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Investigating Service Users and Family Members Experiences of Peer Support and the Implementation of a Rural Early Intervention Psychosis Service: A Research Portfolio

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Research Portfolio Abstract

Objective: This research portfolio examines interventions for the treatment of psychosis or psychosis related experiences. The systematic review synthesised and critically appraised existing research on the experiences of peer support from the perspective of those directly affected by psychosis or related symptoms, as well as their family members or carers. The empirical mixed methods study analysed the implementation of an Early Intervention Psychosis (EIP) service in a rural Scottish health board.

Methods: A systematic search identified qualitative studies examining experiences of peer support from the perspective of individuals with psychosis, or similar experiences, and their family members or carers. Thematic synthesis generated analytical themes from the findings of the included studies. Fifteen interviews were investigated using grounded theory in the empirical project, alongside the analysis of quantitative service evaluation data.

Results: The systematic review identified eight eligible studies. Four analytical themes were conceptualised in a phased structure to reflect the experience of peer support: (1) *connecting with peers,* (2) *learning through mutual support*, (3) *hopeful progression* and (4) *influence of setting.* The empirical project reported that implementation of the EIP service in a rural health board was as achieved through fidelity to the EIP model being indicated by short waiting times, high engagement and change over time demonstrated. However, long duration of untreated psychosis (DUP) was reported. A grounded theory provides a conceptual framework for understanding how staff rely on *collaboration*, *building relationships* and *being there* for service users and families to navigate the challenges present in delivering EIP in the rural health board. Barriers included social isolation and the influence of restricted access to activities and transport links.

Conclusion: The systematic review identified peer support as providing an environment which challenges stigma and aids the recovery from psychosis through peer learning opportunities. The findings of the empirical project emphasised the role of relationship-building and

collaboration is essential in the effective implementation of an EIP service in rural areas. The influence of rurality on isolation and healthcare remains a challenge recovery and future research should explore this within the context of increasing timely access to treatment for psychosis. The role of peer support should also be emphasised.

Lay Summary

Background

Psychosis can include experiences such as seeing or hearing things that other do not (hallucinations) or holding unusual beliefs (delusions). These are called 'positive symptoms'. Social withdrawal, feeling less motivated and losing interest in activities can also be part of psychosis and are called 'negative symptoms'. The treatment of psychosis target both types of symptoms.

One form of intervention is peer support. This involves people using lived experience of mental health difficulties, such as psychosis, to provide recovery-oriented support to others. This can include social and emotional support, help to develop practical skills, and delivering education. A type of service that is designed to treat psychosis is the Early Intervention for Psychosis (EIP) model. EIP aims to provide fast access to a multidisciplinary treatment plan including medication, talking therapies, occupational therapy and peer support. Support is provided for two-to-three years and targets reducing symptom severity and improving long-term functional and social outcomes. This research looks at how care is provided to people who experience psychosis.

Systematic review

This research includes a review of studies exploring how peer support is experienced by people who have psychosis or similar symptoms, as well as their family members or carers. Eight studies were reviewed which included both group, and website-based peer support.

Main findings

1. Four analytical themes were outlined: (1) *connecting with peers,* (2) *learning through mutual support*, (3) *hopeful progression* and (4) *influence of setting.*
2. The first three themes were understood as phases peers move through, shaped by the where peer support was delivered in, for example in a group setting.

Research project

A mixed methods study also examines how an Early Intervention Psychosis service is being delivered in a rural Scottish health board.

Main findings

1. Fifteen interviews were completed with service users, family members and staff involved with the EIP Service in the rural health board. The research found that the EIP staff used collaborative working to build relationships with service users, family members and other professionals. This allowed them to provide an effective EIP service across a sparse, rural landscape. The staff used their limited time and resources efficiently to allow them to be there for service users and families managing a first episode of psychosis. Social isolation was a barrier for both staff and service users to navigate, with lack of activities and limited transport options negatively impacting recovery.
2. Both service evaluation data, and quotes from the interviews supported that the service was viewed as acceptable by service users, family members and staff.
3. Providing an EIP model was achievable in the rural area with short waiting times after referral, multidisciplinary interventions being used, and change over time being demonstrated. There were still delays in getting referred with service users often having symptoms of psychosis for a long time before being referred to the EIP service.

Conclusions

1. Peer support involves moving through phases, where connecting with peers provides an opportunity for learning new skills and challenging stigma related to psychosis. Future research should further explore how peer support can help family members, and how it could be expanded in both clinical and community settings to enhance recovery from psychosis.
2. Interviews and findings from service evaluation data showed that an EIP service was able to be delivered in a rural health board. More research is needed to address the long length of time between the first symptoms of psychosis and being referred to the EIP service, and the impact of reduced access to services in rural communities.

Chapter 1: Systematic Review

Experience of Peer Support in Psychosis: A Thematic Synthesis

(Authors Kirsten Richardson 1 2 4, Dr Helen Griffiths 1, Alec Drew 1, 3)

This chapter has been prepared in accordance with author guidelines for the international peer-reviewed journal *Psychosis* (see Appendix A).

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Abstract

Background: Peer support involves the use of lived experience to provide a recovery-oriented approach. This can include opportunities for social and emotional support, development of practical skills, and delivering psychoeducation (Evans et al., 2023). The current review examines experiences of peer support among individuals with psychosis or psychosis-related experiences, as well as their family members and carers.

Method: Eight studies were identified from a systematic search of electronic databases (PsychINFO, OVID Medline, EMBASE, CINAHL and ASSIA). The quality of the papers was assessed using the Critical Appraisal Skills Program Qualitative Study Checklist (2024) and findings analysed using thematic synthesis by Thomas & Harden (2008).

Results: Four analytical themes were outlined: (1) *connecting with peers,* (2) *learning through mutual support*, (3) *hopeful progression* and (4) *influence of setting.* The first three themes conceptualised within an approximately phased structure, within the setting of peer support.

Discussion: Peer support was identified as providing an environment where connections between peers challenged stigma and aided the recovery from psychosis, through peer learning opportunities. It is recommended that future research further explores the role of peer support for family members, and considers the expansion of peer support in both clinical and non-clinical settings.

Keywords: Peer support, psychosis, experience, family and carers

Introduction

Peer support is defined as the application of experiential knowledge to support and encourage others who are experiencing related issues (Davidson et al., 2006). Within the context of mental health, peer support is a recovery-oriented approach, aiming to provide social and emotional support to others, as well as addressing specific difficulties, such as internalised stigma (Evans et al., 2023). The collaborative structure of peer support is often in contrast with traditional healthcare systems, where there is a hierarchical difference between clinicians as providers and the consumers i.e. service users and their caregivers (Cooper et al., 2024). Peer support environments go beyond the information exchange which is typical within a health care setting and employ lived experience to provide practical support, companionship, and empowerment (Ahmed et al., 2012).

Traditional models of care focus on reduction of clinical symptoms, but the often-overlooked functional recovery has been recognised as a key component for improving overall wellbeing in those with a diagnosis of a severe mental disorder, including psychosis (Sánchez-Guarnido et al., 2024). The complex relationship between social functioning and stigma can be a significant barrier to recovery and therefore presents a challenge within any intervention (Podogrodzka-Niell & Tyszkowska, 2014). Functional improvements have been found to be a priority for those accessing early intervention services for psychosis (Iyer et al., 2011), where peer support can have a key role in social reintegration through the destigmatisation of psychotic experiences, increasing empowerment (Jambawo et al., 2024) and supporting the development of a social network (Nguyen et al., 2022).

When assessing the effectiveness of peer support, the diversity of interventions being delivered presents a significant difficulty. A Cochrane review by Chien et al (2019) examined randomised control trials (RCTs) comparing standard care to standard care plus peer support, for service users with a diagnosis of schizophrenia. The quality of the 13 trials included was deemed low, due to concerns about risk of bias within the study designs. Authors concluded that there was not sufficient high-quality evidence to comment on the effectiveness of peer support intervention in this population. Low quality evidence did suggest that the addition of peer support to standard care does not affect hospital admissions but could improve specific mental state and behavioural outcomes, such as empowerment, personal confidence and help seeking behaviours. However, the interpretation of the findings is limited by the heterogeneity of the peer support interventions delivered, and the populations targeted.

A more recent scoping review by Evans et al (2023) examined peer support for schizophrenia across 22 studies, where 20 different interventions were examined. Although there were common themes, such as practical skills, and psychoeducation within interventions, there was a significant difference in content and variance in outcome measures. Within this review around half of interventions were within mixed diagnostic groups, where it was unclear how tailored the support was and whether it included diagnosis specific strategies, such a discussion of delusions and hallucinations. Research on Hearing Voices Network (HVN) groups provide an insight into peer support programmes specifically tailored for those who experience auditory and visual hallucinations (Longden et al., 2018). It was found that understanding the meaning and context of voices was a key aspect of the peer support groups, alongside developing coping skills and reducing isolation (Corentin et al., 2023).

Peer support intervention for family members or carers of those with psychosis symptoms is more limited within the literature. Group initiatives, such as the Journey to Recovery Group in Australia (Petrakis et al., 2013), deliver a combination of peer support and psychoeducation for carers of those experiencing first episode psychosis (FEP). Family and carers peer support in group form has been found to increase participants understanding of psychosis as well as reducing isolation and the experience of stigma (Day et al., 2017; Petrakis et al., 2014). To date, a systematic review of peer support literature has not included interventions involving family members or carers.

Within peer support literature a review examined peer support within the context of severe mental health disorders generally but lacked a systematic search of the literature and meta-analysis (Shalaby & Agyapong, 2020). A more recent meta-analysis examined peer support for both individuals with experience of serious mental illness and family members, with improvements reported for medication adherence, reduced loneliness, decreases in hospital admissions and psychotic symptoms (Wang et al., 2022). Although the reviews search terms were focussed on schizophrenia and psychosis, studies were included which assessed mixed populations such as those with a diagnosis of bipolar disorder. This restricted the comment that could be made about the influence of peer support on psychosis specifically. Studying peer support within specific contexts, such as psychosis related experiences, provides an opportunity to examine key components across the diversity of peer support interventions being delivered. There is currently a limited understanding of the mechanisms that underpin the potential effectiveness of peer support (Pitt et al., 2013; Lloyd-Evans et al., 2014), although previous

research suggests increased empowerment and self-efficacy could provide a theoretical basis (Burke et al., 2019).

Qualitative research in this area analyses the experiences and behaviours of those involved in peer support and the context in which it is delivered. Previous qualitative studies have highlighted potential key elements of peer support such as its role in the exchange of information, facilitating social support (White et al., 2017) and destigmatising psychosis (Nguyen et al., 2022). Only one previous qualitative review was identified. Corentin et al. (2023) examined the benefits of attending a Hearing Voices Group and other self-help groups. This review suggested that such groups provided reduced isolation, and helped participants gain an understanding of their voice hearing experience, but limited details were provided about content of the groups themselves. While Hearing Voice Groups are peer support, it is unclear of the role of peer support in the self-help groups. This limits conclusions that could be made about the experience of peer support from this review, therefore further analysis is required to specifically examine the experience of peer support.

Qualitative evidence synthesis or QES, is a systematic approach to reviewing and synthesising qualitative research. The findings from a QES approach provide rich interpretations of experiences within the context of intervention effectiveness. This is achieved through question formulation, protocol development, quality assessment, data extraction and synthesis. Thematic synthesis (Thomas & Harden, 2008) is a recommended method for undertaking QES (Fleming & Noyes, 2021). The mechanism of producing a thematic synthesis moves beyond a mere description of previous literature as a collective and allows for the synthesising of data from multiple qualitive studies to identify overarching, analytical themes (Thomas & Harden, 2008).

To the author's knowledge there is no current synthesis of the existing qualitive research on the experiences of peer support in the context of psychosis or psychotic experiences which includes the perspectives of people who have psychotic experiences and their family members or carers. This review aimed to improve our understanding of the role of peer support in the context of the treatment of psychosis and psychotic experiences. Examining the perspectives and experiences of those accessing services may give an insight into the key mechanisms of change within peer support interventions.

The present systematic review aims to provide an up-to-date thematic synthesis to explore the research question: what are individuals with psychosis/psychotic experiences and their families and carers experiences of peer support?

Methodology

The systematic review protocol was registered with PROSPERO (reg: CRD420251038140) on 13 May 2025 and was conducted following the Thomas & Harden (2008) guidelines for thematic synthesis, as recommended within QES (Fleming & Noyes, 2021).

Search Strategy

The SPIDER tool for Qualitative Evidence Synthesis (Cooke et al., 2012) was applied to develop inclusion and exclusion criteria, see Table 1. Studies were included if they were (1) focused on adults with psychosis or psychotic experiences, or their family members/carer's experience of peer support and (2) used qualitive or mixed methods design, both in peer reviewed and grey literature. Peer support was broadly defined as the delivery of support and/or services to those with psychosis/psychotic experiences with input from individuals who have lived experience of this presentation. A formal diagnosis of a psychotic disorder was not required to allow for the inclusion of studies outwith health care settings where self-identification of psychotic experiences is encouraged, for example Hearing Voices Network groups. Exclusion criteria included (1) studies examining the views of those delivering peer support (2) non-English language papers and (3) existing reviews, protocol for studies without published results, case reports, editorials, and opinions. Key papers were identified during scoping searches and search terms were developed through reviewing literature and discussion with a librarian, see Table 2.

Table 1

SPIDER Tool for Qualitative Evidence Synthesis (Cooke et al., 2012) application

SPIDER	**Inclusion and Exclusion Criteria**
Sample	Inclusion Criteria - Individuals with psychosis, psychosis related disorders or psychotic experiences or their family members/carers. - Only participants over the age of 16 were included, reflecting the age of onset of a first episode of psychosis typically being age 16 or older. Exclusion criteria - Research focussed on the experiences of those delivering peer support or staff members.
Phenomenon of Interest	Inclusion Criteria - "Peer support interventions": broadly defined as the delivery of support and/or services to those with psychosis/psychotic experiences with input from individuals who have lived experience of this presentation. - Both in person and remotely delivered interventions, including both individual and group-based modalities. - Remotely delivered, or technology assisted, peer support interventions. Exclusion criteria - Psychoeducation intervention with a small component of peer support e.g. access to a support forum online.
Design	Inclusion criteria - Any appropriate methods of qualitative data collection i.e. interviews, focus groups and questionnaire. - Grey literature. Exclusion criteria - Protocol for studies without published results. - Case reports and series. - Reviews and meta-analyses. - Editorials and opinions.
Evaluation	Inclusion criteria - The experiences, views, and/or perspectives of peer support interventions from individuals with psychosis/psychotic experiences and/or their family or carers.
Research Type	Inclusion criteria - Qualitative. - Mixed methods. Exclusion criteria - Quantitative.

A systematic search of PsychINFO, OVID Medline, EMBASE, CINAHL and ASSIA was first conducted in September 2025, including papers published up until this date. A final search was

conducted on 2 February 2026. Forwards and backward citation searching were undertaken, and grey literature was analysed to identify unpublished studies. Grey literature searches involved using combinations of terms applied in the database searching in Google Scholar, as well as hand searching by examining the reference lists of included studies. Grey literature that met inclusion criteria was then included.

Table 2

Search string informed by SPIDER Tool for Qualitative Evidence Synthesis (Cooke et al., 2012)

SPIDER (Cooke et al., 2012)	**Search Terms**
Sample	Psychosis* OR psychotic* OR hallucinat* OR delusion* OR "hearing voices" OR schizo* OR Psychoses*
Phenomenon of Interest	(Peer* OR "lived experience*") adj5 (support* OR expert* OR worker* OR advisor* or consultant* OR leader* OR educator* OR tutor* OR instructor* OR facilitator* OR coach* OR group* OR service* OR network*)
Design, Evaluation, Research	qualitative OR "grounded theor*" OR "lived experience*" OR narrative* OR "life experience*" OR "thematic analys*" OR "discourse analys*" OR "focus group*" OR interview*

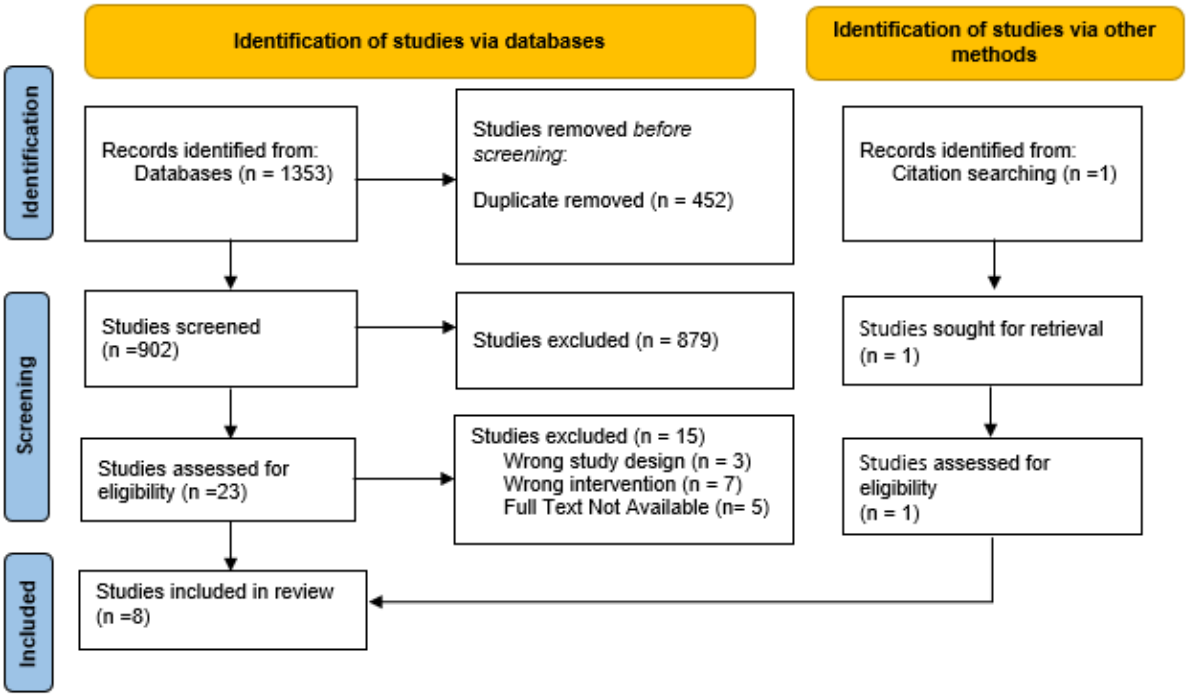
Data screening

A total of 1354 studies were identified. After removing duplicates, 902 titles and abstracts were screened by the lead researcher, with 10% being independently screened by a second reviewer (also a doctoral student in clinical psychology). The eligibility of 23 full texts was assessed independently by both the lead researcher and second reviewer and all studies which did not

meet inclusion criteria were removed. Through the review process, a small number of discrepancies were recorded and resolved through discussion. The inter-review agreement for the full text review was calculated using the kappa coefficient (κ = .85), indicating a high level of agreement (Dettori & Norvell, 2020). The PRISMA flow chat is outlined in Figure 1. Eight studies were included in the review.

