. She then went back to her proper job leaving a vacancy. Whilst the secondee was not particularly expert in mental health commissioning she was at least there and able to argue the case for mental health, funding etc. Now since the PCT reorganisation, there isn't anyone so we get even less priority or attention or whatever. We have been left in limbo.' PCT Joint commissioner IV 4 R3

3.2.6 Concordance between adult and children's policy frameworks

Several EISs and CAMHS team leads and commissioners discussed how national policy and guidance appeared to be different in terms of long term strategic outcomes and planning for children's and adults' mental health services, in particular *The National Service Framework for Adult Mental Health* (1999), *Every Child Matters* (2003) and *The National Service Framework for Children, Young people and Maternity services* (2005). This often led to tensions between services and commissioners when trying to develop partnerships between services, and a call for national policy to clarify service and individual roles and responsibilities more clearly. The quote below is from an executive in a PCT responsible for commissioning EISs. The EIS in this case appeared to have been 'adopted' according to NPT (see Section 2.2.1, page 68, Chapter Three).

'National policy and guidance is not particularly aimed at bringing Adult and Children's services together. 'Every child matters'...yes that's important to both of us but the interpretation of 'early intervention' differs greatly in meaning. For them [CAMHS] it is general early intervention not specifically for psychosis, which can create problems when you are looking at working together in a team for first episode psychosis and with funding and so forth. Perhaps more clarity at a higher level would resolve some of these anomalies.' PCT AMHS senior executive IV 46 R2

Interpretation of national policy at a local level also created some tensions between EIS team leads and commissioners at times. Commissioners were described as inflexibly implementing national policy without consideration of local need. The

quote below was from an EIS team lead where the EIS in this case appeared to have been ‘*adopted*’ in this Trust according to NPT (Section 2.2.1, page 68, Chapter Three).

‘We do not need more nurses, we need other staff like an OT or psychologist. There’s certainly resistance to this coming down from management because what we need doesn’t conform to what we’re supposed to have so we won’t be PIG-compliant, like it’s some holy grail.’ EIS team lead IV 1 R1

3.3 ‘Bridging the divide’

Despite some of the negative comments on partnership working, EISs, in partnership with some CAMHS and other services, had addressed the issue of how to ‘bridge the gap’ in a number of different ways. These included basic protocol development, using a generic children’s/ adult service link worker within their organisation; the consultant liaison and joint working and more innovative methods and models of working including the development of a specific role of a CAMHS-EIS link worker; and the development of a new service model altogether. These different methods required various levels of collaboration, innovative thinking and commitment.

3.3.1 Child and Adolescent Mental Health Services and Early Intervention

Services link worker

Some EISs had considered developing or were in the process of developing the role of a specific CAMHS-EIS link worker. This individual acted variously as a case

manager for transitional patients and a liaison between CAMHS and adult EISs. This role was developed and funded by adult services in all but one case. EISs with this worker had usually developed protocols with CAMHS to support the worker's role and better clarify individual and service responsibilities. At the time of the interviews, only five EI teams had a specific link worker, of which only one person was 100 per cent devoted to that role. The other four also had additional caseloads and duties within the team.

'My post involves being the lead for the CAMHS/adult interface, drawing up protocols to define this interface. I'm also looking at joint training and supervision. I have developed links into social care, education, youth offending and the voluntary sector to support the partnership board and help develop better partnership working.'

EIS team member link worker IV 84 R4

3.3.2 The Early Intervention Service youth focussed service model

The EIS Youth Focussed service model was neither CAMHS, AMHS, nor EIS, but included elements from all these teams and was the most complex method of bridging the EIS-CAMHS divide. It required innovative thinking, senior support and considerable commitment of resources, time and energy. A wide range of age appropriate services were gathered in one place, which facilitated access and enhanced continuity of care for patients. In addition, the presence of multiple teams and organisations under one roof was seen as beneficial for staff too, enabling access to each other for meetings, advice and training.

This type of model lessened the need for more formal service support and whilst a number of youth services had considered the development of protocols, few had yet found the need to develop these. In addition, some of the barriers to partnership working that EISs had experienced with CAMHS such as historical differences, geographical and philosophical differences, were overcome as there was a greater sharing of knowledge and working practices with the different team members being housed under one roof. In total, four of the 15 EISs appeared to be developing this model of care from the interviews. Focus groups three, five and six also discussed this model of care.

'Multiple services being located in one building has thrown up a number of issues such as joint working patterns, as well as internal referral pathways. We have focussed on these areas and have resolved them by discussion as a group rather than individual team leads meeting and making decisions. I think this is really important as this service [EIS] is one of the first to straddle the boundary of adult and child mental health so it has the potential to help to raise and resolve any issues for those trying to do the same thing.' EIS team lead IV 88 R4

3.3.2.1 Features of the youth focussed service model

Specific features of the youth focussed model included a flexible, adaptive approach, particularly when considering the ages of many of the young people presenting with first episode psychosis. It also appeared that individuals recognised that flexible working across organisational boundaries were important especially when receiving or making referrals. EISs emphasised offering integrated activities that were

appropriate for young people in the service age range, rather than activities for young people with first episode psychosis. Activities would often be mainstream community activities for young people and had an emphasis on educational and vocational training and social activities. Two of the EIS team leads felt that it was this approach that made the team different to traditional mental health services such as CMHTs. The place where the EIS was based was a core component of the service being youth focussed. One EIS had developed into a Youth Focussed service model working together with other statutory and non-statutory youth organisations, based in one building. The quote below is from the team lead of a 'unique' EIS, in that it had developed into a new and different model of working compared to *The Mental Health Policy Implementation Guide* (DH, 2001) model. This model that did not appear to fulfil the criteria for EIS implementation as '*normalized*', '*adopted*' or '*de-normalized*' according to NPT (Section 2.2.1, page 68, Chapter Three).

'So we try and gear the activities to young people, with a particular focus on links with education, the employment workers will look for training opportunities for young people, social activities are provided by the staff, a football group run by MIND that we use – seems to be good fun and the youngsters enjoy it.' EIS team lead IV 91 R4

Three EIS team leads and members and one CAMHS team member discussed the impact being based in one organisation had on integrating working practices and developing more effective transition working. This resulted in easier, more informal communication between the services, less complicated arrangements when co-working with a young person and easier transition from one service to another.

‘Well, we’ve been based here now for the past four months and in that time an outreach CAMHS service and the youth drug service have joined us. It’s brilliant now. If I want to talk to someone about a CAMHS issue, I walk down the corridor and go into their room and we chat. So much easier...’ EIS team lead IV 88 R4

3.4 Facilitators

The development of these more innovative ways of partnership working were facilitated by supportive senior management within the different organisations involved, joint training and education activities and the role of a specific individual described as the ‘facilitator’.

3.4.1 Senior managerial and executive support

Having support from senior managers within the commissioning or provider Trust enabled EISs and CAMHS to develop the youth focussed service model more successfully. Two senior managers describe the underlying processes, which resulted in the development of the youth focussed model as providing social enterprise and peer support. Characteristics of this role were seniority within a healthcare organisation, being supportive of innovative models of service development and having a pioneering and strategic vision of mental health services working together in a cohesive way.

‘Absolutely, social enterprise is very much the focus. You might want to take a look at saying “Well ok, we want to set up a youth focussed service to deal with these young

people with psychosis or whatever; how are we going to target adolescents? Who are the partners they want to be engaged with?" You might want to consider something like Birmingham Brook pregnancy advice service for young people but there are loads of key agencies that we know are providing services for young people that need to be co-ordinated and pulled in. That's where these youth centres can fill the gap.'

HSCT chief executive IV 69 R4

This individual's seniority was important as it gave them 'authority' to influence how services developed. A permissive attitude to suggestions by those at the operational level was also key. These individuals were able to influence budgets, financial and policy issues and encourage collaboration with different groups within their remit to promote strategic service development. An innovative and permissive attitude from senior managers and their support was also vital in terms of the development of new models of care, housed in non-traditional health care settings and which deviated from the original *Mental Health Policy Implementation Guide* (2001).

'I decided we needed to move away from the traditional model of commissioning and try and be more innovative and broader in our thinking so we develop an EI service in parallel with other services that young people would access like CAMHS, Connexions, education, GU services, further education and so on...This is where my role is useful as it allows me to plan, develop and support inclusive services across the whole spectrum of youth and adult services.' Joint commissioner for AMHS IV 43

R3

A number of joint commissioners and managers responsible for the development of

EISs described how they had received senior support, which had helped in EIS service planning and development. Comments made by senior executive suggested that they facilitated the commissioners' role by raising the profile of EISs through discussion of the service on several different organisational agendas; by encouraging workforce development and by encouraging an integrated multi-agency approach to commissioning, particularly important when commissioners had identified concerns around the complexity of the mental health service system they were trying to commission for. This individual below was from a provider Trust responsible for delivering EISs.

'I have focussed on an approach called 'agendarisation.' My own term! Basically I can get EI put on lots of different local and national agendas and try and keep it as a hot topic.' HSCT senior director IV 69 R3

3.4.2 Joint training and educational initiatives

Joint training and educational initiatives appeared to be important in their own right in overcoming the barriers to transition and partnership working, but were also a significant component of the youth focussed service model. They also helped in breaking down barriers between organisations and improving communication and dialogue. Joint training and educational initiatives were easier when EISs were based in a Youth Focussed model of care, as the presence of multiple teams and organisations under one roof enabled access to each other for meetings, advice and training. CAMHS and EIS team members who had participated in joint training and educational initiatives described how their awareness of the priority issues for each

service and understanding the philosophy of care from each other's perspective had helped in breaking down some of these barriers. Some respondents from EISs and Children's services, who tended to be the more experienced individuals, also described how joint learning and training initiatives had helped develop more collaborative working and fostered communication. Contrary to what might be expected from an integrated 'one stop shop' service, the practitioners were not confused about their professional identity and commented that it was possible to maintain some independent team identity within the youth focussed service, whilst also offering a broad and holistic service to the young person.

'I have had colleagues in other services ask how we 'do' EI in this sort of set-up. I think the key thing for me is that not only do we have regular meetings with all of the teams based here; we have our own meetings and supervision too. We have set up some care pathways which can be used if needed to guide people through this service, although we haven't needed them yet. But I think it is the meetings and supervision with your own team that helps you keep a sense of your own identity and what we are supposed to be practising.' EIS team lead IV 38 R3

3.4.3 The facilitator

The value of being supported by a senior individual with experience in EISs or in a senior management role was important to the majority of the EIS team leads when discussing the development of partnerships. EIS team lead IV 20 was from an EIS which appeared to be 'adopted' (according to NPT, Section 2.2.1, page 68, Chapter Three).

'Lack of support has been a major issue. People see our team as 'supported' even though we don't feel that way so a lot more profile and support would help us. And in fact just verbal support from management is useful – it just puts you on the agenda.'

EIS team lead IV 15 R2

The 'facilitator' could either be relatively senior in one of the organisations involved and champion EI or have significant expertise in the area of mental health and EIS development and use this to influence partnership development. This person appeared to facilitate partnership development by enhancing communication between the two partners and the exchange of information and resources, and to help those involved at the interface to negotiate past any difficulties that arose.

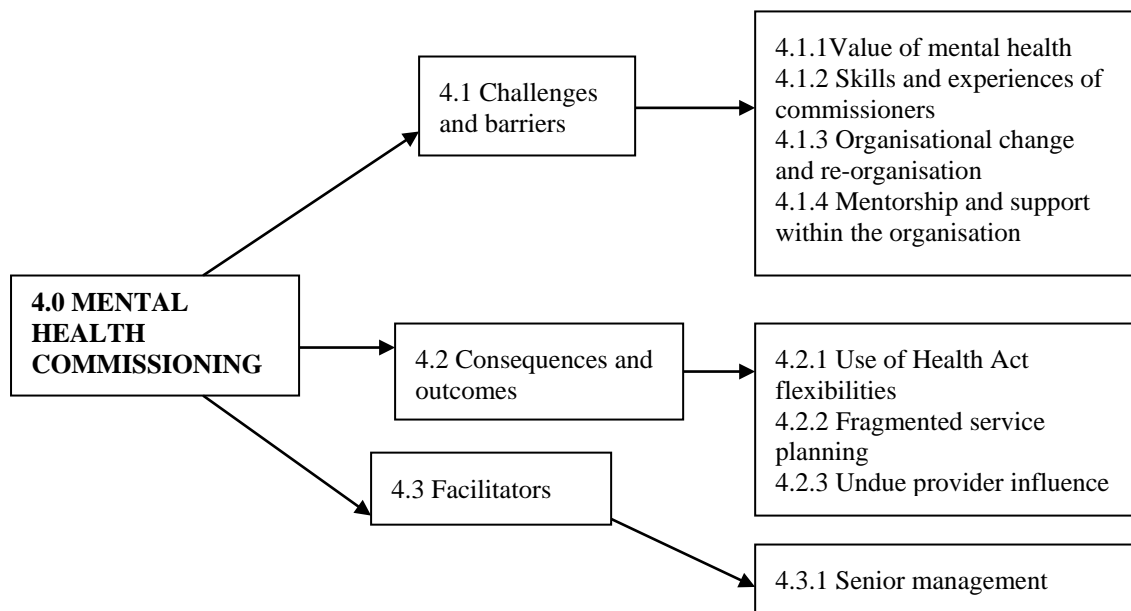
In terms of developing partnership working between CAMHS and EISs, the facilitator used mentoring skills to act as an intermediary between the different levels of organisations and services. The individual did not tend to use their position of seniority or expertise to approach partnership development in a top down or hierarchical fashion but used more of a negotiating or mediating approach and their knowledge of the different services involved. They often had a mental health background and were aware of the different range of services that needed to be involved in a CAMHS-EIS enterprise. Their function appeared to be to steer and coordinate the different individuals involved at the CAMHS-EIS interface into more effective partnership working. Both CAMHS and EIS team leads and team members commented on this role. It was also discussed in the focus groups in which the participants mainly had an operational background (five and six).

