Implementing the THRIVE Framework for System Change in Greater Manchester: A mixed-methods service evaluation

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Abstract

This thesis documents a commissioned service evaluation of the implementation of the THRIVE Framework for System change, in the context of devolved child and adolescent mental health service transformation in the Greater Manchester area. Known locally as GM i-THRIVE, this nationwide initiative hopes to address the shortcomings of previous models of service provision, including that which was allocated under the well-established CAMHS tiered model. The key aims of the framework are ensuring that more children and young people (CYP) receive the support that they need, and that the options available are diversified. This thesis evaluated GM i-THRIVE from various angles, utilising a range of research methods. These areas of focus were pragmatically selected as the most important conduits through which positive changes to the CYP mental health landscape could be made.

Two of the four studies in the thesis focussed on staff training. Through a qualitative systematic literature review (Study 1), the barriers to, and facilitators of, mental health training for all CYP-facing professionals were identified. Following this, a qualitative content analysis (Study 2) explored the extent to which these factors were evident in the experiences of those trained under GM i-THRIVE. The key aim of Study 3 was to establish whether reports of implementation progress from Greater Manchester localities matched whether "THRIVE-like" care was experienced by CYP. It also assessed the quality of evaluation tools used by GM i-THRIVE, to draw overarching meta-inferences on progress made. Finally, Study 4 interviewed a range of professionals on the topic of sustainable practice within GM i-THRIVE.

Ensuring that an intervention is "built to last" during the earliest stages of implementation is vital if changes made are to be widespread and enduring. Areas of strength and weakness identified in these testimonies were highlighted using qualitative framework analysis. The discussion section of the thesis collates and contextualises the findings from all four studies in terms of what we know (and do not know) following this evaluation. Elements from the introductory chapter of the thesis, which placed models of mental health provision within the current social, political, and economic climate, are drawn upon in light of the insights produced.

Declaration

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Banwell, E., Qualter, P., & Humphrey, N. (2023). Barriers and facilitators to training delivery and subsequent implementation of a localised child and adolescent mental health initiative: A qualitative content analysis. *BMC Medical Education, 23*(1), 264. https://doi.org/10.1186/s12909-023-04238-9 **(PhD Study 2)**

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Chapter 1: Background

1.1: The broader context of my PhD thesis project

1.1.1: Defining mental health

"Mental health" lacks a universally agreed definition. The characterisation proposed by the World Health Organisation (WHO) is commonly referred to by researchers when the question of "what exactly *is* mental health?" is raised. The WHO suggest that mental health is "a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community" (World Health Organisation, 2022). Whilst this definition acknowledges that complete mental health goes far beyond the absence of mental illness or disorder, and that its antecedents vary from person to person, Galderisi et al. (2015) argue that it is too simplistic. To provide one example of why, it may be that an individual is not able to work or contribute to their community because of a physical illness or disability. This does not mean, in the absence of other causal factors, that this individual cannot be mentally healthy. The salience of work and societal contribution within this definition was likely to have been influenced by North American cultural ideals and norms that relate to productivity.

Galserisi et al (2015) also suggest that consistent positive emotion and functioning is focussed upon too heavily in many definitions. Keyes (2002), for example, provided a popular operationalisation of mental health as "a syndrome of symptoms of positive feelings and positive function in life" (Keyes, 2002, p.208), and that optimally high levels of subjective wellbeing and psychosocial functioning are necessary. Neither the WHO's conceptualisation, nor that of Keyes (2002), encapsulate the day-to-day fluctuations of emotion and functioning that are experienced by us all, and should not be, in isolation, blindly considered unhealthy (Galderisi et al., 2015). Accordingly, Galderisi et al. (2015) proposed a holistic definition of mental health that compensates for personal and cultural differences, *and* the regular "ups and downs" that we each face as we navigate our complex inner worlds and external environments. To this end, they suggest that mental health is "a dynamic state of internal equilibrium" (Galderisi et al., 2015, p. 231),

through which we can regulate our emotions, and adaptively cope with life events. Inversely, a difficulty or disorder might arise when an individual pervasively struggles to maintain their personal emotional equilibrium. The fluidity of this definition is important to the context of this thesis. This is especially true within this chapter, where I go on to explore the influence of a range of factors on the mental health of children and young people (CYP) and discuss what having a mental health difficulty means under the current social, economic, and political climate.

1.1.2: Children and young people's mental health: The importance of early intervention

This thesis was written amid a mental health crisis for CYP in the United Kingdom. To broadly summarise the enormity of this crisis in recent years, the latest wave of the Mental Health of Children and Young People survey (NHS Digital, 2022) showed that the prevalence of probable mental health disorders in 7- to 16-year-olds increased from one in nine (12.1%) to one in six (16.7%), from 2017 to 2020. An even sharper increase was found in 17- to 19-year-olds, with the prevalence of these difficulties growing from 1 in 10 (10.1%) to 1 in 4 (25.7%) by 2022. A recent study by Deighton et al. (2021) reported that less than half of CYP (41%) were in a long-term, enduring state of mental health. This unfortunately suggests that most CYP, who in this study were aged 14 and under, have at least some experience of mental health problems (Deighton et al., 2021).

It is evidently vital that mental health concerns are addressed as early in a young person's life as possible. When we look at the incidence of mental health problems and diagnosed psychiatric disorders across the human lifespan, the peak age of onset for these is 14.5 years old (Solmi, Radua, et al., 2022). Three-quarters of these disorders have appeared by a person's mid-twenties (Kessler, Amminger, et al., 2007). Dissecting this statistic by disorder type, behaviour and anxiety disorders are usually the earliest problems to appear, whereas mood disorders typically first appear during adolescence (de Girolamo et al., 2012). A review by Kessler, Amminger, et al. (2007) examined data from the WHO's mental health surveys. The researchers found that in adults, the most severe disorder presentations, plus those with later onsets, were commonly preceded by milder

difficulties that were present yet untreated in childhood. These findings clearly demonstrate the stark need for early detection and treatment, to prevent mental health concerns from continuing into, and exacerbating during, adulthood (Kessler, Angermeyer, et al., 2007).

Further emphasising this need, when such concerns *do* persist into adulthood, the risk of associated detrimental outcomes increases. Adult outcomes that have been linked to early mental ill-health include increased criminal behaviour (Aebi et al., 2014), loneliness (Trotta et al., 2020), and substance abuse (Martin-Storey et al., 2011). In agreement with and elaborating on Kessler, Amminger, et al. (2007)'s findings, adults who had experienced psychotic episodes in childhood had significantly elevated risks for lifetime diagnosable psychiatric disorders, and for the diagnosis of additional disorders as time progressed (Carey et al., 2021). Although potential treatment of difficulties in childhood was not explicitly discussed by Carey et al (2021), a lack of early intervention at the onset of a psychiatric disorder has, unsurprisingly, been found to predict longer illness durations (Birchwood et al., 2013). Long-term mental ill-health, even in comparison with physical illnesses of similar durations, leads to reduced quality of life (Busija et al., 2017; Kurtz, 2013), which further highlights the importance of early detection and amelioration of concerns in childhood as means of protecting adult wellbeing.

In addition to these important individual outcomes, whilst it can appear insensitive to discuss the financial burden of mental health, early intervention is demonstrably more cost-effective than treatment for more severe and entrenched mental health concerns. According to a report by the Children's Commissioner (2017), a course of counselling or group CBT sessions within a school cost the National Health Service (NHS) £229 per child in 2017 (Children's Commissioner, 2017; Department of Health, 2015). If a young person was able to fully benefit from this type of support, given that a referral to community CAMHS, for example, cost £2,338 at time of publication, and an in-patient admission cost £61,000, a large saving of public funds would be made (Children's Commissioner, 2017). Although these figures are a little out-of-date (no equivalent recent statistic is available) they clearly demonstrate the eventual societal benefit that may be possible if greater investment into early intervention is made.

1.1.3: Suggested explanations for the current prevalence of mental health concerns in children and young people

If the need for early intervention is so evident, why is it that the rates of mental health concerns in CYP are continuing to climb year on year? Some have argued that both the reporting and detection of such concerns have improved. Indeed, some studies have suggested that prevalence estimates might be sensitive to reporting effects as simple as small wording changes in assessment and diagnostic measures (Goodman et al., 2007). However, the fact that converging reports by multiple informants, and the specificity of observed trends (Collishaw, 2015), suggest that real changes are reflected in this increased prevalence. For example, considerably more variation has been observed in emotional and conduct issues, than in hyperactivity symptoms. Collishaw (2015) suggests, therefore, that it is not solely the case that informants, like parents and teachers, have simply become better at identifying and reporting concerns.

Social and cultural factors are likely to have played a role in the increase during the 21st century (Bor et al., 2014). These include frequent smartphone and social media usage by CYP (Abi-Jaoude et al., 2020), and greater pressure within modern schooling environments (Bor et al., 2014; Sweeting et al., 2010). Within the latter, examination-related stress is one factor that has been linked to poorer mental health outcomes (Long et al., 2021). There is also a large mental health disparity between CYP from low- and high-income families (Collishaw et al., 2019). The inequitable effects of government-enforced austerity, which will be discussed in greater depth in sub-section 1.1.4, continue to worsen mental health outcomes for CYP from poorer families (Hanley et al., 2020; Stuckler et al., 2017).

Any combination of these indicative stressors and risk factors means that childhood, particularly during the approach to adolescence, when several new biological, social, and educational changes are faced (Patalay & Fitzsimons, 2018), is a critical period in the trajectory of mental health (Fusar-Poli, 2019). The following two key theories, whilst not the only ones available, are helpful ways of considering, together, the explanations for the UK's mental health crisis that is detailed within this chapter. The theory of "cumulative risk" states that the more

individual risk and victimisation factors that somebody is exposed to, the more likely they are to experience detrimental life outcomes. Such factors include poverty, illness, environment, or being part of a marginalised group. Higher cumulative risk during childhood has been linked to negative mental health outcomes in several studies, both within childhood in the shorter term (Salisbury et al., 2020; Turner et al., 2006), and when adulthood is reached (Garon-Bissonnette et al., 2022). Despite the popularity of the cumulative risk theory for explaining the detrimental effect of combined stressors, some researchers have suggested that this model is too simplistic.

McLoughlin & Sheridan (2016) note that the cumulative risk approach implies that all types of adversity and environmental experience accumulate in the same way, through identical mechanisms, for every individual. Their proposed "dimensional approach" (McLaughlin & Sheridan, 2016), without denying that each additional risk factor presents additional stress, distinguishes between deprivation (absence of expected input, e.g., poverty or neglect) and threat (harm, or threat of harm, e.g., abuse, or witnessing violence), as two separate types of adversity. The researchers argue that these dimensions impact emotional learning pathways in different ways, resulting in distinct negative outcomes. For example, deprivation has been independently linked to poorer learning outcomes, such as reading scores, whilst threat is linked to negative emotional and behavioural outcomes (Wolf & Suntheimer, 2019). Whilst the cumulative risk model can be helpful for identifying CYP who need support, precise knowledge of pathways and outcomes is vital when risk is measured for the purpose of providing targeted interventions (Berman et al., 2022).

The dimensional model is clearly a useful way of conceptualising how risk factors build up, especially when considering the elements that have contributed to the magnitude of the current mental health crisis. The COVID-19 pandemic, which began in 2019, has presented yet another risk factor, and has created a complex mixture of deprivation; for example, of education and social contact, and threat; for example, fear of illness, and domestic and child abuse. Many suggest that the pandemic created the "perfect storm" (Usher et al., 2021, p. 1022) for the latter to occur, particularly for those forced into lockdown with an abusive family member

or partner. The idea of "staying safe" under such circumstances is clearly an ironic paradox (Bradbury-Jones & Isham, 2020). Although still an emerging evidence base at the time of writing this thesis, many researchers are currently investigating the influence of the COVID-19 pandemic on the mental health of CYP. Some of this initial research suggests that the widespread pandemic-induced "mental health crisis" predicted early on has not materialised (Haeffel, 2022). Rather, longitudinal studies have shown that following an initial deterioration in early 2020, the mental health of adults (Pierce et al., 2021) and young people (Gagné et al., 2021) alike has, in general terms, "bounced back" to pre-pandemic levels. But, whilst our mental health may not have been as drastically and universally impacted as expected, the research highlighted a more nuanced picture: one best summarised by saying that the mental health impact was far from being the same for everyone.

I will now explore some of the inequalities that were uncovered by this early pandemic research. The effects of social isolation and loneliness (Marchini et al., 2021), infection anxiety (Adegboye et al., 2021), and educational disruption (Scott et al., 2021), have all been presented as sources of stress, and predictors of subsequent negative mental health outcomes, for CYP during the pandemic. A survey completed by parents of 4-16-year-olds (Waite et al., 2021) examined the impact of national lockdowns in the UK at two time points (March and May 2020). This study found 10%, 20%, and 35% increases in emotional, hyperactivity, and conduct symptoms respectively in pre-adolescent CYP. However, in the same period, a 3% reduction in emotional problems was noted in adolescents. In addition, adolescents experienced much smaller increases than younger children in hyperactivity (4%) and conduct issues (8%). For CYP from lower income households, and/or who had special educational needs, symptoms were elevated for all ages, and at both time points. This again suggests that risk accumulation is an important predictor of mental health, and in particular, the extent to which CYP were likely to have experienced adverse mental health outcomes during the pandemic. A study by Pereira et al. (2021) found additional evidence for this, reporting that pre-existing psychosocial vulnerability factors moderated the relationship between pandemic-related mental health risk factors and CYP and carer anxiety and well-being. The mental health effects of the pandemic may also differ by gender, with a greater

negative effect found for girls than boys in the UK, and this difference was even stronger for those from lower-income households (Mendolia et al., 2022). By shedding light on which groups of CYP were the most impacted by COVID-19, these studies and reports highlight the need for appropriately targeted support.

Despite the interesting preliminary insights noted above, some researchers have suggested that the desire to research and publish quickly has compromised the robustness of the research methods used to explore the mental health of CYP during the COVID-19 pandemic (Demkowicz et al., 2021). This includes an over-reliance on convenience sampling, a lack of co-production with those with lived experience of poor mental health, and underutilisation of qualitative inquiry. These pitfalls, stemming from the desire to produce rapid insights, may mean that valuable information about the true impact of the pandemic is missing from the research produced thus far. If the studies carried out over the next few years take these methodological considerations into account, the mental health effects of COVID-19 for CYP, both in the short and long term, will be revealed with more certainty.

The regional positioning of the work within this thesis also deserves discussion, owing to the health inequalities, both mental and physical, that exist in the United Kingdom. Greater Manchester is a city region in the North-West of England, with a population of approximately 2.8 million residents. 898,000 of these residents are under 25 years old, which gives the region a slightly higher proportion of young people than the average for the rest of England (Greater Manchester Combined Authority, 2019). CYP living in Greater Manchester are more likely to live below the poverty line and tend to have poorer health outcomes and a shorter life expectancy compared to the English average (Greater Manchester Combined Authority, 2019). As a Northern region, the “North-South divide” is keenly felt in Greater Manchester. This long-existing schism was arguably amplified by the decline in manufacturing and heavy industry, such as coal mining, during the 1970s and 1980s, which resulted from Conservative party policy. This caused mass unemployment and, inevitably, a wider economic gap between the richer and the working classes (Jones, 2013). In terms of health outcomes, those living in the North have higher levels of diagnosed health conditions (Watt et al., 2022), and are

20% more likely to die before the age of 75 (Buchan et al., 2017; Lee et al., 2019). Two-thirds of these excess deaths in the North can be explained by socioeconomic deprivation (Kontopantelis et al., 2018). Those living in the North also tend to suffer disproportionately at times of national crisis and economic hardship, and mental health is an important facet of wellbeing that is negatively affected in such times. A study by Möller et al. (2013) found that mental health issues associated with unemployment were more prevalent in the North than in the South of England, with pre-existing deprivation and financial precariousness linked to this mental health disparity (Akhter et al., 2018; Harrison et al., 1998).

These regionally incongruent outcomes are not just evident in adulthood. A recent report entitled "The Child of the North" by the Northern Health Service Alliance (Pickett et al., 2021) reported that the mental health of CYP living in the North of England deteriorated, and loneliness increased, more sharply during the pandemic compared to those living elsewhere in England. Northern regions spent, on average, 41 additional days under the most stringent lockdown conditions than did the South, suffered 17% more COVID-related deaths, and additionally experienced a larger drop in income and increase in unemployment through redundancy than the South (Munford et al., 2021; Pickett et al., 2021). Incidentally, the mental health of those who faced precarious employment and financial concerns during the pandemic decreased the most (Cheng et al., 2021; J. M. Wilson et al., 2020), and financial strain was found to indirectly impact CYP mental health through the mediator of parental mental health (Adegboye et al., 2021). Hence, it is probable that the additional financial hardship faced by families in the North, combined with, and resulting from, an overall harsher impact of the pandemic, has contributed to these regional and economic inequalities. A closer look at exactly what these inequalities, situated within a wider climate of austerity, mean for CYP, their families, and the services they use can be found in sub-sections 1.1.4 and 1.1.5.

1.1.4: Mental health support under a strained National Health Service

Even in the absence of unanimous evidence about the impact of COVID-19 on CYP mental health, it is obvious that child and adolescent mental health services

(CAMHS) are facing a “new, post-COVID-19 normality” (Raballo et al., 2021, p. 1067). Even before the pandemic, healthcare providers across Europe saw discrepancies between the resources and services available for CYP mental health, and the actual epidemiological burden presented (Signorini et al., 2017). The UK’s NHS is no exception to this, and CYP face lengthy waits to access specialist mental health services, with a lack of advice and support on mental health management offered in the interim (England & Mughal, 2019; Roughan et al., 2019; J. Smith et al., 2018; Wolpert et al., 2016). Additionally, in the 2013-14 period examined by J. Smith et al. (2018), 12% of referrals to CAMHS were rejected. Whilst this number does not appear high at first glance, the chances of a referral being rejected were increased if it related to an emotional or behavioural difficulty. Early signs of mental health concerns, especially when these are seen in younger children, often fall short of meeting clinical diagnostic or treatment thresholds (Gustafsson et al., 2017). These early indicators often manifest as emotional problems, including low self-esteem and behavioural conduct issues. Both were precursors of later depressive symptoms in a study by Leung et al. (2018). In line with that study, as noted earlier, more severe issues are often preceded by milder symptoms (Kessler, Amminger, et al., 2007). This combination of evidence might suggest that those denied access to specialist services through having their referral rejected (J. Smith et al., 2018) are those who would benefit the most from early support.

For CYP, long waiting periods, and higher than ideal rejection rates, are just two barriers to receiving mental health support. Each of these will be discussed comprehensively in section 1.2. However, the broader key message is that the presence of numerous obstacles means that only small numbers of CYP manage to access the support that they need. The proportion of CYP accessing appropriate help sat at few as 25% in the UK’s most recent epidemiological study (Department of Health, 2015; Green et al., 2005). The idea of a strained and overwhelmed NHS in the UK is core to the context of this thesis: a health service where across the board, 5.45 million patients are waiting for routine care (Rimmer, 2021). This central thread is especially pertinent given that the four studies within this thesis were conducted during the COVID-19 pandemic, when a multitude of additional pressures were felt across the entire NHS.

At this point, it seems prudent to provide an overview of the long-standing challenges faced by the whole NHS, in which CAMHS services are situated. Staffing issues are core to the difficulties faced within the NHS. In a 2020 staff survey, over half of NHS staff in England frequently work more than their contracted hours, with 44% reporting work-related stress (Bailey, 2021; NHS England, 2021). This latter figure was currently at its highest level since 2016. As well as high workloads (Ravalier et al., 2020), low job autonomy and a lack of senior support contribute to this stress (Basu et al., 2016). Staff frequently feel undervalued (Wilkinson, 2015): feelings which were exacerbated during the pandemic, when hospital staff essentially risked their lives by coming to work (Best, 2021). Poor workforce planning, particularly in terms of staff shortages, have quite predictably led to this demanding level of overwork (Bradley, 2021), and the subsequent "burnout" (Iacobucci, 2021) experienced by staff. Mentally and physically exhausted NHS staff are at risk of making dangerous errors, and often feel less engaged with their work (House of Commons Health and Social Care Committee, 2021). This inevitably leads to poorer patient safety and satisfaction, in addition to a greater likelihood of staff quitting their jobs. Poor staff retention further intensifies the pressure felt by remaining colleagues (Weyman et al., 2019).

The impact of the UK leaving the European Union (EU) in 2020, known as Brexit, has further contributed to the labour deficit that already existed within the NHS (Savage, 2019). The magnitude of this shortfall currently stands at over 100,000 vacancies (D. Oliver, 2022). A recent qualitative study with EU doctors working in the UK demonstrated that sadly, many felt unwelcome following Brexit. The uncertainty faced in relation to their legal status, as both employees and UK residents, compounded the stress that they felt (Milner et al., 2021). These factors have discouraged many from remaining in the UK, and over 10,000 EU nationals have ceased working for the NHS since the 2016 referendum (Savage, 2019).

Combining the impact of Brexit with the demands of COVID-19 means that over 480,000 new healthcare staff will be needed by 2030 to continue the models of care currently used by the NHS, and to ameliorate system-wide pandemic recovery (Bailey, 2021; Rocks et al., 2021). Since 2020, an inevitable demand for staff capacity across the NHS has risen, owing to a higher number of patients

requiring urgent care (Pandit, 2020). Some of this critical need has been met by redeploying staff from other departments (Endacott et al., 2021), which has added to the pressure felt by staff who remain in these other departments, and negatively impacted the quality of care given. Those redeployed to work on intensive care units during the pandemic were concerned about making mistakes due to mismatched skills, and pervasive negative psychological impact relating to this strain was commonly reported (Endacott et al., 2021). In fact, 40% of the staff surveyed in a recent study in England met a clinically significant threshold for post-traumatic stress disorder (Greenberg et al., 2021). Healthcare workers of all kinds also faced huge occupational risk in terms of an increased likelihood of contracting COVID-19, as well as strain from the sickness absence of their colleagues (van der Plaat et al., 2022). Furthermore, a review of testimonies from over 2000 UK mental health staff found that infection control, rapid workplace adaptations, and concerns about vulnerable service-users, were all salient worries for these staff (Johnson et al., 2021). These worries were combined with feelings of despair, uncertainty, and overwhelm, which were reported by many frontline NHS workers during COVID-19's peak (Newman et al., 2022).

1.1.5: An "age of austerity"

It is obvious that the pandemic has amplified the pressures faced across the NHS in recent years. One additional significant issue that has been faced by those working within the NHS is that their annual pay rises fall considerably below the UK's rates of inflation (Campbell, 2022a). In 2022, for example, this pay rise was 3%, compared to an inflation rate of 5.5%. Because of this discrepancy, many NHS staff struggle to keep up with the rising cost of living, despite facing long working hours (Francis, 2022). In 2017, £2.6 billion was saved by "freezing" wages in this way, but national saving on this scale is not tenable long-term given the considerable increase in inflation year on year (Dayan, 2018). These wage freezes are just one facet of the "age of austerity" (Kerasidou & Cribb, 2019, p.153) that the UK has witnessed following the fiscal crisis of 2008, and the Conservative government's return to power in 2010. The huge national debt caused by "bailing out" banks resulted in a plan to save £99 billion by reducing public spending, and to procure an additional

£29 billion through increased taxes by 2015 (Kerasidou & Cribb, 2019). This led to, amongst other widespread cuts, a lack of inflation-appropriate increases in NHS funding that included wages (Campbell, 2022a). Combined with budget cuts elsewhere in the health and social sector, this meant that the impact of austerity was acutely felt by those on the front lines of delivering care (Kerasidou & Kingori, 2019). For example, in a qualitative study, NHS Accident and Emergency (A&E) workers felt that an increased focus on delivering care with haste, and the need to follow stricter operationalised procedures that were implemented to save money, meant that crucial values of empathy and personalised care were becoming lost due to a lack of time (Kerasidou & Kingori, 2019).

Mental healthcare provision specifically has fallen victim to reduced funding since 2010. Between then and 2015, there was an 8% financial cut to mental health trusts. This resulted in the loss of 2,100 dedicated beds (McNicoll, 2015). This came at a time when mental health support need was at an all-time high. Shockingly, around 120,000 excess deaths were attributed to austerity within England between 2010 and 2017 (Watkins et al., 2017), and these mortality figures include a 20% rise in suicides in the UK regions that were the most impacted by austerity-related job losses (Stuckler et al., 2017).

CYP are in no way immune to the effects of austerity, with data from the Millennium Cohort Study showing that in the UK, one in five young people aged 14 years or under live in persistent poverty (Lai et al., 2019). Social security is another element of public spending where severe reductions have been made: a sum of £27 billion a year in cuts to this funding were made between 2010 and 2018 (Child Poverty Action Group, 2018). Flaws associated with the introduction of Universal Credit in 2013, which replaced six individual benefit types, has been linked to an increase in child poverty (Institute for Social and Economic Research, 2021). As one example of these flaws, Universal Credit was reduced by £20 a week per family in October 2021. This represented the largest social security decrease in the UK since World War II (Joseph Rowntree Foundation, 2021).

The consequences of these cuts are keenly felt by many, and families with children formed 980,000 of the 2.5 million visits to a Trussell Trust Network food bank in the UK during 2020/21 – a need that has increased by 128% in the last five

years (The Trussell Trust, 2022). Most recently, in October 2021, the UK's price cap on household energy rose by 17.1% for gas, and 8.7% for electricity (Office for National Statistics, 2022), drastically compounding the cost-of-living crisis. Further utility increases are expected over the winter of 2022/23. The price of food has also increased exponentially. On behalf of the Office for National Statistics, Casey et al. (2022) produced a report analysing the increase in cost of 30 essential grocery items at seven major UK supermarkets. The cost of 24 of these items increased by an average of 6.7% between April 2021 and April 2022. It is unsurprising that many families no longer have areas within their personal budgets from where their spending can be reduced (Patrick & Pybus, 2022), and that they are often forced to choose between heating their homes or eating a minimally adequate amount of food.

What do these figures mean for the mental health of those CYP living below the poverty line? Poverty leads to stress, shame, and stigma for both parents and their children (Rose & McAuley, 2019), and austerity-induced benefit loss can lead to deterioration in parental mental health, and strained parent-child relationships (Mari & Keizer, 2020). These outcomes undoubtedly bear a negative impact on the long-term mental health of CYP. Several studies have identified poverty and deprivation as risk factors for poorer CYP mental health outcomes (Deighton et al., 2019; Fitzsimons et al., 2017). Additionally, Lai et al., (2019) suggests that any duration of exposure to poverty, whether in early or later childhood, leads to an increased risk of mental or physical health problems. This is especially true given that poverty is rarely experienced in isolation of other risk factors for poor mental health. Poverty's status as a key factor that contributes to deprivation-associated risk accumulation (McLaughlin & Sheridan, 2016) has been well evidenced (Evans & Kim, 2007; Turner et al., 2006). To further demonstrate the recent impact of austerity on CYP mental health, a qualitative study by Hanley et al. (2020) found that school staff reported an ever-increasing need to provide emotional support to their pupils. School staff felt that this was directly linked to socio-political factors, such as austerity. This idea of alternative forms of support existing outside of NHS provision, and the important role that this can play in ameliorating the mental health crisis, will be discussed in depth later in the thesis. However, to conclude this

section, the outlined evidence shows that that austerity, and the resulting poverty inflicted upon many in the UK, undeniably impacts the mental health of people of all ages. This includes CYP, who formed the focus of the four studies within this thesis.

1.1.6: Section summary

In this section, that opened the thesis, I began by defining "mental health" before exploring the mental health crisis faced by CYP. This crisis appears to be worsening with time. I then discussed the various apparent reasons and explanations as to why this is the case, including socio-economic and education-related circumstances, and the onset of COVID-19. The unique regional circumstances of the North of England, where the research within this thesis was conducted, were discussed. A higher accumulation of risk factors, including, but not limited to, those outlined, are more likely to lead to poorer mental health outcomes in both the short and long term. These outcomes have been suggested to differ depending on the nature of the accumulated risks (McLaughlin & Sheridan, 2016). This idea of a "build-up" of adverse factors leading to worse outcomes can also explain why the NHS has become so strained over the recent years. This becomes apparent when we think about the pressures placed upon employees, and on the system as an overarching whole. These stressors included issues arising from Brexit, and the impact of austerity on wages and direct health and social care funding. Placed within the unprecedented context of a global pandemic, it is easy to understand how the NHS has struggled to meet the increasingly prevalent mental health needs of CYP. This, overall, paints a largely pessimistic picture whereby an already-struggling healthcare system is unable to cope with sharply increasing demand. In the next section of Chapter 1, I will narrow the focus of the thesis. As the wider economic, social, and epidemiological factors that have led to a mental health crisis for CYP have already been discussed, I will examine what mental health support provision presently looks like within this context, and explore, in depth, the barriers to access.

1.1.7: How does this section contribute to the overall thesis?

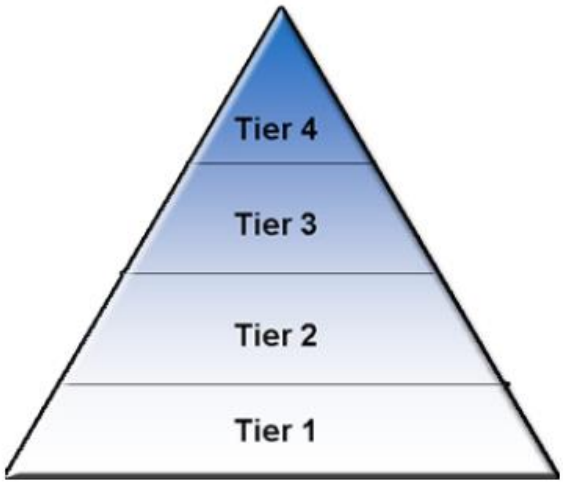
- This opening section provided important details of the social, economic, and political context in which the original studies within this thesis are situated.
- Awareness of the links between the range of factors within this context, and the gravity of the current mental health crisis, is vital for understanding the wider rationale behind the body of research conducted in this thesis.

1.2: The shortcomings of mental health support provision for children and young people in the UK

1.2.1: Introducing the CAMHS "tiered model" of mental health support allocation

In 1995, a policy document entitled "Together We Stand" was produced by the NHS (NHS Health Advisory Service, 1995). The outlined restructuring of CAMHS commissioning and service provision within that document envisioned an integrated, "universal" CAMHS, that was well connected to other health services, and would provide accessible and appropriate care (Callaghan et al., 2017). A cornerstone of this document was the introduction of a tiered model of support service allocation and delivery. Visualised as a pyramid (see *Figure 1.1*), the model was designed to categorise the issues and severity levels that CYP may present with, and the services available to provide support at each level (The Association for

Figure 1.1*: A simple visualisation representing the tiered model of child and adolescent mental health support provision (NHS Health Advisory Service, 1995; Wolpert et al., 2016)*



Child and Adolescent Mental Health, 2022; Wolpert et al., 2016). Service provision at tier one consists of non-specialist primary care workers, including GPs, school nurses, and health visitors. The remit of mental health support available at this level is limited to mild behavioural issues, such as those associated with sleeping or eating. This support is placed as the base of the pyramid as the most frequently accessed and provided.

At tier two, primary mental health professionals, such as psychologists or counsellors, offer consultation and assessment. Some CYP who are consulted at tier two may eventually be treated under a different tier.

Those CYP with more complex or persistent disorders are supported under tier three care. This tier covers assessment of neurodevelopmental conditions such as autism and ADHD, in addition to depression and early-onset psychosis. This support is provided by multidisciplinary teams, usually within a specialist mental health setting.

Finally, CYP at the very greatest risk or severity, who typically form a smaller number than those at other tiers, are supported at tier four. Professionals trained to provide care at this tier do not usually differ from those at tier three, but settings include highly specialised day or inpatient units, where intensive support can be provided (McDougall et al., 2008).

When the model was first introduced in 1995, it was extremely well regarded, and was rapidly implemented across the UK. Prior to its inception, mental health provision for CYP within the NHS had no unifying strategy, and very few guidelines available for how to organise services to decide what issues should be dealt with by whom (Barrett, 2019). This initial optimism, as a stark improvement to the way that provision was previously organised, is perhaps why the tiered model has been so long-lasting and influential (Wolpert et al., 2016). It remains the dominant paradigm used to conceptualise and demarcate service provision for several Clinical Commissioning Groups in the UK.

Many argue, however, that the tiered model has not stood the test of time, and that numerous flaws associated with its use mean that service allocation and provision has become less than ideal. The main criticism of the tiered model is that putting services, and indeed the mental health issues that “correspond” to these

services, into categories, places strict barriers between support providers (Department of Health, 2015). This results in fragmented rather than integrated care - contrary to what the 1995 document had hoped for. These barriers mean that many CYP "fall between the gaps" that have inadvertently been placed between tiers if they do not completely fulfil criteria for the support associated with each. Service providers have commonly passed responsibility back and forth between each other when they do not feel that a particular young person fulfils their criteria (Department of Health, 2015). This often results in a support experience that is neither timely nor smooth.

Tiered provision, then, means that young people and their needs must fit neatly into the entry criteria of available services. Consequently, this means that they are not offered a tailored support experience that caters to their own unique needs. Additionally, moving between tiers and services is difficult, and lengthy referrals and waits are involved when doing so. CYP are therefore, in essence, limited to the support available within one tier (Rocks, Fazel, et al., 2020). Progression through the tiers, when this occurs, is often linear, meaning that CYP must meet professionals from various specialisms, before receiving treatment under the tier that is deemed the most appropriate for them. Primary care practitioners such as GPs (who fall under tier one of the model), often adopt the role of "gatekeeper" for access to other services, and are the source of most onward referrals (Rocks, Glogowska, et al., 2020). After this initial referral, appropriate treatment in higher tiers might only come after a lengthy battery of assessments, often within tier two. This process means that CYP and their families often need to repeat their story many times, to a variety of professionals (Department of Health, 2015). This disruption and lack of care continuity leads to frustration and distress, given that it can take a significant amount of time to build trust in a therapeutic relationship (Lester et al., 2011; Plaistow et al., 2014). Even after interacting with several professionals, CYP and their families often report that the support received was unsatisfactory (Bone et al., 2014). This suggests that communication between services is less than ideal. It is possible that the compartmentalised nature of the tiered model could be contributing to a "silo working" mindset (Care Quality Commission, 2018; Hacker, 2021; McCartney,

2016), where valuable information is not shared between professionals or departments. According to Hacker (2021), this is a problem that prevents CYP from being supported holistically.

1.2.2: The medicalisation of mental health services: biological reductionism?

You will notice that the questions of what mental health and mental ill-health truly mean features several times in this chapter. Their frequent reappearance emphasises the importance of considering the definitions of these terms when making decisions about mental health support provision, and whether certain types of care are appropriate and suitable. Across history, popular conceptualisations of the causes of psychiatric disorders and mental health have evolved dramatically. These explanations have ranged from the Ancient Greek Hippocrates and his theory of imbalanced "humours" (M. Smith, 2013), to possession by Satanic forces in the Middle Ages (Scull, 2015), to the idea of "wandering womb" induced hysteria, a problem that could allegedly be fixed with smelling salts, that prevailed in Victorian Britain (Tasca et al., 2012). Nowadays, it is widely accepted that mental health is the result of a complex interplay between biological and psychosocial factors (Borsboom et al., 2019). The exact nature of this interplay is neither uniform across individuals, nor fully understood.

Whilst the knowledge of neurotransmitters, hormones, and other biomarkers that underpin mental health issues is well established (Nedic Erjavec et al., 2021), many researchers, clinicians, and policymakers argue that this paradigm is too simplistic, and is relied upon too heavily in terms of how it guides the provision of support. Indeed, Callaghan et al. (2017) state, in their critical analysis of CAMHS policy in England, that "the positioning of mental health as a biomedical problem is one that is clearly in evidence in policy narratives and public discourses" (Callaghan et al., 2017, p. 113). This biological reductionism (the hasty attribution of behaviour and emotion to physical causes) can be harmful and obstructive in many ways, namely because it ignores the intricate complexity of mental health concerns. The social, cultural, and political factors associated with negative mental health outcomes, including but not limited to poverty (as outlined in section 1.1.5), are not

properly addressed when a solely biological explanation is given precedence (Pembroke et al., 2007).

Here, I return once again to the idea of cumulative risk, a theory which is predominantly used to encapsulate the impact of multiple socio-economic risk factors. Rather than biological disturbances acting as the primary causes of poor mental health, it is probable that a high number of environmental stressors accrue to act as catalysts for neurobiological changes. These eventual neurobiological changes may be indirectly responsible for a variety of deprivation- or threat-related outcomes (McLaughlin & Sheridan,2016), and the theory that focusses on how biological mechanisms underpin behavioural and mental health change is known as allostatic load (McEwen, 1998).

The theory of allostatic load suggests that repeated exposure to stressful situations, particularly in early development, leads to a gradual deterioration of the bodily defences that are usually in place to deal with acute stress (McEwen, 1998; Rogosch et al., 2011). Several studies have looked at the effects of allostatic load on CYP mental health, in a variety of positions along the causal pathway. For example, Rogosch et al. (2011) found that maltreated child status, and high allostatic load (allostatic load was indicated in this study by a range of physical factors, including elevated salivary cortisol levels and high resting blood pressure), each independently predicted behavioural issues. Additionally, allostatic load status was found to moderate the impact of maltreatment on mental health outcomes (Rogosch et al., 2011). Another study by Schulz et al. (2012) found a positive association between neighbourhood poverty and allostatic load, and that this relationship was mediated by psychosocial stress.

Vulnerability to poor mental health can also be inherited, an idea which may go some way towards explaining why some individuals are more susceptible to the negative consequences of having a high allostatic load. Whilst no single candidate gene for schizophrenia has been identified thus far, and the full aetiology of the disorder remains unclear (Perez et al., 2016; Tsuang & Faraone, 1995), it is widely regarded that some degree of familial susceptibility exists (Birnbaum & Weinberger, 2020). This has given rise to the well-known “diathesis-stress” model, which, in simplistic terms (Pruessner et al., 2017), states that a pre-existing vulnerability to

the dopaminergic dysfunction associated with schizophrenic symptoms (Brisch et al., 2014) can be triggered by environmental stressors and their impact on the hypothalamic-pituitary-adrenal axis (Pruessner et al., 2017; Walker & Diforio, 1997). The heritable transmission of intergenerational trauma has also been explored. Given that the first few years of life are sensitive developmental periods, high stress and adverse experiences can lead to telomere shortening and higher rates of mitochondrial DNA mutation - both of which contribute to poorer overall health, and accelerated aging (Ridout et al., 2018).

The body of research outlined above only "scratches the surface" when exploring how biological predictors of mental health have been explored in recent years. Yet, it clearly demonstrates that biological factors should only be considered valid predictors of mental health when placed within an individual's unique set of social factors and experiences. As touched upon earlier, it can be argued that the neurobiological school of thought has guided the narrative of mental health provision in the UK in recent years to too great an extent (Callaghan et al., 2017), and this has led rise to a good deal of discourse on how mental health should be situated within medicine. The "parity of esteem" philosophy states that psychiatric disorders are illnesses, like any other (Timimi, 2014). Thus, they should be regarded as equally worthy and important. This conversation led to legislation mandating an equivalent duty towards mental and physical health, as part of the Health and Social Care Act of 2012. Although there has been a good deal of debate over the extent to which this parity has been achieved in the NHS, indeed there are no universal ways to measure it (Baker & Gheera, 2020), the parity of esteem concept is well-intended, and has resulted in overwhelmingly positive outcomes. For instance, it has been paramount in addressing incongruities in quality between mental and physical healthcare (Mitchell et al., 2017), that have often arisen because of funding allocation discrepancies: physical healthcare has typically taken precedence here (Royal College of Psychiatrists, 2012). It has also helped trigger an important mind-set change, by shifting stigma and the locus of blame away from the suffering individual. Conversations such as "you wouldn't tell somebody with a broken leg to just snap out of it!" have become more common owing to a gradual public attitude shift, moving from the trivialisation of mental health concerns,

towards their being viewed as valid reasons for support seeking. This societal attitude change may have positively contributed to a greater propensity to report mental health difficulties and increased professional recognition of these: both of which have been argued, albeit in a limited way, to explain the rise in mental health concerns outlined in section 1.1.3 (Collishaw, 2015).

However, Callaghan et al. (2017) suggest that the parity of esteem viewpoint has inadvertently led to CYP mental health being viewed, too narrowly, through an illness lens. Stressing that mental health is akin to other health issues and can therefore be treated straightforwardly within a clinical setting, is an indisputably unhelpful view. Whilst it is undeniable that social inequalities can also lead to disparate levels of physical illness (Galobardes et al., 2008; O'Dowd et al., 2015), this medical model overwhelmingly neglects the variety of predictive psychosocial and environmental factors that specifically interact with mental health. The ideas of early preventative mental health provision for those at risk, and the wider promotion of wellbeing to all, may also be overlooked (Department of Health, 2015).

The structure of the CAMHS tiered model has arguably contributed to the over-medicalisation of mental health. To recap, under the tiered model, CYP usually need to be referred to specialist services by a primary care provider, like GPs or Accident & Emergency (A&E) departments, and this process can often be problematic. A systematic review of studies exploring adolescents' experiences with mental health services in the UK was conducted by Plaistow et al. (2014), who identified several instances where issues with GPs were explicitly mentioned by young people. One study in this review (Biddle et al., 2006) found that young adults often perceived GPs as unsuitably qualified to deal with mental health issues, and that they were only equipped to handle physical ailments. Thus, they lacked confidence in their GP's ability to help in this way, and often felt disinclined to approach them. This belief that GPs do not have the facilities or knowledge to appropriately assist has been echoed in a more recent qualitative study (Appleton et al., 2022), where young people felt that their lack of expertise heightened their anxiety. Many in Biddle's (2006) study felt that primary care practitioners were keen to attribute the mental health difficulties they reported to physical causes.

Participants reported being subjected to multiple unnecessary blood tests (Biddle et al., 2006), or being "fobbed off" with medication (Salaheddin & Mason, 2016), which they feel is hastily prescribed in the absence of any psychological therapy (Plaistow et al., 2014; Storey et al., 2005).

Despite these experiences, little evidence exists to *directly* indicate an over-prescribing of psychotherapeutic medications in the UK (McCartney, 2014). However, data from the Royal Pharmaceutical Society found that between 2015 and 2020, the number of under 17s who were prescribed antidepressants rose by 26%. This figure peaked during COVID-19 lockdowns (Robinson, 2021). This figure, combined with CYP's apparent desire for a de-medicalisation of their concerns, suggests that alternative support instead of, or in conjunction with, physical treatments is both wanted and needed. However, the question of whether "over-prescription" occurs predominantly because of a lack of knowledge or of feasible alternatives, or whether there is a genuine increase in need. Research in the USA by Barnett et al. (2020) suggested that even when doctors are aware that medication prescribing is not the best option, a lack of alternative options, such as counselling or educational accommodations, means that they are given little choice but to do this. Studies in the UK suggest a similar picture, in that a lack of resources prevents GPs from making decisions that are more clinically helpful for CYP. One study found that most GPs believe that their training for handling CYP mental health is inadequate (O'Brien et al., 2020), and that poor communication with CAMHS, and unclear referral criteria, create further challenges (Lambert et al., 2020). Contrasting with this, a recent study by Henderson et al. (2021) found that temporal prescription increases were not uniform across diagnosis or disability status. This could indicate, although tentatively, that prescription, when it occurs, is generally clinically appropriate, or on the other hand, that some groups of CYP are not able to access the same range of therapeutic options as others. More research into the nature of prescribing patterns is therefore needed.

1.2.3: Mental health promotion: beneficial to all

This leads on to another criticism of the tiered model, which is its failure to account for the possibility of receiving alternative mental health support outside of the NHS.

This is especially true when we consider, once more, progression through the tiers; even contacting a professional at tier one technically requires reaching a certain threshold of disorder presentation. An individual is only likely to meet professionals at tier one once they have already experienced a significant amount of distress. Even then, reluctance is common, especially among young adults (Biddle et al., 2006). Sixteen to twenty-four-year-olds experiencing psychiatric distress are less likely than older age groups to approach a medical professional for mental health concerns (M. I. Oliver et al., 2005). This chapter sub-section, and the following (sub-section 1.2.4) discuss, in turn, the issues that are at hand here, which can be viewed as interconnected shortcomings of the CAMHS tiered model. The first of these is the idea of mental health promotion and early prevention, that are beneficial to all. The second explores the limited options available for CYP with any level of mental health support need.

As discussed in sub-section 1.1.1, most psychiatric disorders show their first signs by the time a person reaches their mid-teens (Solmi et al., 2022). At the very start of this chapter, the broader individual and societal benefits of early mental health intervention were discussed. However, at this juncture I will focus on the ways in which the over-medicalised system fails to encompass the promotion of good mental health to all, rather than just those with a certain diagnosis or level of symptom severity. In the same vein, every adult who interacts with CYP in a professional capacity, from teachers to the police, should be suitably equipped to support and be mindful of the mental health of those they work with (Ford et al., 2007). A core example of how mental health promotion can be delivered to CYP at a universal level is through schools (Lendrum et al., 2013). Schools are well-placed to implement evidence-based mental health and wellbeing interventions (O'Reilly, Svirydzenka, et al., 2018) to an entire targeted age group. CYP spend a substantial quantity of their waking hours at school or college (Leiss & Kim, 2022; Rutter, 1994). As a result, educational institutions play a prominent role in their social, behavioural, and emotional development: skills that are all extraneous to those that are academic (Fazel et al., 2014). Additionally, in a Children's Commissioner report on early mental health support, CYP said that they would like to be able to discuss mental health and wellbeing at school (Children's Commissioner, 2022). This finding

emphasises the desirability of the school environment as a point of access for such support.

Several school-based interventions have demonstrably enhanced CYP's mental health problem identification skills (Onnela et al., 2021), and reduced stigma (Ma et al., 2022; Onnela et al., 2021). Increasing knowledge about difficulties, and promoting positive attitudes towards such issues, is a way of reducing mental health related stigma in young people. Following a teaching programme on mental health, fewer pejorative expressions were used by 14- and 15-year-olds in a study by Naylor et al. (2009). This accompanied a decrease in their own conduct problems, and an increase in their prosocial behaviour. Other school-based interventions focus on social and emotional learning, which is an umbrella term for key competencies such as self-awareness, relationship skills, social awareness, and responsible decision-making (Humphrey et al., 2020; Weissberg et al., 2015). Two such interventions are the Social and Emotional Aspects of Learning Programme (SEAL), which was launched in England in 2007, and the Promoting Alternative Thinking Strategies (PATHS) curriculum. Both are delivered through a range of lessons, activities, and scenarios designed to help CYP identify and deal with emotions and feelings in themselves and others.

The concept of mental health literacy (MHL) can aid our understanding of what mental health promoting interventions aim to do. Although the topic of MHL is not of direct relevance to the studies within this thesis, it is presented here as an example of an early mental health strategy that is unaccounted for by the tiered model. Being "health literate", according to the WHO, is the most powerful social determinant of health. It accounts for variation in health outcomes to a stronger degree than any other factor, including income or education (Kickbusch et al., 2013). The ability to obtain and comprehend basic health information is a prerequisite for informed and appropriate health decisions to be made (Coulter et al., 2006). In terms of MHL specifically, it has been argued that early definitions of this term were too focussed on mental ill-health and psychiatric disorder identification. Thus, an overarching definition of MHL was proposed by Jorm et al. (1997), who conceptualised MHL as "the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and

causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking" (Jorm et al., 1997, p. 182).

However, this definition still fails to account for a number of key antecedents of MHL. To this end, a new definition of MHL, proposed by Kutcher et al. (2016), took the *maintenance* of good mental health into account, as an important component of overall wellbeing. They argued that MHL is "understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy (knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management capabilities)" (Kutcher et al., 2016, p. 155). Developing this even further, a systematic literature review by Mansfield et al. (2020) proposed a "critical mental health literacy", whereby social and contextual nuances and varying developmental stages and challenges, are taken into account when considering what MHL truly means for adolescents. Like Kutcher et al. (2016), Mansfield et al. (2020) noted that the promotion of positive mental health should be emphasised above a discourse of psychiatric illness. This modern definition of MHL provides a broad picture of what a comprehensive and wide-reaching mental health promoting intervention for CYP should look like: importantly, that it should be beneficial to all. Mental health literate CYP can act as informed collaborators alongside mental health professionals and their parents when making decisions about their own mental health care. When this happens, the likelihood of better treatment outcomes is increased (Edbrooke-Childs et al., 2016). However, for those outcomes to occur, MHL promotion should be developmentally appropriate (Ronzoni & Dogra, 2011; Winters & Pumariega, 2007), and free of complicated jargon (Hayes et al., 2020).

As an example of recent policy implemented in relation to MHL, in May 2021, the UK Government announced that £17 million would be allocated to improving and broadening school and college-based mental health support, particularly in the wake of the COVID-19 pandemic. By 2025, it is hoped that a senior mental health lead in every state school and college will be trained (Department for Education, 2021). Whilst this plan seems ambitious, it reflects a

step in the right direction towards widening the provision of mental health promotion through schools, who are clearly a suitable avenue for such guidance and support to be provided outside of the NHS.

1.2.4: An overreliance on diagnostic thresholds

As I have reiterated on several occasions, the concepts of mental health promotion and MHL, and their role in early prevention, follow the idea that information on mental health and wellbeing should be accessible to everyone. This ethos is at odds with the structure of medical models, under which only a small proportion of the population can receive support. This tends, as we have learned, to be those who exhibit more advanced symptoms of mental distress.

However, in the context of a model that relies so heavily on categorisation and severity thresholds, those with comparatively high mental health and wellbeing are not the only individuals excluded from such a model. The structure of the tiered model, and the fact that it is so tightly restricted to NHS CAMHS provision, means that many CYP with tangible mental health concerns, who would undoubtedly benefit from targeted mental health support, also fail to receive it. Even when we consider the small number of CYP who fully meet the criteria for a diagnosable disorder (Department of Health, 2015; Green et al., 2005), it is also important to consider that reaching a diagnostic threshold should not be the only method of determining whether a CYP has a mental health concern that is "valid" or "worthy" of support. This, again, relates back to the idea of a system where mental health is often over-medicalised.

A vital distinction that must be made here is between a mental health *disorder*, and a mental health *problem* (Kutcher et al., 2016; Pescosolido et al., 2008). Mental health *disorders* relate to a recognisable presentation of symptoms, that fulfil the minimum criteria for diagnosing a specific condition. These include, for example, major depressive disorder, generalised anxiety disorder, and anorexia nervosa. A mental health *problem,* on the other hand, might relate to less severe, albeit distressing, and to a certain degree persistent, negative affect. This might stem from a shorter-term adverse reaction to a traumatic event which, within the circumstantial context, is an adaptive, or even healthy, response. The conceptual

lines between “disorder” and “problem” are not clearly demarcated (Kutcher et al., 2016), especially when we think back to the issues presented by the parity of esteem model: that mental ill-health cannot be separated from its environmental context as easily as physical ailments (Callaghan et al., 2017; Timimi, 2014). Hence, the exact point at which an individual can be called “ill”, rather than suffering as expected under a set of external stressors, is not clear. I will now explore how barriers come into force for CYP who, for a range of reasons, do not fulfil diagnostic disorder requirements. This includes those who have, or indeed are erroneously deemed to have, a “problem” rather than a “disorder”.

“Milder” mental health concerns, if untreated, can lead to more severe and persistent symptoms as a young person ages (Kessler, Amminger, et al., 2007). A mixed-methods audit carried out by the Scottish government in 2018 interviewed CYP, asking them why their referral to CAMHS had been rejected. The most common reason was that their case was not deemed serious enough – they were not considered at a high enough level of risk or of illness to qualify for specialist support (Scottish Government, 2018). In line with these findings, a more recent study found that referrals made to CAMHS by a GP were three times more likely to be rejected than other referrals (Hansen et al., 2021). This is an interesting finding given that such referrals are likely to, initially, relate to milder presentations than those made through other routes. Those made by A&E, for example, usually involve more acute distress (Cratsley et al., 2008).

Whilst the study by Hansen et al. (2021) was conducted in Denmark rather than the UK, a similar study by Hinrichs et al. (2012), although slightly dated, found the same pattern within the NHS. Both sets of authors acknowledge that this could relate to GPs’ lack of skills for accurately identifying and describing mental health symptomatology. However, taken in combination with the finding of the Scottish Government’s (2008) report, it is plausible that a high proportion of rejections are made because the patient is not considered “ill enough”. Being labelled in this way can be detrimental in several ways. Returning to the Scottish study, over 50% of those with a rejected referral did not pursue any further support after their rejection (Scottish Government, 2018). Indeed, one young person stated, “it made me feel rejected because it made me feel am I not worthy of help. Am I not

deserving, am I not ill enough?" (Scottish Government, 2018, p. 56). It is clear how such feelings, elicited by this denial of assistance, can lead to non-persistence with support-seeking, and deterioration in mental health as symptoms remain untreated.

There are also numerous published incidences of support being denied because of a perceived lack of measurable "evidence" of a young person's psychological distress. The Guardian newspaper recently reported that a 12-year-old was not accepted by CAMHS despite a ligature being found in their bedroom, simply because no visible marks on their neck were present (Campbell, 2022b). Disordered eating is another key example. Many CYP are declined support from specialist services when they are not evaluated as "thin enough". A participant in a study by Wales et al. (2022) recounted that "my BMI was not always correlated to my mental state. When I reached a so called "healthy weight" I had little improvement mentally" (Wales et al., 2022, p. 223). Such perceptions are especially harmful for those with eating disorders, given that so many patients lack insight into the extent of their poor relationship with food. They often do not perceive themselves as requiring intervention, especially when the disorder has already progressed significantly. In the case of anorexia nervosa, a lower body mass was associated with reduced clinical insight in a study by Gorwood et al. (2019).

Older teenagers, aged 16 years old and over, face a unique set of issues as they fall within a "grey area" for service provision. They are seen as too old for CAMHS, yet too young for adult services (Barrett, 2019). For continued support once they reach 18 years, re-acceptance by adult services is often required. These services use different assessment criteria and boundaries to CAMHS. This means that despite no change in clinical presentation or need, acceptance for further support is not guaranteed (A. Wilson et al., 2015). This lack of post-CAMHS provision, combined with poor preparation for the termination of support, which often ends abruptly (Appleton et al., 2021), are just some of the reasons why older teenagers are at a particularly high risk of missing out on appropriate support. This can result in feelings of abandonment, and difficulties with coping once contact with CAMHS ceases (Appleton et al., 2021).

Any of these individual barriers can lead to feelings of unworthiness among CYP, and they may feel that their distress has been trivialised when they do not meet required "severity levels". Steps should evidently be taken to ensure that they can access appropriate specialist support. However, it may be the case that some referrals judged as unsuitable for CAMHS, which are subsequently rejected, should not have been directed to CAMHS in the first place. As well as desiring more training to help them identify needs and direct CYP appropriately (Lambert et al., 2020), GPs report a lack of knowledge surrounding sources of focussed support that exist as alternatives to CAMHS (Hinrichs et al., 2012; Lambert et al., 2020). These sources can include services within the voluntary sector, such as community "hubs" that can provide information, advice, and counselling (Hassan, 2022), or digital therapeutic services that can be accessed online without the prerequisites of referral or previous support contact (Hanley et al., 2021). Such services, which are also likely to have fallen victim to cuts in local spending (Hassan, 2022; O'Reilly, Adams, et al., 2018), are invaluable for CYP who cannot access CAMHS. As well as rejected referrals, difficulties with engaging with structured support are common, as is dissatisfaction with previous professional support (Hassan, 2022).

Wide-reaching staff training, a topic discussed in depth in Chapters 3 and 4 of this thesis, is one way of ensuring that every CYP can access mental health advice and support from any adult professional that they encounter. The ability to direct CYP to alternative sources would not only mean that more appropriate support is accessed quicker, but the strain on CAMHS could also be reduced. This in turn would shorten the waiting times that have, historically, been notoriously long (J. Smith et al., 2018). Waits for support are especially long for those deemed to have less severe difficulties (Edbrooke-Childs & Deighton, 2020). Being placed on a waiting list, even once a referral has been accepted, presents a host of issues, namely that little interim support is offered whilst the lengthy wait is in progress. Young people report feeling "lost", and unsure of where to turn in the meantime (Punton et al., 2022). A similar picture is evident following a rejection from CAMHS. Many CYP and their families reported that post-rejection, they were offered no, or unhelpful, signposting to other sources of support outside of CAMHS. Where signposting did occur, few reported being directly referred to alternative provision

– instead, they were often left responsible for seeking and accessing this (Scottish Government, 2018).

What types of issues do those who cannot access CAMHS services commonly present with? As already discussed, those showing early or less severe signs of disorders are often turned away, however the most common difficulties reported for those with rejected referrals were emotional and behavioural difficulties (J. Smith et al., 2018). Such issues are often considered normal, healthy responses to distressing experiences, such as physical illness, bereavement, or parental separation, or perhaps a one-off traumatic occurrence, such as assault or witnessing a crime. Although it is clear that these CYP should not be immediately considered "ill", this does not mean that they would not benefit from specialist care to deal with their circumstances, some of which might fall under tiers 3 or 4. Despite this, some CAMHS referral guidelines regard a referral as inappropriate if a) difficulties relate to "normal adjustment reactions", or b) there is no indication of a disorder being present (NHS Lothian, 2022). Treating such CYP, even those with more severe and immediate mental health needs, need not involve care within a medical treatment facility. However, a paper by McDougall et al. (2008) reported that whilst there are several viable alternatives to inpatient ward care, such as home treatment and 24-hour rapid response systems, these were not implemented in many parts of the UK at the time of their paper. Although many alternative options have been developed since this 2008 work, they have failed to reduce the number of admissions in the UK (Ougrin et al., 2021). Review evidence suggests that in-home interventions, as part of multi-model treatment packages, successfully improved psychological outcomes, even when combined with in-patient care (Clisu et al., 2022). The idea that a distressed young person would not qualify for help like this, solely because they have no previous mental health history or diagnosis, is difficult to comprehend, and Clisu's (2022) review demonstrates examples of how intensive support could be implemented for a range of needs. An example of an isolated incident that has led to widespread trauma in both adults and CYP was the terrorist attack that took place at Manchester Arena in 2017. As a response, a "Resilience Hub" was established by local NHS trusts, to screen and treat those impacted by the event. Although 877 children and 2,375 adults were screened in

the hub, it received criticism for strict adherence to clinical thresholds – ones that are inappropriate and irrelevant in such a scenario. Unfortunately, little provision was made for those who did not pass this screening (Hind et al., 2021).

1.2.5: Section summary

This section focussed on the CAMHS tiered model, and the issues associated with how it is used to allocate mental health support to CYP. Although the model was ground-breaking at inception, several problems have since emerged, rendering it less than ideal in present times. I explored how the model lends itself to biological reductionism, and a subsequent overmedicalized view of mental health. I then considered the extent to which mental health issues can and should be considered akin to physical illnesses, and how there is demand for a wider range of mental healthcare options.

One way that this can be facilitated through mental health promotion through schools and colleges. Such a wide-reaching and inclusive implementation of promotion and very early prevention is evidently necessary. However, it remains abundantly clear that even those who have already demonstrated a definite need for support are still missing out. Thus, in the penultimate sub-section, 1.2.4, I examined the barriers that CYP must overcome in their efforts to receive appropriate help. To provide a concluding statement, the focus of the tiered model, as evidenced across this chapter section, appears to be on diagnoses and thresholds. Exactly what an individual requires, at any given time, is not fully regarded. CYP who do not present as a "textbook case", and therefore do not easily fit into a tier for a plethora of reasons, are faced with a range of challenges. Following on from this, the final section of this chapter will discuss a national CYP mental health initiative that has been implemented across England in hopes of remedying these identified shortcomings.

1.2.6: How does this section contribute to the overall thesis?

- The problems associated with the tiered model of service provision are numerous, and the impact of these problems form the rationale for the evaluative work carried out within this thesis.

- As we move into the next section of this chapter, the urgent need for reforming the system of service provision, and for a reconceptualisation of CYP mental health, will become abundantly clear.