Figure 1

PRISMA flow chart



Quality assessment

The Critical Appraisal Skills Program Qualitative Study Checklist (CASP) (2024) was applied to assess the quality of the papers (see Appendix C). The checklist is recommended by the Cochrane Qualitative Research Methods Group and is a ten-question based framework, widely

used in qualitive research (Long et al., 2020). It considers the appropriateness of study design, methodology, recruitment, risk of bias, ethical issues, data analysis, findings, and generalisability.

Two reviewers independently assessed the quality of all the studies using a standardised quality assessment tool to minimise potential error and improve rigour. The CASP checklist does not use a numerical scoring system, therefore the method devised by Butler et al., (2016) was used to compare ratings between the lead researcher and the second reviewer. When a discrepancy in reviewer rating's was identified, disagreements were noted, studies were re-read and agreement was reached through discussion. The kappa coefficient ($\kappa = .75$) was calculated, accounting for the probability of agreement occurring by chance, with a value indicating a proficient level of agreement (Dettori & Norvell, 2020). A third reviewer was available to resolve disagreements, but this was not required.

Data extraction

To characterise the included studies, the study aims, sample size, population characteristic, country, and analysis type were extracted into a predesigned spreadsheet, outlined in Table 3. Where any data was missing, efforts were made to gather additional details by contacting the authors. Data in all sections within the included studies entitled "findings", "results" or any other synonyms were extracted and exported into NVivo (14.24.3). This included key themes, subthemes, illustrative quotes, and interpretations.

Data synthesis

The epistemological and ontological stance and the type of research questions were considered when developing the strategy for data synthesis. An interpretive stance acknowledges that it is the researcher's interpretation of participants perspectives and experiences which is central to the analysis. The researcher followed the process for thematic synthesis outlined by Thomas & Harden (2008), within QES (Fleming & Noyes, 2021) and utilised NVivo (14.24.3) for coding and developing themes, providing a clear audit trail. This approach allowed for the findings in the selected studies to be explored, to identify recurring themes and generate new insights into this area of research. 'Line-by-line' coding was applied to data from all sections within the studies entitled "findings", "results" or any other synonyms. Both verbatim codes and themes identified by the original authors were included in the synthesis. Line-by-line coding involved assigning an initial code to a segment of data, with these codes being refined as analysis continued. This initial coding process involved 'free codes' which were descriptive in nature and stayed close to the information reported by participants. These codes were without a hierarchical structure and were labelled with details of the studies they originated from. The codes from all studies were then reviewed and organised into meaningful clusters. It was through this process that 'descriptive themes' were developed by categorising groups of codes into a pattern or theme. Codes were grouped based on their content, with similarities and conflicts being considered. This provided an organisational structure to the free codes to form descriptive themes, grounded in the original meaning of the studies. At this stage, both NVivo and the drawing out of thematic maps were used (see Appendix D).

From the descriptive themes, analytical themes were generated by the lead author in consultation with the research team, by considering the meaning of the codes and themes and their interpretation in relation to the research question. Analytical themes were then conceptualised from the descriptive themes by reaching beyond the original individual studies to infer new understanding or hypotheses. Analytical themes explored the experiences of peer support from the perspective of individuals receiving support for psychosis and their family/carers, providing a synthesis of the studies through the identification of analytical themes and their interpretation, building upon the individual study's findings. This process enabled the researcher to reach beyond the participant's individual experiences, and the interpretation within studies, to explore the impact of these findings when considered together.

The inductive and iterative approach to coding allowed concepts and themes to be developed throughout the stages and minimised the presence of priori assumptions impact on the analysis. Each study was revisited to ensure consistency of interpretation and collapsing or expanding of codes. A reflexive log was kept of emerging themes and relationships.

Epistemological stance

A social constructivist stance underpins this review, where there is no objective reality as the social context is central to the meaning making process (Thomas et al., 2014). Gaining knowledge is an active process, with learning taking place through interactions within the social context rather than information being simply known or passively obtained. Taking a social constructivist approach is particularly appropriate within thematic synthesis as key themes

across studies are actively engaged with and ultimately integrated. This stance was an important part of the review process, both in terms of how participants within the studies made sense of their experiences, and the subsequent interpretation of these.

Researcher Reflexivity

Throughout the review process the researcher was mindful of the impact of their own experiences, values, and beliefs on the review process, from choosing a topic to interpreting the data. Remaining committed to being reflexive throughout the review allowed for potential biases to be openly acknowledged and a conscious effort made to minimise the potential for these to unfairly interfere with producing an accurate interpretation of the findings.

The researcher is a trainee psychologist who has worked alongside peer support staff in an Early Intervention Psychosis (EIP) service during their training, although the researcher did not work clinically within psychosis services during the review process. They had seen instances of peer support positively influencing service users and held the view that mental health services could benefit from lived experience roles.

While conducting the review the researcher was also examining the views of staff, service users and family members on their experience of EIP being implemented. The role of peer support in EIP services was explored and may influence the present synthesis. A reflexive diary was used alongside discussions in supervision to manage the influence of the interpretation of the data. The researcher recognised a desire to portray a positive narrative of the peer support however, focussing on the experiences of participants within the studies and reflecting on personal responses ensured the researchers views were not projected onto the findings.

Table 3

Characteristics of studies included in the systematic review.

Authors	Aim of Study	Country	N	Age	Gender	Population	Interventions	Data Collection	Analysis	Epistemology
Dos Santos & Beavan, 2015	To explore the experiences of some voice-hearers who regularly attend the HVN peer support groups	Australia	4	late 30s to late 50s	Not reported	HVN attendees - 3 schizophrenia - 1 bipolar	HVN peer support groups (unknown locations)	Semi-structured interviews	IPA	Interpretivist
Hornstein et al., 2020	To understand of how HVN groups work through examining member's experiences	United States of America	113	19 to 79 years	Female 62 Male 31 Non-binary 8 Unknown 12	HVN attendees	HVN peer support groups (unknown locations)	Open-ended questionnaire designed and semi-structured interviews	Thematic analysis	Interpretivist
Hyde, 2001	To examine experience of supportive group therapy facilitated by OT	United Kingdom	10	18 to 38 years	Not reported	Inpatients with an admission with psychotic symptoms	Peer support group facilitated by occupational therapy (inpatient ward)	Interviews and field notes	Content analysis	Interpretative constructivist
Levasseur et al., 2019	To explore the experience of the participants of a family peer support project in EIP service	Canada	44	Not reported	Not reported	Family members of an EIP service users	EIP family peer support group	Questionnaire including 12 open-ended questions	Thematic analysis	Critical subjectivist
Oakland & Berry, 2015	To explore the experiences of individuals who attend HVN groups	United Kingdom	11	30 to 60 years	Not reported	HVN attendees	HVN peer support groups (health care and community settings)	Semi-structured interviews	Thematic analysis	Interpretivist
Payne et al., 2017	To HVN group attendees experiences change within the group and out with	United Kingdom	8	34 to 60 years	Female 4 Male 4	HVN attendees - 4 schizophrenia - all receiving mental health care	HVN peer support groups (unknown locations)	Semi-structured interviews	IPA	Interpretivist
Schaefer et al., 2021	To learn about the meaning and experience of HVN group participation	Nether-lands	30	20 to 79 years	Female 15 Male 15	HVN attendees	HVN peer support groups (health care and community settings)	Interviews	Grounded theory	Interpretative constructivist
Williams et al., 2018	To explore experiences of viewing lived experience videos on interactive website	Australia	36	19 to 64 years	Female 24 Male 12	Diagnosis of a psychotic disorder	Interactive website with peer support videos	Semi-structured interviews	Grounded theory	Constructivist

HVN = Hearing Voices Network IPA= Interpretative Phenomenological Analysis

Results

Study Characteristics

Study characteristics of the eight studies included are outlined in Table 3. A total of 256 participants were included: 212 of whom identified as having psychosis or psychotic type experiences, and 44 of whom were family members of individuals with psychosis. There were variations in analysis methods with three studies applying thematic analysis, two interpretative phenomenological analysis, two grounded theory and one content analysis. There was a wide age range of participants from 19 years to 79 years old. A total of five countries were represented: United Kingdom (3), Australia (2), United States of America (1), The Netherlands (1) and Canada (1). Four types of peer support interventions were included in the analysis: HVN peer support groups (5), inpatient peer support group (1), EIP family peer support group (1) and interactive website with peer videos delivered in a community mental health setting (1). Most papers referred to a group-based setting, except for Williams et al. (2018) which referred to an online platform where videos of people with lived experience of psychosis discussing their recovery could be accessed with or without the assistance of a mental health worker. Peer support interventions in all the studies analysed were framed within the recovery model and therefore aligned with the key component of peer support by adopting a recovery-oriented approach (Evans et al., 2023).

The inclusion of interview schedules or examples of questions asked of participants with the papers varied, therefore consideration had to be given to bias within data collection. The questions posed to participants were outlined in three studies, where there was clear evidence of seeking information on both positive and negative experiences (Oakland &

Berry, 2015; Schaefer et al., 2021; Williams et al., 2018). A further two studies did not provide details of the questions asked during data collection, but results outlined both positive and negative experiences (Payne et al., 2017; Levasseur et al., 2019). The remaining three studies did not include details of questions being asked and therefore comment cannot be made as to whether negative experiences of peer support were explored (Dos Santos & Beavan 2015; Hornstein et al., 2020; Hyde, 2001).

Quality appraisal

Application of the CASP appraisal tool deemed all the studies to be of good quality. However, three studies did not consider item six "Has the relationship between researcher and participants been adequately considered?" (Hornstein et al., 2020; Hyde, 2001; Payne et al., 2017). Two studies did not report how ethical issues were taken into consideration (Hornstein et al., 2020; Levasseur et al., 2019). The thematic synthesis approach outlined by Thomas & Harden (2008) included all studies which answer the research question regardless of quality. Issues concerning quality were instead managed by examining the contributions of lower quality studies in the final analytical themes. This was not an issue in the current review as all studies were rated as being of good quality.

Thematic Synthesis

Context of the eight papers was considered throughout the thematic synthesis. The following factors were key considerations (1) the participant groups included and method of data collection, (2) the epistemological stance of each study, (3) the opportunity for exploration of both positive and negative experiences of peer support. Initial line-by-line coding initially preserves contextual meaning, with the source of the code remaining clearly labelled as they are grouped into descriptive themes. Specific notations were used throughout

this process to signify the key factors out lined above from eight studies. The data from different epistemological stances and contexts were then integrated in analytical themes. The use of thematic maps, using notations and a key, was essential to the consideration of context during the analysis (see examples in Appendix D).

The included studies adopted differing epistemological stances, as outlined in Table 3. Throughout the analysis, the focus on reported findings of each paper allowed for different epistemological stances to be considered. Findings from interpretivist studies were viewed as being focused on understanding the lived experience of participants, whereas both the constructivist and interpretative constructivist studies view findings as co-constructed, where context is a key consideration. Levasseur et al.'s (2019) use of the critical emancipatory paradigm, with a critical subjectivist stance explicitly acknowledge the role of power as well as context and requires the use of experiential knowledge to inform both research design and interpretation of findings.

Nine descriptive themes were identified. These were organised into four analytical themes, see Table 4. All studies contributed to the development of the four analytical themes, except for Williams et al. (2018) had a more limited contribution to Theme 2 and was not reflected in Theme 4. The evolution of thematic maps in Appendix D highlights the contribution to each analytic theme, where detachable notes were used to track the source of theme development, and then removed in later reiterations of the maps.

Figure 2 outlines the interaction of subthemes, and their contribution to the overarching theme. The overarching theme outlined that the *connection with peers* through peer support provides a foundation for learning new coping strategies and engaging in mutual support, with empowerment promoting a hopeful view for the future.

The experience of peer support involves progression through successive phases, where each phase lays the groundwork for the next. The first phase involves those attending support developing a *connection with peers,* by being *understood, accepted* and *being part of a community.* This facilitates an environment where peers are then able to feel secure enough to enter the next phase of *learning through mutual support*. The ability to engage in learning within the peer support environment becomes closely linked with the next phase where a recovery focussed outlooked is consolidated. This is where peers describe *hopeful progress* by seeing *evidence of peers living well* and being *empowered* by the experience of peer support. These three phases are influenced by the setting that peer support is delivered as these present challenging and facilitating factors for each phase.

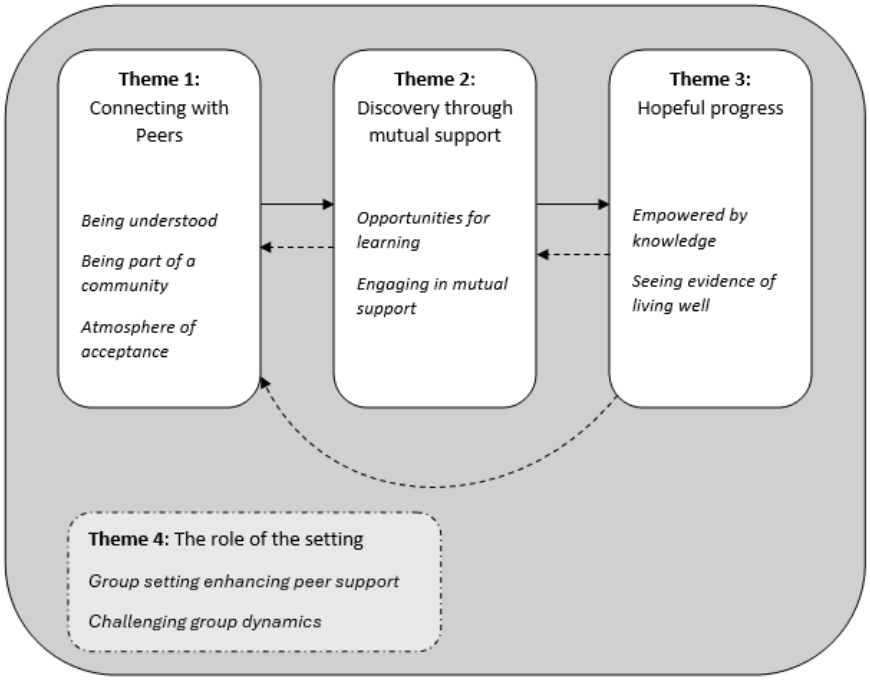
Table 4.

Summary of descriptive, analytical, and overarching themes

Descriptive Theme/ Sub-Theme	**Analytical Themes**	**Overarching Theme**
Feeling understood Atmosphere of acceptance Being part of a community	Theme 1 - Connecting with peers	Theme 5 - Themes 1, 2 and 3 form a phased model, where peer's experience of peer support involves movement through successive, interdependent phases. These phases are influenced by the modality of peer support delivery.
Opportunities for learning Engaging in mutual support	Theme 2 – Learning through mutual support	
Empowered by knowledge Seeing evidence of living well	Theme 3 – Hopeful progress	
Group setting enhancing peer support Challenging group dynamics	Theme 4 – Influence of the setting	

Figure 2.

Visual representation of major themes and sub-themes



Although the experience of peer support is framed within successive phases, movement through these phases does not appear to be in a strict linear fashion. While peer experiences do reflect a movement through consecutive phases, the progression incorporates returning to earlier phases to reinforce connections and learning.

Theme 1: Connecting with peers

The first theme *connecting with peers* reflects the opportunity to form relationships with others who also have lived experience of psychosis, psychotic experiences, or their family members/carers. This was explicitly explored in seven of the eight studies, with the remaining study making a brief reference to this concept (Hyde, 2001). The ability to connect with others, in an accepting environment, and experience a sense of belonging appears to provide a secure base for skill development. As outlined in Figure 2, the connection formed

with peers can be considered as the first phase of peer support experience, and subsequent themes rely on this mechanism.

"*Participants concurred that identification with others was central to the experience of the group, but emphasised the importance of a compassionate attitude from others*"
Interview response from HVN group attendee (Payne et al., 2017, p209)

Sub-theme Theme 1.1: Feeling understood

Feeling understood by peers during interactions was central to the experience of peer support and the subtheme was present in all studies. The label of 'peer' within the peer support settings signalled a shared experience which peers recognise in each other, without a prerequisite explanation of individual circumstances. An example from carers highlighted that attendees "*don't have to explain; other caregivers understand you and offer support and guidance*" Questionnaire response from EIP family member (Levasseur et al., 2019, p13).

This stance of understanding is achieved through two contrasting forms of action: implicit and explicit. The implicit nature of understanding builds on the concept of "*effortless understanding*" (Hornstein et al., 2020, p6) where the act of attending the peer support, in whatever form, appears to foster a notion of shared experience where peers can "*sit in quiet understanding*" (Hornstein et al., 2020, p8), without the need to verbalise their insight. Attendees, supported by peer support facilitators, hold a space for each other where peers can feel understood by merely being in the presence of those who can relate to their experience.

In addition to the implicit nature of peer support attendance contributing to peers feeling understood, participants also identified explicit actions that contribute to the perception that peers could relate to experiences being discussed. This included observing peers nod along to show active listening and agreement, or other actions which show an active interest in what is being said.

"*Bob [pseudonym] was just nodding and kind of agreeing, but I think we were talking about hallucinations and um, just him nodding and agreeing felt, kind of nurturing.*" Interview response from HVN group attendee (Payne et al., 2017, p209)

"*They seemed to take an interest in what I was saying … and when I went back they had bought me a book and they all signed it and that was the best present ever ... and I just thought wow*." Interview response from HVN group attendee (Oakland & Berry, 2015, p124)

These explicit interactions and behaviours not only contribute to feeling understood by peers, but it also evokes a sense of being nurtured or cared for in participants. Connecting with peers through peer support was more than meeting people who have had similar experiences but experiencing recognition and validation of experiences (Levasseur et al., 2019; Schaefer et al., 2021; Williams et al., 2018).

Feeling understood within the context of peer support reaches beyond peers understanding psychotic type experiences to also include an understanding of the associated misunderstanding or stigma. In this first phase of peer support, the experiences of peers are shaped by the ability to connect with peers through a mutual understanding of the challenges faced in wider society.

"*Group members not only know the experience of hearing voices but also easily understand what it is like to feel powerless when dealing with voices or what it is like to have to deal with misunderstandings of people who do not hear voices.*" Interview response from HVN group attendee (Schaefer et al., 2021, p6)

Sub-theme Theme 1.2: Atmosphere of acceptance

The concept of an "*atmosphere of acceptance*" (Hyde, 2001, p172) was identified in five studies (Hornstein et al., 2020; Levasseur et al., 2019; Oakland & Berry, 2015; Payne et al., 2017; Schaefer et al., 2021). Peer support was viewed as a place where others would not judge peers for their experiences or as people.

"*So there's no judgement, there's no judgement of who you are or what you've been*." Interview response from website user with psychosis (Williams et al., 2018, p8)

The restorative function of being understood by peers was associated with participants experiencing peer support as being in an intentionally accepting atmosphere, which in turn facilitates connection between peers. Peers are viewed as being able to understand each other because they cannot only relate to the experience but can also relate to the impact of the associated stigma.

"The validating process of the HVN is not merely due to others experiencing the same thing, which decreases perceived stigma, but also because other participants understand what it is like to hear voices." Interview response from HVN group attendee (Schaefer et al., 2021, p6).

The impact of acceptance in a peer support setting contrasts with the lack of understanding or acceptance in the wider population. By identifying similar experiences in peers, there is a validation and acceptance of their own experience in relation to their own sense of self.