*'He's very useful because he's clicked in to all of the services right across the region through his work with *** [Name of organisation removed]. He has also had practical experience himself so he's able to take all of that and be really quite effective in terms of consultancy as we're developing.'* EIS team member FG 6

The role of facilitator, however, did not appear to carry the same authority or influence with non-health services. No interviews or focus groups discussed a facilitator role from the perspective of social care, education or voluntary sector services.

4.0 Theme Two: Mental health commissioning

Figure Four: Mental health commissioning



A number of areas were identified which appeared to impact on the implementation of EISs at the organisational or Trust level. These included perceptions of the value of

mental health as a commissioning priority, the skills and experience of some mental health commissioners, organisational change and restructuring and a perceived lack of mentorship or support in the role of commissioner of mental health services,

4.1 Challenges and barriers

4.1.1 Value of mental health

Three SHA mental health leads and two senior PCT executives described how in their opinion, mental health and mental health commissioning had been less of a priority compared to other health topics in terms of the national health agenda with reduced investment, a perception of being less of a priority compared to acute services and a perceived lack of experience and skills of some mental health commissioners:

'...because, sadly, mental health still is the Cinderella service. If you read anything that comes out of the department it is all aimed at acute services.' SHA mental health lead IV 25 R1

Implementation of mental health policy was compared with other areas of health which had also received national attention and focus such as cancer services.

'I don't think the right approach was adopted with the NSF for mental health in terms of implementation. It might have been developed better if the modus operandi had followed that operated in the cancer field for example.' SHA mental health lead IV 65

R3

4.1.2 Skills and experience of commissioners

Commissioners' and executives' background and previous experience in health and social care services appeared to be an important issue. Only a few of the commissioners interviewed described a structured approach to planning EISs, referring to initial needs assessments within their communities, future evaluation of services and goal setting, use of routine data and consultation with wider stakeholders in service planning.

'I think most commissioners don't actually have a clear idea of you know what they should be doing or how it should be working and commissioning does change from authority to authority or from organisation to organisation.' PCT joint commissioner for AMHS IV 20 R3

Several commissioners did not appear to be following a structured approach to service development, possibly reflecting their lack of experience in this area. The quote below is from a children's service commissioner who worked for a PCT responsible for commissioning EISs. The EIS in this case appeared to have been '*decommissioned*' or '*de-normalized*' according to NPT (Section 2.2.1, page 68, Chapter Three).

'I was lead for developing children's services and was asked to pick up the chair of the local planning group the last March and started doing that from a very poor knowledge and experience base. In fact starting from a knowledge base that was precisely nil so my role has developed and extended into the commissioning part of

children's services...but having said that I've never been involved in any mental health services, and definitely never been involved in mental health commissioning.'

PCT joint commissioner for children's services IV 82 R3

4.1.3 Organisational change and re-organisation.

Several commissioners and executives commented on the impact of NHS reorganisation (previously discussed in Section 3.2.5 of this Chapter). From a commissioning perspective, it appeared to have an impact in several different ways including affecting strategic planning of services, long term development of services through commissioning post job vacancies, the development of contacts, relationships and partnerships to facilitate EIS implementation and the potential recruitment of staff that had less commissioning experience in the area of mental health. The quote below is from a commissioner working in a Trust where the EIS appeared to have been 'adopted' (according to NPT, Section 2.2.1, page 68, Chapter Three).

*There has been some real organisational fragmentation really which has slowed down lots of development and growth in different areas of the NSF, and because I suppose the Local Authority still doesn't have structures which can relate to four different PCTs so really, well we've got a meeting this afternoon-where we are just beginning to look, because I think, like me they've created another post in the ***, they've created another post in South, so the fact that we've got these three in *** makes a big difference because when I started, I was the only joint post.'* PCT joint commissioner for AMHS IV 4 R3

4.1.4 Mentorship and support within the organisation.

Communication within the Trust and the availability of support or mentorship within the Trust seemed particularly important to a number of commissioners. Individuals with a social work or community psychiatric nursing background were generally more aware of the issues in commissioning EISs, than individuals who had management backgrounds or who lacked social work or clinical experience. However, there were some individuals with these backgrounds who felt that they would have benefited from further support and development from within their Trust. The quote below is from a commissioner working in a Trust where the EIS appeared to have been *'adopted'* (according to NPT, Section 2.2.1, page 68, Chapter Three).

'I think from a professional viewpoint it worries me that I don't have a mentor for this new role as it is a responsible position. I have plenty of experience in clinical things, as a provider, albeit none in mental health but I'm actually doing this as a commissioner which is totally different' PCT lead for children's service development

IV 79 R3

Three adult and children's service commissioners discussed their perceived lack of support within their Trust. Lack of support was seen in terms of mentorship and also communication structures within the PCT. Poor quality relationships and communication between individuals within the organisation appeared to have a negative impact on the commissioners' ability to undertake effective service planning and development and increased their perception of a lack of support and isolation.

'I didn't know anything about commissioning really, that's been a real drawback. There is no longer a commissioning directorate within this PCT so I feel the level of expertise has been really fragmented. My role has been a bit isolating I think.' PCT joint commissioner AMHS IV 4 R2

4.2 Consequences and Outcomes

4.2.1 Use of Health Act Flexibilities

It appeared that some commissioners with less experience had greater difficulty in commissioning services, which used *'Health Act flexibilities.'* Previously referred to as Section 31 Health Act flexibilities, they cover lead commissioning, integrated provision and pooled budgets. Joint commissioning aims to develop the capacity of both the Council and PCT in meeting the targets of national performance frameworks for the NHS and local authority. Joint commissioners described a lack of participation in the process of using Health Act flexibilities, with senior colleagues making key decisions, and not communicating these decisions and difficulties around understanding the process of developing services using Health Act flexibilities.

'I started to try and develop the Health Act flexibilities and register our intention to integrate EIS but I have to confess I didn't really get very far. There was never the right information available at the right time.' Joint commissioner for AMHS IV 5 R2

4.2.2 Fragmented service planning

These same commissioners who had been experiencing difficulties using Health Act flexibilities also described problems around the strategic long term approach to commissioning EISs. Their comments reflected those made at the operational level in Section of this Chapter, in terms of partnership working, with commissioners describing difficulties with cross boundary working and developing relationships with other commissioners across the Trust. As a result some EISs were described as being developed in a ‘silo’ or isolated fashion, not integrating with wider mental health services. The quote below is from a commissioner working in a Trust where the EIS appeared to have been ‘*adopted*’ (according to NPT, Section 2.2.1, page 68, Chapter Three).

‘I think that we are working in our functional silo so to speak and we don’t have that level of integration in terms of the forward planning for some of these things which might have been achieved I suppose with more senior direction.’ PCT senior executive for AMHS IV 68 R3

The consequences of less experienced mental health commissioners implementing EIS policy included provider organisations having more influence over the commissioning process, less ability to use ‘tools’ such as Health Act Flexibilities which were introduced to improve collaborative commissioning between health and social care and more fragmented service development.

4.2.3 Undue provider influence

Less experienced joint commissioners, who did not appear to fully understand the

process of EIS commissioning or who had less experience in negotiating the commissioning process, described how rather than them managing the service providers, service providers appeared to have developed an ‘undue influence’ over EIS service development.

‘Her lack of experience in commissioning has meant that the provider has led on some service developments, which isn’t as bad as it could be and sometimes it’s a good thing but when it’s all the time then I think you got a problem really and so a provider has led on the mental health issues.’ PCT Director for AMHS IV 42 R2

4.3 Facilitators

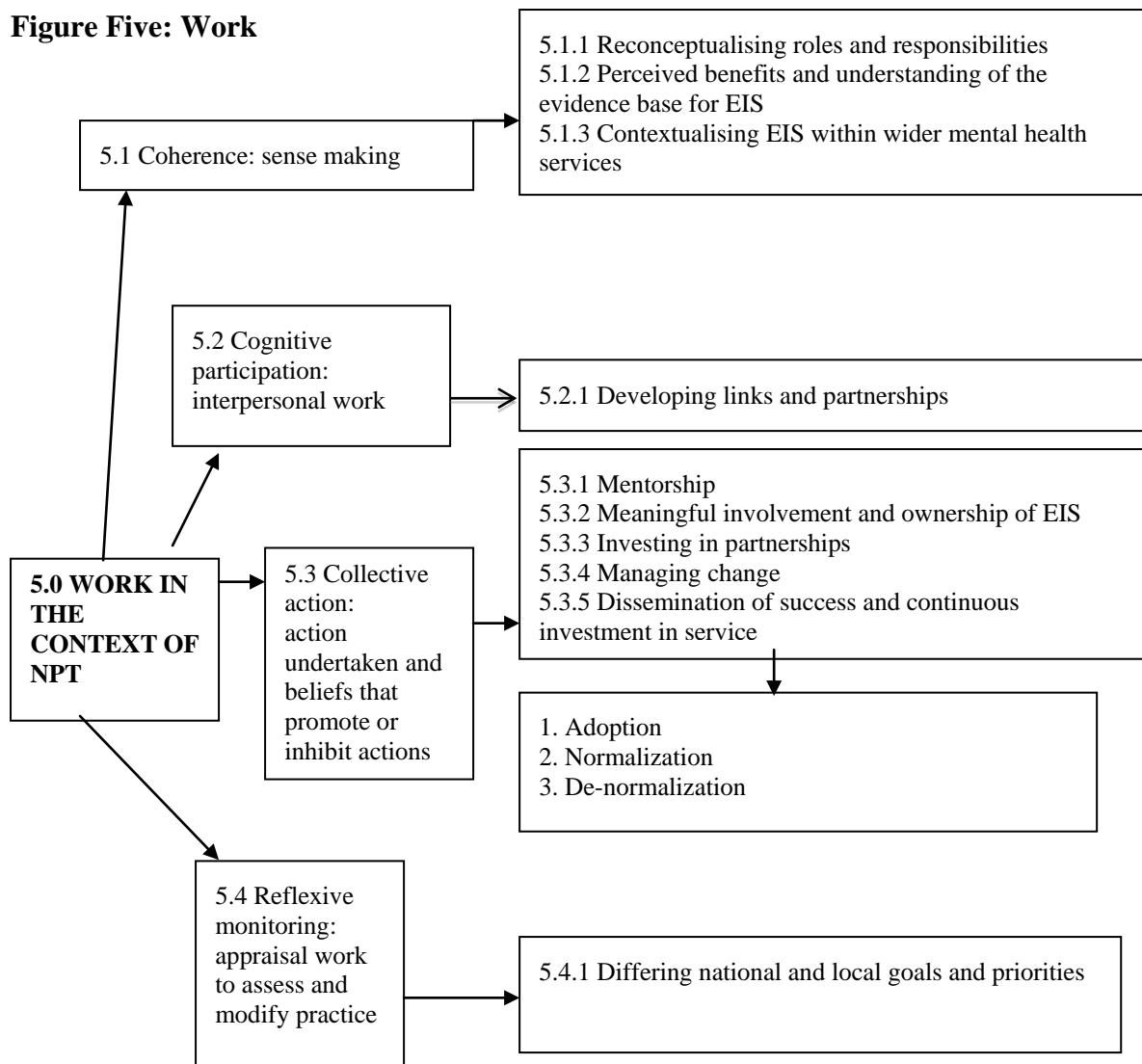
4.3.1 Senior management support

Supportive senior managers focussed on developing their commissioning workforce as a way of improving the quality of commissioning. This included developing the commissioning skills of commissioners, partnership working skills and communication skills (and awareness of these issues). These senior managers referred to the ethos of their organisation in terms of workforce development using phrases such as ‘learning community.’

‘I think we need to pay heed to who we employ as commissioners, that we are getting the best. We need to try and make sure that they are supported and get the same opportunities in terms of development as the rest of the workforce.’ PCT senior executive for AMHS IV 68 R3

5.0 Theme Three: ‘Work’ within the context of Normalization Process Theory.

Figure Five: Work



This was a cross cutting theme across the other two themes and, by virtue of the core concepts which form NPT, provides a snapshot of which issues and themes were relevant in a longitudinal fashion. Coherence, the first domain of NPT, for example examines those issues at the beginning of a service development whilst ‘collective action’ explores those issues involved in maintaining or ongoing service development. The domains of NPT were discussed in Section 2.2.1, page 68, Chapter Three. Care

will be taken not to be repetitive, but by necessity in describing ‘work’, some areas will be discussed briefly a second time.