1.3: Towards more comprehensive and inclusive mental health provision for children and young people

1.3.1: Introducing the THRIVE framework for system change

In the previous section, a multitude of issues associated with the dominant model of mental health service provision were explored. The THRIVE model, which hopes to act as an ameliorative intervention, will be introduced in the current section, alongside the areas that it hopes to improve. The THRIVE Framework for System Change was born from the idea that most previous efforts to remedy the range of mental health provision issued in the UK resulted in the designing of multiple specific health or medical interventions (Wolpert et al., 2016). This meant that each issue was dealt with separately. Whilst this approach did lead to pockets of change, the worsening economic climate meant that this strategy became less and less sustainable. Consequently, reform needed to become all-encapsulating and unified. The focus needed to move away from the medical model, towards emphasising the social correlates of mental health and the vital role of an inclusive approach from which all can benefit. Owing to this, although THRIVE is commonly referred to as an "intervention", an "implementation", or in the case of local applications, a "programme", it is more accurately described as a "framework", a "model", or a "mind-set change". These latter three terms will be used interchangeably within this sub-section.

THRIVE can be viewed as a direct replacement of the CAMHS tiered model (Wolpert et al., 2016). At its core is the idea that any CYP, regardless of diagnosis, severity, or history of mental health, should have a wide range of support options available whenever they require them. THRIVE call this ethos a needs-based approach: one that recognises mental health needs as dynamic, and that CYP should not be placed in categories where support allocation is based solely upon meeting a threshold. Rather, this provision should be based upon what resources

they require, at that moment in time. Accordingly, five needs-based groupings were conceptualised based upon the types and levels of support that are sought, and what the characteristics of a young person might be at the time that they are seeking this support. THRIVE are keen to emphasise that although certain issues might be seen more frequently under some groupings than others, the groupings are not based upon severity or symptomatic presentation. The model accepts that CYP will move fluidly between the different groupings as per the predictable ups and downs of their personal mental health journeys.

Figure 1.2 below shows the five needs-based groupings of the THRIVE framework. In the very centre of the visualisation is the concept of **thriving.** This category refers to the 80% of CYP who do not require specialist advice or support (Wolpert et al., 2019). Despite this absence of tangible mental health need, they are still experiencing the inevitable environmental, family, and school stressors that can lead to periods of stress and upset. Accordingly, they will still benefit from community-level mental health promotion, and early preventative interventions.

Figure 1.2*: A visualisation of the five needs-based groupings of the THRIVE Framework for System Change (Wolpert et al., 2016)*

To the top left of the figure is **getting advice.** Support given under this category may be given to CYP with mild and/or temporary difficulties, for which signposting to appropriate services or self-support strategies is needed. Guidance for self-support should also be provided to those who have severe or fluctuating

ongoing difficulties, but who have expressed a wish to self-manage their own mental health and recovery process.

Getting help features at the top right of the figure. CYP seeking support here are likely to benefit the most from an evidence-based outcome-focussed intervention that addresses a specific mental health issue. Outcomes and progress towards meeting mental health aims should be regularly monitored, with transparent expectations of the limitations associated with support provided at the outset. This includes co-formulating a clear plan for what will happen if the treatment does not go as expected.

On the bottom right is **getting more help.** Although conceptually similar to "getting help", support given here will require greater resource allocation, dedicated to a smaller number of CYP. These CYP may have multiple overlapping difficulties and needs that greatly interfere with their daily functioning and life participation. They may be unable to attend school, or to fully participate in family life or social activities. For these comprehensive needs, extensive and focussed interventions should be offered by a mental health professional.

The final category is **getting risk support**. Whilst an inevitable element of risk management is involved in providing support under all groupings, this grouping refers to CYP who cannot, for a plethora of possible reasons, make use of any available support. Some CYP and their families that receive help under this grouping will have been in contact with social services or the criminal justice system (Wolpert et al., 2019), and they may also frequently experience mental health crises. Yet, whilst they may have tried many forms of support in the past, the sporadic nature of their difficulties has made consistent engagement difficult (Wolpert et al., 2016). As a result, very little improvement in their mental health has been made. Notwithstanding the complexity of their mental health presentations, it is paramount that these young people are not simply told "there is nothing more we can do to help you". Instead, managing the risk they present to themselves, or others, will become the key priority.

It is clear from these groupings that the design of THRIVE is intended to represent an inclusive mental health model, one that all CYP can benefit from. Even those who are deemed mentally healthy, i.e., "thriving", are taken into

consideration, owing to the value of mental health promotion. The same is true for those with clear issues, but who cannot access appropriate help. To bring the model to fruition, the THRIVE model suggests a common language conceptual framework for CYP mental health, meaning that terminologies used to describe where an individual is on their mental health journey are consistent, and understood by all involved professionals. In sub-section 1.2.1, the issue of fragmented care was raised, which leads to some CYP "falling between the gaps". THRIVE aims to eliminate the presence of the unnecessary barriers that exist between and within health, school, and community services (Department of Health, 2015), by making sure that the first professional a CYP encounters with their difficulty, be it a GP, teacher, or youth worker, knows how to signpost or assist appropriately. More effective cross-sector communication in this manner means that responsibility and accountability should become shared. Providers of different forms of support will be less inclined to "pass the buck" (Department of Health, 2015) to one another, and it is hoped that when CYP seek support from a professional, they will never feel that they have approached the "wrong" person.

This idea that every CYP-facing professional should be involved in mental health support follows on naturally from the fact that the THRIVE model aims to include all young people. The training provided to these professionals to help achieve this vision will be discussed in greater depth in Chapters 3 and 4 of this thesis. However, the key message that I wish to convey here is that if this is implemented successfully, a multi-agency model of shared responsibility, where every professional has core knowledge of how to assist with mental health needs, will be hugely beneficial to the provision of timely and accessible support. Waiting times and inappropriate referrals to CAMHS will hopefully be reduced, with the knock-on effect of relieving the strain on these services. More resources can then be dedicated to helping those in need of specialist services, rather than to the resource-intensive process of dealing with referrals for those who could have been helped more appropriately through community or voluntary sector mental health services. The final point that I wish to make in this sub-section is that the needs-based approach of THRIVE aims to provide a more individualised pattern of support. It is obvious that no two individuals have identical support needs. If this

vision is actualised, a new environment of personalisation, accompanying the idea that CYP and their families will be able to share the decision-making process alongside the professionals they meet, will make programmes of care more tailored and helpful.

1.3.2: Implementing THRIVE in Greater Manchester – GM i-THRIVE

After considering the introduction to the THRIVE framework above, the question "so, how is this actually being implemented?" is inevitably raised. Without considering the practicalities of implementing a significant mind-set change like THRIVE, the framework appears abstract: difficult to fully comprehend when we consider the ubiquity of the tiered model and the format of provision that it fosters. Whilst the term "THRIVE" denotes the evidence-based framework underpinning the model, the National i-THRIVE Programme represents the practical implementation strategy. This programme has, at time of writing, been rolled out in over 70 localities across England, and national teams are working with local NHS trusts, voluntary services, and schools, to align their ways of working with the framework.

The implementation of THRIVE across Greater Manchester's ten locality boroughs (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, and Wigan), known as GM i-THRIVE, forms the basis of this thesis. The introduction of the framework in the city-region, which began in 2018, followed a transformational devolution deal made between the Greater Manchester Health and Social Care Partnership (GMHSCP) and the UK government. This allowed resources to be allocated according to the needs of the 2.8 million residents of the Greater Manchester area (Greater Manchester Health and Social Care Partnership, 2021). This contrasted with having this allocation determined by a central point within the British government.

One area identified as falling short of meeting local need was CYP mental health provision. Since CAMHS had used the tiered model to guide resource distribution for many years, THRIVE was quickly identified as a suitable way of improving CYP mental health conceptualisation and support within the city-region. In Chapters 3 and 4, I will discuss a comprehensive training programme that was designed to embed the THRIVE framework thoroughly into the working practices of

CAMHS staff and the wider CYP workforce. Since training is one of the biggest drivers of change during any implementation process (Beidas & Kendall, 2014), it was paramount that this was put into operation as soon as possible, to reach as many CYP-facing staff members as possible within the area.

Three of the locality boroughs of Greater Manchester (Manchester, Salford, and Stockport) were assigned the status of "accelerator sites" by the national programme. This meant that they initially received a higher level of support and guidance than other localities, in the hope that they would quickly be able to share experiences and evidence with other areas. Across Greater Manchester, a dedicated team of expert professionals have been employed to the GM i-THRIVE programme, to steer the implementation process. This core team consists of a programme manager, a clinical lead, and an assistant psychologist, as well as project and data coordinators. This group of professionals, alongside a "THRIVE lead" working from each locality borough, are responsible for locally embedding the THRIVE message. Subject-matter experts were also recruited to shape and develop GM i-THRIVE in an informed and knowledgeable way. These experts were drawn from areas such as schools, youth offending teams, and local authority children's services. Provision for an initial implementation period of four years (2018-21) was given to embed GM i-THRIVE into the locality boroughs. An informal embedding phase began in 2021, whereby increased responsibility for implementation is gradually bestowed upon the staff working in the localities. The research within this thesis conveniently straddled both phases, providing a comprehensive evaluation of the implementation process as it progressed.

1.3.3: GM i-THRIVE in the context of the COVID-19 pandemic

The outbreak of COVID-19 has significantly impacted how CAMHS, and other providers of CYP mental health support, have delivered their services. In April 2020, shortly after the first round of nationwide lockdown measures in the UK were enforced, a 56.6% decrease in CYP psychiatric admissions to A&E was reported, compared with April 2019 (Ougrin, 2020). Similarly, CAMHS in Greater Manchester experienced a 50% reduction in referrals between March and May 2020 (Davis, 2020). Ougrin (2020) noted that this drop might represent a decrease in stressors

such as bullying, school pressure, and engagement in risky behaviour. But, on the other hand, quarantine measures may have led to fewer CYP seeking help with mental health, especially given that in-person schooling was more erratic and contact with other health professionals was less frequent (Ofsted, 2022). This initial drop was swiftly followed, as predicted, by a 134% increase in CYP mental health referrals in England between the early summer periods of 2020 and 2021. Compared to pre-pandemic levels, this represented a 96% increase (Royal College of Psychiatrists, 2021). Researchers in the Republic of Ireland also found a sharp increase in CAMHS referrals, beginning in September 2020, that similarly followed an initial decline (McNicholas et al., 2021). They provided a commentary to their findings that raises issues of relevance to UK CAMHS, such as an increased strain on already-underfunded services, and lengthier waiting lists owing to a post-pandemic surge. They also reported that a higher proportion of referrals were considered urgent, with more CYP presenting with complex issues that required specialist services (Huang & Ougrin, 2021; McNicholas et al., 2021). This growing case seriousness was reflected across the entire CYP health and social care sector (Baginsky & Manthorpe, 2020), suggesting that the vulnerability of CYP has risen during the pandemic in a multitude of aspects, including neglect and domestic violence.

Returning the focus to Greater Manchester, in response the forecasted increase in CAMHS, which equated to an extra 400 referrals per month in the region (Davis, 2020), a CAMHS COVID-19 Support Plan was devised by the Manchester University NHS Foundation Trust. This provided guidance and resources, enabling the wider CYP workforce to support the mental health needs of the CYP they worked with during the pandemic, according to the guidelines of the THRIVE model. This included providing support to those deemed “thriving” and offering a range of help and signposting for those requiring support under any of the other four needs-based groupings. This effort to encourage other professionals to increase their engagement with the mental health of CYP during this unprecedented crisis not only highlighted the core ethos of the THRIVE framework, but it also aimed to reduce strain on specialist services during this time. If support is provided

elsewhere, more resources and time can be dedicated to those requiring the most specialist CAMHS services for the most severe mental health issues.

The onset of the pandemic, and the resulting restrictions in face-to-face working practices, inevitably influenced the trajectory of the GM i-THRIVE timeline. The additional strain placed upon mental health staff, both within and outside of CAMHS, diverted attention away from the embedding of new practices. Heavy and urgent workloads led to a working culture of "firefighting", where multiple critical issues must be dealt with as they occur. These chaotic and unpredictable work environments meant that very few practical or mental resources could be devoted to considering the wider mental health context, especially to the extent required to embed GM i-THRIVE fully and reliably. The idiom "fiddling while Rome burns" may be considered relevant here, and its application to overworked NHS staff has already been explored in a study by Sheard & Peacock (2020). This study examined the role of healthcare research within the NHS, emphasising the difficulties that researchers and healthcare workers have when trying to undertake and prioritise this amid a staffing crisis. Chapters 4 and 6 of this thesis include accounts from staff working with GM i-THRIVE, and they similarly detail their experiences with juggling implementation alongside the day-to-day priorities of their roles and the incidents that they are required to attend to.

It is unsurprising, given the magnitude of pandemic-related burden, that six weeks into the introduction of lockdown measures in the UK, the mental wellbeing of CAMHS practitioners fell considerably (Bentham et al., 2021). The factors that led to this decline included a reduction in perceived personal capability, and a shift to remote working. A study on the experiences of mental health nurses found that the digital transition was difficult for many, especially when dealing with patients who lack competence with, or are suspicious of, technology (Foye et al., 2021). It is worth considering, however, that the latter study was not limited to CAMHS, as it interviewed nurses working in all-age mental health provision. However, notwithstanding the issues described above, the GM i-THRIVE team, from a strategic level, were also required to shift many of their implementation practices to an online format. As mentioned previously, training forms a key part of delivering the framework's aims, and sessions formerly held in-person were shifted

to a virtual format. The perceived positive and negative consequences of this change are reported in Chapter 4.

To summarise, the unique context of the COVID-19 pandemic is crucial for understanding the wider picture of mental health and support provision in the UK. More specifically, the pandemic affected the implementation of the THRIVE framework in Greater Manchester, the evaluation of which forms the basis of this thesis. GM i-THRIVE's initial implementation period commenced in 2018, and with the arrival of COVID-19 in 2020 falling less than halfway into this, under no circumstances could 2018-21 be considered a "normal" four years.

1.4: Chapter summary

This chapter began by setting the broad societal context of the thesis. The current mental health crisis in the UK was explored, and the influence of numerous detrimental factors such as a climate of austerity, the COVID-19 pandemic, and Brexit, was discussed. I then explained how CYP mental health is traditionally conceptualised in the UK, and how this system impacts service and support provision. How this has led to an overreliance on a medical narrative of mental health, and the consequences of this, was then considered.

The next part of the chapter focussed, in more depth, upon CYP who are unable to make use of mental health services. I explored how these challenges relate to issues surrounding the structure of the tiered system of service allocation. Finally, the THRIVE model was introduced. I provided a summary of how the framework hopes to ameliorate the shortcomings of previous mental health models, and I explored how this is currently being implemented within the city-region of Greater Manchester. Whilst Chapter 1 outlined the wider societal climate that this thesis was produced within, Chapter 2 will introduce the thesis itself. A thorough explanation of the rationale for the project, and the four resulting studies, will be provided.

1.5: References

Abi-Jaoude, E., Naylor, K. T., & Pignatiello, A. (2020). Smartphones, social media use and youth mental health. *Canadian Medical Association Journal*, *192*(6), E136–E141. https://doi.org/10.1503/cmaj.190434

Adegboye, D., Williams, F., Collishaw, S., Shelton, K., Langley, K., Hobson, C., Burley, D., & van Goozen, S. (2021). Understanding why the COVID-19 pandemic-related lockdown increases mental health difficulties in vulnerable young children. *JCPP Advances*, *1*(1), e12005. https://doi.org/10.1111/jcv2.12005

Aebi, M., Giger, J., Plattner, B., Metzke, C. W., & Steinhausen, H. C. (2014). Problem coping skills, psychosocial adversities and mental health problems in children and adolescents as predictors of criminal outcomes in young adulthood. *European Journal of Child & Adolescent Psychiatry*, *23*(5), 283–293. https://doi.org/10.1007/s00787-013-0458-y

Akhter, N., Bambra, C., Mattheys, K., Warren, J., & Kasim, A. (2018). Inequalities in mental health and well-being in a time of austerity: Follow-up findings from the Stockton-on-Tees cohort study. *SSM - Population Health*, *6*, 75–84. https://doi.org/10.1016/j.ssmph.2018.08.004

Appleton, R., Loew, J., & Mughal, F. (2022). Young people who have fallen through the mental health transition gap: A qualitative study on primary care support. *British Journal of General Practice*, *72*(719), e413–e420. https://doi.org/10.3399/BJGP.2021.0678

Appleton, R., Elahi, F., Tuomainen, H., Canaway, A., & Singh, S. P. (2021). "I'm just a long history of people rejecting referrals" experiences of young people who fell through the gap between child and adult mental health services. *European Child & Adolescent Psychiatry*, *30*(3), 401–413. https://doi.org/10.1007/s00787-020-01526-3

Baginsky, M., & Manthorpe, J. (2020). *Managing through COVID-19: The experiences of children's social care in 15 English local authorities*. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's

College London. https://kclpure.kcl.ac.uk/portal/en/publications/managing-through-covid19-the-experiences-of-childrens-social-care-in-15-english-local-authorities(93814072-18ea-4d76-af2d-ec124c6a8494).html

Bailey, S. (2021). NHS staffing: The longest wait of all. *BMJ*, n2723. https://doi.org/10.1136/bmj.n2723

Baker, C., & Gheera, M. (2020). *Mental health: Achieving 'parity of esteem'*. https://commonslibrary.parliament.uk/mental-health-achieving-parity-of-esteem/

Banwell, E., Humphrey, N., & Qualter, P. (2021). Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation. *BMC Medical Education*, *21*(1), 103. https://doi.org/10.1186/s12909-021-02530-0

Barnett, E. R., Trepman, A. Z., Fuson, H. A., Acquilano, S. C., McLaren, J. L., Woloshin, S., & Leyenaar, J. K. (2020). Deprescribing psychotropic medications in children: Results of a national qualitative study. *BMJ Quality & Safety*, *29*(8), 655–663. https://doi.org/10.1136/bmjqs-2019-010033

Barrett, S. (2019). From Adult Lunatic Asylums to CAMHS Community Care: The Evolution of Specialist Mental Health Care for Children and Adolescents 1948-2018. *Revue Française de Civilisation Britannique. French Journal of British Studies*, *XXIV*(3), Article 3. https://doi.org/10.4000/rfcb.4138

Basu, S., Yap, C., & Mason, S. (2016). Examining the sources of occupational stress in an emergency department. *Occupational Medicine*, *66*(9), 737–742. https://doi.org/10.1093/occmed/kqw155

Beidas, R. S., & Kendall, P. C. (Eds.). (2014). *Dissemination and implementation of evidence-based practices in child and adolescent mental health*. Oxford University Press.

Bentham, C., Driver, K., & Stark, D. (2021). Wellbeing of CAMHS staff and changes in working practices during the COVID-19 pandemic. *Journal of Child and*

Adolescent Psychiatric Nursing, *34*(3), 225–235. https://doi.org/10.1111/jcap.12311

Berman, I. S., McLaughlin, K. A., Tottenham, N., Godfrey, K., Seeman, T., Loucks, E., Suomi, S., Danese, A., & Sheridan, M. A. (2022). Measuring early life adversity: A dimensional approach. *Development and Psychopathology*, *34*(2), 499–511. https://doi.org/10.1017/S0954579421001826

Best, J. (2021). Undermined and undervalued: How the pandemic exacerbated moral injury and burnout in the NHS. *BMJ*, n1858. https://doi.org/10.1136/bmj.n1858

Biddle, L., Donovan, J. L., Gunnell, D., & Sharp, D. (2006). Young adults' perceptions of GPs as a help source for mental distress: A qualitative study. *The British Journal of General Practice*, *56*(533), 924–931.

Birchwood, M., Connor, C., Lester, H., Patterson, P., Freemantle, N., Marshall, M., Fowler, D., Lewis, S., Jones, P., Amos, T., Everard, L., & Singh, S. P. (2013). Reducing duration of untreated psychosis: Care pathways to early intervention in psychosis services. *British Journal of Psychiatry*, *203*(1), 58–64. https://doi.org/10.1192/bjp.bp.112.125500

Birnbaum, R., & Weinberger, D. R. (2020). Special Article: Translational Science Update. Pharmacological Implications of Emerging Schizophrenia Genetics: Can the Bridge From 'Genomics' to 'Therapeutics' be Defined and Traversed? *Journal of Clinical Psychopharmacology*, *40*(4), 323–329. https://doi.org/10.1097/JCP.0000000000001215

Bone, C., O'Reilly, M., Karim, K., & Vostanis, P. (2014). 'They're not witches. …' Young children and their parents' perceptions and experiences of Child and Adolescent Mental Health Services. *Child: Care, Health and Development*, *41*(3), 450–458. https://doi.org/10.1111/cch.12161

Bor, W., Dean, A. J., Najman, J., & Hayatbakhsh, R. (2014). Are child and adolescent mental health problems increasing in the 21st century? A systematic review.

Australian & New Zealand Journal of Psychiatry, *48*(7), 606–616. https://doi.org/10.1177/0004867414533834

Borsboom, D., Cramer, A. O. J., & Kalis, A. (2019). Brain disorders? Not really: Why network structures block reductionism in psychopathology research. *Behavioral and Brain Sciences*, *42*, e2. https://doi.org/10.1017/S0140525X17002266

Bradbury-Jones, C., & Isham, L. (2020). The pandemic paradox: The consequences of COVID-19 on domestic violence. *Journal of Clinical Nursing*, *29*(13–14), 2047–2049. https://doi.org/10.1111/jocn.15296

Bradley, P. (2021). MPs blame NHS stress on staff shortages. *British Journal of Healthcare Assistants*, *15*(6), 310–310. https://doi.org/10.12968/bjha.2021.15.6.310

Brisch, R., Saniotis, A., Wolf, R., Bielau, H., Bernstein, H.-G., Steiner, J., Bogerts, B., Braun, K., Jankowski, Z., Kumaratilake, J., Henneberg, M., & Gos, T. (2014). The Role of Dopamine in Schizophrenia from a Neurobiological and Evolutionary Perspective: Old Fashioned, but Still in Vogue. *Frontiers in Psychiatry*, *5*, 47. https://doi.org/10.3389/fpsyt.2014.00047

Buchan, I. E., Kontopantelis, E., Sperrin, M., Chandola, T., & Doran, T. (2017). North-South disparities in English mortality1965-2015: Longitudinal population study. *Journal of Epidemiology and Community Health*, *71*(9), 928–936. https://doi.org/10.1136/jech-2017-209195

Busija, L., Tan, J., & Sanders, K. M. (2017). Associations between illness duration and health-related quality of life in specified mental and physical chronic health conditions: Results from a population-based survey. *Quality of Life Research*, *26*(10), 2671–2681. https://doi.org/10.1007/s11136-017-1592-7

Callaghan, J. E., Fellin, L. C., & Warner-Gale, F. (2017). A critical analysis of Child and Adolescent Mental Health Services policy in England. *Clinical Child Psychology and Psychiatry*, *22*(1), 109–127. https://doi.org/10.1177/1359104516640318

Campbell, D. (2022a, February 23). Health unions criticise 'miserly' 3% NHS staff pay rise. *The Guardian*. https://www.theguardian.com/society/2022/feb/23/health-unions-criticise-nhs-staff-pay-rise

Campbell, D. (2022b, April 3). Swamped NHS mental health services turning away children, say GPs. *The Guardian*. https://www.theguardian.com/society/2022/apr/03/swamped-nhs-mental-health-services-turning-away-children-say-doctors

Care Quality Commission. (2018). *Are we listening? Review of children and young people's mental health services*. https://www.cqc.org.uk/sites/default/files/20180308_arewelistening_qualitative.pdf

Carey, E., Gillan, D., Healy, C., Dooley, N., Campbell, D., McGrane, J., O'Neill, A., Coughlan, H., Clarke, M., Kelleher, I., & Cannon, M. (2021). Early adult mental health, functional and neuropsychological outcomes of young people who have reported psychotic experiences: A 10-year longitudinal study. *Psychological Medicine*, *51*(11), 1861–1869. https://doi.org/10.1017/S0033291720000616

Casey, A., Banks, A., & King, A. (2022). *Tracking the price of the lowest-cost grocery items, UK, experimental analysis—Office for National Statistics*. Office of National Statistics. https://www.ons.gov.uk/economy/inflationandpriceindices/articles/trackingthelowestcostgroceryitemsukexperimentalanalysis/april2021toapril2022

Cheng, Z., Mendolia, S., Paloyo, A. R., Savage, D. A., & Tani, M. (2021). Working parents, financial insecurity, and childcare: Mental health in the time of COVID-19 in the UK. *Review of Economics of the Household*, *19*(1), 123–144. https://doi.org/10.1007/s11150-020-09538-3

Child Poverty Action Group. (2018). *The austerity generation: The impact of cuts to universal credit on family incomes and child poverty*.

https://cpag.org.uk/sites/default/files/files/CPAG-the-austerity-generation-Poverty-159-Winter-2018.pdf

Children's Commissioner. (2022). *A Head Start: Early support for children's mental health*. Children's Commissioner for England. https://www.childrenscommissioner.gov.uk/report/a-head-start-early-support-for-childrens-mental-health/

Children's Commissioner. (2017). *Briefing: Children's Mental Healthcare in England*. Www.Basw.Co.Uk. https://www.basw.co.uk/resources/briefing-children%E2%80%99s-mental-healthcare-england

Clisu, D. A., Layther, I., Dover, D., Viner, R. M., Read, T., Cheesman, D., Hodges, S., & Hudson, L. D. (2022). Alternatives to mental health admissions for children and adolescents experiencing mental health crises: A systematic review of the literature. *Clinical Child Psychology and Psychiatry*, *27*(1), 35–60. https://doi.org/10.1177/13591045211044743

Collishaw, S. (2015). Annual Research Review: Secular trends in child and adolescent mental health. *Journal of Child Psychology and Psychiatry*, *56*(3), 370–393. https://doi.org/10.1111/jcpp.12372

Collishaw, S., Furzer, E., Thapar, A. K., & Sellers, R. (2019). Brief report: A comparison of child mental health inequalities in three UK population cohorts. *European Child & Adolescent Psychiatry*, *28*(11), 1547–1549. https://doi.org/10.1007/s00787-019-01305-9

Coulter, A., Ellins, J., Health Foundation (Great Britain), Quest for Quality and Improved Performance, & Picker Institute. (2006). *Patient-focused interventions: A review of the evidence*. Health Foundation.

Cratsley, K., Regan, J., McAllister, V., Simic, M., & Aitchison, K. J. (2008). Duration of Untreated Psychosis, Referral Route, and Age of Onset in an Early Intervention in Psychosis Service and a Local CAMHS. *Child and Adolescent Mental Health*, *13*(3), 130–133. https://doi.org/10.1111/j.1475-3588.2007.00467.x

Davis, M. (2020). *GMCHWB Forum Health and Education—Navigating through COVID recovery.* https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2020/08/GMCHWB-Forum-10.07.2020-slides.pdf

Dayan, M. (2018). How much has the NHS saved by holding down pay? *British Journal of Healthcare Assistants*, *12*(2), 91–91. https://doi.org/10.12968/bjha.2018.12.2.91

de Girolamo, G., Dagani, J., Purcell, R., Cocchi, A., & McGorry, P. D. (2012). Age of onset of mental disorders and use of mental health services: Needs, opportunities and obstacles. *Epidemiology and Psychiatric Sciences*, *21*(1), 47–57. https://doi.org/10.1017/S2045796011000746

Deighton, J., Lereya, S. T., Casey, P., Patalay, P., Humphrey, N., & Wolpert, M. (2019). Prevalence of mental health problems in schools: Poverty and other risk factors among 28 000 adolescents in England. *The British Journal of Psychiatry*, *215*(3), 565–567. https://doi.org/10.1192/bjp.2019.19

Demkowicz, O., Panayiotou, M., Parsons, S., Feltham, A., Arseneault, L., Ingram, B., Patalay, P., Edge, D., Pierce, M., Creswell, C., Victor, C., O'Connor, R. C., & Qualter, P. (2021). Looking Back to Move Forward: Reflections on the Strengths and Challenges of the COVID-19 UK Mental Health Research Response. *Frontiers in Psychiatry*, *12*. https://www.frontiersin.org/article/10.3389/fpsyt.2021.622562

Department for Education. (2021). *Schools and colleges to benefit from boost in expert mental health support*. GOV.UK. https://www.gov.uk/government/news/schools-and-colleges-to-benefit-from-boost-in-expert-mental-health-support

Department of Health. (2015). *Future in Mind: Promoting, protecting, and improving our children and young people's mental health and wellbeing*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Edbrooke-Childs, J., & Deighton, J. (2020). Problem severity and waiting times for young people accessing mental health services. *BJPsych Open*, *6*(6), e118. https://doi.org/10.1192/bjo.2020.103

Edbrooke-Childs, J., Jacob, J., Argent, R., Patalay, P., Deighton, J., & Wolpert, M. (2016). The relationship between child- and parent-reported shared decision making and child-, parent-, and clinician-reported treatment outcome in routinely collected child mental health services data. *Clinical Child Psychology and Psychiatry*, *21*(2), 324–338. https://doi.org/10.1177/1359104515591226

Endacott, R., Pearce, S., Rae, P., Richardson, A., Bench, S., Pattison, N., & Team, the S. S. (2021). How COVID-19 has affected staffing models in intensive care: A qualitative study examining alternative staffing models (SEISMIC). *Journal of Advanced Nursing*, *n/a*(n/a). https://doi.org/10.1111/jan.15081

England, E., & Mughal, F. (2019). Underprovision of mental health services for children and young people. *British Journal of General Practice*, *69*(680), 112–113. https://doi.org/10.3399/bjgp19X701381

Evans, G. W., & Kim, P. (2007). Childhood Poverty and Health: Cumulative Risk Exposure and Stress Dysregulation. *Psychological Science*, *18*(11), 953–957. https://doi.org/10.1111/j.1467-9280.2007.02008.x

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools in high-income countries. *The Lancet Psychiatry*, *1*(5), 377–387. https://doi.org/10.1016/S2215-0366(14)70312-8

Fitzsimons, E., Goodman, A., Kelly, E., & Smith, J. P. (2017). Poverty dynamics and parental mental health: Determinants of childhood mental health in the UK. *Social Science & Medicine*, *175*, 43–51. https://doi.org/10.1016/j.socscimed.2016.12.040

Ford, T., Hamilton, H., Meltzer, H., & Goodman, R. (2007). Child Mental Health is Everybody's Business: The Prevalence of Contact with Public Sector Services by Type of Disorder Among British School Children in a Three-Year Period.

Child and Adolescent Mental Health, *12*(1), 13–20. https://doi.org/10.1111/j.1475-3588.2006.00414.x

Foye, U., Dalton-Locke, C., Harju-Seppänen, J., Lane, R., Beames, L., Vera San Juan, N., Johnson, S., & Simpson, A. (2021). How has COVID-19 affected mental health nurses and the delivery of mental health nursing care in the UK? Results of a mixed-methods study. *Journal of Psychiatric and Mental Health Nursing*, *28*(2), 126–137. https://doi.org/10.1111/jpm.12745

Francis, A. (2022). *Cost of living: 'I work 60 hours a week for NHS but must buy food on credit cards, I'll never vote Tory again'*. https://inews.co.uk/news/cost-of-living-crisis-nhs-worker-60-hour-week-credit-card-food-shopping-inflation-1419013

Fusar-Poli, P. (2019). Integrated Mental Health Services for the Developmental Period (0 to 25 Years): A Critical Review of the Evidence. *Frontiers in Psychiatry*, *10*, 355. https://doi.org/10.3389/fpsyt.2019.00355

Gagné, T., Schoon, I., McMunn, A., & Sacker, A. (2021). Mental distress among young adults in Great Britain: Long-term trends and early changes during the COVID-19 pandemic. *Social Psychiatry and Psychiatric Epidemiology*, 1–12. https://doi.org/10.1007/s00127-021-02194-7

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry*, *14*(2), 231–233. https://doi.org/10.1002/wps.20231

Galobardes, B., Lynch, J. W., & Smith, G. D. (2008). Is the association between childhood socioeconomic circumstances and cause-specific mortality established? Update of a systematic review. *Journal of Epidemiology & Community Health*, *62*(5), 387–390. https://doi.org/10.1136/jech.2007.065508

Garon-Bissonnette, J., Bolduc, M.-È. G., Lemieux, R., & Berthelot, N. (2022). Cumulative childhood trauma and complex psychiatric symptoms in

pregnant women and expecting men. *BMC Pregnancy and Childbirth*, *22*(1), 10. https://doi.org/10.1186/s12884-021-04327-x

Goodman, R., Iervolino, A. C., Collishaw, S., Pickles, A., & Maughan, B. (2007). Seemingly minor changes to a questionnaire can make a big difference to mean scores: A cautionary tale. *Social Psychiatry and Psychiatric Epidemiology*, *42*(4), 322–327. https://doi.org/10.1007/s00127-007-0169-0

Gorwood, P., Duriez, P., Lengvenyte, A., Guillaume, S., & Criquillion, S. (2019). Clinical insight in anorexia nervosa: Associated and predictive factors. *Psychiatry Research*, *281*, 112561. https://doi.org/10.1016/j.psychres.2019.112561

Greater Manchester Combined Authority. (2019). *Children and Young People's Plan*. https://www.greatermanchester-ca.gov.uk/media/2115/gmca-children-young-peoples-plan-2019-2022.pdf

Greater Manchester Health and Social Care Partnership. (2021). *About Devolution*. https://www.gmhsc.org.uk/about-devolution/

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental Health of Children and Young People in Great Britain, 2004: (557702010-001)* [Data set]. American Psychological Association. https://doi.org/10.1037/e557702010-001

Greenberg, N., Weston, D., Hall, C., Caulfield, T., Williamson, V., & Fong, K. (2021). Mental health of staff working in intensive care during Covid-19. *Occupational Medicine*, *71*(2), 62–67. https://doi.org/10.1093/occmed/kqaa220

Gustafsson, B. M., Proczkowska-Björklund, M., & Gustafsson, P. A. (2017). Emotional and behavioural problems in Swedish preschool children rated by preschool teachers with the Strengths and Difficulties Questionnaire (SDQ). *BMC Pediatrics*, *17*(1), 110. https://doi.org/10.1186/s12887-017-0864-2

Hacker, J. (2021, November 18). *GPs' support for children's mental health limited by 'silo working', CQC suggests*. Healthcare Leader.

https://healthcareleadernews.com/news/gps-support-for-childrens-mental-health-limited-by-silo-working-cqc-suggests/

Haeffel, G. J. (2022). Psychology needs to get tired of winning. *Royal Society Open Science*, *9*(6), 220099. https://doi.org/10.1098/rsos.220099

Hanley, T., Sefi, A., Grauberg, J., Prescott, J., & Etchebarne, A. (2021). A Theory of Change for online therapy and support services for children and young people: A collaborative qualitative exploration. *JMIR Pediatrics and Parenting*, *4*(1), e23193. https://doi.org/10/gjg5hw

Hanley, T., Winter, L. A., & Burrell, K. (2020). Supporting emotional well-being in schools in the context of austerity: An ecologically informed humanistic perspective. *British Journal of Educational Psychology*, *90*(1), 1–18. https://doi.org/10.1111/bjep.12275

Hansen, A. S., Christoffersen, C. H., Telléus, G. K., & Lauritsen, M. B. (2021). Referral patterns to outpatient child and adolescent mental health services and factors associated with referrals being rejected. A cross-sectional observational study. *BMC Health Services Research*, *21*(1), 1063. https://doi.org/10.1186/s12913-021-07114-8

Harrison, J., Barrow, S., & Creed, F. (1998). Mental health in the North West Region of England: Associations with deprivation. *Social Psychiatry and Psychiatric Epidemiology*, *33*(3), 124–128. https://doi.org/10.1007/s001270050032

Hassan, S. M. (2022). An exploration of young people's, parent/carers', and professionals' experiences of a voluntary sector organisation operating a Youth Information, Advice, and Counselling (YIAC) model in a disadvantaged area. *BMC Health Services Research*, *22*(383), 1–10.

Hayes, D., Edbrooke-Childs, J., Town, R., Wolpert, M., & Midgley, N. (2020). Barriers and facilitators to shared decision-making in child and youth mental health: Exploring young person and parent perspectives using the Theoretical Domains Framework. *Counselling and Psychotherapy Research*, *20*(1), 57–67. https://doi.org/10.1002/capr.12257

Henderson, A., Kinnear, D., Fleming, M., Stanley, B., Greenlaw, N., Young-Southward, G., Pell, J. P., & Cooper, S.-A. (2021). Antipsychotic and antidepressant prescribing for 704 297 children and young people with and without intellectual disabilities: Record linkage study. *The British Journal of Psychiatry*, *218*(1), 58–62. https://doi.org/10.1192/bjp.2020.232

Hind, D., Allsopp, K., Chitsabesan, P., & French, P. (2021). The psychosocial response to a terrorist attack at Manchester Arena, 2017: A process evaluation. *BMC Psychology*, *9*(1), 22. https://doi.org/10.1186/s40359-021-00527-4

Hinrichs, S., Owens, M., Dunn, V., & Goodyer, I. (2012). General practitioner experience and perception of Child and Adolescent Mental Health Services (CAMHS) care pathways: A multimethod research study. *BMJ Open*, *2*(6). https://doi.org/10.1136/bmjopen-2012-001573

House of Commons Health and Social Care Committee. (2021). *Workforce burnout and resilience in the NHS and social care: Second report of session 2021-22*. https://committees.parliament.uk/work/494/workforce-burnout-and-resilience-in-the-nhs-and-social-care

Huang, H. C.-H., & Ougrin, D. (2021). Impact of the COVID-19 pandemic on child and adolescent mental health services. *BJPsych Open*, *7*(5), e145. https://doi.org/10.1192/bjo.2021.976

Humphrey, N., Lendrum, A., Wigelsworth, M., & Greenberg, M. T. (2020). *Social and Emotional Learning*. Routledge.

Iacobucci, G. (2021). Staff burnout: MPs demand "total overhaul" of NHS workforce planning. *BMJ*, n1461. https://doi.org/10.1136/bmj.n1461

Institute for Social and Economic Research. (2021). *New research on impact of Universal Credit cut shows significant increase in child poverty*. https://www.iser.essex.ac.uk/2021/09/27/new-research-on-impact-of-universal-credit-cut-shows-significant-increase-in-child-poverty

Johnson, S., Dalton-Locke, C., Vera San Juan, N., Foye, U., Oram, S., Papamichail, A., Landau, S., Rowan Olive, R., Jeynes, T., Shah, P., Sheridan Rains, L., Lloyd-

Evans, B., Carr, S., Killaspy, H., Gillard, S., & Simpson, A. (2021). Impact on mental health care and on mental health service users of the COVID-19 pandemic: A mixed methods survey of UK mental health care staff. *Social Psychiatry and Psychiatric Epidemiology*, *56*(1), 25–37. https://doi.org/10.1007/s00127-020-01927-4

Jones, A. (2013, April 19). How our cities changed during the Thatcher years. *Centre for Cities*. https://www.centreforcities.org/blog/how-our-cities-changed-during-the-thatcher-years/

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, *166*(4), 182–186. https://doi.org/10.5694/j.1326-5377.1997.tb140071.x

Joseph Rowntree Foundation. (2021). *UK heading for the biggest overnight cut to the basic rate of social security since World War II*. JRF. https://www.jrf.org.uk/press/uk-heading-biggest-overnight-cut-basic-rate-social-security-world-war-ii

Kerasidou, A., & Cribb, A. (2019). Austerity, Health and Ethics. *Health Care Analysis*, *27*(3), 153–156. https://doi.org/10.1007/s10728-019-00378-6

Kerasidou, A., & Kingori, P. (2019). Austerity measures and the transforming role of A&E professionals in a weakening welfare system. *PloS One*, *14*(2). https://doi.org/10.1371/journal.pone.0212314

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: A review of recent literature: *Current Opinion in Psychiatry*, *20*(4), 359–364. https://doi.org/10.1097/YCO.0b013e32816ebc8c

Kessler, R. C., Angermeyer, M., Anthony, J. C., De Graaf, R., Demyttenaere, K., Gasquet, I., De Girolamo, G., Gluzman, S., Gureje, O., Haro, J. M., Kawakami, N., Karam, A., Levinson, D., Medina Mora, M. E., Oakley Browne, M. A.,

Posada-Villa, J., Stein, D. J., Adley Tsang, C. H., Aguilar-Gaxiola, S., … Ustün, T. B. (2007). Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry*, *6*(3), 168–176.

Keyes, C. L. M. (2002). The Mental Health Continuum: From Languishing to Flourishing in Life. *Journal of Health and Social Behavior*, *43*(2), 207–222. https://doi.org/10.2307/3090197

Kickbusch, I., Pelikan, J. M., Apfel, F., Tsouros, A. D., & World Health Organization (Eds.). (2013). *Health literacy: The solid facts*. World Health Organization Regional Office for Europe.

Kontopantelis, E., Buchan, I., Webb, R. T., Ashcroft, D. M., Mamas, M. A., & Doran, T. (2018). Disparities in mortality among 25–44-year-olds in England: A longitudinal, population-based study. *The Lancet Public Health*, *3*(12), e567–e575. https://doi.org/10.1016/S2468-2667(18)30177-4

Kurtz, M. M. (2013). In individuals with schizophrenia, duration and severity of mental illness, health status, mutuality, employment and household income influence quality of life. *Evidence Based Nursing*, *16*(3), 79–80. https://doi.org/10.1136/eb-2012-101050

Kutcher, S., Wei, Y., & Coniglio, C. (2016). Mental health literacy: Past, present, and future. *Canadian Journal of Psychiatry*, *61*(3), 154–158. https://doi.org/10.1177/0706743715616609

Lai, E. T. C., Wickham, S., Law, C., Whitehead, M., Barr, B., & Taylor-Robinson, D. (2019). Poverty dynamics and health in late childhood in the UK: Evidence from the Millennium Cohort Study. *Archives of Disease in Childhood*, *104*(11), 1049–1055. https://doi.org/10.1136/archdischild-2018-316702

Lambert, A. K., Doherty, A. J., Wilson, N., Chauhan, U., & Mahadevan, D. (2020). GP perceptions of community-based children's mental health services in Pennine Lancashire: A qualitative study. *BJGP Open*, *4*(4), bjgpopen20X101075. https://doi.org/10.3399/bjgpopen20X101075

Lee, J. A., Meacock, R., Kontopantelis, E., Matheson, J., & Gittins, M. (2019). Deprivation and primary care funding in Greater Manchester after devolution: A cross-sectional analysis. *British Journal of General Practice*, *69*(688), e794–e800. https://doi.org/10.3399/bjgp19X705545

Leiss, J., & Kim, J.-H. (2022). Against sedentary school environment: Rethinking the aims of education through physical education. *The Journal of Educational Research, 115*(2), 111–121. https://doi.org/10.1080/00220671.2022.2064801

Lendrum, A., Humphrey, N., & Wigelsworth, M. (2013). Social and emotional aspects of learning (SEAL) for secondary schools: Implementation difficulties and their implications for school-based mental health promotion. *Child and Adolescent Mental Health*, *18*(3), 158–164. https://doi.org/10.1111/camh.12006

Lester, H., Marshall, M., Jones, P., Fowler, D., Amos, T., Khan, N., & Birchwood, M. (2011). Views of Young People in Early Intervention Services for First-Episode Psychosis in England. *Psychiatric Services*, *62*(8), 882–887. https://doi.org/10.1176/ps.62.8.pss6208_0882

Leung, C. Y., Leung, G. M., & Schooling, C. M. (2018). Behavioral problem trajectories and self-esteem changes in relation with adolescent depressive symptoms: A longitudinal study. *Social Psychiatry and Psychiatric Epidemiology*, *53*(7), 673–684. https://doi.org/10.1007/s00127-018-1508-z

Long, E., Zucca, C., & Sweeting, H. (2021). School Climate, Peer Relationships, and Adolescent Mental Health: A Social Ecological Perspective. *Youth & Society*, *53*(8), 1400–1415. https://doi.org/10.1177/0044118X20970232

Ma, K. K. Y., Anderson, J. K., & Burn, A.-M. (2022). Review: School-based interventions to improve mental health literacy and reduce mental health stigma – a systematic review. *Child and Adolescent Mental Health*, *n/a*(n/a). https://doi.org/10.1111/camh.12543

Mansfield, R., Patalay, P., & Humphrey, N. (2020). A systematic literature review of existing conceptualisation and measurement of mental health literacy in adolescent research: Current challenges and inconsistencies. *BMC Public Health*, *20*(1), 607. https://doi.org/10.1186/s12889-020-08734-1

Marchini, S., Zaurino, E., Bouziotis, J., Brondino, N., Delvenne, V., & Delhaye, M. (2021). Study of resilience and loneliness in youth (18–25 years old) during the COVID-19 pandemic lockdown measures. *Journal of Community Psychology*, *49*(2), 468–480. https://doi.org/10.1002/jcop.22473

Mari, G., & Keizer, R. (2020). Families of Austerity: Welfare Cuts and Family Stress in Britain. In *SocArXiv* (No. vdej8; SocArXiv). Center for Open Science. https://ideas.repec.org/p/osf/socarx/vdej8.html

Martin-Storey, A., Serbin, L. A., Stack, D. M., Ledingham, J. E., & Schwartzman, A. E. (2011). Self and peer perceptions of childhood aggression, social withdrawal and likeability predict adult substance abuse and dependence in men and women: A 30-year prospective longitudinal study. *Addictive Behaviors*, *36*(12), 1267–1274. https://doi.org/10.1016/j.addbeh.2011.07.043

McCartney, M. (2014). Overprescribing antidepressants: Where's the evidence? *BMJ*, *348*(jun30 1), g4218–g4218. https://doi.org/10.1136/bmj.g4218

McCartney, M. (2016). Margaret McCartney: Breaking down the silo walls. *BMJ*, *354*, i5199. https://doi.org/10.1136/bmj.i5199

McDougall, T., Worrall-Davies, A., Hewson, L., Richardson, G., & Cotgrove, A. (2008). Tier 4 Child and Adolescent Mental Health Services (CAMHS) - Inpatient Care, Day Services and Alternatives: An Overview of Tier 4 CAMHS Provision in the UK. *Child and Adolescent Mental Health*, *13*(4), 173–180. https://doi.org/10.1111/j.1475-3588.2007.00481.x

McEwen, B. S. (1998). Stress, Adaptation, and Disease: Allostasis and Allostatic Load. *Annals of the New York Academy of Sciences*, *840*(1), 33–44. https://doi.org/10.1111/j.1749-6632.1998.tb09546.x

McLaughlin, K. A., & Sheridan, M. A. (2016). Beyond Cumulative Risk: A Dimensional Approach to Childhood Adversity. *Current Directions in Psychological Science*, *25*(4), 239–245. https://doi.org/10.1177/0963721416655883

McNicholas, F., Kelleher, I., Hedderman, E., Lynch, F., Healy, E., Thornton, T., Barry, E., Kelly, L., McDonald, J., Holmes, K., Kavanagh, G., & Migone, M. (2021). Referral patterns for specialist child and adolescent mental health services in the Republic of Ireland during the COVID-19 pandemic compared with 2019 and 2018. *BJPsych Open*, *7*(3), e91. https://doi.org/10.1192/bjo.2021.48

McNicoll, A. (2015, March 20). Mental health trust funding down 8% from 2010 despite coalition's drive for parity of esteem. *Community Care*. https://www.communitycare.co.uk/2015/03/20/mental-health-trust-funding-8-since-2010-despite-coalitions-drive-parity-esteem/

Mendolia, S., Suziedelyte, A., & Zhu, A. (2022). Have girls been left behind during the COVID-19 pandemic? Gender differences in pandemic effects on children's mental wellbeing. *Economics Letters*, *214*, 110458. https://doi.org/10.1016/j.econlet.2022.110458

Milner, A., Nielsen, R., & Norris, E. (2021). Brexit and European doctors' decisions to leave the United Kingdom: A qualitative analysis of free-text questionnaire comments. *BMC Health Services Research*, *21*(1), 188. https://doi.org/10.1186/s12913-021-06201-0

Mitchell, A. J., Hardy, S., & Shiers, D. (2017). Parity of esteem: Addressing the inequalities between mental and physical healthcare. *BJPsych Advances*, *23*(3), 196–205. https://doi.org/10.1192/apt.bp.114.014266

Möller, H., Haigh, F., Harwood, C., Kinsella, T., & Pope, D. (2013). Rising unemployment and increasing spatial health inequalities in England: Further extension of the North–South divide. *Journal of Public Health*, *35*(2), 313–321. https://doi.org/10.1093/pubmed/fds085

Munford, L., Khavandi, S., Bambra, C., Barr, B., Davies, H., Doran, T., Kontopantelis, E., Norman, P., Pickett, K., Sutton, M., Taylor-Robinson, D., & Wickham, S. (2021). *A year of COVID-19 in the North: Regional inequalities in health and economic outcomes*. Northern Health Service Alliance. https://www.thenhsa.co.uk/2021/09/north-inequalities-cost-uk-economy-7-3bn-over-first-year-of-the-pandemic/

Naylor, P. B., Cowie, H. A., Walters, S. J., Talamelli, L., & Dawkins, J. (2009). Impact of a mental health teaching programme on adolescents. *British Journal of Psychiatry*, *194*(4), 365–370. https://doi.org/10.1192/bjp.bp.108.053058

Nedic Erjavec, G., Sagud, M., Nikolac Perkovic, M., Svob Strac, D., Konjevod, M., Tudor, L., Uzun, S., & Pivac, N. (2021). Depression: Biological markers and treatment. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, *105*, 110139. https://doi.org/10.1016/j.pnpbp.2020.110139

Newman, K. L., Jeve, Y., & Majumder, P. (2022). Experiences and emotional strain of NHS frontline workers during the peak of the COVID-19 pandemic. *International Journal of Social Psychiatry, 68*(4), 783-790. https://doi.org/10.1177/00207640211006153

NHS Digital. (2022). *Mental Health of Children and Young People in England 2022—Wave 3 follow up to the 2017 survey*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey

NHS England. (2021). *National results across the NHS in England—NHS Staff Survey*. NHS England. https://www.nhsstaffsurveys.com/results/national-results/

NHS Lothian. (2022). *Inappropriate Referrals to CAMHS*. https://apps.nhslothian.scot/refhelp/guidelines/FurtherInfo/Pages/InappropriateReferralstoCAMHS.aspx

O'Brien, D., Harvey, K., & Creswell, C. (2019). Barriers to and facilitators of the identification, management and referral of childhood anxiety disorders in

primary care: A survey of general practitioners in England. *BMJ Open*, *9*(4), e023876. https://doi.org/10.1136/bmjopen-2018-023876

O'Dowd, E. L., McKeever, T. M., Baldwin, D. R., Anwar, S., Powell, H. A., Gibson, J. E., Iyen-Omofoman, B., & Hubbard, R. B. (2015). What characteristics of primary care and patients are associated with early death in patients with lung cancer in the UK? *Thorax*, *70*(2), 161–168. https://doi.org/10.1136/thoraxjnl-2014-205692

Office for National Statistics. (2022). *Energy prices and their effect on households*. https://www.ons.gov.uk/economy/inflationandpriceindices/articles/energypricesandtheireffectonhouseholds/2022-02-01

Ofsted. (2022). *Children's social care 2022: Recovering from the COVID-19 pandemic.* https://www.gov.uk/government/publications/childrens-social-care-2022-recovering-from-the-covid-19-pandemic/childrens-social-care-2022-recovering-from-the-covid-19-pandemic

Oliver, D. (2022). David Oliver: Act on workforce gaps, or the NHS will never recover. *BMJ*, *376*, n3139. https://doi.org/10.1136/bmj.n3139

Oliver, M. I., Pearson, N., Coe, N., & Gunnell, D. (2005). Help-seeking behaviour in men and women with common mental health problems: Cross-sectional study. *British Journal of Psychiatry*, *186*(4), 297–301. https://doi.org/10.1192/bjp.186.4.297

Onnela, A., Hurtig, T., & Ebeling, H. (2021). A psychoeducational mental health promotion intervention in a comprehensive schools: Recognising problems and reducing stigma. *Health Education Journal*, *80*(5), 554–566. https://doi.org/10.1177/0017896921994134

O'Reilly, M., Adams, S., Whiteman, N., Hughes, J., Reilly, P., & Dogra, N. (2018). Whose responsibility is adolescent's mental health in the UK? Perspectives of key stakeholders. *School Mental Health*, *10*(4), 450–461. https://doi.org/10.1007/s12310-018-9263-6

O'Reilly, M., Svirydzenka, N., Adams, S., & Dogra, N. (2018). Review of mental health promotion interventions in schools. *Social Psychiatry and Psychiatric Epidemiology*, *53*(7), 647–662. https://doi.org/10.1007/s00127-018-1530-1

Ougrin, D., Corrigall, R., Stahl, D., Poole, J., Zundel, T., Wait, M., Slater, V., Reavey, P., Byford, S., Ivens, J., Crommelin, M., Hayes, D., Middleton, K., Young, P., & Taylor, E. (2021). Supported discharge service versus inpatient care evaluation (SITE): A randomised controlled trial comparing effectiveness of an intensive community care service versus inpatient treatment as usual for adolescents with severe psychiatric disorders: self-harm, functional impairment, and educational and clinical outcomes. *European Child & Adolescent Psychiatry*, *30*(9), 1427–1436. https://doi.org/10.1007/s00787-020-01617-1

Ougrin, D. (2020). Debate: Emergency mental health presentations of young people during the COVID-19 lockdown. *Child and Adolescent Mental Health*, *25*(3), 171–172. https://doi.org/10.1111/camh.12411

Pandit, J. J. (2020). Demand–capacity modelling and COVID-19 disease: Identifying themes for future NHS planning. *Anaesthesia*, *75*(10), 1278–1283. https://doi.org/10.1111/anae.15144

Patalay, P., & Fitzsimons, E. (2018). Development and predictors of mental ill-health and wellbeing from childhood to adolescence. *Social Psychiatry and Psychiatric Epidemiology*, *53*(12), 1311–1323. https://doi.org/10.1007/s00127-018-1604-0

Patrick, R., & Pybus, K. (2022). Cost of living crisis: We cannot ignore the human cost of living in poverty. *BMJ*, o925. https://doi.org/10.1136/bmj.o925

Pembroke, L., Shaw, C., & Thomas, P. (2007). Biological reductionism of self-harm. *Mental Health Practice (through 2013)*, *10*(8), 16–17.

Pereira, A. I., Muris, P., Roberto, M. S., Stallard, P., Garcia-Lopez, L.-J., Tulbure, B. T., Podina, I., Simon, E., Sousa, M., & Barros, L. (2021). Cumulative Risk Exposure and Social Isolation as Correlates of Carer and Child Mental Health During the COVID-19 Pandemic: An Online Study with Families from Various

Europeans Countries. *Child Psychiatry & Human Development*. https://doi.org/10.1007/s10578-021-01233-3

Perez, S. M., Aguilar, D. D., Neary, J. L., Carless, M. A., Giuffrida, A., & Lodge, D. J. (2016). Schizophrenia-Like Phenotype Inherited by the F2 Generation of a Gestational Disruption Model of Schizophrenia. *Neuropsychopharmacology*, *41*(2), 477–486. https://doi.org/10.1038/npp.2015.169

Pescosolido, B. A., Jensen, P. S., Martin, J. K., Perry, B. L., Olafsdottir, S., & Fettes, D. (2008). Public Knowledge and Assessment of Child Mental Health Problems: Findings From the National Stigma Study-Children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(3), 339–349. https://doi.org/10.1097/CHI.0b013e318160e3a0

Pickett, K., Taylor-Robinson, D., & Erlam, J. (2021, December 7). *Child of the North: Building a fairer future after COVID-19* [Monograph]. Northern Health Science Alliance. https://www.thenhsa.co.uk/app/uploads/2022/01/Child-of-the-North-Report-FINAL-1.pdf

Pierce, M., McManus, S., Hope, H., Hotopf, M., Ford, T., Hatch, S. L., John, A., Kontopantelis, E., Webb, R. T., Wessely, S., & Abel, K. M. (2021). Mental health responses to the COVID-19 pandemic: A latent class trajectory analysis using longitudinal UK data. *The Lancet Psychiatry*, *8*(7), 610–619. https://doi.org/10.1016/S2215-0366(21)00151-6

Plaistow, J., Masson, K., Koch, D., Wilson, J., Stark, R. M., Jones, P. B., & Lennox, B. R. (2014). Young people's views of UK mental health services. *Early Intervention in Psychiatry*, *8*(1), 12–23. https://doi.org/10.1111/eip.12060

Pruessner, M., Cullen, A. E., Aas, M., & Walker, E. F. (2017). The neural diathesis-stress model of schizophrenia revisited: An update on recent findings considering illness stage and neurobiological and methodological complexities. *Neuroscience & Biobehavioral Reviews*, *73*, 191–218. https://doi.org/10.1016/j.neubiorev.2016.12.013

Punton, G., Dodd, A. L., & McNeill, A. (2022). 'You're on the waiting list': An interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. *PLoS ONE*, *17*(3), e0265542. https://doi.org/10.1371/journal.pone.0265542

Raballo, A., Poletti, M., Valmaggia, L., & McGorry, P. D. (2021). Editorial Perspective: Rethinking child and adolescent mental health care after COVID-19. *Journal of Child Psychology and Psychiatry*, *62*(9), 1067–1069. https://doi.org/10.1111/jcpp.13371

Ravalier, J. M., McVicar, A., & Boichat, C. (2020). Work Stress in NHS Employees: A Mixed-Methods Study. *International Journal of Environmental Research and Public Health*, *17*(18), 6464. https://doi.org/10.3390/ijerph17186464

Ridout, K. K., Khan, M., & Ridout, S. J. (2018). Adverse Childhood Experiences Run Deep: Toxic Early Life Stress, Telomeres, and Mitochondrial DNA Copy Number, the Biological Markers of Cumulative Stress. *BioEssays*, *40*(9), 1800077. https://doi.org/10.1002/bies.201800077

Rimmer, A. (2021). Leaders call for NHS funding boost as data show 5.5 million patients are waiting for routine care. *BMJ*, n2014. https://doi.org/10.1136/bmj.n2014

Robinson, J. (2021). *Peaks in number of young people prescribed antidepressants coincide with lockdowns*. The Pharmaceutical Journal. https://pharmaceutical-journal.com/article/news/peaks-in-number-of-young-people-prescribed-antidepressants-coincide-with-lockdowns

Rocks, S., Boccarini, G., Charlesworth, A., Idriss, O., McConkey, R., & Rachet-Jacquet, L. (2021). *Health and social care funding projections 2021—The Health Foundation*. https://www.health.org.uk/publications/health-and-social-care-funding-projections-2021

Rocks, S., Fazel, M., & Tsiachristas, A. (2020). Impact of transforming mental health services for young people in England on patient access, resource use and

health: A quasi-experimental study. *BMJ Open*, *10*(1), e034067. https://doi.org/10.1136/bmjopen-2019-034067

Rocks, S., Glogowska, M., Stepney, M., Tsiachristas, A., & Fazel, M. (2020). Introducing a single point of access (SPA) to child and adolescent mental health services in England: A mixed-methods observational study. *BMC Health Services Research*, *20*(1), 623. https://doi.org/10.1186/s12913-020-05463-4

Rogosch, F. A., Dackis, M. N., & Cicchetti, D. (2011). Child maltreatment and allostatic load: Consequences for physical and mental health in children from low-income families. *Development and Psychopathology*, *23*(4), 1107–1124. https://doi.org/10.1017/S0954579411000587

Ronzoni, P., & Dogra, N. (2011). Children, adolescents and their carers' expectations of child and adolescent mental health services (CAMHS). *International Journal of Social Psychiatry*, *58*(3), 328–336. https://doi.org/10.1177/0020764010397093

Rose, W., & McAuley, C. (2019). Poverty and its impact on parenting in the UK: Re-defining the critical nature of the relationship through examining lived experiences in times of austerity. *Children and Youth Services Review*, *97*, 134–141. https://doi.org/10.1016/j.childyouth.2017.10.021

Roughan, L. A., Parker, J. R., & Mercer, L. (2019). Improving interventions for parents of children and young people with autism spectrum disorder (ASD) in CAMHS. *BMJ Open Quality*, *8*(2), e000261. https://doi.org/10.1136/bmjoq-2017-000261

Royal College of Psychiatrists. (2021). *Record number of children and young people referred to mental health services as pandemic takes its toll*. https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2021/09/23/record-number-of-children-and-young-people-referred-to-mental-health-services-as-pandemic-takes-its-toll

Royal College of Psychiatrists. (2012). *Whole-person care: From rhetoric to reality (achieving parity between mental and physical health)* (Occasional paper 88). Royal College of Psychiatrists.