"It was almost impossible because people have a notion that you just snap out of it… take a pill. Clearly, the general population does not understand these situations." Questionnaire response from EIP family member (Levasseur et al., 2019, p9)

"*For years I had felt that I wasn't really a human being . . . I became human in relation to the other members in the group*" Interview response from HVN group attendee (Hornstein et al., 2020, p7)

Sub-theme Theme 1.3: Belong to a Community

The "*acceptance, identification and bonding promoted connecting*" Interview response from HVN group attendee (Payne et al., 2017, p209) between peers, allowing participants to be open to connection and relationship development, fostering a sense of belonging and being part of a community. The recognition of a shared experience appears to be central to building a community for individuals who experience symptoms of psychosis, where the isolating nature of symptomology, and the lack of awareness in the general population can reduce the opportunity to see evidence of others with similar experiences (Levasseur et al., 2019; Payne et al., 2017; Schaefer et al., 2021). *Belonging to a community* by building connections through shared experience appears to help develop a sense of safety for individuals during this first phase of the peer support experience.

"*I felt like I belonged somewhere so I could take my mask off and feel safe*" Interview response from HVN group attendee (Oakland & Berry, 2015, p124)

The online peer support modality involved no direct interaction between peers but instead peer support was accessed through watching prerecorded videos of peers (Williams et al.,

2018). Even when direct interaction is omitted, the theme of belonging to a community is still evident through being connected to a community through mutual understanding.

"*It just seemed that I'm not the only one with this type of problem, there are other people with other different types of problems, I don't have to go through it by myself*" Interview response from website user with psychosis (Williams et al., 2018, p6).

Within the Hearing Voices group model, the period where group members learn about peer's voice hearing experiences and report a sense of relief that they are not alone in their experiences has been described as the "discovery" stage (Hornstein et al., 2020, p6; Oakland & Berry, 2015, p122). This was echoed within family peer support systems. Meeting other family members was viewed as beneficial as "knowing you are not alone somehow helps" (Levasseur et al., 2019, p9). Belonging to a community reflects the development of a collective being facilitated by peers caring for each other, and providing a source of solidarity through peer support.

"I felt that people were on your side and, you know, had similar experiences but also cared about you" Interview response from HVN group attendee (Payne et al., 2017, p209).

There was evidence of challenges presented by *belonging to a community*, with some participants feeling outside of the community (Payne et al., 2017) or new peer support groups taking time to feel cohesive. Within this review the duration of the initial phase, outlined in the overarching theme, differed between individuals attending peer support. While *connecting with peers* occurred and feeling part of a community occurred quite quickly for some participants, others outlined a more gradual process.

"*It was not the case initially, but this feeling of togetherness began [to emerge] after a year or so*" Interview response from HVN group attendee (Schaefer et al., 2021)

Theme 2: Learning through mutual support

The second phase of the experience of peer support, *learning through mutual support,* involves the reciprocal exchanging of information and ideas, which was present across all studies, bar the online platform intervention (Williams et al., 2018). The term *mutual support* is utilised within peer support literature to define the bi-directional nature of support, which is an active process where peers are both the recipient and provider of care (Pitt et al., 2013). This is a central component of peer support and distinguishes it from relationships with clinicians or other professionals. The analytical theme is composed of two main aspects: the *opportunity for learning* through peer support and *engaging in the mutual support* process.

Sub-theme Theme 2.1: Opportunities for learning

All studies outlined learning new information and coping strategies as a key aspect of the peer support experience. This was often why participants chose to engage in peer support services in the first place (Schaefer et al., 2021; Williams et al., 2018).

Hearing peers' experiences and learning from them was often described as having a practical focus on everyday situations and how to handle difficulties like hearing voices, while also considering wider social issues such as impact of relationships and employment (Dos Santos & Beavan 2015; Hyde, 2001; Schafer et al., 2021). The frequencies of the opportunities to learn from peers was highlighted regularly within studies, often in the form of sharing within group discussions where "*the other members may have a suggestion from their experiences*"

(Dos Santos & Beavan 2015, p31) and peers have the opportunity to gain information from a number of different sources.

This form of informal interaction is distinct from more didactic methods used in a clinical setting with health care professionals (Oakland & Berry, 2015). Hearing peers discuss how they manage difficulties is viewed within a lens of peers understanding each other's circumstances and being on their side. The opportunity to learn from peer experiences and try out different coping strategies is introduced within an environment of understanding and active recognition of the challenges faced in the wider community. Seeing others can evoke a sense of belief in a participant's own abilities to apply their learning.

"Yes, I found some of that useful. . . I thought, "Ooh, I will try that too," or. . . uh, "Ooh, maybe I can do it that way."" Interview response from HVN group attendee (Schaefer et al., 2021, p6)

The difference in clinicians or professionals offering advice in comparison to peers is actively addressed. While this could again refer to a more practical approach being more applicable in a peer support setting, the role of being a 'expert' through lived experience is also outlined.

"*I think there are tips and tricks that psychologists don't know about. . . that are beneficial for people who hear voices"* Interview response from HVN group attendee (Schaefer et al., 2021, p6)

Sub-theme Theme 2.2: Engaging in mutual support

Peer support environments provide the opportunity for mutual support, with peers being open to listening to others and making contributions as well as having space to receive

advice themselves (Dos Santos & Beavan, 2015; Schaefer et al., 2021). Mutual support relies on the foundations built in the first phase, where the experience of connecting with peers is already established but can also be strengthened through the process of *engaging in mutual peer support*.

"I like it when I can share my experiences and see that it is helpful to other people. . . yes. . . I just think it is valuable. . . it is also nice to hear all those examples. . . because, of course, that is what we are looking for. . . what helps in which situation!" Interview response from HVN group attendee (Schaefer et al., 2021, p6).

Mutual support was identified as being practical in nature in most studies (Dos Santos & Beavan 2015; Hyde, 2001; Levasseur et al., 2019; Oakland & Berry, 2015; Schafer et al., 2021). Through the process of mutual support, the discovery of new approaches is rooted in the reality of everyday difficulties. The dynamic nature of the process allowed for testing out new ideas, and receiving feedback on this, while also sharing their own learning, and contributing to other's development through this process (Schaefer et al., 2021). The lack of a hierarchical structure, with one individual's expertise not being prioritised over another, provides opportunities from confidence building through peers seeing others gain from their contributions. The experience of peer support outlined in the studies suggests that peers identify themselves as active participants in the intervention, where they held a dual role of being supported and supporting others.

"*I don't feel like a sick person there. I can get support but still be treated like I have wisdom. I feel like I have something to offer*." Interview response from HVN group attendee (Hornstein et al., 2020, p8)

Mutual support moves beyond gaining coping strategies and knowledge in isolation, to experiencing a process that evokes feelings of empowerment though helping others (Oakland & Berry, 2015). Therefore the combination of subthemes encompassed by *learning through mutual support* both strengthens the *connections between peers* whilst also building confidence and empowering peers to allow them to access the third phase.

"*I hope that each time I share my story that someone in the group was helped through my story. Because their sharing and listening helped me*." Questionnaire response from EIP family member (Levasseur et al., 2019, p13).

Theme 3: Hopeful Progress

The analytical theme which forms the third phase is defined as *hopeful progress*. This reflects a movement in a positive direction, whether that is better management of difficulties, recovery or improved ability to support a family member, which is grounded in hope. Building on the first two phases, this theme encapsulates how peer support develops a forward looking, hopeful viewpoint in participants. All studies outlined the role of looking towards a more positive future, whether that is in a group or web-based setting and both as individuals and family members.

"*I can see it, I'm going to recover, I want to recover, I have to recover*." Interview response from website user with psychosis (Williams et al., 2018, p8)

Sub-theme Theme 3.1: Empowered by knowledge

The empowering aspect of mutual support helps the individual to cope more effectively by increasing their sense of agency within their own lives, especially in relation to psychosis or related experience. Moving beyond acquiring knowledge about their difficulties through peer support and possible coping strategies, it is the experience of peer support that contributes to the increase in self-efficacy that is vital to the application of the learning. Seeing peers successfully applying skills creates a reference point for participants own possibility for success.

"I was hiding in cupboards, I was so afraid of the voices, whereas now I feel when it does happen I'm more empowered to deal with the situation than I was when I first started" Interview response from HVN group attendee (Oakland & Berry, 2015, p124)

Participants valued hearing advice from a diversity of experiences and stages of recovery. The hopeful outlook and being empowered to try out new approaches were central aspects of the peer support experience.

"*They hear that different coping strategies can help different voice hearers (at different times in their lives), which provides hope for trying different strategies*" Interview response from HVN group attendee (Schaefer et al., 2021, p6).

Sub-theme Theme 3.2: Seeing evidence of living well

While this analytical theme reflects the desire for progress, it is the unique element of peer support where there is an opportunity to see evidence of this process in peers. Seeing peers living well and managing their difficulties is a vital component developing hope, and is present in all studies.

"*I suppose I looked up to these people on the site and thought, well if other people can, with a mental illness, can be articulate and have a voice and have meaning in their life, well that means perhaps I can too*." Interview response from website user with psychosis (Williams et al., 2018, p8)

"*I say "look maybe seeing me it will give you hope, knowing that, OK you're in hospital, you're sectioned but that doesn't mean that's the end of your life. Look at me you know, I'm doing things*." Interview response from HVN group attendee (Oakland & Berry, 2015, p124)

Experiences of peer support also shapes the aims individuals have and what recovery means to them. This is often informed by seeing peer's journeys and relating this to their own.

"*Getting rid of the voices completely is not the goal, it's controlling and living with them. It's like living with diabetes, you don't get rid of your diabetes, you control it [y] plus having a goal*" Interview response from HVN group attendee (Dos Santos & Beavan, 2015, p33)

Seeing evidence of living well is also closely linked with the desire to share with, and help others. It specifically examines the progress towards a place where there is a desire to help others, as peers themselves feel they have improved enough to be in a place to do so. Given the complexity of recovery, this is unlikely to be linear progress but expressing a desire to help others can be viewed as the next step in recovery, building on the key component of mutual support. Experiences in peer support locate learning within a real-world setting. This is in direct juxtaposition to a medical model, led by experts who often aim to instil hope but provide their interventions in a clinical setting removed from the context of people's lives.

Theme 4: Influence of the setting

The final theme specifically reflects this influence of the setting in which peer support takes place. Seven studies referred to a group-based setting (Dos Santos & Beavan 2015; Hornstein et al., 2020; Hyde., 2001; Levasseur et al., 2019; Oakland & Berry, 2015; Payne et al., 2017; Schaefer et al., 2021). This theme considers the strengths and challenges identified in the peers support experience according to the setting context.

Sub-theme Theme 4.1: Group setting enhancing peer support

This subtheme reflects the concept that in a group setting, peers themselves inform the dynamics and content of the peer support by not only influencing the topics discussed, but also how the group itself functions (Dos Santos & Beavan 2015). This was explicitly referenced in all studies of group-based peer support except Hyde (2001). *The "group shapes the group*" (Payne et al., 2017, p212) is a key concept within Hearing Voices Network studies (Dos Santos & Beavan 2015; Oakland & Berry, 2015; Payne et al., 2017; Hornstein et al., 2020; Schaefer et al., 2021). It is identified as important to the experience of peer support with participants appreciating the sense of agency they have to inform the peer support environment. The dual role peers hold by both receiving support from the group and informing how the group operates, is mirrored within the identification of mutual support as a key element with the peer support experience.

"*That's one thing I love about this group, it's there's no control – it's, it's about the group.*" Interview response from HVN group attendee (Payne et al., 2017, p212).

This process can cause apprehension at first, with the desire to have someone take the lead and occupy the more traditional role of an "expert" leading a group support intervention.

The facilitator in all groups within this review are described as having lived experience and occupied the position of providing logistical support and encouraging group members to engage in the process of mutual support.

"*At first, I thought, . . . you need a strong moderator. . . but no. . . our facilitator also has experience with voices and is just a member of our group.*" Interview response from HVN group attendee (Schaefer et al., 2021, p9)

Sub-theme Theme 4.2: Challenging group dynamics

While *connecting to peers* has been considered to be the foundation of the peer support experience, a group setting also presented challenges to developing connections between group members. *Challenging group dynamics* reflects difficulties within the group where peers feel unable to relate to other group members, resulting in difficulties moving forward though the phases of the peer support experience. The influence of challenging group dynamics appeared to have a greater impact on peers while they were initially accessing peer support and had a more limited role once peers had become a more established group member.

"*Before I just felt a bit like a loose key. You know, everybody else had been in the voices group for a long time*" Interview response from HVN group attendee (Payne et al., 2017, p209).

Challenges were identified when there became a mismatch between the individual peers and the wider group. Schaefer et al,. (2021) gave examples of this being in relation to how experiences are perceived in relation to illness, the desire to discuss specific themes which differ from the group's preference and different content of voices themselves i.e. positive or

negative tones. This can lead to difficulty continuing to access peer support due to ruptures in the first phase of connection with peers.

"*Such misalignments prevent these individuals from taking full advantage of the processes of validation, information, connection, and reflection within the group, which means that they regularly leave the group after a while*" Interview response from HVN group attendee (Schaefer et al., 2021, p10).

Discussion

The present systematic review synthesised qualitative findings from eight studies to explore the experiences of peer support for individuals with psychosis, or similar experiences, as well as their family members or carers. The thematic analysis identified four analytical themes and considered these within a phased structure: (1) *connecting with peers,* (2) *learning through mutual support*, (3) *hopeful progress* and (4) *influence of setting.* The findings suggest that experience of peer support initially focuses on feeling connected to others. This facilitates learning and making changes that move individuals and families in the direction of a more hopeful future. These processes are shaped by the environment in which peer support is accessed.

The phases seemed to reflect the sequential basis of the peer support experience. The process of *connecting to peers* to allowed participants to feel understood and cared for, acting as the foundation of the role of peer support in recovery. Within the Hearing Voices group model, the relief felt when peers identified that others also have voice hearing experiences has been described as the "discovery" stage (Hornstein et al., 2020, p6; Oakland & Berry, 2015, p122). The current review expands on the idea of discovery, suggesting that there is a similar process across a variety of peer support settings, including with families and carers.

The role of the exchange of information and facilitating social support as important aspects of peer support has also been highlighted in previous studies (White et al., 2017). The progressive stages of the themes reflect movement from an initial period of connection to the ability to engage in social learning and therapeutic change has echoes of key ideas expressed in mentalisation theory. The current review highlighted that the initial phase of

peer support provided a secure environment where peers could engage and make connections. From the perspective of mentalisation theory, the peer support environment could be considered to facilitate the development of epistemic trust. Epistemic trust enables social learning as peers have the capacity to believe that the information conveyed within peer support is reliable and applicable to their personal circumstances (Fonagy & Campbell, 2017). This creates a basis to move from the *connection* phase to having the opportunity to learn from others, while also supporting a hopeful outlook, allowing change to take place.

Another important aspect of the current findings is considering the phases outlined in relation to previous research on peer supports role in destigmatising psychosis (Nguyen et al., 2022). High levels of internalised stigma in those experiencing psychosis have been identified in previous research (Brohan et al., 2010). Associations have been identified between high internalised stigma and low self-esteem (Yanos et al., 2008), lower quality of life and difficulties accessing social support (Livingston & Boyd, 2010). Parental stigma has also been identified as a barrier to help seeking (Baron et al., 2019). A previous thematic synthesis of stigma in psychosis identified eight key processes that underpin the cause and maintenance of stigma (Wood et al., 2015). These processes map onto the different phases of the peer support experience in the current review, where *connection with peers* could be perceived as addressing five of these processes: “social exclusion”, “devaluing difference”, “stereotypes and discrimination”, “inferiority and inequity” and “shame and secrecy” (Wood et al., 2015, p158). *Learning through mutual support* could be seen as combatting “lack of understanding “ and “lack of power and control” while *hopeful progress* counteracts “pessimism about recovery” (Wood et al., 2015, p158). Nonetheless, the construct of stigma remains heavily debated (Livingston & Boyd, 2010). This said, the themes outlined in the current synthesis suggest that peer support is experienced as influencing internalised stigma

and that different phases of the peer support experience have a role to play in reducing its impact.

Clinical implications

Despite increased recognition that the importance of incorporating the views of those with lived experience into service design, access to peer support within psychosis care remains challenging (Hopkins et al., 2021). Previous research highlighting the need for development of peer support interventions beyond a symbolic inclusion of experts by experience to include integration into existing clinical systems (Hopkins et al., 2021). Considering the phase model identified in the current review, integrating peer support at a service design level early in the treatment of psychosis would facilitate opportunities to improve care through reducing stigma and providing hope for recovery, for both service users and their families or carers. The definition and boundaries of peer support interventions need to be established with the specific context it is being delivered in. This would likely include governance considerations such as supervision frameworks for peer facilitators and information sharing policies.

Peer support could also be utilised to improve clinical practice, by peers being included in the design and delivery of training to staff working in the field of psychosis. The recovery-focussed outlook and development of coping strategies which can be applied in everyday scenarios, where strengths of peer support are identified in this review. Integrating these aspects in non-peer support interventions, such as through lived-experience informed professional develop opportunities could improve outcomes within traditional service delivery.

Although this review has a group-based focus, the positive impact of website-based peer support was also outlined. Therefore, exploring opportunities for peer support within clinical practice could be a key area of development for psychosis services in the future. Online platforms would increase the reach of peer support interventions, to those individuals who are isolated, either geographically or socially. It also provides a flexible approach to engagement as was highlighted in the study by Williams et al. (2018). However, challenges around digital literacy and access to technology would require careful consideration in relation to equity of service provision (Fortuna et al., 2020).

Strengths and Limitations

The review focussed on hearing directly from service users and their families or carers about how they experience peer support. At present, no review or quality appraisal was available within the literature that explores the experience of peer support from the perspective of both individuals directly affected by symptoms and their family members or carers. The thematic synthesis facilitated an amalgamation of perspectives, from multiple studies, to highlight the facilitating factors and challenges that influence the peer support experience. Although only one study in this review involved the views of family and carers, the sample did provide a diversity of settings (HVN, inpatient, EIP) and included the views of service users and family members/carers from five different countries. The motivation to gain an understanding of peer support from the perspective of those who access it, informed the inclusion criteria basis with respect to psychosis or psychotic experience which was applied to allow for the inclusion of Hearing Voices Network (HVN) groups. There is a significant amount of literature available in this area and exclusion based on the requirement for a

diagnosis of psychosis could have introduced bias into the review by imposing a medical model which could exclude relevant data.

The inclusion of only English language papers is a limitation of the study and may have restricted the geographic area represented. There is a risk that important findings from non-English language papers have been omitted and have inserted a western bias into the review (Liberati et al., 2009). This may affect the current review, although exhaustive search strategy is a strength, alongside the inclusion of a second reviewer. A variety of databases were utilised, with broad search terms applied and measures were taken to conduct manual searches using reference lists. This said, potential for error cannot be fully mitigated and suitable studies may not have been identified.

Future Research

The current review was restricted by a lack of available literature exploring the experience of peer support interventions for family members and carers. Further research in this area would allow for a more comprehensive commentary to be made of the role peer support can have supporting family members and carers. Similarly, the current review is predominantly group-based peer support so more research into other modalities, such as web-based would be beneficial.