5.1 Coherence-sense making work

The core subthemes of coherence included the factors promoting or inhibiting initial development of EI and the beliefs and behaviours which define or organise EIS development. Several factors were identified which promoted or inhibited the mobilisation or initial development of EISs including the background, experience, knowledge and beliefs of the mental health commissioners and EIS team leads particularly in understanding new organisational roles and responsibilities within EISs and perceived benefits and understanding of the evidence base for EISs.

5.1.1 Reconceptualising organisational roles and responsibilities.

In policy terms, the notion of EISs for first episodes psychosis has emerged against a background and skill set in which generic secondary care norms and modes of operation dominated the everyday clinical practice of mental health care. There was considerable variation between interviewees in terms of their awareness of the differences between the EISs for FEP and generic mental health services.

‘There is resistance from within our own services [referring to mental health services] in terms of working with us, taking referrals, transferring patients over, that sort of thing. We’re the new kids on the block-an unknown entity!’ EIS team lead IV 1

R1

Several EIS team leads also discussed concerns about new roles and responsibilities arising from the development of the EISs specifically around managing young people aged 14-17 years. EISs varied in the age of the child they would accept, with few services providing services for those under 16 years, despite the suggested age range in *The Mental Health Policy Implementation Guide* (DH, 2001) of 14-35 years. At the other end of the age range, EISs had frequently lowered their cut off point with some services only seeing young people up to 25 years. One EIS team lead suggested that this was because of a lack of resources and funding issues, and another because of what was described as the relative lack of individuals with a diagnosis of FEP in the under 16 and over 25 year age group. EIS team interviewees who identified that their team did not take young people less than 16 years, generally felt that they did not have the correct skills to manage this group.

'We need to develop people with expertise with people of that age, but we are not there yet. The things we need to be up to date with the legal sort of responsibilities that we have and they have got the contacts for probably the younger group, inpatient services should they be required.' EIS team lead IV 15 R3

5.1.2 Perceived benefits and understanding of the evidence base for early intervention services.

How individuals perceived the evidence base for EISs could also positively or negatively affect their working to develop EISs by influencing the time and money individual commissioners were prepared to invest. Four commissioners including an individual working in the local authority, identified that they felt there needed to be a

more robust evidence base for EISs before they invested in the EI model as it was considerably more expensive than other models of care available such as the CMHT, at least in the short term.

'We weren't prepared to put more money into the EIS ... we're not going to money in when the evidence isn't there.' Adult Social Care Lead IV 50 R2

5.1.3 Contextualising early intervention services within mental health services.

One important area of work that EIS workers felt they had to undertake was that of 'justifying' both to themselves and to others about the value of EISs and where it sits within wider the mental health services available.

'I think one issue which few people have considered in all of this specialist team development is what is actually going to happen to the community mental health teams' HSCT development and planning director AMHS IV 37 R2

'I suppose I am reluctant to commission this model-and especially in the long term. What these people who have challenged me are saying is 'Why are you pumping money into a service which at the end of three years we [CMHT] will have to pick these guys up?' PCT joint commissioner for AMHS IV 20 R2

5.2 Cognitive participation

This is the 'relational' or 'interpersonal' work undertaken in implementing EISs and

those factors that might promote or inhibit participation in relational work. EIS team leads and workers described ‘relational’ work as the need to develop links and partnerships with other services and organisations across the community. The theme of partnership working has previously been discussed in detail in Section 3.0, page 134 of this Chapter. From the perspective of ‘work’ and partnerships, there was a great deal of variation in terms of the number of partners that had been developed by different EISs and the quality of those partnerships. Factors influencing relational work included practical work such as the development of protocols but was reliant in some cases on personalities and attitudes of those involved in the partnership. The two quotes below are from the same person at different points in time. In the first quote, the respondent is describing good working relationships with a local CAMHS consultant. However, this working relationship appears personality or individual dependent as the working relationship had broken down by the last round of interviews. The quote below is from an EIS team member working in a Trust where the EIS appeared to have been ‘*normalized*’ (according to NPT, Section 2.2.1, page 68, Chapter Three).

‘*** [name removed] *a consultant in CAMHS is very keen to develop things to the benefit of the service users. She’s not defensive at all in terms of working alongside or developing services with adult services, so we’re able to work together very well.*’

EIS team member IV 59 R3

The relational work of EISs was sometimes facilitated by more senior figures within the provider Trust or commissioning organisation. This senior figure appeared to help with networking and identifying contacts. The quote below is from a commissioner

working in a Trust where the EIS appeared to have been ‘*adopted*’ (according to NPT, Section 2.2.1, page 68, Chapter Three).

‘Our early intervention service is a youth focussed team and they have been working well with youth services and CAMHS in this patch. I think by getting everyone ‘higher up’ on board has really helped link everyone together in a more coherent way of working, and plan and share the development of not just an early intervention or a CAMHS service or whatever on it’s own, but as part of a wider approach with a proper all inclusive service, which is much more useful to the young person I think.’

PCT lead for children’s services development IV 85 R4

5.3 Collective action

These are the actions taken in implementing and developing EISs and those beliefs and behaviours which can promote or inhibit these actions. These included the availability of mentorship, the ability to become involved meaningfully in EIS development, the ability to invest in partnerships, how change was managed within the EISs and the dissemination of successes and learning from collective action.

5.3.1 Mentorship

Two interviewees describe how the role of the facilitator had in their opinion helped EIS establishment and development. The quote below was from a team member of a ‘unique’ EIS (in that it had developed into a new and different model of working compared to The *Mental Health Policy Implementation Guide* (DH, 2001) model that

did not appear to fulfil the criteria for EIS implementation as ‘*normalized*’, ‘*adopted*’ or ‘*de-normalized*’ according to NPT (Section 2.2.1, page 68, Chapter Three).

‘Because of his involvement [at a regional level in EIS development] he is aware of some of the pitfalls, I suppose or the barriers that other services have come across when trying to work with different people and organisations, so I think that the advantage that we have is learning from other services and how they’ve developed and avoiding some of those pitfalls and that’s quite useful pointing them out and helping us to steer around them.’ EIS team member FG 6

5.3.2 Meaningful involvement and ownership of early intervention services

A number of EIS team leads and team members suggested that a greater level of involvement at both an individual and team level had facilitated the implementation and development of EISs. EIS team leads and team members had been involved in different ways including participation in a steering group designed to organise the implementation and development of EISs and involvement in finance and budget management. One EIS team lead described this as a ‘sense of ownership.’ The quote below was from a team lead of a ‘unique’ EIS (in that it had developed into a new and different model of working compared to The *Mental Health Policy Implementation Guide* (DH, 2001) model) that did not appear to fulfil the criteria for EIS implementation as ‘*normalized*’, ‘*adopted*’ or ‘*de-normalized*’ according to NPT (Section 2.2.1, page 68, Chapter Three).

‘I suppose some of it is that xxx [name removed] is involved at a national level which

he brings back to the team and shares so we feel that we are involved and more knowledgeable about EI. I think that has really helped in creating a good team spirit.

More of a sense of ownership I suppose.' EIS team lead IV 91 R4

5.3.3 Investing in partnerships

A number of EIS team leads described the need to continually reinforce and identify contacts and networks they had made or were part of, partly in response to organisational change and also as it appeared that investment in partnerships in an on going fashion helped to ensure EIS were remaining high on more senior individuals' agenda's in planning meetings and other fora. The two quotes here from two EIS team leads (who worked in succession in one EIS) reflect how after the organisational changes, individuals perhaps placed a greater emphasis on network and contact development.

'I've got good links in the area. I've got senior people who were interested in what we are trying to do and I think the director of service planning is also very helpful.' EIS team lead IV 51 R2

'I think because there's been so much change going on it is vital to make sure that you are up to date with your contacts, that you are devoting time to developing your networks so that you are on their [senior management within PCT] radar.' EIS team lead IV 58 R2

5.3.4 Managing organisational change.

One area which interviewees found challenging was maintaining service development, partnership working and other activities in the face of significant organisational change in the NHS in 2006. This appeared to affect continuity of roles, clarity of roles and responsibilities and the priority placed upon mental health within the different organisations.

‘One of the main issues recently has been service reorganisation [has changed from three PCTs to one] and there are a lot of issues including embedding and time to establish selves, changes of personnel which increases difficulties in getting attendees at meetings or even establishing groups or meetings in the first place.’ MHT development lead for AMHS IV 44 R3

5.3.5 Dissemination of success and continuous investment in service.

One of the ways that NPT seeks to explain the process of implementation is to explore work done as ‘continuous investment in time and space.’ Due to the longitudinal nature of this PhD, it was possible to explore the decisions and actions of some individuals in sustaining the development of EISs. These EIS team leads talk about investing time in developing their EISs through observation of other EISs considered ‘successful.’ The quote below was from an EIS team lead where the EIS in this case appeared to have been *‘normalized’*.

*‘I spent some time observing the *** [name of area removed] model – and another service that was very useful for me to observe has been the *** [name of area*

removed] *which – I think it's quite strong on a social care model and partnership working and using the community as a resource.*' EIS team lead IV 51 R2

Another EIS team lead in the next round of interviews also comments on the value of continued investment in developing EISs and suggested that part of the development and implementation process of EISs was the sharing and learning from other 'successful' EIS. The EIS team lead below was from a 'unique' EIS (in that it had developed into a new and different model of working compared to *The Mental Health Policy Implementation Guide* (DH, 2001) model) that did not appear to fulfil the criteria for EIS implementation as '*normalized*', '*adopted*' or '*de-normalized*' according to NPT (Section 2.2.1, page 68, Chapter Three).

'I can play a part in spreading good practice and sharing learning around effective service development. I see part of my role as spreading or disseminating learning to the different teams [EIS] about what works and therefore helping them become established as we have done.' EIS team lead IV 91 R3

5.4 Outcomes

One important concept of NPT is that the outcome of the process of implementation should not be assumed to be normalization. As described in Section 2.2.1, page 68, Chapter Three, normalization is only one possible outcome of collective action. Others include '*adoption*', '*rejection*' and '*de-normalization*.' EIS team leads described what they considered were the various outcomes of their efforts to develop and implement the EIS ranging from one service which had been de-commissioned

(de-normalized), several which had been established but were struggling to embed themselves in the local mental health community (*adopted*) and a smaller number that had been '*normalized*'. No EIS had been rejected. Three EIS described by EIS team leads did not appear to fulfil any of the outcome criteria above, with two EIS team lead describing their service as 'trailblazing' or 'gold-standard'.

*'At the start of this year, we were told that the *** [name of Partnership Trust removed] had to make savings of more than £5 million. Apparently this is because of an overspend in the *** [name of PCT removed] health economy. As a result the team is being decommissioned. I say team, there is only me at the moment.'* EIS team lead IV 52 R2 (*de-normalized*)

'Well I suppose we are in a much better position than last year when we faced decommissioning. We are at least still here! However, I would say that we are still no further forward despite the Recovery Plan. I am still limited in terms of staff recruitment meaning we can only offer a very limited service. I think this leads to problems with team work, morale etc and a total lack of opportunities for training and team development.' EIS team lead IV 1 R3 (*adopted*)

'I think we've pretty much established ourselves here. We work quite well with the majority of other services like CAMHS, Connexions, the CMHTs. Referrals were quite low to start but they've picked up now that people know we're here so that's good. The next stage is to sort out what we do at the end of the three year period.' EIS team member IV 58 R2 (*normalized*)

'We have been called trailblazers in the national press! We are specifically accessible in terms of we are not in an institutional building in the middle of nowhere. We are in the centre of town, easy to find and that I think is a key thing and some clients do come to us here and we offer them the option and there is a shop around the corner that the PCT run as a youth information shop. We work really hard to offer a totally integrated service' EIS team lead IV 13 R3 (*trailblazer*)

5.5 Reflexive monitoring

This refers to the factors involved in either facilitating or inhibiting the appraisal (measuring) of EISs and then subsequent response to this at a personal and operational and organisational level. EISs were formally evaluated according to national standards and targets laid out in the Mental Health Policy Implementation Guide (DH, 2001). However, there were differing views about the value of national goals and targets. At the operational level, many EIS team leads discussed how they considered locally focussed targets more meaningful. As many of the EISs were early in their development at the time of the interviews and focus groups, only limited reflexive monitoring had taken place. The quote below was from a team member of a 'unique' EIS (in that it had developed into a new and different model of working compared to *The Mental Health Policy Implementation Guide* (DH, 2001) model) that did not appear to fulfil the criteria for EIS implementation as '*normalized*', '*adopted*' or '*de-normalized*' according to NPT (Section 2.2.1, page 68, Chapter Three).