Rutter, M. (1994). *Fifteen thousand hours: Secondary schools and their effects on children* (New ed.). Paul Chapman.

Salaheddin, K., & Mason, B. (2016). Identifying barriers to mental health help-seeking among young adults in the UK: A cross-sectional survey. *British Journal of General Practice*, *66*(651), e686–e692. https://doi.org/10.3399/bjgp16X687313

Salisbury, M. R., Stienwandt, S., Giuliano, R., Penner-Goeke, L., Fisher, P. A., & Roos, L. E. (2020). Stress system reactivity moderates the association between cumulative risk and children's externalizing symptoms. *International Journal of Psychophysiology*, *158*, 248–258. https://doi.org/10.1016/j.ijpsycho.2020.09.016

Savage, M. (2019, November 24). NHS winter crisis fears grow after thousands of EU staff quit. *The Observer*. https://www.theguardian.com/society/2019/nov/24/nhs-winter-crisis-thousands-eu-staff-quit

Schulz, A. J., Mentz, G., Lachance, L., Johnson, J., Gaines, C., & Israel, B. A. (2012). Associations Between Socioeconomic Status and Allostatic Load: Effects of Neighborhood Poverty and Tests of Mediating Pathways. *American Journal of Public Health*, *102*(9), 1706–1714.

Scott, S., McGowan, V. J., & Visram, S. (2021). 'I'm Gonna Tell You about How Mrs Rona Has Affected Me'. Exploring Young People's Experiences of the COVID-19 Pandemic in North East England: A Qualitative Diary-Based Study. *International Journal of Environmental Research and Public Health*, *18*(7), 3837. https://doi.org/10.3390/ijerph18073837

Scottish Government. (2018). *Rejected Referrals Child and Adolescent Mental Health Services (CAMHS): A qualitative and quantitative audit*.

Scull, A. (2015). Melancholie and Madnesse. In *Madness in Civilization* (pp. 86–121). Princeton University Press. https://doi.org/10.2307/j.ctvc77hvc.7

Sheard, L., & Peacock, R. (2020). Fiddling while Rome burns? Conducting research with healthcare staff when the NHS is in crisis. *Journal of Health Organization and Management*, *34*(1), 77–84. https://doi.org/10.1108/JHOM-04-2019-0105

Signorini, G., Singh, S. P., Boricevic-Marsanic, V., Dieleman, G., Dodig-Ćurković, K., Franic, T., Gerritsen, S. E., Griffin, J., Maras, A., McNicholas, F., O'Hara, L., Purper-Ouakil, D., Paul, M., Santosh, P., Schulze, U., Street, C., Tremmery, S., Tuomainen, H., Verhulst, F., … de Girolamo, G. (2017). Architecture and functioning of child and adolescent mental health services: A 28-country survey in Europe. *The Lancet Psychiatry*, *4*(9), 715–724. https://doi.org/10.1016/S2215-0366(17)30127-X

Smith, J., Kyle, R. G., Daniel, B., & Hubbard, G. (2018). Patterns of referral and waiting times for specialist Child and Adolescent Mental Health Services. *Child and Adolescent Mental Health*, *23*(1), 41–49. https://doi.org/10.1111/camh.12207

Smith, M. (2013). *Balancing Your Humors—A Short History of Mental Health*. Psychology Today. https://www.psychologytoday.com/gb/blog/short-history-mental-health/201311/balancing-your-humors

Solmi, M., Radua, J., Olivola, M., Croce, E., Soardo, L., Salazar de Pablo, G., Il Shin, J., Kirkbride, J. B., Jones, P., Kim, J. H., Kim, J. Y., Carvalho, A. F., Seeman, M. V., Correll, C. U., & Fusar-Poli, P. (2022). Age at onset of mental disorders worldwide: Large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry*, *27*(1), 281–295. https://doi.org/10.1038/s41380-021-01161-7

Storey, P., Hurry, J., Jowitt, S., Owens, D., & House, A. (2005). Supporting young people who repeatedly self-harm. *Journal of the Royal Society for the*

Promotion of Health, *125*(2), 71–75. https://doi.org/10.1177/146642400512500210

Stuckler, D., Reeves, A., Loopstra, R., Karanikolos, M., & McKee, M. (2017). Austerity and health: The impact in the UK and Europe. *European Journal of Public Health*, *27*(suppl_4), 18–21. https://doi.org/10.1093/eurpub/ckx167

Sweeting, H., West, P., Young, R., & Der, G. (2010). Can we explain increases in young people's psychological distress over time? *Social Science & Medicine*, *71*(10), 1819–1830. https://doi.org/10.1016/j.socscimed.2010.08.012

Tasca, C., Rapetti, M., Carta, M. G., & Fadda, B. (2012). Women And Hysteria In The History Of Mental Health. *Clinical Practice and Epidemiology in Mental Health : CP & EMH*, *8*, 110–119. https://doi.org/10.2174/1745017901208010110

The Association for Child and Adolescent Mental Health. (2022). CAMHS (Child and Adolescent Mental Health Services). *ACAMH*. https://www.acamh.org/topic/camhs/

The Trussell Trust. (2022). The Trussell Trust—End of Year Stats. *The Trussell Trust*. https://www.trusselltrust.org/news-and-blog/latest-stats/end-year-stats/

Timimi, S. (2014). Parity of esteem for mental and physical health is a red herring. *BMJ*, *349*(dec16 21), g7618–g7618. https://doi.org/10.1136/bmj.g7618

Trotta, A., Arseneault, L., Caspi, A., Moffitt, T. E., Danese, A., Pariante, C., & Fisher, H. L. (2020). Mental health and functional outcomes in young adulthood of children with psychotic symptoms: A longitudinal cohort study. *Schizophrenia Bulletin*, *46*(2), 261–271. https://doi.org/10.1093/schbul/sby015.239

Tsuang, M., & Faraone, S. V. (1995). The case for heterogeneity in the etiology of schizophrenia. *Schizophrenia Research*, *17*(2), 161–175. https://doi.org/10.1016/0920-9964(95)00057-S

Turner, H. A., Finkelhor, D., & Ormrod, R. (2006). The effect of lifetime victimization on the mental health of children and adolescents. *Social Science & Medicine*, *62*(1), 13–27. https://doi.org/10.1016/j.socscimed.2005.05.030

Usher, K., Bradbury Jones, C., Bhullar, N., Durkin, D. J., Gyamfi, N., Fatema, S. R., & Jackson, D. (2021). COVID-19 and family violence: Is this a perfect storm? *International Journal of Mental Health Nursing*, *30*(4), 1022–1032. https://doi.org/10.1111/inm.12876

van der Plaat, D. A., Madan, I., Coggon, D., van Tongeren, M., Edge, R., Muiry, R., Parsons, V., & Cullinan, P. (2022). Risks of COVID-19 by occupation in NHS workers in England. *Occupational and Environmental Medicine*, *79*(3), 176–183. https://doi.org/10.1136/oemed-2021-107628

Waite, P., Pearcey, S., Shum, A., Raw, J. A. L., Patalay, P., & Creswell, C. (2021). How did the mental health symptoms of children and adolescents change over early lockdown during the COVID-19 pandemic in the UK? *JCPP Advances*, *1*(1), e12009. https://doi.org/10.1111/jcv2.12009

Wales, J., Brewin, N., Williamson, I., Štický, J., Lawrence, R., & Eivors, A. (2022). Transitioning services for eating disorder treatment, the relative importance of factors from patient, carer and clinician perspectives: A Q-methodology study. *Mental Health Review Journal*, *27*(2), 226–237. https://doi.org/10.1108/MHRJ-10-2021-0074

Walker, E. E., & Diforio, D. (1997). Schizophrenia: A Neural Diathesis-Stress Model. *Psychological Review*, *104*(4), 667–685.

Watkins, J., Wulaningsih, W., Zhou, C. D., Marshall, D. C., Sylianteng, G. D. C., Rosa, P. G. D., Miguel, V. A., Raine, R., King, L. P., & Maruthappu, M. (2017). Effects of health and social care spending constraints on mortality in England: A time trend analysis. *BMJ Open*, *7*(11), e017722. https://doi.org/10.1136/bmjopen-2017-017722

Watt, T., Raymond, A., & Rachet-Jacquet, L. (2022). *Quantifying health inequalities in England*. https://health.org.uk/news-and-comment/charts-and-infographics/quantifying-health-inequalities

Weissberg, R. P., Durlak, J. A., Domitrovich, C. E., & Gullotta, T. P. (Eds.). (2015). Social and emotional learning: Past, present, and future. In *Handbook of social and emotional learning: Research and practice* (pp. 3–19). The Guilford Press.

Weyman, A. K., Roy, D., & Nolan, P. (2019). One-way pendulum? Staff retention in the NHS: determining the relative salience of recognised drivers of early exit. *International Journal of Workplace Health Management*, *13*(1), 45–60. https://doi.org/10.1108/IJWHM-06-2019-0084

Wilkinson, E. (2015). UK NHS staff: Stressed, exhausted, burnt out. *The Lancet*, *385*(9971), 841–842. https://doi.org/10.1016/S0140-6736(15)60470-6

Wilson, A., Tuffrey, A., McKenzie, C., & Street, C. (2015). After the flood: Young people's perspectives on transition. *The Lancet Psychiatry*, *2*(5), 376–378. https://doi.org/10.1016/S2215-0366(15)00126-1

Wilson, J. M., Lee, J., Fitzgerald, H. N., Oosterhoff, B., Sevi, B., & Shook, N. J. (2020). Job Insecurity and Financial Concern During the COVID-19 Pandemic Are Associated With Worse Mental Health. *Journal of Occupational and Environmental Medicine*, *62*(9), 686–691. https://doi.org/10.1097/JOM.0000000000001962

Winters, N. C., & Pumariega, A. (2007). Practice Parameter on Child and Adolescent Mental Health Care in Community Systems of Care. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(2), 284–299. https://doi.org/10.1097/01.chi.0000246061.70330.b8

Wolf, S., & Suntheimer, N. M. (2019). A dimensional risk approach to assessing early adversity in a national sample. *Journal of Applied Developmental Psychology*, *62*, 270–281. https://doi.org/10.1016/j.appdev.2019.03.004

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2016). *THRIVE Elaborated* (Second). http://implementingthrive.org/wp-content/uploads/2016/09/THRIVE-elaborated-2nd-edition.pdf.

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2019). *THRIVE Framework for system change*. CAMHS Press. https://www.annafreud.org/media/9254/thrive-framework-for-system-change-2019.pdf.

World Health Organisation. (2022). *Mental health*. https://www.who.int/health-topics/mental-health

Chapter 2: Thesis overview

2.1: A general introduction to my PhD work

My PhD was commissioned by GMHSCP, to provide a thorough evaluation of GM i-THRIVE's implementation. In essence, the project assessed the extent to which the programme has successfully transformed CYP mental health services in Greater Manchester, and it aimed to provide evidence of its effectiveness when compared to previous ways of working. This evidence is vital if future investments, not only of money, but also of effort, are to be made to GM i-THRIVE in future. These are both factors that the longevity of the programme relies upon. In my thesis, given that Greater Manchester includes three of the eleven national accelerator sites that are being used to predict implementation likelihood in demographically similar sites, I also contribute to the wider national evaluation of i-THRIVE's implementation.

Owing to these aims, and the clear importance of generating a diverse array of findings to meet them, a "journal format" thesis was deemed the most suitable way to present my evaluative work. Four independent yet inter-related studies are presented: one systematic literature review (Chapter 3), plus one purely qualitative (Chapter 4) and two mixed-methods empirical studies (Chapters 5 and 6). *Figure 2.1* provides a visual summary of the four studies presented in this thesis, and the pragmatically identified areas of research inquiry that they encapsulate. The rationale underpinning each, as well as a deeper overview, are provided in section 2.3.

My key contact in the GM i-THRIVE team was Angela Daniel, who is the GM i-THRIVE Programme Manager. Angela manages a small project team, who support all Greater Manchester's localities in their implementation of the THRIVE Framework. Angela acted as gatekeeper during recruitment of participants for the three empirical studies within this thesis. My PhD supervisors, Professors Neil Humphrey and Pamela Qualter, from the Manchester Institute of Education, are co-authors on the four resulting journal articles, however all studies were designed, conducted, and submitted for journal publication by me.

2.2: Designing the research: Planning an evaluation using a pragmatic research paradigm

2.2.1: What do we want to know?

The concept of "evaluation", at first glance, appears to be very broad. It is a task that can be approached in a myriad of ways. When the evaluation of GM i-THRIVE was first commissioned to the University of Manchester by GMHSCP, four indicative research questions were provided by the implementing team - questions that they hoped to see answered within the work:

1. Has implementing GM i-THRIVE broadened the mental health offer to CYP?
2. Has implementing GM i-THRIVE improved access and accessibility to CYP's mental health service provision, including NHS CAMHS?
3. Do CYP feel like they have a choice in what, where, and how they access support for their mental health?
4. Are CYP and those who care for them reporting an improved experience in access and receiving care?

Although these questions provided direction to the evaluation's focus, I was given the freedom to answer them in any way I chose. Thus, I could allow my own epistemological views to guide my selection of evaluative methods. I felt that the most appropriate way to approach this evaluation was through the lens of pragmatism. I will now outline how this paradigm guided the overall research process, from inception to conclusion (Kelly & Cordeiro, 2020) before providing a deeper explanation of how pragmatic principles were woven through each stage of the four studies (see *Figure 2.1*) in the thesis.

When determining the areas of focus for the evaluation, the methodological freedom that I was afforded extended to investigating additional areas of GM i-THRIVE, that I personally identified as vital elements of a thorough evaluation. My PhD scholarship was preceded by three months of preparation work, running from July to September 2019. This period allowed me to prepare for the project, immerse myself in the culture of GM i-THRIVE, and narrow the focus of my

evaluation. During this time, and throughout the duration of my PhD, I regularly attended meetings and discussions with GM i-THRIVE's implementing teams and stakeholders, where I was able to listen to accounts of progress made, and the concerns that were raised as time progressed. This meant that, as well as using the four indicative questions as foci for my work, I identified three additional key areas as pertinent topics for exploration:

1. Staff training, with a particular focus on the barriers and facilitators underpinning effective and sustainable implementation of this training.

2. Implementation plans and evaluation tools, and the importance of considering CYP voice when using these to infer implementation success

3. The overall sustainability and potential longevity of GM i-THRIVE. With a time-restricted implementation period, it is paramount that new practices are introduced in a sustainable way, with a view to long-term viability.

It should be noted, at this juncture, that the identification of these three areas is the reason why only two of my thesis studies (3 and 4) directly answer the initial indicative research questions (see *Figure 2.1*). This process of recognising additional areas for research attention aligns well with the philosophy of pragmatism. Kelly & Cordeiro (2020) produced a paper that focussed on how organisational processes can be explored pragmatically. According to Kelly & Cordeiro (2020), a pragmatic attitude to identifying key problems is necessitated in research that requires actionable and practical conclusions. This research evidence must be both relevant and useful to the organisation or intervention in question. With this motivation, researchers must first identify the issues that are the most salient: those that would create the most positive change if resolved. Adding these three areas to my evaluation provided additional relevance and richness.

2.2.2: Choosing a methodological approach

Deciding *how* the lines of inquiry should be investigated in this project was also a pragmatically driven process. In its entirety, my thesis can be viewed as a piece of mixed-methods research. This is true firstly at an overall level, given that four

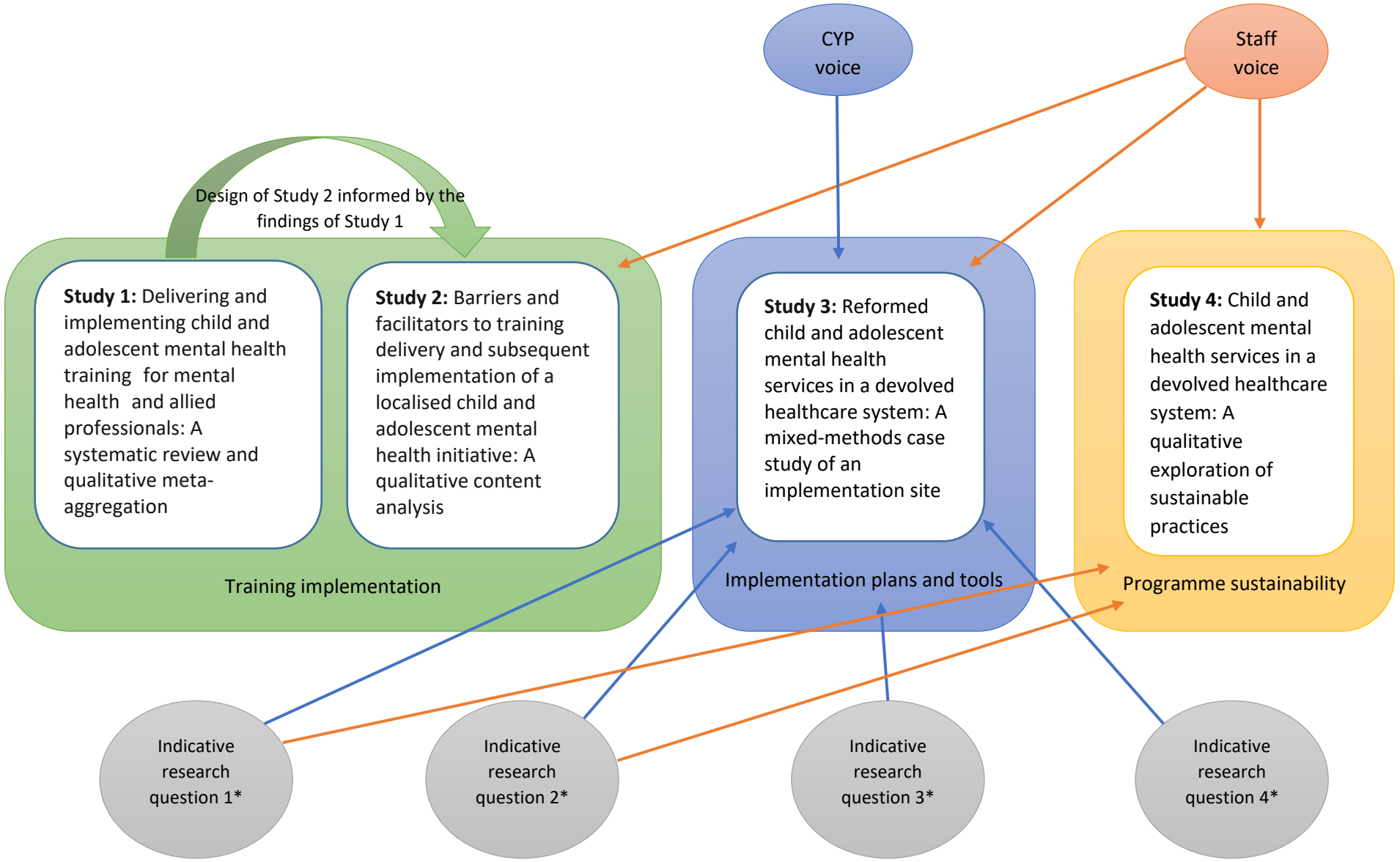
unique pieces of research were conducted, using a variety of investigative methods. With these methods, a comprehensive evaluative thesis, from which overarching conclusions and inferences were drawn, was built. Mixed methods were also applied at a more "micro" level, when we look within as well as across the individual studies, and consider the strategies employed to undertake each compartmentalised piece of research. Within each study, pragmatism was used to identify not only each research need, but also the tools, participant samples, and analytic strategies needed to generate the required knowledge. With this body of pragmatically produced knowledge, we could then draw relevant and actionable conclusions (Kelly & Cordeiro, 2020).

Mixed-methods research aligns well with a pragmatic epistemological approach (Feilzer, 2010). The current evaluation comprised several components, each requiring a tailored investigative approach. This tailoring was governed by recognising that knowledge on a topic can never be truly complete (Feilzer, 2010). Therefore, combining a range of experiential and informational sources can give an understanding that is more complex than the insights gained from examining just one source in isolation (Kelly & Cordeiro, 2020). Pragmatic mixed-methods researchers often reject the existence of the commonly implied dichotomy separating purely quantitative from purely quantitative approaches (Feilzer, 2010). Hanson (2008) suggested that the divide is likely driven by academic political issues such as status, funding opportunities, and the attractiveness of technological automation of analyses, all of which tend to favour quantitative methods. No tangible scientific or intellectual difference truly exists to render one approach objectively superior to the other.

Although the current evaluation appears to adopt predominantly qualitative methods to collect and analyse data, the decision to use these methods was reached by concluding that they were in fact the best possible "means to an end" in terms of research strategy (Biesta, 2010). Health care settings are extremely complex, with many confounding issues that can make evaluating implementation difficult, particularly when quantitative methods are attempted. This issue is especially relevant when conducting research, like evaluation, that operates outside of the stringent research environments offered by randomised controlled trials.

Patients, and services, are often concurrently experiencing or working with several interventions at a time, making it difficult to attribute change to just one of them (Feeley & Cossette, 2015). Wider contextual issues, such as the COVID-19 pandemic, further question the appropriateness of statistical measures of implementation progress. This uniquely chaotic period is unlikely to be accurately or meaningfully comparable to any other. Even survey research may lack the depth needed to fully understand factors such as the delivery of timelines, or implementation sustainability, within a global pandemic. Pragmatism therefore helped me to navigate the complexity of the circumstances I was working under (Borglin, 2015) and to reflect upon the types of evidence that would yield the most actionable content. To this end, I concluded that deeper personal experiences of working with, and experiencing care under, GM i-THRIVE, were necessary. True insight into the complexity of implementing such a framework, at such a time, could not be established using numerical data alone.

Figure 2.1: *A visual summary of the four papers presented in this thesis and the areas of inquiry that they encapsulate*



2.2.3: A mixed-methods service evaluation

The overarching qualitative methods that I adopted were complemented with quantitative evidence where appropriate, as in Studies 3 and 4 (Chapters 5 and 6 respectively). More detail on the specific underpinning rationale, and the exact methods of data integration that were used, are discussed in section 2.3 of this chapter, and within the journal paper chapters themselves. But, when considering my approaches to mixing methods for these studies at a more general level, it was important to pinpoint *why* a mixed-methods approach to the evaluation was needed (Greene et al., 1989), the priority and balance given to each methodological strand (Johnson et al., 2007), and *how* data from each strand would be combined to make meta-inferences (Moseholm & Fetters, 2017). A paper by Greene et al. (1989) taught me the importance of considering my pragmatic motivations for taking a mixed methods evaluative approach: what knowledge did I hope to generate? Greene et al. (1989) put forward five purposes (triangulation, complementarity, development, initiation, and expansion) for a mixed-methods design. They suggested that the word "triangulation" is commonly over-used, and it is often erroneously applied as a catch-all term. In its purest definition, it is, by contrast, a specific and rare type of mixed-methods design. Out of the five purposes suggested in Greene's typology, the motivations behind each of my mixed-methods strategies are outlined in *Table 2.1*.

Johnson et al. (2007) explained the varying statuses given to each strand (qualitative and quantitative) of mixed-methods research, and how this weighting can impact how inferences are made. They suggested the existence of a continuum, with pure qualitative research at one end, and pure quantitative at the other. All mixed-methods research falls somewhere along this spectrum depending upon the precise mix, be it of quantity or emphasis of data that is produced from each strand of inquiry. Mixed-methods research can, essentially, either take the form of a clear 50/50 split between the strands, or it can be dominated by one strand. To provide some examples, conducting interviews to further explore specific findings of a numerical survey could be seen as a "quantitative dominant" approach, whereas using survey findings to support views given in an interview would be viewed as "qualitative dominant". The framing of the investigative strands used in the two

mixed-methods studies of this thesis (Studies 3 and 4, in Chapters 5 and 6) are also outlined in *Table 2.1.* These were, again, based upon the nature of the information that I hoped to add to the evaluation. Meta-inferences were also drawn from all four of the thesis studies, providing wider conclusions with which each of the areas of inquiry necessary for the overall evaluation of GM i-THRIVE (*Figure 2.1)* could be resolved. The approaches taken to integrate the four studies into a mixed-methods service evaluation can also be found in *Table 2.1.*

It is easy to see how the emphasis placed on each strand impacts how conclusions are drawn in mixed-methods studies. A break-down of integration pathways, suggested by Moseholm & Fetters (2017), provides a deeper insight into the ways in which data from all strands can converge to produce meta-inferences. According to Tashakkori & Teddlie (2008, p. 101) a meta-inference is "an overall conclusion, explanation, or understanding developed through an integration of the inferences obtained from the qualitative and quantitative strands of a mixed methods study". How these meta-inferences are made depends, again, on the research rationale, as well as the emphasis placed on each strand. It goes without saying, as a side note, that the quality of inferences can only be as high as the quality of inquiry methods in each strand. This means that two sets of research standards must be adhered to if high-quality inferences are to be produced (Tashakkori & Teddlie, 2008). These inferences can be made in several ways. Moseholm & Fetters (2017) suggested that in terms of direction, data can be merged either unidirectionally, where strands are analysed one after the other before unification, or in an iterative, bidirectional way. The approaches taken within this thesis can be found in *Table 2.1.*

To summarise this section, I have emphasised how the decisions I made, from identifying areas of interest, to choosing methods, to making meta-inferences, were all driven by pragmatism. The decisions were based purely upon the needs and requirements of the evaluation, rather than calling upon abstract, deductive theories about the constructions of knowledge. Indeed, many pragmatists view other epistemological viewpoints as objectively less useful in their ability to produce practical and relevant findings (Kelly & Cordeiro, 2020). This theme of

Table 2.1: *A summary of approaches taken to the mixing of methodologies in this thesis and the studies within.*

Mixed-methods element of thesis	**Rationale for mixing methods (Greene et al., 1989)**	**Weighting of methods (Johnson et al., 2007)**	**Integration approach (Moseholm & Fetters, 2017)**
Study 3: Implementing THRIVE in Greater Manchester (GM i-THRIVE): A mixed-methods case study	**Triangulation:** Corroborate the results from different methods, increase validity of constructs, ameliorate bias. **Initiation:** Reveal the paradox that exists between findings from different methods. Discrepancies and consistencies are equally interesting.	**Equal status:** Qualitative and quantitative strands are used in equal measure to draw conclusions.	**Simultaneous bidirectional:** An active "back and forth" as findings emerge. Results are framed using findings from both strands, equally.
Study 4: Child and adolescent mental health services in a devolved healthcare system: A qualitative exploration of sustainable practices	**Triangulation:** Corroborate the results from different methods. **Complementarity:** Enhance meaningfulness and validity by drawing upon the strengths of each strand.	**"QUAL+quan" – qualitative dominant:** Quantitative findings are only used to "back up" points made in the qualitative.	**Exploratory bidirectional:** Analysis is framed in a qualitative lens, but elaborated with quantitative findings.
Overall thesis	**Expansion:** Extend the breadth and scope of inquiry by exploring different components with different methods.	**Equal status:** Findings from all STUDIES are considered equally as important.	**Exploratory bidirectional:** Analysis is framed in a qualitative lens, but elaborated with quantitative findings.

interweaving explanations of my pragmatic decision-making throughout this thesis will continue in the next section, where I will present the rationale and methodology of each of the four thesis studies.

2.3: Overview of studies

Figure 2.1 provides a visual summary of the four studies presented in the thesis, the predefined indicative research questions and pragmatically identified topics of interest that they cover, and the ways in which they interlink. The rationales of each study will be summarised in turn in this section. When I describe the rationale and method justification for each study, parts of this information may appear repeated when the reader reaches the journal article chapters (Chapters 3, 4, 5, and 6). However, the purpose of this repetition is to provide a foundation upon which to elaborate on certain details. Although these details were important considerations when I designed my studies, they were excess to the requirements of the journals that we submitted the manuscripts to. Contrastingly, other points have been presented in this section in *less* depth than in the journal articles; again, this depended on how and where I felt it was the most appropriate to present each piece of information.

2.3.1: Study 1: Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation

Study 1, presented in Chapter 3, was published in BMC Medical Education in 2021. A link to the open access published paper is available below:

Banwell, E., Humphrey, N., & Qualter, P. (2021). Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation. *BMC Medical Education, 21*(1), 103. https://doi.org/10.1186/s12909-021-02530-0

Author contributions:

I designed the systematic literature review (SLR) and wrote and published the Prospective Register of Systematic Reviews (PROSPERO) protocol in December 2019

(reference: CRD42020162876) with input and suggestions from NH and PQ. The protocol was updated regularly to document the progress of the review. I developed the search strategy and inclusion and exclusion criteria, and built and conducted the database searches. All stages of screening and data extraction were also carried out by me, and a sub-set of screening was independently replicated at each stage by PQ. PQ and I then compared and discussed our findings, and collaboratively drew conclusions where discrepancies occurred. Quality appraisal was carried out separately by PQ and I, and disagreements were, again, discussed and resolved. I wrote the first draft of the manuscript, with input from NH and PQ. All authors read and approved the submitted version and made suggestions for edits throughout the peer review process.

Rationale:

One topic that was consistently mentioned in my interactions with the GM i-THRIVE team is the issue of how the local implementation can be "rolled out" in line with principles of the framework. Staff training, as one of the most widely used methods of implementing novel evidence-based practices in CYP mental health (Beidas & Kendall, 2014) is evidently of utmost importance for GM i-THRIVE. This importance was indicated to me in terms of how often it was mentioned, and the complexities surrounding the issue that were raised. I decided, therefore, to focus two of my thesis papers on the topic of training.

The nature of the THRIVE framework indicates that, ideally, anyone who meets CYP in a professional capacity should be able to assist in times of mental health need. This pool of professionals does not only consist of specialist mental health workers, but also includes teachers, the police, youth workers, and GPs, amongst others. These professionals should know how, when, and where to provide appropriate mental health signposting or support to CYP (Wei et al., 2015). For GM i-THRIVE, staff who are equipped with this knowledge should then provide a consistent, helpful, and widespread support network. Factors such as long waiting lists (Wolpert et al., 2016), strict diagnostic barriers (Smith et al., 2018), and underfunded NHS CAMHS services (Neufeld et al., 2017) mean that alternative provision outside of the healthcare system is desperately needed. To provide

comprehensive training to such a diverse range of allied professionals, it is important that the potential gains of training programmes are maximised. I decided that establishing what the GM i-THRIVE Training Academy was doing well, or not-so-well, from the perspective of those participating in or delivering it, was a vital part of the evaluation.

Whilst this rationale directly led to the development of Study 2 (Chapter 4), I appreciated that any attempts, on my part, to construct an appropriate interview schedule, that would provide that study with the richest possible data, would be naïve. Consequently, I needed to devise a strategy to highlight which training issues were the most important, so that I knew which questions to ask my participants. The questions needed to be grounded in research evidence, to provide a frame of reference through which meaningful information could be drawn. A qualitative systematic review and evidence synthesis, of studies where experiences, barriers, and facilitators pertaining to CYP mental health training, was decided upon as an appropriate way of generating such information.

In addition to providing the foundation for my own empirical research (Study 2), I hoped that the review and synthesis could simultaneously provide a valuable guidance document. It would detail practical recommendations for a range of CYP mental health interventions, that could be used when designing, delivering, and implementing their own training programmes. The closest comparable published SLR was conducted by Scantlebury et al. (2018). Like mine, this review also used qualitative synthesis to identify the barriers and facilitators underpinning all-age mental health training for non-mental health trained allied professionals. My scope was narrower than this, focussing only on training relating to CYP. However, my SLR also expanded on Scantlebury et al. (2018)'s review, by including studies that explored experiences of not only a wide variety of *allied* CYP-facing professionals, but also of previously mental health-trained staff. This meant that my findings could, potentially, be applicable to *any* workplace or professional group. This falls in line with THRIVE's core ethos: that CYP mental health is "everybody's business" (Ford et al., 2007, p. 13).

Aims/research questions:

The review and synthesis sought to answer the following questions:

1. What are the barriers and facilitators that a) mental health professionals, and b) allied professionals, perceive as influencing the training delivery process?
2. What are the barriers and facilitators that a) mental health professionals, and b) allied professionals, perceive as influencing the implementation of training in the workplace?
3. Based on the above, what evidence-based recommendations can be made in order to improve training delivery and implementation?

Justification for method:

A systematic review is a specific type of literature review. It follows a prescribed set of transparent steps, to locate, appraise, and synthesise research evidence, with the aim of answering a specific question or set of questions (Boland et al., 2017). Data from every relevant and available resource on the topic, identified through systematic search, are synthesised to produce meta-level explanations and insights. The stringent and replicable review process, and the subsequent reduction of bias, gives SLRs the status of the most robust type of literature review.

When we consider how SLRs can aid our understanding of intervention implementation, if one's research aims require investigation that goes deeper than "does this work?", a qualitative review may be more appropriate than one that synthesises quantitative evidence (Boland et al., 2017). Richer understandings of experiences and emotions can be harnessed this way. The questions that I aimed to answer within this SLR were focussed on the facilitators and barriers, that help and hinder respectively, delivery and workplace implementation of CYP mental health training. A paper by Lavis (2009) explored and summarised the use of SLRs within policy making. They suggested, in agreement with Boland et al. (2017) above, that qualitative reviews can help us understand "how" and "why" health interventions work or fail.

As mentioned in section 2.2, all four of this thesis's studies were guided by pragmatism. In terms of choosing a method with which to synthesise my review evidence, I firstly thought about what I hoped to produce (directive, actionable recommendations that are grounded in evidence), before considering the nature of the data that would be synthesised (experiences within the contexts of participants' working lives). The SLR's rationale was deductive rather than inductive, with key concepts of interest (barriers and facilitators) clearly outlined within the search terms that were used (see *Appendix 1*). Additionally, the practical nature of the research questions meant that my qualitative summative approach did not need to be interpretative. Instead, an integrative approach, whereby evidence is summarised rather than being used to generate new theory (Boland et al., 2017), was most appropriate.

Letting these notions guide my choice of summative method, I concluded that qualitative meta-aggregation (Lockwood et al., 2015) was the most suitable. A self-described pragmatic method (Hannes & Lockwood, 2011), meta-aggregation involves extracting every conclusive remark from each included study. These are then consolidated based on shared meaning, resulting in condensed categories that are finally overarched by short "synthesis statements". These statements, when viewed in isolation, should provide the reader with a synthesised version of authors' original intended meanings (Lockwood et al., 2015). Whilst the meta-aggregative method has been criticised for potentially reducing the richness of qualitative data (Bergdahl, 2019), I argue that my SLR's aims negated the need for deeper interpretation. Collating study findings, at face value, made qualitative meta-aggregation a necessary and sufficient synthesis method in this instance.

Qualitative meta-aggregation, although a structured synthesis method (Hannes & Lockwood, 2011), is not completely free of the criticism faced by other qualitative methods, including that which relates to subjectivity. Had a different team of researchers followed my systematic review process, to the letter, a different set of synthesis statements, and consequently conclusions, may well have been drawn. However, I argued in the published paper (Chapter 3) that rigour and transparent explanation are the most important features of a qualitative review like this. Provided that my thought and judgement processes were clear, exact

replicability of results should not be expected as in quantitative SLRs. Indeed, acknowledging the position of the researcher, and the impact that they have on their research, is a key tenet of qualitative research: one that does not need to be viewed as a limitation.

I will now briefly outline the procedures of good practice that were adhered to in the SLR's methodology. When constructing search terms for inclusion and exclusion criteria, mnemonics such as PICOSS (participants, intervention, comparison, outcomes, setting, study design) or SPIDER (sample, phenomenon of interest, design, evaluation, research type) are often used to ensure that various criteria are considered when making academic database searches. I deduced that these commonly used mnemonics, whilst helping me to conceptually dissect each element that I needed to account for, were not specific enough for my review. Therefore, I considered topic (CYP mental health training programmes), sample (mental health or allied professionals), design/methods/analysis (qualitative or mixed-methods research and analysis methods), study aims (exploration of perceived barriers and facilitators) to be the key criteria for deciding whether a paper should be included or excluded. A complete example of a search strategy can be found in *Appendix 1.* Throughout the SLR, Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were followed, and the published paper includes a flowchart outlining the process of study identification. The final batch of studies were appraised for quality using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015). This tool consists of ten questions designed to assess the robustness of papers that are considered for review.

2.3.2: Study 2: Barriers and facilitators to training delivery and subsequent implementation of a localised child and adolescent mental health initiative: A qualitative content analysis

Study 2, presented in Chapter 4, was under review with BMC Medical Education when this thesis was submitted.

Author contributions:

I designed the study with input from NH and PQ. This included development of the semi-structured interview schedule, which was based upon the concluding synthesis statements and categories of Study 1. Participant recruitment was carried out by Angela Daniel in her position as gatekeeper, but interviewing, transcribing, and other administrative tasks relating to participant interaction were all carried out by me. I conducted the qualitative analysis of the data, with all resulting themes and accompanying extracts being sense-checked by PQ and NH. I wrote the first draft of the manuscript, with input from NH and PQ. All authors read and approved the submitted version and will continue to make suggestions for edits throughout the peer review process.

Rationale:

A point that has been stressed several times thus far is that training dissemination, as a key method of implementing change (Beidas & Kendall, 2014), is one of the most significant drivers of THRIVE's implementation in Greater Manchester. The GM i-THRIVE Training Academy aims to prepare the wider CYP mental health workforce to meet the aims of the programme, by means of delivering the four training modules listed below. The modules are described in greater detail in the full version of the study (Chapter 4):

- Shared decision making
- Getting advice and signposting
- Getting risk support
- Building confidence in letting go and managing difficult endings

Study 1, through the process of qualitative meta-aggregation, identified nineteen practical recommendations to guide those designing, delivering, or implementing CYP mental health training programmes. These actionable statements will be used by the GM i-THRIVE team as standalone guidance for their ongoing training. However, as my task was to *evaluate* GM i-THRIVE, the key rationale behind Studies 1 *and* 2 was to investigate the barriers and facilitators of training that are specific to the programme itself, whilst ensuring that the investigation was well-informed and that I knew which questions to ask. Using SLR evidence to guide research design is an underutilised approach (Cooper et al., 2005), yet one that can ameliorate the wider problem that exists in the health research field, of "research waste" (Nikolakopoulou et al., 2019). The approach allowed me to assess the extent to which experiences of the GM i-THRIVE Training Academy were typical of those identified in the wider literature, namely, how training has helped or hindered the overall implementation of THRIVE and the delivery of its aims. This allowed tailored recommendations for GM i-THRIVE to be generated.

Aims/research questions:

The aims of this study were to:

1. Establish whether the barriers and facilitators to training delivery and implementation reported in our review were present within GM i-THRIVE Training Academy
2. Identify any additional barriers and facilitators present in the experiences of those completing GM i-THRIVE Training Academy modules, that were not evidenced in our review
3. As a result of the above two aims, generate tailored recommendations pertinent to GM i-THRIVE, to form part of a comprehensive evaluation of the programme's implementation.

Justification for method:

An evaluative case-study approach was followed in this qualitative, semi-structured interview study. The GM i-THRIVE core team have conducted various surveys,

designed to harness trainees' opinions and experiences of the training, to identify gaps in their knowledge, and to guide the design of further training content. Surveys can be distributed to many participants, to quickly capture useful insights into the reception of the training. However, qualitative interviews, although typically involving fewer participants, tend to offer richer understandings of the research topic. The personal dialogue facilitated by the semi-structured interview method produces deeper, more detailed accounts than surveys can (Jain, 2021).

The interview schedule itself was developed by transforming each of the nineteen meta-aggregation categories of our SLR (Banwell et al., 2021) into an appropriately worded interview question. This was to ensure that every pertinent factor highlighted by the SLR was explored with the interviews. Several prompts and sub-questions were also developed, so that the interview felt like a natural conversation rather than formal or interrogative. A full copy of this schedule can be found in *Appendix 2.*

Participants were eligible for interview if they had attended at least one training session on one of the four GM i-THRIVE Training Academy modules. This recruitment pool was homogenous, in the sense that all attendees work, in varying contexts, with CYP. Nevertheless, a maximum variation strategy was utilised. This was to ensure that a variety of GM localities, module attendances, and job roles, both mental health and allied, were represented. According to Benzer et al. (2013), qualitative studies of intervention implementation should aim for a diverse representation of different sites and professional roles. Their differing perspectives offer rich and informative insights into the themes raised. My variation strategy, however, only reflected what an ideal sample might look like for this study. As such, the strategy was not strictly adhered to. This is because an opportunistic "work with the willing" approach was needed when recruitment of a sufficiently large sample was markedly more difficult than anticipated.

As "service evaluation research" where non-invasive questions about working practices were asked, the study did not require official ethical approval either from the University of Manchester's ethics committee (UREC), or from the NHS Research Ethics Committee (NHS REC). Ethical research procedures of good practice, such as obtaining consent, managing data securely, and ensuring

anonymity when reporting, were nonetheless complied with. Steps were also taken to avoid overburdening participants. Post-interview, participants were simply required to read through their transcript rather than co-establishing the accuracy of themes when they were generated. This is a process that can serve to threaten validity rather than boost it (Elo et al., 2014), given that participants are not usually familiar with how their own transcript fits in with the wider data set. As a way of saying "thank you", participants were provided with a £20 Amazon gift card as compensation for the time spent taking part in the research. The final themes and supporting extracts were sense-checked by my supervisors NH and PQ.

The appropriateness of the term "validity" for qualitative research is frequently debated (Sandelowski, 1993). Several researchers have argued that qualitative research should not, by its very nature, be subject to the same positivist forms of quality and rigour criteria that quantitative research requires (Rolfe, 2006). Contrarily, the ethos of qualitative research is underpinned by the idea that all generated knowledge is subjective. Processes such as full repetition of analysis, or joint production of themes, whilst appearing at face value to add rigour to such studies, are likely to be futile exercises (Graneheim & Lundman, 2004; Vaismoradi et al., 2013). They are at odds with the qualitative paradigm, where ideas of consensus are essentially meaningless (Braun & Clarke, 2021). Confirming that data labelling makes sense to a second reader, ensuring that the analysis appears adequate, and checking that themes represent the data logically (Elo et al., 2014; Graneheim & Lundman, 2004; Thomas & Magilvy, 2011) are considerably more suitable ways of adding rigour to qualitative studies. "Confirmability" (Graneheim & Lundman, 2004, p. 110) and "representativeness" (Thomas & Magilvy, 2011, p. 152) are perhaps more appropriate qualities of trustworthy qualitative research than "validity" or "consensus". These points also apply to the justification of Studies 3 (sub-section 2.2.3) and 4 (sub-section 2.3.4).

Qualitative content analysis was selected as the most suitable method of analysing this study's interview data. Although methodologically similar to thematic analysis, content analysis focusses more on surface meaning than interpretation, and uses frequency as the key indicator of relevance and significance (Vaismoradi et al., 2013). To recap, the study's aims were centred, firstly, on establishing the

presence or absence of the barriers and facilitators raised in the SLR, followed by the identification of additional pertinent factors. If additional topics were raised several times by participants, it logically followed that they would be of research interest. This differs from interpretative studies, where meaning and significance are not necessarily assumed at face value, but contextual and metaphorical constructs are analysed to a greater degree. From the various approaches to qualitative content analysis outlined by Hsieh & Shannon, (2005), I chose a directed approach. This approach is commonly taken when the researcher already possesses a certain level of knowledge of the topic but seeks to expand this knowledge through their qualitative research.

This was the most appropriate choice given that my study aims required a mixture of deductive and inductive inquiry. Given that the interview schedule was developed with the findings of my SLR, it would be impossible to deny the influence of this closely related research when coding and theming the transcripts. Furthermore, the study was purposely designed to apply these findings to GM i-THRIVE. However, despite these preconceptions, it was also crucial to remain aware of the possible presence of additional pertinent themes. This was so not to force the codes into themes that solely relate to the SLR. It can therefore be said that themes were generated both deductively and inductively, in line with the directed approach to content analysis (Hsieh & Shannon, 2005).

The directed method also allowed me to explore divergent responses: patterns of difference as well as of convergence, across participants' perceptions. The frequent mention of a topic across informants is often treated as an indicator of validity in qualitative research. However, Benzer et al. (2013) suggested that exploring disparity is just as important, especially in qualitative implementation studies that involve multi-site interventions like GM i-THRIVE. Benzer et al. (2013) state that such analyses should account for divergent *and* convergent views if resulting themes are to be of practical use. My themes, therefore, were named and conceptualised in a topic-based manner, rather than in a more "one-tailed" directional way. This meant that the themes encompassed the potentially contrasting experiences of my participants. For example, the theme named "peer

support" can cover the opinions of participants who said this was valued, as well as any who said that they did not feel that peer support was beneficial.

2.3.3: Study 3: Reformed child and adolescent mental health services in a devolved healthcare system: A mixed-methods case study of an implementation site

Study 3, presented in Chapter 5, was under review with Frontiers in Health Services Research when this thesis was submitted.

Author contributions:

I designed all components of the study, with input from NH and PQ. This included semi-structured interview construction and deciding which secondary data from GM i-THRIVE should be analysed. Full ethical approval was applied for and obtained, and I worked closely with NH and PQ for their guidance on this process. Participant recruitment was carried out by Angela Daniel in her position as gatekeeper, but interviewing, transcribing, and other administrative tasks relating to participant interaction were all carried out by me. Angela also provided me with the secondary data for the document analysis components of the study. All elements of data analysis and the drawing of conclusions were carried out by me, and sense-checked by NH and PQ. I wrote the first draft of the manuscript, with input from NH and PQ. All authors read and approved the submitted version and will continue to make suggestions for edits throughout the peer review process.

Rationale:

Given that the initial implementation period of GM i-THRIVE is limited to four years (2018-2022), it is vital that a strong foundation for the continued development of the programme is developed during this time. To this end, I concluded that an in-depth look at the progress made, pre- and during implementation, was necessary. I examined a range of secondary data, in the form of GM i-THRIVE's implementation plans and self-evaluation progress measures, and corroborated the findings with qualitative interview data from CYP who had recent experience of support in GM. I hoped that the study conclusions would indicate key areas for GM i-THRIVE to focus

their efforts during the next stage of embedding the programme across the GM localities.

Aims/research questions:

The key research questions for this study were as follows:

1. Does GM i-THRIVE's overarching implementation plan, and self-assessment evaluation system, contain the components deemed necessary for successful implementation and evaluation of an intervention?
2. Do the localities within Greater Manchester report a shift towards aligning their practices with the THRIVE framework within the four-year initial implementation period?
3. Do the experiences of CYP in Greater Manchester align with the implementation progress reported by localities?

Justification for method:

A mixed-methods case study approach was taken, combining two forms of document analysis with qualitative interview data. The study's conclusions took the form of meta-inferences that were made from this amalgamation of sources. I will now outline all data sources in turn, before explaining how each was analysed. First, GM i-THRIVE's broad implementation plan was examined, which contains five categories that represent the stages of implementation and a plan for the attainment of each (see *Appendix 3*). The second set of documents for analysis were self-assessment matrices, which are completed annually by a representative from each GM locality borough. The staff representative completing a matrix must specify their perception of whether, and to what extent, their locality's practices are currently aligned to the THRIVE model. 22 principles are included in the matrix, to be rated on a scale of 1 ("some way to go to achieving THRIVE-like practice") to 4 ("practice is very THRIVE-like").

The final data set was produced by interviewing CYP, aged between 13 and 21, who had received mental health support within GM since September 2018. They were eligible to take part in the study if they had been discharged from their

support service, or alternatively if they were in the final stages of receiving this help. Those currently in the early or middle stages of receiving support were not eligible. This was primarily because such CYP may be vulnerable to distress, and such an interview could, in the worst case, serve to hinder their mental health progress. Additionally, focussing on those later in their journey also ensured that the interview process was a truly reflective exercise: participants were likely to have a range of memories, opinions, and experiences to discuss. Contrary to commonly held beliefs, CYP *are* reliable witnesses of their own mental health (Macleod et al., 2017), and their experiences with mental health services (Bone et al., 2014), which justifies my inclusion of their testimonies.

The semi-structured interview consisted of questions and prompts which were designed around the aims of the THRIVE framework. This was to establish whether these aims had been achieved, according to those in direct receipt of care. A copy of the semi-structured interview schedule can be found in *Appendix 3.* Full ethical approval was obtained (UREC reference number: 2021-11033-18945) for this element of the study. Confirmation of this can also be found in *Appendix 3.* Consent and assent procedures appropriate to each participant's age were followed, and a distress protocol was designed so that I was prepared to handle any scenarios that arose owing to the sensitive nature of the interview. This included unexpected and sensitive disclosures, such as those relating to abuse or criminal activity, as well as ensuring that I knew the steps to take if a participant became very upset during the interview.

The study featured three distinct stages of data analysis, corresponding to each of the three research questions. To answer the first research question, blank versions of GM i-THRIVE's implementation plan and of the self-assessment matrix were compared against the 29 action steps of the Quality Implementation Tool (QIT) by Meyers, Katz, et al. (2012), which is an actionable version of the Quality Implementation Framework (Meyers, Durlak, et al., 2012). By conceptually synthesising 25 pre-existing implementation frameworks, Meyers, Katz, et al. (2012) sought to identify the most important steps to take if an evidence-based implementation is to be of the highest possible quality. These steps were chosen by grouping items and recommendations that featured across the frameworks, and

action strategies to address them were assigned to each. The QIT can be used at any stage of implementation to guide and evaluate the process (Meyers, Katz, et al., 2012). By cross-referencing GM i-THRIVE's initial plan and evaluation matrix with the QIT, I hoped to establish the extent to which these documents were of a level of robustness sufficient for planning and evaluating the changes made. The 29 steps of the QIT are broken down into six overarching components. These components are outlined in *Table 2.2,* where I also explain which steps each component covers, and which of our two documents they were used to evaluate. As evidenced in *Table 2.2*, combining the implementation plan with the matrix for this analysis was to ensure that every stage of GM i-THRIVE's implementation process, from inception through to evaluation, could be checked for evidence of the 29 steps of the QIT.

To answer the second research question, line graph visualisations were produced based on the results of completed self-assessment matrices. 22 visualisations were produced: one per principle of the matrix, to show the progress made towards achieving each. Although a full set of these 22 visualisations was presented as supplementary material addendum to the submitted paper (*Appendix 3*), only a subset of these were chosen for presentation in the manuscript itself (Chapter 5) and for comparison with the themes identified from the CYP interviews.

This leads seamlessly into the third research question, which is arguably the most important. The self-assessment matrix is a useful way of assessing each locality's shift, and by proxy Greater Manchester's overall shift, towards "THRIVE-like" working over the four-year initial implementation period. However, to fully investigate the extent to which GM i-THRIVE has met its overarching aims of providing a better mental health care experience for CYP, the experiences of those CYP must be explored. I concluded that without these testimonies, the self-assessment matrices could not provide a comprehensive evaluation. The interview data was analysed using reflexive thematic analysis (Braun & Clarke, 2021): a clearly defined yet flexible qualitative research method that is not bound to a particular epistemology (Braun & Clarke, 2006; Campbell et al., 2021). This allowed me to decide, pragmatically, how to carry out this analysis based on which meta-inferences were needed to answer the research questions. Consequently, a mixed deductive and inductive code generation strategy was adopted. As I mentioned

earlier, the aims of THRIVE were so intrinsic to the design of the interview schedule, as well as to the self-assessment matrices against which they were compared. The fact that these aims were so intricately woven through the study, it made sense to pre-emptively generate a list of deductive codes with which to begin the thematic analysis. New codes were then generated inductively if data did not fit into this deductive coding, before grouping all codes into reflexively refined themes.

In section 2.2, I discussed my motivations behind mixing methods in this study, and the specific ways in which the data sources were combined to form meta-inferences. By corroborating CYP experiences with locality staff self-assessments, I hoped to ameliorate any bias that existed in the latter, and to reveal areas of both paradox and agreement across the testimonies. To this end, the final themes from the interview data were compared to the data from nine out of the 22 matrix principles. The nine principles that were selected for this comparative analysis were chosen based upon their subjective, opinion-based nature, and how well they related to items within the interview schedule. This was to allow meaningful comparison between staff and CYP experiences and opinions of key matters that related to THRIVE's aims. To demonstrate examples of this, principles that were more objective in nature, such as "outcome data is used to inform individual practice with the purpose of improving quality", were not chosen for comparison. However, those covering concepts that were covered within the interview schedule and were therefore directly comparable with interview data such as "Shared Decision Making (SDM) is at the heart of all decisions" were included, as they allowed me to corroborate the data sources in a clearer way.

In line with epistemology of the entire thesis, the methodologies in this paper were chosen pragmatically. The nature of the inquiry was therefore fundamental to the selection of approaches taken. In part, the methodological decisions I made were a result of the availability of resources, and the analyses that could be performed with these resources. Combining the available implementation documents with qualitative interviews allowed me to capitalise on the duality of my data (Feilzer, 2010). Each additional strand served to strengthen the inferences made from each. Referring once again to *Table 2.1*, I stated that a simultaneous bidirectional approach to combining data sources was needed. Findings were

therefore considered iteratively and revisited alongside each new generated finding. At the same time, the new findings were framed within in the context of observations that had already been made. Using this approach, each component was given equal weighting (Johnson et al., 2007) when drawing overarching conclusions within the study's discussion. The range of meta-inferences drawn from the various lines of inquiry in the study can be seen in *Figure 2.2*, which highlights how the data were unified.

Table 2.2**:** *Components of implementation quality and action steps of the QIT (Meyers, Katz, et al., 2012), and which GM documents were used in Study 3 to evaluate GM i-THRIVE with the QIT*

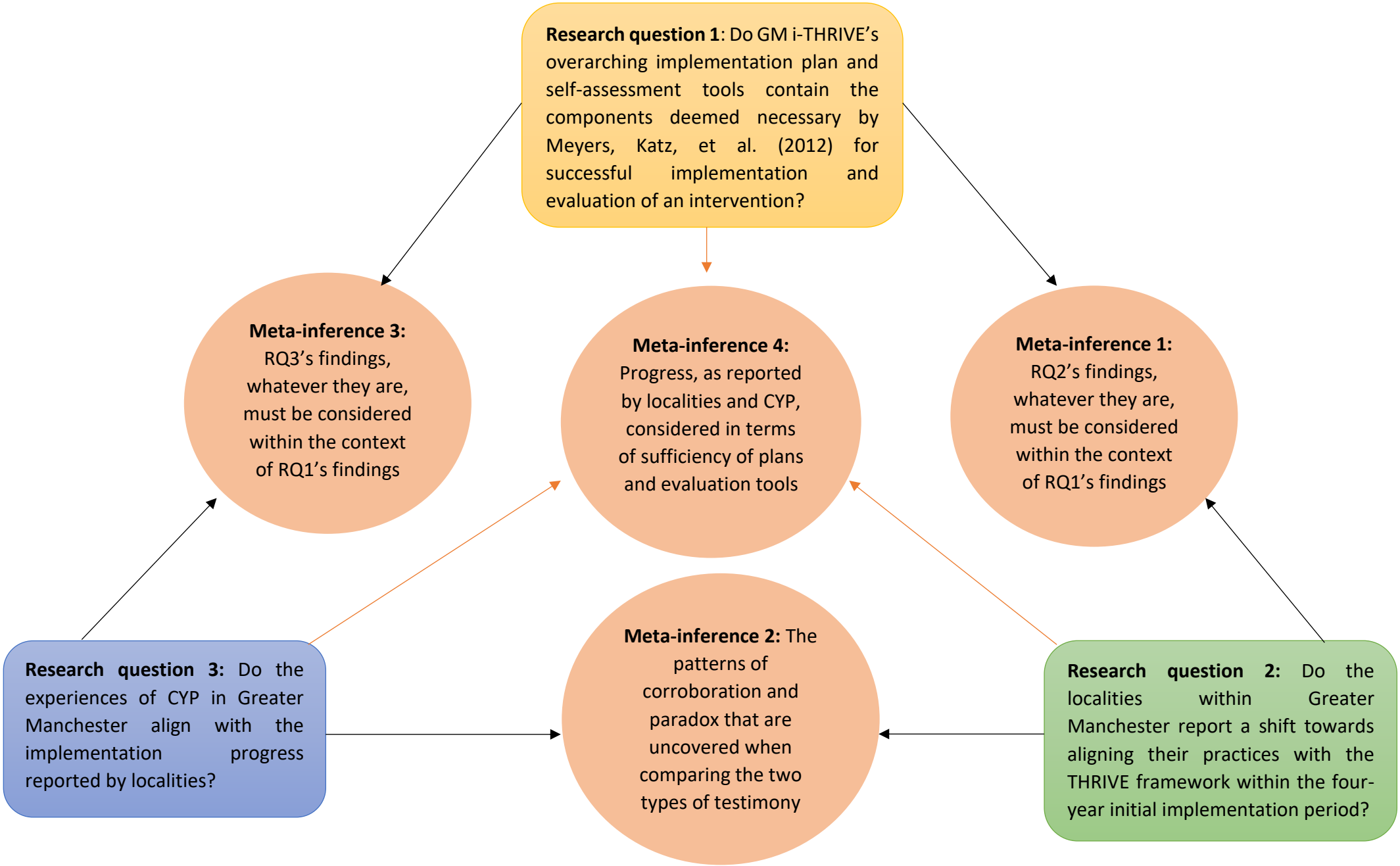
Component	Action step
1. Develop an implementation team	1.1 Decide on structure of team overseeing implementation (e.g., steering committee, advisory board, community coalition, workgroups, etc.) 1.2 Identify an implementation team leader 1.3 Identify and recruit content area specialists as team members 1.4 Identify and recruit other agencies and/or community members such as family members, youth, clergy, and business leaders as team members 1.5 Assign team members roles, processes, and responsibilities
2. Foster supportive organizational/ communitywide climate and conditions	2.1 Identify and foster a relationship with a champion for the innovation 2.2 Communicate the perceived need for the innovation within the organization/community 2.3 Communicate the perceived benefit of the innovation within the organization/community 2.4 Establish practices that counterbalance stakeholder resistance to change 2.5 Create policies that enhance accountability 2.6 Create policies that foster shared decision-making and effective communication 2.7 Ensure that the program has adequate administrative support
3. Develop an implementation plan	3.1 List tasks required for implementation 3.2 Establish a timeline for implementation tasks 3.3 Assign implementation tasks to specific stakeholders
4. Receive training and technical assistance (TA)	4.1 Determine specific needs for training and/or TA 4.2 Identify and foster relationship with a trainer(s) and/or TA provider(s) 4.3 Ensure that trainer(s) and/or TA provider(s) have sufficient knowledge about the organization/community's needs and resources 4.4 Ensure that trainer(s) and/or TA provider(s) have sufficient knowledge about the organization/community's goals and objectives 4.5 Work with TA providers to implement the innovation
5. Practitioner–developer collaboration in implementation	5.1 Collaborate with expert developers (e.g., researchers) about factors impacting quality of implementation in the organization/community 5.2 Engage in problem solving

Implementation set-up: GM i-THRIVE implementation plan checked for the action steps under components 1-5

6. Evaluate the effectiveness of the implementation	6.1 Measure fidelity of implementation (i.e., adherence, integrity) 6.2 Measure dosage of the innovation—how much of the innovation was actually delivered 6.3 Measure quality of the innovation's delivery—qualitative aspects of program delivery (e.g., implementer enthusiasm, leader preparedness, global estimates of session effectiveness, leader attitudes towards the innovation) 6.4 Measure participant responsiveness to the implementation process—degree to which participants are engaged in the activities and content of the innovation 6.5 Measure degree of program differentiation—extent to which the targeted innovation differs from other innovations in the organization/community 6.6 Measure program reach—extent to which the innovation is delivered to the people it was designed to reach 6.7 Document all adaptations that are made to the innovation—extent to which adjustments were made to the original innovation or program in order to fit the host setting's needs, resources, preferences, or other important characteristics

Implementation evaluation: self-assessment matrices checked for the action steps under component 6

Figure 2.2: *Meta-inferences that were drawn from the data sources used in Study 3.*



2.3.4: Study 4: Child and adolescent mental health services in a devolved healthcare system: A qualitative exploration of sustainable practices

Study 4, presented in Chapter 5, at time of thesis submission, had recently been accepted by Health Research Policy and Systems:

Banwell, E., Humphrey, N. & Qualter, P. (In press). Child and adolescent mental health services in a devolved healthcare system: A qualitative exploration of sustainable practices. *Health Research Policy and Systems.*

Author contributions:

I designed Study 4 with input from NH and PQ. This included the design of the semi-structured interview, the construction of which was largely guided by the NHS Sustainability Model (Maher et al., 2010), but also included additional questions based on issues that were unique to GM i-THRIVE. Participant recruitment was carried out by Angela Daniel in her position as gatekeeper, but interviewing, transcribing, and other administrative tasks relating to participant interaction were all carried out by me. I conducted the qualitative analysis of the data, and all resulting themes and the extracts that accompanied them were sense-checked by NH and PQ. I also carried out the quantitative analysis of the questionnaire data, and the tying together of the strands to form meta-inferences. I wrote the first draft of the manuscript, with input from NH and PQ. All authors read and approved the submitted version and made suggestions for edits throughout the peer review process.