Findings of the thematic analysis identifies the potential role peer support has in combatting stigma on an individual level. The socially embedded nature of stigma requires both individual and systemic changes to challenge both public and self-stigma (Corrigan et al., 2005). Future research contributing to the continued development of psychosocially informed public health campaigns aiming to reduce stigma about psychosis in the wider population, is needed. The inclusion of lived experience, for example through consultation

with those attending peer support would be essential to providing an insight into the impact of stigma on individuals and families.

Conclusion

Understanding the experience of peer support from the perspective of those accessing the services is essential to exploring how peer support can influence positive outcomes within the context of psychosis or psychotic type experiences. This review identifies *connecting with peers* as an essential initial component of peer support which then allows *for learning through mutual support* and progress to be made by instilling hope. Future research into the influence of different modality of peer support would allow further comment on the role of groups, web-based support, and other environments in the facilitation of peer support. Additionally further research should focus on further developing an understanding of family peer support and consider opportunities for peer support applications within existing clinical services.

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Chapter 2: Empirical Study

Evaluating the Implementation of an Early Intervention Psychosis Service in a Rural Scottish Health Board: A Mixed Methods Study

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Abstract

Aim: While the effectiveness of early intervention psychosis (EIP) services has been demonstrated in previous research, the understanding of its application in a rural context is more limited. The purpose of this research was to develop an understanding of how an EIP service has been implemented in a rural health board. Fidelity to the EIP model, acceptability and change over time was also assessed.

Method: A mixed methods design was utilised to examine the experiences of service users, family members or carers and staff, alongside the analysis of routine outcome data. Descriptive statistics assessed fidelity to the EIP model, and the Kruskal-Wallis H analysed change over time. Using constructivist grounded theory, data was collected through semi-structured interviews, with concurrent data collection and analysis.

Result: Implementation of the EIP model was achieved with short waiting times, high engagement and change over time demonstrated, but a long duration of untreated psychosis (DUP) remained. The grounded theory provides a conceptual framework for understanding how staff rely on *collaboration*, *building relationships* and *being there* for service users and families to navigating the challenges presents in the rural health board. Social isolation and the influence of restricted access to activities, and transport links were identified as barriers to implementation.

Conclusions: The integration of qualitative and quantitative data demonstrated effective implementation of the EIP service as staff work collaboratively within the rural health board. Further research should examine the challenges of long DUP and reduced access to services in rural health boards.

Keywords: early intervention psychosis, rural, mixed methods, grounded theory

Introduction

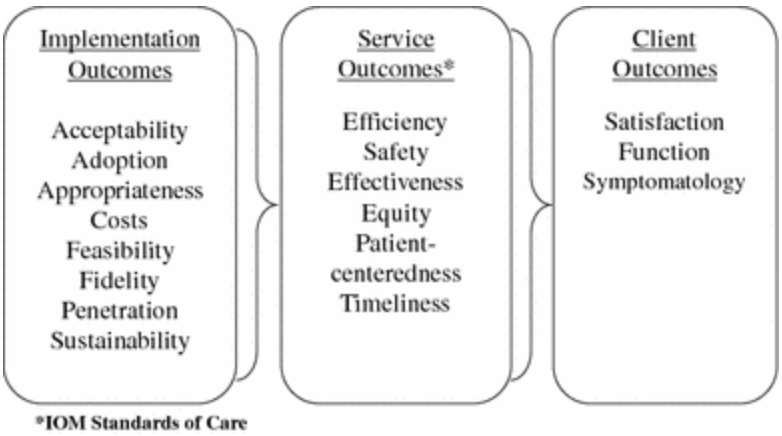
Prognosis after a first episode of psychosis (FEP) varies, with an estimated recovery rate of 38% at a 7 year follow up (Lally et al., 2017). Compared to the general population, those who have had a FEP have higher levels of mental health service use (Fusar-Poli et al., 2017), an increased risk of poor physical health, and higher mortality rates (Hayes et al., 2017). A key factor is the duration of untreated psychosis (DUP), defined as the time between the onset of psychosis symptoms and the start of treatment (de Pablo et al., 2024). The longer the DUP the poorer the treatment response (Drake et al., 2020). The 'critical period hypothesis' (Birchwood, 1999) identifies the impact of the early phase of a FEP on the long-term outcomes, highlighting an opportunity for prevention of subsequent episodes and long-term functional impairment by accessing treatment during this time. The 'critical period' is a window of opportunity for secondary prevention in the first three years after onset by addressing biopsychosocial factors with a multidisciplinary intervention (Birchwood et al., 2014).

The Early Intervention Psychosis (EIP) model of treatment aims to reduce the duration of untreated psychosis and target the 'critical period' through the early detection and treatment of psychotic symptoms (Csillag et al., 2018). Informed by key aspects of Birchwood's (1999) hypothesis, EIP services are designed to provide timely access to intensive interventions over a one-to-three-year timescale. EIP services apply a multidisciplinary approach to implement recovery-oriented, evidence-based interventions such as access to antipsychotic medication, psychological therapy, family support, occupational therapy and peer support (O'Connell et al., 2022). A key characteristic of the model is assertive engagement which is facilitated by low caseload numbers held by case coordinators/key workers (Williams et al., 2025). EIP interventions address psychological wellbeing, resistance to treatment and disruption to social networks in the prodromal phase and during first onset (McGorry et al., 2008). Meta-analyses and systematic reviews highlight EIPs effectiveness compared to treatment-as-usual for various clinical and functional outcomes including psychosis symptoms (Correll et al., 2018), inpatient admissions (Randall et al., 2015) and employment rates (Bond et al., 2014) for individuals who experience a FEP.

Whilst clinical trials have focussed on the efficacy and efficiency of EIP, the effectiveness of such complex interventions is dependent on their implementation within the context in which they are being delivered (Pfadenhauer et al., 2017). Therefore it is important to consider how the multiple aspects of complex interventions, such as EIP, are being delivered in practice, within a specific setting. Proctor et al. (2009) highlighted the need to address the gap between evidence based, effective treatment derived from research and what is delivered in routine care. The application of implementation research to investigate this gap involves the study of process and strategies which are required in the application of evidence-based treatment in health care settings. The conceptual model proposed by Proctor et al. (2011), see Figure 1, outlines implementation outcomes preceding service and client related outcomes.

Figure 1.

Types of Outcomes in Implementation Research Proctor et al. (2011)



The processes involved in implementation can be an intermediate outcome to quality of care (Proctor et al., 2011). Analysing implementation effectiveness as a distinct entity from treatment effectiveness is key to understanding the execution of evidence-based models in practice. Factors such as geographic location are likely to impact the application of a service model, such as EIP (Kelly et al., 2007). For example, the challenge of delivering EIP in a rural area is the translation of the evidence-based practice developed in an urban area of high population to a rural community (Cheng et al., 2014).

The impact of rurality on FEP is complex, potentially influencing both the desired early detection and recovery. Residing in a rural area has been found to decrease access to care

for psychosis and offer less opportunity for socialisation (Welch & Welch, 2007), although study findings are mixed. In an Australian context, service users with FEP who live in rural areas have to travel further to access care in comparison to other psychiatric disorders (Stain et al., 2008). However, evidence from India suggest there is no difference between length of DUP between urban and rural residing service users (Thirthalli et al., 2017). This is consistent with more recent findings in a UK context (Kaminska et al., 2025) which suggested there was there was no relationship between DUP and residential area (urban vs rural). A shorter DUP was however observed in those with an acute onset in comparison to a more gradual onset of symptoms (Kaminska et al., 2025). Acute onset is more likely to involve hospitalisation or multiagency involvement, receiving a consistent response across an urban and rural area. On the other hand, a gradual onset may be an important factor in treatment delay in rural areas, where the progressive development of symptoms may be harder to identify and there is reduced availability of specialist service provision resulting in delays to referrals (Kvig et al., 2017).

When considering the impact of rurality on recovery, social inequalities related to unemployment appear to have a more pronounced association with mental health outcomes in a rural area than in an urban setting (Riva et al., 2011). Social disconnectedness can contribute to the development and maintenance of mental health difficulties in a rural area, whilst stigma can potentially impact on help seeking behaviours (Thirlwall & Whitelaw, 2020). On the other hand, individuals residing in a rural area were more likely to connect with family and be employed, with higher unemployment rates in urban areas (Kaminska et al., 2025). These mixed findings highlight the complexity of the relationship between geographic setting and FEP, and the factors that may contribute to this. This said, social isolation remains an important consideration as it is a significant challenge for adults with psychosis (Stain et al., 2012). Further research is needed to understand the impact of living in a rural area on FEP.

EIP services have been effectively established in rural areas across the world, including in the United Kingdom (Burbach et al., 2009), Australia (O'Keamey et al., 2004), Greece (Mantas & Mavreas, 2012) and Canada (Cheng et al., 2014). The literature highlights the central mechanism to the success of EIP as being timely access to intensive treatment (Fusar-Poli et al., 2017). However, it has not been established how this transpires in a rural setting, where

geographical barriers present a challenge to model adherence and time sensitive delivery of treatment (Thirthalli et al., 2017). Although there are international guidelines on the delivery of EIP (IRIS, 2012) there are likely to be differences in service provision across different nations. For example, EIP services in India place a greater emphasis on family members role in treatment compared to Canadian models (Iyer et al., 2022). Outpatient care does face a universal challenge in sparse geographic locations where increased clinician time is spent on travel. Implementation studies in Australia (Welch & Garland, 2000) and Canada (Tee et al., 2003) highlighted the importance of working within existing rural services to establish local networks targeting early recognition of FEP. Collaboration and communication within health and social care partnerships and the value of service outreach to third sector services has been recognised as key to EIP delivery and this has a greater role in rural areas where geographical barriers can decrease access to services. Positive aspects of rural delivery of EIP have also been identified in the form of high levels of informal care, the role of community spirit and opportunity to engage in agricultural or environmental work (Dodgson et al., 2008).

The effectiveness of EIP is well established in the literature but there is a more limited understanding of its application in a rural setting, particularly within the context of the National Health Service (NHS) in the United Kingdom. Pipkin (2021) identified a need to examine the extent to which rural EIP services are adhering to the evidence-based model and addressing the specific challenges of rural service provision. Evidence from Western countries indicate that adherence to the EIP model can be affected by staff resistance due to time constraints and travel challenges with insufficient funding being the most cited barrier to implementing EIP (Bedard et al., 2016; O'Connell et al., 2022). Further research is needed to understand how these barriers to implementation of in rural areas can be overcome within the context of the United Kingdom.

With respect to implementation research, a range of outcome measures and research designs have been utilised within the literature (Pipkin, 2021). A meta synthesis by Hansen et al., (2018) highlighted the diversity in experiences of EIP services and recovery from the perspective of service users. Themes were identified as part of a process where service users navigate their contact with EIP services on their path to recovery. The influential role of relationships built between staff and service users was identified through a focus on service

user experiences, and it was suggested that future research to explore staff perspectives would be beneficial (Hansen et al., 2018). Incorporating the views of service users and their family members or carers has also been identified as a gap in the literature with only a limited number of studies focusing on more than one participant group (Allard et al., 2018).

A mixed methods design is employed by the current study to incorporate the experiences of key stakeholders alongside routine outcome data to analyse the implementation of an EIP service in a rural health board. The aim was to examine the key factors influencing the implementation of EIP within a rural health board by identifying barriers and facilitators from the perspective of clients, their families, and carers as well as the services delivering the intervention. Drawing further on Proctor et al.'s (2011) conceptual model of implementation, the service's fidelity to the EIP model and its acceptability in a rural health board from the perspective of service users, their family members/carers and staff was also explored.

Research questions

1. What are the processes that influence the implementation of EIP in a rural area?
2. What are the barriers and facilitators to implementing the EIP model in a rural area?
3. Can fidelity to the EIP model be demonstrated in a rural area?
4. Are there changes in service users presentations over the course of the EIP intervention when EIP is delivered in a rural area?
5. Is the way in which the EIP service has been implemented rurally acceptable to service users, family members and staff members?

Methodology

Research Design

An implementation research approach was utilised using a mixed method design, where qualitative data was collected alongside routine service evaluation quantitative data. A mixed method design is particularly appropriate for implementation research as it allows the study to examine multiple viewpoints and outcomes. Qualitative methods are suited to understanding the context of complex, real-world settings, whereas quantitative methods can measure aspects relating to the content of the intervention and implementation outcomes (Palinkas et al., 2011). In addition to facilitating analysis of both context and content, mixed methods allow for the incorporation of views from those delivering and receiving evidence-based practice (Proctor et al., 2009). Proctor et al.'s (2011) implementation outcomes (see Figure 1) were used as a framework with specific outcomes of fidelity and acceptability being identified and researched using both qualitative and quantitative methods. Qualitative data within the current study consisted of interviews with participants and quantitative data included outcome data relevant to implementation research design.

Ethics

Approval from NHS Research Ethic Committee (25/WS/0019) and The University of Edinburgh, School of Health in Social Science was obtained, see Appendix F and G. Approval was also obtained from NHS Dumfries and Galloway (D&G) Research and Development Office.

Context

Prior to the implementation of new pathfinder services in Scotland, only 20% of the population had access to an EIP service if they were to experience a FEP (Health Improvement Scotland, 2025). Supported by the Scottish Government and Health Improvement Scotland, NHS Dumfries and Galloway were chosen as a pilot site in 2022 for the implementation of a bespoke EIP service as part of a national programme which aimed to address the variation in access to treatment for FEP in Scotland. EIP in NHS Dumfries and Galloway was launched in June 2022 for an initial two-year period, which has since been

extended. NHS Dumfries and Galloway have implemented a stand-alone bespoke model of EIP, where care was delivered by the EIP team but service users remaining on the Community Mental Health Team (CMHT) caseload to access psychiatry reviews as required.

NHS Dumfries and Galloway provided care to a population of over 148,000 who reside in the Southwest of Scotland (NHS Scotland, 2022). The EIP service is based in the largest town, Dumfries. Dumfries and Galloway is one of Scotland's most rural regions, with 40% of the population living in what has been defined as rural areas, compared to the national average of 17% (Scottish Government, 2024).

Qualitative data

Study Design

Grounded theory was used to allow for theories to emerge from simultaneous data collection and analysis, whilst facilitating integration of existing knowledge of the EIP model (Charmaz, 2014). A social constructivist grounded theory approach was applied to analyse the interviews. This involved a reflective stance being adopted where the role of the researcher as an active participant was acknowledged during the data collection and interpretation (Charmaz, 2014). Other qualitative methodologies were considered during the development of the study. However, applying grounded theory allowed for the exploration of the research question by analysing the lived experience of service users, families, and NHS staff, within the specific context of a rural area. Grounded theory analyses the development of social processes that in turn provide a theoretical basis for how EIP is implemented. The analysis also gives the option to modify questions and interview schedules as concepts are constructed from the data and gives the flexibility to explore themes emerging from the data.

Recruitment

Potential participants were made aware of the current study by the lead researcher's field supervisor (staff) or an EIP key worker (service users and family members/carers). Figure 3

outlines inclusion and exclusion criteria. Those expressing an interest were provided with an information sheet and were contacted by the lead researcher to discuss the purpose of the study and answer any questions. Written consent was obtained prior to an interview taking place, see Appendix H and I.

Figure 3.

Inclusion and Exclusion Criteria for Recruitment

Inclusion Criteria	**Exclusion Criteria**
All participants All individuals must be over the age of 16 and have capacity to give informed consent. **Service user/Family/Carers** Individuals engaged with EIP services in NHS D&G as a service user or family member/care giver of service user. **NHS Staff Members** Current employee in NHS D&G Job role involves direct working within the NHS D&G EIP and/or directly involved in implementation of the service.	**All participants** Individuals who currently reside out with the NHS D&G health board area due to duty of care requirements. **Service user/Family/Carers** Individuals who are experiencing an acute mental health crisis which will be defined as being an inpatient or being identified as being in the 'risk' category by the EIP. Individuals who are identified as being not suitable for lone working because of the risk to the researcher if unable to access a video call.

Participants

EIP service users, family members or carers of EIP service users, and NHS Dumfries and Galloway staff members directly involved in the implementation of the EIP service were invited to take part in individual interviews. A total of 15 participants took part in the study consisting of service users (*n* = 5), family members (*n* = 4) and staff (*n* = 6). Sampling was purposeful with the aim of recruitment being balanced across all three groups throughout the recruitment process. All staff members approached agreed to take part. Data is not available on the acceptance rate for service users and family members as potential participants were identified and approached by EIP staff members. Theoretical sampling was utilised to guide data collection in such a way that the emerging categories from initial coding and analysis were refined. This included considering the geographical location of

service users and family members within the rural area, and how long they had been involved with the EIP service. The EIP service staff team is small, so this limited the pool of participants available.

Procedure

Interviews

A pilot interview was conducted by the lead researcher with an Assistant Psychologist associated with the EIP service prior to the first interview with a study participant. This allowed the researcher to become acquainted with the interview technique, seek feedback through supervision and to revise the interview schedule.

Interviews were conducted over a seven-month period and followed an open format, where questions were administered flexibly in response to the participants information. Initial questions focussed on participants' early experiences of the EIP service (see Appendix J) which was then used to guide a discussion about the participant's experiences without necessarily employing specific questions around barrier and facilitators to implementation in a rural health board. Prompts were used when appropriate, such as "what was that like?" and "you mentioned x, can you tell more about that". Sharing of autobiographical memories was encouraged using probes such as "Can you remember an example of x that you could share with me?". This allowed for rich data to be gained (Charmaz, 2014). Throughout sampling, interviews were informed by initial coding, the use of memos and the reflective discussion of these in supervision. Interviews ranged from 25 to 55 minutes (*M*=34:35, *SD*=8:15). All interviews were audio recorded and transcribed verbatim with data being anonymised at the point of transcription.

Quality Assurance

Validity in qualitative research is recognised as being vital to best practice and providing high quality research. A clear account of the methodology for data collection and analysis was employed to ensure rigour in the research process (Pope & Mays, 2020). Respondent

validation was more challenging to achieve given the researcher's focus on producing a theoretical interpretation of the EIP model implementation which may not be accessible to service users and families. Efforts were made to complete this with the staff group. As outlined by Charmaz (2014), memos were written throughout the research process to ensure transparency. Memos took a range of forms: documenting emerging themes, making comparisons between interviews and highlighting potential biases from the researcher (Charmaz, 2014). Discussion of coding and emerging themes in supervision was considered essential for quality assurance processes.

Reflexivity

A constructivist position was adopted, where reality was viewed as socially constructed and influenced by interactions between participants and the researcher (Charmaz, 2014). Constructivist grounded theory requires careful consideration of the researchers' assumptions and biases within the context of the researcher's active role in the collection and the interpretation of the data (Charmaz, 2014). The lead researcher was aware of their own preconceptions, informed by being part of the EIP service during their training and their continued contact with staff outside of the research project. All staff and some family members were aware of lead researcher's previous role in the EIP service. The researcher's existing knowledge of the EIP model required adopting an open-minded stance while collecting and analysing data. This allowed for existing knowledge to be utilised in developing a higher-level analytic understanding as well as identifying patterns and refining concepts, without imposing preconceptions by remaining grounded in the data. Both reflection in supervision and memos were used to consider the impact of the researcher on the data collection and analysis. The concurrent data collection and analysis process allowed the researcher to remain immersed in the data. The use of memo writing throughout the iterative process produced an audit trail that linked raw data to the final theory.
The researcher's assumptions about the experience of working and living in a rural health board were an important consideration during the study. A reflexive diary was used throughout data collection and analysis, with biases around rurality being actively explored.