'My concern is and always has been that there is limited value in simply measuring throughput, how many people are seen by the service and how many people are

managed by one case worker. I think we need to be looking at standards that reflect our clients' needs like getting back into work or education, independent living etc'

EIS team lead IV 13 R3

At an organisational level, some AMHS commissioners and executives viewed EIS targets differently and often more positively. For them, targets provided a lever to use to argue for resources and to prioritise mental health and EISs:

'I don't see targets as the enemy! Basically having a target in an area makes it happen so no targets means less priority, funding and focus. So for something like early intervention, I think targets are brilliant.' AMHS commissioner IV 46 R2

From the perspective of mental health leads at the SHA level, targets were seen as a tool to guide and enhance service development:

'It is about outcomes. We have two instances where some of the service models [for EIS] people started to think about, just aren't going to give us the right outcomes. I am able to say that's kind of not ok really, you could do better. You could get better outcomes and a better value for money and a better service if you talk to each other. You can do better than that.' SHA mental health lead IV 65 R3

6.0 Conclusion

A total of 147 semi-structured interviews and six focus groups involving 35 participants were held between February 2004 and March 2009. Six focus groups

were carried out with 35 participants from two PCTs, two MHTs, one Partnership Trust and one HSCT. Individuals were invited to participate from different backgrounds within the organisations including individuals with senior executive or managerial content to their role, although all had responsibility for either adult or children's' mental health service development. Three main themes were identified and 11 subthemes. The first main theme identified focussed on the importance of partnership working between EISs and other statutory and non-statutory organisations and how some CAMHS and EISs worked together in partnership resulting in the development of an EIS Youth Focussed service model. The second themes related to issues and challenges which arose when commissioning mental health services. The third theme was the 'work' or the specific actions and behaviours of individuals in implementing EISs from the perspective of NPT.

These different themes will now be discussed in more detail in the next Chapter, which will aim to explore the meaning and validity of these results and how they fit within the current knowledge available on the commissioning and implementation of EISs.

CHAPTER SIX

DISCUSSION

This final chapter aims to draw the different elements of this PhD together and in particular to comment on and explain the results described in chapter five. Firstly the aims and objectives of this PhD will be reexamined and discussed. Secondly, the limitations of this PhD will be considered. Thirdly, a summary of the findings will be presented, followed by discussion, explanation and interpretation of the findings and comparison with published literature. Lastly, recommendations and suggestions for future work in this area will be made.

1.0 The aims and objectives of this PhD

The aim of this PhD was to undertake an evaluation of the factors influencing the commissioning and implementation of EISs for FEP across a number of sites in England from the perspective of micro (service delivery: EIS), meso (Primary Care Trusts) and macro (Strategic Health Authority) levels of the National Health Service (NHS).

This was achieved by firstly undertaking a literature review which summarised, synthesised and critiqued the different bodies of academic knowledge relevant to the implementation of EISs for FEP. The implementation of EISs for FEP was then considered from the perspective of May's NPT (2006). NPT was then used to inform the second part of this PhD, which used longitudinal, qualitative research methods to

explore the implementation of EISs for FEP in England.

Objectives

1. To determine the barriers and facilitators influencing EIS commissioning in the EIS literature and related bodies of academic knowledge.

2. To use NPT to inform data collection and explore those factors influencing EIS commissioning and implementation in a number of health and social care organisations in England in a longitudinal, qualitative study.

1.1 Were the aims and objectives addressed?

1.2 Objective One

The literature review explored the empirical literature on EISs for FEP and the literature and relevant policy documents addressing implementation of EISs. From 270 papers, only 19 were thought to be relevant to the implementation of EISs for FEP. Ten papers addressed the empirical evidence supporting EISs (RCTs and a systematic review), five were cohort studies and four papers specifically addressed the implementation of EISs. The findings from the RCTs and cohort studies were concordant with each other and the findings of the systematic review and concluded that an EIS intervention did not produce significant clinical or patient satisfaction benefits. The OPUS trial and Harris et al.'s study (2008) showed that any initial benefits conferred whilst in receipt of EISs, including some protection against suicide,

were not sustained at two years. Both the RCT and cohort studies appear to agree that there may be a positive downward influence on admission rates, particularly involuntary admission rates for people receiving EISs (Zhang et al. 1994, Craig et al. 2004, Goldberg et al. 2006, Mihalopoulos et al. 2009). The total number of days spent in hospital was not significantly different for people treated in EISs or standard care. However, fewer admissions may represent significant benefits to patients and their families, as it is likely to be less disruptive and enable better continuity of care for patients with their usual mental health care provider. The limited research exploring implementation of EISs for FEP suggested that there were a number of difficulties and challenges associated with commissioning EISs for FEP and that many EISs were not able to develop partnerships easily with social care and education.

In summary, the overall conclusion of the literature review was that there is insufficient empirical evidence to suggest that EISs lead to improved clinical outcomes or satisfaction with care for people with a FEP over standard care. Whilst there is evidence that EISs may offer some protective effect against suicide and improve patient's clinical symptoms whilst people are in receipt of services, this is not a long-term effect, with the benefits of receiving EISs lost once patients are discharged. This has implications on the length of time people are followed up by EISs, which in turn could impact on costs of service delivery and care. The findings of the literature review therefore concurred with Marshall and Lockwood's systematic review (2004) that it may be premature to develop policies supporting the widespread implementation of EISs for people with a FEP based on the current empirical evidence. The findings of the literature review with regards to the implementation of EISs for FEP were also limited and largely based on the work in this PhD. Again the

findings suggest a number of issues and challenges in implementing EISs related to partnership development, poor communication between different services, difficulty working across organisational boundaries and a lack of skills and experience in mental health commissioning.

1.3 Objective Two

NPT was the key theory underpinning this PhD. Chapter three explored the development of NPT from the original NPM developed by Carl May and colleagues. May and colleagues (2007) state that NPT provides a framework to describe how new technologies, ways of acting and ways of working become embedded in everyday practice. Features of NPT, which informed the second part of this PhD included the ‘workability’ of a complex intervention, which was EISs for FEP, and how EISs might be successfully integrated into existing or new configurations of health services and professional practice. NPT also contributed towards the methodology described in chapter four by informing certain aspects of the topic guide which reflected the four key constructs of NPT: coherence, cognitive participation, collective action and reflexive monitoring. NPT also influenced data collection. NPT focusses on ‘context,’ referring to the wider system into which a complex intervention is implemented. The context in this PhD was initially considered reflected traditional commissioning processes, focussing mainly on PCTs and the EIS themselves. However, when considering context from the perspective of NPT, individuals and organisations influencing EIS implementation more widely were considered. One example of this was the theoretical sampling of individuals from CAMHS at a later stage in the data collection. NPT was also used as a framework to support the analysis of the data. By

approaching the analysis through the lens of NPT, emphasis was placed on interpretation of certain aspects of the data, which reflected the theme of the ‘work’ needed to embed and normalize a complex intervention. This wider system approach to collection and analysis of the data contributed to achieving the overall aim of exploring implementation of EISs from micro (service level), meso (Trust or organisational level) and macro (SHA) level perspectives.

2.0 Limitations

This PhD had a number of limitations which are now discussed.

2.1 Single researcher

One limitation of this PhD is that a single individual (EE) carried out all of the interviews and focus groups. This has the potential to introduce bias into the PhD. Bryman (1998) discussed how research quality is heavily dependent on the individual skills of the researcher and rigour is more difficult to maintain, assess, and demonstrate when there is a single person undertaking the research. There are however, also some benefits to only having one person undertake interviews, in that consistency in interviewing technique is achieved more easily and it may be possible to develop greater rapport with interviewees and the development of the ‘relationship’, discussed by Molloy and Woodfield (see Section 8.0, Chapter Four) which can help to reduce attrition in longitudinal studies.

2.2 Background of the researcher and perceived legitimacy

The background of the interviewer might also be considered a limitation. A number of authors have suggested that the background of an interviewer may have an effect on the information divulged (Hoddinott and Pill, 1997; Richards and Emslie, 2000). Richards and Schwartz (2002) suggest this is particularly important if the interviewer is a healthcare professional as there is potential for a 'power imbalance' to develop between the interviewer and interviewees, particularly when interviewees are patients. In addition, information disclosed by interviewees may be modified when the interviewer is known professionally or is a colleague or peer. EE was transparent about her professional background, which may have had some effect on the findings with interviewees perhaps modifying their responses? There were instances when this 'power imbalance' was sensed in some interviews. In particular two new or inexperienced commissioners expressed reluctance to talk about how they perceived GPs managed mental health and would commission specialist mental health services. To address this, EE emphasised her role as a researcher and that the focus of the study did not relate to personal clinical practice or experience and also re-emphasised the anonymity of the interviews.

Symon et al. (2008) suggest that individuals' responses and participation in a study can change depending on the perceived legitimacy of the researcher(s) involved. The concept of perceived legitimacy is discussed by Symon et al. (2008). They suggest how, from the perspective of those participating in the study, a researcher can have a legitimate or illegitimate role. Legitimate roles generally mean that the researcher is from the same background or has experience in the area concerned, so in the case of this PhD that might mean a researcher from an EIS team background or with actual EIS experience. Therefore in this PhD, EE may not have been perceived by a number

of participants as a legitimate person to be undertaking this research. However, Suchman (1995) argues that universities benefit from a certain moral legitimacy (based on practising sound procedures, such as science, and promoting social welfare through education and knowledge), which may have mitigated this effect.

2.3 Lack of service user and family carer involvement

Due to time constraints, it was not possible to interview service users and family carers in this PhD. This means the findings do not reflect all of the stakeholders' views and opinions involved in the implementation of EISs for FEP. Decision making processes about implementation of EISs could have been influenced by service users views and opinions, although at the time of the interviews, no EIS team leads or team members reported service user involvement in discussions around team development and implementation.

2.4 The large number of interviews

This PhD included a large number of interviews in response, partly, to the major NHS reorganisation, which took place from July to October 2006. This, however, created a large volume of data, which made analysis and interpretation very time consuming. It also increased the complexity of the analysis, particularly in the processes of charting and mapping.

2.5 Focus group weaknesses

Kitzinger (1995) discusses the weaknesses of focus group methodology describing how focus groups rely on group interaction; are not naturalistic in that they are 'created' by a researcher; may not always focus on the research topic, particularly if participants 'steer' the discussion; can be dominated by some participants and raise ethical issues about confidentiality and a lack of anonymity for those involved. Dominant respondents can negatively affect the outcome of a focus group and group pressures may influence the comments made by individuals (Wimmer and Dominick, 1997). In focus group two, there was 'over-representation' of some levels of management and seniority and only one individual from a service level background. Therefore membership of this focus group was not equally representative of each of the professions. This may have led to a different focus in terms of the topics discussed within the groups and a bias of opinion expressed.

In addition, the presence of senior organisational executives within three of the focus groups might have had an impact on other participants expressing their own individual views. The issue of power imbalance, discussed as a limitation above in Section 2.1, was perhaps felt most in some of the focus groups involving individuals from different managerial levels and seniority within an organisation. In focus groups two and six it was apparent that some individuals at a service delivery level were reluctant to criticise or talk negatively about their direct line managers or management structures within their organisation. As these were focus groups, anonymity could not be used as a method of mitigating these individuals' concerns around discussing sensitive material. If sensitive material was discussed but focus group participants became uncomfortable, then the topic of discussion was changed and the focus group redirected and a note made in the accompanying field notes to possibly facilitate

further exploration of the issue at an individual level.

2.6 Temporal issues

The retrospective data collection in this PhD may have led to recall bias being introduced into the study. Individuals were being asked to recall events that had in some cases happened up to a year beforehand, especially in the cases of EISs, which were already established, or in the process of being established at the beginning of the study. However, Sabatier (2007) proposed that policy evaluation requires a long timeframe and suggested in some cases this may be at least a decade. In this PhD, the longitudinal approach was valuable in terms of the depth and richness of the data, with 40 people participating in two interviews, seven in three interviews (four EIS team leads and three AMHS commissioners) and three people in all four interviews (all EIS team leads). In addition, themes were also explored from a longitudinal perspective to see how changes evolved over time. A longitudinal approach to data collection was particularly important for the themes of the impact of organisational change (Section 3.2.5, Chapter Five) and partnership working (Sections 3.1.2; 3.1.4; 3.2.1; Chapter Five).

3.0 The findings of this PhD

Three main themes were identified and 11 subthemes. The first main theme identified focussed on the importance of partnership working between EISs and other statutory and non-statutory organisations, and how some CAMHS and EISs worked together in partnership resulting in the development of an EIS Youth Focussed service model.

The second themes related to issues and challenges, which arose when commissioning mental health services. The third theme was the ‘work’ or the specific actions and behaviours of individuals in implementing EISs from the perspective of NPT. Within these themes and subthemes were four novel findings. The first is that effective partnership working and the development of partnerships is vital to the development and implementation of EISs for FEP. The novel aspect of this finding highlighted in this PhD is that an individual in a facilitator role influenced partnership working positively. The second new finding relates to the challenges created by variable quality mental health commissioning in implementing and developing EIS. This was alleviated by the involvement of senior management roles within commissioning organisations who acted in a mentorship capacity. The third novel finding is the ‘work’ (related to the domains of NPT), which positively influenced implementation and normalization of EISs. The fourth new finding is that NPT does not account for the development of services that went beyond normalization and were described as ‘trailblazer’ or ‘gold-standard’ services.

3.1 Partnership working

The first finding was the importance of developing effective partnership working between EISs and other statutory and non-statutory organisations for EISs to be implemented successfully. This PhD found variable levels of partnership working with the different groups of stakeholders. EISs appeared to be able to develop more successful partnerships with third sector organisations and CAMHS, compared to social care and education. Factors found to impact negatively on partnership working included a lack of financial and time resources, different ways of working historically,

different services having different philosophies and destabilisation related to major organisational change.