Rationale:

GM i-THRIVE's initial implementation phase is four years long. This period is comparatively short, especially when we consider that the most reported figure for how long it takes to fully integrate research evidence into routine healthcare practice is seventeen years (Morris et al., 2011). When I reflect upon my interactions with the GM i-THRIVE team since I commenced work on this project in mid-2019, I do not remember attending a meeting or conversation where the future longevity of the programme was not mentioned. To me, in my status as a

relative outsider, it appeared that figuring out how to embed the framework into the ethos, mindsets, and practices of all CYP-facing professionals in GM was threaded through every decision that the team make.

Driven by the clear salience of this topic, a qualitative-dominant mixed-methods approach (Johnson et al., 2007) was taken, to investigate the occurrence of key sustainable practices occurred during implementation, from the perspective of a diverse range of professionals working with GM i-THRIVE. With this study, I hoped to show GM i-THRIVE what they were already doing well in terms of preparing the intervention for sustainability once the four-year implementation period is over, plus highlight areas where improvements could be made during the continuing process of embedding the framework. Thinking more broadly, I hoped that the study would address some of the problems and issues present in the sustainability literature that is seated within implementation science. These issues will be discussed below in the "justification for method" section.

Aims/research questions:

The aims of this study, whilst addressing a variety of issues identified within sustainability literature, were to:

1. Identify what has already been done to promote sustainable practices in the initial implementation period of GM i-THRIVE

2. Identify areas where sustainability can be enhanced during the embedding phase of GM i-THRIVE's implementation

Justification for method:

Research into the factors that underpin sustainability of evidence-based practice (EBP) is both scant and inconsistent. Traditionally neglected in favour of effectiveness studies, the factors that predict long-term sustainability, including why and how implementation fails, have received comparatively little research attention (Nilsen, 2015).

In this study, qualitative data from semi-structured interviews were complemented by selected participants' responses to a quantitative self-

assessment questionnaire. A good deal of sustainability research employs quantitative methods to examine the predictive capabilities of a range of variables on sustainability outcomes (McIntosh et al., 2018; Sainio et al., 2020; Spoth et al., 2011). However, whilst these methods remain an excellent way of pinpointing the factors that lead to sustainable implementation, they cannot be suitably applied to every intervention. There are several reasons why a qualitative-dominant mixed-methods approach (Johnson et al., 2007) was deemed the most appropriate for investigating the sustainable practices that occur, or do not occur, within GM i-THRIVE. Most quantitative methods require a strong level of statistical power to meaningfully explore patterns and trends. This is easily achieved with larger interventions, such as national-scale educational or health interventions, but it presents a challenge for smaller, localised programmes, like GM i-THRIVE (Shelton et al., 2018). Whilst a range of sites are involved in implementing the changes required by GM i-THRIVE, obtaining the level of statistical magnitude required for robust inferential tests of predictive factors would be tremendously difficult.

Another reason why a solely quantitative approach was disregarded for this study was referred to in section 2.2. The COVID-19 pandemic meant that nationwide, healthcare sites and support providers needed to adapt their ways of working to adhere with government guidelines designed to limit the spread of the illness. This resulted in the shift from face-to-face meetings, both between staff and with patients, to an online format. Also, the demand for support services has increased exponentially during the pandemic, with a huge amount of strain placed upon those who provide it (Byrne et al., 2021; Molodynski et al., 2021). These pandemic-related upheavals across the sector led me to conclude that any statistical measures of sustainability recorded during this time would not be transferable in the future. Without deeper investigation and explanation of the context surrounding them, any efforts to explain the findings would be pure conjecture. Within sustainability research, qualitative studies have strong potential for uncovering rich and valuable stakeholder insights into sustainable practices, especially with smaller-scale implementations. Findings can be suitably contextualised, and barriers and facilitators can be explored (Shelton et al., 2018): an intricacy that would be difficult to achieve with numerical data alone. Indeed,

Stirman et al. (2012) found that qualitative sustainability studies produced a wider variety of findings and were better able to highlight areas for further exploration than quantitative.

In the small but emerging sustainability field, many researchers appear to favour designing and using their own measures of sustainability over using those that already exist. Sustainability research, according to Proctor et al. (2015, p. 9), calls for "more rigorous tools that are more consistently used". Also, despite the advantages of qualitative research in this field that have been outlined above, many such qualitative studies fail to include enough detail within their publications to allow close replication (Stirman et al., 2012). These issues show that the problem of measure consistency within the field is in no way limited to quantitative measures, and they must ultimately be resolved if sustainability research is to progress in a common direction (Stirman et al., 2012). So that I might avoid producing yet another qualitative-dominant study with this flaw, I decided to make use of an existing framework, the NHS Sustainability Model (Maher et al., 2010) to guide the development of measures for my study. This model, predominantly designed to assess implementation sustainability within the NHS, is a self-assessment questionnaire for services to report their perceived adherence to key sustainability indicators. In its original form, the model is a quantitative, tick-box type measure. However, the components have been successfully converted into qualitative interview questions on at least one occasion (Ploeg et al., 2018).

The use of this design strategy by Ploeg et al. (2018) inspired me to follow suit, and I devised an interview schedule based around the 10 factors of the NHS Sustainability Model, with questions worded to the context of GM i-THRIVE. The model's 10 factors cover the three broader topics of "process" (relating to implementation of the procedures and practices of the intervention), "staff" (relating to the role that staff play and the support they receive in delivering the implementation), and "organisation" (relating to how the intervention sits within the overall ethos of the implementing environment) (Maher et al., 2010).

Whilst I hoped to contribute to the consistency of the field by utilising an existing sustainability measure, I realised that amendments were needed to fully address GM i-THRIVE-specific intricacies relating to sustainability. Therefore,

additional questions, based around training, adaptability, and reflection on past practices were added, owing to how salient these factors were in my interactions with the implementing teams. This pragmatic amalgamation of an existing framework with intervention-specific questions meant that the interview component of the study was robust, yet relevant. The interview was semi-structured, including prompts and sub-questions to stimulate a natural conversation. A copy of the schedule can be found in *Appendix 4.*

The small quantitative strand of this mixed-methods study came from the completion of the NHS Sustainability Model self-assessment in its original form, which was issued to certain participants. This element was added to the study to support and corroborate the interview data. Using these methods in tandem added robustness and validity to my approach (see *Table 2.1*). Ploeg et al. (2018) found that their interviewees' responses tended to match their answers on the self-assessment questionnaire, showing that their interview was a valid standalone measure. However, I chose to include it in my study to replicate their approach, strengthen the inferences I was able to draw, and to add a quantitative visual element to the recommendations made in my paper.

Akin to Study 2, Study 4 did not require official ethical approval owing to its status as a service evaluation. Participants were identified and approached by the gatekeeper on the grounds that they had encountered the "roll-out" of GM i-THRIVE within their workplace, to a degree that they were deemed able to reflectively discuss their experiences with working with the model. However, I wanted to ensure that a wide variety of experiences could be harnessed, thus a maximum variation strategy was adopted to aid this. I hoped to interview those responsible for planning, designing, and implementing GM i-THRIVE in a top-down way, as well as those who were more involved in delivering the intervention "on the ground". Those in the former group are responsible for decisions that are made in terms of sustainability, and the practices that occur as a result. Those in the latter group are likely to have lower levels of authority and freedom to innovate in their workplaces (Bridges et al., 2017), and their perceptions of sustainable practices can be seen as reflecting the efforts made by more senior colleagues. I also wished to interview those situated in the middle of this implementation hierarchy, which

were GM i-THRIVE's locality leads. These participants, although directly responsible for implementation within their localities, still receive guidance from the GM i-THRIVE team. As a result, they do not have the same control over implementation as those at the core of implementation-related decision making. This participant recruitment specification meant that some potential participants were eligible to take part in both Study 2, and Study 4, as many had taken part in GM i-THRIVE's training as well as having been involved with its implementation. I assessed this on a case-by-case basis, and as a result, four participants took part in both interview studies based upon this eligibility. One of these participants was a GM i-THRIVE locality lead, and the remaining three were working to implement the changes instigated by the framework. Three localities were represented by these participants, however another worked across several GM boroughs.

Another decision made on a case-by-case basis was whether participants were also given the NHS Sustainability Model self-assessment questionnaire. With each participant who I scheduled to interview, I considered whether they possessed knowledge of the top-down implementation of GM i-THRIVE *and* had intricate familiarity with how it worked at a locality level. Due to their central positioning matching this requirement, the questionnaire was provided to all participants who were locality leads (n=4).

The five stages of qualitative framework analysis (Ritchie & Spencer, 1994) were used to analyse the interview data. The method was chosen for its applicability to health policy research (Gale et al., 2013), where actionable and directive outcomes are necessitated (Ritchie & Spencer, 1994). An inductive thematic framework was developed and used to build themes based on the characteristics of the transcripts. Whilst the NHS Sustainability Model can be viewed as a pre-existing framework, an inductive approach was chosen so that the data was not forced into this. This allowed full appreciation of the unique experiences of the participants, without the limitation of viewing the data through a strict theoretical lens.

The sample size for the quantitative strand was very small (n=4), therefore the concluding meta-inferences drawn were drawn proportionally. This meant that the study's mixed-methods design was qualitative-dominant (Johnson et al., 2007).

The quantitative element was used to *elaborate* on the interview findings (Moseholm & Fetters, 2017b) rather than make a substantial contribution to the study as might a more equal mixed approach. We also identified several limitations associated with the use of the quantitative measure, which further restricted our ability to draw inferences from the data it generated. These can be found in the discussion section of Chapter 6. Although still broadly a mixed-methods study, at the advice of the peer reviewers who recently accepted the manuscript, the title of the study reads "qualitative" rather than "mixed-methods" for this reason.

2.4: Researcher reflexivity

I have attempted to weave reflexivity through this chapter, for example by describing the ways that I arrived at certain decisions, and how a pragmatic viewpoint helped me to do this, in section 2.1. However, here, I present a dedicated section in which I provide additional transparency on how I approached the project, to better clarify my position as a PhD researcher of GM i-THRIVE. Prior to applying for the PhD studentship attached to the project, I had not heard of the THRIVE Framework. Whilst this lack of prior knowledge meant that I had to quickly get to grips with the intricate workings of the programme as I began work on the project, it allowed me to approach it from a neutral position from which I had no preconceptions, good or bad, about the framework. This meant that my role as an evaluator could be considered as independent as it is possible to be. The fact that I was, and still am, an "early career researcher" further enhanced this, as I did not bring any previous experiences of similar projects into my work with GM i-THRIVE. As such, I arrived to the project with a mind that was open to a range of practices. This was the first service evaluation that I have been involved in, and its multicomponent nature has allowed me to incorporate, and gain familiarity with, a range of research methods.

I mentioned earlier in this chapter how my attendance of meetings in these early stages shaped the decisions I made for the areas of focus for my work, and the fact that I was offered a good deal of freedom, both in methodological and in subject matter, in how I approached this. I found this process of combining the wants and needs of the commissioners and implementers with my own

observations of what was salient to be both enjoyable and intellectually stimulating. The meetings and conversations I had were also paramount in developing my working knowledge of THRIVE and GM i-THRIVE: a knowledge which has continued to grow across the 3.5 years of my involvement. Although I felt sufficiently immersed in the environment and working practices of the implementing team, I believe that my role as a PhD student at the University of Manchester gave me a certain level of detachment which I view as a benefit to my work. As such, at no point did I view myself as working "for GM i-THRIVE", but rather as a student and an employee of the university. This meant that although I was in regular and friendly contact with the implementing team and other stakeholders, my independent viewpoint was maintained. From this, a more accurate and honest evaluation could be built, and I did not feel pressured, nor emotionally obligated, to present the implementation in a certain way.

2.5: Being a PhD researcher during the COVID-19 pandemic

Although the disruption I have personally faced is minimal compared to that of other PhD researchers, and indeed of the general population, I think that it is wise for me to also acknowledge, at this juncture, the effect that the COVID-19 pandemic has had on my PhD journey. In section 1.3, I discussed the pandemic's impact on both GM i-THRIVE, and the wider provision of mental health care, but in this short section, I will reflect briefly upon what it was like to work as a PhD researcher during COVID-19.

When the first UK lockdown was announced towards the end of March 2020, I had been working on the evaluation project, and as a PhD researcher, for only 9 months. As extensions to the lockdown period were introduced, my supervisors and I began discussing how measures such as social distancing would impact the course of my work. Luckily, the growing popularity of the video conferencing software Zoom meant that I could carry out all interview components of my studies by video call. The practicalities of this, including ethical and data security considerations, were discussed, and officially decided upon as the best course of action. I also quickly realised that the onset of the pandemic would represent a huge upheaval to my entire research setting. GM i-THRIVE meetings,

plus many forms of service provision, were switched to being carried out remotely: services which, because of the pandemic, were operating under a massively strained healthcare system. It was very clear I was not researching under "normal" times, and by no stretch of the imagination could my research outputs be treated as though the implementation took place in just a "regular" three-year period. This meant that my work needed to be contextually reframed, and for the pandemic to be considered alongside any of my findings. I have reiterated this positioning at regular intervals across the thesis.

Alongside almost every other person in the world, I also had to make personal adaptations owing to the pandemic. I consider myself in an enormously privileged position, in that I have had access to a comfortable and safe home working environment for the duration of the lockdown periods. Despite this, the social isolation and lack of routine brought about meant that I needed to be mindful of my mental health and motivation in ways that were not necessary, to the same extent, beforehand. This primarily taught me how much I value routine, and a clear distinction between home and work environments. In addition, although I unequivocally perceive myself as an introvert, the social aspect of research became more important to me than I initially anticipated. I have often heard it said that the PhD journey is a lonely and solitary one, however I could not have predicted the extent to which this has been true for me and my colleagues! The lessons I have learned about myself during this pandemic, and about the type of researcher that I hope to be in the future, will undoubtedly be carried on to the next phases of my academic journey.

2.6: Chapter summary

This chapter explained the reasoning behind the commissioning of my PhD project, and for each of the four studies it comprised of. Early on, I explained how a pragmatic epistemological viewpoint was taken towards designing the research, and how a mixed-methods approach was used to produce overarching meta-inferences. Then, an in-depth justification for the importance of each piece of research and their methodologies was provided. The chapter ended with two short reflexive pieces, firstly about my PhD journey and my work with GM i-THRIVE, and

how I navigated this during the COVID-19 pandemic. Across the next four chapters, Chapters 3, 4, 5, and 6, the four thesis studies will be presented. In Chapter 7, they will be tied together for discussion.

2.7: References

Banwell, E., Humphrey, N., & Qualter, P. (2021). Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation. *BMC Medical Education*, *21*(1), 103. https://doi.org/10.1186/s12909-021-02530-0

Beidas, R. S., & Kendall, P. C. (Eds.). (2014). *Dissemination and implementation of evidence-based practices in child and adolescent mental health*. Oxford University Press.

Benzer, J. K., Beehler, S., Cramer, I. E., Mohr, D. C., Charns, M. P., & Burgess, J. F. (2013). Between and within-site variation in qualitative implementation research. *Implementation Science*, *8*(1), 4. https://doi.org/10.1186/1748-5908-8-4

Bergdahl, E. (2019). Is meta-synthesis turning rich descriptions into thin reductions? A criticism of meta-aggregation as a form of qualitative synthesis. *Nursing Inquiry*, *26*(1). https://doi.org/10.1111/nin.12273

Biesta, G. (2010). Pragmatism and the Philosophical Foundations of Mixed Methods Research. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of Mixed Methods Research for the Social & Behavioural Sciences* (2nd ed., pp. 95–118). SAGE Publications, Inc.

Boland, A., Cherry, M., & Dickson, R. (2017). *Doing a systematic review: A student's guide* (2nd ed.). SAGE.

Bone, C., O'Reilly, M., Karim, K., & Vostanis, P. (2014). 'They're not witches. …' Young children and their parents' perceptions and experiences of Child and Adolescent Mental Health Services. *Child: Care, Health and Development*, *41*(3), 450–458. https://doi.org/10.1111/cch.12161

Borglin, G. (2015). The value of mixed methods for researching complex interventions. In D. A. Richards & I. R. Hallberg (Eds.), *Complex Interventions in Health* (pp. 29–46). Routledge.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Bridges, J., May, C., Fuller, A., Griffiths, P., Wigley, W., Gould, L., Barker, H., & Libberton, P. (2017). Optimising impact and sustainability: A qualitative process evaluation of a complex intervention targeted at compassionate care. *BMJ Quality & Safety*, *26*(12), 970–977. https://doi.org/10.1136/bmjqs-2017-006702

Byrne, A., Barber, R., & Lim, C. H. (2021). Impact of the COVID-19 pandemic – a mental health service perspective. *Progress in Neurology and Psychiatry*, *25*(2), 27–33b. https://doi.org/10.1002/pnp.708

Campbell, K., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., Gehrke, P., Graham, L., & Jack, S. (2021). Reflexive Thematic Analysis for Applied Qualitative Health Research. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2021.5010

Cooper, N. J., Jones, D. R., & Sutton, A. J. (2005). The use of systematic reviews when designing studies. *Clinical Trials*, *2*(3), 260–264. https://doi.org/10.1191/1740774505cn090oa

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative Content Analysis: A Focus on Trustworthiness. *SAGE Open*, *4*(1), 2158244014522633. https://doi.org/10.1177/2158244014522633

Feeley, N., & Cossette, S. (2015). *Testing the waters: Piloting a complex intervention* (D. A. Richards & I. R. Hallberg, Eds.; pp. 166–175). Routledge.

Feilzer, M. Y. (2010). Doing Mixed Methods Research Pragmatically: Implications for the Rediscovery of Pragmatism as a Research Paradigm. *Journal of Mixed Methods Research*, *4*(1), 6–16. https://doi.org/10.1177/1558689809349691

Ford, T., Hamilton, H., Meltzer, H., & Goodman, R. (2007). Child Mental Health is Everybody's Business: The Prevalence of Contact with Public Sector Services by Type of Disorder Among British School Children in a Three-Year Period. *Child and Adolescent Mental Health*, *12*(1), 13–20. https://doi.org/10.1111/j.1475-3588.2006.00414.x

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, *13*(1), 117. https://doi.org/10.1186/1471-2288-13-117

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a Conceptual Framework for Mixed-Method Evaluation Designs. *Educational Evaluation and Policy Analysis*, *11*(3), 255–274. https://doi.org/10.3102/01623737011003255

Hannes, K., & Lockwood, C. (2011). Pragmatism as the philosophical foundation for the Joanna Briggs meta-aggregative approach to qualitative evidence synthesis. *Journal of Advanced Nursing*, *67*(7), 1632–1642. https://doi.org/10.1111/j.1365-2648.2011.05636.x

Hanson, B. (2008). Wither Qualitative/Quantitative?: Grounds for Methodological Convergence. *Quality & Quantity*, *42*(1), 97–111. https://doi.org/10.1007/s11135-006-9041-7

Hsieh, H.-F., & Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, *15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687

Jain, N. (2021). Survey Versus Interviews: Comparing Data Collection Tools for Exploratory Research. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2021.4492

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a Definition of Mixed Methods Research. *Journal of Mixed Methods Research*, *1*(2), 112–133. https://doi.org/10.1177/1558689806298224

Kelly, L. M., & Cordeiro, M. (2020). Three principles of pragmatism for research on organizational processes. *Methodological Innovations*, *13*(2), 2059799120937242. https://doi.org/10.1177/2059799120937242

Lavis, J. N. (2009). How Can We Support the Use of Systematic Reviews in Policymaking? *PLoS Medicine*, *6*(11), e1000141. https://doi.org/10.1371/journal.pmed.1000141

Lockwood, C., Munn, Z., & Porritt, K. (2015). Qualitative research synthesis: Methodological guidance for systematic reviewers utilizing meta-aggregation. *International Journal of Evidence-Based Healthcare*, *13*(3), 179–187. https://doi.org/10.1097/XEB.0000000000000062

Macleod, E., Woolford, J., Hobbs, L., Gross, J., Hayne, H., & Patterson, T. (2017). Interviews with children about their mental health problems: The congruence and validity of information that children report. *Clinical Child Psychology and Psychiatry*, *22*(2), 229–244. https://doi.org/10.1177/1359104516653642

Maher, L., Gustafson, D. H., & Evans, A. (2010). *NHS Sustainability Model*. https://improvement.nhs.uk/resources/Sustainability-model-and-guide/

McIntosh, K., Mercer, S. H., Nese, R. N., Strickland-Cohen, M. K., Kittelman, A., Hoselton, R., & Horner, R. H. (2018). Factors predicting sustained

implementation of a universal behavior support framework. *Educational Research*, *47*(5), 307–316. https://doi.org/10.3102/0013189x18776975

Meyers, D. C., Durlak, J. A., & Wandersman, A. (2012). The Quality Implementation Framework: A Synthesis of Critical Steps in the Implementation Process. *American Journal of Community Psychology*, *50*(3/4), 462–480. https://doi.org/10.1007/s10464-012-9522-x

Meyers, D. C., Katz, J., Chien, V., Wandersman, A., Scaccia, J. P., & Wright, A. (2012). Practical Implementation Science: Developing and Piloting the Quality Implementation Tool. *American Journal of Community Psychology*, *50*(3/4), 481–496. https://doi.org/10.1007/s10464-012-9521-y

Molodynski, A., McLellan, A., Craig, T., & Bhugra, D. (2021). What does COVID mean for UK mental health care? *International Journal of Social Psychiatry*, *67*(7), 823–825. https://doi.org/10.1177/0020764020932592

Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: Understanding time lags in translational research. *Journal of the Royal Society of Medicine*, *104*(12), 510–520. https://doi.org/10.1258/jrsm.2011.110180

Moseholm, E., & Fetters, M. D. (2017). Conceptual models to guide integration during analysis in convergent mixed methods studies. *Methodological Innovations*, *10*(2), 2059799117703118. https://doi.org/10.1177/2059799117703118

Neufeld, S. A., Jones, P. B., & Goodyer, I. M. (2017). Child and adolescent mental health services: Longitudinal data sheds light on current policy for psychological interventions in the community. *Journal of Public Mental Health*, *16*(3), 96–99. https://doi.org/10.1108/jpmh-03-2017-0013

Nikolakopoulou, A., Trelle, S., Sutton, A. J., Egger, M., & Salanti, G. (2019). Synthesizing existing evidence to design future trials: Survey of methodologists from European institutions. *Trials*, *20*(1), 334. https://doi.org/10.1186/s13063-019-3449-6

Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science*, *10*(1), 53. https://doi.org/10.1186/s13012-015-0242-0

Ploeg, J., Ireland, S., Cziraki, K., Northwood, M., Zecevic, A. A., Davies, B., Murray, M. A., & Higuchi, K. (2018). A Sustainability Oriented and Mentored Approach to Implementing a Fall Prevention Guideline in Acute Care Over 2 Years. *SAGE Open Nursing*, *4*, 2377960818775433. https://doi.org/10.1177/2377960818775433

Proctor, E., Luke, D., Calhoun, A., McMillen, C., Brownson, R., McCrary, S., & Padek, M. (2015). Sustainability of evidence-based healthcare: Research agenda, methodological advances, and infrastructure support. *Implementation Science*, *10*(1), 88. https://doi.org/10.1186/s13012-015-0274-5

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), *Analyzing qualitative data* (pp. 173–194). Routledge.

Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing*, *53*(3), 304–310. https://doi.org/10.1111/j.1365-2648.2006.03727.x

Sainio, M., Herkama, S., Turunen, T., Rönkkö, M., Kontio, M., Poskiparta, E., & Salmivalli, C. (2020). Sustainable antibullying program implementation: School profiles and predictors. *Scandinavian Journal of Psychology*, *61*(1), 132–142. https://doi.org/10.1111/sjop.12487

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science Methods of Inquiry*, *16*(2), 1–8.

Scantlebury, A., Parker, A., Booth, A., McDaid, C., & Mitchell, N. (2018). Implementing mental health training programmes for non-mental health trained professionals: A qualitative synthesis. *PloS One*, *13*(6). https://doi.org/10.1371/journal.pone.0199746

Shelton, R. C., Cooper, B. R., & Stirman, S. W. (2018). The Sustainability of Evidence-Based Interventions and Practices in Public Health and Health Care. *Annual Review of Public Health*, *39*(1), 55–76. https://doi.org/10.1146/annurev-publhealth-040617-014731

Smith, J., Kyle, R. G., Daniel, B., & Hubbard, G. (2018). Patterns of referral and waiting times for specialist Child and Adolescent Mental Health Services. *Child and Adolescent Mental Health*, *23*(1), 41–49. https://doi.org/10.1111/camh.12207

Spoth, R., Guyll, M., Redmond, C., Greenberg, M., & Feinberg, M. (2011). Six-Year Sustainability of Evidence-Based Intervention Implementation Quality by Community-University Partnerships: The PROSPER Study. *American Journal of Community Psychology*, *48*(3/4), 412–425. https://doi.org/10.1007/s10464-011-9430-5

Stirman, S. W., Kimberley, J., Cook, N., Calloway, A., Castro, F., & Charns, M. (2012). The sustainability of new programs and innovations: A review of the empirical literature and recommendations for future research. *Implementation Science*, *7*(1), 17. https://doi.org/10.1186/1748-5908-7-17

Tashakkori, A., & Teddlie, C. (2008). Quality of inferences in mixed methods research: Calling for an integrative framework. In M. M. Bergman (Ed.), *Advances in mixed methods research* (pp. 101–119). SAGE Publications, Inc.

Thomas, E., & Magilvy, J. K. (2011). Qualitative Rigor or Research Validity in Qualitative Research. *Journal for Specialists in Pediatric Nursing*, *16*(2), 151–155. https://doi.org/10.1111/j.1744-6155.2011.00283.x

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, *15*(3), 398–405. https://doi.org/10.1111/nhs.12048

Wei, Y., McGrath, P. J., Hayden, J., & Kutcher, S. (2015). Mental health literacy measures evaluating knowledge, attitudes and help-seeking: A scoping review. *BMC Psychiatry*, *15*(1). https://doi.org/10.1186/s12888-015-0681-9

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2016). *THRIVE Elaborated* (Second). http://implementingthrive.org/wp-content/uploads/2016/09/THRIVE-elaborated-2nd-edition.pdf.

Chapter 3: Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation

Banwell, E., Humphrey, N., & Qualter, P. (2021). Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation. *BMC Medical Education*, *21*(1), 103. https://doi.org/10.1186/s12909-021-02530-0

This chapter presents the version of Study 1 that was published, open access, in BMC Medical Education. However, it has been reformatted for consistency with the rest of the thesis. All supplementary materials referred to in this chapter can be found in *Appendix 1*.

3.1: Abstract

Background:

The increasing prevalence of mental health difficulties among children and young people (CYP) suggests that early intervention is vital. A comprehensive system of care and support requires the involvement of mental health professionals, including psychologists and psychiatrists, and allied professionals, including teachers, police, and youth workers. A critical starting point is the provision of effective training, in order that these professionals can better support the mental health needs of the CYP that they encounter.

Objectives:

Given the primacy of training in the CYP mental health support system, understanding the factors that maximise potential gains and facilitate uptake is pertinent. The current review therefore located and explored qualitative research evidence, to identify the barriers and facilitators underpinning successful delivery and implementation of training focussed on the mental health of CYP, for both mental health and allied professionals.

Methods:

A systematic review and qualitative meta-aggregation were conducted. Systematic searches were carried out using ASSIA, EMBASE, MEDLINE, NICE Evidence,

PsycINFO, and Scopus databases, for papers published between 2000 and 2020. 12,448 records were identified, of which 39 were eligible for review. The records were appraised for quality using the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research, and synthesised using the qualitative meta-aggregation method.

Results:

182 raw findings were extracted from the 39 papers, which were condensed into 47 sub-categories, 19 categories, and finally 5 synthesis statements. These synthesis statements reflected the barriers and facilitators influencing the training delivery process ("support"; "content, design, and planning"), and the implementation of training into the workplace ("context"; "perceived value"; "organisational factors").

Conclusions:

The synthesis statements and underlying categories provide practical recommendations for those designing, delivering, or implementing CYP mental health training. Recommendations ranged from facilitating peer support during training, to the idea that training will be better implemented when perceived need is high. The review provides a robust evidence-based foundation to "common-sense" principles, drawing them into a coherent and organised framework using a synthesis method grounded in pragmatism.

Protocol registration number:

PROSPERO reference ID: CRD42020162876

Keywords:

Training; mental health; children; adolescents; young people; professional development; implementation science; qualitative; systematic review; meta-aggregation

3.2: Introduction

Rationale:

Mental health difficulties are common among children and young people (CYP). In 2020, one in six 5-16 year-olds (16%) in England had a probable diagnosable disorder (NHS Digital, 2020). This pattern is similar worldwide, with 10-20% of children and adolescents experiencing mental ill health (World Health Organisation,

2020b). Looking at incidence across the lifespan, half of all psychiatric conditions start before the age of 14 (P. B. Jones, 2013; World Health Organisation, 2020b). Mental health difficulties are associated with multiple salient individual and societal outcomes. Longitudinal studies have found associations between poor mental health in childhood and adolescence, and lower quality of life and loneliness (Trotta et al., 2020), higher criminal behaviour (Aebi et al., 2014), and poorer health, both mental and physical, in adulthood (Aebi et al., 2014; Naicker et al., 2013). In terms of financial burden, mental ill health is estimated to cost over £100 billion in England per year (Centre for Mental Health, 2010) when the detrimental impact on economic productivity is considered alongside higher service utilisation (Belfer, 2008). These statistics clearly suggest that early intervention is vital if poor mental health among CYP is to be ameliorated.

Mental health professionals, such as psychologists, psychiatrists, and mental health nurses immediately come to mind when we consider those who provide relevant care and support for CYP. High quality training, whether basic or specialist, should be offered actively and regularly to these professionals, to improve and update their skills and knowledge (Edwards et al., 2008). However, CYP also encounter a wide variety of non-mental health trained professionals in their everyday lives, including teachers, police, and general healthcare providers. These allied professionals also need to be well placed to support the needs of the CYP they encounter, irrespective of whether or not they have been referred to specialist mental health services.

A climate of austerity and budget cuts to Child and Adolescent Mental Health Services (CAMHS) in the UK means that these alternative, non-specialised services are increasingly being relied upon to provide mental health support. In 2014/2015, only 25% of CYP with a psychiatric disorder had made contact with mental health services (NHS England, 2015), compared to 38% in 2005/2006 (Neufeld, Dunn, et al., 2017). A funding cut of 5.4% to CAMHS within this period is perhaps responsible for this severely reduced rate of service contact (Neufeld, Jones, et al., 2017). Additionally, an increase in average waiting times for access to CAMHS (Wolpert et al., 2016), along with a substantial likelihood of referral rejection (Smith et al., 2018), means that many CYP cannot benefit from specialist

support, particularly when the cross-sector communication needed to signpost to alternative sources of support is notoriously poor (Department of Health, 2015). Indeed, a recent systematic review found that over 25% of CYP with diagnoses or elevated symptoms were not utilising *any* form of mental health support, specialist or otherwise (Duong et al., 2020), suggesting that even alternative support is inaccessible to many.

Bearing these issues in mind, teachers were found to be the most common allied service contact that CYP and/or their parents utilised regarding emotional, behavioural, or concentration difficulties (Ford et al., 2005). Teachers perceive themselves as being the "front line" for help-seeking for several reasons, including the close bonds forged throughout the school year, and the mental health stigma held by some parents (O'Reilly et al., 2018). However, because mental health support is not the primary role of school staff, they do not have the time and resources needed to effectively provide it, nor do they feel adequately trained to do so (O'Reilly et al., 2018). Even primary medical professionals such as general practitioners feel under-equipped to recognise issues and provide appropriate support for CYP, with the criteria for CAMHS referral poorly understood (Hinrichs et al., 2012). Reduced government funding for mental healthcare means that patients of all ages are more likely to turn to Accident and Emergency (A&E) departments at times of crisis (Kerasidou & Kingori, 2019). For CYP specifically, between 2010 and 2015, the number of psychiatric A&E attendances doubled (Community Practitioner, 2016). A&E staff perceive their own knowledge and effectiveness for dealing with CYP psychiatric admissions as low (Timson et al., 2012), with the A&E environment decidedly unsuitable to care for such patients (Kerasidou & Kingori, 2019).

Clearly, CYP are clearly "falling between the gaps" in terms of accessing the support they need. Recent efforts have consequently been made to ensure that CYP mental health is "everybody's business". Initiatives such as i-THRIVE (Wolpert et al., 2019), introduced in 70 areas in England, emphasise the value of providing support through a diverse range of access points, not only health services (e.g. the UK's National Health Service). i-THRIVE represents a shift from a mind-set where mental health is solely the purview of health professionals, to one where schools, social

care, and even the arts sector, can be informed advisors - providing support, and signposting effectively and confidently (Wolpert et al., 2019). For this vision to become a reality, training a diverse range of allied professionals should be a priority. They should be equipped with the skills required to provide appropriate support, be this individualised or community-based care. The latter, for example school-based mental health promotion (Wu et al., 2019) can benefit even healthy populations of CYP, helping them to deal with the inevitable "ups and downs" of life (Wolpert et al., 2019).

What should training look like? In broad terms, mental health training should improve the mental health literacy of its trainees. Mental health literacy refers to the understanding of mental health problems, how to improve mental health, and confidence in knowing when, where, and how, to provide or signpost to assistance (Wei et al., 2015). Additionally, an increase in literacy and awareness should result in a reduction of negative stigma (Kutcher et al., 2016). In terms of content, training programmes often vary in specificity, depending on the type of professionals being trained. Basic level programmes such as Youth Mental Health First Aider training (Haggerty et al., 2019), or basic psychotherapeutic skills (Lempp et al., 2016), may be suitable for allied professionals. However, mental health professionals should be offered more focussed training that reflects their level of background knowledge (Haggerty et al., 2019). Training is also one of the most widely used implementation strategies when disseminating new evidence-based practices in CYP mental health (Beidas & Kendall, 2014).

Objectives and research questions:

Given the primacy of training in the CYP mental health support system, it is vital to understand the factors that maximise its potential gains and facilitate uptake, for example, a training programme being of appropriate complexity for those completing it (Lempp et al., 2016). To date, a number of qualitative studies have explored these barriers and facilitators, by speaking to those receiving and delivering training. However, a systematic review that aggregates research across the field, where both mental health *and* allied professionals are participants, has not yet been conducted.

Considering this, the current review located and explored relevant qualitative research evidence, to identify the barriers and facilitators underpinning successful delivery and implementation of training that focusses on the mental health of CYP. These barriers and facilitators were established by collating the experiences and views of mental health trained professionals, along with any allied professionals who might, in their daily roles, encounter CYP who require mental health support. The review built upon the findings of a similar qualitative review by Scantlebury et al. (2018). Their qualitative synthesis identified several delivery and organisational factors, reported by allied professionals, as predictive of whether or not training was well implemented. By simultaneously narrowing the reach of the systematic search to only include studies of training pertaining to CYP, and broadening it to include the views of mental health professionals, the current review sought to provide further insights into how training delivery, and its subsequent implementation in practice, could be improved for all professionals. Given that such a wide range of professionals are currently so closely involved with supporting CYP, even those with diagnosed psychiatric disorders, it may be the case that their experiences do not vary as much as one would immediately imagine. As such, the current review was able to explore whether, and if so, how, the reported barriers and facilitators differed by professional group.

The review sought to answer the following questions:

1. What are the barriers and facilitators that a) mental health professionals, and b) allied professionals, perceive as influencing the training delivery process?
2. What are the barriers and facilitators that a) mental health professionals, and b) allied professionals, perceive as influencing the implementation of training in the workplace?
3. Based on the above, what evidence-based recommendations can be made in order to improve training delivery and implementation?

3.3: Methods

A systematic review and qualitative meta-aggregation were conducted, following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.

Protocol:

The methodology and inclusion and exclusion criteria for the review were published in a PROSPERO protocol in January 2020 (reference: CRD42020162876). Progress updates were documented periodically.

Eligibility criteria:

The inclusion and exclusion criteria that were used to decide if a paper was eligible for the review can be found in *Table 3.1.* In this review, the distinction between the two professional types was made as follows. **"Mental health professionals"** provide targeted mental health interventions, ranging from early assessment and support, through to disorder-specific services and inpatient units. They include, for example, mental health nurses, psychiatrists/psychologists, and therapists.

The term **"allied professionals"** refers to those who, as part of their job role, are likely to encounter CYP requiring mental health support, however their role is not specialised towards providing this. They include, for example, teachers, police, or youth workers, plus medical professionals who do not specialise in mental health, such as GPs or paediatric nurses. Students were included under the two definitions, provided that their course was sufficiently vocational (e.g., trainee clinical psychologists, trainee social workers).

***Table 3.1**: Inclusion and exclusion criteria*

Inclusion:	**Exclusion:**
Topic:	
• Training or staff development programmes focussed on responding to, and/or improving knowledge of, the mental health of CYP	• Training to improve professionals' own mental health • Studies focussed on all-age mental health where the data pertaining to CYP is not separable • Studies where training focusses heavily on another topic (e.g., child protection, physical health, behavioural management), and any data on mental health is not separable
Sample:	
• Mental health or allied professionals as defined above, who received and/or provided the training programme	• Students of university or college courses that did not involve contact with CYP
Design, methods, and analysis:	
• All qualitative study designs • Mixed methods study designs, providing that the qualitative element was entirely separable from any quantitative analysis	• Studies with no separable qualitative findings • Studies where qualitative data collection methods were used, but qualitative analytic methods were not
Study aims:	
• Studies that explored the perceived barriers and facilitators of training delivery and/or implementation	
Other:	
Studies with at least one extractable qualitative finding, to allow inclusion into the meta-synthesis	• Studies unavailable in the English language • Studies published prior to the year 2000 • Research protocols or conference abstracts for which a full study write-up could not be located

It was anticipated that studies might not explicitly specify the ages of the CYP that the training focussed on, instead using broader descriptors such as “children”, “adolescents”, “young people”, etc. Such studies were considered for inclusion. However, where an age bracket *was* mentioned, the review included studies focussed on training pertaining to those up to, and including, the age of 24. Despite debate around the age at which an individual is considered an adult, this age corresponds with the WHO’s definition of a “young person” (World Health Organisation, 2020a), as well as with a recently proposed developmentally appropriate definition of “adolescence” (Sawyer et al., 2018).

Search strategy:

The search strategy was initially developed by the first author, based upon methodological guidance and prior SLRs. The second and third authors were consulted periodically, in order to develop the strategy in an iterative manner. The strategy included terms relating to a) staff roles (e.g., “practitioner”; “teacher”), b) mental health (e.g., “depression”; “crisis”), c) CYP (for example “teen”; “young offender”), d) training (e.g., “professional development”; “learning package”), e) study aims (e.g., “evaluation”; “experiences”), and f) data generation (e.g., “qualitative”; “interview”).

The search terms were adapted as per the requirements of each bibliographic database. See *Appendix 1* for a complete example of a search strategy.

Data sources:

The following databases were searched: ASSIA, EMBASE, MEDLINE, NICE Evidence, PsycINFO, and Scopus. In addition to this, the reference lists of eligible studies and relevant review articles were hand-searched for any further studies. Studies in a variety of formats were considered for inclusion, including peer-reviewed journal papers, doctoral theses, unpublished research, and conference papers, providing that extractable information was available. This approach mitigates the issue of publication bias, where the findings of peer-reviewed studies might differ substantially from those of unpublished research (Ayorinde et al., 2020). The years 2000 to present (January 2020) were used as date parameters in each search,

minimising the chance of research findings being outdated. Whilst studies prior to 2000 may indeed be relevant, this 20-year period was deemed sufficient in order to capture research findings that were contemporary, and reflective of recent policy in relation to the mental health of CYP.

Study selection:

Results from initial searches were uploaded to Endnote, and duplicate hits were removed. The paper titles and abstracts were screened manually by the first author, and those that appeared to adhere to the inclusion criteria were retained. The third author independently replicated 10% of the screening, to check the clarity of the eligibility criteria. Discrepancies and uncertainties were discussed, and the criteria clarified as a result. Full text versions of the retained papers were then assessed by the first author against the full inclusion and exclusion criteria. 10% of these were independently reviewed by the third author to ensure consistency in approach. An agreement rate of 96.7% suggests strong replicability of the search strategy.

Quality appraisal:

The included papers were reviewed for quality using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015). Designed by the JBI, the tool was deemed a suitable fit for the chosen qualitative synthesis method (see "data synthesis" section). The tool comprises ten questions, ensuring that methodology, analysis, and interpretations do not contradict one another, and addressing researcher influence, ethical approval, participant representation, and logical flow from analyses to conclusions. Each item is given a score of one if it is evidenced in the paper, and zero otherwise, producing a total score from 0-10. All papers were independently checked by the first and third authors. Scores within three points' difference of one another were said to agree. If the authors' rating of a criterion differed by more than three points, they discussed their reasoning, and reached a consensus score together.

Data extraction:

A data extraction spreadsheet was designed based upon the papers' key features, including research and analysis methods, and the purpose of the described training

programmes. Details of the participants' job roles, trainer or trainee status, and information pertaining to the populations of CYP that the training dealt with (e.g. healthy school populations, those with a specific mental health issue) were additionally extracted, in order to establish the representation of these characteristics across the papers.

Data synthesis:

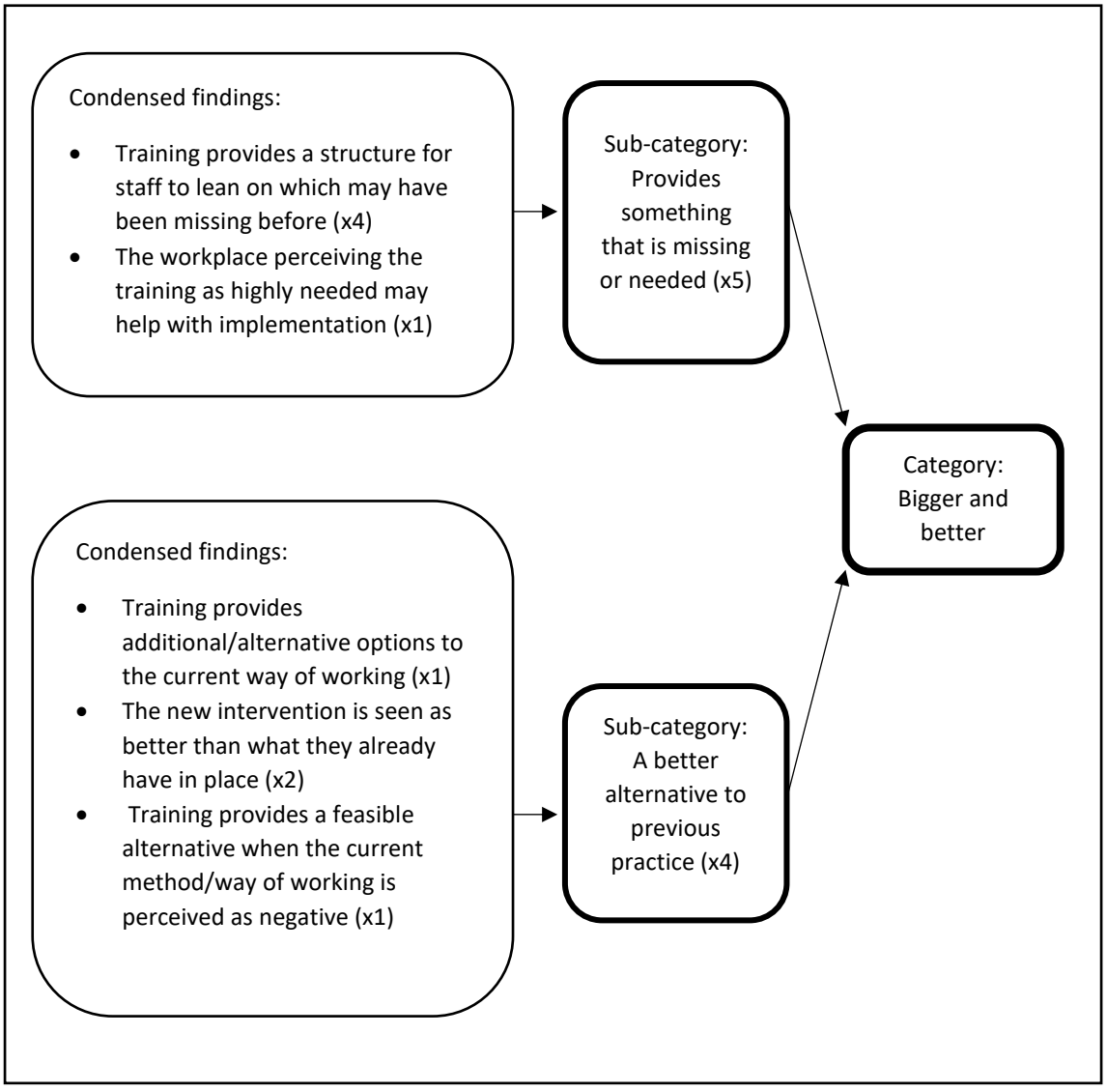
The review took a deductive approach, with concepts of interest (barriers and facilitators) defined *a-priori,* and accounted for within the search terms. This left extraction and summation of the included studies as the key aim of the review and synthesis (Boland et al., 2017). Consequently, qualitative meta-aggregation was deemed the most appropriate method of doing this. Outlined in the Joanna Briggs Institute Qualitative Assessment and Review Manual (JBI QARI), the meta-aggregative method is a qualitative evidence synthesis strategy grounded in a pragmatic philosophical stance (Hannes & Lockwood, 2011). It involves extracting the concluding findings from every included paper, and categorising them based on shared meaning. It then groups these categories further, summarising them to produce synthesised findings: practical, directive action points that can be used to guide policy and make recommendations (Lockwood et al., 2015). Qualitative meta-aggregation seeks to avoid reinterpreting the conclusions drawn in the literature, instead aiming to present a synthesised version of the authors' original intended meanings (Lockwood et al., 2015).

To identify a "finding" within a paper, a reviewer commonly draws from the list of themes presented in a qualitative study. However, in the current review, this strategy was problematic because presented themes were often very short and lacking detail. To gain a richer set of findings, a line-by-line examination of the papers' results sections was conducted, extracting the authors' concluding observations and remarks verbatim. The discussion and conclusion sections were also closely examined to capture any ideas not mentioned in the results sections. Along with each finding, a supporting extract was identified, in the form of a verbatim participant quotation. A level of credibility was then allocated to each

finding, based upon the congruence between the author's conclusion, and the participant's voice (Lockwood et al., 2015).

The method of extracting concluding remarks meant that findings were numerous and often lengthy. Consequently, two additional categorisation steps were taken to produce the final synthesis statements: the production of condensed findings and sub-categories. First, a simple summative statement was produced for each finding, condensing the essence of each, and allowing more effective categorisation. Longer findings, where multiple topics were addressed, were

Figure 3.1*: An example of the progression from condensed finding, to sub-category, to category. The numbers in brackets represent how many "raw findings" are represented by each, providing an indication of how well each category represents the data*



assigned more than one condensed finding, and conversely, findings that were extremely similar were assigned to the same condensed finding. A note was made of how many raw findings were represented by each. Then, condensed findings were classified into broad categories based upon the overarching topic and meaning of the findings, before further splitting them into sub-categories. This was deemed a more appropriate method of representing the richness of the data, and was used in a qualitative meta-aggregation by Johnson & Woodgate (2017). An example of this process can be found in *Figure 3.1.* Finally, the categories were grouped into synthesis statements, providing a useful broad heading for the recommendations within. Throughout the aggregation process, corresponding extracts from the papers were used to guide categorisation. The extraction of findings and data synthesis processes were carried out by the first author, however the final synthesis statements, categories, and sub-categories were discussed with the second and third authors, to gain consensus on their validity.

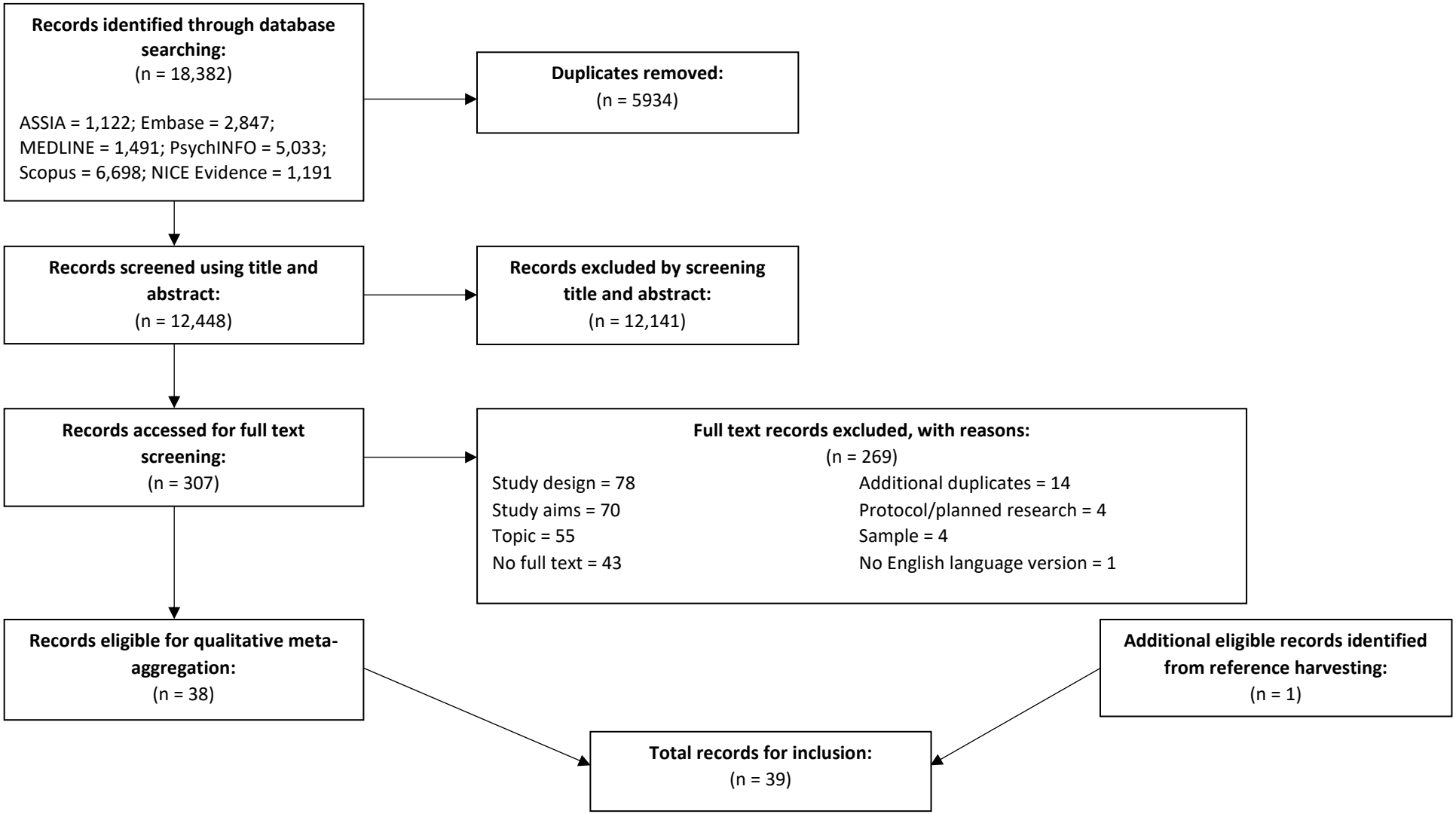
3.4: Results

Study selection and characteristics:

The review process yielded 38 eligible studies from the 12,448 that were gathered from initial searches. One additional study was identified through manual checking of the reference lists of eligible studies, bringing the total number of included studies to 39. *Figure 3.2* is the PRISMA flowchart showing the number of studies retained and excluded at each stage of the review process.

The characteristics of the 39 studies can be found in *Table 3.2* within *Appendix 1.* Fifteen of the studies were conducted in the USA (38%), seven in the UK (18%), and six in Australia (15%). The remaining eleven studies were conducted in nine other countries, including Canada, India, Ethiopia, and Haiti. 20 studies involved training programmes undertaken by allied professionals, with 14 involving mental health trained professionals, and five using a mixed sample. Only two studies involved trainers as participants, with 37 involving trainees.

Figure 3.2: *PRISMA flow diagram illustrating the process of study identification*



Quality appraisal results:

Using the JBI Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015), each paper was scored out of 10 for quality. Each paper was then categorised into the ranks "low" (scores of 0-3); "moderate" (scores of 4-7); and "high" (scores of 8-10). 10% (n=4) of the 39 papers were rated as low quality, 64% (n=25) were rated as moderate quality, and 26% (n=10) were rated as high quality. The precise score and rank assigned to each paper can be found in *Table 3.2* within *Appendix 1*. Dissertations and theses tended to score higher, presumably owing to a more generous word count than peer-reviewed journal articles.

No papers were excluded from the synthesis on the basis of this appraisal. They key reason for that decision was the observation that certain items almost universally scored poorly. For example, only six of the 39 papers stated a philosophical perspective, and only five gave an indication of the researchers' cultural or theoretical position. Other studies have found a similar pattern (McInnes & Wimpenny, 2008). An explanation for this could be that studies in the healthcare field are often guided by pragmatic rather than philosophical or theoretical concerns (McInnes & Wimpenny, 2008). Failing to report such standpoints does not necessarily undermine the utility of the study's findings; however, the remainder of the items, such as declaring the study's ethical approval, were deemed important quality indicators. Consequently, the results of the critical appraisal were not discounted entirely, and were considered when deciding how to organise, and proportionally draw from, the results of the synthesis.

Level of credibility:

The meta-aggregation method stipulates that a level of credibility should be assigned to each finding (Lockwood et al., 2015). Consequently, after each finding was extracted, a supporting verbatim quotation was sought. Based on these illustrative quotations, the findings were categorised as "unequivocal", meaning that the drawn conclusion reflects, beyond reasonable doubt, the views of the participant, or "equivocal", meaning that although an association between the illustration and the finding can be deduced, the association is tenuous, or open to interpretation (Lockwood et al., 2015). As the guidance suggests, findings rated

unequivocal and equivocal were given equal recognition in the current synthesis. However, findings where a supporting quotation was not available were rated "unsupported" and were consequently excluded from analysis. The process of assigning credibility ensures that participant voices are adequately represented by the authors' interpretations, and that these interpretations are made transparent (Lockwood et al., 2015).

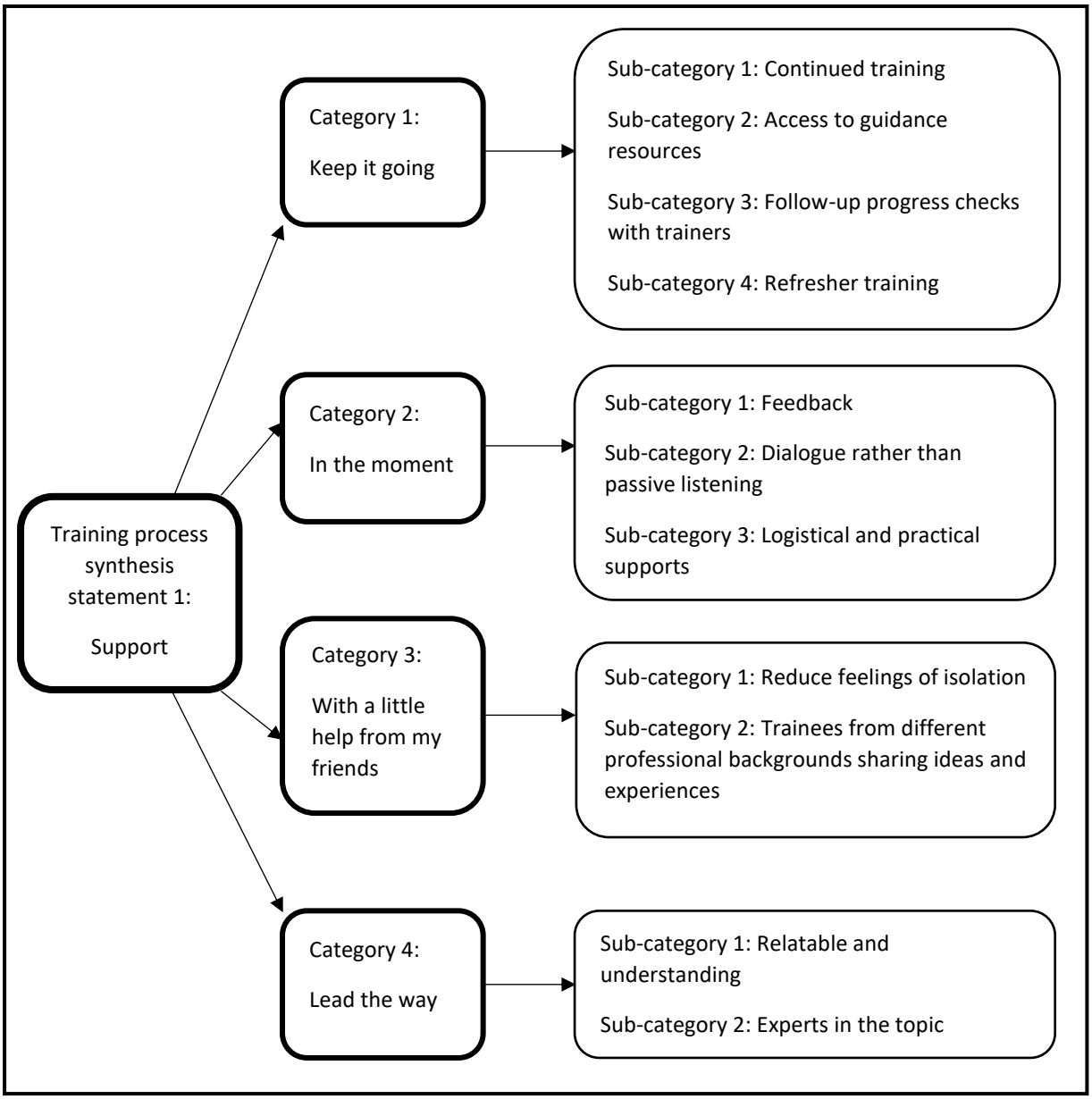
Synthesised findings:

230 raw findings were extracted from the 39 papers. When those rated "unsupported" in terms of credibility were removed, 182 raw findings remained. Then began the process of condensing and synthesising. As discussed earlier, longer findings were broken down and assigned more than one condensed finding, resulting in 219 condensed findings. These were summarised further into 47 sub-categories, 19 categories, and finally 5 synthesis statements. 12 of the 39 studies included barriers and facilitators relating solely to the training process itself, with 6 dedicated to discussing the implementation of training in the workplace. 21 studies discussed a mixture of both factors. Before synthesis, the raw findings were divided based on whether they related to training or implementation. The synthesis consequently produced two synthesis statements relating to the training process, and three relating to implementation. Three factors were taken into account, equally and in combination, when deciding how to order and present the data below. Priority and emphasis has been given to synthesis statements, categories, and sub-categories that a) score highest for quality; b) represent the greatest number of papers; and c) best represent both mental health and allied professionals. This means that within each overarching synthesis statement group ("training process" and "implementation"), the synthesis statements and categories will be discussed, and displayed in the accompanying figures, in order of strength based upon these three considerations.