Supervision was utilised to discuss the potential influence of bias on the data interpretation and resulting theory.

Analysis

The grounded theory approach by Charmaz (2014) was applied to analyse interview data. Line-by-line coding of the raw interview data allowed for key descriptive concepts to be identified. These were grounded in the data, limiting the influence of pre-analytic assumptions during the initial stage of analysis. Charmaz (2014) highlighted that examining gerunds encourages researchers to be more aware of action-oriented language and therefore able to consider the relationships between these and social processes. Initial categories facilitated an inductive process of generating new interview questions as a conceptual understanding of the data developed. Analytical memos were used to record and reflect on ideas throughout this process. Grounded theory analysis is an interactive process involving moving backwards and forwards between coding and conceptualising data, with comparisons being made between participants' data to examine the relationships between categories and themes (Charmaz, 2014). This facilitated the development of theory by examining contrasts allowing for abstraction from the data to theoretical categories. This process involved the use of diagrams and memos until the data was clustered and represented in what seemed to be the most appropriate way (Charmaz, 2014). As recruitment progressed, theoretical sampling was employed to refine the high-level categories until theoretical sufficiency was reached. Theoretical sufficiency was preferred over theoretical saturation to ensure that the data collected adequately addresses the study aims and the theory constructed. Examples of coding and analysis are outlined in Appendix K.

The analysis is distinct from other qualitative methods. Data collection and analysis were simultaneous across three groups of participants, with constant comparisons between data, codes and categories, to produce a theory of the processes occurring in the EIP implementation. Where thematic analysis organises data into themes, the grounded theory analysis in this research links categories into a theoretical model. The analysis explores lived

experience and examines social processed but goes beyond this to build a theory from the data.

Quantitative Data

Quantitative data was collated from anonymised service evaluation data collected routinely by the EIP Service from June 2022 to March 2025, which was the agreed funding period including the first extension.

Fidelity

Fidelity to the EIP model was analysed by examining data from different aspects of the implementation model. Length of DUP was defined as the time (in days) between the first occurrence of psychotic symptoms, based on information provided by the service user or their family/carers and the beginning of treatment (Health Improvement Scotland, 2025). Time taken to access treatment was operationalised as the duration between referral to the EIP service and first contact made with a service user to start an assessment. This is referred to as waiting time. Input from the multidisciplinary team (MDT) was defined as a service user being offered input from a staff member from one or more of three specialities (psychology, occupational therapy and peer support) and received an input from that staff member. This was in addition to keyworker and pharmacy input, which was received as standard by all service users, as well regular reviews by psychiatry. Access to the MDT data was analysed using descriptive statistics. Length of DUP and waiting time were analysed using the Kruskal-Wallis H test to compare the respective means across the five localities in NHS Dumfries and Galloway.

Effectiveness

Effectiveness of the EIP model in the local context was operationalised as changes in the services users' presentations in relation to symptoms of FEP and more general wellbeing, in the direction of recovery. Outcome data in the form of questionnaires were used to analyse change in service user's presentations over time. Admission data for inpatient treatment at

the local inpatient mental health facility was also analysed, with an admission indicating a deterioration in mental health. Admission rate was operationalised as the number of admissions to the inpatient psychiatric ward for one night or more.

Recovery from psychosis was measured using the 15-item version of the Questionnaire about Process of Recovery (QPR) (Neil et al., 2009), the QPR-15 (Law et al., 2014). The items removed from the original 22 item scale were identified as lacking face validity or being ambiguously worded (Law et al., 2014). The QPR-15 was found to have good internal consistency, test retest reliability, convergent validity and sensitivity to change (Williams et al., 2015).

Positive symptoms, general psychopathology and affective symptoms were measured by the 18-item scale Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962). A seven-point Likert scale assessed a range of symptoms of psychosis, including hallucinations, delusions and mood disturbances and is clinician rated (Lindenmayer et al., 2007). The questionnaire is administered via a clinician's interview with a service user, as well as the clinician's observations of behaviour. The questionnaire has good internal consistency at 0.87 and can be utilised to identify both psychosis specific symptoms and more general psychopathological symptoms (Hofmann et al., 2022).

Quality of life was assessed by the EuroQol 5 Dimension 5 levels *(EQ-5D-5L)* (Herdman et al., 2011), utilising a thermometer like visual analogue scale and is a patient reported outcome measure on health status. The measure comprises of five dimensions (mobility, self-care, usual activities, pain/discomfort and anxiety/depression) which are rated on a 5-point scale. The measure has good test-retest reliability (Feng et al., 2021).

Missing data is known to be a challenge for routinely collected outcomes. The percentage of questionnaires completed at each timepoint varied, with 23.2% of service users having one or more missing data points from three-month and six-month data. Considering missing data and due to the long-term nature of EIP, it was deemed appropriate to make a comparison between scores on measures recorded at the initial assessment and at 12 months. This did reduce the sample to n = 20, as less service users who had been accessing

the service for over 12 months at the time of data collection, but all data points were available.

Acceptability

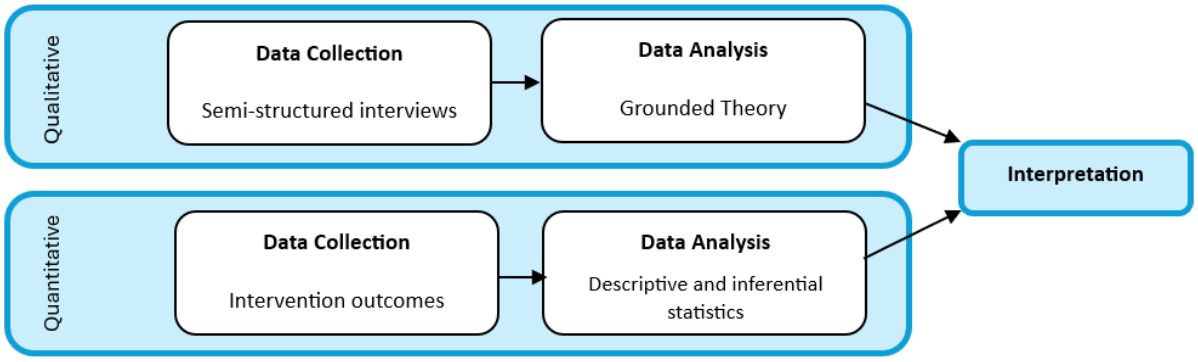
Acceptability can be seen as a dynamic process (Proctor et al., 2011) which can be captured by engagement data as well through the qualitative component of the study. Engagement does not have a universal definition but can be operationalised using attendance and treatment adherence (Casey et al., 2016).
Variation in recording precluded any meaningful analysis of data pertaining to the number of appointments attended. Therefore, within this study, acceptability was considered to be the percentage of service users deemed to be engaged monthly. That is, engagement was defined as having contact with a EIP staff member during that calendar month to review their progress and update their treatment plan. Acceptability data was reported descriptively.

Mixed Methods

A mixed methods approach was employed, integrating qualitative and quantitative data. This pragmatic approach allowed for flexibility, where the decision to analyse quantitative and/or qualitative data was informed by the research questions. The integrative nature of the mixed methods approach allowed for the combination of different sources of data to capture multiple aspects of the implementation process: the fidelity to the EIP model, the effectiveness and the acceptability of the service. Other implementation processes, including the barrier and facilitators in rural EIP implementation, relied on exploration of the service users, their families/carers and staff members perspectives using qualitative data. This mixed methods approach provided rich analysis into the implementation of the EIP service in a rural health board.

Figure 2.

Diagram Representing Mixed Methods Approach



As outlined in Figure 2, analysis of qualitative and quantitative data occurred concurrently. Routinely collected service outcome data was available from April 2025, and interviews were conducted in from April 2025 until November 2025. Analysis of quantitative data began in mid-2025 and informed qualitative data collection. For example, emphasis was placed within the interview schedule on participants first involvement with EIP, for both service users and family members, and what was their journey to a referral being made. The decision to include undertaken exploratory analysis to explore waiting time and DUP variations across different localities was informed by qualitive data, where differences in access to services were identified in different localities.

Epistemological stances in mixed methods research can be complex as quantitative components care often frames within a positivism. A social constructivist stance was adopted to frame both quantitative and qualitative findings within the context of a complex healthcare service implementation. This allowed the researcher to explore the social processes within the context of the EIP service implementation with the qualitative component, while also understanding trends and patterns from the quantitative data. The two forms of data are complementary and situated with a real-world context, and reflexivity

is applied throughout the research. Epistemological tensions are still present, but this research adopts a pragmatic approach, where the research questions are prioritised over strict adherence to a single epistemological stance. The research questions require both measurements to assess fidelity to the EIP model, as well as interpretation of both quantitative and qualitative data.

Results

EIP service in NHS Dumfries and Galloway

Routinely collected service evaluation data from a total of 43 service users was analysed. This suggested that the service was used by individuals ranging from 16 years to 36 years at time of data extraction (*M* = 27.23, *SD* = 5.97). Most service users were male (n = 36) and identified as white. The Scottish Index of Multiple Deprivation (2020) indicated that 37.5% of EIP service users were in Quintile 1, which represents the 20% most deprived areas in Scotland. This is higher than the 9.15% in Quintile 1 within the general population of Dumfries and Galloway. Clinician ratings on the BRPS (Overall & Gorham, 1962) at the initial assessment gave an average total score of 40.41 (*SD* = 12.54). This score is in the moderately ill range (Leucht et al., 2005) and is comparable to previous research examining young people experiencing psychosis (Cross et al., 2016).

Early intervention

The rural health board service provision fidelity to the EIP model was assessed. A key aspect of the EIP model is fast access to care, which aims to reduce DUP. The average waiting time for the service was 5.84 days (*SD* = 5.83). A total of 39.5% of service users were seen within 2 days of a referral being received by the EIP service. The average length of DUP was 299.79 days (*SD* = 516.98). Length of DUP scores ranged from 7 days to 2484 days. When outliers were removed the average length of DUP was 152.28 days (*SD* = 186.95).

A DUP of less than 6 months (182 days) was considered in the research to have more favourable outcomes (Albert & Weibell, 2019). Exploratory analysis was applied to examine variations across different localities. The data violated the assumptions of normality required for a one way, between subjects ANOVA, so the non-parametric Kruskal-Wallis H test was conducted. Results indicated there was no significant difference in waiting times between the different localities within NHS Dumfries and Galloway, H (4, 43) =1.07, p=.899. Length of DUP also did not differ significantly between localities, H (4, 43) =4.67, p=.322.

Staff member's accounts supported the quick access to treatment following referral reflected in the evaluation data and identified this as a key strength of the EIP service.

"*It's very reactive … So crisis team pick someone up overnight. We could see them in the next day or the day after. So we've got to have that ability to be reactive to get involved really quickly to start the education really quickly start treatment really quickly as well.*" Staff Member 5

The impact of an extended DUP was reflected in family member accounts.

"*It's been. It's been a long time for both of us. Yeah, years and years. So this wasn't something that just sort of popped up over the last few years. It's been ongoing. So actually it was although. It was a great relief*" Family Member 2

Access to multidisciplinary intervention

A core component of the EIP model is the availability of multidisciplinary team interventions. The staffing composition of the service in NHS Dumfries and Galloway is outlined in Figure 4. Each service user was assigned a key worker and had regular input from a prescribing mental health pharmacist. Both the team leader and key worker role were recruited from the nursing profession. Their role included assertive outreach, risk assessment, medication adherence and developing relapse prevention plans including identification of early warning signs. This work was often supported by the peer support role.

Figure 4

Staffing Hours in the EIP Service in NHS Dumfries and Galloway

Team Leader - 0.5 WTE
Key Worker - 1.5 WTE
Peer Support Worker - 0.6 WTE
Occupational Therapist - 0.5 WTE
Consultant Clinical Psychologist - 0.4 WTE
Clinical Pharmacist - 0.1 WTE *WTE = whole time equivalent

Psychological interventions were delivered to 65.1% of the service users, of which 50% received Cognitive Behavioural Therapy for psychosis, 21.4% Behavioural Family Therapy and 17.9% Interpersonal Psychotherapy. A total of 72.1% of service users were provided an occupational therapy intervention. Interventions focussed on educational and vocational needs as well as 31% receiving a behavioural activation approach. Peer support was provided to 32.6% of service users. The lower percentage input of peer support may have been influenced by the recruitment process of the service as the Peer Support Worker was not in post during the first year of the service being operational. The multidisciplinary approach to treatment was viewed as having an accumulative influence by service users, with staff members contributing to different aspects of their intervention.

"*Each person is responsible for something different. Mm hmm, and it's all builds. The one picture mm hmm. 'cause. It's medicines. It's therapy. Yeah."* Service User 1

The EIP service had a weekly meeting of all staff members, where all clients were discussed. This allowed clinicians to have indirect input to the care of service users not on their caseload.

"Even if you don't see them face to face but during the formulation it just like the weekly meetings, you really get to know the, the clients that we work with who are who are other colleagues, work with, but even just kind of bouncing off ideas or talking about." Staff Member 3

The ease of access to MDT colleagues was viewed by staff as a strength of the EIP models implementation, allowing for clinicians to provide timely access to different aspects of intervention available within the EIP service.

"If I am doing work on some, you know, CBT for psychosis with someone and they start talking about, you know, feel like they want to get back into work. Well, rather than spend a lot of sessions on that … I can just, you know, say that "there's an OT in the team. Would you like to meet with them?" And, you know, on a good few occasions, you know, it's been she's been able to give them a call. Er, you know that week" Staff Member 1

Assertive engagement

Quantitative data was not available to assess assertive engagement, but service users accounts reflected the flexible approach adopted by the EIP staff, including using different forms of communication, such as phone calls and texts, as well as home visits. Assertive engagement refers to a persistent and continuous offer of support, even when the service user is ambivalent, as outlined in the quote below from a service user who was supported to remain engaged and "come back" to the EIP service.

"Like, I tried to leave, like, quite a few times. And they're always, like, trying to. Like trying to like to get me to come back." Service User 4

Key workers provided regular contact with both service users and families, and this was prioritised when a service user was first referred, with an aim to start interventions, including pharmacological interventions quickly.

"He was constantly giving me reassurance. There was a lot of visits quite regularly to make sure I was alright. He quite quick, quickly got me on medication." Service User 3

Telehealth video call software Near Me is widely utilised within NHS Dumfries and Galloway to provide health care services within the rural region. It's use was trialled during the initial implementation stage of the EIP service to reduce travel time for clinicians. The decision to offer in person input appeared to be central to the service being able to engage service users quickly after referral, using a form of contact that was acceptable to them.

"Initially we thought digital first using Near Me, but the evidence was Near Me and things like that for people with psychosis, wasn't great. People weren't attending and phone calls are only so good. So eventually what we realised was we're suck up and we're going to have to travel, we're going to have to go there." Staff Member 5

Effectiveness

Change over time was analysed by comparing outcome measures at the initial assessment to those at 12 months. The data violated assumption of normality; therefore, the non-parametric Wilcoxon signed-rank test was employed. Scores on the BPRS (Overall & Gorham, 1962) were significantly higher at initial assessment (*M* = 40.41*, SD* = 12.54) than at 12 months (*M* = 21.78*, SD* = 5.31), *z* = -4.011, *p* = <.001, indicating a reduction in symptomology. EQ-5D-5L (Herdman et al., 2011) scores were significantly lower at initial assessment (*M* = 57.70*, SD* = 22.95) than at 12 months (*M* = 76.74*, SD* = 14.27), *z* = -2.85, *p* = <.05, indicating an improvement in quality of life. Change on the QPR-15 (Law et al., 2014) was also observed between initial assessment (*M* = 34.75*, SD* = 12.34) and 12 months (*M* = 41.61*, SD* = 7.39) suggesting improvements in personal recovery, but this was not a significant difference, *z* = -1.887, *p* = .059

The admission rate was low within the sample, with 83.7% of service users being recorded as having no admissions to the local inpatient mental health facility whilst engaged with EIP service. A total of 11.6% had a single admission, one service user (2.3%) had two admissions and further one service user (2.3%) had three admissions.

Service users highlighted the role of different aspects of the EIP service which they felt were effective, with positive changes in both mental health and confidence. The notion of "building back" signifies a process of structuring input, working collaboratively with service users and family members, to allow for progress in the direction towards recovery.

"*Just the fact I was getting my confidence back. That's the only thing I can say. The fact that they they {EIP staff} put the work in and managed to build me back up.*" Service User 2

"*I just. I just feel sort of like, more happier in general. I don't feel these horrible mood swings. I just want to break down crying anymore. That's that's all gone away. So I don't know if that's medication or not.*" Service User 5

Acceptability

The percentage of service users deemed to be engaged monthly was high at 93.04% (*SD* = 5.53). This suggested that service users found the EIP service acceptable, continuing to receive input from the service over time. Acceptability was also explored extensively during interviews. From the perspective of service users and family members, gratitude was expressed that a service was available for those with FEP in the region. The use of home visits, regular contacts and the two-year period of the intervention were identified as key.

"Aye like I wouldn't have changed it, like just the visits like a lot the start and slowly, gradually decreasing like I think that's perfect for me" Service User 3

"*He'd been involved in a kind of online kind of a self-help type thing and and you know the that little booklet … It was all right. But it wasn't. It wasn't anywhere like as positive as the team have been though, they're that. It was a little sticking plaster, whereas actually the team getting involved has made a huge difference."* Family Member 2

Staff highlighted acceptability being informed by the use of a timely and intensive MDT intervention. Working within the EIP model was referred to as luxury, whilst acknowledging the methods of working within EIP would also benefit the wider mental health service.

"*You don't have to wait until six months or 12 months down the road until OT or psychology get involved. It's like right off the bat. If we [MDT staff members] see a need we get we get involved right away. And I think that is different in other services. So you don't have that luxury. I always talk about EIP as being like a luxury, even though it it really shouldn't be, it should just be the [pause] like the baseline, but in D&G I think it is the luxury.*" Staff Member 3

How is an EIP service implemented in rural area?