3.2 Literature exploring EIS and partnership working with wider health and voluntary organisations

There is very limited literature, which specifically explores EIS partnership working with wider health and non-health services. Two studies were found that discussed EIS and partnership working with other health organisations and the voluntary or third sector. No studies have explored EIS partnership working with social care services. Lester et al. (2008) explored the partnerships made by 12 English EISs with voluntary service sector organisations. They commented that most partnerships were ‘ad hoc’ and informal in nature although four formal partnerships between EISs and voluntary and community sector organisations had been established. Lester et al. (2008) comment that more successful partnerships appeared to be based on shared agendas, the ability to refer clients onto an organisation that could provide a service they could not, and shared training. In this PhD, EIS team leads considered that they shared closer agendas and priorities with some of the third sector or voluntary organisations, and so were able to develop more successful relationships than with local authority organisations such as social care and education. This may have been due to perceived similarities with the third sector youth focussed ‘philosophy’ and way of working. Aldridge (2005) commented that the characteristics and approach of the voluntary sector make it an ideal partner for mental health services, being ‘mission-driven’ rather than ‘profit-driven,’ enabling a user-focussed approach to meeting service users’ needs.

3.3 Partnership working with social care

Partnership formation with social care services and education appeared to be particularly difficult. Partnership working across the health and social care boundaries has been a particularly important theme in a number of recent Government publications (DH, 2004; DH, 2005; DH, 2007a; NMHDU, 2009). In this PhD a number of issues arose at the social care and EIS interface. Interviewees from a social care background generally had less knowledge about EI and tended to view partnerships through a more traditional lens. They described their 'more natural' or 'more traditional' partners as education and other local authority services. This appeared to be because their funds and management structures arose from the same source-the local authority.

3.4 Partnership working, resources and organisational change

A lack of resources, were also identified by Lester et al. (2008) as impacting on partnership development as a number of respondents in their study suggested that EISs were a specialist service and potentially therefore receiving an unfair share of resources and staff, compared to established CMHTs. At the same time as implementation of EIS policy in England in 2006, PCTs and SHAs were undergoing significant reorganisation. This reorganisation may have impacted on partnership development through a lack of continuity of funding and service development, with some mental health commissioner posts becoming vacant and people in other management posts being moved to different Trusts or dispensed with altogether. Changes to PCT and other Trust and organisation leadership and management

structures could also have affected relationships and previously formed partnerships as further time and effort would need to be invested in developing these again after organisational and role changes. Glenndining et al. (2002) suggested that organisational change could create a leadership vacuum and management instability, which can then negatively impact on partnership working.

3.5 Partnership working and the role of the facilitator

A more positive influence on partnership working, and a novel finding of this PhD, was the role of a facilitator who acted variously as an intermediary or link between EISs and those organisations and groups with whom they were experiencing challenges in developing partnership working. In addition, EIS team leads described how valuable joint training initiatives could be on partnership development and the influence and support of senior management within their Trust. These findings were presented in two papers published by EE in 2009 (England and Lester, 2009; Lester et al., 2009).

There is limited literature that explores the implementation of complex interventions into mental health services. Barry (2007) summarised the evidence and research available to support community mental health promotion interventions. She identified that these programmes are generally complex interventions and advocated an inclusive approach to developing and implementing an intervention, meaning that all the stakeholders were involved from the conception of a project through to its maintenance and evaluation. Barry (2007) suggested that this process was enhanced by active engagement of all stakeholders through a project manager, joint steering

group and structured planning model. In addition, project champions were identified who facilitated cross boundary working. Stevens and Sin (2005) also commented on the benefits of multidisciplinary input, through active information sharing and consultation with all stakeholders as a programme was implemented and progressed. They evaluated the implementation of a self-management relapse prevention model for psychosis and demonstrated that a multidisciplinary approach to their programme implementation resulted in enhanced communication and was key to embedding their programme within normal working practices.

In the literature exploring implementation of complex interventions into mental health care or similar complex environments, there is very little written about the role of the facilitator, which is a key finding in this PhD. Important features of this role included a degree of seniority, gained through knowledge or experience from an academic, managerial or clinical position. This was demonstrated by the various job titles held by individuals considered as facilitators: chief executive of a MHT; GP with an interest in EI; advisor for mental health in the **** region and regional development centre programme lead for NIMHE and the Care Services Improvement Partnership; consultant clinical psychologist; consultant psychiatrist and EIS team lead. The role of the facilitator was to enable the exchange of information between different individuals and groups, particularly when communication had been shown to be difficult. The facilitator was also a collaborative role encouraging negotiation and discussion around difficult areas including financial problems, which often involved discussions across different levels of the health service including operational, PCT and Trust levels and the SHA level. In addition it could also be a co-coordinating role, enabling service development through bringing together those individuals or groups

needed for the process. Importantly, the facilitator's role was always informal or indirect and not formally associated with the development and implementation of EISs. They usually became involved because of their association with EIS development through their general expertise or involvement in mental health service development at a national level or other work such as policy or EI research. Facilitators appeared to offer a consultancy or mentorship role rather than direct leadership. This individual appeared to be able to enhance service development at different organisational levels within the NHS, but was also able to encourage a wider range of interactions with non-statutory organisations and voluntary services through their range of contacts and knowledge of service development.

There are some similarities between the role of facilitator and that of the 'champion' described in a study by Myers et al. (2010) exploring the implementation of a mental health service telepsychiatry innovation. However, unlike in this PhD, Myer's champion role was important in terms of being representative of the stakeholders involved and passionate about service development, rather than in facilitating the formation of partnerships and collaborative working. Gold and colleagues (2006) explored barriers to the translation of evidence based psychological treatments into routine mental health practice. They identified that opinion leaders can influence plans and programme development and help solve problems arising as policy is developed and implemented. These are additional functions fulfilled by the role of the facilitator in this PhD.

Whilst the role of the facilitator was positive in this PhD, Lester et al. (2004, p. 288) caution that whilst new services are often championed by 'hero innovators' (an allied

but different role), these individuals are likely to move on and ‘seek fresh challenges once a new scheme is up and running’. Therefore to be truly sustainable, new approaches to partnership working cannot depend on single individuals but need to be embedded in the fabric of the service. The role of the facilitator in developing EISs and other team members’ commitment to partnership working involved enhancing communication on both sides of the interface and a mutual understanding and respect for different ways of working and approaches to care. These features were supported by inter-professional education, which enabled practitioners to learn about each setting’s strengths and weaknesses and helped encourage a culture of collaboration and mutual respect.

3.6 Partnership working and senior managerial or organisational support

Some EIS team leads and team members described the value and benefit of senior management involvement in implementing EISs. This was also demonstrated by Kaner et al. (2003), who evaluated the implementation of a new model of service delivery and organisation in mental health care. Their findings concluded that in the implementation of a new service within this context, senior management involvement was vital. Implementation was enhanced when they used a consultative approach to implementation, rather than imposing changes ‘from the top’. They also concluded that all stakeholders needed to be involved in the process of implementation.

Other EIS team leads and members in this PhD felt that the involvement of senior managers could sometimes mean that guidelines and templates were more rigidly adhered to and there was less flexibility in how they could develop the service

relevant to local needs and priorities. Tensions in how a complex intervention should be implemented also arose in a study by England and Lester (2007) evaluating the implementation of Primary Care Mental Health Workers (PCMHWs) into primary care in England. Managers in this study tended to impose a top-down model of implementation, and PCMHWs, who were trying to develop the role, tended towards a 'bottom-up' approach. Clearer communication between the PCMHWs and a senior individual responsible for their role and implementation, and protected time to discuss issues, increased satisfaction with the role and facilitated implementation.

3.7 Bridging the divide

In this PhD, some services had attempted to bridge the 'divide' between EI and CAMHS in particularly innovative ways. Some EISs had considered developing or were in the process of developing the role of a specific CAMHS-EIS link worker. This individual acted variously as a case manager for transitioning patients and a liaison between CAMHS and adult EISs. This role was developed and funded by adult services in all but one case. EISs with this worker had usually developed protocols with CAMHS to support the worker's role and better clarify individual and service responsibilities. At the time of the last interviews, only four EISs had a specific link worker, of which only one person was 100 percent devoted to that role. The other three also had additional caseloads and duties within the team.

The most complex method of reducing the EIS-CAMHS divide required innovative thinking and considerable commitment of resources, time and energy. This was the development of a type of service which was neither CAMHS, adult or EIS but

included elements from all these teams: the form of a Youth Focussed service model. A wide range of age appropriate services were gathered in one place which facilitated access and enhanced continuity of care for patients. In addition, the presence of multiple teams and organisations under one roof was beneficial for staff, enabling access to each other for meetings, advice and training.

There is some evidence in both the generic mental health literature and the EIS literature supporting the development of an integrated Youth Focussed service model. Telfair and colleagues (2004) considered that systematic transition pathways were needed and that this might be brought about by the development of an integrated national planning framework for young people in this age range. Boeing et al. (2007) have previously identified that the low prevalence, complexity of needs and multiple stakeholders involved support recommendations for a national planning framework which integrates primary care, secondary care, mental health services, social work, education and the voluntary sector and specifically focusses on the needs of young people in the 14-25 year age group.

McGorry et al. (2007: s5) suggested that 'Early intervention in youth mental health is a best buy' commenting that greater investment is required in mental health care. They argued that the integrated youth focussed approach to adolescent (aged 12-25 years) health service development would 'provide... access to integrated mental health, substance use, and vocational recovery supports and services.' They suggested that this model of care, based on work by Patel et al. (2007) might also reduce prevalence, cost and morbidity by preventing progression of illness and minimise the 'collateral damage to social, educational, and vocational functioning.' (p. 2) However,

both Edwards et al. (2005) and Arcelus et al. (2008) suggest that this is unlikely to happen in today's health economic climate.

However this radical approach could be somewhat mitigated by approaching service development and implementation using an integrated, multi-disciplinary approach to service development (Quam and Smith, 2005; Ham et al. 2009). Patel et al. (2007) recognised the difficulties in implementing such care pathways in the current challenging international health economic climate, and suggested that a realistic way forward was the integration of adolescent mental health services into general youth and welfare programmes such as education and sexual health establishments. They argued that this inter-sectorial approach benefits not just youth mental health and mental health services but has a far reaching effect on other health and non-health services which could be integrated into the single service model including justice services, vocational services and a wide range of other potential partners.

4.0 Mental health commissioning

The second theme related to implementation of EISs and qualities of mental health commissioning. A number of areas were identified which appeared to impact negatively on the implementation of EISs at the organisational or Trust level. These included perceptions of the value of mental health as a commissioning priority, the skills and experience of some mental health commissioners, organisational change and restructuring and a perceived lack of mentorship or support in the role of commissioner of mental health services.

4.1 The value of mental health commissioning

In this PhD, a number of senior executives commented on a perceived lack of priority being given to mental health commissioning at a national level compared to acute health service commissioning. Only one paper was found in the literature, which commented on the perceived value of the role of mental health commissioning. Lester et al. (2009) used a multiple-case study approach involving staff, users, carers and commissioners of 14 EISs to evaluate the development, implementation and impact of existing and newly formed EISs in England. In Lester et al.'s study, however, PCT commissioners rather than senior figures within Trusts, as in this PhD, described problems in commissioning because they felt the PCT placed a low priority on mental health. They described an unexpected feeling of stigma attached to their own role that they felt reduced their potential to develop intra- and inter-organisational relationships.

4.2 Organisational support

Several PCT commissioners in this PhD also reported feeling that their commissioning work was not being properly supported by their organisation. Specific areas identified included difficulties in using Health Act Flexibilities due to organisational financial pressures, lack of senior input and support and an unequal contribution to service planning and development from social care and the local authority. As a result of these issues, a small number of commissioners discussed how EISs in some places were being developed as 'silo's', which meant they were not integrated into wider mental health services. As a consequence of this perceived lack

of support, several commissioners described their lack of experience in commissioning with a subsequent impact on the final model of care developed, which was heavily influenced by the provider organisation. In addition to a perceived lack of support at an organisational level, several PCT commissioners and individuals responsible for developing EISs within the Trust also described how they felt that the role of the SHA was not supportive and that they had identified that a barrier for them in developing effective EISs was lack of senior or strategic support.

These issues have been discussed in previous literature in this area. Dowling et al. (2004) described how PCT commissioners lacking the essential skills to commission effectively resulted in unbalanced partnerships and consequently the PCT (the commissioner), had less 'leverage' over NHS providers. This potentially influenced service level agreement areas such as outcome monitoring, target setting and team specification.

Willcocks (2003) explored the development of commissioning in newly formed PCTs and found that relationships with the SHA were sometimes problematic, characterised by communication problems, a lack of information sharing and cultural differences related to power structures and hierarchies within the different organisations. Pickup (2004) discussed a local case study reviewing the progress in joint working in adult mental health services in a single county in England. She identified that there were concerns around the focus of the SHA on acute sector performance management and performance indicators and partnership arrangements related to this; to the detriment of mental health. This focus on acute sector performance management meant less priority was placed on supporting mental health commissioning development within

the PCT. Fletcher et al. (2008) explored the implementation of PCMHs in one SHA and found that a key aspect of successful implementation was keeping the momentum of the initiative going in the SHA in particular.