Training process – synthesis statement 1: Support

Professionals identified support as a vital part of the training process. This statement reflects the synthesis of four categories (*Figure 3.3).*

Figure 3.3: *Training process – synthesis statement 1: Support*



Category 1: Keep it going

The strongest category of findings in this synthesis statement was the idea that support should continue beyond the duration of the training programme. The desire for continued or additional training was frequently mentioned. Further training could build on already acquired knowledge or skills (Eustache et al., 2017), or help imbed the knowledge into practice by maintaining familiarity and enthusiasm (Grant et al., 2016). Indeed, providing follow-up training may maximise the future gains of the training in terms of future sustainability (Bryson & Ostmeyer 2014). “Refresher training” could be offered, taking place on a regular, scheduled

basis (Omigbodun et al., 2007), so that trainees do not forget what they have learned (Grant et al., 2016) or lose confidence. The latter is a concern when training is used irregularly (Killick & Allen, 2006), or when many conflicting demands are present within the workplace (Donald, 2015).

Having access to guidance resources such as manuals or handbooks (Drahota et al., 2014; Tchernegovski et al., 2015), was reported as a valuable supportive tool, along with shared learning resources (Gonzalez et al., 2019), or practical documents to use with clients (Tchernegovski et al., 2015). Participants were reassured by having materials to refer to, and monitor their own usage of the training (Donald, 2015).

Ongoing dialogue with trainers would also have been welcomed, to talk through progress, acquire feedback (Tchernegovski et al., 2015), and to feel supported in their efforts to implement their training efficiently (Christie et al., 2013). Routine progress checks should therefore be offered (Heyeres et al., 2019), plus a recourse for trainees to informally connect with trainers (Drahota et al., 2014; Sherwin, 2014).

Category 2: In the moment

Support should also be provided whilst training is taking place. Feedback should be given, and it is important that this feedback is personalised. This sense of individual guidance can boost skill development (Drahota et al., 2014), with timely constructive criticism viewed as helpful (Donald, 2015). Live supervision with immediate feedback during practical training is seen as a comforting support, and this method of learning is preferable to watching recorded sessions (Post et al., 2020)

Linked to the latter observation, training sessions should allow open discussion between trainers and trainees: preferred over a lecture format (Askell-Williams & Murray-Harvey, 2016; Harris, 2013). Trainees appreciate being listened to (Harris, 2013), with sufficient time spent within a group format to allow time for this (Grant et al., 2016).

Logistical and practical supports should also be taken into consideration. Training should be held in a suitable venue. As an example, trainees found it

difficult to hear in a large room (Wu et al., 2019). Training should ideally be free to undertake (Tchernegovski et al., 2015), with financial support offered if travel is necessary (Eustache et al., 2017).

Category 3: With a little help from my friends

The importance of peer support was frequently highlighted. Training that facilitates interaction with peers, whether face-to-face or online, can reduce feelings of isolation (Bazyk et al., 2015); with one participant describing the bonds they formed as almost familial (Dababnah et al., 2019). Building a support network that may have been missing before (Bazyk et al., 2015) can be especially beneficial in terms of normalising the difficult emotions associated with certain professions (Grant et al., 2016), creating the sense that they are "all in this together" (Askell-Williams & Murray-Harvey, 2016, p. 203).

Sharing ideas with professionals from a wide range of backgrounds was often reported as helpful. Learning is facilitated (Lusk et al., 2018) by allowing trainees to hear others' experiences and take away new insights and ideas that can then be applied to their own practice (Coiro et al., 2016). It also provides valuable experience in working and collaborating with diverse teams of people (Dunsmuir et al., 2017).

Category 4: Lead the way

This category grouped findings pertaining to the ideal personal qualities of trainers. Firstly, trainers should be aware of their trainee audience, possessing insight into their roles and circumstances. They can then provide tailored, specific guidance (Wu et al., 2019). They should also be mindful of the varying levels of background knowledge and experience the trainees might have, especially when training an assortment of professionals. Nurses and teachers, for example, are likely to approach the training from very different perspectives (McAllister et al., 2019). This high level of understanding should make the trainer relatable and approachable should trainees wish to ask questions (Harris, 2013).

Trainers should also be experts in the topic they are delivering: learning is best facilitated by a high quality trainer (Askell-Williams & Murray-Harvey, 2016;

McAllister et al., 2019) who is knowledgeable and passionate about the subject matter (Bond & Dogaru, 2019). Indeed, a lack of expertise can limit the potential of the training, influencing its subsequent transfer to practice (Gonzalez et al., 2019).

Training process – synthesis statement 2: Training content, design, and planning:
Six categories were identified, encompassing the nature of the training programmes themselves (*Figure 3.4)*. This synthesis statement provides recommendations for what training should ideally offer.

Category 1: Light a fire

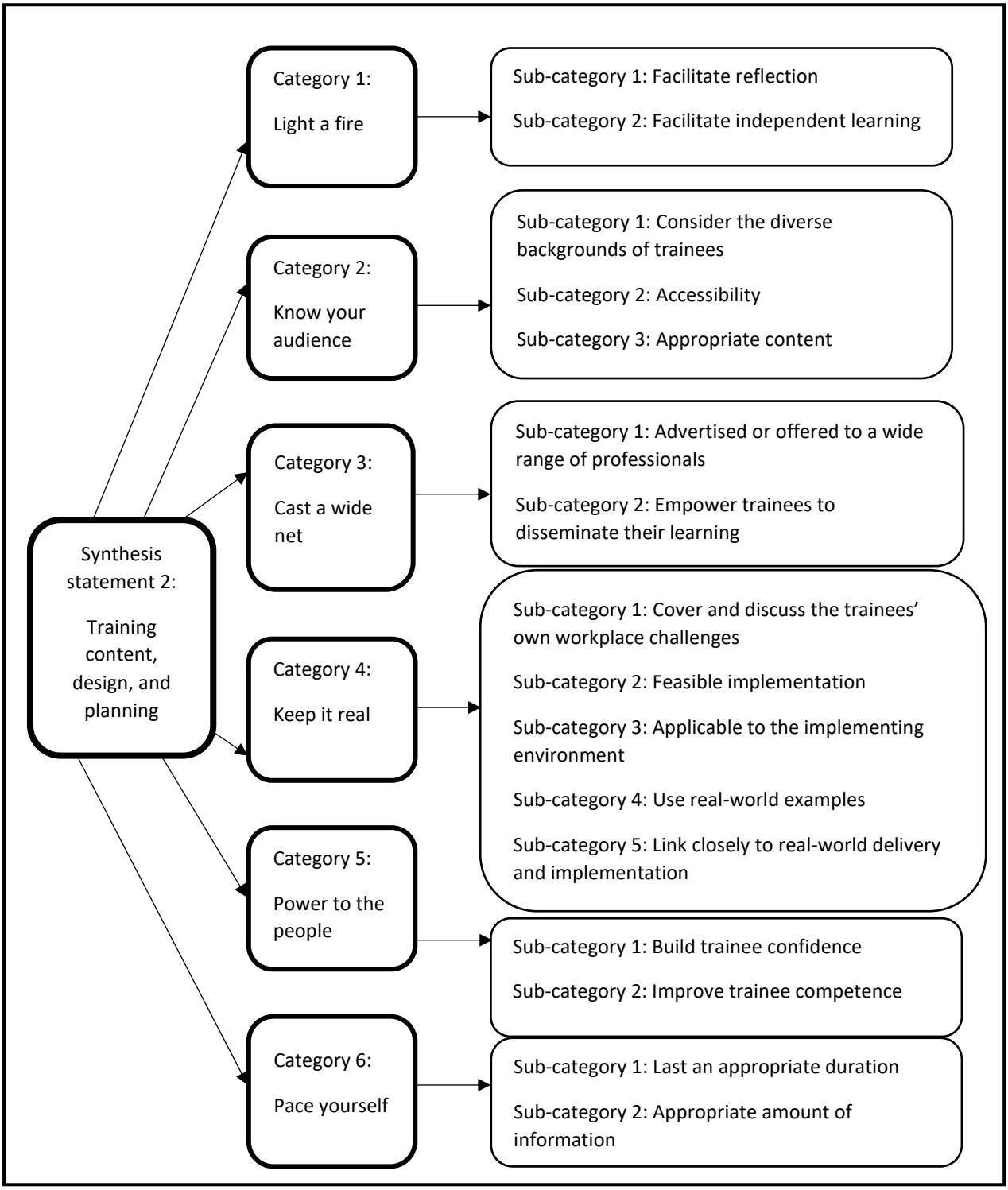
Training should act as a catalyst for further reflection and learning. It should be thought provoking (Manning et al., 2017) actively promoting introspection on one's own practice (Bazyk et al., 2015). Challenging one's own preconceptions in this manner can build compassion towards clients (Manning et al., 2017): crucial in a mental health context. Trainees were also encouraged to view their role with a wider lens, in terms of how their work fits in with other services (Bazyk et al., 2015), how important their role is (Askell-Williams & Murray-Harvey, 2016) or enlightening them as to the scope of the issues at hand (Bond & Dogaru, 2019).

Training should also provide a solid foundation for independent learning, helping trainees to become active in their own skill acquisition (Dunsmuir et al., 2017). One way to promote this is by limiting the amount of information available at the outset of training, allowing space for reflection and mistakes (Donald, 2015). Although time-consuming, this may be an effective method of knowledge consolidation.

Category 2: Know your audience

Training should be suitable for its target group of trainees. Firstly, diversity should be borne in mind when designing training. The literature highlighted potential language barriers, especially if a significant proportion of trainees speak the language of instruction as a second language (Tilahun et al., 2017), and the importance of respecting cultural sensitivities (Eustache et al., 2017). At a professional level, if trainees come from a diverse range of professional

***Figure 3.4**: Training process – synthesis statement 2: Training content, design, and planning*



backgrounds, it may be pertinent to provide separate, tailored training, ensuring that content is relevant and accessible by all (Wu et al., 2019).

Accessibility is an important concept to explore further. Training information should be easy to understand (Askell-Williams & Murray-Harvey, 2016); unclear language or jargon should be thoroughly explained (Gonzalez et al., 2019). Special

attention should be given to supporting those using online or digital materials (Tchernegovski et al., 2015). Varying activities is seen as positive, as it caters for a wider range of preferences and strengths (McAllister et al., 2019), and scaffolding between training stages, so that skills build upon each other, is a helpful way of ensuring understanding (Donald, 2015).

Taking diversity and accessibility into consideration, a more general observation is that the training content itself should be appropriate. The level of difficulty should be appropriate, as it is frustrating for trainees when they are already familiar with the content (Lee, 2016). Good communication should exist between trainers: their agreement on what needs to be covered (Gonzalez et al., 2019) should ensure comprehensive yet relevant coverage (Tchernegovski et al., 2015).

Category 3: Cast a wide net

Training should be offered to as wide a range of relevant professionals as possible, to ensure consistency of approach when dealing with CYP mental health (Wu et al., 2019). For example, teachers attending one training programme suggested that it should be offered to other professional groups, such as the police, so that help can be sought anywhere (Eustache et al., 2017). Expanding training in this way can also promote cross-professional idea sharing (Omigbodun et al., 2007). In addition, raising awareness of CYP mental health training and interventions by educating the general public may further widen the impact of such programmes (Omigbodun et al., 2007).

Dissemination of acquired knowledge to others through trainees is another important way to extend the reach of training. Training programmes should therefore empower trainees to confidently disseminate their knowledge (Omigbodun et al., 2007), or train others back in their workplace (K. Jones & Howley, 2010)

Category 4: Keep it real

Training should tie in closely with the reality of the environment in which it is due to be implemented. Trainees appreciated the chance to raise and discuss the

specific challenges they were facing at work, which they valued more than studying pre-prepared examples (Harris, 2013) or theoretical overviews (Blackburn et al., 2016; Bryson & Ostmeyer, 2014). Discussion of real-world issues can build empathy towards clients (Askell-Williams & Murray-Harvey, 2016), especially when explored through multiple perspectives (Bond & Dogaru, 2019)

The workplace application of training should be as feasible as possible for maximum impact. Elements of training were seen as unhelpful if delivery simply would not work "on the ground", due to, for example, time constraints (Tchernegovski et al., 2015). Extra care should be taken with interventions that were designed in research settings, to ensure that they are adaptable to local realities (Gonzalez et al., 2019). Immediate practical application of skills leads to training being viewed positively, as well as maximising its effectiveness (Bazyk et al., 2015). Additionally, training should be delivered at a pertinent time, for example at a suitable point in the school year (Wu et al., 2019), or when a particular issue is salient.

Learning should be directly relevant to practical implementation (McAllister et al., 2019): a lack of clarity on how to apply training is a clear barrier (Wu et al., 2019). It follows that guiding trainees through the practical application of training, and how to overcome the possible dilemmas faced, would be appreciated (Davies & Ray, 2014).

Category 5: Power to the people

Building staff confidence, knowledge, and competence can improve workplace capability (Dunsmuir et al., 2017). Several studies reported that training improved trainee confidence (Dame, 2016; Manning et al., 2017). It can do this through reducing anxiety (Grant et al., 2016) and reassuring them that they are already doing well (K. Jones & Howley, 2010), ultimately building faith in their own abilities (Bazyk et al., 2015). Training should also teach a solutions-focussed way of thinking that allows trainees to face challenges pragmatically (Grant et al., 2016).

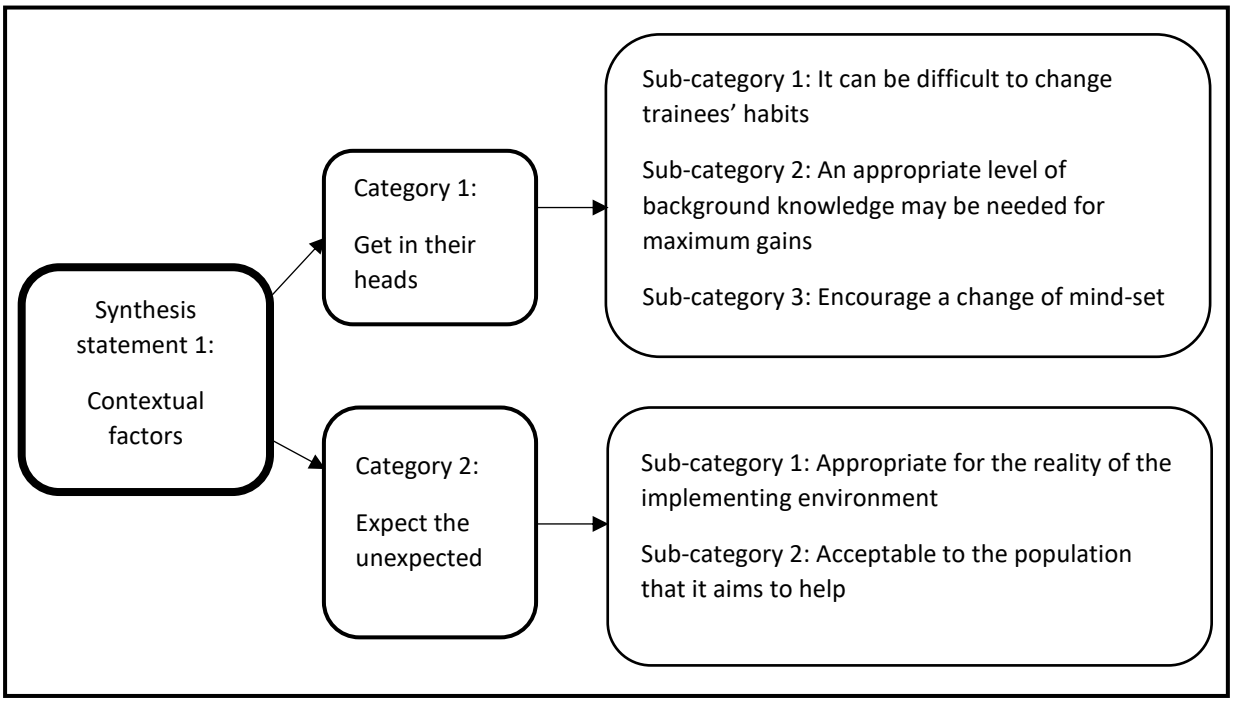
Category 6: Pace yourself

The pacing of training should be considered. Long sessions can be overwhelming (McAllister et al., 2019), so regular breaks should be given to avoid fatigue (Eustache et al., 2017). The coverage of multiple topics, however, should be undertaken in longer or multiple sessions, so sufficient time can be given to each (Omigbodun et al., 2007) building a fuller understanding (Askell-Williams & Murray-Harvey, 2016).

Implementation – synthesis statement 1: Contextual factors

This synthesis statement explores the barriers and facilitators underpinning successful workplace implementation of training. It comprises two categories *(Figure 3.5).*

***Figure 3.5**: Implementation – synthesis statement 1: Contextual factors*



Category 1: Get in their heads

Changing habits and mind-sets of trainees can be difficult. This can influence how seamlessly training becomes embedded into daily practice. Trainees are often used to carrying out their work in a particular way (Donald, 2015), and changes can be

stressful for both staff and clients (Sherwin, 2014). Training should therefore encourage a change of mind-set by actively challenging existing views and prejudices (Manning et al., 2017), and helping organisations to overwrite out-dated beliefs and practices (D'Oosterlinck et al., 2009). Fortunately, one study suggested that reframing knowledge, (in this example, trainees were taught to imagine mental health as a continuum rather than as "health" versus "illness"), can happen quickly when this is facilitated effectively in training (Bazyk et al., 2015).

For successful implementation, familiarity with the trained intervention must reach a certain level, in order to meaningfully learn and apply the information. Using simple language, and thorough explanations of basic concepts, can aid their understanding (Lee, 2016). For this reason, implementation often happens "bit by bit", with gradual benefits (Wu et al., 2019).

Category 2: Expect the unexpected

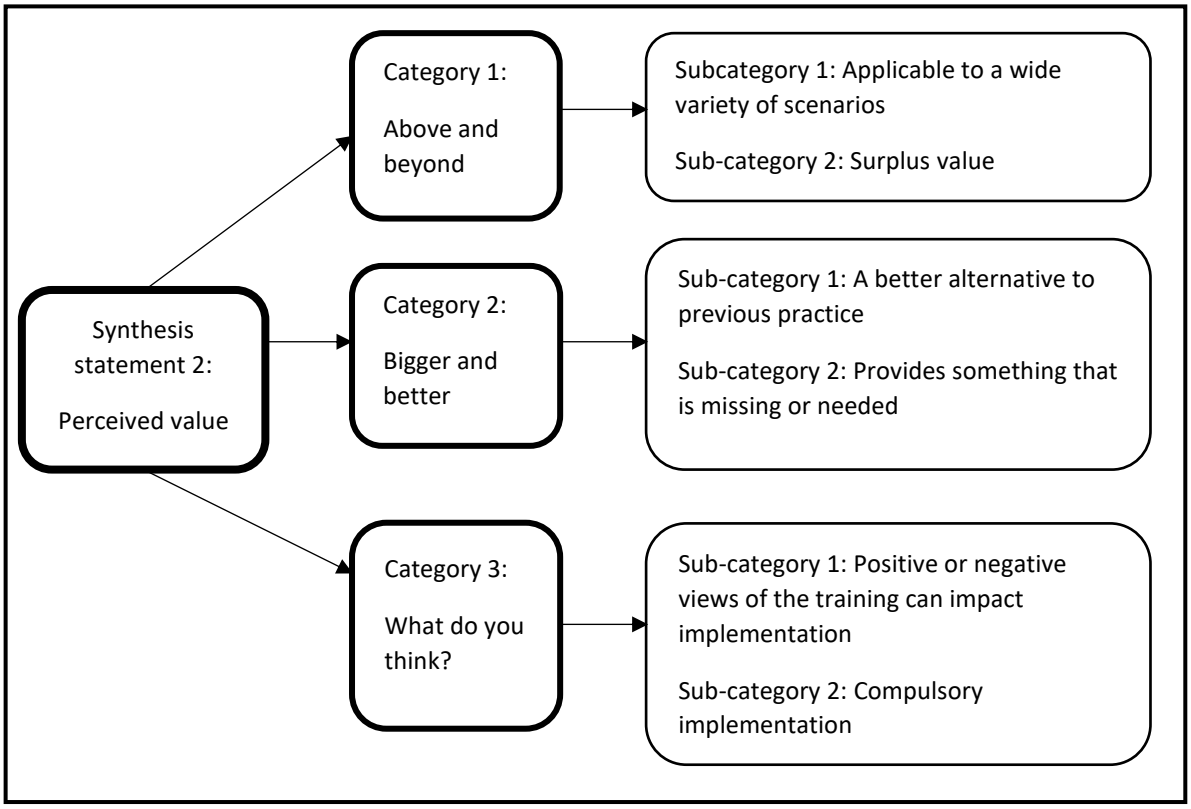
This category suggests that implementation should be flexible enough to use in real workplaces - contexts that are diverse and unpredictable by nature. CYP mental health training in particular must be flexible enough to apply to clients' unique therapeutic needs (Bazyk et al., 2015). If training fails to consider these diverse needs and contexts, it can be difficult to apply it (D'Oosterlinck et al., 2009; Wu et al., 2019). One study, for example, reported challenges with applying an intervention ill-suited for children with communication problems (Dababnah et al., 2019). Another reported concerns about using aggression management with physically larger adolescents (Killick & Allen, 2006). Additionally, implementations should be flexible enough to provide value to all targeted organisations, in terms of client age group (Wu et al., 2019) or special needs status (Harris, 2013).

Training should also consider the various ways of working and therapeutic styles of staff, perhaps suggesting multiple usage strategies (Tchernegovski et al., 2015): providing such flexibility can improve acceptability. Cultural and religious beliefs held by certain populations may influence how receptive clients and their families are to treatments, and financial problems may also limit suitability (Tilahun et al., 2017). Adapting the training content to suit the targeted population may alleviate these issues.

Implementation – synthesis statement 2: Perceived value

This statement consolidates three categories *(Figure 3.6)* that discuss trainees' attitudes towards the training, and how these can influence their ability to implement the skills at work.

***Figure 3.6**: Implementation – synthesis statement 2: Perceived value*



Category 1: Above and beyond

If trainees perceive that the skills they have learned can be applied widely to their work, successful implementation is more likely. For example, training can boost staff confidence when dealing with a wider range of clients than usual (Bazyk et al., 2015). If staff members view the training as having wide value, they are also more likely to recommend it to others, increasing its reach (Dababnah et al., 2019).

The wide application of training feeds into the idea that training can sometimes provide the skills needed to work with a broader range of people or scenarios than it originally intended. Training that goes "above and beyond" in this manner can be said to have surplus value, and is generally viewed favourably by trainees. They appreciate being able to apply training to all CYP they encounter at

work, not solely those the training was aimed at (Dababnah et al., 2019), and some reported gaining skills that could be applied to their family or community lives, as well as at work (D'Oosterlinck et al., 2009; Eustache et al., 2017).

Category 2: Bigger and better

Trainees should view their learning as a strong alternative to systems or procedures that are already in practice. It should enable them to handle situations in a stronger, more effective way (Post et al., 2020), providing feasible alternatives that are especially valued when current methods are viewed negatively. For example, staff in one study appreciated being taught alternative methods that helped them avoid restraining or medicating patients (Blackburn et al., 2016).

Training that provides something that is missing or needed in the workplace may result in better implementation. This perceived need can build enthusiasm, which may encourage implementation (Donald, 2015; Leventhal et al., 2018). Trainees commonly reported that training provided a structure to lean on, which they felt was missing previously. These structures can provide focus to therapy sessions, allowing them to target specific behaviours or issues (Drahota et al., 2014). This was greatly appreciated by those working in high-pressured, conflict-heavy situations (D'Oosterlinck et al., 2009).

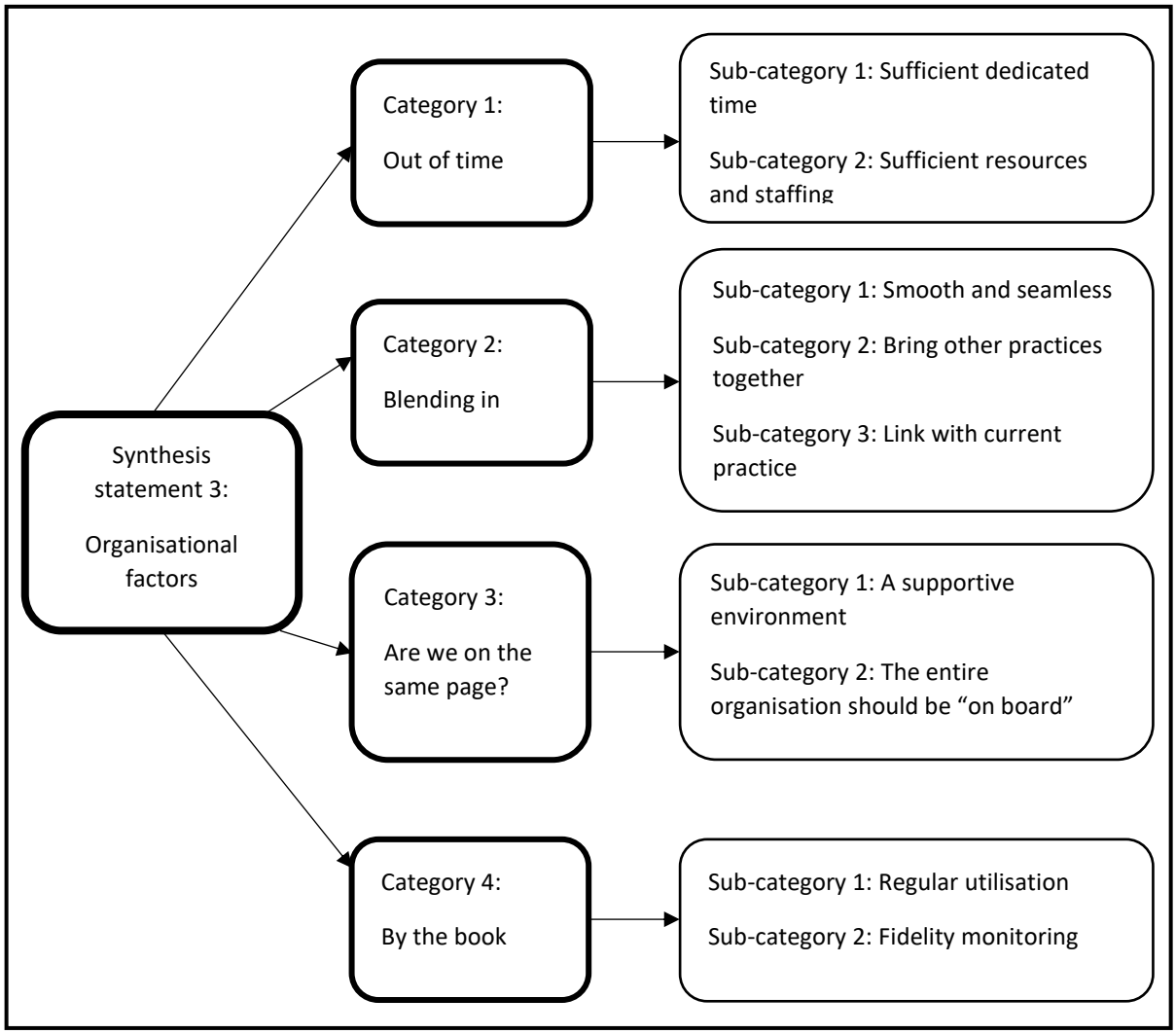
Category 3: What do you think?

Related to the previous category, it was found that trainees' attitudes towards the training were important. If the implementing organisation or workplace views the training as valuable, implementation will be more likely. One study reported that time, effort, and resources were dedicated to implementation because the training was well recognised, and perceived as valuable (K. Jones & Howley, 2010). Another study reported that mandating implementation following training encourages change (Tchernegovski et al., 2015). On the other side of the coin, hearing negative information about training programmes from colleagues can reduce receptiveness to both attending and implementing the training (Wu et al., 2019).

Implementation – synthesis statement 3: Organisational factors

The final synthesis statement relates to factors within the implementing organisation, which were suggested as influential to the success of application. It involved the synthesis of four categories *(Figure 3.7).*

***Figure 3.7**: Implementation – synthesis statement 3: Organisational factors*



Category 1: Out of time

Resource availability appears to be an important predictor of training implementation. A key resource is time, a lack of which can limit the sustainability of training gains (Bryson & Ostmeyer, 2014). Trainees reported challenges with finding time to utilise the training, struggling to embed it into a busy schedule with conflicting demands (Blackburn et al., 2016). These demands often take priority, meaning that the training does not get used (D'Oosterlinck et al., 2009). There are

therefore several recommendations that warrant attention. The time constraints of each workplace should be considered to assess feasibility (Adelman, 2014), namely how it will fit into schedules that are often rigid (Gonzalez et al., 2019). Logistical factors, such as time spent preparing rooms, should also be factored in (K. Jones & Howley, 2010), along with the fact that extra time may be needed at the beginning, to account for the concentration and precision needed to simultaneously learn and implement (Dababnah et al., 2019). Whether an organisation has sufficient and appropriate physical resources, such as equipment and space, are also vital if training can be implemented to its full potential (Dababnah et al., 2019), along with staffing levels (D'Oosterlinck et al., 2009), and consideration of how implementation will fare in the face of absenteeism (Leventhal et al., 2018).

Category 2: Blending in

Implementation should be as smooth and seamless as possible. New processes should not be clunky and cumbersome to implement, rather they should feel natural to use in the workplace (David & Schiff, 2018). Ideally, implementation should align well with the ideologies and attitudes that are held by organisations (Dunsmuir et al., 2017): trainees are more likely to use skills if a large deviation in their way of thinking is not required. In addition, if trainees are able to see an overlap between the training and skills that they already use, the consistency is appreciated (Drahota et al., 2014). Indeed, a good training programme could help unify other learnings and sources (Heyeres et al., 2019) that previously seemed distinct and isolated (Drahota et al., 2014).

Category 3: Are we on the same page?

The idea of a cohesive workplace, where the entire organisation is "on board" with implementation, was evidenced as important. Trainees mentioned that implementation was simplified because all staff in their organisation were trained. The way they interacted with CYP was therefore consistent (Wu et al., 2019). This sentiment was echoed by a trainee in another study, who wished that all staff members in their workplace were at least aware of the intervention (Donald, 2015). Explaining, or justifying the use of, new skills can prove challenging when others are

not aware of them (Donald, 2015). In summary, if everybody is "on the same page" (Jolivette et al., 2014, p. 76), implementation goals are more likely to be met.

It follows that a supportive workplace is the ideal environment for implementation. Trainees mentioned that the support of senior staff in their organisation was of vital importance (Wu et al., 2019), and although the challenges of implementation can be overcome by a small number of motivated individuals, it can be extremely difficult without helpful, supportive colleagues (Leventhal et al., 2018).

Category 4: By the book

This category combined a small number of findings relating to implementation fidelity. For maximum gain, implementation should adhere as closely as possible to the model stipulated within training guidance. To ensure high fidelity, monitoring may be necessary. This could be facilitated by additional trainer support, especially when trainees express concern about whether they are implementing skills correctly (Grant et al., 2016). Regular use of training is also vital. If trainees do not have an opportunity to use the new skills, for whatever reason, their confidence will decline, resulting in a further reduction of use (Killick & Allen, 2006).

3.5: Discussion

Summary:

This systematic review and qualitative meta-aggregation sought to investigate the experiences of mental health and allied professionals, who undertook training relating to the mental health of CYP. Specifically, it aimed to identify the barriers and facilitators that these professionals reported as having hindered or helped them during the training process, and in the subsequent implementation of the trained skills back in the workplace. To our knowledge, this is the first review of training experiences that focuses solely on those who work with CYP, and that synthesises literature pertaining to both mental health *and* allied professionals. It is hoped that the review will provide accessible and organised guidance for those designing and delivering training, as well as for leaders within implementing workplaces who desire to make the training that their employees receive as effective as possible.

Literature that qualitatively explored these barriers and facilitators was identified systematically, and the resulting 39 papers were synthesised using meta-aggregation: a method used to develop practical, directive action points that are a synthesised version of the authors' original intended meanings (Lockwood et al., 2015). Two synthesis statements relating to the training process, and three relating to workplace implementation, were identified. Support from peers and trainers, both during and after training were seen as vital for maximisation of training gains, as were several qualities of the training itself, such as reach, pacing, and suitability. The success of implementation in the workplace depended firstly upon contextual factors, including the prior knowledge and habits of trainees, and the applicability of new skills to unpredictable workplace scenarios. Secondly, perceived value was seen as important, in terms of both broad worth, and whether it provided a better alternative to current practice. Finally, qualities within the organisation itself, such as available resources, workplace cohesiveness, and the potential for implementation fidelity, were notable.

At first glance, the findings of the review are unlikely to cause a great deal of surprise, and may be seen as "common-sense" principles. However, since the review collates the voices of those very professionals that it aims to produce guidance for, this review provides strong evidence-based backing to principles that, as evidenced in the literature, resonate widely. It ties widely appreciated qualities into a coherent and organised framework, giving structure for the reader, and more importantly, providing an accessible resource for those involved in training delivery or implementation.

Guidance for use:

Some of the recommendations, for instance that feelings of support and empowerment should emanate from training, can be applied almost universally to any training or implementation scenario. However, it should also be pointed out that not all recommendations are suitable for every training programme or organisation. It is expected, therefore, that those using the review will choose recommendations that are suitable within their own context. For example, whilst a training programme that allows flexible implementation could be extremely useful

when broad application to a large range of CYP is desired, for training that is very specific by nature, perhaps only destined for use within a niche area of mental health, this is not a relevant recommendation. This idea is also evidenced by the fact that some categories seem to contradict one another. The category “get in their heads” recommends that if successful implementation is to occur, training should challenge trainees’ existing views by reframing knowledge, and challenging out-dated beliefs. Conversely, the category “blending in” suggests that a large deviation in thinking should not be required. Although these findings appear to oppose one another, users can strike their own balance between the two, again depending on their own contexts and requirements. Indeed, “get in their heads” points out that implementation often happens gradually as mind-sets adapt, which could be borne in mind as an idea that bridges the gap between the two recommendations. Whilst change is important, perhaps it does not need to happen instantly. Another similar example is the suggestion that training should be able to be implemented flexibly (“expect the unexpected”) but also with fidelity (“by the book”). Whilst some empirical studies have found that implementation fidelity does predict its long-term sustainability (McIntosh et al., 2018), over-rigid programme adherence might be detrimental (Mazzucchelli & Sanders, 2010). Whilst a training intervention should remain recognisable in spite of any adaptations, inflexibility can result in a close-minded culture that is reluctant to integrate better practices (Stirman et al., 2012). This again suggests the importance of balance, and of contemplating the intricacies of each training situation when considering the recommendations in this review.

Some categories also appear to cover similar content. “Expect the unexpected” and “above and beyond”, for example, both refer to the wide applicability of training to multiple scenarios, despite falling under separate synthesis statements. This owes to the fact that the findings of “expect the unexpected” relate to the context of the implementing workplace and the influencing factors within it, whereas those forming “above and beyond” are discussions of participants’ perceptions of the training’s personal value. Thus, they were categorised and synthesised according to how the participants framed their observations.

Strengths and limitations:

As *Figure 3.2* shows, this is a comprehensive review. Over 12,000 titles and abstracts were screened, which were eventually narrowed down to 39 eligible papers. Regarding the state of the field, we reported that only 10 of these papers were classified as "high quality" using the JBI Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015), however 25 were marked as "moderate quality". As discussed, the varying relevance of the items in the appraisal tool led to the inclusion of all papers. However, the scores were utilised alongside volume of evidence, and professional representation when constructing the results section, in order to organise and emphasise the findings. This led to the development of strong, evidence-based principles, presented based upon an intersection of quality, frequency, utility, and representativeness.

Meta-aggregation is occasionally discounted as a valid method of meta-synthesis. A critical paper accuses the method of turning "rich descriptions into thin abstractions" (Bergdahl, 2019, p. 7), and noted a lack of re-interpretation and generation of new theories. However, given that the aim of this review was to generate practical statements to guide change, a reliable collation of study findings, presented as intended (Lockwood et al., 2015), was undoubtedly useful. This aim negates the need for new, overarching interpretations to be made.

Meta-aggregation is the only qualitative meta-synthesis method that aligns with the philosophical approach of pragmatism (Hannes & Lockwood, 2011). Akin to all qualitative synthesis methods, it can come under scrutiny for not producing entirely replicable results, and although meta-aggregation is the most practical, structured form of qualitative meta-synthesis (Hannes & Lockwood, 2011), the process still involves a level of subjectivity that would not occur in quantitative work. Perhaps a different set of synthesis statements and categories may have been produced had the process been conducted by a different set of authors. Despite this, we tend to agree with the stance that although an identical level of rigour should be applied to both qualitative and quantitative syntheses, transparency should be the ultimate goal when presenting the former, rather than reproducibility (Bearman & Dawson, 2013). The essence of qualitative synthesis lies in "making structured judgements" (Bearman & Dawson, 2013, p. 258), and

providing that the framework underpinning the authors' thought processes is made transparent, the judgement outcomes do not need to be replicable. We hope that this has been achieved in this review.

3.6: Conclusions

Five synthesis statements were produced using qualitative meta-aggregation. Two of these related to the process of training and its delivery, and three related to the implementation of the training back in the workplace. The synthesis statements, and underlying categories, provide practical recommendations for those designing, delivering, or implementing CYP mental health training, with a range of both mental health, and allied, professionals. They can be used to improve training content and delivery, and to maximise gains during implementation. The review provides a strong evidence-based foundation to "common-sense" principles, drawing them into a coherent and organised framework using a synthesis method grounded in pragmatism.

3.7: References

Adelman, A. S. (2014). *Structured observation as a professional development tool to prepare teachers for observing social responsiveness in preschool students with autism spectrum disorder (Doctoral dissertation)*. University of Miami.

Aebi, M., Giger, J., Plattner, B., Metzke, C. W., & Steinhausen, H. C. (2014). Problem coping skills, psychosocial adversities and mental health problems in children and adolescents as predictors of criminal outcomes in young adulthood. *European Journal of Child & Adolescent Psychiatry*, *23*(5), 283–293. https://doi.org/10.1007/s00787-013-0458-y

Askell-Williams, H., & Murray-Harvey, R. (2016). Sustainable professional learning for early childhood educators: Lessons from an Australia-wide mental health promotion initiative. *Journal of Early Childood Research*, *14*(2), 196–210. https://doi.org/10.1177/1476718X15570958

Ayorinde, A. A., Williams, I., Mannion, R., Song, F., Skrybant, M., Lilford, R. J., & Chen, Y. F. (2020). Assessment of publication bias and outcome reporting bias in systematic reviews of health services and delivery research: A meta-

epidemiological study. *PloS One*, *15*(1). https://doi.org/10.1371/journal.pone.0227580

Banwell, E., Humphrey, N., & Qualter, P. (2021). Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation. *BMC Medical Education*, *21*(1), 103. https://doi.org/10.1186/s12909-021-02530-0

Bassilios, B., Nicholas, A., Ftanou, M., Fletcher, J., Reifels, L., King, K., Machlin, A., & Pirkis, J. (2017). Implementing a primary mental health service for children: Administrator and provider perspectives. *Journal of Child and Family Studies*, *26*(2), 497–510.

Bazyk, S., Demirjian, L., LaGuardia, T., Thompson-Repas, K., Conway, C., & Michaud, P. (2015). Building Capacity of Occupational Therapy Practitioners to Address the Mental Health Needs of Children and Youth: A Mixed-Methods Study of Knowledge Translation. *American Journal of Occupational Therapy*, *69*(6). https://doi.org/10.5014/ajot.2015.019182

Bearman, M., & Dawson, P. (2013). Qualitative synthesis and systematic review in health professions education. *Medical Education*, *47*(3), 252–260. https://doi.org/10.1111/medu.12092

Beidas, R. S., & Kendall, P. C. (Eds.). (2014). *Dissemination and implementation of evidence-based practices in child and adolescent mental health*. Oxford University Press.

Belfer, M. L. (2008). Child and adolescent mental disorders: The magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry*, *49*(3), 226–236. https://doi.org/10.1111/j.1469-7610.2007.01855.x

Bergdahl, E. (2019). Is meta-synthesis turning rich descriptions into thin reductions? A criticism of meta-aggregation as a form of qualitative synthesis. *Nursing Inquiry*, *26*(1). https://doi.org/10.1111/nin.12273

Blackburn, J., McKenna, B., Jackson, B., Hitch, D., Benitez, J., & McLennan, C. (2016). Educating Mental Health Clinicians About Sensory Modulation to Enhance

Clinical Practice in a Youth Acute Inpatient Mental Health Unit: A Feasibility Study. *Issues in Mental Health Nursing*, *37*(7), 517–525. https://doi.org/10.1080/01612840.2016.1184361

Boland, A., Cherry, M., & Dickson, R. (2017). *Doing a systematic review: A student's guide* (2nd ed.). SAGE.

Bond, E., & Dogaru, C. (2019). An Evaluation of an Inter-Disciplinary Training Programme for Professionals to Support Children and Their Families Who Have Been Sexually Abused Online. *British Journal of Social Work*, *49*(3), 577–594. https://doi.org/10.1093/bjsw/bcy075

Bryson, S. A., & Ostmeyer, K. F. (2014). Increasing the Effectiveness of Community Mental Health Center Social Skills Groups for Children with Autism Spectrum Disorder: A Training and Consultation Example. *Administration and Policy in Mental Health*, *41*(6), 808–821. https://doi.org/10.1007/s10488-013-0533-1

Centre for Mental Health. (2010). *Centre for Mental Health. The economic and social costs of mental health problems in 2009/10*. Centre for Mental Health. http://www.ohrn.nhs.uk/resource/policy/EconomicandSocialcostofMI.pdf.

Christie, G., Black, S., Dunbar, L., Pulford, J., & Wheeler, A. (2013). Attitudes, skills and knowledge change in child and adolescent mental health workers following AOD screening and brief intervention training. *International Journal of Mental Health and Addiction*, *11*(2), 232–246. https://doi.org/10.1007/s11469-012-9414-1

Coiro, M. J., Kotchick, B. A., & Preis, J. (2016). Youth social skills groups: A training platform for promoting graduate clinician interprofessional competence. *Journal of Interprofessional Education Practice*, *4*, 89–92. https://doi.org/10.1016/j.xjep.2016.04.004

Community Practitioner. (2016). Community Practitioner. Children's mental illness stretching A&E services. *Community Pract*, *89*(2).

Dababnah, S., Habayeb, S., Bear, B. J., & Hussein, D. (2019). Feasibility of a trauma-informed parent–teacher cooperative training program for Syrian refugee

children with autism. *Autism*, *23*(5), 1300–1310. https://doi.org/10.1177/1362361318805368

Dame, S. L. (2016). *Training elementary teachers about childhood anxiety: Perception and self-efficacy (Doctoral dissertation)*. Capella University.

David, P., & Schiff, M. (2018). Initial clinician reports of the bottom-up dissemination of an evidence-based intervention for early childhood trauma. *Child Youth Care Forum*, *47*(1), 115–132. https://doi.org/10.1007/s10566-017-9422-1

Davies, S. C., & Ray, A. M. (2014). Traumatic brain injury: The efficacy of a half-day training for school psychologists. *Contemporary School Psychology*, *18*(1), 81–89. https://doi.org/10.1007/s40688-013-0003-5

Department of Health. (2015). *Future in Mind: Promoting, protecting, and improving our children and young people's mental health and wellbeing*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf.

Donald, E. (2015). *The effects of child teacher relationship training (CTRT) on residential care workers: A mixed methods study (Doctoral dissertation)*. NC: University of North Carolina.

D'Oosterlinck, F., Soenen, B., Goethals, I., Vandevelde, S., & Broekaert, E. (2009). Perceptions of Staff Members on the Implementation of Conflict Management Strategies in Educational and Therapeutic Environments for Children and Youths with Emotional and Behavioural Disorders. *Therapeutic Communities*, *30*(2), 157–172.

Drahota, A., Stadnick, N., & Brookman-frazee, L. (2014). Therapist Perspectives on Training in a Package of Evidence-Based Practice Strategies for Children with Autism Spectrum Disorders Served in Community Mental Health Clinics. *Administration and Policy in Mental Health*, *41*(1), 114–125. https://doi.org/10.1007/s10488-012-0441-9

Dunsmuir, S., Frederickson, N., & Lang, J. (2017). Meeting current challenges in school psychology training: The role of problem-based learning. *School Psychology Review*, *46*(4), 395–407. https://doi.org/10.17105/SPR-2016-0017.V46-4

Duong, M. T., Bruns, E. J., Lee, K., Cox, S., Coifman, J., Mayworm, A., & Lyon, A. R. (2020). Rates of Mental Health Service Utilization by Children and Adolescents in Schools and Other Common Service Settings: A Systematic Review and Meta-Analysis. *Administration and Policy in Mental Health*, *17*, 1–20. https://doi.org/10.1007/s10488-020-0108

Edwards, R., Williams, R., Dogra, N., O'Reilly, M., & Vostanis, P. (2008). Facilitating and limiting factors of training available to staff of specialist CAMHS. *The Journal of Mental Health Training, Education and Practice*, *3*(3), 22–31. https://doi.org/10.1108/17556228200800018

Eustache, E., Gerbasi, M. E., Smith Fawzi, M. C., Fils-Aime, S., JR, J, R., & G.J. (2017). Mental health training for secondary school teachers in Haiti: A mixed methods, prospective, formative research study of feasibility, acceptability, and effectiveness in knowledge acquisition. *Global Mental Health*, *4*(e4), 1–16. https://doi.org/10.1017/gmh.2016.29

Ford, T., Hamilton, H., Goodman, R., & Meltzer, H. (2005). Service contacts among the children participating in the British child and adolescent mental health surveys. *Child and Adolescent Mental Health*, *10*(1), 2–9. https://doi.org/10.1111/j.1475-3588.2005.00108.x

Gonzalez, J. E., Stoiber, K. C., Clayton, R. J., Keller-Margulis, M., Reddy, L. A., & Forman, S. G. (2019). A qualitative analysis of school psychology trainers' perspectives on evidence-based practices. *International Journal of School & Educational Psychology*, *1–16*. https://doi.org/10.1080/21683603.2019.1668317

Grant, L., Sangha, A., Lister, S., & Wiseman, T. (2016). Cancer and the family: Assessment, communication and brief interventions—The development of an

educational programme for healthcare professionals when a parent has cancer. *BMJ Supportive & Palliative Care*, *6*(4), 493–499. https://doi.org/10.1136/bmjspcare-2015-001006

Haggerty, D., Carlson, J. S., McNall, M., Lee, K., & Williams, S. (2019). Exploring youth mental health first aider training outcomes by workforce affiliation: A survey of project AWARE participants. *School Mental Health*, *11*(2), 345–356. https://doi.org/10.1007/s12310-018-9300-5

Hannes, K., & Lockwood, C. (2011). Pragmatism as the philosophical foundation for the Joanna Briggs meta-aggregative approach to qualitative evidence synthesis. *Journal of Advanced Nursing*, *67*(7), 1632–1642. https://doi.org/10.1111/j.1365-2648.2011.05636.x

Harris, N. (2013). *The effects of a one day in-service workshop on the self-efficacy of physical educators to include students with autism into the general physical education setting (Doctoral dissertation)*. VA: University of Virginia.

Heyeres, M., McCalman, J., Langham, E., Bainbridge, R., Redman-Maclaren, M., & Britton, A. (2019). Strengthening the Capacity of Education Staff to Support the Wellbeing of Indigenous Students in Boarding Schools: A Participatory Action Research Study. *The Australian Journal of Indigenous Education*, *48*(1), 79–92. https://doi.org/10.1017/jie.2017.42

Hinrichs, S., Owens, M., Dunn, V., & Goodyer, I. (2012). General practitioner experience and perception of Child and Adolescent Mental Health Services (CAMHS) care pathways: A multimethod research study. *BMJ Open*, *2*(6). https://doi.org/10.1136/bmjopen-2012-001573

Johnson, S. F., & Woodgate, R. L. (2017). Qualitative research in teen experiences living with food-induced anaphylaxis: A meta-aggregation. *Journal of Advanced Nursing*, *73*(11), 2534–2546. https://doi.org/10.1111/jan.13325

Jolivette, K., Patterson, D. P., Swoszowski, N. C., McDaniel, S. C., Kennedy, C., & Ennis, R. P. (2014). School-Wide Positive Behavioral Interventions and Supports in a Residential School for Students With Emotional and Behavioral Disorders:

First Years of Implementation and Maintenance Follow-Up Focus Groups. *Residential Treatment For Children & Youth*, *31*(1), 63–79. https://doi.org/10.1080/0886571X.2014.878584

Jones, K., & Howley, M. (2010). An investigation into an interaction programme for children on the autism spectrum: Outcomes for children, perceptions of schools and a model for training. *Journal of Research in Special Educational Needs*, *10*(2), 115–123. https://doi.org/10.1111/j.1471-3802.2010.01153.x

Jones, P. B. (2013). Adult mental health disorders and their age at onset. *BJPsych*, *202*(s54). https://doi.org/10.1192/bjp.bp.112.119164

Kerasidou, A., & Kingori, P. (2019). Austerity measures and the transforming role of A&E professionals in a weakening welfare system. *PloS One*, *14*(2). https://doi.org/10.1371/journal.pone.0212314

Killick, S., & Allen, D. (2006). Training staff in an adolescent inpatient psychiatric unit in positive approaches to managing aggressive and harmful behaviour: Does it improve confidence and knowledge? *Child Care in Practice*, *11*(3), 323–339. https://doi.org/10.1080/13575270500151870

Kutcher, S., Wei, Y., & Coniglio, C. (2016). Mental health literacy: Past, present, and future. *Canadian Journal of Psychiatry*, *61*(3), 154–158. https://doi.org/10.1177/0706743715616609

Lee, F. (2016). Self-harm training in secondary schools: An educational psychology intervention using interpretative phenomenological analysis. *Educational & Child Psychology*, *33*(2), 118–129.

Lempp, T., Heinzel-Gutenbrunner, M., & Bachmann, C. (2016). Child and adolescent psychiatry: Which knowledge and skills do primary care physicians need to have? A survey in general practitioners and paediatricians. *European Journal of Child & Adolescent Psychiatry*, *25*(4), 443–451. https://doi.org/10.1007/s00787-015-0757-6

Leventhal, K. S., Andrew, G., Collins, C. S., DeMaria, L., Singh, H. S., & Leventhal, S. (2018). Training School Teachers to promote Mental and Social Well-being in

Low and Middle Income Countries: Lessons to facilitate scale-up from a Participatory Action Research Trial of Youth First in India. *International Journal of Emotional Education*, *10*(2), 42–58.

Lockwood, C., Munn, Z., & Porritt, K. (2015). Qualitative research synthesis: Methodological guidance for systematic reviewers utilizing meta-aggregation. *International Journal of Evidence-Based Healthcare*, *13*(3), 179–187. https://doi.org/10.1097/XEB.0000000000000062

Lusk, P., Hart Abney, B. G., & Melnyk, B. M. (2018). A Successful Model for Clinical Training in Child/Adolescent Cognitive Behavior Therapy for Graduate Psychiatric Advanced Practice Nursing Students. *Journal of the American Psychiatric Nurses Association*, *24*(5), 457–468. https://doi.org/10.1177/1078390317723989

Manassis, K., Ickowicz, A., Picard, E., Antle, B., McNeill, T., & Chahauver, A. (2009). An innovative child CBT training model for community mental health practitioners in Ontario. *Academic Psychiatry*, *33*(5), 394–399. https://doi.org/10.1176/appi.ap.33.5.394.

Manning, J. C., Carter, T., Latif, A., Horsley, A., Cooper, J., & Armstrong, M. (2017). 'Our Care through Our Eyes'. Impact of a co-produced digital educational programme on nurses' knowledge, confidence and attitudes in providing care for children and young people who have self-harmed: A mixed-methods study in the UK. *BMJ Open*, *7*(4). https://doi.org/10.1136/bmjopen-2016-014750

Mazzucchelli, T. G., & Sanders, M. R. (2010). Facilitating practitioner flexibility within an empirically supported intervention: Lessons from a system of parenting support. *Clinical Psychology*, *17*(3), 238–252. https://doi.org/10.1111/j.1468-2850.2010.01215.x

McAllister, M., Knight, B. A., Handley, C., Withyman, C., Dawkins, J., & Hasking, P. (2019). Evaluation of a professional development experience designed to equip school support staff with skills to facilitate youth mental health

promotion. *Contemporary Nursing*, *55*(4–5), 408–420. https://doi.org/10.1080/10376178.2019.1682464

McInnes, E., & Wimpenny, P. (2008). Using Qualitative Assessment and Review Instrument software to synthesise studies on older people's views and experiences of falls prevention. *International Journal of Evidence-Based Healthcare*, *6*(3), 337–344. https://doi.org/10.1111/j.1744-1609.2008.00104.x

McIntosh, K., Mercer, S. H., Nese, R. N., Strickland-Cohen, M. K., Kittelman, A., Hoselton, R., & Horner, R. H. (2018). Factors predicting sustained implementation of a universal behavior support framework. *Educational Research*, *47*(5), 307–316. https://doi.org/10.3102/0013189x18776975

Naicker, K., Galambos, N. L., Zeng, Y., Senthilselvan, A., & Colman, I. (2013). Social, demographic, and health outcomes in the 10 years following adolescent depression. *Journal of Adolescent Health*, *52*(5), 533–538. https://doi.org/10.1016/j.jadohealth.2012.12.016

Neufeld, S. A., Dunn, V. J., Jones, P. B., Croudace, T. J., & Goodyer, I. M. (2017). Reduction in adolescent depression after contact with mental health services: A longitudinal cohort study in the UK. *Lancet Psychiatry*, *4*(2), 120–127. https://doi.org/10.1016/S2215-0366(17)30002-0

Neufeld, S. A., Jones, P. B., & Goodyer, I. M. (2017). Child and adolescent mental health services: Longitudinal data sheds light on current policy for psychological interventions in the community. *Journal of Public Mental Health*, *16*(3), 96–99. https://doi.org/10.1108/jpmh-03-2017-0013

NHS Digital. (2020). Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey. *Government Statistical Service.* https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up#.

NHS England. (2015). Implementing the Five Year Forward view for Mental Health. *NHS England*. https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf.

Omigbodun, O., Bella, T., Dogra, N., & Simoyan, O. (2007). Training health professionals for child and adolescent mental health care in Nigeria: A qualitative analysis. *Child and Adolescent Mental Health*, *12*(3), 132–137. https://doi.org/10.1111/j.1475-3588.2007.00455.x

O'Reilly, M., Adams, S., Whiteman, N., Hughes, J., Reilly, P., & Dogra, N. (2018). Whose responsibility is adolescent's mental health in the UK? Perspectives of key stakeholders. *School Mental Health*, *10*(4), 450–461. https://doi.org/10.1007/s12310-018-9263-6

Post, P. B., Grybush, A. L., Elmadani, A., & Lockhart, C. E. (2020). Fostering resilience in classrooms through child-teacher relationship training. *International Journal of Play Therapy*, *29*(1), 9–19. https://doi.org/10.1037/pla0000107

Sawyer, S. M., Azzopardi, P. S., Wickremarathne, D., & Patton, G. C. (2018). The age of adolescence. *Lancet Child & Adolescent Health*, *2*(3), 223–228. https://doi.org/10.1016/S2352-4642(18)30022-1

Scantlebury, A., Parker, A., Booth, A., McDaid, C., & Mitchell, N. (2018). Implementing mental health training programmes for non-mental health trained professionals: A qualitative synthesis. *PloS One*, *13*(6). https://doi.org/10.1371/journal.pone.0199746

Sherwin, M. (2014). *An investigation into best practices in training para-educators of students with autism (Doctoral dissertation)*. Northeastern University.

Smith, J., Kyle, R. G., Daniel, B., & Hubbard, G. (2018). Patterns of referral and waiting times for specialist Child and Adolescent Mental Health Services. *Child and Adolescent Mental Health*, *23*(1), 41–49. https://doi.org/10.1111/camh.12207

Srivastava, M., Boer, A. A., & Pijl, S. J. (2015). Know how to teach me... Evaluating the effects of an in-service training program for regular school teachers toward inclusive education. *International Journal of School & Educational Psychology*, *3*(4), 219–230. https://doi.org/10.1080/21683603.2015.1064841.

Stirman, S. W., Kimberly, J., Cook, N., Calloway, A., Castro, F., & Charns, M. (2012). The sustainability of new programs and innovations: A review of the empirical literature and recommendations for future research. *Implementation Science*, *7*(1). https://doi.org/10.1186/1748-5908-7-17

Suldo, S., Loker, T., Friedrich, A., Sundman, A., Cunningham, J., & Saari, B. (2010). Improving School Psychologists' Knowledge and Confidence Pertinent to Suicide Prevention Through Professional Development. *Journal of Applied School Psychology*, *26*(3), 177–197. https://doi.org/10.1080/15377903.2010.495919.

Tchernegovski, P., Reupert, A., & Maybery, D. (2015). Let's Talk about Children": A pilot evaluation of an e-learning resource for mental health clinicians. *Clinical Psychology*, *19*(1), 49–58. https://doi.org/10.1111/cp.12050

Tilahun, D., Hanlon, C., Araya, M., Davey, B., Hoekstra, R. A., & Fekadu, A. (2017). Training needs and perspectives of community health workers in relation to integrating child mental health care into primary health care in a rural setting in sub-Saharan Africa: A mixed methods study. *International Journal of Mental Health Systems*, *11*(15). https://doi.org/10.1186/s13033-017-0121-y

Timson, D., Priest, H., & Clark-Carter, D. (2012). Adolescents who self-harm: Professional staff knowledge, attitudes and training needs. *Journal of Adolescence*, *35*(5), 1307–1314. https://doi.org/10.1016/j.adolescence.2012.05.001

Trotta, A., Arseneault, L., Caspi, A., Moffitt, T. E., Danese, A., Pariante, C., & Fisher, H. L. (2020). Mental health and functional outcomes in young adulthood of children with psychotic symptoms: A longitudinal cohort study. *Schizophrenia Bulletin*, *46*(2), 261–271. https://doi.org/10.1093/schbul/sby015.239

Wei, Y., McGrath, P. J., Hayden, J., & Kutcher, S. (2015). Mental health literacy measures evaluating knowledge, attitudes and help-seeking: A scoping review. *BMC Psychiatry*, *15*(1). https://doi.org/10.1186/s12888-015-0681-9

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2016). *THRIVE Elaborated* (Second). http://implementingthrive.org/wp-content/uploads/2016/09/THRIVE-elaborated-2nd-edition.pdf.

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2019). *THRIVE Framework for system change*. CAMHS Press. https://www.annafreud.org/media/9254/thrive-framework-for-system-change-2019.pdf.

World Health Organisation. (2020a). *Adolescent health in the South-East Asia Region*. https://www.who.int/southeastasia/health-topics/adolescent-health.

World Health Organisation. (2020b). *Improving the mental and brain health of children and adolescents*. https://www.who.int/activities/improving-the-mental-and-brain-health-of-children-and-adolescents.

Wu, Y. Q., Chartier, M., Ly, G., Phanlouvong, A., Thomas, S., & Weenusk, J. (2019). Qualitative case study investigating PAX-good behaviour game in first nations communities: Insight into school personnel's perspectives in implementing a whole school approach to promote youth mental health. *BMJ Open*, *9*(9). https://doi.org/10.1136/bmjopen-2019-030728

Chapter 4: Barriers and facilitators to training delivery and subsequent implementation of a localised child and adolescent mental health initiative: A qualitative content analysis

Banwell, E., Qualter, P., & Humphrey, N. (2023). Barriers and facilitators to training delivery and subsequent implementation of a localised child and adolescent mental health initiative: A qualitative content analysis. *BMC Medical Education, 23*(1), 264. https://doi.org/10.1186/s12909-023-04238-9

This chapter presents the version of Study 2 that was published, open access, in BMC Medical Education. However, it has been reformatted for consistency with the rest of the thesis. All supplementary materials referred to in this chapter can be found in *Appendix 2.*

4.1: Abstract

Background:

Ensuring that children and young people (CYP) can obtain mental health support from a broad variety of sources is of utmost importance. This is especially true given the increasing prevalence of mental health difficulties in this population, and the associated challenges with receiving support from specialised healthcare services. Equipping professionals, from a wide range of sectors, with the skills needed to provide this support is a vital starting point. This study explored the experiences of professionals who had participated in CYP mental health training modules that related directly to the local implementation of the THRIVE Framework for System Change in Greater Manchester, UK (GM i-THRIVE) to establish the perceived barriers and facilitators behind the implementation of this training programme.