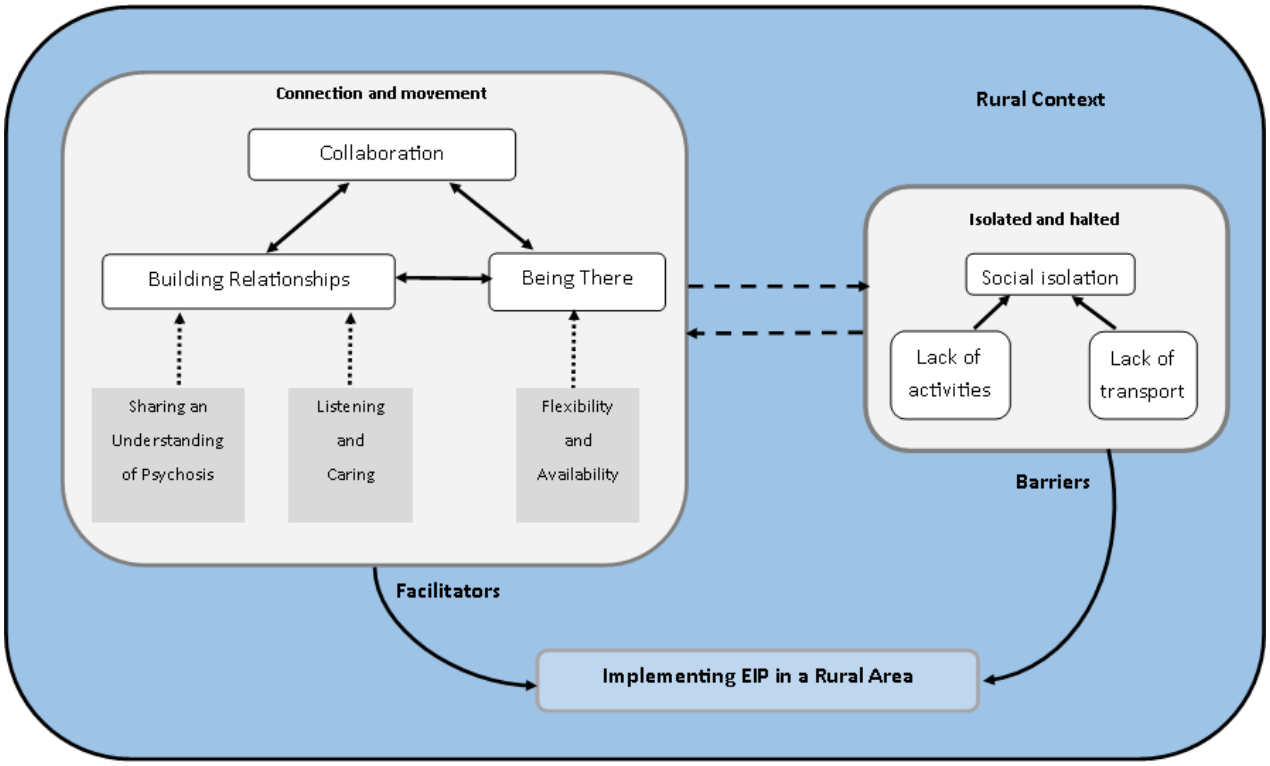
A grounded theory was developed to explore of how an EIP service was implemented in NHS Dumfries and Galloway, from the perspective of service users and family members accessing the service, as well as the staff. Themes were grounded in the data and interpreted by the researcher. Excerpts from interviews are utilised to illustrate the emerging themes and subthemes. Figure 5 displays the main themes which were generated and provides a visual representation of the grounded theory.

Understanding how EIP is being implemented within the rural context requires an exploration of barriers and facilitators that impact the services ability to apply an EIP model in a rural health board. Facilitating factors promote *connection and movement* towards recovery, where EIP staff use their limited time and resource to provide consistent support to service users and families across the rural health board. *Relationships are built* through *sharing an understanding of psychosis*, both from a lived experience and clinical perspective. The EIP service provides a *caring* environment where *listening* to each other is prioritised. This is achieved by EIP staff *being there,* both physically through traveling across the rural landscape and being able to provide a source of support and empowerment through a*vailability and flexibility* in their approach to working with FEP. The time taken to engage those who are hard to reach due to the geography or their symptoms of psychosis is valued by service users and their families. The presence of strong relationships and the ability for the EIP staff to travel alongside service users and their family members fosters a *collaborative* approach to the delivery of the EIP model that underpins its implementation in the rural context.

Within the rural health board barriers to implementation were identified as practical challenges derived from the rural context. Difficulties accessing vocational and recreational activities, both in terms of the availability of activities and travel infrastructure, and the impact of *social isolation* presented challenges for the EIP service. These barriers to implementation restrict progress over time, leading to *isolation and stagnation*, and reducing the ability for the EIP service to effectively operate within the rural health board.

Figure 5

Themes and Subthemes of How the EIP Service was Implemented in a Rural Health Board



Facilitating the implementation EIP in a rural area

Building relationships

The higher-level theme of *building relationships* emerged from all interviews, and it is the process of establishing, and then continuing to develop relationships which was seen as being central to the EIP service's implementation. The process of *building* refers to the progressive nature of relationships development. Increased knowledge and *understanding of people as individuals* is facilitated by EIP staffs' ability to prioritise their time to create opportunities for connection between staff and the individuals they are supporting, i.e. service users and family members, but also with their EIP colleagues. Navigating the physical space is central to allowing staff to learn about service users and family members in their own environment, by visiting them in their communities. This was particularly relevant for service users based in more remote parts of the region, as indicated below.

"I think one of the things that is going to stay with me is that it's like, you know, someone took like quite a lot of time to like, you know, try and support me. When I was being like, quite difficult." Service User 4

Family members highlighted that the *consistency of staff* involved in service user care allowed for the development of relationships. This in turn enabled EIP staff to tailor their approach to the individual service user and identify changes in presentation quickly. Interventions and associated staff travel plans were adjusted to meet the needs of the service users whilst also managing rurality.

"They're known to you and you know that person they build up a relationship and they can see when things are changing that they can tell when, you know, when somebody's not doing so well and much more anxious, whereas if it was different people. They wouldn't know whether that was normal behaviour or whether this was something." Family Member 2

Staff valued their ability to take a client centred approach, *building connections* and developing good therapeutic relationships to move towards positive outcomes. This was facilitated by their smaller caseloads allowing the necessary time for travel across the large geographic region and the opportunity to properly get to know a service user and their family. This was also supported by the framework of a two-year period of input for the service users as part of the EIP model implemented in NHS Dumfries and Galloway.

"So the best thing about it is its client centred, actually get time to spend with people to really get to know them. I really like the relationship building part of it. [pause] ... And because they're in our service for two years, you've got two years' worth of rapport." Staff Member 2

Relationships between EIP staff members are central to how the team members were able to work together to deliver care, as all staff members highlighted the familiarity between the staff in the EIP service allowed them to work more effectively together.

"*You can build those relationships not with just with the clients but with your colleagues and have a little bit of fun during the dark times as well … But we are we are also human and sharing some little snippits of our life is what kind of makes us mesh really well and know how to work with each other*." Staff Member 3

Building relationships was identified by all staff as being an important aspect of working effectively within the wider rural health board care systems. Within the mental health directorate, the key workers office is positioned at the entrance to the corridor where most adult mental health staff based in Dumfries work. Although this may have not been a conscious choice of location, it appears to facilitate an openness with the wider CMHT and crisis services. The door is often open with EIP staff being available for consultations and updates. This is reflective of the willingness of the service to collaborate with the wider mental health system to allow quick access for service users potentially experiencing FEP within the rural health board. While the EIP staff are based in the main population centre of Dumfries, the strong relationship with other locality teams, who can be based a considerable drive away, highlights the EIP ability to *build relationships* both at close and more distant proximity. The rural health board provides a service to a relatively small population, where staff teams from all aspects of health care are covering expansive geographic locations. This smaller population of both service users and staff appears to foster the *building relationships.*

"*Definitely being in a smaller health board is a positive on how the model works because we already had the connections with the CMHTS … widely dispersed teams are a lot more close in terms of connections. I don't think that the size had an impact on that*." Staff Member 5

Listening and caring

This sub theme of *listening and caring* encompasses the process of building relationships. The process of listening and sharing information is reciprocal between staff members, service users and their families, enhancing the connection. Staff members were being

perceived as valuing the experiences of the people they were supporting and allowing them to feel *listened to* and *understood*. One service user expressed her sense of relief that she was being listened to after feeling dismissed by other services:

"First, I finally felt heard, I finally felt heard. Yeah, I felt heard finally. And and it's what I needed" Service User 1

When considering the long length of DUP outlined above, the experience of being listened to by staff after a period of symptoms not being identified highlights the important role a specialist EIP service has in a rural health board, where there is more limited specialist service availability in comparison to an urban area. This service user again outlined the direct impact of being listened to as they associated this with a *sense of safety* and *being cared for*, allowing them to explore their psychotic experiences and therefore access the treatment that led to their recovery from FEP.

"hmmm I felt like I can finally tell what I feel, think, feel and all of these delusions. Which they like, figured out to be delusions, but I felt safe to talk about it with [EIP Staff]… I was looked after." Service User 1

This was echoed by another service user who highlighted the reassuring approach adopted by staff. Staff's communication style and non-judgemental stance was emphasised as key to their ability to build connections, particularly with service users living in rural parts of the regions who had limited social contacts.

"*And it was like with {key worker}, I managed to talk about through some of the fears and he was always just like really, he was always just like. You know, really sort of calm and reassure and like it wasn't judgement all and like, you know, they just listened to you*" Service User 4

The impact of the EIP model, with low case numbers and long-term input allowing key workers to visit service users regularly also contributed to a sense of *being cared for*. This was alongside the ethos of moving towards recovery together that was promoted by the EIP staff.

"*A low number of cases just helps to facilitate the human relationships rather than it just being a sort of 'what medication do you need?' … Yeah, general feeling it's a nice service and with people involved, it genuinely cared about those, those under care*" Staff Member 4

Sharing an understanding of psychosis

This sub theme reflects that the EIP staff team were able to *share an understanding of psychosis* from a clinical perspective whilst incorporating the lived experience of service users and their *reality of living with psychosis*. This was central to the process of relationship building, echoed in accounts by service users and family members, as trust was built by staff members being available to ask and answer questions, while providing reassurance.

"He sat next to me in the hospital and just asked me. [pause] I tried to explain him some of the unexplainable things that happened and he kind of chopped it down to psychosis." Service User 5

The theme was often associated with the initial period of contact with the EIP service where staff listening to those referred to the service and introducing the possibility of a psychosis diagnosis was a collaborative process. Staff's ability to recognise psychosis within the service users presentation and sharing their perspective allowed service users to define their own experiences.

"I thought that he [staff member] knows what's happening with me and he kinda helped me to put it in definitions. Like to so I could understand like, oh, so it is psychosis." Service User 1

The consistent message of hope for recovery was seen as a refreshing view from all three participants groups. The inclusion of a peer support worker role in the team also provides an alternative perspective and evidence of living well with psychosis. The peer support role provided a lived experience of psychosis which was embedded in living and receiving treatment within a rural setting. Staff valued the lived experience perspective and

recognised how different it was from the clinician's knowledge source. The peer support role allowed for exploration of the impact of rurality on the movement towards recovery.

"And I think {the peer support} is able to then go into that in a far deeper level. I think a lot of clinicians will go in a kind of surface level. This is what we've been taught. These are recognised symptoms." Staff Member 2

Being there

The higher-level theme of *being there* is defined as the EIP services ability to both physically visit service users and families but also metaphorically provide a hopeful presence through the challenging process of dealing with FEP. Staff members reflected on the benefits of their job roles allowing them to have in person contacts with those they were supporting and, related to flexibility, being able to spend time focussing on engagement within the EIP model.

"*We're all visible. But definitely for families, you know, we're at the house, we're seeing the person, you know, that's just the end of the phone. We're not just a leaflet, and we'll actively try and engage families."* Staff Member 5

This was echoed by family members who emphasised the role of staff being able to consistently spend time with the service user in the community and provide an individualised intervention. This is particularly significant within the context of a rural health board, where specialist health care appointments often require travel to the main centres of population.

"It was just nice to know that actually somebody was going to be coming and and just helping… And it's going to be regular. And we've not just like one visit. And here's some worksheets and off you pop kind of thing, you know, it's like we'll see you next week." Family Member 3

This family member reflected on a physical presence not being as necessary as recovery progressed, but EIP staff continued availability and connection with service users and family of that two-year period was appreciated.

"*It's just it was such an invaluable back up. But you know, although it started to tail off, obviously over as things got better. We always knew that we could still pick up the phone."*
Family Member 3

The EIP service prioritises regular home visits as well as being available between these visits for phone calls. The decision not to rely on telehealth video call software appears to have been an important factor in the implementation within a rural health board. Many other services within the region offer a 'digital first' approach, where health care appointments are offered via video, where appropriate. This was trialled briefly within the EIP service, but it was felt that assertive engagement using this modality was not achievable in practice due to a high number of missed appointments. Although the service did use video calls to facilitate some appointments, particularly for psychology and occupational therapy, the primary modality was face to face. The physical proximity of *being here* was therefore a deliberate decision as to how the EIP model is implemented, which not only impacted engagement but also the key processes of *building relationships* and *collaboration.*

Flexibility and availability

The sub theme of *flexibility* was an important aspect that facilitated *being there* within the EIP service. The concept of *trust* in the service was identified by service users and family members closely linked to the process of *building relationships* while also reflecting *consistency* and *flexibility* of contacts. Staff use their time flexibly to ensure frequent contact during the early stages of EIP involvement and during periods of increased risk, before decreasing contact frequency throughout recovery, while remaining consistent. Staff manged this by dedicating time to travelling across the rural health board proving *flexibility* in their communication methods to allow for advice to be sought by service user and families between appointments.

"*Time with their family as well sometimes, to really get in that sense that that communication is two way and it's open and you know, I'm more than happy for people to contact me whenever rather and saying, well, "I've only got a little space. If you message me, you know, next week on Thursday morning, I'll get back to you". But I can be much more flexible*." Staff Member 2

Staff rely on their diary being able to be planned *flexibly*, to maximise the number of contacts when travelling longer distances within the rural health board and increase their *availability* through careful time management.

"I take responsibility for my diary. So I'll plan things so that I'm trying to make the most use of my time." Staff Member 2

EIP staff's *flexibility and availability* was valued by service users but appeared to be particularly important for family members. Each family member spoke of *relief* in association with the EIP service becoming involved to support which can be understood within the context of long DUP and the challenges that would come with that. This appeared to derive from the reassurance of knowing there was a team whose remit was *being there* for two years.

"If something kicks off, I mean, there had been incidents in the past where it was really quite scary. So to know that if anything did happen. There was that someone you could refer to, someone you could talk to and let you know. We had phone numbers and it he was kind of past that stage, but it still felt it still felt reassuring and a relief." Family Member 2

Staff not only acknowledge the challenges FEP present to a family unit but also recognise the potential role for families with the context of long-term recovery, such as identifying early warning signs. Therefore, having the *flexibility and availability* to work collaboratively with families is prioritised.

"The impacts that's had on them as a whole family and how they support someone's been massive. You know, knowing [EIP staff] are at the end of the phone if they need them as well." Staff Member 5

Collaboration

Collaboration emerged as a high-level theme and was defined as the ability of service users, their family and EIP staff to work in partnership to make progress towards the goal of EIP, to reduce the impact of FEP. The process of *building relationships* and the EIP service *being there* allows for the development of effective collaboration, where the implementation of the service relies on valuing input from service users and families, as well as staff providing clinical knowledge. The process of *working together*, where there is a shared responsibility in enabling service users to progress in their recovery from FEP within the rural context, where provisions from other agencies were more limited. The relationships between staff, service users and families allowing them to work together towards an individualised goal was viewed as a key part of the service user experience. Demonstration of the effective collaboration included engaging in a stepped process needed for a service user to make progress, alongside the pace of new challenges being agreed together, with EIP staff providing an environment where service users were able to succeed and move towards recovery.

"If you had said when I was first introduce to the EIP team, [pause] I would never have made it to the snooker club, but we went when it was quiet, it was on my own terms, we could have left whenever I wanted. So it was basically trying to, to get back to normality but just trying to use bits, like building blocks to try and get back into stuff." Service User 2

Staff member's therapeutic relationship underpinned their interactions with service users to enable them to believe in their own capabilities to make changes over time. A key aspect of this is reintegration into local community, where key workers support service users to access opportunities for socialising and activity, which are often limited within the rural region. The

service focusses on collaboratively working with service users to enable them to access the limited resources that are available, reducing isolation in the rural region.

"He was just he was very encouraging. And but he wasn't pushy, he let me go at my pace. I always felt like he believed in me. Yeah. So it kind of made me believe in myself as well." Service User 3

Collaboration was underpinned by the value placed on the close working professional relationships within the context of the EIP service. Staff working collaboratively as an MDT where team members being close to each other to achieve a common goal of helping service users.

"*We're kind of breaking down some of the barriers that other services might have and it might be, oh. You're an OT. You're a nurse. It's it's very separate. But because we work so closely with in, in terms of the EIP service*." Staff Member 3

There can be a contradiction where some staff initially didn't want to encroach on each other's job roles, but this appeared to be overcome by a stance of *welcoming* all input within the team and acknowledgement of flexibility in job role. Staff had concerns about this interconnected way of working initially but as the service progressed the relaxed nature of the team appeared to combat this.

"*Aye I mean, I suppose to begin with I was a bit afraid that was stepping on [other staff member's] toes. Yeah, because of sort of operating in the same space. But that's quite relaxed … we do still work together on ideas*." Staff Member 4

The collaborative approach to care also reflected how the staff within the EIP service connect with the wider systems. For example, EIP staff travel times was reduced as the CMHTs provided local clinics for medication administration, therefore reducing EIP staff travel time as they didn't need to visit service users for this purpose. Close working relationships ensured time and resource are used effectively within the rural health board.

"*Everybody's opening to the CMHT. So we can access to the CMHTS depot clinics so that we don't have to go, so we aren't travelling just for a depot. So linking into the depot clinics and that's all had a massive impact on how we transfer people over as well*" Staff Member 5

At the point of discharge from EIP, service users who require ongoing treatment are supported by the CMHT. Due to the established relationships, this process is viewed by staff as being coherent. No reflections were available from service users due to this process being more relevant after they have been discharged from the service.

Connection and movement

Connection and movement incorporate the key components outlined in the grounded theory of how EIP has been implemented in a rural area. It highlights the role of *collaboration*, through having the time to *build relationships* and the ethos to prioritise *being there* for service users, their families and the staff community, to allow progress and a movement towards recovery. This facilitating process is in stark contrast to the barriers presented, where isolation, both in term of social and physical isolation, impact the continued recovery from FEP within a rural health board.

"*It's about the people*" (Family Member 2) reflects a theme present throughout interviews with service users, family members and staff, where the EIP service was viewed as being able to operate effectively because of the people at the centre of the implementation. Being able to connect with service users and families, as individuals not just a number on a caseload, allows the EIP staff to implement the EIP model in a way that supports the service user to move towards the goal of recovery. The way the EIP model is implemented in the rural health board, aims to overcome the barrier presented by isolation, where achievable, and the passion of the staff had for the EIP model was evident throughout the research

"*When the EIP bus came along, so to speak well, I had to get on it*" Staff Member 2

Barriers to implementing EIP in a rural area

Isolation and halted encompasses several challenges identified within the rural context that impacted the ability to implement the EIP model: social isolation, lack of opportunities and the need to travel. This reflects the difficulties of being unable to access opportunities for social contact, including vocational, educational and recreational avenues, that *halt* the progress of recovery. The effect of the barriers on service users, families and staff in the current sample is complex and differ according to the stage of recovery being discussed.

Social isolation

All staff and family members identified *social isolation* as a significant concern within the context of recovery from FEP in a rural health board. This was consistently identified as a key challenge for the EIP service to manage to support continued progress in a service users recovery. Staff viewing mitigating social isolation as part of staff's job role highlights their awareness the rural context's influence on service users experiences and therefore the role of the EIP service.

"*Obviously you do come across folks who are isolated. So I suppose it's really dealing with isolation as part of my job*." Staff Member 4

Service users presented a more nuanced account of the role social isolation has on their treatment. Rural living can provide an environment for service users to increase their activity level within the community in a more manageable way, as there was less chance of unplanned social contact in a rural environment.