4.3 Commissioners experience

It became apparent during the interviews that there were a significant number of less experienced commissioners, which resulted in several barriers to successful implementation of EISs. These included a lack of strategic and longer term planning of EISs, confusion around lines of accountability, and a lack of clarity regarding individual roles and responsibilities. There is evidence in the literature of a historical lack of focus on the development of commissioning within the NHS. Wade et al. (2006) undertook a literature review of health service commissioning, public sector governance and the development of commissioning and concluded that ‘NHS commissioning has been a largely under-developed function to date... there is a need for PCTs to develop commissioning capacity and capability as an immediate priority.’ (p. 1)

In the context of EIS development and implementation, much of the literature appears to have focussed on the potential for longer term benefits to mental health, a reduction in the other consequences of FEP including unemployment, impoverished social networks and loss of self esteem and the medium to long term effectiveness of EISs in helping to reduce costs and demands on mental health services. This longer term strategic perspective may not sit well with the more short term commissioning strategies described in this PhD which have tended to focus on more immediate

results, rather than the commissioning of strategic EISs that deliver savings and high quality services and care in the long term (DH, 2009).

4.4 Workforce development and leadership

Gold et al. (2006) suggest that leadership from the top with a more 'hands-on' role for chief executives and senior organisational support is important. In addition leadership development is needed within the organisation to involve local partners in developing strategic commissioning. Smith and Goodwin (2006) identified that there is an urgent need to develop the skills and competencies of commissioning staff. However, having identified this, they go on to point out that there are few formal training opportunities available for commissioners. One recent study explored the support needs of health and social care commissioners seeking to develop world class commissioning competencies and the role of service improvement agencies in meeting these needs (Cornes et al., 2009). They found that there was a lack of 'employer-led' or Trust-led training opportunities. They concluded that achieving 'world class commissioning' may depend on a more fundamental rethink of commissioning organisations' approaches to learning and development.

This PhD reflects Cornes et al.'s findings in that some organisations had started to develop these competencies with some commissioners and managers being more positive about the implementation and commissioning of EISs. National policy directing EIS planning and development was seen as a positive thing, as several commissioners felt it would help to 'drive through' implementation of EISs more effectively and raise the profile of EISs on the national priority planning agenda.

There were a number of actions and behaviours that contributed to more successful implementation of EISs. One area that was recognised by managers and commissioners from all levels was the need for greater workforce development at the managerial level to improve and develop commissioners' and managers' skills in commissioning and developing services in general and the value of senior support in this process. Those Trusts who focussed on workforce development and developing commissioners through senior support seemed to find the process of implementation more straightforward.

4.5 Organisational change

Several commissioners identified organisational change as having a negative impact on their commissioning ability. Commissioners described difficulty in rebuilding contacts and often being thrust into new roles with little prior training or experience. Glendinning (2002) identified the impact that structural reorganisation of the health service can have on commissioning and described the positive and negative aspects of reorganisation. Structural reorganisation resulting in more integrated organisations can transform preoccupations over narrow sectorial responsibilities and boundaries to a 'whole systems' paradigm of service planning and delivery. However, major internal barriers such as professional domains and identities, and differential power relationships between newly integrated services and professionals, means integration may not be achieved, a situation more commonly found in this PhD.

5.0 Work as defined by 'NPT' and the conditions needed to 'normalize' early intervention services for first episode psychosis

The third theme in this PhD was the ‘work’ needed to implement EISs as defined by NPT. The two novel aspects of this theme are that this is the first time NPT has been used to evaluate the commissioning and implementation of EISs and secondly that the finding of the ‘trailblazer’ or ‘gold-standard’ service is not accounted for within the outcomes of NPT (Section 2.2, Chapter Three).

NPT has four constructs: coherence, cognitive participation, collective action and reflexive monitoring (discussed in Section 2.2, Chapter Three). Particular attention in this section is given to coherence, cognitive participation, collective action.

5.1 How do the findings of this PhD compare with other work in the area of NPT and Coherence?

The coherence work in implementing EIS focussed on reconceptualising roles and responsibilities and understanding EIS’ position within current mental health services and the evidence base. At the time of writing up this PhD, the majority of the work focussing on NPT has been theoretical and involved with refining theory. One study by Gask and colleagues (2008) explored the implementation of clinical governance in the context of mental health care in primary care, and how quality improvement initiatives which clinical governance includes, were embedded in practice. Their findings included little shared knowledge or understanding of roles and responsibilities in improving the quality of mental health care within the PCTs and practice. Gask et al. (2008) identified that identity, personnel and strategic direction impeded implementation of clinical governance processes. Mair et al. (2008) used NPT to explore a range of health professionals’ attitudes towards e-Health systems

and to identify, describe and understand those factors that promoted or inhibited the use of e-Health systems and other computerised tools across different health care professional groups and sectors. They found that clarity of tasks, roles and responsibilities influenced successful implementation. Professional attitudes to the implementation and integration of e-Health systems related to perceptions of the effectiveness of the technology and how clinicians perceived their 'new role' when the technology was introduced.

Finch et al. (2007) explored how the evidence base, or lack of, can influence implementation of teledermatology services into primary care. They identified that successful implementation was enhanced by stakeholders' perceptions of the benefits of the new service and a willingness to rely on utility and function of the service rather than purely the evidence base. These findings resonate with the findings in this PhD in that certain commissioners were reluctant to become actively engaged and committed to implementing EISs as they were unsure of the evidence base for EISs. Other individuals, particularly in CAMHS, were uncertain of their role and responsibilities within the context of new EIS and how they should engage with and participate in the development of EISs, as there was no clear direction for their 'new' roles and responsibilities.

5.2 How do the findings of this PhD compare with other work in the area of NPT and Cognitive Participation?

In this PhD, the findings of necessary cognitive participation work or relational work largely focussed on the development of partnerships and links, which could be

influenced positively or negatively by the ‘personalities’ of individuals involved and the involvement of senior organisational figures. Implementation and fulfillment of the domain of cognitive participation largely rested on whether senior management within the PCTs and SHAs were engaged in the development of EISs. Finch et al. (2007) identified that ‘acceptance’ of the complex intervention on the part of professionals and managers and administrators was a key part of successfully implementing their new teledermatology service. In their study, the more senior the manager involved, the greater the resources that followed, which facilitated implementation. They also identified that the more senior a manager involved, the greater the degree of flexibility in terms of service development and implementation. In this PhD, where senior organisational managers became involved, this flexibility was seen in a number of EISs with development of new roles such as the EIS-CAMHS link worker and the development of the new service model, the Youth Focussed EIS. Senior managers facilitated this by focussing resources in the direction of EIS, encouraging more innovative working and providing leadership and strategic direction. Barry (2007) suggested that this can be developed further by a focus on aligning policy leadership with policy implementation and pointed out that leadership should be local and not at the macro-level to enable informed agreements about local roles and responsibilities in commissioning, development and implementation of EISs. Barry (2007) also suggested that local leadership which spans health and social care, and is aligned with more national policy ambitions, can help focus the direction of travel of service implementation, enhance relationships and develop mechanisms for joining health and social care agencies together. She suggested that this style of leadership could result in an increased perception of ownership of service development and implementation on the part of stakeholders and reduce other

uncertainties about tasks, roles and responsibilities that disrupt implementation (Barry, 2007).

5.3 How do the findings of this PhD compare with other work in the area of NPT and Collective Action?

The findings of this PhD identified that for normalization to take place, the conditions which needed to be fulfilled included the availability of mentorship to commissioners from senior colleagues and effective management of change within the organisations.

5.3.1 Mentorship

The concept of mentorship to commissioners is not yet found in the NPT implementation literature. Finch et al. (2007; p. 526) identified that ‘cross-sector and professional support’ for the implementation and normalization of their initiative was crucial. May and Finch (2009) discussed collective action as ‘enactment’ of a practice and considered that it was dependent on the local working environment and conditions of those involved, and the conditions or factors that organised these working conditions. The organising conditions included material and symbolic resources available, which might have included financial resources or resources based on the skills, knowledge and support of a senior individual. Therefore in this PhD, mentoring by senior organisational figures could be seen as a necessary resource or condition required for implementation to take place.

5.3.2 Management of change

Another area which significantly influenced the ‘normalization’ or implementation of EISs was that of organisational change. Gask et al. (2008) identified that the persistent instability of organisational structures, identity, personnel and strategic direction impeded the contextual integration of clinical governance. It also led to a disconnection between the formal managerial ‘commissioning’ view and the actual work going into developing the service. This ‘disconnection’ was also apparent in this PhD between management and service providers. There was, however, a more profound problem in that many of the managerial posts and commissioning positions were actually vacant. This meant that EISs and other services were not only disconnected from the managerial level but also completely detached, in some cases, in terms of any relationship between service provider organisation and commissioning organisation. This was often a negative situation for them to be in, as rather than have ‘free reign’ on how they developed and perhaps less stringent monitoring of contracts, they often described themselves as having little or no organisational support, few resources and less priority on organisations’ agendas. These EISs often found implementation more challenging. May and Finch (2009) identified that in their study, participants emphasised the role of ‘champions’ in managing organisational change, but also commented that this could focus attention on individual leadership, which could result in a lack of shared organisational vision and encouraged different groups of professionals to see each other as barriers not facilitators of change.

5.3.3 Outcomes of Collective Action

May et al. (2007) stated that ‘Normalization is only one possible outcome of collective action.’ (p. 3) In this PhD, of the 15 EISs evaluated, one EIS had been de-

commissioned (de-normalized), seven had been established but were struggling to embed themselves in the local mental health community (adopted), four had been 'normalized' and three did not meet any of the outcome criteria of NPT. No EISs had been rejected. [It was not possible for those responsible to reject an EIS as their implementation in a set format was mandated in The *Mental Health Policy Implementation Guide* (DH, 2001) and national policy including the *National Service Framework for Mental Health* (DH, 1999).]

The other outcomes of adoption and normalization are well described by May et al. (2007) and other authors who have used NPT to analyse implementation of a complex intervention (May et al. 2003; Gask et al., 2008; May et al., 2009). However, there were three EISs described by EIS team leads that did not appear to fulfil any of the outcome criteria above, with EIS team leads describing their service as 'trailblazing' or 'gold-standard.'

6.0 Implications for future research

6.1 Expanding methodologies

Mair et al. (2008) explored the embedding of a home telecare system for chronic respiratory disease using the qualitative methodology of semi-structured interviews. They concluded that ethnographic research could have added additional useful insights into the 'workability' of the telecare system. They suggested that future process evaluations of complex interventions should use a range of robust methodologies to ensure that a complete picture of processes defined by the NPT can

be addressed.

Mair et al. (2008) also discussed how NPT was focussed on ‘workability in practice,’ meaning the way people perceived whether something might or might not work in practice. They identified that over a period of time this workability can change depending on different circumstances. They therefore suggested that evaluators and implementers should use NPT in an iterative way, with preliminary work serving to sensitise implementers to potential problems and to increase their awareness of difficulties in other areas that might arise following the real-life use of a system over time. This suggests that NPT is best used in an iterative longitudinal fashion and potential future research should consider and incorporate this into the research design.

One potential way of using NPT in a more iterative fashion, would be to place greater emphasis on the NPT construct ‘reflexive monitoring.’ This is the appraisal work that people do to assess and understand the ways that a new set of practices affects them and others around them, and involves the work of collecting a variety of experiential and systematised information relevant to the implementation of the complex intervention. The second step in reflexive monitoring involves appraising this information and the effects it might have on individuals and the team, then using this information to redefine procedures, modify practices or to change the shape of a new complex intervention itself. This domain was only partially explored in this PhD due to time limitations and future research might focus on this area to further inform the development of EISs.

6.2 Developing the evidence base for early intervention services for first episode

psychosis further

A key problem for proponents of EISs for FEP has been the evidence base on which it is founded. Systematic reviews and the empirical evidence base have all highlighted the poor quality evidence. In the case of EISs, the conditions that lead to normalization of EISs are not well understood and future work could focus on exploring and evaluating those health organisations and EISs that were most successful in terms of becoming embedded in the wider mental health system.

6.3 Evaluation of the gold standard or trailblazer EIS

In principle, EISs for FEP met the conditions required for NPT, but the data in this PhD suggest that there is an area of implementation and normalization not addressed by NPT. NPT does not allow for those services, which went beyond ‘normalization’ and developed into ‘trailblazer’ or ‘gold standard’ services. Therefore it is difficult to evaluate the development and implementation of such services using NPT in its current form, and further work could usefully focus on extending and developing NPT to include and evaluate these types of services. In addition there is scope to explore the sustainability of the different models of EIS by developing and extending NPT.

6.4 Evidence and outcomes

There is a need for more evidence that evaluates the ‘trailblazer’ or ‘gold standard’ model of EIS in comparison with other more established models to compare cost

effectiveness, and most importantly whether this approach improves outcomes for young people with FEP.

6.5 Service user and family member involvement

One of the most important areas for further research is to explore the views and experiences of those young people who have been supported by these different EIS models. Both McGorry et al. (2008) and Lester et al. (2009) describe the ‘next steps’ for EISs as most importantly focussing on public health initiatives and the development of service models that best meet the needs of people with FEP.