Methods:

Directed qualitative content analysis of semi-structured interview data from nine CYP-facing professionals was conducted. Both the interview schedule and initial deductive coding strategy were developed using the findings of a systematic literature review by the authors, that was conducted to explore wider CYP mental health training experiences. This methodology was used to establish the presence

or absence of these findings within GM i-THRIVE, before generating tailored recommendations for their training programme.

Results:

When the interview data were coded and analysed, a strong level of thematic similarity with the authors' review was found. However, we deduced that the emergence of additional themes might reflect the contextual uniqueness of GM i-THRIVE, that is likely to be further compounded by the COVID-19 pandemic. Six recommendations were made for further improvement. These included the facilitation of unstructured peer interaction during training, and ensuring that jargon and key words are fully clarified.

Conclusions:

Methodological limitations, guidance for usage, and potential applications of the study's findings are explored. Whilst the findings were largely akin to those of the review, subtle yet important differences were found. These are likely to reflect the nuances of the training programme discussed, however, we tentatively suggest that our findings are transferable to similar training interventions. This study provides a valuable example of how qualitative evidence syntheses can be used to aid study design and analysis: an underused approach.

Keywords:

Child and adolescent mental health; evaluation; implementation science; professional development; qualitative content analysis; training; barriers and facilitators

4.2: Introduction

Background:

One in six 6–16-year-olds (17.4%) in England had a probable diagnosable psychiatric disorder in 2021: a concerning increase from the one in nine (11.6%) reported in 2017 (NHS Digital, 2021). Given that the peak age of onset for psychiatric disorders is 14.5 (Solmi et al., 2022), the need for the earliest possible intervention is clear. Despite this, many CYP are unable to access appropriate mental health support.

Funding cuts to Child and Adolescent Mental Health Services (CAMHS) (Neufeld et al., 2017), lengthy waiting times (Wolpert et al., 2016), and high referral rejection rates (Smith et al., 2018) are all plausible explanations for why specialist support is inaccessible to many. Referrals are often considered inappropriate, and are therefore rejected, when CYP do not meet a diagnostic threshold in terms of symptoms or severity (Scottish Government, 2018).

Although efforts *are* being made to improve CYP access to specialist NHS services (Department for Education, 2021; National Audit Office, 2018), there remains an obvious need for alternative provision of support. CYP already rely on the various non-mental health trained professionals that they encounter in their day-to-day lives for support and advice, with teachers being particularly valued sources (O'Reilly, Adams, et al., 2018). At times of mental health crisis, Accident and Emergency departments are frequently a port of call, despite being poorly equipped for psychiatric admissions (Kerasidou & Kingori, 2019). Teachers, similarly, feel under-trained in this area. The time and resources needed to provide an ideal level of mental health support are simply not available (O'Reilly, Adams, et al., 2018). Even GPs lack the expertise needed to both support and refer appropriately when it comes to mental health. These shortcomings have been acknowledged by GPs themselves (Hinrichs et al., 2012; Lambert et al., 2020), as well as CYP reporting that they do not feel comfortable approaching GPs for these reasons (Biddle et al., 2006; Plaistow et al., 2014; Storey et al., 2005).

THRIVE – A nationwide initiative:

As an initiative aiming to remedy some of the shortcomings of current CYP mental health services, THRIVE (Wolpert et al., 2019) has so far been introduced in over 70 areas in England. The THRIVE framework epitomises a holistic view of mental health care, meaning that anyone who encounters CYP in a professional capacity, for example through school, social care, the criminal justice system, or even the arts sector, will be equipped with the level of training and knowledge needed to act as informed advisers in times of mental health need. Within CAMHS specifically, THRIVE aims to improve cross and within-sector communication, meaning that accountability becomes shared. This will hopefully build a more effective service for

those requiring specialist care. The fact that THRIVE represents a common-language framework means that a consistent service should be provided by all THRIVE-trained professionals. For CYP, this means that there will never be a "wrong door" in which to turn (Department of Health, 2015). In all, those unable to access specialist CAMHS, for whatever reason, should have a diversified range of options through which to receive assistance. To make these goals a reality, the widening of mental health support, and the accompanying implementation of a consistent approach to care, evidently require a wide-spread training agenda.

Greater Manchester – An implementation site:

The implementation of the THRIVE framework in Greater Manchester (known locally as GM i-THRIVE) commenced in 2018, and represents part of a wider devolution deal drawn between the Greater Manchester Health and Social Care Partnership (GMHSCP) and the UK government. This devolution allowed the region to make its own decisions about how local NHS services are funded (Greater Manchester Health and Social Care Partnership, 2021), based on the needs of the 2.8 million city-region residents. The core GM i-THRIVE team work with leaders in each of Greater Manchester's ten locality boroughs (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, and Wigan) to align the CYP mental health services within each, including CAMHS, voluntary sector, and wider CYP-facing, to THRIVE's principles (Implementing THRIVE, 2021). To do this, four key training modules have been developed, for what is known as the GM i-THRIVE Training Academy. These were designed to facilitate implementation, allowing services to equip their workforce to deliver THRIVE's objectives. The four training modules are as follows:

1. **"Shared decision making":** trainees learn the importance of having conversations about treatment or care *alongside* CYP and their families, to make joint decisions.
2. **"Getting advice and signposting":** trainees learn how to signpost effectively and efficiently to other services or help sources.

3. **"Getting risk support":** trainees learn to recognise the needs of CYP and families that are at risk of harmful experiences, and how these experiences can relate to mental health outcomes. This is especially important in cases where CAMHS services have thus far been unable to elicit a positive change for a particular individual. It helps professionals to safeguard effectively, and to use methods that support multi-agency working.

4. **"Building confidence in letting go and managing difficult endings":** Ending therapeutic support is difficult for CYP and those helping them. This module discusses what makes these endings challenging, and helps professionals to instigate an open dialogue with CYP about what successful and realistic therapeutic outcomes look like.

The training modules are broadly accessible to a wide variety of professionals, so that a comprehensive system of support for CYP can be built (Implementing THRIVE, 2021). These include CAMHS staff, local authority, and educational professionals. From 2019 onwards, the training was held face-to-face, repeated in geographically accessible locations for those working in any of the ten Greater Manchester localities. However, after the outbreak of COVID-19, training was moved to an online format, comprising both synchronous and asynchronous content.

The authors of the present study are involved in evaluating GM i-THRIVE, part of which is an investigation of the barriers and facilitators underpinning successful CYP mental health training delivery and implementation. To identify whether such factors had been explored in other qualitative studies with professionals who had completed similar training, we recently conducted a systematic literature review (SLR) and qualitative meta-synthesis (Banwell et al., 2021). In the review, we searched the literature for qualitative studies, whereby participants discussed their experiences with training designed to improve their knowledge of CYP mental health. These studies included both participants who had previous mental health training, plus allied professionals who had not. The resulting findings were then synthesised using qualitative meta-aggregation, and we made nineteen practical recommendations for those designing, delivering, or

implementing such training (see *Table 4.2).* These ranged from highlighting the importance of training support, to ensuring that the training is needed and appreciated within the implementing organisation. The paper drew what were essentially "common-sense" principles, from a strong evidence base. They were then tied, using a pragmatic methodology, into a coherent and accessible framework.

The present study:

SLRs are thorough collations of evidence often focused on a very narrow topic. It is therefore surprising that few researchers refer to these papers when designing their own studies (Cooper et al., 2005). Only 51% of respondents in a study by (Nikolakopoulou et al., 2019) stated that they consulted a meta-analysis when determining outcomes that warranted investigation in their research. Doing this can reduce "research waste". Efficiency is crucial within the health field: one that often lacks research resources (Nikolakopoulou et al., 2019). It follows that SLRs, as one of the most robust forms of research summary, "should be capable of directing all types of health research" (Urra Medina & Barría Pailaquilén, 2010, p. 830). These findings and observations indicate a clear need for more studies that evidence the value of synthesis papers (Nikolakopoulou et al., 2019).

Considering the above, it made logical sense that the findings of our review (Banwell et al., 2021) could be used to guide this primary research in two ways. First, the directive points produced were used to build a schedule to interview a range of professionals who had undertaken GM i-THRIVE Academy training modules. Second, using a combination of deductive and inductive reasoning, transcript analysis was guided by the evidence-based synthesis factors, using them as indicative themes for what we could reasonably expect to see. This underutilised approach, whereby review evidence is tested against an active, current training intervention, had the potential to generate specific and relevant, yet evidence-based, recommendations.

The aims of the present study were to accomplish the following tasks:

- Establish whether the barriers and facilitators to training delivery and implementation reported in our review were present within the GM i-THRIVE Training Academy.
- Identify any additional barriers and facilitators present in the experiences of those completing GM i-THRIVE Training Academy modules, that were not evidenced in our review.
- As a result of the above two aims, generate tailored recommendations pertinent to GM i-THRIVE, to form part of a comprehensive evaluation of the programme's implementation. The extent to which these recommendations can be applied to other training programmes will be reasoned and discussed.

4.3: Methods

Reporting guidelines:

The production of this paper was guided by the Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014). These guidelines consist of 21 criteria, developed to improve transparency in the reporting of qualitative studies. We have adhered to these by, for example, ensuring that the member checking process (Birt et al., 2016) was sufficiently described, researcher characteristics were explained, and that the data analysis process was comprehensively detailed.

Design:

The present study was a qualitative case study evaluation, involving semi-structured interviews with attendees of the GM i-THRIVE Training Academy modules. A directed approach to the qualitative content analysis was adopted. This meant that although our prior research findings (Banwell et al., 2021) were used to guide analysis, there was also the potential for revealing additional knowledge (Hsieh & Shannon, 2005). This approach aligns well with a pragmatic epistemology. In essence, we focussed on the suitability and purpose of the employed research methods when choosing them, which did not necessitate thinking too abstractly about the construction of knowledge (Morgan, 2014).

Participants:

Participants needed to have attended at least one of the four GM i-THRIVE Training Academy modules. Those eligible (N=623) were approached by email. We attempted to vary the sample of participants by considering the following three factors:

- The training module(s) that they completed
- Their professional role, namely whether they work within CAMHS, or within the wider workforce
- The Greater Manchester locality borough within which they work

The factors were considered in that order of importance, in hopes of recruiting a suitably diverse sample, as is desirable for qualitative multi-site implementation research (Benzer et al., 2013). However, so that a suitable number of participants could be recruited, the above strategy was applied with flexibility, and a primarily opportunistic approach was adopted. Nine participants (*Table 4.1*) were eventually recruited. In terms of Greater Manchester locality, nine boroughs were represented, although two participants reported that their work took them across multiple boroughs. A third of participants (n=3) represented one borough. Attendees of all four training modules were represented, with most participants having only attended one. Three participants attended face-to-face training sessions prior to COVID-19 lockdowns, whilst four attended virtual sessions once restrictions were in place. One participant attended sessions in both formats. Participant 6 had not attended a training module. Despite failing to meet the inclusion criteria, we decided that their data should be included owing to the valuable insights given regarding their inability to gain a training place. As the remainder of the interview schedule did not apply to them, only one extract from their transcript was included in the content analysis below.

Table 4.1: *Characteristics of the participants recruited for the present study. Note: Professional roles were excluded from this table, and locality names were masked, to ensure anonymity.*

Participant number	GM i-THRIVE Training Academy module(s) attended	Online or face-to-face training?	GM locality borough
1	All	Both	A
2	Building confidence in letting go and managing difficult endings	Online	Multiple
3	Getting risk support	Face-to-face	B
4	Shared decision-making; Getting risk support	Face-to-face	C
5	Building confidence in letting go and managing difficult endings	Online	D
6	Did not attend	N/A	Multiple
7	Getting advice and signposting	Online	E
8	Getting advice and signposting	Face-to-face	B
9	Getting advice and signposting	Online	B

Researcher characteristics:

The authors were externally commissioned by GMHSCP to conduct a comprehensive evaluation of i-THRIVE in Greater Manchester. Because the authors are affiliated with the University of Manchester rather than GMHSCP, the data analyses and conclusions drawn were unlikely to be biased by vested interest. The first author attended in-person training sessions to establish a feel for the content and format of the delivery. It is predicted that the structured nature of the data analysis method, and the authors' impartial professional positions, contributes towards ameliorating the impact that any subjective opinions gained in these sessions might have. The data analysis process was primarily carried out by the first author, yet overseen and "sense-checked" by the second and third authors. Whilst the latter authors did not receive the same immersive experience of GM i-THRIVE

training of the first author, they were also free of any resultant biases. Their role was driven, therefore, by checking that analyses appeared logical, readable, and comprehensive: crucial characteristics of qualitative reports (Elo et al., 2014).

Ethical considerations:

The present study was categorised as a "service evaluation" by the NHS Health Research Authority (HRA). This was confirmed by both the HRA's online decision-making tool, and the University of Manchester's Research Ethics Committee (UREC)'s decision tool. This was in addition to verbal agreement from the commissioners of the evaluation of GM i-THRIVE. Consequently, ethical review was not required from either the NHS Research Ethics Committee (NHS REC), or UREC. The study was, however, informally reviewed and approved by the second and third authors (the first author's supervisory team), and the study's commissioners. Ethical principles such as obtaining full informed consent, ensuring anonymity, and stating a participant's right to withdraw were followed. Participants were given a £20 voucher, to thank them for their time. All procedures within this research were performed in accordance with the British Psychological Society's Code of Human Research Ethics (2021).

Data collection procedures:

A semi-structured interview schedule was developed, guided by the nineteen categories from the aforementioned SLR findings (Banwell et al., 2021). Each category pertained to a barrier or facilitator of training delivery or implementation as identified through meta-synthesis (see *Table 4.2*). The 47 sub-categories, also presented in *Table 4.2*, further informed question generation, to ensure that these key factors were probed. The schedule consisted of 20 broad questions, overarching several prompts and sub-questions used to a varying degree depending on the detail and direction of the participants' responses. All interview questions and prompts are included in *Appendix 2.*

Owing to COVID-19, interviews were held using online conferencing software. Detailed study information sheets were provided, and consent obtained, prior to meeting. After transcription by the first author, each typed transcript was returned to the corresponding participants for "member checking", to ensure that

the transcript represented their interview, and to allow amendments or omission of any data that they no longer wish to be analysed (Birt et al., 2016). Despite this task, we were careful to ensure that participants did not feel overburdened by the research process. For this reason, and in line with guidance by Elo et al. (2014), who suggested that without full insight into the entire research process, participants cannot meaningfully validate final themes, we chose not to verify the post-analysis themes with our participants (Elo et al., 2014; Morse et al., 2002; Pyett, 2003).

Data analysis:

Data were analysed using qualitative content analysis. Thematic analysis and content analysis are both suitable for studies with relatively descriptive research questions, that do not warrant deep and complex interpretation of meaning to answer (Vaismoradi et al., 2013). However, the latter uses theme frequency as proxy for significance, concentrating more on surface features than assuming latent meaning (Vaismoradi et al., 2013). This relatively objective, systematic method was considered more suitable given our study aims.

According to Hsieh & Shannon (2005) the "directed" qualitative content analysis approach is best suited to scenarios where prior knowledge of a topic exists, but the study aims to clarify or expand that knowledge. The findings of our recent SLR (Banwell et al., 2021) form a strong evidential framework through which to explore i-THRIVE's own training, thereby developing knowledge that could be truly meaningful and relevant to the programme. Using this directed approach, before the interviews commenced, a list of initial (deductive) themes were drawn, matching the nineteen concluding categories of our review (Banwell et al., 2021) (see *Table 4.2*). The 47 sub-categories were treated as deductive codes. This was so that the transcripts could be checked for extracts corresponding to these. Since the findings of the review related closely to the interview schedule, this was deemed an appropriate way of cross validating the review findings against our participants' experiences. Any topics that appeared in the transcripts that could *not* be categorised with these initial codes were given a new code, allowing for a mixture of deductive and inductive code and theme generation. We could consequently "test" the GM i-THRIVE interview data against the findings of the SLR (Banwell et

al., 2021), but still remain open-minded about the possibility of additional salient factors unaccounted for by the SLR.

When all interviews were complete, they were transcribed, member checked, then re-read to enhance familiarity. Using NVivo (version 12), the first transcript was read, and data were coded using the deductive codes and themes. Any ideas not suitably covered by a pre-existing code were added under a separate heading for inductive codes. Subsequent transcripts followed a similar process, although newly generated inductive codes were used alongside existing deductive codes when categorising extracts. Once all transcripts had been coded like this, they were read through once more, ensuring that all transcripts were considered with all inductive codes. All extracts relating to a certain code were considered together, to refine code titles, or to split extracts into further codes where necessary. Once coding was judged complete, codes referring to a similar barrier, facilitator, or other training element were grouped. They were then checked against the SLR's list of categories ("themes") to establish whether they could be grouped under any of these. It was important not to force the data into the categories, so this was only done where it appeared suitable. These deductive themes were also modified or expanded as necessary, to encompass the content of any new codes added. As mentioned previously, the frequency of each code was noted, with frequent codes influencing, to a greater degree, how themes were worded, and the extent to which they were discussed. A subset of final themes, codes, and extracts were "sense-checked" by the second and third authors. This process of verifying confirmability (Graneheim & Lundman, 2004) by ensuring that data labelling and thought processes make sense, is a suitable way of adding rigour to qualitative research. Endeavouring to add validity, as we should with quantitative data, is neither worthwhile nor suitable.

4.4: Results

The interviews were coded using 43 of the 47 deductive codes. However, all 19 deductive themes were represented within the data (see *Table 4.2*). 26 inductive codes emerged during this part of the analysis, of which 22 were grouped under the existing 19 deductive themes. Two new inductive themes were constructed with

the four remaining codes, which were entitled “expectations versus reality” and “issues relating to the COVID-19 pandemic”. *Table 4.2* shows the themes that represented the data, listed in order by frequency of extracts relating to each, and their accompanying codes. Inductive codes and themes are clearly marked in the table. Owing to the large number of themes, only a selection are discussed within this results section, guaranteeing that the analyses are sufficiently deep (Braun & Clarke, 2012). In line with principles of content analysis, whereby frequency indicates thematic significance (Vaismoradi et al., 2013), the three themes formed by the highest number of extracts were chosen for full analysis. These themes also, conveniently, contain the most inductive codes. Each one is therefore informed by a balance of deductive and inductive reasoning. Additionally, the two new inductive themes were chosen for full analysis, owing to their immediate relevance to GM i-THRIVE, specifically under the context of the COVID-19 pandemic. Participant numbers given after each supporting extract correspond to those in *Table 4.1*.

Table 4.2: *An exhaustive list of the themes and codes that represent the data and the number of extracts pertaining to each. Phrases in brackets refer to the names that were given to themes in the authors' SLR.* ***Note:*** *Starred (*) themes and codes are inductive. Those unstarred represent the categories and sub-categories from the review by Banwell et al. (2021) that were used to guide interview schedule production, and the deductive element of the present study's qualitative content analysis.*

Themes (and codes)	**Extracts**	**Number of inductive codes per theme**
Peer support (with a little help from my friends)	37	4
Trainees from different professional backgrounds sharing ideas and experiences	*13*	
*Provided opportunities to interact**	*8*	
*Make connections with similar people**	*6*	
*Encourage conversation**	*5*	
Reduce feelings of isolation	*4*	
*Learning about problems in the wider sector**	*1*	
Does it reflect reality? (keep it real)	32	3
Cover and discuss the trainees' own workplace challenges	*7*	
Use real-world examples	*6*	
Link closely to real-world delivery and implementation	*4*	
*Dealing with complex cases**	*4*	
*Patient point of view explored**	*4*	
Applicable to the implementing environment	*3*	
Feasible implementation	*2*	
*Theory to practice**	*2*	
Suitability (know your audience)	31	5
Consider the diverse backgrounds of trainees	*8*	
Appropriate content	*8*	
Accessibility	*4*	
*Training builds upon previous knowledge**	*4*	
*Design process**	*3*	
*The sequencing of the training modules**	*2*	
*Gaps in knowledge are easy to identify**	*1*	
*Inclusivity**	*1*	
In-training support (in the moment)	28	1
Feedback	*12*	
Dialogue rather than passive listening	*9*	
Logistical and practical supports	*5*	
*Within training resources**	*2*	

Themes (and codes)	Extracts	Number of inductive codes per theme
Everyone on board (are we on the same page?)	23	2
The entire organisation should be "on board"	*15*	
*System-wide implementation**	*6*	
*Training informs about current and relevant issues**	*2*	
A supportive environment	*0*	
Timing (pace yourself)	20	1
Last an appropriate duration	*10*	
Appropriate amount of information	*8*	
*Prep work was needed**	*2*	
*Expectations versus reality**	19	2
*Reasons for attending**	*13*	
*Did it match your expectations?**	*6*	
Changing mind-sets (get in their heads)	17	1
An appropriate level of background knowledge may be needed for maximum gains	*9*	
*Is this any of my business?**	*4*	
It can be difficult to change trainees' habits	*2*	
Encourage a change of mind-set	*2*	
Leadership qualities (lead the way)	14	2
Experts in the topic	*7*	
Relatable and understanding	*5*	
*Multiple trainers present**	*4*	
*Support from "above"**	*3*	
Flexible application (expect the unexpected)	14	2
Appropriate for the reality of the implementing environment	*6*	
*Dealing with complex cases**	*4*	
Acceptable to the population that it aims to help	*3*	
*Are we allowed to be flexible?**	*1*	
*Issues relating to the COVID-19 pandemic**	13	2
*Issues specific to the online training environment**	*12*	
*Struggles with gaining a place because of COVID-19**	*1*	
Smooth and seamless (blending in)	13	1
Link with current practice	*5*	
*Training builds upon previous knowledge**	*4*	
Bring other practices together	*3*	
Smooth and seamless	*1*	
Confidence and capability (power to the people)	12	1
Build trainee confidence	*6*	
Improve trainee competence	*5*	
*Signposting knowledge increased**	*1*	

Themes (and codes)	Extracts	Number of inductive codes per theme
Broad reach (cast a wide net)	11	0
Empower trainees to disseminate their learning	*7*	
Advertised or offered to a wide range of professionals	*4*	
Wider attitudes (what do you think?)	11	1
Positive or negative views of the training can impact implementation	*7*	
Compulsory implementation	*3*	
*Organisation taking ownership of making the required changes**	*1*	
Spark further learning (light a fire)	7	0
Facilitate reflection	*7*	
Facilitate independent learning	*0*	
A strong alternative? (bigger and better)	7	0
Provides something that is missing or needed	*4*	
A better alternative to previous practice	*3*	
Post-training support (keep it going)	4	0
Follow-up progress checks with trainers	*2*	
Access to guidance resources	*1*	
Refresher training	*1*	
Continued training	*0*	
Implementation fidelity (by the book)	4	0
Regular utilisation	*2*	
Fidelity monitoring	*2*	
Resource availability (out of time)	3	0
Sufficient dedicated time	*3*	
Sufficient resources and staffing	*0*	
Surplus value (above and beyond)	2	0
Applicable to a wide variety of scenarios	1	
Surplus value	1	

Deductive theme 1: Peer support (with a little help from my friends):

Trainees appreciated meeting and interacting with colleagues from diverse professional backgrounds. Opportunities to make professional connections were valued, through which a broad range of roles and experiences could be discussed. One way that this was facilitated was through group work. One participant, who attended in-person training, mentioned that the plethora of professional backgrounds and ways of working, that were made apparent when working through scenarios together as part of a group task, were beneficial to problem-solving.

"There was like a scenario, or a couple of different scenarios, that we looked at in the afternoon. Where people's differences really came out in the way that we were all approaching the same challenge. You could really see different backgrounds and different kinds of professional training, and how that played out, and how we were all approaching it slightly differently. So it was really good to get many heads together". (Participant 3)

Participants also mentioned specific elements of GM i-THRIVE, and how interacting with staff from other locations and professions allowed them to discuss experiences of implementing a certain concept. They could then take this knowledge back to their own workplace.

"There were a few examples from other localities about how they were using "Getting Advice and Signposting" as a principle and how they were implementing it. It was good to have that thought process. It did apply to what we were trying to do". (Participant 7)

It was also helpful to learn that issues and problems with implementing the changes were shared by others. This dialogue, of discussing these concerns with colleagues with the same professional goals, reduced feelings of personal failure.

"Because we were all in the job to help people out. So when we can't, it's quite difficult. But it was nice to know that nationally that happens. And that's not a reflection on you as such". (Participant 5)

Participants reported maintaining the links they forged during the training sessions. As a result, they gained a wider network of colleagues to contact and get support from.

"From that day, I've got better relationships and a better network of people that I personally would feel comfortable reaching out to. From that day". (Participant 3)

Deductive theme 2: Does it reflect reality? (keep it real):

Participants desired more opportunities to discuss their own workplaces: to share unique perceived challenges and barriers with leaders and other trainees. A

consultation-style system was recommended here. This would enable localities to present their own scenarios to leaders, who could then fill gaps in their thinking by suggesting specific ways to implement a concept.

> *"It would be good to have a smaller group or a breakout session, a bit like a consultation offer, as part of the training, where we could come up with our ideas. Then ask more specific questions and have that opportunity to have them ask us questions about things that we might not have thought about. That would have been useful". (Participant 7)*

In terms of whether trainees felt the training equipped them to deal with the diverse reality of their workplace, a mix of views were raised. Concerns were held about applicability to cases that presented the biggest professional challenges. Learning how to deal with complex, non-routine cases appeared to be a common training need, with one participant reporting that the training had limited applicability to the disengaged CYP that they worked with. As a result, they wished they had been given more information about how to utilise the GM i-THRIVE training in their work with these CYP.

> *"For me, the young people I work with are the most disengaged. So, it is quite difficult. The universal service doesn't always fit, so things like 42nd Street, so brilliant, but for a lot of my young people, they won't engage with it, they won't go to it, they won't go to appointments. And so, it'd be useful to just have more information about how to access support for those young people". (Participant 8)*

Training played a vital role in providing meaning to the whole implementation process of GM i-THRIVE. Ensuring that the programme remains visible and central was seen as vital in terms of sustainability.

> *"Keeping it live and meaningful, I think is really important. So I think those two connect. So in order to be able to kind of keep it sustained, you've got to be able to keep it live and meaningful in each locality". (Participant 9)*

However, whilst keeping GM i-THRIVE relevant and meaningful to trainees is crucial, deeper system change is also necessary. This is so that services, as a means of providing reformed care, are fully prepared to receive the programme. This participant felt that although the THRIVE model advocates a flexible mindset, the current structure of services, that are likely aligned to older models of provision, makes this new mindset difficult to apply.

> *"Mental health services aren't as fluid as the model states they should be. That can be difficult to implicate sometimes". (Participant 5)*

Deductive theme 3: Suitability (know your audience):

Participants respected the difficulties of appropriately pitching training to such a diverse group of professionals. This is a pertinent issue for GM i-THRIVE, as an implementation with multi-agency working at the heart of its ethos. Despite these challenges, the training was reported as well structured, with concepts explained in order of complexity to aid understanding.

> *"It explained some basic theory about the approach. But in a way that you didn't feel that it was too superficial or patronising. It then scaffolded a bit more and took you into more detail about the model. But I think you could just join it nicely at the level that it was". (Participant 3)*

Even those with an extensive level of previous work in the CYP mental health sector did not feel that the training was too simplistic. They felt that the knowledge obtained was timely and relevant.

> *"I think it was really well pitched for a really wide area. Although I've got, I don't know, 15 plus years of qualified work, it didn't feel like it was too basic, because actually, it was just building on, and adding kind of tools, which were really, really pertinent at the time, actually". (Participant 2)*

Some trainees, however, said that even though they were mental health trained, their position outside of the medical field made some of the language used in the training difficult to understand. It was consequently more difficult to imagine using the concepts in their work.

"A challenge from it has been some of the language used. I've not come from a medical background, and a lot of language feels very "medically" and isn't necessarily something that we understand. And you know, I find myself having to Google things, which is all my professional development, which is great. But I think that sort of can be a challenge". (Participant 4)

Language was also mentioned in terms of how the training forged links between GM i-THRIVE and trainees' own background knowledge, work, and other related training programmes. This emphasises the importance of the "common-language" element of GM i-THRIVE, showing that understanding can be enhanced by unifying terminology. This is especially true where, as this participant states, similar concepts and theories are often explained differently by different training providers.

"Understanding the model helped me in the role that I was in at that point as well, to look at how it might link with other changes, in other languages. Because lots of different training was going on at the same time, and there were lots of changes in language. And I was really mindful that these things aren't in competition. They're all very much from the same kind of theoretical approach. But if I understand what the language means, in each of these different contexts, I'll be able to make sense of it better". (Participant 3)

Inductive theme 1: Expectation versus reality:

In this inductive theme, participants expressed an assortment of motivations for attending the GM i-THRIVE training. These motivations moulded the expectations they had prior to attending, resulting in varying levels of satisfaction depending upon whether these expectations were met. Although the training was not mandatory, a small number of participants mentioned being asked to take part by senior colleagues. These participants tended to have fewer prior expectations of the knowledge or skills that they might gain, but this did not seem to influence their perception of its usefulness. In the extract below, the participant appreciated the

insights into current ways of working and thinking within CYP mental health. They appeared optimistic about the changes that GM i-THRIVE hopes to make.

> *"I'm not even sure what I expected from it really, I guess because it wasn't something I requested. It was just something that I was told to go on, but I enjoyed it because it was good to see what was going on in the background in mental health, and what plans that they were considering for young people over the next few years. Hopefully, there will be a lot of changes". (Participant 1)*

Most participants, however, had made a personal decision to book onto the training. Some described specific gaps in their own skills, or processes that they found difficult. They hoped that the training would help them to overcome these obstacles.

> *"I chose to attend it […] The thing I identified that I struggle with the most is discharging people and feeling sad about discharging people, or feeling bad, so it was good to get on it". (Participant 5)*

Another related motivation was to disseminate the learning to teams within a locality. This participant attended as a representative of their locality. They hoped to gain a deeper insight into the programme's principles, that could then be translated back into their work.

> *"I thought it'd be useful to come along and see first-hand what the principles were and how it was articulated, then I could take it back into my role and articulate it in the same way […] the reason I came along to that one, again, through choice was to make sure that we capture all of the key principles of what that meant for young people and for families. And we could implement that in our hubs". (Participant 7)*

Many participants reported that the training exceeded their prior expectations. They readily mentioned the practical utility of the topics discussed, and as a result, how quickly they could transfer their learning to their work.

"I think it was definitely useful to come along. In terms of my expectations, they made things really clear about what the principles were and how they applied. So that sort of exceeded my expectations". (Participant 7)

However, not all trainees felt that their expectations were met. Attending with a specific training need can lead to frustration and disappointment when this requirement is not actualised. This participant said that they had hoped to learn more ways to refer CYP, but instead felt that the training covered content that they already knew.

"I think I found it frustrating, really, because I think I wanted to have different pathways to refer young people. I felt like it was telling me how to refer. Whereas the problem is that the referral pathways are so limited. I know how to refer. And I know a lot of the organisations have just got massive waiting lists. So, I was hoping, I think, to get some extra pathways". (Participant 8).

Inductive theme 2: Issues relating to the COVID-19 pandemic:

Owing to social distancing guidelines enforced in the UK at the onset of the COVID-19 pandemic, in-person training modules were moved to an online format. Unsurprisingly, issues associated with this modality shift were frequently reported. The networking element of training was mentioned several times: better facilitation of group conversation would have been appreciated in online sessions, but participants acknowledged that the virtual training environment, by nature, made this difficult. Longer networking periods are less practical and useful when offered through video conferencing, and importantly, less pleasant.

"I think you were given around 10-15 minutes, which, when virtually, I really don't think you can do much more can you, you lose like the networking side". (Participant 5)

Participants were sympathetic to the fact that engaging trainees is harder online. Even though training was delivered well, the live virtual environment can never provide the same immersive networking experience as in-person meetings.

> *"With the "Getting Advice and Signposting", it was delivered well over (Microsoft) Teams […] again, just having that opportunity to have conversations I think, was missing a bit. But that was just due to the nature of the way it was set up". (Participant 7)*

Completing training remotely often resulted in reduced focus, which was especially difficult for group work. It was very easy for people to turn off their cameras and disengage, with no consequence. Here, a resolution is suggested.

> *"You went into breakout rooms, and say there were five of you, sometimes it would only be three talking. Because two people would, you know, be off camera, and clearly not there! I don't know how they could manage that differently really, apart from maybe putting facilitators in each breakout room, that could be a way forward for future, if it was going to continue to be done online". (Participant 1)*

When attending in-person training, trainees were united during breaks, meaning that focus on GM i-THRIVE topics was maintained for the entirety of the session. When attending virtually, it is easier to become distracted and distanced. Again, this is especially true during breaks, where trainees are likely to choose to complete other tasks rather than continue networking.

> *"On the online ones, it felt as if when there was a break, everyone scattered for half an hour and then came back […] So I didn't really use that time to reflect on what I was doing that was related to the training […] Whereas if you're in that space, where you've got all these other people in front of you and they're all talking about THRIVE, even if you don't have a conversation, you've still got that break to reflect on some of the learning and some of the practices that you do in your everyday work". (Participant 7)*

Finally, one participant mentioned problems with getting a training place, despite their keen interest. Whilst this was an isolated account, this highlights potential issues with the reach and access of the programme. The participant was also unaware that the programme continued online during the lockdowns.

"I was trying to book on […] And I just couldn't. I just... didn't get any details about it. So I filled in the form. And then I didn't hear anything back, and then COVID happened. So obviously I never kind of chased it up after that". (Participant 6)

4.5: Discussion

In the present study, nine professionals from across Greater Manchester, UK, were interviewed to discuss their experiences with GM i-THRIVE training modules. This was to establish the typicality of the reported barriers and facilitators when compared to those identified within the existing literature (Banwell et al., 2021). In our earlier work, we synthesised nineteen practical categories based on previous literature (*Table 4.2*). By converting these nineteen directive action points into interview questions for the present study, evidence-led evaluations of the strengths and weaknesses of GM i-THRIVE's training were undertaken, showing where improvements can be made, and which elements of the training have been delivered successfully. "Testing" SLR evidence against an active, current training intervention for a piece of primary research is an underutilised method, yet one with potential for a robust, evidence-informed set of recommendations. We optimistically view this approach as the key strength of the present study.

As explained earlier, the 47 sub-categories of the SLR were treated as deductive codes, of which 43 were represented within the interviews. 26 new inductive codes were also produced, however only four of these could not be classified under the nineteen deductive themes of the SLR. The remaining 22 codes were thus incorporated into the deductive themes. This means that rather than reporting experiences entirely at odds with the literature, the participants' reports were of a similar nature, and could therefore be used to *expand* the categories. When we look at specific examples of the inductive codes that were incorporated into the pre-existing themes (*Table 4.2*), they are not dissimilar in nature to the deductive. Rather, they appear to focus more narrowly upon one element of a deductive code. To provide an example of this, under the "peer support (with a little help from my friends)" theme, the deductive code "trainees from different professional backgrounds sharing ideas and experiences" shared the theme with

inductive codes like “encourage conversation” and “learning about problems in the wider sector”. These two codes can clearly be conceptualised as the sharing of ideas and experiences, except that the specific experiences of the facilitation of discussion, and hearing about cross-sector difficulties, were raised, and therefore coded as such. This broadening of the thematic content resulted in those points receiving attention within the analysis.

As a conclusive statement on how closely the present study’s findings match those of the SLR, we would assert that although very similar, the contextual nuances of the training programme meant that slight but important differences were seen. Given that every intervention, training or otherwise, has its own unique differences and circumstances, we would predict that using this evidence-driven interview design method in other studies, to examine other interventions, would lead to a similar outcome. Qualitative SLRs akin to ours (Banwell et al., 2021) should therefore be treated as reliable yet broad evidence syntheses. The extent to which findings are treated as guidance should also reflect that. Implementers should, thus, not ignore the importance of speaking to those working with their own intervention, to consider the range of diverse experiences, contexts, and problems present within their teams. With more research effort given towards taking advantage of the deep and detailed investigative work of evidence syntheses, especially when designing primary research, it would be interesting to observe if this reasoning is true. The SLR and the present study, although interesting standalone pieces of research, can be treated as a “part one” and a “part two” of a combined investigation. The SLR served as a scoping mechanism through which to identify the questions that would yield the most valuable insights, with the present study going on to apply this knowledge.

There are several limitations to the methodology used in the present study that warrant discussion. A methodological paper (Hsieh & Shannon, 2005) was used to guide the choice of qualitative content analysis used in the present study. Those authors acknowledged limitations to the directed method, which will now be addressed in turn. Although content analysis is a relatively systematic way of exploring qualitative data, a direct approach means that prior theory is used as a starting point in the process of sorting the data into themes. As much as we might

consciously try to ignore the influence of our previous knowledge when using deductive codes, the confirmation bias caused by this knowledge is still, unavoidably, likely to influence our work. The data may then appear more likely to conform to these deductive codes. Although the processes of "sense-checking", and of the development of inductive codes, may have ameliorated this bias somewhat, it is nevertheless worth considering the influence that biases, including the more general subjectivity bias that is so often raised as a weakness of qualitative research, may have had on this research. We appear, however, to be moving towards holding qualitative research to a different, yet just as rigorous, set of standards as quantitative studies (Graneheim & Lundman, 2004). Providing that it is acknowledged appropriately, bias should not necessarily be seen as a problem to overcome, rather it should be accepted as a core principle, and indeed a strength, of interpretative work (Galdas, 2017). Another limitation is that theory-driven analysis can lead to context being ignored (Hsieh & Shannon, 2005). We believe that our earlier discussion of the nuances associated with individual interventions, and the consequent deviation of participant accounts from pre-existing frameworks goes some way to addressing this. This is particularly true given that the present study, and the implementation of GM i-THRIVE, took place during the COVID-19 pandemic. We cannot expect previous research to match these unprecedented circumstances in any way.

In terms of limitations relating specifically to the present study, we note the relatively small sample size. Whilst the ideal sample size for qualitative research appears predominantly a matter of opinion (Marshall et al., 2013), we nonetheless appreciate that a few more participants would have added strength to this study. Though, the eventual opportunistic nature of our recruitment did not allow that. Despite this, however, we believe that our sample was sufficiently homogenous for a robust picture of perceived barriers and facilitators, yet sufficiently diverse to capture a wide range of views and experiences (see *Table 4.1).* Examining divergent as well as convergent perceptions is a crucial element of multi-site implementation evaluations such as this (Benzer et al., 2013). In line with this, the closer focus on individual experiences allowed by a smaller sample can be viewed as a strength, and the value of these individual opinions and insights should not be downplayed.

The mixed deductive and inductive coding system resulted in a large number of themes, some of which were backed by only a small number of extracts. Initially, the fact that only a few of these could be analysed fully in this paper appeared concerning - perhaps the richness of the data would be lost if so many themes remained unexplored. Further reflection, however, led us to conclude that the direct and pragmatic nature of the interview resulted in extracts that often covered several concepts. Indeed, extracts were often coded more than once. Additionally, many themes are conceptually similar, and are often just different ways of focusing on a certain topic. These ideas were also highlighted in the SLR, where theming was guided by the framing of a concept as well as the content (Banwell et al., 2021). Ultimately, the way that the themes were built, in that several were conceptually similar, means that fully exploring more than a handful within this paper would have resulted in a great deal of repetition. As those themes chosen for presentation either contained the most extracts, or were completely inductive, it follows that they should form the backbone of the recommendations made, owing to their salience and relevance to GM i-THRIVE respectively.

Below, we present the recommendations for the GM i-THRIVE training implementers. Before that, however, it seems prudent to discuss the generalisability, or transferability, of the present study's findings, especially in light of these recommendations. A key question is whether the findings can be applied to other training settings, particularly outside of the CYP mental health sphere. Without further in-depth investigation, we cannot state, either way, whether similar findings would emerge had the same interviews been given to staff receiving training in a different field. The perceived barriers and facilitators may, or may not, be universal characteristics that can be used to improve training across the board. However, given that transferability was not a central aim of this study (Carminati, 2018), this should be done cautiously, with due consideration given to the context of our research. Nonetheless, we optimistically suggest that given the substantial and focussed nature of the SLR findings (Banwell et al., 2021) that were used to guide this study, the recommendations that we make can and should be used to develop and improve other training programmes relating directly to the mental health of CYP. Indeed, qualitative meta-syntheses can be seen as a way of

combining several investigations. This makes them easier to apply to practice and research, but also to enhance the transferability of the included studies (Finfgeld-Connett, 2010). Our focus on GM i-THRIVE as a case study frames our findings within a localised public health intervention. Thus, although the recommendations are worded accordingly, GM i-THRIVE can simply be seen as a good example of application to a relevant training intervention.

Based on qualitative investigation, we make the following recommendations for the continued dissemination of the GM i-THRIVE Training Academy. The citations within these recommendations relate to studies that were included in our SLR.

- Participants valued time to interact with others attending the training. Ensure that structured group dialogue can bring out the strengths and differences of each group member (Coiro et al., 2016), and that they are aware of each other's roles and where these roles fit into the wider system of CYP mental health provision in Greater Manchester.

- Unstructured peer interaction was also valued, and the advantages of interaction were lost in the online training environment (Tchernegovski et al., 2015). Where training must continue online owing to the pandemic, efforts to ameliorate these issues, and facilitate discussion, should be made.

- Many participants wished for more opportunities to discuss the nuances of their own workplaces (Harris, 2013), and to reflect upon what elements of GM i-THRIVE would look like in their contexts. This is especially true for those working with CYP who are at the highest risk level. Providing as much applicable and tangible meaning to the training as possible will be valuable (Tchernegovski et al., 2015; Wu et al., 2019).

- Participants valued the scaffolded structure of the training (Donald, 2015). However, consideration should be given to fully explaining key words and concepts. Ensuring that language, terminology, and jargon are fully clarified at the start will maximise understanding by trainees of different professional backgrounds (Askell-Williams & Murray-Harvey, 2016; Gonzalez et al., 2019). By

further reinforcing their “common language” tenet, GM i-THRIVE can make the dissemination of their training more effective. Trainees will be able to make closer links between GM i-THRIVE and the practices and procedures that they already follow.

- Clarifying the aims of the training, and for whom it is the most suitable, will maximise satisfaction (Lee, 2016), especially when trainees are made aware of this in sufficient advance.

- It is vital that everyone who needs or wishes to take part in the training can do so (Eustache et al., 2017; Wu et al., 2019). Some keen individuals may slip “under the radar” owing to miscommunication or confusion about how to take part. Making the sign-up process easy to understand, and ensuring that managers are clear on how their staff can take part, will improve training reach.

4.6: Conclusions

The present study examined semi-structured interview transcripts, the schedule for which were developed using a coding scheme devised from qualitative SLR findings (Banwell et al., 2021). Identified themes largely echoed those of the review, which provided a vital starting point in terms of the questions that needed to be asked, and the elements likely to be of interest in the data. Several important differences were also found, and it is plausible that these may reflect the contextual nuances of GM i-THRIVE itself, and of issues arising because of the COVID-19 pandemic. The study provides a valuable example of how qualitative evidence syntheses can aid study design and analysis. Studies following a similar research strategy will further demonstrate the utility of SLRs for guiding research: an approach that is, thus far, underused. Study limitations were discussed, and six key recommendations were made. We suggest that these findings are transferable to similar settings. Still, for optimal training effectiveness and efficiency, implementers should invest time and effort into considering the unique issues and challenges surrounding their intervention and trainee pool.

4.7: References

Askell-Williams, H., & Murray-Harvey, R. (2016). Sustainable professional learning for early childhood educators: Lessons from an Australia-wide mental health promotion initiative. *Journal of Early Childood Research*, *14*(2), 196–210. https://doi.org/10.1177/1476718X15570958

Banwell, E., Humphrey, N., & Qualter, P. (2021). Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation. *BMC Medical Education*, *21*(1), 103. https://doi.org/10.1186/s12909-021-02530-0

Benzer, J. K., Beehler, S., Cramer, I. E., Mohr, D. C., Charns, M. P., & Burgess, J. F. (2013). Between and within-site variation in qualitative implementation research. *Implementation Science*, *8*(1), 4. https://doi.org/10.1186/1748-5908-8-4

Biddle, L., Donovan, J. L., Gunnell, D., & Sharp, D. (2006). Young adults' perceptions of GPs as a help source for mental distress: A qualitative study. *The British Journal of General Practice*, *56*(533), 924–931.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological.* (pp. 57–71). American Psychological Association. https://doi.org/10.1037/13620-004

British Psychological Society. (2021, April). *BPS Code of Human Research Ethics*. BPS Code of Human Research Ethics. https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics

Carminati, L. (2018). Generalizability in Qualitative Research: A Tale of Two Traditions. *Qualitative Health Research*, *28*(13), 2094–2101. https://doi.org/10.1177/1049732318788379

Coiro, M. J., Kotchick, B. A., & Preis, J. (2016). Youth social skills groups: A training platform for promoting graduate clinician interprofessional competence. *Journal of Interprofessional Education Practice*, *4*, 89–92. https://doi.org/10.1016/j.xjep.2016.04.004

Cooper, N. J., Jones, D. R., & Sutton, A. J. (2005). The use of systematic reviews when designing studies. *Clinical Trials*, *2*(3), 260–264. https://doi.org/10.1191/1740774505cn090oa

Department for Education. (2021). *Schools and colleges to benefit from boost in expert mental health support*. GOV.UK. https://www.gov.uk/government/news/schools-and-colleges-to-benefit-from-boost-in-expert-mental-health-support

Department of Health. (2015). *Future in Mind: Promoting, protecting, and improving our children and young people's mental health and wellbeing*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Donald, E. (2015). *The effects of child teacher relationship training (CTRT) on residential care workers: A mixed methods study (Doctoral dissertation)*. NC: University of North Carolina.

Eustache, E., Gerbasi, M. E., Smith Fawzi, M. C., Fils-Aime, S., JR, J, R., & G.J. (2017). Mental health training for secondary school teachers in Haiti: A mixed methods, prospective, formative research study of feasibility, acceptability, and effectiveness in knowledge acquisition. *Global Mental Health*, *4*(e4), 1–16. https://doi.org/10.1017/gmh.2016.29

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative Content Analysis: A Focus on Trustworthiness. *SAGE Open*, *4*(1), 2158244014522633. https://doi.org/10.1177/2158244014522633

Finfgeld-Connett, D. (2010). Generalizability and transferability of meta-synthesis research findings. *Journal of Advanced Nursing*, *66*(2), 246–254. https://doi.org/10.1111/j.1365-2648.2009.05250.x

Galdas, P. (2017). Revisiting Bias in Qualitative Research: Reflections on Its Relationship With Funding and Impact. *International Journal of Qualitative Methods*, *16*(1), 1609406917748992. https://doi.org/10.1177/1609406917748992

Gonzalez, J. E., Stoiber, K. C., Clayton, R. J., Keller-Margulis, M., Reddy, L. A., & Forman, S. G. (2019). A qualitative analysis of school psychology trainers' perspectives on evidence-based practices. *International Journal of School & Educational Psychology*, *1–16*. https://doi.org/10.1080/21683603.2019.1668317

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Greater Manchester Health and Social Care Partnership. (2021). *About Devolution*. https://www.gmhsc.org.uk/about-devolution/

Harris, N. (2013). *The effects of a one day in-service workshop on the self-efficacy of physical educators to include students with autism into the general physical education setting (Doctoral dissertation)*. VA: University of Virginia.

Hinrichs, S., Owens, M., Dunn, V., & Goodyer, I. (2012). General practitioner experience and perception of Child and Adolescent Mental Health Services (CAMHS) care pathways: A multimethod research study. *BMJ Open*, *2*(6). https://doi.org/10.1136/bmjopen-2012-001573

Hsieh, H.-F., & Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, *15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687

Implementing THRIVE. (2021). *Greater Manchester i-THRIVE Programme*. http://implementingthrive.org/greater-manchester-i-thrive/

Kerasidou, A., & Kingori, P. (2019). Austerity measures and the transforming role of A&E professionals in a weakening welfare system. *PloS One*, *14*(2). https://doi.org/10.1371/journal.pone.0212314

Lambert, A. K., Doherty, A. J., Wilson, N., Chauhan, U., & Mahadevan, D. (2020). GP perceptions of community-based children's mental health services in Pennine Lancashire: A qualitative study. *BJGP Open*, *4*(4), bjgpopen20X101075. https://doi.org/10.3399/bjgpopen20X101075

Lee, F. (2016). Self-harm training in secondary schools: An educational psychology intervention using interpretative phenomenological analysis. *Educational & Child Psychology*, *33*(2), 118–129.

Marshall, B., Cardon, P., Poddar, A., & Fontenot, R. (2013). Does Sample Size Matter in Qualitative Research?: A Review of Qualitative Interviews in is Research. *Journal of Computer Information Systems*, *54*(1), 11–22. https://doi.org/10.1080/08874417.2013.11645667

Morgan, D. L. (2014). Pragmatism as a Paradigm for Social Research. *Qualitative Inquiry*, *20*(8), 1045–1053. https://doi.org/10.1177/1077800413513733

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods*, *1*(2), 13–22. https://doi.org/10.1177/160940690200100202

National Audit Office. (2018). *Improving children and young people's mental health services—National Audit Office (NAO) Report*. National Audit Office. https://www.nao.org.uk/report/improving-children-and-young-peoples-mental-health-services/

Neufeld, S. A., Jones, P. B., & Goodyer, I. M. (2017). Child and adolescent mental health services: Longitudinal data sheds light on current policy for

psychological interventions in the community. *Journal of Public Mental Health*, *16*(3), 96–99. https://doi.org/10.1108/jpmh-03-2017-0013

NHS Digital. (2021). *Mental Health of Children and Young People in England 2021—Wave 2 follow up to the 2017 survey*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2021-follow-up-to-the-2017-survey

Nikolakopoulou, A., Trelle, S., Sutton, A. J., Egger, M., & Salanti, G. (2019). Synthesizing existing evidence to design future trials: Survey of methodologists from European institutions. *Trials*, *20*(1), 334. https://doi.org/10.1186/s13063-019-3449-6

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for Reporting Qualitative Research: A Synthesis of Recommendations. *Academic Medicine*, *89*(9), 1245–1251. https://doi.org/10.1097/ACM.0000000000000388

O'Reilly, M., Adams, S., Whiteman, N., Hughes, J., Reilly, P., & Dogra, N. (2018). Whose responsibility is adolescent's mental health in the UK? Perspectives of key stakeholders. *School Mental Health*, *10*(4), 450–461. https://doi.org/10.1007/s12310-018-9263-6

Plaistow, J., Masson, K., Koch, D., Wilson, J., Stark, R. M., Jones, P. B., & Lennox, B. R. (2014). Young people's views of UK mental health services. *Early Intervention in Psychiatry*, *8*(1), 12–23. https://doi.org/10.1111/eip.12060

Pyett, P. M. (2003). Validation of Qualitative Research in the "Real World". *Qualitative Health Research*, *13*(8), 1170–1179. https://doi.org/10.1177/1049732303255686

Scottish Government. (2018). *Rejected Referrals Child and Adolescent Mental Health Services (CAMHS): A qualitative and quantitative audit*.

Smith, J., Kyle, R. G., Daniel, B., & Hubbard, G. (2018). Patterns of referral and waiting times for specialist Child and Adolescent Mental Health Services.

Child and Adolescent Mental Health, *23*(1), 41–49. https://doi.org/10.1111/camh.12207

Solmi, M., Radua, J., Olivola, M., Croce, E., Soardo, L., Salazar de Pablo, G., Il Shin, J., Kirkbride, J. B., Jones, P., Kim, J. H., Kim, J. Y., Carvalho, A. F., Seeman, M. V., Correll, C. U., & Fusar-Poli, P. (2022). Age at onset of mental disorders worldwide: Large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry*, *27*(1), 281–295. https://doi.org/10.1038/s41380-021-01161-7

Storey, P., Hurry, J., Jowitt, S., Owens, D., & House, A. (2005). Supporting young people who repeatedly self-harm. *Journal of the Royal Society for the Promotion of Health*, *125*(2), 71–75. https://doi.org/10.1177/146642400512500210

Tchernegovski, P., Reupert, A., & Maybery, D. (2015). Let's Talk about Children": A pilot evaluation of an e-learning resource for mental health clinicians. *Clinical Psychology*, *19*(1), 49–58. https://doi.org/10.1111/cp.12050

Urra Medina, E., & Barría Pailaquilén, R. M. (2010). Systematic Review and its Relationship with Evidence-Based Practice in Health. *Revista Latino-Americana de Enfermagem*, *18*(4), 824–831. https://doi.org/10.1590/S0104-11692010000400023

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, *15*(3), 398–405. https://doi.org/10.1111/nhs.12048

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2016). *THRIVE Elaborated* (Second). http://implementingthrive.org/wp-content/uploads/2016/09/THRIVE-elaborated-2nd-edition.pdf.

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2019). *THRIVE Framework for system change*. CAMHS Press.

https://www.annafreud.org/media/9254/thrive-framework-for-system-change-2019.pdf.

Wu, Y. Q., Chartier, M., Ly, G., Phanlouvong, A., Thomas, S., & Weenusk, J. (2019). Qualitative case study investigating PAX-good behaviour game in first nations communities: Insight into school personnel's perspectives in implementing a whole school approach to promote youth mental health. *BMJ Open*, *9*(9). https://doi.org/10.1136/bmjopen-2019-030728

Chapter 5: Reformed child and adolescent mental health services in a devolved healthcare system: A mixed-methods case study of an implementation site

Banwell, E., Humphrey, N., & Qualter, P. (2023). Reformed child and adolescent mental health services in a devolved healthcare system: A mixed-methods case study of an implementation site. *Frontiers in Health Services, 3.* https://www.frontiersin.org/articles/10.3389/frhs.2023.1112544

This chapter presents the version of Study 3 that was published, open access, in Frontiers in Health Services. However, it has been reformatted for consistency with the rest of the thesis. All supplementary materials referred to in this chapter can be found in *Appendix 3.*

5.1: Abstract

Background:

Efforts are being made to reform and reconceptualise children and young people's (CYP) mental health services. This is in response to a rapid increase in mental health difficulties in this population, and the shortcomings of current service provision. The present study seeks to comprehensively evaluate the local implementation of the THRIVE Framework for System Change in Greater Manchester, UK (GM i-THRIVE) from 2018-2021. The framework was designed to change the way mental health is perceived, and subsequently how support is allocated.

Methods:

The study comprised three methodological components, beginning with examination of the GM i-THRIVE implementation plan and self-assessment questionnaire measure using the Quality Implementation Tool (Meyers et al., 2012). This was to provide a wider backdrop of implementation method adequacy to the rest of the study's findings. Subsequently, evaluation measures completed by professionals across Greater Manchester were examined to establish implementation progress, before corroborating key items from this measure with

thematically analysed interview data from six CYP (13-22 years) who recently received mental health support in the region. Levels of agreement between staff and CYP were examined.

Results:

GM i-THRIVE's implementation plan and self-assessment measure were respectively deemed a strong guiding foundation, and a suitable way of evaluating implementation progress. Every principle within the self-assessment measure demonstrated closer alignment with the THRIVE Framework as time progressed. Two themes were developed from the qualitative interview data, each overarching four subthemes: (1) *Qualities of the service:* information and decision sharing; communication and continuity; needs-based support; compassion and trust, and (2) *The mental health journey:* beginnings; endings; waiting; satisfaction with support. A good level of agreement between CYP testimony and staff progress reports was found.

Conclusions:

Findings suggested that the experiences of the CYP in the sample were overwhelmingly positive. The rich insights into mental health support offered by the young participants lead us to recommend continued qualitative research with service-users as GM i-THRIVE's embedding period continues, with focus on representing a wide range of experiences in future research samples. Methodological limitations were explored, including the extent to which true cross-references could be made between professional and CYP accounts.

Keywords:

Mental health services; child and adolescent mental health; reformed health services; implementation science; programme evaluation

5.2: Introduction

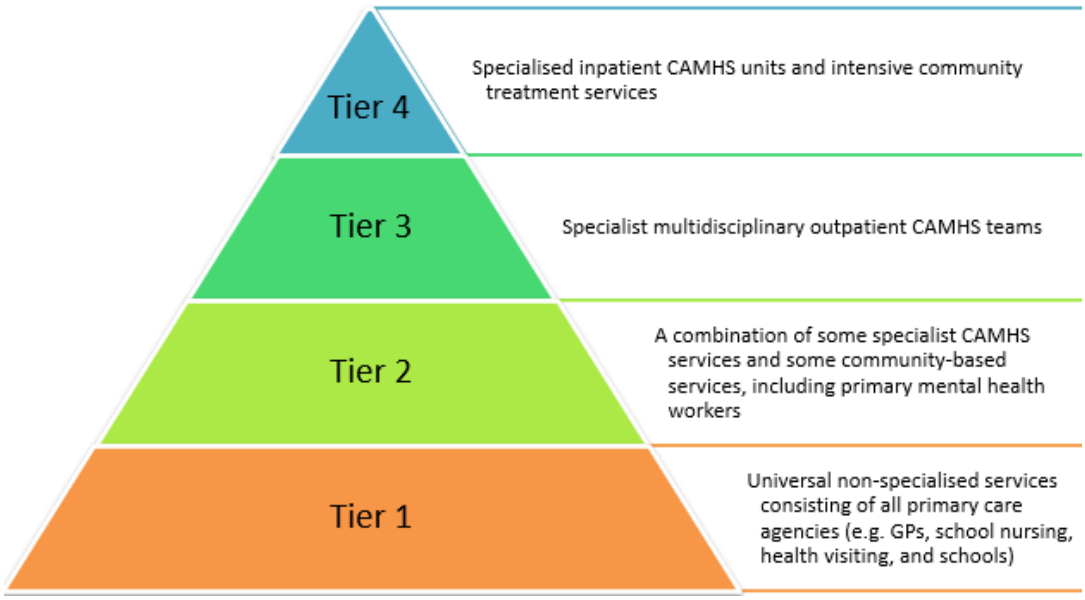
Background:

The prevalence of mental health difficulties in children and young people (CYP) is increasing year on year (NHS Digital, 2021). The peak age of onset for all mental health conditions is 14.5 years (Solmi et al., 2022), with 75% of all mental health conditions appearing before a person reaches their mid-twenties (Kessler et al., 2007). Accordingly, efforts to ameliorate the impact of these difficulties as early as possible should be policy priority, as is, consequently, the meticulous evaluation of these efforts. The present study provides an in-depth mixed-methods evaluation of how successfully the THRIVE Framework for System Change (Wolpert et al., 2019) is being implemented in Greater Manchester, United Kingdom.

To fully understand what the implementation of THRIVE, a national reconceptualisation of CYP mental health and service provision in England, hopes to achieve, we must first explore the various ways that previous provision of child and adolescent mental health services (known by the acronym of CAMHS when this refers to services provided by the National Health Service (NHS) in the UK) fell short of providing adequate support. The key inadequacy was that appropriate specialist support was often tremendously difficult for CYP to access. For example, in 2018, only 25% of CYP with a diagnosable condition managed to utilise specialist CAMHS services in England (Department of Health, 2015; Green et al., 2005). Reduced government spending allocation to mental healthcare provision (McNicoll, 2015) including to CAMHS (Neufeld et al., 2017), substantial waiting times (England & Mughal, 2019; Wolpert et al., 2016), and high referral rejection rates (Smith et al., 2018) may contribute towards our understanding of why, despite the rise in demand for these services (NHS Digital, 2021), so many remain unseen by specialist mental health professionals. In addition to those likely explanations, the rigid nature of how mental health services were conceptualised by CAMHS was, by its nature, prohibitive to CYP receiving appropriate and timely support. The tiered model (see *Figure 5.1*) that has dominated CAMHS provision since its 1995 inception (NHS Health Advisory Service, 1995) meant that accessing specialist

support required contact with a myriad number of professionals across the tiers before finally receiving appropriate care (Bone et al., 2014; Department of Health, 2015). The model has been criticised for unnecessarily compartmentalising services and their provision (Hacker, 2021); a reification that has resulted in many being unable to receive support, or "falling between the gaps", if they do not perfectly fulfil the criteria pertaining to a certain tier (Department of Health, 2015; Wolpert et al., 2016).