"I was like, you know, like try to challenge myself to try to challenge me or to go out more and I think that was made it a bit easier to live in the country and there's not as many people about" Service User 4

This service user reflected on having less opportunities for social contact being helpful during acute stages of illness but subsequently became a barrier as they progressed in their

recovery and sought opportunities to expand their social network. This highlights the impact of rurality on the later stages of the EIP intervention, where reintegration into the community and future planning is a focus.

"*I'm not a very social person, but maybe maybe like peer groups as well, like finding peer groups my age is maybe a bit hard …. Anyway, I thought I thought that was maybe a bit easier … like, challenge myself to go into town*." Service User 4

Staff recognise the significant impact of social isolation on psychosis but the restricted availability of opportunities in the rural area remain a persistent challenge. Comparisons were often made to urban areas where there was a view that the social isolation could be addressed more effectively and therefore be less of a barrier to the EIP service implementation.

"*The opportunities aren't there as much as you would in a city or even in a town and a lot of people don't have their own way of transporting to a town. So we're very limited, which is we know in terms of psychosis, social isolation is one of the first things to go as well and hard to come back from. There's not that many options out there*." Staff Member 3

Travelling within a rural health board

Reflecting on the impact of living rurally on FEP, a family member stated, "*you're isolated in your head, but you're also physically isolated*" (Family Member 3). The below example outlines an everyday task that can be challenging to complete in some parts of the region without a form of transport. Continued progress and recovery being constrained by the rural environment and the restricted options for transportation in the area highlights the barrier faced by EIP service users.

"*The kind of opportunities for, you know, maybe going down and getting a pint of milk, or maybe going and getting a beer off from the shop? It's just not there, you know, you have to ask your mum. You're kind of stuck in a kind of almost like a teenage dependency and you just want your own life*." Family Member 1

In contrast, while staff travelling was identified as a challenge due to the sparce rural area the EIP service provided input, it was viewed as manageable. Careful diary management and the attitude of staff to use their travel time to meet their own needs as a clinician were key concepts highlighted in interviews.

"*I don't mind the challenge over covering quite large distances because I'd like to say I'm trying manage my diary well… It's quite nice to have a wee bit of head space between appointments just to process things. Yeah, think things through*." Staff Member 2

When staff discussed the challenges of travelling in their job role, reporting it could be "*quite exhausting at times*" (Staff Member 3), there was always quick counteracted point highlighting that travelling in the rural landscape as being a positive factor, with statements such as "*how are we so close to all this beauty?"* (Staff Member 3). This positive perspective was not exhibited in any service users interviews.

Lack of activities

Service users highlighted the positive benefits on their mental health as being able to leave their homes and engage in an activity as part of their EIP treatment plan. EIP staff were able to provide opportunities to access activities within in the rural landscape and use this to promoting progress by embedding this into their contacts with service users.

"Maybe coming from a walk. Just things to get me out the house that helping my mental health." Service User 3

Accessing activities beyond going for a walk was a lot more challenging, highlighting the lack of activities available in the rural health board. The perceived impact of the lack of opportunities on continued progress towards recovery. There was a sense that engaging in new opportunities was viewed as more important in the latter stages of recovery and this is

where the barrier of restricted opportunities due to rurality appeared to have a larger impact.

"*We went to the cafes and stuff but that is all there is for people to do in {small town} for people my age. Like there's nothing else*." Service User 5

The EIP staff were acutely aware of the barriers presented by lack of opportunities in a rural area, outlining the issue that the activities that were available being targeted at an older age group. Accessing employment presented challenges including the lack of public transport as well as restricted range of vocational opportunities.

"*Like yeah, there's nothing for the population of people that we're working with on it could be like more of the older population. You have your knit natter, you have your cups of tea and chat, but you don't really have things not even just activities but like jobs*." Staff Member 3

Although the recovery focus view was embodied by staff, service users faced the barrier of lack of opportunities being available to them. This negative impact of lack of opportunities on future planning was apparent, where continued recovery would often include employment opportunities and reintegration into society.

"*So {EIP staff member] kept trying to, like, get me to think about the future and stuff. And it was like there wasn't as many opportunities for, like, maybe like, moving on to work or something like straight away, like, afterwards or. Yeah. And so there wasn't all like. Like really restricted and like things like work and stuff."* Service User 4

Isolation and halted

From staff perspectives, the impact of the barriers appeared to influence the process of recovery more than the implementation and delivery of the EIP model specifically. The barriers contribute to continued isolation, halting continued progress in terms of recovery from FEP through limited opportunities for accessing activities and the restricted transport

network. These factors negatively impact social isolation and remain a challenge for the EIP service. Within the EIP model implementation, staff are able overcome some barriers by integrating travelling and facilitating activities into their job role. However, this barrier remains present and become more problematic as recovery progresses.

"What we've identified as before, a lot of people in rural settings, the networks are in terms of limited. They don't drive so. Access and third sector agencies employability, all those things that had massive impacts and an impact on the recovery as well. … But that's I think the real rural aspect has more of an impact on the recovery than it does on the treatment."
Staff Member 5

Discussion

The study aimed to explore how the EIP service was implemented in a rural health board by applying a mixed methods approach. Informed by Proctor et al.'s (2011) implementation outcomes, fidelity and acceptability of the EIP model were analysed, alongside the effectiveness of the intervention and the identification of barrier and facilitator to EIP models application.

Fidelity to the model was evident in the short waiting times, high level of psychosocial intervention offered, low admission rate and high engagement. Challenges remained in relation to reduction in DUP, suggesting there were problems identifying the early signs of psychosis within the rural health board. The percentage of service users receiving occupational therapy and/or psychological therapy in addition to pharmacy and nursing interventions was higher than has been outlined in the recent literature (Oduola et al., 2025; Thomas et al., 2023). A lower percentage of service users were engaging in peer support, but this may be accounted for by the delayed recruitment of a peer support worker. Interview data reflected the collaborative nature of the MDT. The study is unable to comment on contact frequency or rates or re-engagement after an initial period of disengagement which have been used as a measure of assertive engagement in previous research (Mlay et al., 2025).

Reducing DUP remains challenging for EIP services globally (Albert & Weibell, 2019). When an EIP service has first been established previous research indicates a higher incidence of service users being referred who have been unwell for a long period of time (Malla et al., 2005). In the current research, when outliers were removed the average length of DUP remained longer than those outlined in a previous meta-analysis (Correll et al., 2018). A DUP of less than six months has been associated with favourable outcomes (Albert & Weibell, 2019). Quick access to treatment, once a referral has been made, was demonstrated but the EIP service relies on the identification of psychosis and subsequent referral from other health care professionals such as CMHTs and GPs. Family member accounts reflected an extended period between onset of symptoms and referral to the EIP service. Previous research highlighted the need to work within existing local networks to target the early recognition of FEP (Tee et al., 2003; Welch & Garland, 2000). Frischherz et al., (2025)

proposed that this presentation of service user is likely to reduce once a EIP service has been established for extended period. The current research examines the first two years of the EIP service implementation, therefore research after several years of implementation would accurately assess the service's influence on DUP reduction.

Significant reductions in psychosis symptoms and improvements in quality of life were reported in the current research. The variety of outcome measures applied within EIP research makes direct comparisons challenging (Ferrari et al., 2023), but similar reductions in symptomology and improvements in quality of life are reflected in previous research (Brown et al., 2022; Robinson et al., 2022). The service user rated QPR-15 (Law et al., 2014) identified no significant difference on the measure of recovery from psychosis. It may be that symptom remission is possible within a 12-month period, but service user defined recovery requires longer intervention periods and does not demonstrate a significant change over merely a one-year period.

The high level of monthly engagement and interview data outline the acceptability of the EIP service, with regular appointments and the extended two-years of input being identified as key characteristics. There is limited comment on the acceptability of EIP services in the literature and future research could include an objective measure of this.

How is EIP implemented and Barriers and Facilitators

The implementation of the EIP model was achieved in the rural health board by staff prioritising their limited time and resource to promote *connection and movement* towards recovery. *Collaboration* was central to *building relationships* and *being there* for service users and the families through *listening and caring* whilst providing education around FEP within a rural context

The current research supports previous findings identifying service user's view of the influential role of relationships with EIP staff (Hansen et al., 2018; Watkins et al., 2018) and expands on this to include staff's perspectives. The emphasis on *connection* supportive interpersonal relationships was identified as a key to implementing the EIP service in a rural context but was also a barrier to service users continued recovery. Rurality's impact on isolation interpreted as reduced access to activities and transport negatively impacting on opportunities for socialisation.

The disruption in social networks by psychosis has been widely established (McGorry et al., 2008). Cognitive models of psychosis outline the role of interpersonal context in the interpretation of psychotic experiences (Garety et al., 2007) with the impact of delusions and paranoia being reduced when trusted external reference point is available within a social network (Ritunnano et al., 2022). The stress vulnerability model considers EIP staff's ability to build relationships and work collaboratively with service users as a protective factor when managing the negative impact psychological and environmental stressors can have on symptoms of psychosis. Within a rural context, previous evidence reported staff resistance due to time constraints and travel challenges negatively impacting fidelity to the EIP model (Bedard et al., 2016; O'Connell et al., 2022). The current research did not identify this barrier to implementation but highlights the challenges to continued recovery in a rural as being the limited resources available to support increased socialisation and reintegration into the local community. While EIP staff were able to develop connections and provide individualised interventions, the rural area lacked opportunities to continue expanding social networks and build routines which facilitate further recovery.

Limitations

Limitations were present as the current study only represented the perspectives of individuals who chose to participate, reflecting a potential wider issue of bias within the sample. Motivation to take part in the research could be derived from having a positive experience and bias could be present in the quantitative component as no data was recorded from those who chose not to engage in the service. Additionally, the current findings are restricted by the availability of routinely collected outcome data. Incomplete outcome measures may represent bias in the data due to service users not engaging.

The current study was only able to represent the perspectives relating to an EIP service in a single Scottish health board. Future research on the implementation of EIP services in other areas of the country, for example in island health boards where rurality presents different challenges, would allow for a greater understanding of the impact of rurality. The number of interviews completed was deemed sufficient to reach data saturation, but the progressive nature of service implementation means there is a potential for the continued emergence of themes. Few service users had completed a full two years of EIP input, restricting the comments that could be made on presentation at discharge. Further research after several

years of implementation would allow for continued examination of themes and further assessment of DUP and progress of recovery.

Although the lead researcher's previous role in the EIP service was considered and reflexivity highlighted, this is likely to have a role in the interpretation of the data. The grounded theory was constructed by the researcher interpreting the participant's experiences from an analytical viewpoint. Therefore, individual participant feedback was not sought as it may be challenging to recognise individual experiences within an abstract theory. The social constructivist epistemological stance of the research creates a point of tension in the research between measurable outcomes of the EIP and the experience of those delivering and accessing the service. Whilst a pragmatic approach was adopted to manage this, this approach is also a limitation of the research. A positive stance could have been adopted with the quantitative data reflecting the reality of service outcomes, while a constructivist stance could provide a more context driven understanding of the lived experience through grounded theory.

Implications for Future Research and Clinical Practice

The findings suggest that the EIP model can be implemented in a rural health board and is viewed as an acceptable form of treatment for FEP, although further research at late stages of implementation is needed. Future research designs may expand on the quantitative component, with additional measures such as Positive and Negative Symptom Scale (Kay et al., 1987) which would allow for comparison to existing research. A review by Ferrari et al., (2023) highlighted that less than 10% of measures used within EIP services include a family members perspective which could provide a valuable area to explore subsequently.

A key part of the implementation is the use of critical feedback loops to refine interventions over time (Damschroder et al., 2009). The implementation of the EIP service will continue to need refinement and with analysis of both quantitative and qualitative service evaluation sources being vital to this process. Implementing an EIP service in a rural health board was found to require careful management of staff time to prioritise travelling across the region and delivering the intervention within service user's homes and community. The amount of protected time and flexibility clinicians have available is pertinent to the feasibility of the service.

The current research indicates that the detection of FEP in a rural health board remains a challenge. Limited evidence within the research demonstrates that EIP services support reduction in DUP (Lloyd-Evans et al., 2011). In previous research by Birchwood et al., (2013) DUP was strongly correlated with delays in accessing EIP once entering the mental health system. A shorter DUP was associated with a service users first contact being with a 'crisis service', either through home treatment or admission. However, first contact being with a generic mental health service, such as CMHTs, was associated with treatment delays and a longer DUP. Service users presentation of symptoms not being recognised as FEP within generic mental health services, as well as early discharge through non-attendance of appointments were found to contributed to delays (Birchwood et al., 2013). Although specific data was not available in the current research exploring the association between referral pathways and DUP, the collaborative approach EIP service adopts their colleagues in the CMHTs was outlined. EIP services could have important contribution to provide, by enhancing education and staff training within health boards. The aim of this would be to improve early detection and potentially reduce DUP, and in the case of rural health boards, ensuring the impact of rurality is explicitly considered.

Implementation of EIP model needs to utilise traits specific to the sociocultural context of the health board service it's being delivered in. The barriers identified in the current research consider the impact of isolation and lack of resources in a rural health board but are applicable to a diverse range of settings. Addressing these challenges needs to be an embedded component of EIP service implementation in a rural context, while similar challenges could also be present in the delivery of EIP in mixed rural and urban setting. The facilitating factors of EIP that result in promoting *connection and movement* towards recovery, as detailed in this research, could inform practice in a wide range of settings, as well as provide an understanding of the funding required for EIP to ensure staff can engage in these facilitating processes. The current research highlights the need to target barriers identified in EIP implementation, both in established services and those being commissioned, where social isolation due to lack of activities and transport connections negative impacts on service user outcomes. Future research exploring interventions and approached targeting social isolation within the EIP model could inform guidance on how the service can address this key barrier. Co-producing this research with lived experience

involvement would allow for further exploration of the role of stigma and community in rural areas.

The influence of stigma on help seeking behaviours (Thirlwall & Whitelaw, 2020) and the high levels of informal care (Dodgson et al., 2008) within rural communities could impact the long DUP reported in the current research. The use of education and awareness campaigns have been met with mixed results in the literature (Lloyd-Evans et al., 2011) and it is likely that a more nuanced approach is required to ensure timely referrals are being made. The current research provided evidence for the acceptability and effectiveness of EIP in a rural area and could inform a wider public health campaign, tailored to rural communities. A key target of any initiative would be encouraging seeking support for suspected psychosis at an early stage, and this could be promoted through the quick access to services that has been demonstrated, while also highlighting positive outcomes from early intervention. The promotion of the EIP service needs to be tailored to the local community and an accessible form of the grounded theory developed in this research, focussing on the facilitating factors, could endorse how the service operates.

Conclusion

The implementation of the EIP model is achievable in a rural health board but requires careful consideration to manage rurality and the challenges it presents. EIP staff need access to the required resources to provide a service tailored to the rural context, where collaboration is achieved through close working relationships and the ability to provide flexible support over an extended period, both in person and at a distance. Future research should be addressing isolation and long DUP would help to improve outcomes within the rural context.

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Appendices

Appendix A: Psychosis Journal Author Guidelines

Can be viewed online at:
https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=rpsy20

Appendix B: Prospero Protocol

Can be viewed online at: https://www.crd.york.ac.uk/PROSPERO/view/CRD420251038140

Appendix C: CASP Quality Criteria Checklist

CASP Checklist:
For Qualitative Research

Reviewer Name:	
Paper Title:	
Author:	
Web Link:	
Appraisal Date:	

During critical appraisal, never make assumptions about what the researchers have done. If it is not possible to tell, use the "Can't tell" response box. If you can't tell, at best it means the researchers have not been explicit or transparent, but at worst it could mean the researchers have not undertaken a particular task or process. Once you've finished the critical appraisal, if there are a large number of "Can't tell" responses, consider whether the findings of the study are trustworthy and interpret the results with caution.

Section A Are the results valid?	
1. Was there a clear statement of the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
2. Is a qualitative methodology appropriate?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
3. Was the research design appropriate to address the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	
4. Was the recruitment strategy appropriate to the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher has explained how the participants were selected* • *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* • *If there are any discussions around recruitment (e.g. why some people chose not to take part)*	

5. Was the data collected in a way that addressed the research issue?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data*	
6. Has the relationship between researcher and participants been adequately considered?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* • *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Section B: What are the results?	
7. Have ethical issues been taken into consideration?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* • *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	

8. Was the data analysis sufficiently rigorous?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If there is an in-depth description of the analysis process* • *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* • *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* • *If sufficient data are presented to support the findings* • *To what extent contradictory data are taken into account* • *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	
9. Is there a clear statement of findings?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the findings are explicit* • *If there is adequate discussion of the evidence both for and against the researcher's arguments* • *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* • *If the findings are discussed in relation to the original research question*	
Section C: Will the results help locally?	
10. How valuable is the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature* • *If they identify new areas where research is necessary* • *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*	

APPRAISAL SUMMARY: *List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.*		
Positive/Methodologically sound	**Negative/Relatively poor methodology**	**Unknowns**

Referencing recommendation:

CASP recommends using the Harvard style referencing, which is an author/date method. Sources are cited within the body of your assignment by giving the name of the author(s) followed by the date of publication. All other details about the publication are given in the list of references or bibliography at the end.

Example:

Critical Appraisal Skills Programme (2024). CASP (insert name of checklist i.e. systematic reviews with meta-analysis of randomised controlled trials (RCTs) Checklist.) [online] Available at: insert URL. Accessed: insert date accessed.