6.6 The role of the facilitator and leadership

Participants emphasised the role of champions or facilitators in implementing EISs but this role is not well defined and currently poorly understood. There is little in the literature which explores the requirements of individuals to fulfil this role and whether different characteristics of the facilitator influence different models of EIS development. Future research could focus on further defining the qualities and characteristics of the individuals who fulfilled the role of facilitator, and exploring and describing in more detail the context and circumstances in which they arose and appeared to benefit EIS development and implementation most.

7.0 Conclusion

This PhD adds to the relatively small amount of information and evidence available on the implementation of EISs for FEP and has highlighted key barriers and facilitators to the implementation of EISs for FEP within existing patterns of mental health care services in England. Using a ‘whole system’ approach based on NPT, the four novel findings of this PhD suggest that variable implementation of EISs for FEP may be due to a number of factors at the service (micro), organisational (meso) and strategic (macro) level. These are related to the importance of partnership working in the implementation of EISs which was enhanced by the role of a facilitator, challenges associated with mental health commissioning and the skills and experience of mental health commissioners, the ‘work’ needed to implement EISs and the development of a new EIS model, described by participants in this PhD as ‘gold standard’ or a ‘trailblazer.’

The first finding was the importance of developing effective partnership working between EISs and other statutory and non-statutory organisations for EISs to be implemented successfully. There were variable levels of partnership working with the different groups of stakeholders involved. EISs appeared to be able to develop more successful partnerships with third sector organisations and CAMHS, compared to social care and education. Factors found to impact negatively on partnership working included a lack of financial and time resources, different ways of working historically, different services having different philosophies and destabilisation related to major organisational change. These impacted on communication and integrated working practices, difficulties in translating national policy in local settings and challenges in defining roles, tasks and responsibilities. Stakeholders also described ambiguous policy directives, particularly at the interface with Child and Adult Mental Health

Policy, which contributed to the lack of clarity around roles and reduced opportunities for collaborative integrated working in some cases.

A more positive influence on partnership working, and a novel finding of this PhD, was the role of a facilitator who acted variously as an intermediary or link between EISs and those organisations and groups with whom they were experiencing challenges in developing partnership working. In addition, EIS team leads described how valuable joint training initiatives could be on partnership development and the influence and support of senior management within their Trust. Future research might usefully involve exploring and defining the characteristics, qualities and contexts in which certain roles such as the mentoring role of senior managers and the role of the facilitator arose, which would contribute to facilitating implementation of EIS and partnership working.

The second novel finding was the variable perceived value of mental health commissioning and skill set of commissioners. A number of senior executives commented on a perceived lack of priority being given to mental health commissioning at a national level compared to acute health service commissioning. Several commissioners also reported feeling unsupported in their role by their Trust and the SHA, which impacted on their ability to implement and develop EIS effectively.

The third new finding was the ‘work’ needed to implement EIS as defined by NPT. The four constructs of NPT were variably addressed and fulfilled: coherence, cognitive participation, collective action and reflexive monitoring. Variable fulfilment

of these constructs led to one EIS which being de-commissioned (de-normalized), seven which were established but were struggling to embed themselves in the local mental health community (adopted), four which were '*normalized*' and three did not meet any of the outcome criteria of NPT.

Coherence work in implementing EISs focussed on reconceptualising roles and responsibilities and understanding EISs position within current mental health services and the evidence base. Cognitive participation work largely focussed on the development of partnerships and links. In describing the work undertaken for fulfilling collective action, the availability of mentorship to commissioners from senior colleagues and effective management of change within the organisations was important. It has been suggested that future research could concentrate in defining the roles of mentor and facilitator in more detail. However, further empirical research into EISs clinical efficacy and benefits to patients would contribute to fulfilling the NPT construct coherence as a key problem for proponents of EISs for FEP has been the evidence base on which it is founded, which directly influences the work needed to understand EISs position within current mental health services.

The fourth key finding was the lack of fit for NPT for three EISs described as 'trailblazer' and 'gold-standard' EIS. Further research on NPT and EIS implementation is required to explore how best to adapt and extend NPT to incorporate these service models.

Appendix One-PhD protocol

An Evaluation of Early Intervention Services for First Episode Psychosis in the West Midlands: Commissioning and Implementation perspectives.

May 2006

Dr Elizabeth England Clinical Research Fellow
Primary Care Clinical Sciences Building
Department of Primary Care and General Practice
The University of Birmingham
Edgbaston
Birmingham
B15 2TT

[REDACTED]

[REDACTED]

[REDACTED]

Glossary of Abbreviations

CAQDAS Computer Assisted Qualitative Data Analysis Software

EE Elizabeth England

EIS Early Intervention Study

FEP First Episode Psychosis

HOB tPCT Heart of Birmingham teaching Primary Care Trust

HL Helen Lester

**NCCSDO National Co-ordinating Centre for NHS Service Delivery and
Organisation Research & Development National Service Framework**

NHS National Health Service

PC-CRTU Primary Care Clinical Research & Trials Unit Primary Care Trust(s)

SDU Staff Development Unit

SHA Strategic Health Authority

An Evaluation of Early Intervention Services for First Episode Psychosis in the West Midlands: Commissioning and Implementation perspectives.

Aims of the PhD

Serious mental illness affects up to 3% of the United Kingdom (UK) population, with most GPs seeing 1-2 new people with first episode psychosis (FEP) each year (1). Mental health is currently one of the UK Government's top clinical priorities (2, 3, 4). However despite clinical, economic and policy imperatives to develop new Early Intervention Services (EIS), there is evidence of variable commissioning and implementation (5). This PhD aims to examine and describe barriers and facilitators associated with commissioning and implementing EIS from macro (Strategic Health Authority), meso (Primary Care Trusts, Mental Health Trusts and Health and Social Care Trusts) and micro (Early Intervention Teams) perspectives of the National Health Service (NHS). The findings will provide useful information on policy implementation within a NHS context generalisable beyond mental health.

Objectives

1. To describe the factors influencing EIS planning from a SHA and PCT perspective.
2. To determine the barriers and facilitators influencing EIS commissioning.
3. To establish which factors are most influential on managerial decision making, in implementing EIS policy and service development.

The context of the study: Policy perspectives

Mental health is a key Government priority area, demonstrated through the recent development and improvement of mental health services and financial investment in new models of service delivery (2, 3, 4). Within the context of EIS, The NSF for Mental Health (2) stressed the necessity for prompt assessment of young people with possible psychosis in light of *'the growing evidence that early assessment and treatment can reduce levels of morbidity.'* The National Plan for the NHS (3) further stated, *'Fifty early intervention teams will be established by 2004 so that ...all young people who experience a first episode of psychosis, such as schizophrenia will receive the early and intensive support they need.'* A range of Policy Implementation Guides (5) have since further developed these ideas. EIS are now being set up across England for young people aged between 14-35 years with a first episode of psychotic illness (FEP) to provide support during the first three years of the illness.

The context of the study: Clinical imperatives

FEP has far reaching implications for the individual, disrupting many aspects of their life including education, employment, physical and mental well being (6). In the UK the average duration of untreated psychosis is greater than one year (7). Research suggests that there is a threefold increase in relapse rates when the duration of untreated psychosis exceeds one year (8) and a longer time to recovery (9). A long period of untreated psychosis is also associated with increased behavioural disturbance and family difficulty, multiple attempts to access care, life threatening behaviour and increased use of the Mental Health Act (10). There is a growing

evidence base that EIS can help improve clinical outcomes (11) through providing timely interventions and appropriate support during this period (12, 13).

The context of the study: User imperatives

A recent survey of young people with mental health problems found current services stigmatising, therapeutically pessimistic and youth insensitive (www.rethink.org/reachingpeopleearly/). Rethink (formerly the National Schizophrenia Fellowship) therefore argues that the provision of good quality mental health services for young people with FEP is a pressing reason for the development and evaluation of EIS.

The context of the study: Organisational issues

A joint commissioning approach has been recommended in developing EIS, involving a wide range of stakeholders including statutory and non-statutory mental health services, educational agencies, Criminal Justice Services and Service Users and carers (5). This approach will require these groups to establish effective and integrated patterns of partnership working across a number of diverse organisational boundaries. Despite this emphasis on improving organisational relationships and partnership working, evidence suggests that the implementation of policy and the development of 'cross-boundary' services, especially in mental health, has to date, been variable. *The Workforce Action Team Report* (14) and *Shifting the Balance of Power* (15) both highlight the difficulty in establishing effective partnership working in mental health services. Barriers include geographical boundaries, diverse arrangements for health and social services and the professional boundaries, which appear to exist between new EIS and traditional mental

health services. Communication and relationships between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services has been described previously as poor and inadequate with responsibility for care often falling between CAMHS and Adult Mental Health Services (16). There is a paucity of high quality research, which explores the interfaces between the different organisations involved and the various barriers and facilitators potentially affecting the planning, development and commissioning of Early Intervention services. A number of these issues are emerging as important in the initial pilot findings of the current EDEN study and require further ongoing exploration.

The Context of the study: Commissioning issues

The experience of those working within, and delivering mental health services suggests a rhetoric reality gap between policy formulation, implementation and service organisation and delivery (17). In addition to this, the traditional boundaries between primary care and specialist mental health services are changing due to new commissioning and provider configurations arising from '*Shifting the Balance of Power*' (15). A number of PCTs commission specialist mental health services while others are functionally separate. Some areas are geographically coterminous with uniform configurations of social services but not all. A single PCT may relate to a specialist mental health service and social service in such areas. In other areas, more complex geography, historical influences and varied social service configurations may lead to the development of a wide range of EIS commissioning and development methods, variable EIS delivery, diverse client group involvement and varied outcomes. Furthermore, the potential impact of practice based commissioning, which is currently being introduced (18) is as yet unknown. These issues and influences need evaluation to further understand how they contribute to the provision

of high quality Early Intervention Services.

Methodology

This study benefits from working alongside the nationally funded study ‘The EDEN Project’ (NCCSDO, 2002, £460 000) which is exploring the development and impact of EIS across the West Midlands from the perspective of EIS teams, users and carers. My proposed study, however, focuses on the areas of service commissioning and implementation, highlighted as critical aspects in terms of service development and impact, during the first year of EDEN data collection.

The benefits of working in parallel with, yet autonomous from, the EDEN project include access to the 14 EIS site sampling frame in EDEN, the existence of ethical approval for the study granted by the South West Multi-Centre Ethics Committee and access to multiple stakeholder perspectives since EDEN project officers are interviewing EIS staff, service users and carers. I will also be able to access, collaborate with and learn from the EDEN team and steering group including national and international leaders in the field of EIS and researchers experienced in using qualitative methodologies. In addition, I will have access to funding and secretarial support from the EDEN project.

This study uses a qualitative approach. Qualitative methods were chosen as they play an important role in providing insights and generating theories and explanations of often diverse social behaviour, and facilitate enhanced understanding of emergent relationships between policy implementation, service delivery and patient related outcomes. Semi-structured interviews will be used to explore the views of key stakeholders including the Mental Health Leads in the three West Midlands Strategic Health Authorities, Clinical

and Commissioning Leads for Mental Health in each of the 14 PCTs involved in this study and EIS team leads in each EIS locality. Access to “elites” such as senior PCT managers and leaders in the field of EIS may be facilitated by my dual role as both researcher and an established General Practitioner (19).

It is anticipated that up to a maximum of fifty interviews will take place on a six monthly basis over a two-year period. This will enable me to explore and map changes across time in response to emerging policy and feedback from the EIS. An individual topic guide (appendix one) will be constructed for each group reflecting the different backgrounds and expertise of the stakeholders but common core questions will include barriers and facilitators to commissioning and implementing EIS (appendix two).

Up to a total of three annual focus groups will be carried out with representatives from the different groups including:

1. The mental health strategic leads within the SHA.
2. The clinical and commissioning leads within the PCTs and the EIS team leaders.
3. The EIS Team Leaders.

The defining characteristic of each focus group will be the job description of the participants.

The dynamic interactions between group members in the focus groups will provide greater insight, divergence of opinion and a richer data set than semi-structured interviews alone and enable further exploration of emerging themes (20, 21). A topic guide for the focus groups will be developed based on emergent themes and concepts arising from the semi-structured interviews. Each interview will be audio taped and fully transcribed. Focus groups will be co-led by my supervisor Helen Lester. Field notes will also be taken.

The constant comparison method will be used to generate themes and concepts that consistently emerge from within the data (22). In view of the expected volume of data, the computer package NVivo (QRS release 2.0) will be used to manage data effectively and transparently. Each transcript will be read and re-read with the field notes by myself and HL. Data collection and analysis will be concurrent. Disconfirming evidence will be sought throughout the process of analysis, and emergent theories will be modified in response. All respondents will be invited to comment on their transcripts, and these views will then be incorporated into the analysis.

I will also be able to access and utilise a substantial body of qualitative data collected by the EDEN project detailing demographic characteristics, duration of untreated psychosis and use of the Mental Health Act for all service users in the 14 EIS sites. In addition, access to the wider EDEN project data will enable comparisons of commissioning and implementation strategies with outcomes data in each of the fourteen sites, with the aim of generating a series of further hypotheses.