Figure 5.1: *CAMHS tiered model of service conceptualisation*



The THRIVE Framework for System Change:

The THRIVE Framework, adopted by more than 70 localities in England to date, aims to improve access to mental health services for CYP in many important ways. One of these is to disseminate the idea that CYP mental health is "everybody's business" (Ford et al., 2007, p. 13): that responsibility should not, and indeed *does* not, belong solely to medicalised services that are provided by the NHS. Allied professionals, of which teachers are a prime example, are essentially a "front line" source of mental health support for CYP (O'Reilly et al., 2018). These trusted adults are often relied upon because of the widespread inability to access CAMHS services outlined above, but also because not all wellbeing and mental health concerns require intervention

from a medicalised service. A negative emotional reaction to, for example, a bereavement or a parental separation, is healthy and expected, yet appropriate support is still required to prevent the disturbance from persisting. THRIVE recognises, therefore, that anyone who comes into professional contact with CYP should be well-placed to provide such support or guidance. However, many allied professionals currently feel ill-prepared to assist to the level that they wish they were able (O'Reilly et al., 2018). Thus, THRIVE is training a diverse range of these professionals so that they can provide a more inclusive, seamless, and accessible support network. This should, ideally, lead to a scenario where is never a "wrong door" in which to turn, owing to a widespread and consistent standard of support and signposting (Department of Health, 2015).

Preventative mental health support for CYP, by way of deescalating concerns before they exacerbate, is a key step towards breaking the commonly seen associations between poor mental health in early life and detrimental outcomes in adulthood (Aebi et al., 2014; Trotta et al., 2020). The fact that medicalised support is at the heart of the tiered model means that support can only be given when a problem has escalated to a certain point. THRIVE, on the other hand, advocates a needs-based approach, whereby support is provided based upon present requirement, irrespective of previous diagnoses or service use (Wolpert et al., 2019). This means that every young person is accounted for by one of the five needs-based groupings of the THRIVE model *(Figure 5.2).* It is acknowledged that everyone can benefit from some form of support, depending upon which grouping their needs fall under at any given time.

By offering diversified options for receiving mental health support, and ensuring that more CYP can receive it from any professional they meet in their day-to-day life, the implementation of THRIVE should result in reduced waiting times for specialised CAMHS services and an availability of alternative resources whilst a wait is in progress. An ethos of open communication will mean than decisions are undertaken using a cross-sector approach, eradicating the "silo mentality" that is regarded as a prominent issue across the wider NHS (Hacker, 2021; McCartney,

Figure 5.2: *The THRIVE model. Left: THRIVE's five needs-based groupings. Right: The support that CYP mental health needs can benefit from under each grouping (Wolpert et al., 2016)*

2016) but notably within CAMHS, where a lack of accountability for certain elements of care is a common feature (Department of Health, 2015). The involvement of CYP and their families at every step of this decision-making also features in THRIVE-aligned support (Wolpert et al., 2019) resulting in care that is substantially more tailored towards each young person.

Since 2018, Greater Manchester's ten locality boroughs (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, and Wigan) have gradually aligned their CYP mental health services to the THRIVE Framework. This alignment process, known locally as GM i-THRIVE, is just one element of devolved health and social care resulting from a 2016 deal between the Greater Manchester Health and Social Care Partnership (GMHSCP) and the UK government. GMHSCP can now decide how services are funded at a local level, meaning that spending can be allocated appropriately to the 2.8 million residents of Greater Manchester. An initial implementation period of four years (2018-22) was given to introduce, implement, and normalise the Framework within all sectors that provide mental health support for CYP. It is therefore crucial that this formal implementation phase provides the strongest possible foundation for the ongoing

success of the programme. To do this, a careful, iterative process of planning, implementing, and monitoring (Meyers, Durlak, et al., 2012) is essential, with consideration given to the impact of the COVID-19 pandemic on both service provision, and the delivery and evaluation of the programme.

The present study:

By combining a variety of methodological approaches, the present study aimed to evaluate GM i-THRIVE's implementation progress to date. At the time of research, the four-year initial implementation period (2018-22) was ending, and a short "embedding" phase, in which implementation efforts are continuing, was beginning. This meant that sufficient information, data, and informed testimonies were available with which to conduct a comprehensive evaluation. The components of the present study and their objectives will now be outlined in turn.

First, through qualitative document analysis, we assessed the adequacy of GM i-THRIVE's own implementation plan using the Quality Implementation Tool (QIT) (Meyers, Katz, et al., 2012). Second, we established whether the aims of GM i-THRIVE were met, by analysing records of progress, that were self-reported by professionals working across Greater Manchester. Finally, interviews were conducted with CYP who were recently in receipt of support from THRIVE-aligned mental health services in Greater Manchester. This service-user data was compared to the implementation progress reported by the localities. Whilst localities might report a certain level of implementation progress, if CYP in Greater Manchester do not describe experiences that evidence THRIVE-aligned care, such reports would mean very little. Young people's hopes and expectations of the outcomes of mental health care often considerably differ from those of the adults involved in their support. Research has revealed that parents and their children have conflicting ideas of what ideal CAMHS provision would look like (Ronzoni & Dogra, 2011). Differences also exist between CYP, parents, and therapists in terms of what mental health improvement, and desired outcomes of support, look like (Garland et al., 2004; Ronzoni & Dogra, 2011). This lack of consensus can have a detrimental impact on CYP engagement with services, leading to disconnection within the

therapeutic relationship, and ultimately, poorer support outcomes (Garland et al., 2004). These studies suggest that young people's insights provide a valuable source of information, which is often underutilised. Within our study, it followed that their experiences, opinions, and indeed disagreements, could and should be meaningfully compared with localities' reports of progress to form a comprehensive evaluation. To summarise the above components, the key research questions for the present study were as follows:

1. Do GM i-THRIVE's overarching implementation plan, and self-assessment evaluation system, contain the components deemed necessary (Meyers, Katz, et al., 2012) for successful implementation and evaluation of an intervention?
2. Do the localities within Greater Manchester report a general shift towards aligning their practices with the THRIVE Framework within the four-year initial implementation period?
3. Do the experiences of CYP in Greater Manchester align with the implementation progress reported by localities?

5.3: Methods

Reporting guidelines:

The production of this article adhered to the Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014). In addition, the principles of reflexive thematic analysis (Braun & Clarke, 2006, 2021) were used to guide the reporting and analysis of the qualitative data.

Researcher context:

The authors were externally commissioned by GMHSCP to evaluate GM i-THRIVE. As employees of the University of Manchester rather than GMHSCP, the analyses and conclusions drawn in this study were unlikely to be biased by vested interest. However, the first author has been continually immersed in the working environment of GM i-THRIVE as part of this work (e.g., as an attendee of regular meetings with key leaders and stakeholders). As a result, impressions gained during

these meetings may have influenced the analysis of the present study's qualitative data (Noble & Smith, 2015). Despite this, the immersive experience provided an in-depth knowledge of the people, working practices, and systems of GM i-THRIVE that was undoubtedly advantageous. Considering this situation in tandem with the principles of reflexive thematic analysis (Braun & Clarke, 2021), conclusions drawn can only ever reflect the author's interpretation of the qualitative data. Whilst this subjectivity should certainly be considered alongside this study's findings, it should be viewed as a tool that sculpts the analysis rather than as a threat to credibility (Braun & Clarke, 2021).

Setting:

The implementation site of Greater Manchester, which was home to 898,000 under-25s in 2019 (Greater Manchester Combined Authority, 2019), is an ethnically and socially diverse city-region in the north-west of England. It contains a mix of high-density urban areas, suburbs, and rural locations within its 493 square mile boundaries. CYP living in Greater Manchester are more likely to live in poverty and have poorer overall health outcomes than the average in the UK (Greater Manchester Combined Authority, 2019). The city-region comprises ten metropolitan boroughs (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, and Wigan), all of which have a dedicated team responsible for coordinating the implementation of GM i-THRIVE across specialist NHS CYP mental health services, and other local service providers.

Design:

The present study was a mixed-methods case study of GM i-THRIVE. It combined qualitative and quantitative document analyses with semi-structured qualitative interviews. This triangulation enabled the generation of comprehensive meta-inferences, pertaining not only to implementation progress, but also to how successfully it was planned and measured. Acknowledging one's reasons for adopting a mixed methodological approach is an important part of the rationale behind any evaluation design (Greene et al., 1989). One of our broad research aims was to counteract the potential bias in localities' self-reports of progress with

qualitative accounts from CYP. This served to strengthen the validity of our inferences, as per "triangulation" in its most classic sense (Greene et al., 1989). However, the discovery of paradox between the various testimonies in the present study was a key driver of interest. The potential conclusions drawn from discrepancies can indeed be just insightful as consistencies in research of this nature.

We deduced that the most appropriate way to approach the evaluation of GM i-THRIVE was through a pragmatic epistemological lens. The assortment of methods used in the present study were chosen purely for their ability to meet each research aim. The pragmatic notion that knowledge of the inner workings of organisations can be generated through the conflation of participant accounts with the empirically measurable (Kelly & Cordeiro, 2020) meshes extremely well with our study aims. Beyond this, a deeper degree of reflection on the formulation of knowledge was simply not needed for an evaluation of this kind (Morgan, 2014).

Participants:

Eligibility for the qualitative element of the study required participants to have received mental health or wellbeing support since September 2018: the start of GM i-THRIVE's implementation period. This support must have come from a site or service within Greater Manchester that was active in the process of aligning their practices to the THRIVE Framework. Participants needed to be between 13 and 21 years old. The upper age limit meant that they could have received support from CYP mental health services in between 2018 and present, and 13 was deemed a suitable lower cut-off age at which participants could properly assent to and engage with the research. Participants were identified on the basis that they were either former users of a service, or they were in the final stages of receiving support. These criteria ensured that the mental health of participants was sufficiently stable to both assent and take part. A gatekeeper within the GM i-THRIVE implementing team identified participants through their support providers on an opportunistic basis. They were approached based on the providers' perception of them as able and willing to participate in an interview, with a third party, about their experiences

with support. Participants were given the option of having another person present to provide emotional support.

Ethical considerations:

Ethical approval was received (reference number: 2021-11033-18945) from the University of Manchester's research ethics committee (UREC). All participants (and their parents if under 16) were provided with age-appropriate participant information sheets, detailing the nature of the study and their potential contribution. Written consent was obtained from participants who were over 16 (in the UK, this is the age that a person is thought able to independently provide full consent to research participation), and from the parents of the 13- to 15-year-olds. 13- to 15-year-olds gave written assent to take part, confirming that they understood the study and how their data would be used. Through a process of reinstating information and rights, and being attuned to our participants' responses and body language, consent, or dissent, was obtained continuously and reflexively as per a recent reframing of research consent (Klykken, 2021).

Data collection:

Interview data:

Due to social distancing restrictions enforced in response to the COVID-19 pandemic, interviews were conducted by the first author using secure online video conferencing software. Semi-structured interviews were used to explore participants' experiences of receiving recent support for their mental health. The interview schedule was designed to ascertain the extent to which the aims of THRIVE were reflected in the participants' experiences of support or care. The schedule consisted of 10 broad questions, overarching several prompts and sub-questions (see *Appendix 3*).

Secondary data for document analyses:

GM i-THRIVE provided a copy of their implementation plan, which comprised five overarching stages: set-up; engagement, understanding, and planning; building capacity; implementation; and embedding and sustaining. Each stage contained

several granular items that were to be completed during the implementation process. A copy of this implementation plan can be found in *Appendix 3*. Self-assessment matrices were completed annually by each Greater Manchester locality. These provided a report of perceived alignment over time to the THRIVE model. At the beginning of implementation in 2018, completions of the matrix generated a baseline "snapshot" of practices, whilst subsequent completions indicated the success of individual localities' transformation strategies. The matrix outlines 22 underlying principles of the THRIVE Framework that are divided into three categories: micro (considerations for individual CYP and professionals), meso (community-level considerations), and macro (larger-scale considerations for the wider population). The matrix then allows the locality to rate their progress from 1 ("some way to go to achieving THRIVE-like practice") to 4 ("practice is very THRIVE-like"). Detailed commentaries were provided alongside each principle to help guide selection. Completed matrices from 2018-21 were provided to the authors for secondary analysis. A list of the matrix's principles can be found in *Table 5.1.*

Table 5.1: *Principles of the GM i-THRIVE self-assessment matrix*

Principle of GM i-THRIVE self-assessment matrix	**Description** *** those selected for presentation in *Figure 5.3* and comparison with the qualitative themes**
MACRO PRINCIPLE 1:	A locality's mental health policy is interagency.
MACRO PRINCIPLE 2:	All agencies are involved in commissioning care (education, health, social care, third sector)*
MACRO PRINCIPLE 3:	Contracting of services, and the performance management of these, is informed by quality improvement information
MACRO PRINCIPLE 4:	Use of population level preference data is used to support commissioning decisions.
MACRO PRINCIPLE 5:	Services working closely together such that service users experience integration of care positively*
MESO PRINCIPLE 1:	A comprehensive network of community providers is in place
MESO PRINCIPLE 2:	Quality Improvement (QI) data used to inform decisions, and this involves multiagency consideration of the data
MESO PRINCIPLE 3A:	Help is delivered using the conceptual framework of five needs based groups
MESO PRINCIPLE 3B:	As above, but based on results of staff survey about whether they think care is delivered in this way (what % of staff)*

MESO PRINCIPLE 4:	There is a focus on strengths and family resources wherever possible
MESO PRINCIPLE 5:	Evidence based practice is available and aligned to need using the 19 sub categories of needs as set out in the payment systems work
MICRO PRINCIPLE 1A:	Shared Decision Making (SDM) at the heart of all decisions (based on perceived implementation extent)*
MICRO PRINCIPLE 1B:	As above, but based on scores on CollaboRATE (what % of CYP given the chance to rate their experience of SDM)
MICRO PRINCIPLE 2:	People (staff, CYP and families) are clear about which needs based group they are working within for any one person at any one time and this explicit to all*
MICRO PRINCIPLE 3A:	People (staff, CYP and families) are clear about parameters for help and reasons for ending (staff survey)*
MICRO PRINCIPLE 3B:	As above, but based on % of cases with reasons for ending included in proforma and endings discussed with CYP at start
MICRO PRINCIPLE 3C:	As above but based on if staff had training on this/recognise it as an important part of therapy*
MICRO PRINCIPLE 4:	Outcome data is used to inform individual practice with the purpose of improving quality
MICRO PRINCIPLE 5A:	Any intervention would involve explicit agreement from the beginning about the outcome being worked towards and the likely timeframe. There would be a plan for what happens if it is not achieved. (% that are managed in recommended timeframe)*
MICRO PRINCIPLE 5B:	As above, but notes include info on goals/outcomes discussion with CYP*
MICRO PRINCIPLE 6:	The most experienced practitioners inform advice and signposting
MICRO PRINCIPLE 7:	THRIVE plans are used to help those managing risk (Case audit: % of CYP in the "Getting Risk Support" needs based group have a THRIVE plan documented and up to date)

Data analysis:

Qualitative interview data:

Interviews were securely recorded via the video conferencing software, and the automatically generated transcripts were checked manually for accuracy by the first author. Data were analysed following Braun & Clarke's guidelines for reflexive thematic analysis (Braun & Clarke, 2006, 2021). The flexible application and broad epistemological compatibility of this approach (Braun & Clarke, 2021) meant that it to our research aims. The simple yet rich organisational data summary that the method lends itself to when analysis is complete (Braun & Clarke, 2006) was also appealing given that meta-inferences were to be drawn. Thematic analysis allows

both inductive and deductive code and theme identification methods (Braun & Clarke, 2006). Given that the purpose of interviewing CYP was to establish whether their reported experiences matched locality-reported progress, this aim acted as a key driver of the analytic strategy. Initially, therefore, a deductive strategy was used to code the data. For this, a list of provisional codes was generated based upon the principles of the matrix (*Table 5.1*). However, new codes were generated when other notable features were identified in the transcripts, and the deductive codes were developed, renamed to better fit the data, and eventually absorbed into the final themes as these were formed. This added an inductive element to the analysis. Codes were then grouped into semantic themes, which were tested and refined reflexively (Braun & Clarke, 2021) with each transcript, and with the entire data set. A dynamic thematic map was developed to assist this non-linear process. Final themes were then defined, then named in a way that any inconsistencies in CYP's testimonies were still suitably covered by the theme title. Whilst the study's aim was to compare the themes and their content to matrix data, these final themes were not forced to match the principles, rather, they were named to encapsulate their interpretative nature (Braun & Clarke, 2021). The process of naming and re-naming themes continued into the write-up stage of the analysis.

The thematic analysis was completed prior to the document analyses below, to avoid the risk of unintended bias that may have come from the results of the matrices. Researcher subjectivity is not seen as problematic in thematic analysis (Braun & Clarke, 2021; Campbell et al., 2021). Rather, it should be seen as a resource for reflexive data analysis and as an asset to knowledge production (Byrne, 2021). Pursuing researcher consensus, given that interpretation, rather than objective "accuracy", is the goal of thematic analysis, is also discouraged (Byrne, 2021). However, the broad processes of theme generation and mixed-methodological cross-referencing were nonetheless sense-checked by the second and third authors (Byrne, 2021). This was to ensure that the themes appeared to represent the data logically (Elo et al., 2014) and that the interpretation was as rich as possible (Byrne, 2021).

Document analyses:

For the first step of the document analysis, GM i-THRIVE's implementation plan and the blank self-assessment matrix were checked, together, for the presence of each of the 29 action steps of the QIT (Meyers, Katz, et al., 2012) (see *Table 5.2*). The QIT, a practical translation of the Quality Implementation Framework (Meyers, Durlak, et al., 2012) comprises check-list style action steps that provide a blueprint for high-quality implementation of evidence-based interventions (see *Table 5.2*). The QIT is a flexible tool that can be used in all stages of the implementation process, from iteratively guiding design and implementation, through to reflective evaluation (Meyers, Katz, et al., 2012). The decision to check the two documents together owed to the fact that the 29 steps are divided into six overarching components of implementation quality: the first five dealing with the set-up of the intervention, from developing teams, to training, and component 6 focussing solely on evaluating the intervention once it has begun. We thought it appropriate to evaluate the implementation plan using components 1-5, and the self-assessment matrix with component 6. These findings were tabulated (*Table 5.2)*. Completed self-assessment matrices from 2018-21 were used to produce a bar chart to show reported adherence to each principle across the initial implementation period of 2018-2021 *(Figure 5.3)*. As our interest was in overall adherence across Greater Manchester, localities' responses were pooled for this analysis component. Each locality's individual scores for each principle were therefore summed producing an overall score. Of the 22 principles, only nine, those related to staff opinions of CYP experiences, were selected for presentation in *Figure 5.3,* and to compare with the qualitative data, given their relevance to the study's aims (see *Table 5.1*). However, line graph visualisations were produced for all 22 principles to show their reported change over time. These can be found in *Appendix 3.*

Meta-inferences:

Staff and CYP accounts were considered within the boundaries of the quality of the implementation plan, and of the self-assessment matrix, as determined by the QIT (Meyers, Katz, et al., 2012). The self-assessment matrix data and the qualitative

interview data were analysed together in a simultaneous bidirectional manner (Moseholm & Fetters, 2017). This means that both strands were considered as equally important when overarching conclusions were drawn (Johnson et al., 2007). When all analyses were complete, the themes and their extracts were compared, one by one, to the principles of the self-assessment matrix, to cross-reference accounts of progress where possible. A theme was deemed to "match" a principle if the topics covered within the extracts were similar. Owing to the nature of some themes, a match was established with more than one principle. For example, in the first subtheme "information and decision sharing", participants discussed the sharing of decisions and the discussion of outcomes. Micro principles 1A and 5B (see *Table 5.1*) were deemed to match this. Under each relevant subtheme, the extent to which CYP accounts substantiate staff accounts from the conceptually closest matrix principle is denoted as high, moderate, or low. This was done by examining the experiences reported in each theme to establish whether these were positive, negative, or mixed. Returning, again, to the subtheme "information and decision sharing", staff reported modest yet gradually improving adherence to micro principles 1A and 5B, which corresponds with the diverse testimonies relating to them. Please note that not all subthemes suitably matched a principle. Given that uncovering paradox was a key motivation of mixing methods in the present study, consistencies *and* discrepancies between the matrix and the themes were given equal attention and status in this final part of the analysis (Greene et al., 1989). This equal interest in discrepancy provides another explanation as to why it was not important for themes to exactly match the matrix principles. This is also the reason why not all qualitative themes below do not have a corresponding principle.

5.4: Findings

The GM i-THRIVE implementation plan and self-assessment matrix fulfilled 62.1% of the criteria for quality implementation outlined in the QIT (Meyers, Katz, et al., 2012) (see *Table 5.2*). Of the 29 action steps outlined in the tool, 18 (62.1%) of these were explicitly evidenced in the plan, and 7 (24.1%) were not mentioned. It was not clear whether the remaining 4 (13.8%) steps were covered by the plan:

steps were assessed as “unclear” if their fit with the plan was ambiguous. *Figure 5.3* shows Greater Manchester’s self-reported adherence to the principles in *Table 5.1* from 2018-2021.

Table 5.3: *Participant numbers and their ages.*

Participant number	**Age**
1	18
2	16
3	13
4	14
5	20
6	22*

Six participants were recruited by the gatekeeper and were interviewed between April and June 2022. Their participant numbers (which correspond to transcript extracts provided in the thematic analysis) and ages can be found in *Table 5.3.* Participant 6 was 22 years old when they were interviewed. Even though this participant was over 18 when they received support, this deviation from the stipulated upper age limit of 21 was deemed permissible given that their support was provided by a service that only caters for young people.

Table 5.2: *The components and action steps of the Quality Implementation Tool, and whether they were evidenced in GM i-THRIVE's implementation plan and self-assessment matrix*

Component of QIT	**Action step**	**Stage of GM i-THRIVE implementation that action step relates to**	**Document checked for action step**	**Was this step present in the document?**	**Examples from plan/comments** ***Points in this column refer to those in the GM i-THRIVE implementation plan (see *Appendix 3*)**
1. Develop an implementation team					
	1.1 Decide on structure of team overseeing implementation (e.g., steering committee, advisory board, community coalition, workgroups, etc.)	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 0.4*: Undertake stakeholder mapping
	1.2 Identify an implementation team leader	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 0.2*: Have a named lead for implementing THRIVE
	1.3 Identify and recruit content area specialists as team members	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point* 0.6: Multi-agency working group established

	1.4 Identify and recruit other agencies and/or community members such as family members, youth, clergy, and business leaders as team members	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 0.3*: Set up multi-agency Programme Board (include senior leadership from CCG, health provider(s), local authority, education, third sector)
	1.5 Assign team members roles, processes, and responsibilities	Implementation set-up	GM i-THRIVE implementation plan	Unclear	Although not explicitly mentioned, this process is likely captured in points 0.1-0.10*, and 2.0-2.12*
2. Foster supportive organizational/community wide climate and conditions					
	2.1 Identify and foster a relationship with a champion for the innovation	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 2.7*: Identification and creation of local champions and implementation leads
	2.2 Communicate the perceived need for the innovation within the organization/community	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 1.8*: Service performance review (including population need, demand, flow, experience of service, participation levels, clinical outcomes, efficiency, current shared decision-making practice etc.)

2.3 Communicate the perceived benefit of the innovation within the organization/community	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 1.1*: Key messaging for i-THRIVE project established - goals, aspirations, local context
2.4 Establish practices that counterbalance stakeholder resistance to change	Implementation set-up	GM i-THRIVE implementation plan	Unclear	Not explicitly mentioned, but Point 0.1*: Establish cross sector approval to proceed with i-THRIVE, which suggests commitment before proceeding
2.5 Create policies that enhance accountability	Implementation set-up	GM i-THRIVE implementation plan	Unclear	Not explicitly mentioned, but training implementation monitored: Point 2.12*: Review of workforce development delivery and plans for ongoing work
2.6 Create policies that foster shared decision-making and effective communication	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 0.8*: Establish communications functions (contact databases, shared folders, website)
2.7: Ensure that the program has adequate administrative support	Implementation set-up	GM i-THRIVE implementation plan	No	Not mentioned

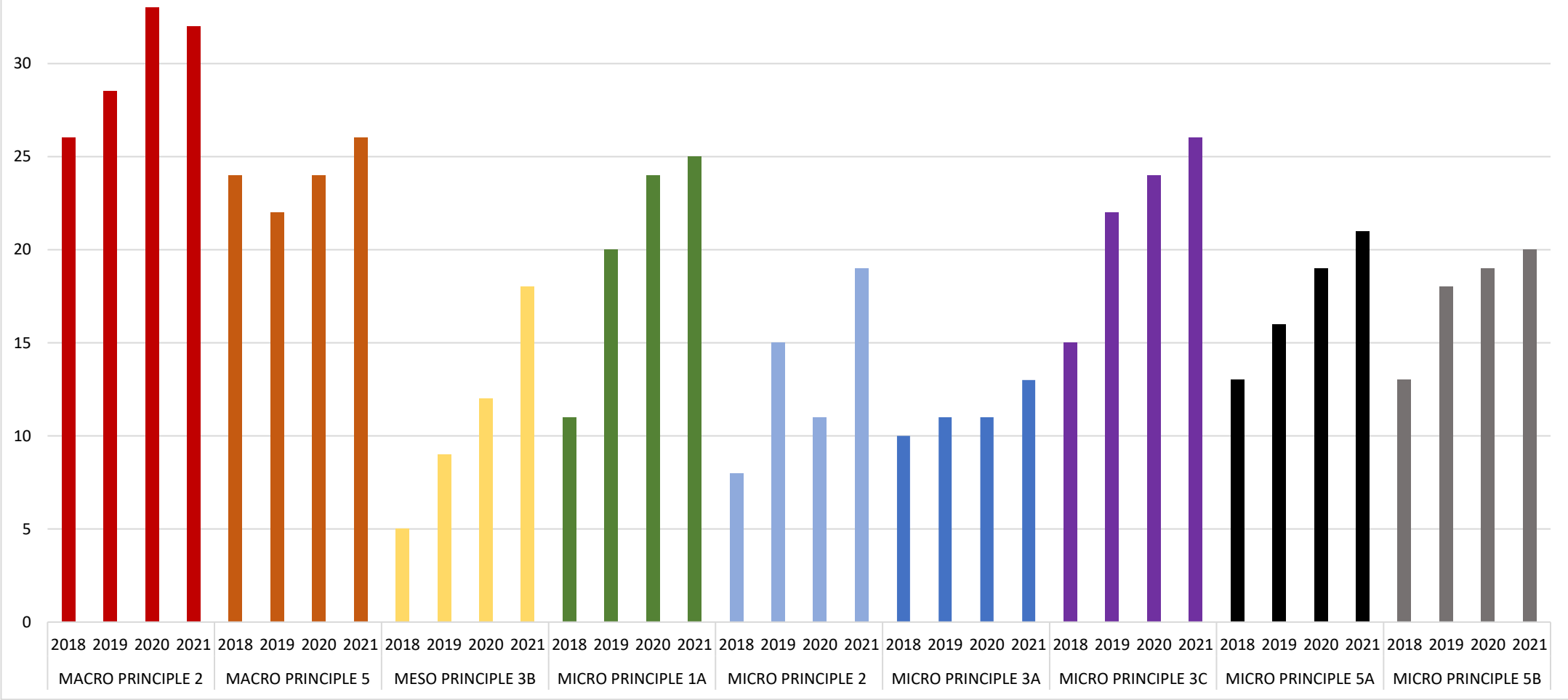
3. Develop an implementation plan					
	3.1 List tasks required for implementation	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 1.13*: Prioritisation and gap analysis workshop
	3.2 Establish a timeline for implementation tasks	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 1.16*: Finalise implementation plan
	3.3 Assign implementation tasks to specific stakeholders	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 3.2*: Detailed implementation planning finalised with lead for each project identified
4. Receive training and technical assistance (TA)					
	4.1 Determine specific needs for training and/or TA	Implementation set-up	GM i-THRIVE implementation plan	Yes	Point 2.1*: Review of staff skills for THRIVE-like working
	4.2 Identify and foster relationship with a trainer(s) and/or TA provider(s)	Implementation set-up	GM i-THRIVE implementation plan	No	Not mentioned
	4.3 Ensure that trainer(s) and/or TA provider(s) have sufficient knowledge about the organization/community's needs and resources	Implementation set-up	GM i-THRIVE implementation plan	No	Not mentioned

	4.4 Ensure that trainer(s) and/or TA provider(s) have sufficient knowledge about the organization/community's goals and objectives	Implementation set-up	GM i-THRIVE implementation plan	No	Not mentioned
	4.5 Work with TA providers to implement the innovation	Implementation set-up	GM i-THRIVE implementation plan	No	Not mentioned
5. Practitioner–developer collaboration in implementation					
	5.1 Collaborate with expert developers (e.g., researchers) about factors impacting quality of implementation in the organization/community	Implementation set-up	GM i-THRIVE implementation plan	Unclear	Touched upon in point 1.8*: Service performance review (including population need, demand, flow, experience of service, participation levels, clinical outcomes, efficiency, current shared decision-making practice etc)
	5.2 Engage in problem solving	Implementation set-up	GM i-THRIVE implementation plan	No	Not mentioned

6. Evaluate the effectiveness of the implementation					
	6.1 Measure fidelity of implementation (i.e., adherence, integrity)	Implementation evaluation	Self-assessment matrix	Yes	Micro principle 7: THRIVE plans are used to help those managing risk
	6.2 Measure dosage of the innovation—how much of the innovation was actually delivered	Implementation evaluation	Self-assessment matrix	Yes	Meso principle 3A: Help is delivered using the conceptual framework of five needs-based groups – measure asks how many groups have been implemented
	6.3 Measure quality of the innovation's delivery—qualitative aspects of program delivery (e.g., implementer enthusiasm, leader preparedness, global estimates of session effectiveness, leader attitudes towards the innovation)	Implementation evaluation	Self-assessment matrix	Yes	Micro principle 4: Outcome data is used to inform individual practice with the purpose of improving quality
	6.4 Measure participant responsiveness to the implementation process—degree to which participants are engaged in the activities and content of the innovation	Implementation evaluation	Self-assessment matrix	Yes	Micro principle 1: Shared Decision Making (SDM) at the heart of all decisions

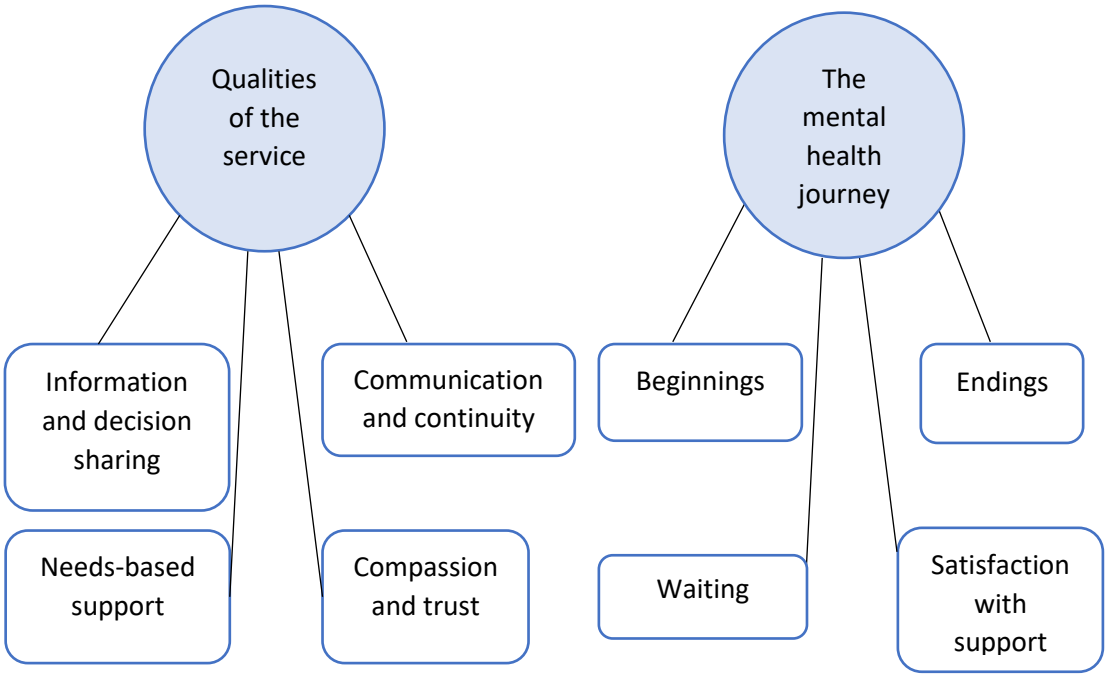
6.5 Measure degree of program differentiation—extent to which the targeted innovation differs from other innovations in the organization/community	Implementation evaluation	Self-assessment matrix	Yes	Micro principle 2: People (staff, CYP and families) are clear about which needs based group they are working within for any one person at any one time and this explicit to all
6.6 Measure program reach—extent to which the innovation is delivered to the people it was designed to reach	Implementation evaluation	Self-assessment matrix	Yes	Micro principle 3B: People (staff, CYP and families) are clear about parameters for help and reasons for ending – measured by % of cases with reasons for ending included in case notes
6.7 Document all adaptations that are made to the innovation—extent to which adjustments were made to the original innovation or program in order to fit the host setting's needs, resources, preferences, or other important characteristics	Implementation evaluation	Self-assessment matrix	No	Not mentioned

Figure 5.3: *Reported adherence to nine principles of the self-assessment matrix. Out of the 22 total principles, these 9 were selected for analysis based on their closer relevance to the aims of the study. Details of principles can be found in Table 5.1*



Two themes were developed through reflexive thematic analysis, each of which overarched four subthemes (see *Figure 5.4*). These are explored in turn, using illustrative examples from the transcripts. Links to the self-assessment matrix, and the findings outlined in *Figure 5.3,* are made after each subtheme where appropriate. Detailed explanations of how each level of agreement was established can be found within the discussion section.

Figure 5.4: *Map of the final themes and subthemes that were created through thematic analysis*



Qualities of the service:

This theme included descriptions of what participants felt that the service offered (or failed to offer) them.

Information and decision sharing:

Some participants said they were allowed an active role in their support experience. This was viewed positively by many. Participant 1 reported that they could see their psychologist as regularly as they chose. The psychologist had passed this decision on to the young person, and appointments could be made as needed through a process of flexible and open contact.

> *“He wouldn't say like, "oh, I’ll see you in two weeks, or I'll see you in a week" he'd say, "whenever you need to see me, you know the process". Sometimes I'd go months without seeing him, and it'd be fine. But other times, I'd call up and say, "can I see you here at this time?” So yeah, I felt as though I was in control”. [Participant 1]*

Conversely, a lack of transparency and clarity was reported in some instances. An older participant felt that their age should have been considered when information about their course of therapy was provided. They felt that knowing more about their treatment would have allowed them to positively integrate this information into their journey. As such, their uncertainty meant that they needed to place a good deal of trust in the staff providing support.

> *“I was a full-grown adult. So, I could have handled being told “you're receiving this type of therapy, because we think this will be beneficial to you” […] I think because I was in such a low place, I just willingly let myself walk into this building. And I had no idea what I could have been walking into”. [Participant 6]*

The following participant would have appreciated more information about the nature of their own mental health. Receiving a diagnosis was an important tool for helping them to understand their difficulties. It may also have helped them to feel valid in their help seeking: they felt that they were one of the only young people in their setting without a formal diagnosis.

> *“I feel like they need to acknowledge that some people want a diagnosis. A lot of the time, people will go there, but they'll have a diagnosis. […] the nurse asked me why I was there, and I just I couldn't say anything, because no-one had told me that I had anything wrong”. [Participant 4]*

Despite the importance of transparency, other testimonies suggested that shared decision-making should be managed carefully. Professional insight should be appropriately applied to guide the process. Participant 5 felt that too much initiative was expected of them. They would have appreciated more help with identifying the most beneficial focus of their sessions.

"It was put down to me to decide the focus of what we'd be talking about. But I think at the time, I didn't really know what I wanted to be talking about. Even though it was my choice, I think I chose the wrong thing […] I think I would have preferred to be told what to do a bit more and told what to focus on". [Participant 5]

Participant 6 actively hoped that decisions would be made on their behalf. They saw the commencement of professional help as an opportunity to pass on the onus of their difficulties. It should not, therefore, be assumed that high autonomy is universally valued. A considered balance should be drawn for each young person.

"I think when I got to the point of needing therapy, it was like I was relinquishing my control, and I wanted someone else to do the work". [Participant 6]

Corresponding self-assessment matrix principle(s): Micro 1A, Micro 5B
Level of agreement between staff and CYP testimony: High

Communication and continuity:

Several participants' schools acted as a gateway to receiving mental health support. When support was not provided directly by their school, teachers were able to refer them to appropriate sources of support. This suggests that school staff have sufficient knowledge of a range of mental health services, and successful lines of communication exist between schools and these services. These qualities build a more seamless support acquisition process.

"It came to me after speaking to multiple pastoral teachers. I have [mental health concern], and they said that they could help me by introducing me to people to talk to: mental health services". [Participant 2]

Participants who encountered multiple professionals and services across their mental health support experience said each new professional was equipped with at least a basic knowledge of them and of their mental health story. Participant 1 felt that when professionals asked them to elaborate on elements of their background, this was treated as part of the therapeutic process. This suggests an element of

communication between providers, where gaps in professionals' knowledge are filled tactfully. This provides a smoother continuous care experience, that removes the strain of restating details about themselves to each person that they meet.

> *"It's always hard between telling, "are they asking me about me because they want to know my perspective on my life?" Or "they're asking me because they genuinely don't know?" But I think they had a general background of my life. And if they were asking me, it felt as though they were asking me for my perspective". [Participant 1]*

The same participant spoke about becoming too old for NHS CAMHS support. Although they were successfully referred to an alternative source of support, they felt that the shift between NHS-based support, and this, was abrupt and difficult to navigate. A smoother post-18 transition would have improved the continuity of their care.

> *"I wasn't perceived as high enough of a threat to be moved on to the NHS adult services. But my support worker at CAMHS referred me to a lower threshold thing […] which is really good […] I just think sort of a step-down service that could be used for anybody who had touch with CAMHS". [Participant 1]*

Corresponding self-assessment matrix principle(s): Macro 2, Macro 5
Level of agreement between staff and CYP testimony: Moderate

Needs-based support:

Several participants felt that they were taken seriously, and that they were listened to. This allowed their support to be tailored appropriately to their individual needs and preferences.

> *"Everything she said to me, everything I said to her, she took very seriously. And I really appreciated that she did that". [Participant 3]*

This participant reported that their predicted duration of care was extended based upon their continued requirements. After their initial period of support ended, they were easily able to recommence at their own request, as their needs changed. The

participant's decision to reengage with the support appears to have been aided by their previous positive experience, and the approachability of the staff they met.

> *"I was supposed to [have support] for 6 weeks, but I think I had 8 or 9. Then a few months later, I asked to go back. There was nothing wrong with the treatment that I previously received. But the people there that I had; she was really nice. I asked to go back, so I did". [Participant 4]*

Some participants, however, reported that their needs were not taken seriously enough. Participant 2 said that when they were younger, a member of their school pastoral team frequently raised irrelevant topics. This meant that they did not receive help with the issue with which they had originally been referred. Although it is unclear whether the pastoral worker lacked expertise in the appropriate area, or whether this experience represents a true example of poor listening, the resulting lack of needs-based support clearly impacted the participants' desire to continue with the sessions.

> *"I started seeing a school nurse, and the sessions were supposed to be about [mental health concern]. I explained to her, but she started talking to me about [an unrelated concern]. Every time I tried to draw away from the topic, she just kept on steering it back to that. It didn't last long after that, I just stopped seeing her". [Participant 2]*

Corresponding self-assessment matrix principle(s): Meso 3B
Level of agreement between staff and CYP testimony: High

Compassion and trust:

This subtheme covers the personal qualities of support or care providers of mental health support that were memorable to the participants. Several participants described the professionals as kind people, who genuinely appeared to care about their wellbeing. The following participant describes that perceiving these qualities allowed a quicker development of trust.

"It took a while to build up the trust to be able to speak to her […] and it only took a few weeks, because she came across as a very nice, genuine person to me". [Participant 3]

Trust is mentioned again in the following extract, where Participant 6's provider made them feel that nothing that they discussed would be passed on outside of the session. The participant detected clear signs that their provider had listened to them in previous sessions, which added a personalised element to the support they provided. This further developed the trust they felt. This professional was just one member of staff operating in a wider compassionate environment, that the participant sensed as soon as they entered the building for the first time.

"I felt very much like all the things I was telling her were 100% confidential […] I felt very safe with her as my therapist. The way she would remember little details and always think of other ways I could have improved […] So, I think the actual genuine support that they gave young people, I could see that throughout the building". [Participant 6]

Participant 5 was impressed with the stoic attitude of their provider. The fact that they did not appear shocked or upset by the information that they disclosed contributed to a calmer and safer environment, where no topic was taboo.

"She always had a friendly face on, even when I was telling her some really not nice stuff. She's very good at dealing with it in a way that I definitely couldn't if someone was telling me those kinds of things". [Participant 5]

The mental health journey:

This theme covered participant experiences that related to the different stages of their personal mental health stories, and how these were accommodated by the services that they got support from.

Beginnings:

Several participants mentioned struggling with their mental health for a long time before they received support. Many referred to a specific moment, almost a "tipping point", where they, a family member, or a teacher, realised that

professional support was needed. They suggest that their mental health difficulties had built over time, developing from lower-level concerns that were not necessarily noticed by those close to them, to more severe challenges that greatly interfered with their functioning. Following feelings of depression from a young age, participant 4 spoke of one evening where they experienced a mental health crisis, and the emergency services were contacted.

> *"I ended up becoming really depressed dead young […] I ended up calling 999. Because I just, I felt really bad one night […] I ended up having to go to hospital because I was a child". [Participant 4]*

The participants talked about the various avenues through which their first contact with mental health support was accessed. Many were either referred to external support by their school, or received early support directly from their school. The next testimony describes the value of knowing that help is available. Even though participant 1 was not ready to engage with support when they were first approached, the process of opening dialogue by informing them of who they could turn to seemed important to them. Participant 1 was able to internally process the idea of receiving support, and they eventually approached the teacher on their own terms.

> *"Whoever is on call at the time to deal with issues like this was like, "what's going on?". I didn't speak to them. I was like, "none of your business". A few weeks later, I approached this teacher and we sat down. We had a chat for about two hours, and I just cried and cried and cried". [Participant 1]*

Participants valued building familiarity before their support formally began. This level of comfort made them feel more relaxed, and that any anxieties were at least partially ameliorated. This early breaking down of barriers between client and professional is likely to have enhanced the benefits of the support.

> *"I was a lot more comfortable talking to her, and she knew some stuff about me as well. So, it was a lot more comfortable between both of us". [Participant 2]*

For Participant 3, these early conversations were used to establish the nature of their needs, so that appropriate support could be given. Following this discussion, regular sessions were set up.

> *"Before we started our sessions, I did meet with her. And she did ask me some questions just to get to know about my home life, my school life […] And then from there, she got a plan, because then she started saying that we'll meet up in these days". [Participant 3]*

Endings:

When participants spoke about their support coming to an end, their level of preparedness was discussed frequently. The ending of support is a stressful time for many young people, and participant 3 stated that the topic was raised regularly in their sessions. This allowed them to imagine a time when the professional was not accessible, and to develop approaches to manage their concerns alone in the future.

> *"She prepared me quite well. When she explained something to me, she would give me advice on how to remember things, and she'd say "don't forget that one day, I won't be here for you to come and speak to. So, you're gonna have to be able to cope on your own and have good strategies to deal with your mental health"". [Participant 3]*

For some, the timing of their ending was less clear. Although the participant below appreciated that their professional decided over time how long their support would need to last, and that there were advantages as well as disadvantages to not knowing, they feel that their ending felt abrupt. Knowing earlier would have given them time to process the next stage of their support.

> *"I just was randomly told one session, like, "Okay, this is your last of four sessions" or whatever. It was very surprising to me. If I'd known, I would have maybe seen it differently […] But I also just think that maybe making it more clear to me how I could have carried on receiving support if I needed to". [Participant 6]*

Whilst many participants felt ready for their support to conclude when it did, some felt anxious and unsure. Participant 5 said that the topic of continuing need was not discussed thoroughly enough. They were left questioning whether they had made the most of their time, and the lack of conversation around this rendered them unsure of what further support they needed, or how to ask for it.

> *"She told me that I can re-refer, and it'll probably be quicker than if I were to start again somewhere else […] But I do remember feeling very anxious about it ending like, "oh no, I don't know if I've gotten everything out of this that I could have" […] the last session could have just been a bit longer, because I find it really difficult on the spot to know what I need […] it was just like, "okay, bye"". [Participant 5]*

Corresponding self-assessment matrix principle(s): Micro 3A, Micro 3C, Micro 5A
Level of agreement between staff and CYP testimony: High

Waiting:

Several participants reported that whilst setting up regular support was not instantaneous after their initial referral, it was shorter than what they were told to expect. This suggests that professionals may give their clients larger timeframes to manage their expectations and avoid disappointment. The following participant waited a small proportion of the maximum duration that they were initially quoted. During this time, they were able to meet the professional to build familiarity before the official start.

> *"It was actually pretty fast. When the pastoral teacher first put me down for it, she said there might be a long wait, like six to 12 weeks. Then I actually met (professional's name) before the sessions started. And then it was like three weeks after that. That's when I started seeing her". [Participant 2]*

Participant 6 believed that their wait, to use a non-NHS service, negatively impacted their mental health. This may be a likely scenario for many, given that a high level of distress is often felt before support is initiated (see subtheme "beginnings"). Participant 6 spoke of the wide-spread issue of waiting times for mental health

support, and how this has perhaps skewed perceptions of what an acceptable waiting time looks like.

> *"It definitely was detrimental for me to have to wait three months. But in comparison, I know the NHS waiting list is insane […] But the three months, I think the fact that it was the minimum that she told me actually was really good. And I saw that as like, wow, amazing, that's so quick like, which is kind of messed up, I guess, that we think of three months as being quick". [Participant 6]*

Another consequence of lengthy waits is that mental health concerns are not dealt with when they are the most salient. Participant 5 said that by the time their sessions began, although they still made use of the support, they had already come to terms with the difficulty they initially sought help for. During this time, in a worst-case scenario, where need is not professionally met, unhealthy coping strategies may be developed. These may be difficult to overcome if related difficulties re-emerge over time.

> *"I signed up, and then it had been so long that I'd moved on from what I originally wanted to talk about. So, once I got there, I was like, maybe I'll use it because I am still struggling in other ways, but it definitely wasn't what I originally signed up to do it for". [Participant 5]*

Satisfaction with support:

All participants stated that overall, they would recommend the type of support that they got to another young person. Participant 5 suggested that the broadness of their support means that they would suggest it to most people. They appeared to find the process insightful and enlightening, in that it helped them to identify the root causes of their difficulties.

> *"The stuff that I was taught is very broadly applicable. The psychoeducation aspect of it, like "oh, this is where those symptoms are coming from" was really, really helpful. So yeah, I think that anyone... I say it all the time to my siblings, "go and get some cognitive behavioural therapy". Can't recommend it enough". [Participant 5]*

Some participants, although stating that their experiences were positive overall, would only recommend their support under certain circumstances. These participants discussed the nuances of their own support-seeking journeys, and said, therefore, that they could only truly endorse it to somebody who's circumstances were near-identical to their own. The following participant felt lucky to have received such good support, and they perceived their experience as the exception rather than the norm in terms of how smooth it was.

> *"I felt so fortunate the entire time […] But that's just my experience. It's not what most people would say. I'd only be recommending the type I got, because I probably know, like six or seven people who've had a really, really bad experience with CAMHS. And it's a shame because I wouldn't want to recommend someone for them not to be getting good treatment". [Participant 1]*

5.5: Discussion

This study explored the implementation of reformed CYP mental health service provision within the context of a recently devolved healthcare system. This broad aim was investigated through a variety of methodological lenses, to establish not only the improvements that have been made, but also the adequacy of the tools used to monitor this progress. Evaluating the plan that was set prior to the implementation of GM i-THRIVE, then cross-referencing professional and service user accounts of adherence to the THRIVE Framework's core principles, provided unique triangulated insights into an intervention across the entirety of its implementation timeline.

Table 5.2 showed that most (62.1%) criteria of the QIT were evidenced within GM i-THRIVE's implementation plan, and the evaluative self-assessment matrix. Most criteria that were either not evidenced, or ambiguously evidenced, fell under the remit of the implementation plan (QIT stages 1-5) rather than the self-assessment matrix (QIT stage 6). Whilst this could suggest that the plan was less sufficient than the matrix, we are reluctant to assert that these processes were, without question, not undertaken in GM i-THRIVE's implementation process. It is

plausible that certain elements of the QIT were not deemed relevant enough to feature within GM i-THRIVE's plan and matrix. For example, Point 4.5 of the QIT, "work with technical assistance providers to implement the innovation" has limited relevance to GM i-THRIVE, given the programme's broader focus. Additionally, whilst most QIT points were straightforward to cross-evaluate, those components classified as "unclear" may simply be worded differently depending on an intervention's nuances. This can make it difficult to ascertain a clear match. For example, point 2.4 of the QIT "establish practices that counterbalance stakeholder resistance to change" was not explicitly referred to within the implementation plan, however cross-sector approval was mentioned. This suggests that a level of commitment to GM i-THRIVE was sought before proceeding. In response to the first research question of this study, we conclude that GM i-THRIVE was equipped with a suitable foundation prior to implementation, and with a strong method of evaluating progress during the implementation process. The remaining findings should, therefore, be considered in the context of these bases.

Figure 5.3 shows that progress across Greater Manchester, although not linear in every instance, was made between 2018 and 2021 on all nine self-assessment matrix principles included in the analysis. A gradual shift towards THRIVE-aligned practice is broadly evident. Each principle will be discussed in the context of the reported experiences of CYP who received support within this time frame, but before this, it is worth noting that not all subthemes could be appropriately compared to a matrix principle. This element of conceptual mismatch relates to the fact that an inductive approach was taken – hence, the qualitative data were not forced into deductive codes that related to the principles. Similarly, the topic of one principle, Micro Principle 2, "people (staff, CYP and families) are clear about which needs-based group they are working within for any one person at any one time, and this is explicit to all" did not feature in the interview data. This is perhaps indicative of a limitation that can be applied to all meta-inferences that we will draw within this section: that evidence of THRIVE principles in CYP testimonies can only be inferred. They are not likely to use or even know the exact terminology used in the Framework, especially if this complex language is not consistently used by professionals in their interactions with CYP. Along with the other principles,

Micro Principle 2 showed improvement over the implementation period, adherence to it was rated as relatively low (*Figure 5.3*), which may reflect this. Agreement between the interview data and the staff accounts in *Figure 5.3* was generally high. This suggests that the self-assessment matrix is a relatively accurate reflection of the care experiences of CYP in Greater Manchester, and also that CYP can provide relevant and accurate accounts of this support (Bone et al., 2014; Macleod et al., 2017). These substantiations will now be explored in turn.

The interview data were split into two overarching themes (see *Figure 5.4).* The first of these, "qualities of the service", covered four sub-themes. "Information and decision sharing" explored the topic of control and taking an active role in the support process. The importance of striking an individualised balance between professional and CYP input was raised, as some may prefer having key decisions made for them. Agreement between staff self-assessments and the points raised in this subtheme was deemed good. By 2021, staff reported their incorporation of shared decision-making moderately, yet with a clear improvement since 2018. This substantiates participants' mixed reports on their perceived ability and desire for involvement. Clinicians' communication skills, understandable information, and CYP capacity were just three factors identified as important for shared decision-making in CYP mental health (Hayes et al., 2020). This study suggested that even when a young person's mental health does not allow them to be fully involved in decision-making, that open communication and the transparent presentation of information should still be offered, as deemed appropriate by the listening process (Hayes et al., 2020).

Under the second subtheme, "communication and continuity", CYP reported that their schools were well connected to a range of helpful services. Participants also felt that any new professionals that they met appeared well-informed of their mental health backgrounds, with little repetition needed. Professional agreement with this subtheme was considered moderate, as the self-assessment principles relating to multi-agency involvement, and integrated care, were consistently rated highly. Whilst some services did appear well-linked, the process of obtaining help from adult services post-CAMHS was reportedly difficult, with continued equivalent level support reported as challenging to obtain. The transition between child and

adult mental health services is, unfortunately, a common source of distress, with changes in care coinciding with a number of other life transitions occurring in late adolescence (Hovish et al., 2012; Memarzia et al., 2015). Disrupted support can result in feelings of stress, struggles with coping, and an increased burden on family members to provide support (Appleton et al., 2021). However, a transition that is well-planned, gradual, and needs-based is more likely to be experienced positively (Hovish et al., 2012).

In the next subtheme "needs-based support", CYP responses were mixed in terms of whether they felt that their requirements were noticed and actioned by their professionals. These experiences matched closely with professionals' scoring of meso principle 3B which relates to needs-based care: a principle that was rated moderately, but with a steady improvement year on year. Feeling listened to is one of the most valued aspects of support for CYP, with professional understanding key to having mental health needs met (Davison et al., 2017). The final subtheme within the "qualities of the service" theme, "compassion and trust" did not relate directly to a matrix principle. However, participants readily reported that the kindness of the professionals they met allowed the development of trust within the therapeutic relationship. Feeling that professionals genuinely care for their wellbeing contributes to a positive support experience (Davison et al., 2017), where better outcomes may be more likely (Persson et al., 2017).

The second theme, "the mental health journey", also comprised four subthemes. In "beginnings", it was common that participants' first contact with mental health services followed a longer struggle with their mental health. Before this point was reached, they valued knowing of the existence of services, and the building of familiarity to foster trust prior to an official start – a process which should not be rushed (Lockertsen et al., 2020). This subtheme emphasises the importance of early recognition of mental health difficulties in CYP, so that support can be given before they exacerbate. Mental health promotion programmes, such as those offered in schools, can help CYP to identify concerns (Onnela et al., 2021), reduce stigma (Ma et al., 2022), and increase help-seeking tendencies (O'Connor et al., 2018).

The subtheme “endings” saw some participants feeling well-prepared for their support coming to an end, whereas for others, the duration was not discussed. As a result, this ending felt abrupt. Agreement with staff reports was good: although they recognised that it was an important part of the therapeutic journey, and that discussions of timeframes were had, they felt that the limitations of help were not always made clear to CYP. The honest setting expectations and defining outcomes at the outset of support is vital (Bear et al., 2022), so it is important that GM i-THRIVE continue to emphasise the importance of such discussions across the sector.

In the subtheme of “waiting”, participants felt that their expectations were managed well, but only within the wider context of the normalisation of long waits. Consequently, participants felt fortunate to receive support in as timely a fashion as they did. A detrimental impact of long waits on mental health was reported, as help is not given when it is needed the most. Other qualitative studies have reported similar negative consequences of long waits, a well-documented issue within CAMHS as well as the wider NHS (England & Mughal, 2019; Smith et al., 2018), with exacerbation of concerns reported when timely support is not given (Punton et al., 2022). In the final subtheme “satisfaction with support”, whilst participants were keen to recommend their support, however this endorsement occasionally came with the caveat that their good experience was an isolated incident. Continuing to monitor CYP and parent satisfaction with support (McNicholas et al., 2016) will be vital during GM i-THRIVE’s embedding phase.

Strengths, limitations, and future directions

The key strength of the present study is the mixed-methods approach, which sought to seek consensus across a range of sources, from multiple informants. Greene et al (Greene et al., 1989) stated that a typical way of mixing quantitative and qualitative approaches is to use the former to assess empirical outcomes of a programme, whilst using qualitative testimonies to gauge how well these outcomes have been implemented. Our approach echoed this, by looking first to the quality of guidance documents and measures, before examining how GM i-THRIVE’s outcomes were measured by staff, then finally asking recipients of the intervention

how their experiences reflected THRIVE-aligned support. The simultaneous bidirectional approach (Moseholm & Fetters, 2017) taken meant that the three research questions were all considered within the context of one another to draw the study's final conclusions. This combines the strengths of corroborating testimonies from multiple informants, which is important for both implementation evaluation (Benzer et al., 2013), and studies on CYP mental health services (Garland et al., 2004; Ronzoni & Dogra, 2011; Van Roy et al., 2010).

However, despite this methodologically strong approach, our findings must be considered within the context of their limitations. First, the overwhelmingly inductive qualitative approach led to an imperfect cross-over between the subthemes and the principles of the matrix presented in *Figure 5.3.* This meant that a true comparison of staff and CYP accounts was difficult to make in some areas. However, the subthemes and their corresponding extracts were used to emphasise the overarching thematic points that were made, and we believe that adding an inductive element to this analysis provided a more genuine representation of the experiences of our participants.

An inductive approach was especially important given the study's small sample of CYP, a result of the challenging nature of recruitment, to ensure that the interviews were themed as suitably as possible. Similar studies undertaken in the health research field (Avery-Phipps et al., 2022), or with a niche set of inclusion criteria (Mohammadsadeghi et al., 2022) have used similar-sized samples, and some researchers have indeed reached thematic saturation with only nine participants (Hennink & Kaiser, 2022). Some even suggest that deeper qualitative inquiry can be facilitated by a smaller sample (Crouch & McKenzie, 2006). However, our small sample might imply that we were not able to harness a wide range of experiences with mental health support. This is a plausible limitation given that the included testimonies were overwhelmingly positive. This suggests that those who had very negative experiences were not identified as potential participants, perhaps because factors associated with the support provider (de Haan et al., 2013) and the therapeutic relationship (Hauber et al., 2020) are linked to drop out or disengagement with services. Focussed efforts on reaching these CYP would have

diversified the range of views captured, and we recommend that future evaluation of GM i-THRIVE attempts to make this effort.

The reporting of predominantly positive views may also explain the agreement between CYP and professionals on THRIVE alignment, especially given that other studies comparing accounts from both have not found such close consensus (Garland et al., 2004). As all participants were aged 13 or over, whether the findings can be applied to the experiences of younger children is uncertain. As this age parameter was set to ensure that participants were capable of engaging fully by providing sufficiently detailed accounts, the support experiences of younger children may need to be accessed through their parents or carers, even though this approach accompanies its own set of limitations relating to the salience of reported outcomes (Ronzoni & Dogra, 2011). In further relation to transferability, we would recommend that other regions within England who are in the process of aligning their CYP mental health provision to the THRIVE Framework conduct their own qualitative studies with CYP, to corroborate with professional accounts of progress. Unique considerations associated with the North of England, an area with poorer deprivation-associated mental health than the South (Akhter et al., 2018; Harrison et al., 1998; Möller et al., 2013), may not be applicable to other regions in the country.

The final limitation that we wish to raise is that although the data within this study covered the entire four-year initial implementation period, it should still be treated as a cross-sectional account. Within GM i-THRIVE, evaluative work should continue, including further conversations with CYP. This is because implementation should not be assumed a linear process. Numerous influencing factors, both wider and organisational, continuously influence progress and sustainability (Song et al., 2022). Additional monitoring is especially necessary following the COVID-19 pandemic and its emerging impact on CYP mental health (Adegboye et al., 2021) and the provision of mental health services (Byrne, 2021).

5.6: Conclusions

Here, we summarise the meta-inferences made by combining the lines of inquiry in this mixed-methods study. GM i-THRIVE's initial plan set a solid foundation for the

implementation work that was to follow between 2018 and 2021, and the embedding period that will follow this. Similarly, the self-assessment matrix was a suitable tool with which to assess alignment of services to the THRIVE Framework. Under this context of good quality planning and measurement, progress was made towards aligning services to the THRIVE Framework. Although limitations were identified, professional staff working within these services, and the CYP receiving support and care, tended to agree on what mental health provision looked like during the reform period. Given the rich insights offered by the study's participants, we recommend continued discourse with service-users with a range of support experiences as the intervention continues to be embedded.