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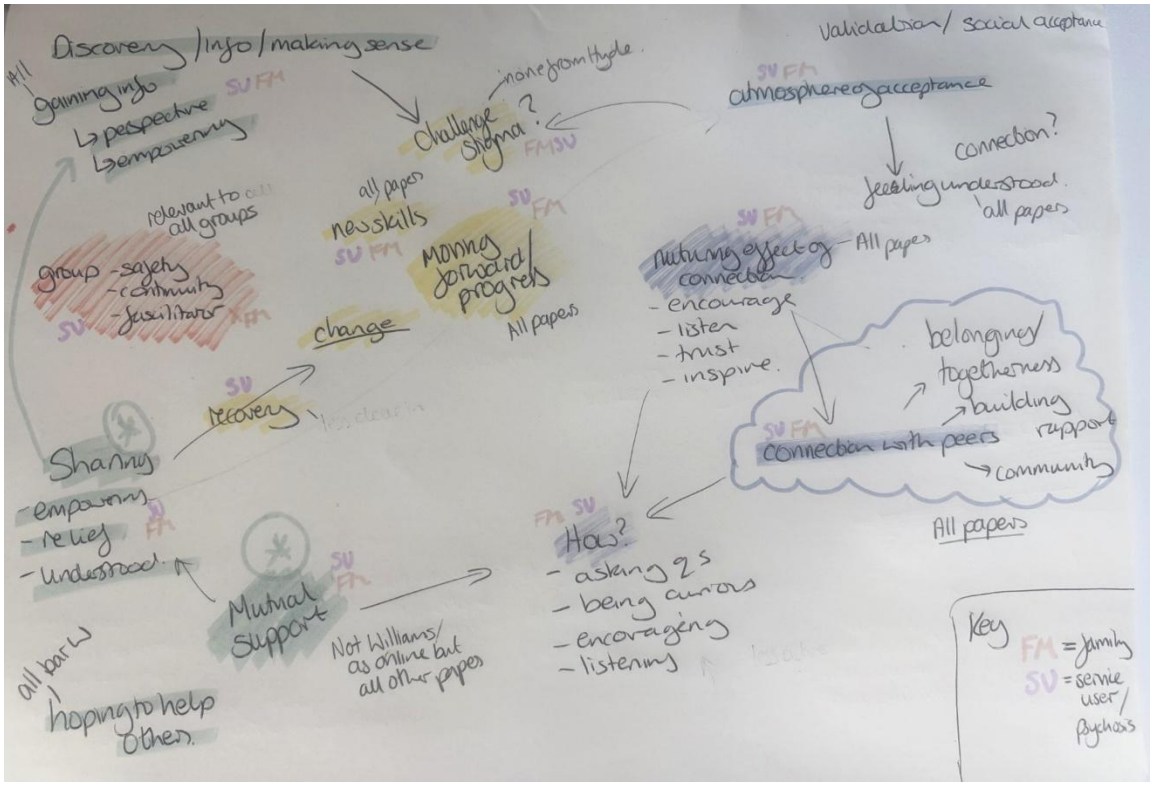
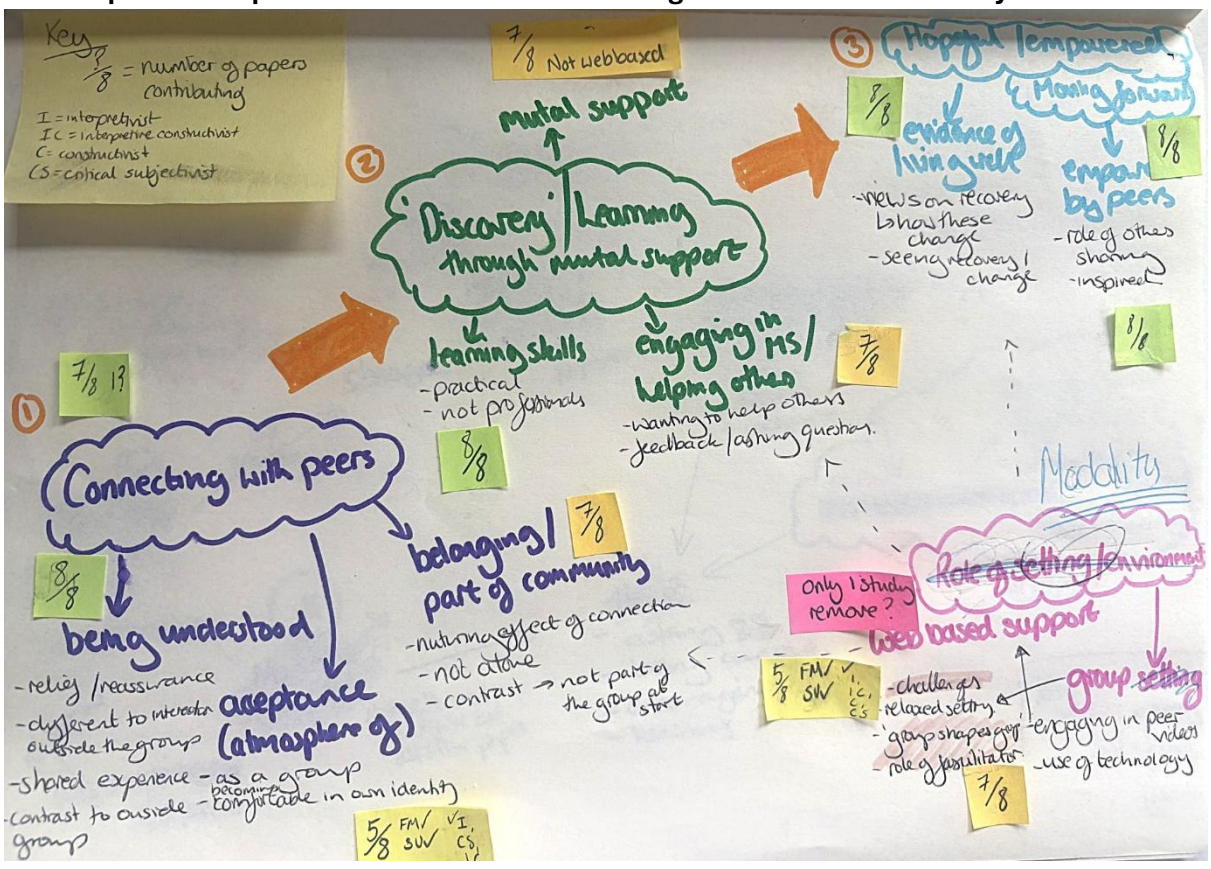
Appendix D: Draft Thematic Maps

Initial draft thematic map with source labels



Continued development of thematic map with notes source labels and corresponding key. This map includes prior iterations of "role of setting" which evolved as analysis continued.



Appendix E: Early Intervention in Psychiatry Author Guidelines

Can be viewed online at:
https://onlinelibrary.wiley.com/page/journal/17517893/homepage/forauthors.html

Appendix F: NHS Ethical Approval

WoSRES

West of Scotland Research Ethics Service

NHS Greater Glasgow and Clyde

Miss Kirsten Richardson

Trainee Clinical Psychologist

NHS Dumfries and Galloway

Mountainhall Treatment Centre

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Date 05 March 2025
Direct line 0141 314 4485/0213
E-mail ggc.wosrec4@nhs.scot

Dear Miss Richardson

Study title:	**Evaluating the implementation of an Early Intervention Psychosis Service in a rural Scottish health board: a mixed methods study.**
REC reference:	**25/WS/0019**
Protocol number:	**CAHSS2410/01**
IRAS project ID:	**346032**

Thank you for your letter of 18 February 2025, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC. A list of the Sub-Committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a public registry before the first participant is recruited and no later than six weeks after. For this purpose,
'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

A 'public registry' means any registry on the WHO list of primary registries or the ICMJE list of registries provided the registry facilitates public access to information about the UK trial.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

Where a deferral is agreed we expect the sponsor to publish a minimal record on a publicly accessible registry. When the deferral period ends, the sponsor should publish the full record on the same registry, to fulfil the condition of the REC favourable opinion.

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Where the study is registered on ClinicalTrials.gov, please inform deferrals@hra.nhs.uk and the Research Ethics Committee (REC) which issued the final ethical opinion so that our records can be updated.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter. Where a deferral is agreed, a minimum research summary will still be published in the research summaries database. At the end of the deferral period, we will publish the full research summary.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: Research summaries - Health Research Authority (hra.nhs.uk)

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at Managing your approval - Health Research Authority (hra.nhs.uk)

Ethical review of research sites (as applicable)

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Flyer Staff]	v2	18 February 2025
Copies of materials calling attention of potential participants to the research [Flyer Service Users Family Carers]	v2	18 February 2025
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor proof of insurance (2024-2025)]		26 July 2024
Interview schedules or topic guides for participants [Interview Schedule]	v2	18 February 2025
IRAS Application Form [IRAS_Form_24012025]		24 January 2025
Other [Lone Worker Procedure v1 21.02.25]	v1	21 February 2025
Other [Debrief information for participants]	v2	03 March 2025
Other [REC Provisional Opinion Feedback]	v1	18 February 2025
Participant consent form [Consent Form Staff]	v2	18 February 2025
Participant consent form [Consent Form Service Users Family Carers]	v2	18 February 2025
Participant information sheet (PIS) [PIS Service Users Family Carers]	v2	18 February 2025
Participant information sheet (PIS) [PIS Staff]	v2	18 February 2025
Research protocol or project proposal [Protocol Version 2 18.02.25]	v2	18 February 2025
Summary CV for Chief Investigator (CI) [Kirsten Richardson CV]		23 January 2025
Summary CV for student [Kirsten Richardson CV]		23 January 2025
Summary CV for supervisor (student research) [Supervisor CV]		27 October 2024

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: Quality assurance - Health Research Authority (hra.nhs.uk)

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: Learning - Health Research Authority (hra.nhs.uk)

IRAS project ID: 346032 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Abibat Adewumi

On behalf of
Dr Michael Fail
Chair

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers"

After ethical review guidance for sponsors and investigators –
Non CTIMP Standard Conditions of Approval

Copy to: Mr Matt Erikson

Lead Nation Scotland: gram.nrspcc@nhs.scot

West of Scotland REC 4

Attendance at Sub-Committee of the REC meeting

Committee Members:

Name	*Profession*	*Present*	*Notes*
Dr Wendy Cohen	Speech & Language Therapist (Vice Chair)	Yes	
Dr Michael Fail	Consultant Physician and Geriatrician (Chair)	Yes	Chair of Merting
Mr Jim McHugh	Independent Financial Advisor	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Mrs Abibat Adewumi-Ogunjobi	REC Manager

Appendix G: University of Edinburgh Ethical Approval

School of Health in Social Science Research Ethics Application

The supervisor or primary investigator must complete and sign this form after checking that all relevant sections are completed, and relevant documents are attached. For all undergraduate (UG) and MSc student projects, it is the supervisor's responsibility to submit this form and all attachments. Please note that failure to do this will result in the application being returned (and not processed) causing your research to be delayed.

THE UNIVERSITY of EDINBURGH

Supervisor (name and UUN): Dr Helen Griffiths	
Primary Investigator (name and UUN): Kirsten Richardson s1230629	
List of all collaborators (with affiliated institutions in brackets): Dr Katie Whyte (NHS Dumfries and Galloway)	
Student's programme of study (if applicable): Doctorate in Clinical Psychology	
Project Title: Evaluating the implementation of an Early Intervention Psychosis Service in a rural Scottish health board: a mixed methods study	
Case Number (if known – assigned by Administrator at time of 1st submission):	
Proposed Project Start Date: 01/04/25	**Proposed Project End Date: 30/04/26**

Please indicate whether the primary investigator on this project is staff or student and select your subject area:

☐ Staff ☐ UG or MSc Student ☒ DClin Student ☐ PhD Student

☐ CPASS Studies ☐ Clinical Psychology ☐ Nursing

This is a:

☒ New application for ethical review – first submission
☐ Resubmission following reviewer comments
☐ Resubmission with requested amendments

Has been reviewed by an external ethical board, such as NHS IRAS or a UK HEI (multi-site studies only) with a favourable opinion? Level 1 *

☒ IRAS (NHS research ethics) ☐ Other: _____

Please tick one option that best describes your application:

☐ Collecting or generating new data involving other people: **Level 2**

☐ Extracting, re-coding and analysing existing data that contains sensitive information (i.e. identifiable information): **Level 2**

☐ I believe my application falls under the criteria for **Level 2F** and have filled in and attached the Level_2F_REQUEST form along with my application.

☐ Analysing secondary (archival) data that is routinely collected or is an existing anonymised dataset: **Level 1**

☒ Collecting new data BUT an external ethical review board (such as NHS IRAS; UK HEI – for multi-site studies; etc) has fully reviewed this project and generated a favourable opinion: **Level 1**

This application is complete with the following attachments (tick <u>all</u> that apply):

Advert/flyer ☒	Caldicott application stating what data was requested ☐	Caldicott signed approval ☐		Consent form/s ☒
Data collection tools (e.g. interview guides) ☒	Debrief with signposting ☒	IRAS application ☒	IRAS opinion letter ☒	NGO or local authority letters ☐
Participant Information Sheet/s ☒	Participant Information Sheet (young person version) ☐	R&D application ☐	R&D approval ☒	Researcher Checklist (C-19) ☐
Risk assessment ☐	Standardised recruitment email ☐	Sponsorship Letter OR Email to confirm no sponsorship needed / statement explaining why sponsorship is not needed. ☒		

Other attachments (please specify):

To be completed by primary investigator or project supervisor
By signing this front sheet, I confirm that I have prepared and/or reviewed this ethics application and related documents in accordance with ethical guidelines. I also confirm I have checked that all relevant sections of the application form are completed and relevant documents are attached. **Supervisor or/PI Signature:**    **Student signature:**    **Date: 17/03/25**

HE

HiSS Research Ethics

To: Kirsten Richardson

Reply | Reply all | Forward

Fri 2025-03-28 05:59

068 application 17.03.25.docx
826 KB

Dear Kirsten,

Thank you for your application. Based on your responses the project meets requirements for favorable opinion from Clinical Psychology Ethics. If you require a formal letter of ethics approval (this is only required if you are approaching third parties, NGOs etc) then please contact the ethics mailbox – ethics.hiss@ed.ac.uk (cc'd' above) requesting this and a formal letter of approval will follow in due course. However in the interim please use this email and signed application as proof of approval.

Best wishes,
Leonor

Dr Leonor Rodriguez
Ethics & Integrity Lead

Appendix H: Consent form for staff

THE UNIVERSITY of EDINBURGH
School of Health in Social Science

NHS Dumfries & Galloway

PARTICIPANT CONSENT FORM

Study Title: Evaluating the implementation of an Early Intervention Psychosis Service in a rural Scottish health board: A mixed methods study.

Researcher's name and contact details: Kirsten Richardson (s1230629@ed.ac.uk)

Participant ID: _____

	Please initial box (or tick box, if online)
1. I confirm that I have read and understood the Participant Information Sheet (Version2 dated18th February 2025) for the above study	☐
2. I have been given the opportunity to consider the information provided, ask questions and have had these questions answered to my satisfaction	☐
3. I understand that my participation is voluntary and that I can ask to withdraw at any time prior to my data being analysed without giving a reason and without my employment or legal rights being affected	☐
4. I consent to my anonymised data being stored for a minimum of 10 years	☐ Yes ☐ No
5. I consent to my anonymised data being used in potential future ethically approved research	☐ Yes ☐ No
6. I understand that relevant sections of my data collected during the study may be looked at by individuals from the Sponsor (University of Edinburgh), where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data	☐
7. I agree to my interview being audio recorded	☐
8. I agree to take part in the above study	☐

(The below signature spaces will be replaced by the above tick box, if interview is online)

Name of person giving consent	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature
_____	_____	_____

If completed in person 1 x copy – into site file; 1x copy – to participant
If completed online 1 x copy – into site file; 1x copy – to participant via email

Appendix I: Consent form for service users and family

THE UNIVERSITY of EDINBURGH
School of Health in Social Science

NHS Dumfries & Galloway

PARTICIPANT CONSENT FORM

Study Title: Experience of the Early Intervention Psychosis Service in NHS Dumfries and Galloway.

Researcher's name and contact details: Kirsten Richardson (s1230629@ed.ac.uk)

Participant ID: _____

Please initial box
(or tick box, if online)

1. I confirm that I have read and understood the Participant Information Sheet (Version 2 dated 18th February 2025) for the above study ☐
2. I have been given the opportunity to consider the information provided, ask questions and have had these questions answered to my satisfaction ☐
3. I understand that my participation is voluntary and that I can ask to withdraw at any time prior to my data being analysed without giving a reason and without my medical care or legal rights being affected ☐
4. I consent to my anonymised data being stored for a minimum of 10 years ☐ Yes ☐ No

. I consent to my anonymized data being used in potential future ethically approved research ☐ Yes ☐ No

6. I understand that relevant sections of my data collected during the study may be looked at by individuals from the Sponsor (University of Edinburgh), where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data ☐
7. I agree to my interview being audio recorded ☐
8. I agree to take part in the above study ☐

(The below signature spaces will be replaced by the above tick box, if interview is online)

Name of person giving consent	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature
_____	_____	_____

If completed in person 1x copy – into site file; 1x copy – to participant
If completed online 1x copy – into site file; 1x copy – to participant via post

Appendix J: Interview schedule

Interview Schedule

Study Title: Evaluating the implementation of an Early Intervention Psychosis Service in a rural Scottish health board: a mixed methods study.

Introduction

Thank you for agreeing to take part in this research. We are interested in hearing about your experience of the new Early Intervention Psychosis Service (EIP) that has been implemented in NHS Dumfries and Galloway. There are some themes that we are likely to explore such as mental health difficulties in a rural area, potential stigma, isolation and accessing services. It would be great to hear about examples and memories you have from the EIP service.

We expect the interview to last between 30 and 60 minutes, but we can stop to take a break at any point, and you can finish the interview at any time without giving an explanation.

[If participant has consented to be recorded, switch on the recording]

May I double-check that you are happy for this interview to be recorded?

[Continue recording, if participant has confirmed their consent.]

Questions for Staff

- Can you tell me what it was like for you when you first became involved with the EIP service?
- Is there anything you like about working in the EIP service?
- What is different, if anything, about when you work with a client in EIP compared to a standard CMHT model of care? Can you give me an example?
- How does the service deliver an intensive intervention in a rural area?
- Do you think being a rural health board has impacted the implementation of the EIP model? And if so, how?
- What barriers, if any, are presented by a rural setting that may not present in an urban area?
- What could be better about the EIP service?
- What do you think your working week should look like in terms of EIP? How does this compare to the reality?
- Do you think EIP is acceptable model of service delivery in a rural area?
    - For clients, families, staff and management
- When you think of being involved with the EIP service, what memory comes to mind?

Questions for Clients/Family Members/Carers

- Can you tell me what it was like when you first became involved with the EIP service? What was it like when you first met [insert key worker name]?
- Was there anything that made you think you didn't want to get involved with the EIP team?
- Is there anything you like about the EIP service?
  - Can you give me an example of what you mean by x?
- What could be better about the EIP service?
- Can you tell what it is like living where you do?
- Do you think that living where you do impacts your/[insert client's name] recovery?
  - If yes, can you give me a specific example of this?
- Follow up if needed: Do you think there are challenges to living rurally? If yes, how do you think this affects your work with the EIP service?
  - Can you give me a specific example / memory that comes to mind?
- When you think of being involved with the EIP service, what memory comes to mind?

Closing question

Is there anything else you would like to discuss that has not already been covered? Thank you very much for taking part in this interview. Would you like to receive a summary of the results via email after the study is completed?

Appendix K: Examples of coding and analysis

Open Coding	Axial Coding	Theory Notes
Walking alongside (SM)	Working closely together / walking alongside Draft theme name: **Collaboration**	Collaboration where support from EIP service is welcomed by service users and family members. The persistent offering of support and encouragement to stay with EIP reflects the model's assertive outreach stance, while the gentle stance of staff members viewed by service users and members may speak to how engagement in achieved. The collaborative language of "walking alongside" and sharing ideas talks to working together and a closeness. Staff working collaboratively as an MDT where team members being close to each other and appreciated. There can be a contradiction where some staff initially didn't want to encroach on each other's job roles, but this appeared to be overcome by stance of welcoming all input within the team and acknowledgement of flexibility in job role. Getting on the EIP bus – collective journey Expanded in staff interviews when thinking about wider CMHT
Working together to help (EIP team, SU and FM)		
Working closely as an MDT		
Like holding hands (SU)		
Feeling welcomed into EIP (SM, SU, FM)		
Encouraging to stay with EIP (SM)		
Using flexibility within job role to work together (SM)		
Welcoming input from others (SM, SU, FM)		
Gentle approach to supporting (FM/SU about SM)		
Contradiction – worrying about boundaries of job role (SM)		
Sharing ideas (SM)		
Persisting with offer of support / Reminding of the availability of support (SM)		