Epistemological Stance

A social constructionist epistemology which is rooted in the Interpretivist philosophy will be used as the guiding philosophical stance in this study. Social constructionism offers a framework that views social realities as constructed rather than objective 'facts' to be discovered and acknowledges that interpretations are constructed against a backdrop of shared understanding, practices and language and that knowledge is in some sense ideological, political and permeated with values (23). This approach considers that individuals, who in this study are participating in the semi-structured interviews and focus

groups, are acting within an understandable world of norms which they understand and it is my role in this study to interpret the findings. It aims to make sense of individual actions in terms of the reason for their action and places emphasis on the notion of coherence in the explanations and understandings that it offers. The value of an interpretivist framework is in its ability to provide a flexibility in which the perceptions of those engaged in the development and implementation of policy can be explored, and how this impacts on the stakeholders concerned.

Generalisability

Green (24) suggests that the generalisability of qualitative research derives from concepts, which may be relevant to other settings and wider groups of individuals, and from the potential to sensitise policymakers and practitioners to the perceptions of health service users and professionals. Current theories on successful implementation of policy have emerged from a number of disciplines including organization theory and guideline implementation (25). Policy analysis theory offers three major theoretical frameworks in considering implementation of policy, broadly categorised as top-down, bottom-up and synthesis-horizontal theories. It is envisaged that concepts within these frameworks, may help us to understand and interpret the influences affecting policy change, decision making and implementation of new policies, and increase the generalisability of this study to other national and international health policy contexts (26, 27).

Funding

2006- Researcher Development Award from the NCCRC, Department of Health.

I have been fortunate to have been awarded £307 000 to undertake research in the area of

Early Intervention for First Episode psychosis. My PhD is titled ‘An evaluation of Early Intervention Services for First Episode Psychosis in the West Midlands’. It aims to explore the barriers and facilitators to commissioning and implementing Early Intervention Services for First Episode Psychosis from the macro (Strategic Health Authority), Meso (Primary Care and Mental Health Trusts) and micro (Early Intervention teams, Child and Adolescent Mental Health Services, General Practitioners) levels.

The Educational value of the Department of Primary Care, Birmingham University

The Department of Primary Care is a recognised centre of research excellence with a 5* rating (indicating international level recognition) in the 2001 Higher Education Funding Council Research Assessment Exercise. The Department is one of only four UK departments of Primary Care rated at this level.

Core research programmes include the interface between primary and secondary care and health services research. Many of the research programmes involve national and international collaborations. Trial support is provided by the PC-CRTU, which includes the second largest research practice network in the UK. The Mental Health Team, with whom I will be based, is the largest research group within the Department with a current research income in excess of £1.5 million, 16 project staff and a growing national and international reputation particularly in the area of EIS and serious mental illness.

Within the Department, there is access to a range of senior clinical and non-clinical research staff with a wide range of skills and experience in both qualitative and quantitative methodologies.

Educational role of PhD

The focus of my PhD represents an extension and development of knowledge and skills acquired from the recent Masters Degree in Primary Care undertaken by EE: *Primary Care Mental Health Workers: The Views and Experiences of the Stakeholders in the HOB tPCT*. This qualitative study involved semi-structured interviews with forty-five stakeholders over a six-month period.

The proposed educational aspects of my PhD, decided after consultation with senior clinical and non-clinical research staff within the Department, include a combination of taught courses and individual weekly supervision with my supervisor(s).

I propose to undertake a three- year programme of education within the PhD:

Year one will focus on a detailed programme of learning exploring the development and management of research projects through attending courses run by the Staff Development Unit (SDU) at Birmingham University and further acquisition of qualitative research skills.

Year two will focus on developing these areas further and incorporate aspects of data collection and analysis including attending a CAQDAS (Computer Assisted Qualitative Data Analysis Software) course at The University of Surrey.

Year three learning outcomes reflect a desire to firmly establish an academic career including learning, through apprenticeship with senior researchers, how to apply for further project grants and attendance at taught courses organised by the SDU on Management and Leadership Skills in preparation for employing further project staff. Throughout the PhD, emerging relevant data will be presented at national and international conferences to gain further experience and also published, where appropriate, in high impact factor journals.

Supervisors

1st Supervisor: Professor Max Birchwood

Professor of Mental Health/ Director of R&D for Birmingham Mental Health Trust

School of Psychology

University of Birmingham

Edgbaston

Birmingham

B15 2TT

[REDACTED]

[REDACTED]

2nd Supervisor: Dr Helen Lester

Reader in Primary Care

Primary Care Clinical Sciences Building

University of Birmingham

Edgbaston B

Birmingham

B15 2TT

[REDACTED]

[REDACTED]

[REDACTED]

Supervision Experience

Appendices 2-4

References for publications from this thesis

Lester H, Birchwood M, Tait L, Shah S, **England E**, Smith J. Barriers and facilitators to partnership working between Early Intervention Services and the voluntary and community sector. *Health Soc Care Community*. 2008 Sep;16(5):493-500. Epub 2008 Mar 5

Lester H, Birchwood M, Stirling B, **England E**, Rogers H and Sirvastava N. Development and implementation of early intervention services for young people with psychosis: a case study. *British Journal of Psychiatry* 2009 May; 194(5): 446-50.

England E, Lester H, Birchwood M. Collaborating to provide early intervention services for persons in England with first episode psychosis. *Psychiatr Serv*. 2009 Nov; 60(11): 1484-8.

Professor Birchwood has extensive supervision experience over the past fifteen years. In the past three years he has had experience supervising five PhD students. These were funded through school studentships, university studentships and NHS R&D funding.

Dr Lester has experience with supervising one PhD student funded through a university studentship.

Appendix Five-Interviewees and focus group

Interview number	Organisation	Title
ROUND ONE	N=41	
2	PCT	Joint commissioner for AMHS
3	PCT	Joint commissioner for AMHS
19	PCT	Joint commissioner for AMHS
4	PCT	Joint commissioner for AMHS
20	PCT	Joint commissioner for AMHS
21	PCT	Commissioner for AMHS
5	PCT	Commissioner for AMHS
22	PCT	Commissioner for AMHS
1	HSCT	EIS team lead
23	PCT	Executive/ manager PCT AMHS
6	PCT	Commissioner for AMHS
7	PCT	Commissioner for AMHS
24	PCT	Commissioner for AMHS
25	SHA	SHA mental health lead
26	PCT	Commissioner for AMHS
8	PCT	Commissioner for AMHS
27	PCT	Executive/ manager PCT AMHS
28	SHA	SHA mental health lead
29	PCT	Commissioner for AMHS
30	MHT	EIS team lead
9	PCT	Executive/ manager PCT AMHS
31	PCT	Executive/ manager PCT AMHS
32	LA	Director Adult Services Local Authority
33	PCT	Executive/ manager PCT AMHS
10	PCT	Executive/ manager PCT AMHS
34	PCT	Executive/ manager PCT AMHS
35	PCT	Executive/ manager PCT AMHS
11	SHA	SHA mental health lead
36	PCT	Executive/ manager PCT AMHS
37	PCT	Executive/ manager PCT AMHS
12	PCT	Executive/ manager PCT AMHS
13	MHT	EIS team lead
14	HSCT	EIS team lead
15	MHT	EIS team lead
16	MHT	EIS team lead
17	MHT	EIS team lead
18	MHT	EIS team lead
38	MHT	EIS team lead
39	LA	Director Adult Services Local Authority
40	MHT	EIS team lead
41	HSCT	EIS team lead

Interview number	Organisation	Title
ROUND TWO	N=32	
13	MHT	EIS team lead
14	HSCT	EIS team lead
15	MHT	EIS team lead
1	HSCT	EIS team lead
19	PCT	Joint commissioner for AMHS
4	PCT	Joint commissioner for AMHS
20	PCT	Joint commissioner for AMHS
21	PCT	Commissioner for AMHS
5	PCT	Commissioner for AMHS
36	PCT	Executive/ manager PCT AMHS
37	HSCT	Executive/ manager PCT AMHS
12	PCT	Executive/ manager PCT AMHS
39	LA	Director Adult Services local authority
42	PCT	Senior executive/ manager PCT AMHS
43	PCT	Commissioner for AMHS
44	PCT	Executive/ manager PCT AMHS
45	PCT	Commissioner for AMHS
46	PCT	Executive/ manager PCT AMHS
47	PCT	Commissioner for AMHS
48	LA	Director Adult Services Local Authority
49	LA	Assistant Director Adult Services Local Authority
50	LA	Assistant Director Adult Services Local Authority
51	MHT	EIS team lead
52	SCHT	EIS team lead
53	MHT	EIS team member
54	MHT	EIS team lead
55	MHT	EIS team member
56	MHT	EIS team lead
57	MHT	EIS team member
58	MHT	EIS team lead
59	MHT	EIS team member
60	HSCT	EIS team lead

Interview number	Organisation	Title
ROUND THREE	N=42	
17	MHT	EIS team lead
18	MHT	EIS team lead
38	MHT	EIS team lead
33	PCT	Executive/ manager PCT AMHS
10	PCT	Executive/ manager PCT AMHS
34	PCT	Executive/ manager PCT AMHS
35	PCT	Executive/ manager PCT AMHS
42	PCT	Executive/ manager PCT AMHS
43	PCT	Commissioner for AMHS
44	MHT	Executive/ manager PCT AMHS
45	PCT	Commissioner for AMHS
59	MHT	EIS team member
13	MHT	EIS team lead
14	HSCT	EIS team lead
15	MHT	EIS team lead
1	HSCT	EIS team lead
19	PCT	Joint commissioner for AMHS
4	PCT	Joint commissioner for AMHS
20	PCT	Joint commissioner for AMHS
61	MHT	CAMHS lead
62	MHT	CAMHS lead
63	MHT	CAMHS lead
70	MHT	CAMHS lead
71	MHT	CAMHS lead
72	MHT	CAMHS lead
64	Acute Childrens Trust	CAMHS lead
65	SHA	SHA mental health lead
66	SHA	SHA mental health lead
67	MHT	EIS team lead
68	PCT	Senior PCT executive AMHS (outside West Midlands)
69	HSCT	Chief executive
73	MHT	CAMHS lead
74	MHT	CAMHS lead
75	MHT	CAMHS lead
76	MHT	CAMHS lead
77	MHT	CAMHS commissioner
78	PCT	CAMHS commissioner
79	PCT	CAMHS commissioner
80	PCT	CAMHS commissioner
81	PCT	CAMHS team lead
82	PCT	CAMHS joint commissioner
83	PCT	CAMHS commissioner

Interview number	Organisation	Title
ROUND FOUR	N=32	
21	PCT	Commissioner for AMHS
40	MHT	EIS team lead
41	HSCT	EIS team lead
5	PCT	Commissioner for AMHS
22	PCT	Commissioner for AMHS
14	HSCT	EIS team lead
15	MHT	EIS team lead
1	MHT	EIS team lead
67	MHT	EIS team lead
68	PCT	PCT executive AMHS (outside West Midlands)
69	HSCT	Senior executive AMHS
73	MHT	CAMHS lead
74	MHT	CAMHS lead
72	MHT	CAMHS lead
64	Acute Childrens Trust	CAMHS lead
82	PCT	CAMHS commissioner
83	PCT	CAMHS commissioner
38	MHT	EIS team lead
84		EIS team member
85		CAMHS commissioner
86		PCT executive AMHS
89		CAMHS team lead
90		SHA mental health lead
88		EIS team lead
91		EIS team lead
92		Social care lead Adult services
93		Social care lead Adult services
94		EIS team member
95		CAMHS team lead
96		CAMHS team member
97	PCT	Commissioner for AMHS
98	PCT	Commissioner for AMHS

Focus Group Round One (Groups One-Three)

Focus Group	Organisation	Role
1	Partnership Trust 1	AMHS senior executive
	Partnership Trust 1	AMHS executive
	Partnership Trust 1	AMHS executive
	Partnership Trust 1	AMHS executive
2	Mental health trust 2	AMHS executive
	Mental health trust 2	AMHS senior executive
	Mental health trust 2	AMHS manager
	Mental health trust 2	AMHS executive
	Mental health trust 2	EIS team lead
	Mental health trust 2	AMHS executive
3	PCT 7	AMHS senior executive
	PCT 7	AMHS senior executive
	PCT 7	CAMHS senior executive
	PCT 7	AMHS Commissioner
	PCT 7	AMHS Commissioner

Focus Groups Round Two- (Groups Four-Six)

Focus Group	Organisation	Role
4	PCT 17	AMHS senior executive
	PCT 17	AMHS senior executive
	PCT 17	CAMHS senior executive
	PCT 17	AMHS commissioner
	PCT 17	AMHS manager
	PCT 17	CAMHS commissioner
5	MHT 1	EIS team lead
	MHT 1	EIS manager
	MHT 1	EIS team member
	MHT 1	EIS team member
6	Healthcare NHS Trust 1	EIS team lead
	Healthcare NHS Trust 1	EIS manager
	Healthcare NHS Trust 1	EIS team member
	Healthcare NHS Trust 1	EIS team member
	Healthcare NHS Trust 1	CAMHS planning group lead
	Healthcare NHS Trust 1	CAMHS lead

	Healthcare NHS Trust 1	EIS team member
	Healthcare NHS Trust 1	Adult services executive
	Healthcare NHS Trust 1	AMHS commissioner
	Healthcare NHS Trust 1	CAMHS executive