The triangulation of methods in the present study aimed to deliver a practical and original insight into how implementation science feeds down to those in receipt of an intervention. The comparison between the unique experiences of CYP, and the opinions of progress expressed by those implementing the programme, provides valuable understanding of whether implementation and evaluation tools, in isolation, can produce accurate and valid representations that are reflected in the experiences of those in receipt of care. The study produces helpful findings that can be used to guide the future of GM i-THRIVE, in addition to providing a valuable and unique contribution to mixed-methods research, particularly that which pertains to implementation evaluation.

5.7: References

Adegboye, D., Williams, F., Collishaw, S., Shelton, K., Langley, K., Hobson, C., Burley, D., & van Goozen, S. (2021). Understanding why the COVID-19 pandemic-related lockdown increases mental health difficulties in vulnerable young children. *JCPP Advances*, *1*(1), e12005. https://doi.org/10.1111/jcv2.12005

Aebi, M., Giger, J., Plattner, B., Metzke, C. W., & Steinhausen, H. C. (2014). Problem coping skills, psychosocial adversities and mental health problems in children and adolescents as predictors of criminal outcomes in young adulthood. *European Journal of Child & Adolescent Psychiatry*, *23*(5), 283–293. https://doi.org/10.1007/s00787-013-0458-y

Akhter, N., Bambra, C., Mattheys, K., Warren, J., & Kasim, A. (2018). Inequalities in mental health and well-being in a time of austerity: Follow-up findings from the Stockton-on-Tees cohort study. *SSM - Population Health*, *6*, 75–84. https://doi.org/10.1016/j.ssmph.2018.08.004

Appleton, R., Elahi, F., Tuomainen, H., Canaway, A., & Singh, S. P. (2021). "I'm just a long history of people rejecting referrals" experiences of young people who fell through the gap between child and adult mental health services. *European Child & Adolescent Psychiatry*, *30*(3), 401–413. https://doi.org/10.1007/s00787-020-01526-3

Avery-Phipps, I., Hynes, C., & Burton, C. (2022). Resistance narratives in patients' accounts of a mandatory pre-operative health optimisation scheme: A qualitative study. *Frontiers in Health Services*, *2*. https://www.frontiersin.org/articles/10.3389/frhs.2022.909773

Bear, H. A., Dalzell, K., Edbrooke-Childs, J., Garland, L., & Wolpert, M. (2022). How to manage endings in unsuccessful therapy: A qualitative comparison of youth and clinician perspectives. *Psychotherapy Research*, *32*(2), 249–262. https://doi.org/10.1080/10503307.2021.1921304

Benzer, J. K., Beehler, S., Cramer, I. E., Mohr, D. C., Charns, M. P., & Burgess, J. F. (2013). Between and within-site variation in qualitative implementation research. *Implementation Science*, *8*(1), 4. https://doi.org/10.1186/1748-5908-8-4

Bone, C., O'Reilly, M., Karim, K., & Vostanis, P. (2014). 'They're not witches. …' Young children and their parents' perceptions and experiences of Child and Adolescent Mental Health Services. *Child: Care, Health and Development*, *41*(3), 450–458. https://doi.org/10.1111/cch.12161

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Byrne, D. (2021). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & Quantity*. https://doi.org/10.1007/s11135-021-01182-y

Campbell, K., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., Gehrke, P., Graham, L., & Jack, S. (2021). Reflexive Thematic Analysis for Applied Qualitative Health Research. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2021.5010

Crouch, M., & McKenzie, H. (2006). The logic of small samples in interview-based qualitative research. *Social Science Information*, *45*(4), 483–499. https://doi.org/10.1177/0539018406069584

Davison, J., Zamperoni, V., & Stain, H. J. (2017). Vulnerable young people's experiences of child and adolescent mental health services. *Mental Health Review Journal*, *22*(2), 95–110. https://doi.org/10.1108/MHRJ-09-2016-0016

de Haan, A. M., Boon, A. E., de Jong, J. T. V. M., Hoeve, M., & Vermeiren, R. R. J. M. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical Psychology Review*, *33*(5), 698–711. https://doi.org/10.1016/j.cpr.2013.04.005

Department of Health. (2015). *Future in Mind: Promoting, protecting, and improving our children and young people's mental health and wellbeing*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative Content Analysis: A Focus on Trustworthiness. *SAGE Open*, *4*(1), 2158244014522633. https://doi.org/10.1177/2158244014522633

England, E., & Mughal, F. (2019). Underprovision of mental health services for children and young people. *British Journal of General Practice*, *69*(680), 112–113. https://doi.org/10.3399/bjgp19X701381

Ford, T., Hamilton, H., Meltzer, H., & Goodman, R. (2007). Child Mental Health is Everybody's Business: The Prevalence of Contact with Public Sector Services by Type of Disorder Among British School Children in a Three-Year Period. *Child and Adolescent Mental Health*, *12*(1), 13–20. https://doi.org/10.1111/j.1475-3588.2006.00414.x

Garland, A. F., Lewczyk-Boxmeyer, C. M., Gabayan, E. N., & Hawley, K. M. (2004). Multiple Stakeholder Agreement on Desired Outcomes for Adolescents' Mental Health Services. *Psychiatric Services*, *55*(6), 671–676. https://doi.org/10.1176/appi.ps.55.6.671

Greater Manchester Combined Authority. (2019). *Children and Young People's Plan*. https://www.greatermanchester-ca.gov.uk/media/2115/gmca-children-young-peoples-plan-2019-2022.pdf

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental Health of Children and Young People in Great Britain, 2004: (557702010-001)* [Data set]. American Psychological Association. https://doi.org/10.1037/e557702010-001

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a Conceptual Framework for Mixed-Method Evaluation Designs. *Educational Evaluation and Policy Analysis*, *11*(3), 255–274. https://doi.org/10.3102/01623737011003255

Hacker, J. (2021, November 18). *GPs' support for children's mental health limited by 'silo working', CQC suggests*. Healthcare Leader. https://healthcareleadernews.com/news/gps-support-for-childrens-mental-health-limited-by-silo-working-cqc-suggests/

Harrison, J., Barrow, S., & Creed, F. (1998). Mental health in the North West Region of England: Associations with deprivation. *Social Psychiatry and Psychiatric Epidemiology*, *33*(3), 124–128. https://doi.org/10.1007/s001270050032

Hauber, K., Boon, A., & Vermeiren, R. (2020). Therapeutic Relationship and Dropout in High-Risk Adolescents' Intensive Group Psychotherapeutic Programme. *Frontiers in Psychology*, *11*. https://www.frontiersin.org/articles/10.3389/fpsyg.2020.533903

Hayes, D., Edbrooke-Childs, J., Town, R., Wolpert, M., & Midgley, N. (2020). Barriers and facilitators to shared decision-making in child and youth mental health: Exploring young person and parent perspectives using the Theoretical Domains Framework. *Counselling and Psychotherapy Research*, *20*(1), 57–67. https://doi.org/10.1002/capr.12257

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, *292*, 114523. https://doi.org/10.1016/j.socscimed.2021.114523

Hovish, K., Weaver, T., Islam, Z., Paul, M., & Singh, S. P. (2012). Transition experiences of mental health service users, parents, and professionals in the United Kingdom: A qualitative study. *Psychiatric Rehabilitation Journal*, *35*(3), 251–257. https://doi.org/10.2975/35.3.2012.251.257

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a Definition of Mixed Methods Research. *Journal of Mixed Methods Research*, *1*(2), 112–133. https://doi.org/10.1177/1558689806298224

Kelly, L. M., & Cordeiro, M. (2020). Three principles of pragmatism for research on organizational processes. *Methodological Innovations*, *13*(2), 2059799120937242. https://doi.org/10.1177/2059799120937242

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & ??st??n, T. B. (2007). Age of onset of mental disorders: A review of recent literature: *Current Opinion in Psychiatry*, *20*(4), 359–364. https://doi.org/10.1097/YCO.0b013e32816ebc8c

Klykken, F. H. (2021). Implementing continuous consent in qualitative research. *Qualitative Research*, 14687941211014366. https://doi.org/10.1177/14687941211014366

Lockertsen, V., Nilsen, L., Holm, L. A. W., Rø, Ø., Burger, L. M., & Røssberg, J. I. (2020). Experiences of patients with anorexia nervosa during the transition from child and adolescent mental health services to adult mental health services. *Journal of Eating Disorders*, *8*(1), 37. https://doi.org/10.1186/s40337-020-00313-4

Ma, K. K. Y., Anderson, J. K., & Burn, A.-M. (2022). Review: School-based interventions to improve mental health literacy and reduce mental health stigma – a systematic review. *Child and Adolescent Mental Health*, *n/a*(n/a). https://doi.org/10.1111/camh.12543

Macleod, E., Woolford, J., Hobbs, L., Gross, J., Hayne, H., & Patterson, T. (2017). Interviews with children about their mental health problems: The congruence and validity of information that children report. *Clinical Child Psychology and Psychiatry*, *22*(2), 229–244. https://doi.org/10.1177/1359104516653642

McCartney, M. (2016). Margaret McCartney: Breaking down the silo walls. *BMJ*, *354*, i5199. https://doi.org/10.1136/bmj.i5199

McNicholas, F., Reulbach, U., Hanrahan, S. O., & Sakar, M. (2016). Are parents and children satisfied with CAMHS? *Irish Journal of Psychological Medicine*, *33*(3), 143–149. https://doi.org/10.1017/ipm.2015.36

McNicoll, A. (2015, March 20). Mental health trust funding down 8% from 2010 despite coalition's drive for parity of esteem. *Community Care*. https://www.communitycare.co.uk/2015/03/20/mental-health-trust-funding-8-since-2010-despite-coalitions-drive-parity-esteem/

Memarzia, J., St Clair, M. C., Owens, M., Goodyer, I. M., & Dunn, V. J. (2015). Adolescents leaving mental health or social care services: Predictors of

mental health and psychosocial outcomes one year later. *BMC Health Services Research*, *15*(1), 185. https://doi.org/10.1186/s12913-015-0853-9

Meyers, D. C., Durlak, J. A., & Wandersman, A. (2012). The Quality Implementation Framework: A Synthesis of Critical Steps in the Implementation Process. *American Journal of Community Psychology*, *50*(3/4), 462–480. https://doi.org/10.1007/s10464-012-9522-x

Meyers, D. C., Katz, J., Chien, V., Wandersman, A., Scaccia, J. P., & Wright, A. (2012). Practical Implementation Science: Developing and Piloting the Quality Implementation Tool. *American Journal of Community Psychology*, *50*(3/4), 481–496. https://doi.org/10.1007/s10464-012-9521-y

Mohammadsadeghi, H., Bazrafshan, S., Seify-Moghadam, N., Mazaheri Nejad Fard, G., Rasoulian, M., & Eftekhar Ardebili, M. (2022). War, immigration and COVID-19: The experience of Afghan immigrants to Iran Amid the pandemic. *Frontiers in Psychiatry*, *13*. https://www.frontiersin.org/articles/10.3389/fpsyt.2022.908321

Möller, H., Haigh, F., Harwood, C., Kinsella, T., & Pope, D. (2013). Rising unemployment and increasing spatial health inequalities in England: Further extension of the North–South divide. *Journal of Public Health*, *35*(2), 313–321. https://doi.org/10.1093/pubmed/fds085

Morgan, D. L. (2014). Pragmatism as a Paradigm for Social Research. *Qualitative Inquiry*, *20*(8), 1045–1053. https://doi.org/10.1177/1077800413513733

Moseholm, E., & Fetters, M. D. (2017). Conceptual models to guide integration during analysis in convergent mixed methods studies. *Methodological Innovations*, *10*(2), 2059799117703118. https://doi.org/10.1177/2059799117703118

Neufeld, S. A., Jones, P. B., & Goodyer, I. M. (2017). Child and adolescent mental health services: Longitudinal data sheds light on current policy for psychological interventions in the community. *Journal of Public Mental Health*, *16*(3), 96–99. https://doi.org/10.1108/jpmh-03-2017-0013

NHS Digital. (2021). *Mental Health of Children and Young People in England 2021—Wave 2 follow up to the 2017 survey*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2021-follow-up-to-the-2017-survey

NHS Health Advisory Service. (1995). *Together we stand: The commissioning, role and management of child and adolescent mental health services*. HMSO.

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-Based Nursing*, *18*(2), 34–35. https://doi.org/10.1136/eb-2015-102054

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for Reporting Qualitative Research: A Synthesis of Recommendations. *Academic Medicine*, *89*(9), 1245–1251. https://doi.org/10.1097/ACM.0000000000000388

O'Connor, C. A., Dyson, J., Cowdell, F., & Watson, R. (2018). Do universal school-based mental health promotion programmes improve the mental health and emotional wellbeing of young people? A literature review. *Journal of Clinical Nursing*, *27*(3–4), e412–e426. https://doi.org/10.1111/jocn.14078

Onnela, A., Hurtig, T., & Ebeling, H. (2021). A psychoeducational mental health promotion intervention in a comprehensive schools: Recognising problems and reducing stigma. *Health Education Journal*, *80*(5), 554–566. https://doi.org/10.1177/0017896921994134

O'Reilly, M., Svirydzenka, N., Adams, S., & Dogra, N. (2018). Review of mental health promotion interventions in schools. *Social Psychiatry and Psychiatric Epidemiology*, *53*(7), 647–662. https://doi.org/10.1007/s00127-018-1530-1

Persson, S., Hagquist, C., & Michelson, D. (2017). Young voices in mental health care: Exploring children's and adolescents' service experiences and preferences. *Clinical Child Psychology and Psychiatry*, *22*(1), 140–151. https://doi.org/10.1177/1359104516656722

Punton, G., Dodd, A. L., & McNeill, A. (2022). 'You're on the waiting list': An interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. *PLoS ONE*, *17*(3), e0265542. https://doi.org/10.1371/journal.pone.0265542

Ronzoni, P., & Dogra, N. (2011). Children, adolescents and their carers' expectations of child and adolescent mental health services (CAMHS). *International Journal of Social Psychiatry*, *58*(3), 328–336. https://doi.org/10.1177/0020764010397093

Smith, J., Kyle, R. G., Daniel, B., & Hubbard, G. (2018). Patterns of referral and waiting times for specialist Child and Adolescent Mental Health Services. *Child and Adolescent Mental Health*, *23*(1), 41–49. https://doi.org/10.1111/camh.12207

Solmi, M., Radua, J., Olivola, M., Croce, E., Soardo, L., Salazar de Pablo, G., Il Shin, J., Kirkbride, J. B., Jones, P., Kim, J. H., Kim, J. Y., Carvalho, A. F., Seeman, M. V., Correll, C. U., & Fusar-Poli, P. (2022). Age at onset of mental disorders worldwide: Large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry*, *27*(1), 281–295. https://doi.org/10.1038/s41380-021-01161-7

Song, Y., MacEachern, L., Doupe, M. B., Ginsburg, L., Chamberlain, S. A., Cranley, L., Easterbrook, A., Hoben, M., Knopp-Sihota, J., Reid, R. C., Wagg, A., Estabrooks, C. A., Keefe, J. M., Rappon, T., & Berta, W. B. (2022). Influences of post-implementation factors on the sustainability, sustainment, and intra-organizational spread of complex interventions. *BMC Health Services Research*, *22*(1), 666. https://doi.org/10.1186/s12913-022-08026-x

Trotta, A., Arseneault, L., Caspi, A., Moffitt, T. E., Danese, A., Pariante, C., & Fisher, H. L. (2020). Mental health and functional outcomes in young adulthood of children with psychotic symptoms: A longitudinal cohort study. *Schizophrenia Bulletin*, *46*(2), 261–271. https://doi.org/10.1093/schbul/sby015.239

Van Roy, B., Groholt, B., Heyerdahl, S., & Clench-Aas, J. (2010). Understanding discrepancies in parent-child reporting of emotional and behavioural problems: Effects of relational and socio-demographic factors. *BMC Psychiatry*, *10*(1), 56. https://doi.org/10.1186/1471-244X-10-56

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2016). *THRIVE Elaborated* (Second). http://implementingthrive.org/wp-content/uploads/2016/09/THRIVE-elaborated-2nd-edition.pdf.

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2019). *THRIVE Framework for system change*. CAMHS Press. https://www.annafreud.org/media/9254/thrive-framework-for-system-change-2019.pdf.

Chapter 6: Child and adolescent mental health services in a devolved healthcare system: A qualitative exploration of sustainable practices

Banwell, E., Humphrey, N., & Qualter, P. (2023). Child and adolescent mental health services in a devolved healthcare system: A qualitative exploration of sustainable practices. *Health Research Policy and Systems, 21*(1), 27. https://doi.org/10.1186/s12961-023-00970-2

This chapter presents the version of Study 4 that was published, open access, in Health Services Research Policy and Systems and is awaiting publication. However, it has been reformatted for consistency with the rest of the thesis. All supplementary materials referred to in this chapter can be found in *Appendix 4.*

6.1: Abstract

Background:

The transference of research evidence into routine healthcare practice remains poorly understood. This includes understanding the prerequisites of longer-term viability. The present study investigated the sustainable practices of GM i-THRIVE, a programme which reconceptualises mental health services for children and young people (CYP) in Greater Manchester, United Kingdom. We aimed to establish whether a sustainable future was likely, and to identify areas of focus to improve that likelihood.

Methods:

The NHS Sustainability Model, typically completed as a questionnaire measure, was converted into interview questions. The responses of nine professionals, from a variety of roles across the CYP mental health workforce, were explored using inductive thematic framework analysis. Selected participants completed the original questionnaire.

Results:

Five themes (communication; support; barriers to implementation; past, present, and future: the implementation journey; and the nuances of GM i-THRIVE) and 21 sub-themes formed the final thematic framework. Relationships with senior leaders

and with colleagues across the workforce were seen as important. Leaders' roles in providing meaning and fit were emphasised. Whilst training delivered the programme's aims well, monitoring its dissemination was challenging. Widespread issues with dedicating sufficient time to implementation were raised. The flexibility of the programme, which can be applied in multiple ways, was discussed positively. This flexibility links to the idea of GM i-THRIVE as a mindset change, and the uniqueness of this style of intervention was discussed. To a varying degree, themes were supported by responses to the quantitative measure, although several limitations to the use of the questionnaire were discovered. Consequently, they were used to infer conclusions to a lesser degree than originally intended.

Conclusions:

Professionals involved with GM i-THRIVE reported many elements that indicate a positive future for the programme. However, they suggested that more attention should be given to embedding the core concepts of the model at the current stage of implementation. Limitations relating to its use within our study are discussed, but we conclude that the NHS Sustainability Model is a suitable way of guiding qualitative implementation research. It is especially valuable for localised interventions. The constraints of our small sample size on transferability is considered.

Keywords:

Child and adolescent mental health; mixed-methods; thematic framework analysis; implementation sustainability; implementation science

6.2: Introduction

Background:

The complete transference of research evidence into routine healthcare takes seventeen years on average (Morris et al., 2011). This lengthy duration contributes to a pessimistic larger picture, whereby only around half of evidence-based practices are ever implemented widely (Bauer et al., 2015). Despite this, intervention sustainability, a vital factor underneath the theoretical "implementation science" umbrella, has attracted relatively little research attention (Shelton et al., 2018). Defined as the "continued use of program components and activities for the

continued achievement of desirable program and population outcomes" (Scheirer & Dearing, 2011, p. 2060), sustainability is deemed "one of the most significant translational research problems of our time" (Proctor et al., 2015, p. 2). Cohesive and definitive knowledge of the core factors underpinning longer-term viability is urgently required if interventions are to be sustainable from their outset, and ultimately, if the temporal research-to-practice gap is to be closed. The present study synthesises some of the key issues raised in recent recognition of this dearth of sustainability research. To do this, a predominantly qualitative research strategy was taken, to explore the sustainable practices of GM i-THRIVE, a current children and young people's (CYP) mental health intervention within Greater Manchester, United Kingdom.

Greater Manchester is one of the regions in England implementing the THRIVE Framework for System Change (Wolpert et al., 2019). The nationwide initiative, known locally as GM i-THRIVE, aims to remedy the inadequacies of current CYP mental health services in the city-region. The THRIVE Framework migrates from the conceptually rigid and notoriously difficult to access tiered model of support traditionally used in the UK's NHS (National Health Service) Child and Adolescent Mental Health Services (CAMHS). It aims to steer support services towards a service where shared decision-making and easy access are core. *Figure 6.1* visualises the THRIVE model's needs-based groupings, under which support is decided upon collaboratively. It represents an inclusive, whole-system approach, where advice, support, and care are allocated flexibly, as per *current* need, rather than by severity or mental health history. As a result, every CYP, including those considered "thriving", can benefit.

THRIVE describes itself as a "shared language" and a mindset change, rather than a tangible "intervention". Consequently, changing the way that mental health and service provision are conceptualised is key. Within Greater Manchester, an initial implementation period of four years (2018-2022) was allocated, followed by a short "embedding" phase, where implementation efforts continue. This overall duration clearly falls drastically short of the seventeen-year figure quoted as necessary for full implementation (Morris et al., 2011). Although the evidence base is currently small, recent studies examining effectiveness of "THRIVE-aligned" support found already-

***Figure 6.1**: The five needs-based groupings of the THRIVE Framework for System Change (Wolpert et al., 2016).*

emerging positive changes (Farr et al., 2021; Lidchi & Wiener, 2021; Rocks et al., 2020). However, focussed investigation into the potential longevity of these changes is needed to assess their eventual impact. This is especially important given GM i-THRIVE's short timeframe. Post-implementation sustainability should be considered as early as possible in the implementation process for complex health interventions, so that protective strategies can be devised to overcome identified barriers (Song et al., 2022). This need, given that sustainable practice is such a crucial predictor of public health impact (Spoth et al., 2011), was a fundamental driver of the present study.

Rationale for the present study:

We used an existing sustainability evaluation tool, the NHS Sustainability Model (Maher et al., 2010), to investigate GM i-THRIVE's sustainable practices. It was designed by 250 subject experts and NHS staff, with 10 factors noted as key sustainability predictors (Doyle et al., 2013). These factors were then divided into

three overarching areas: “process”, “staff”, and “organisation”. Brief explanations of those factors are provided in *Table 6.1.* Services using the model self-assess their own sustainability through a questionnaire measure (QM).

Table 6.1: *Areas and factors that comprise the NHS Sustainability Model* (Doyle et al., 2013; Maher et al., 2010)

Areas:	Factors:	Explanation:
Process	Benefits beyond helping patients	Are there any other benefits to the change besides patient care, e.g. more efficient working practices, or reduced waste?
	Credibility of the benefits	Are the benefits obvious to, and describable by, everyone involved, and are they supported by evidence?
	Adaptability of the improved process	Can the new process withstand internal pressures? Can it meet ongoing needs without reliance on any individual/group/finance?
	Effectiveness of the system to monitor progress	Are there monitoring and feedback systems in place to be used beyond implementation, and is this information communicable?
Staff	Staff involvement and training to sustain the process	Do staff play a role in the design and implementation, and are they suitably trained?
	Staff behaviours toward sustaining the change	Are staff encouraged to express ideas, and do they think the new change is a better way of doing things?
	Senior leadership engagement and support	Are senior leaders trusted, involved, knowledgeable, and responsible?
	Clinical leadership engagement and support	Are clinical leaders trusted, involved, knowledgeable, and responsible?
Organisation	Fit with the organisation’s strategic aims and culture	Are the goals clear, and do they contribute to the overall aims of the organisation? Have similar changes done well in the past?
	Infrastructure	Are staffing, facilities, policies, and equipment suitable to sustain the implementation over time?

The NHS Sustainability Model is just one of several models and tools developed to research sustainability. Such tools have been developed to guide intervention set-up, ensuring that sustainability is considered early on, and to determine whether an intervention is, or is likely to be, sustainable long-term. The NHS Sustainability Model, whilst typically delivered through a questionnaire, has also guided qualitative research. Sustainability barriers and facilitators have been successfully identified by converting the items into an interview schedule (Ploeg et al., 2018). Qualitative research methods are useful for exploring sustainability in smaller, localised interventions, where the statistical power needed for quantitative research is not present (Shelton et al., 2018). Despite capturing just a "snapshot" of an intervention at one time-point, qualitative studies harness valuable stakeholder insights into the current practices, and impeding barriers, surrounding sustained usage (Shelton et al., 2018). The NHS Sustainability Model's track record of methodological flexibility, combined with its NHS-centric design, was why it was ultimately chosen for this study. This choice also stemmed from lack of consistency across sustainability research. Whilst novel research approaches are often excellent ways of exploring ideas and appraising findings, this can make wider conclusions harder to draw, and collaborative progression of a field of research may be hindered. For unanimous progression, and more consistent measurement of implementation and sustainability progress and outcomes, greater reliance on existing models has been posited (Proctor et al., 2015; Stirman et al., 2012). Had we designed the present study based on our own perceptions of what were important elements of sustainability, we would not only have contributed to the measure inconsistency noted as a limitation in the field, but important considerations may have been missed. Thus, the NHS Sustainability Model's factors detailed in *Table 6.1*, were converted into questions in a semi-structured interview.

To tailor the interview to GM i-THRIVE, three additional topics of relevance were added: (1) *adaptability*: that organisations should evaluate, respond, and evolve to meet public health needs (Whelan et al., 2014). This is a vital consideration for GM i-THRIVE as a broadly applied intervention; (2) during implementation, staff should *reflect* upon their situation before the intervention was introduced (Lean et al., 2015). Since THRIVE represents such a significant transformation from the tiered

model, the facilitation of reflection is worthy of focussed investigation; and (3) a large portion of intervention dissemination in GM i-THRIVE is through *training* (Beidas & Kendall, 2014). The emphasis on diffusing knowledge through organisational levels made this a vital interview topic. In addition to the interviews, selected participants completed the original QM, and their responses were corroborated, where appropriate, with the generated qualitative themes. Adopting a purely *post hoc* evaluation approach, that takes place only once official implementation phases have ended (Song et al., 2022) can limit the scope of sustainability analyses, whereas combining retrospective investigation methods with those that offer the potential for ongoing improvement may increase their utility (Bowman et al., 2008).

GM i-THRIVE's implementation and embedding stages are summarised below. The plan was executed at a GM-wide level; however it is clear from the outlined steps that the requirements and capacity of each locality and service within were considered. The present study's data was collected from August to November of 2021, as Stage 4 (the reviewing of implementation projects and goals) was ending, and Stage 5 (the continued embedding and monitoring of outcomes) was set to begin. This timing sits comfortably between *a priori* and *post hoc* research approaches, allowing investigation of sustainable factors occurring towards the end of, but still in the midst of, implementation (Song et al., 2022).

Stage 1: Set up:

- Cross-sector approval of GM i-THRIVE established
- Stakeholder mapping undertaken
- Communication and engagement plan created

Stage 2: Engagement, understanding, and planning:

- Key goals and messages established, including locality contexts
- Staff, CYP, and family consultations
- Service performance review: need, current practice, demand, clinical outcomes, current outcome measures, etc.
- Progress monitoring method established
- Locality models of GM i-THRIVE created

Stage 3: Capacity building:

- Staff capacity, recruitment need, and workforce development plan established
- Creation and training of locality leads
- THRIVE training for front-line staff and managers begun

Stage 4: Implementation:

- Finalising implementation outcomes in each locality
- Implementation projects designed, undertaken, and monitored

Stage 5: Embedding and sustaining:

- Learning collaboration established
- Embedding, sustaining, and monitoring implementation projects

Through this positioning, our objectives were to identify:

- Already-occurring sustainable practices
- Areas where sustainability could be enhanced during GM i-THRIVE's "embedding" period.

6.3: Methods

Reporting guidelines:

The production of this article was guided by the Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014).

Researcher context:

The authors were commissioned by the Greater Manchester Health and Social Care Partnership (GMHSCP) to evaluate GM i-THRIVE. As external researchers, our analyses were not influenced by vested interest. It is, however, prudent to acknowledge that impressions gained by the first author during regular meetings with GM i-THRIVE leaders and stakeholders may have inadvertently impacted the analyses and conclusions (Noble & Smith, 2015). Despite this possible bias, the

benefits of these afforded insights into working environments and practices undoubtedly outweighed the risk of biases attained through the same contact.

Design:

Our rationale for choosing a mixed-methods approach was driven by complementarity (Greene et al., 1989): meaningfulness and validity are improved by drawing on strengths of qualitative *and* quantitative approaches. A pragmatic epistemological viewpoint was adopted, with the research and analysis methods selected purely for their practicality (Morgan, 2014). This paradigm emphasises the value of useful and actionable research: higher level abstraction is unnecessary, or even obstructive, when attempting to meet the aims of such studies (Kelly & Cordeiro, 2020).

Setting:

GM i-THRIVE is part of a wider devolution deal, drawn in 2016, between GMHSCP and the UK government. GMHSCP can now allocate resources to health and social care services, as per the needs of Greater Manchester's 2.8 million city-region residents. Alignment of Greater Manchester's CYP mental health services to THRIVE principles follows the philosophy of the wider devolution, by aiming to provide an appropriate and diversified range of support and care.

The ethnically and socially diverse city-region of Greater Manchester (GM) is in North-West England, and comprises high-density urban areas, suburbs, and rural locations. 898,000 under-25-year-olds reside in GM, who are more likely to experience poverty, and suffer poorer overall health outcomes than the average young person in the UK (Greater Manchester Combined Authority, 2019). Ten locality boroughs (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, and Wigan) make up GM, each with a GM i-THRIVE "lead" accountable for managing implementation across specialist NHS and other local services. These leads are overseen by a dedicated GM i-THRIVE team.

Ethical considerations:

Under NHS Health Research Authority guidelines, the present study was categorised as a "service evaluation". The need for formal review by the NHS

Research Ethics Committee, and the University of Manchester's own research ethics committee, was therefore waived. However, informal approval was sought from the second and third authors (the first author's supervisory team), and the study commissioner. Principles such as obtaining informed consent and ensuring secure data storage were followed.

Participants:

Nine participants were recruited with an opportunistic maximum variation strategy. Participants could respond to an email, sent by a gatekeeper within the GM i-THRIVE team, if they wished to take part. The key variation point of the strategy was that participants represented the levels of professional control and autonomy often present in healthcare organisations. Demonstrating this, an implementation sustainability study within nursing identified that staff had little authority over how they spend their time, how much freedom they had to innovate, and crucially, how much of an intervention is truly "received" by them (Bridges et al., 2017). Most factors that promote or hinder sustainability are influenced by the most senior staff, and exist outside the sphere of influence of those involved in practical implementation (Bridges et al., 2017). We consequently decided that a hierarchical range of "control" levels should be represented, encapsulating a full array of multi-organisational perspectives. Eventually, the sample comprised *n*=2 participants with the highest amount of control: top-down implementers who make the key decisions that impact intervention sustainability. Those with moderate control (*n*=4) were GM i-THRIVE locality leads. These senior staff members with roles and responsibilities that are extraneous to GM i-THRIVE., however they are responsible for implementation activity in their locality. Although they possess some degree of control over how they disseminate GM i-THRIVE, they sit centrally between receiving versus providing guidance. The final group of participants (*n*=3) are pure intervention recipients. Whilst influencing sustainable practices in a minor way, perhaps through suggestions and feedback, they are predominantly responsible for enacting their training, and as a result, have a low level of control. All of these participants worked with CYP within GM localities, as practitioners or therapists. Participants from six of

GM's locality boroughs were represented in the sample, and one participant (of low control) worked for a voluntary sector service that operates across seven boroughs.

Data collection procedures:

Construction of the semi-structured interview schedule was guided by items of the NHS Sustainability Model (Maher et al., 2010). Additional questions added focus on adaptability, reflection, and training. The schedule was tailored per interview, ensuring relevance to each participant's professional role. A full copy of the interview schedule can be found in *Appendix 4.* Owing to COVID-19 restrictions, interviews were held through online conferencing software. After verbatim transcription by the first author, each typed transcript was "member checked", which allowed participants to expand, amend, or omit data that they no longer wished to be represented (Birt et al., 2016). The QM was completed by all GM i-THRIVE locality leads (n=4). These participants had the necessary level of expertise of the strategic inner workings and implementation-to-workplace translation of GM i-THRIVE for completion of the QM, for which the 10 factors (*Table 6.1*) were presented as a tick-box questionnaire, for participants to select their perception of sustainability progress.

Data analysis:

Transcripts were analysed using thematic framework analysis (TFA). TFA is a practical and transparent qualitative analysis method, deemed well-suited to both health (Gale et al., 2013) and applied policy research (Srivastava & Thomson, 2009). Situated within the broader family of thematic analytic methods (Gale et al., 2013), TFA is suitable for research that, like the present study, has *a-priori* issues that warrant exploration, a pre-determined sample, and a limited research timeframe (Srivastava & Thomson, 2009). Directive and actionable research outcomes are typically produced by TFA (Ritchie & Spencer, 1994).

Verbatim transcripts were analysed by the first author, using the stages of TFA outlined by Gale et al. (Gale et al., 2013). Firstly, familiarisation and data immersion occurred by re-reading transcripts, with key ideas coded line-by-line. Then, a working thematic framework was gradually developed to sort coded data. The interview schedule *can* be viewed as a pre-existing "framework", as it undeniably

guided the authors' thematic thinking (Srivastava & Thomson, 2009). However, to ensure that the data were not forced into this framework, no deductive codes were used, allowing a predominantly inductive analytic approach. This approach differs from other qualitative studies guided by the NHS Sustainability Model (Ploeg et al., 2018), and alongside the inclusion of three additional intervention-specific foci, represents the study's aim of identifying the sustainability factors deemed the most important for GM i-THRIVE.

Following coding, data were "indexed": sections of data corresponding to each theme were identified, then "charted" in a matrix using Microsoft Excel under headings from the newly developed thematic framework. Finally, the characteristics outlined in the charts were interpreted, and themes were refined and finalised. A portion of the final themes, codes, and extracts, were "sense-checked" by the second and third authors, to enhance confirmability (Graneheim & Lundman, 2004). Ensuring that coding, charting, and the underpinning thought processes make logical sense is a methodologically appropriate way of adding rigour to qualitative studies. Traditional "validity", is not a worthwhile goal of such research (Galdas, 2017).

Meta-inferences:

Meta-inferences between the qualitative data and the QM were reached through an exploratory bidirectional approach. This means that, although the qualitative strand heavily predominates, and the quantitative results are presented separately, we aimed to conflate both sets of data iteratively when drawing study conclusions (Moseholm & Fetters, 2017). As the discussion section shows, however, our eventual ability to do this was hindered by several factors, which were presented as limitations of the QM's use in this study.

6.4: Results and discussion

The final thematic framework comprised five overarching themes and 21 sub-themes, each pertaining to a factor influencing sustainability within GM i-THRIVE. For consideration alongside the analysis, *Table 6.2* shows the thematic framework in its entirety, supported by example illustrative participant extracts. Please note

that within the following theme analyses, sub-theme names (*Table 6.2)* are italicised within each.

Communication:

The importance of open dialogue and widespread communication for *the dissemination of GM i-THRIVE* was raised by a range of participants. Well-attended core meetings, where ideas and strategies were shared, were reported. This demonstrates engagement with the programme, and active staff involvement in staying up-to-date. However, testimonies from participants with lower professional control questioned the reach of such platforms. Although they acknowledged that THRIVE featured in workplace conversations, participants wished for more formal briefings. One participant felt that those in the CYP workforce's wider peripheries had not yet been sufficiently immersed in THRIVE's conceptual framework. *The relationship between Greater Manchester and locality teams* was also raised as key. Several participants praised the helpfulness and approachability of GM i-THRIVE's programme manager, who was easy to contact, and keen to assist. Opportunities to share experiences and successes with this team were appreciated. In the literature, the role of managers as galvanisers, who encourage innovation during implementation, has been documented (Engle et al., 2017). However, this may be just one factor of group efficacy, a factor more vital than senior management alone (Iden & Eikebrokk, 2015).

This efficacy within GM i-THRIVE may be fostered by *networking and joint working*. THRIVE's common language enhanced communication between services, uniting the broad sector, and diverse peer networks within implementation helped inform improvement and navigate ambiguity in a contextually relevant way (Worton, 2020). Participants also discussed the importance of knowing each other's roles and practices, which is key for providing the cohesive service advocated by THRIVE. Accurate perceptions of others', and one's own role in implementation is crucial when aligning an intervention with already-existing organisational practices. Misunderstandings may be detrimental to sustainability (Hasson et al., 2014).

Table 6.2: *Thematic framework, showing overarching themes, sub-themes, and example illustrative extracts. Numbers in brackets represent the number of participants that contributed to each theme and sub-theme.*

Overarching theme	**Sub-theme**	**Example illustrative extract (Participant number and professional control over the implementation process in bold)**
Communication (9)	The dissemination of GM i-THRIVE (7)	"I'm responsible for coordinating our THRIVE partnership […] forum through which we engage, keep informed, work with collaboratively in terms of our strategy and planning work, sharing information. And we have very good attendance and engagement. I think that illustrates that people are bought into the agenda and know where to go". ***(Participant 1, medium control)*** **"**That's one of the biggest things really, about that shared language. And I don't think we are there with that. I don't think that the wider workforce knows enough about it". ***(Participant 6, low control)***
	The relationship between Greater Manchester and locality teams (6)	"I think that the GM team around THRIVE are really responsive. They celebrate the work that you do in a locality […] And they are a team that is quite approachable to problem solve, so I think that's definitely a real help". ***(Participant 2, medium control)***
	Accountability (7)	"I think some of them (locality leads) definitely have that personal accountability and responsibility, and you can see in some areas where it's really flourished […] And other areas, it's just starting to take off so there's definitely something about having the right people in place". ***(Participant 4, high control)*** "A challenge will be moving forward, to support the practitioners and understanding what it means to them. Where do they fit within it? What do they already offer? ***(Participant 9, low control)***

	Networking and joint working (7)	"I think that the whole THRIVE process has strengthened our services, links with CAMHS, we've got much stronger relationships. We're more connected and understanding of each other's ways of working. And I think that sort of helps. I think just being clear on the different quadrants and what they mean for people". ***(Participant 6, low control)***
Support (9)	The responsibility of locality leads (6)	"Being an advocate for the THRIVE principles, being that conduit in a system that tries to facilitate conversations between different organisations […] getting people to reflect on their own practices in accordance with the THRIVE principles, is one of the main responsibilities I'd say for a THRIVE lead". ***(Participant 8, medium control)***
	The role of the Greater Manchester team (8)	"One of the key things is building relationships, that's it, and being open and helpful to people and trust, so bringing that familiar, having that relationship". ***(Participant 4, high control)***
	Other senior support (4)	"What you couldn't pretend was that just having the fancy new diagram with THRIVE was going to solve that if you didn't sort out putting in the new and the extra services and the support to people. So I was somewhat cynical". ***(Participant 5, high control)***
	Training and capacity building (8)	"I don't think we had the right representation at the start […] It's the same people that always put their hand up, or always get nominated". ***(Participant 3, medium control)*** **"**One of the things we probably struggle with is knowing how that training's been progressed […] to say actually 'have you used that training for your own practice?' or 'have you managed to train other people in your team?' and understand kind of how far that's gone". ***(Participant 2, medium control)***

Barriers to implementation (9)	Workload (5)	"I feel like I've probably not got as much capacity to be able to truly focus on that all the time, which I think it could, it could be a role that someone could do full time, and still probably not be able to solve everything". ***(Participant 2, medium control)***
	Conflicting priorities (6)	"The THRIVE Leads are really passionate and keen, but maybe more limited with their capacity, because of their other work that they've got to do. And I think that's quite common across quite a lot of roles. But I think if you can then have that shared... ownership is probably the right word? Of continuing to implement it, bit by bit. I think that's more of a sustainable model as well". ***(Participant 9, low control)*** "THRIVE has tried to change practices so that it's working smarter, not harder. In the short term, it might look as if there's a little bit more of an effort, and there's a bit of time that you need to take out to reflect on your service and build it in a THRIVE-like way". ***(Participant 8, medium control)***
	The effect of "firefighting" on progress (4)	"When I look where we were at say 18 months ago, and what our aspirations were to do next, we've not been able to move on some of those things because it's about staff well-being, staff shortages, people being off sick, system changes, it's all been about firefighting and business continuity, sadly". ***(Participant 1, medium control)***

Past, present, and future: the implementation journey (9)	GM i-THRIVE was, and is, needed (7)	"What we were drawing on wasn't… It was things that were unsatisfactory really, actually a desire to move away from things that didn't work, and weren't as universally engaging or adaptable as what THRIVE actually is". ***(Participant 1, medium control)*** "It's a really good way to challenge decisions. It didn't mean that there was a different outcome. But it's always good to have the theory behind what we should be doing". ***(Participant 7, low control)*** "We had what was previously the tiered model. Now, I don't think that framework is bad or wrong. And I think there's been a bit of a confusion with people saying "oh, THRIVE's so much better and THRIVE's much easier'. And it misses the point that the failure around the tiered model was about investment". ***(Participant 5, high control)***
	A strong foundation (7)	"There's always been that commitment that THRIVE is the approach that that we're going to take". ***(Participant 2, medium control)*** "We've put that effort in, and now it's just about sustaining it, keeping it, keeping the momentum going". ***(Participant 3, medium control)***
	Evidence of change (9)	"I think the biggest difference is just more conversations and less referrals". ***(Participant 8, medium control)*** "I think, if it wasn't good, people wouldn't stretch it out anywhere, it wouldn't go as far as it's going now, if the effort was too much". ***(Participant 4, high control)***
	Becoming routine (4)	"I think it has potential. But I think there needs to be a culture/thought shift amongst the whole system. And I think the challenge with that is how it aligns with other systems". ***(Participant 6, low control)***

	Learning from reflection (7)	**“**Some observations I have made over time is that it's got to be more than a word. And I think that's key. It's got to be meaningful”. ***(Participant 9, low control)***
	Looking to the future (8)	“To make it sustainable, they need to sell this. It's that synergy of the bits coming together really, rather than just lots of training and people using pretty diagrams, which THRIVE does give us. But it's got to be more than that”. ***(Participant 5, high control)*** “It feels as if now we're at that pivotal, turning point where everyone's starting to get it. ***(Participant 8, medium control)*** “Rethinking how we use the resources we've got now, for the best effect […] training and capacity building is one of those, you can't just do that for a couple of years, and then hope that you’ve long-term sustained benefits, you’ve got to keep doing it”. ***(Participant 1, medium control)***
The nuances of GM i-THRIVE (8)	Unexpected consequences (4)	“A couple of people not understanding it, or thinking it was more than what it was”. ***(Participant 9, low control)*** “We never set out to look at that in the broadest context that we have. In a positive way, we certainly didn't set out with an ambition to apply the THRIVE concepts across much broader children’s services systems and that's been a positive consequence”. ***(Participant 1, medium control)***
	Widespread change (8)	“Part of my portfolio encroached on the homelessness agenda. And I thought, you know what, we could use THRIVE here”. ***(Participant 3, medium control)*** “If I was to quote THRIVE every time I made a referral, I imagine that would help in terms of the outcome of that, and that might be something I can implement myself”. ***(Participant 7, low control)***

Flexible application (5)	"It allows people to use it in different ways as well, but brings a commonality to it, so that shared language that everyone understands". ***(Participant 4, high control)*** "I find that a positive and a negative, because you feel like you've got free run to do what's right for your area. But equally you've not got anything to compare to whether you're on track". ***(Participant 2, medium control)***
How does the nature of THRIVE as a model influence implementation? (5)	"Because it's such a universal approach, and that it can apply to a lot of things, there's never like a definitive end where you say "we've officially embedded THRIVE". It feels like it could always go on and on". ***(Participant 2, medium control)*** "I think people thought THRIVE was a thing, rather than a set of principles and a framework. And that was the most difficult thing to overcome […] I think a framework takes longer. But I think there's many benefits to it, because it's more flexible for the system". ***(Participant 3, medium control)***

Participants thought that if staff feel *accountable* for their role in implementation, the benefits would be more effective. Communicating and evidencing personal meaning to implementing staff, by demonstrating where their own roles fit and emphasising the differences that they could make, is vital. It was also important for busy GM i-THRIVE locality leads to feel accountable. Leads who could seamlessly integrate THRIVE work into their other responsibilities reportedly made the quickest progress. A review of sustainability tools found that accountability for intervention delivery featured in slightly over half of models (Lennox et al., 2018). This suggests that whilst its importance may differ per intervention, in THRIVE's instance, varied application across job roles means that knowing how it applies to one's own work, and feeling responsibility for this application, is vital.

Support:

Staff at all levels reported the value of providing and/or receiving support across the implementation process. *Locality leads saw their key responsibility* as galvanising and steering, rather than direct implementation. Although a lack of clinical knowledge was reported, they perceived themselves as conduits between the Greater Manchester team and locality staff. Leads deliver key messages, and encourage reflection and conversation. *The role of the Greater Manchester team,* as reported by a member of this team is, again, to enable. They saw themselves as facilitating relationships and promoting familiarity around THRIVE. Other participants described this team as a friendly central point of contact. Their support and direction were vital, and as such, should not be withdrawn in the near future. The key point raised under the sub-theme "*other senior support"* was the necessity of senior buy-in. It was essential for service leaders, and those in commissioning roles, to be convinced that THRIVE can make positive changes. One such participant admitted initial cynicism, stating that other issues, such as staffing and service provision, needed to be resolved before the THRIVE could be properly received. Cynicism is an identified barrier to organisational change and reform across all professional levels (Kroll & Pasha, 2021; LaMontagne et al., 2021; J. D. Watt & Piotrowski, 2008), with manager cynicism influencing employee commitment to

change (Kroll & Pasha, 2021). The senior leadership QM factor, although deemed one of the most important (Maher et al., 2010), produced mixed results. However, owing to the ambiguity of QM guidance, exactly who leads were referring to when answering is unclear in this instance.

Training and capacity building was raised many times. Whilst participants reported that, generally, the training delivered THRIVE's aims well, an appropriate foundation of suitable trainees, who possessed the correct level of background knowledge, was not in place at first. This meant that the same individuals attended all sessions, inevitably limiting the training's reach. Keeping track of whether and how training is embedded and disseminated was also reported as challenging, with no formal mechanism in place to assess this. Having enough trained staff is an important predictor of intervention outcome (McKay et al., 2018), yet the factors underpinning the transfer of new skills to behaviour remain poorly understood (Mosson et al., 2019). Our findings further demonstrate the need to monitor this, especially considering that within GM i-THRIVE, a diverse group of staff receive identical training. Understanding and application inevitably vary greatly, requiring tailored monitoring. Training, and progress monitoring, featured in 76% and 84% of sustainability frameworks respectively (Lennox et al., 2018), demonstrating their near-universal reputation as important for long-term viability. This observation is particularly noteworthy given that studies directly investigating THRIVE-aligned support have suggested that better outcome (Farr et al., 2021) and performance monitoring (Rocks, Fazel, et al., 2020) are needed for full impact. In the QM, the "staff involvement and training" item was generally scored positively, yet "effectiveness of the system to monitor progress" revealed mixed opinions. These echoed sentiments from the interviews: whilst training content was good, dissemination had room for improvement.

Barriers to implementation:

Several barriers were discussed. A high *workload* limited the hours that locality leads could dedicate to GM i-THRIVE. Leads mentioned that although the ethos of the programme allows localities to work within the constraints of their resources, a full-time role would still be needed to dedicate a required amount of attention. One

participant suggested creating this role to make GM i-THRIVE more sustainable. It was clear that staff at all levels handle *conflicting priorities*. Whilst GM i-THRIVE has created enthusiasm, implementation must fit alongside other tasks and roles. Greater responsibility sharing was suggested, plus promoting the idea that whilst initial investment of time and effort is needed, this will eventually result in more streamlined work practices. The related *effect of "firefighting" on progress,* particularly in the context of COVID-19, was frequently mentioned. Dealing with urgent challenges as they arise, to maintain equilibrium, often take the fore. As a result, the time and energy needed to innovate and champion new strategies becomes limited. In 2020, the Academy of Medical Sciences produced a report outlining the lack of capacity allocated to research within the NHS (The Academy of Medical Sciences, 2020). This limits scientific innovation, and the subsequent implementation of evidence-based care. From this report, it is hoped that links between health and academia will be strengthened, and that NHS staff can dedicate more time to developing and incorporating evidence. The "infrastructure" factor of the QM connects with this theme, yet covered facilities, policy, and equipment in addition to staffing. This may be why mixed reports were yielded.

Past, present, and future: the implementation journey:

This theme includes discussions covering a range of implementation time points, which are grouped together under one theme because of the chronological story they tell. A variety of opinions on the extent to which *GM i-THRIVE was, and is, needed* were expressed. The strict tiered model previously used meant that THRIVE's diversified and flexible support options were appreciated. Although better outcomes were not always evident, having the framework available when making decisions was valuable. Despite these observations, THRIVE should not be seen as a "quick fix". One participant believed that the shortcomings of the tiered model are due to investment allocation rather than the nature of the model itself.

Locality leads felt that their own early involvement in implementation had built a *strong foundation* for the process. They felt that their locality had had a head start in making and sustaining change. These leads reported commitment to the framework, and had no doubts about its suitability. This commitment has built

enthusiasm and motivation, and now that this solid foundation is in place, sustainability is priority. Desire for improvement has been identified as a key driver of change (Flannery & Rotondo, 2016; Shelton et al., 2018), and staff commitment is important for overall implementation (Kaper et al., 2021), fidelity (Filter et al., 2016) and maintaining adaptations (Jones et al., 2019). However, sustaining commitment can be challenging when conflicting priorities are present (Frakt et al., 2018).

Whilst the previous two sub-themes scoped the situation before GM i-THRIVE, and the starting points that the localities were working with, the next sub-themes discuss what progress looked like to participants at time of interview. Various examples of *evidence of change* were mentioned. Participants reported that there had been a gradual shift to THRIVE's shared language, and they felt that the process of allocating mental health provision had been simplified. Referrals are now fewer, and those made are handled more appropriately. Many participants focussed on aspects of networking, stating that services are more connected, and that they feel more supported. Natural dissemination was also mentioned, including the idea that if GM i-THRIVE was not widely perceived as beneficial, it would not have developed to its current extent. Being able to demonstrate tangible advantages is widely reported as necessary for sustainability (Lennox et al., 2018). This means that GM i-THRIVE staff, upon recognising that changes have already taken place, may feel more motivated to continue, or even bolster, their efforts. "Credibility of the benefits" in the QM was rated unanimously, in that although some benefits are clear to see, there was room for improvement. Evidencing and documenting THRIVE's improvements should therefore continue into the next phase of implementation.

Whilst familiarisation with THRIVE was reported as initially slow, it is steadily *becoming routine.* The model now features in daily working lives, though some mentioned that a wider culture and mind-set shift is still forming, and that embedding this change is key for the future. Continuing to assess fit with current practice across the sector is vital, and this assessment should consider the distinct yet intricately related conceptualisations of technical, cultural, and political fit (Slager et al., 2020). Participants also felt that to move forward, THRIVE must shift from an abstract to a tangible concept for every involved member of the workforce. They must be given the tools to think about what THRIVE means to their role, and where

their role fits into the wider implementation. This is an example of how *learning from reflection* can build sustainability (Lean et al., 2015), improve future outcomes, and make an intervention meaningful in all contexts (Chambers et al., 2013). "Fit with the organisation's strategic aims and culture" was the best-scored item of the QM, suggesting that THRIVE's strategic aims align well with those of localities.

Reflecting in this way also facilitates the proposal of "next steps" that can be applied when *looking to the future.* One locality lead felt that after three years of implementation, a significant turning point had just been reached. Understanding and familiarity had become sufficiently deep and widespread, providing a suitable basis for bigger changes. This was echoed by acknowledgement that true sustainability would involve the broad synergy of professionals and their knowledge. Efforts invested into strategies such as training must therefore continue if benefits are perceivable long-term.

The nuances of GM i-THRIVE:

A key *unexpected consequence* of GM i-THRIVE related to misunderstanding its nature. On occasion, prior expectations of what the framework would offer were not met. Some anticipated greater changes that would rapidly resolve issues, whilst others expected a defined "intervention" instead of a mindset change. THRIVE's shared language has also been interpreted differently by different individuals. However, an unexpected yet positive outcome was the broadness of THRIVE's relevance. The diverse systems against which it can be applied far exceeded initial plans. Interventions with surplus value are generally viewed positively (Banwell et al., 2021; Dababnah et al., 2019). "Benefits beyond helping patients" was mostly well-rated in the QM, which supports the interview data.

This links closely to the sub-theme of *widespread change.* THRIVE as a mind-set shift has allowed staff to apply their new knowledge to other responsibilities outside CYP mental health. This *flexible application* also allows it to be used in numerous ways, rather than by following a regimented set of instructions. Despite this flexibility, the framework still brings commonality to the sector, with principles that are understandable by all. However, a negative side to flexibility can result from localities applying the principles non-uniformly, which can present a challenge

to comparison, “best practice”, and progress monitoring. Implementing so that the intervention remains recognisable, whilst simultaneously ensuring that guidelines are flexible and broadly applicable, is widely reported as a challenging balance to strike in the sustainability literature. Many researchers exploring implementation fidelity and adaptability have eventually concluded that these two concepts are a false dichotomy (Forehand et al., 2010; Mazzucchelli & Sanders, 2010). Not only are adaptations intrinsically necessary for many interventions, but actively encouraging them can make full adoption more likely (Mazzucchelli & Sanders, 2010). Many sustainability researchers have used ecological theory to explain that implementation inevitably involves constant adaptation according to constantly changing internal and external contexts (Rimehaug, 2014; Song et al., 2022). Whilst the importance of implementation fidelity varies per intervention (Stirman et al., 2012), THRIVE clearly requires adaptation to meet the diverse needs of CYP and locality staff. Pragmatically establishing what “best practice” looks like, identifying the core components of THRIVE, and considering what each of these look like per locality context, is suggested (Shelton et al., 2018; Stirman et al., 2012). Once determined, other variations should not be seen as problematic deviations from the model’s core ethos (Forehand et al., 2010).

Several nuances relating to *THRIVE as a model influence implementation.* Several participants mentioned the positioning of THRIVE as a framework, and as a set of principles to work with. THRIVE has described within the literature as a “paradigm shift” (Wolpert, 2014), a “re-design” (Lidchi & Wiener, 2021), and a “conceptualisation” (Wolpert et al., 2016). Whilst some consider implementation complete if its core elements are sustained over time (Stirman et al., 2012), participants felt that THRIVE’s nature does not demarcate a clear endpoint to implementation. Reinforcement, training, and embedding will be necessary for years to come. Although explaining THRIVE in these terms has been difficult, one locality lead said that whilst frameworks do take longer to implement than other types of intervention, the advantages are likely to be greater. Ensuring that mind-set changes are as widespread as possible before the implementation period expires is therefore essential, given that these changes are unlikely to be complete by this time. The factor referring to adaptability within the QM discusses whether

implementation can withstand removal of support. The findings suggested that GM i-THRIVE had not yet reached a point in its sustainability journey where such support could be fully withdrawn.

Strengths and limitations:

A key strength is that an existing sustainability framework guided this study's design. This contributes, albeit in a small way, to alleviating inconsistent measure use within the field (Proctor et al., 2015; Stirman et al., 2012). The NHS Sustainability Model added evidence-based structure to our investigation of sustainability within GM i-THRIVE (Ploeg et al., 2018). The model's factors, of known relevance to sustaining NHS-centred interventions, were an important starting point for our interviews, and our predominantly qualitative approach enabled substantially deeper discussion of sustainability than the QM alone.

Despite using the model to develop the interview schedule, analysis was inductive. In a similar study, the model's factors formed a deductive coding structure (Ploeg et al., 2018). Yet, as extra topics were covered to improve application to GM i-THRIVE, forcing our transcripts into a strict framework was inappropriate. Rather, the most salient topics developed the thematic framework. This inductive approach does, however, warrant discussion as a study limitation. The thematic framework's lack of direct match with the NHS model inevitably led to difficulties corroborating it with QM completions. The lead author therefore used their judgement when linking responses. As a result of this, some QM items were not cross-referenced if they did not fit. Whilst this questions the existence of true meta-inferences, it is worth reiterating that the QM formed only a small part of this research. They were merely used to elaborate upon the qualitative findings (Moseholm & Fetters, 2017). Owing to the poor ability to cross-reference, the eventual role that the QM played was even lower than originally intended.

The fact that themes did not perfectly match the model's factors may appear surprising given that it guided the interview. However, this essentially portrays the NHS Sustainability Model, particularly when converted to interview, as comprehensive enough for participants to discuss what *they* deem important for sustainability, within their implementation. In fact, a model that includes the "right"

sustainability constructs for *every* intervention does not, and certainly should not, exist, owing to the unique nature and contexts of each (Lennox et al., 2018). An inductive exploration is consequently important. Additionally, the advantageous peri-implementative standpoint of this study allowed us to look back as well as forwards. The positioning was especially opportune, as in 2021, most of the initial work of planning, locality assessing, and workforce building had already begun. This paved the way for the embedding of core concepts and ideas to build understanding, which was incidentally perceived by participants as a vital "next step". Considering this, is crucial that the GM i-THRIVE team continue to monitor these sustainable practices and outcomes. After all, sustainability should not be considered a single outcome that only needs to be measured once (Lennox et al., 2018). Instead, it is a dynamic process that is highly sensitive to changes in the contexts in which it occurs (Shelton et al., 2018; Song et al., 2022).

Although rich insights were obtained, we acknowledge the impact of the small sample size on the representativeness and transferability of our findings. Despite attempting a maximum variation strategy, the final sample was taken opportunistically. From points raised by participants, we attribute our recruitment difficulties to time constraints across the sector. Despite this, the locality boroughs participants worked in were well represented across the sample, which brought a diverse range of experiences with the implementation to the interviews. All participants contributed to each theme; with all sub-themes containing views from at least four participants (see *Table 2*). An even smaller number of perspectives were included in the QM. However, the locality leads were the only participants with an appropriate level of strategic knowledge for meaningful completion. Even then, difficulties and ambiguity when answering some factors were informally raised. One may question why, given the small pool of participants, and the issues raised with answering and using the data, we chose to include our QM findings within this paper. Whilst completely omitting use of the measure from this report would have been a valid decision that would have perhaps presented a more streamlined set of findings, we decided that the limitations to the QM's use within this context should be shared. Such presentation may indeed help other researchers designing similar studies. This transparency is important given that measure replicability and consistency is, as

reported in the introduction, lacking in the implementation sustainability research field. These limitations also highlight the value of qualitative approaches for translating the measure into a more accessible, flexible, and meaningful format. Through these methods, participants with any level of strategic knowledge can express insights into implementation sustainability. Questions can be worded appropriately for each participants' role, whilst the essence of each of the model's questions is still captured. Finally, the nature of THRIVE as a framework, and that it is not a tangible, directly applicable intervention, limits transferability to comparable innovations. This is especially true under the unprecedented context of the COVID-19 pandemic. Further qualitative investigations, using the NHS Sustainability Model, with other types of intervention, are hence recommended.

Conclusions and implications:

This study took a predominantly qualitative approach to exploring sustainable practices within GM i-THRIVE. Using an interview schedule, that was developed by combining the NHS Sustainability Model with intervention-specific additional points of interest, the qualitative data was summarised with five overarching themes. We tentatively conclude, overall, that GM i-THRIVE, as the implementation moves into its "embedding" phase, should look forward to a sustainable future, providing that attention is given to a number of key points that were gleaned from the thematic framework. Firstly, we found that senior staff played a vital part in facilitating GM i-THRIVE, and that locality leads should continue to ensure that staff understand exactly what the principles mean to them. Monitoring knowledge dissemination is therefore a crucial consideration, and enhancing this knowledge and familiarity will be key for embedding long-lasting change in all localities. Although this is a problem rooted in wider systemic issues, a culture of "firefighting" has limited implementation. Sustaining commitment to the key messages and practices of GM i-THRIVE is vital under these circumstances, so that they do not get lost or forgotten in favour of older methods that are familiar and easy, yet unhelpful in the long-run. Clear strategies for how to overcome this may need to be devised. Finally, whilst the adaptability of THRIVE principles enhances its reputation, the length of time that it takes to fully implement and sustain a mind-set change like THRIVE should not be

underestimated. Even towards the end of the four-year initial implementation period, the nature of THRIVE, as a framework of principles rather than a standalone concept, means that the process is likely to take a good deal longer. Accordingly, measures to enhance sustainability, as indicated by this study, are going to be key. From a methodological standpoint, the study provides a helpful example of how the NHS Sustainability Model can be used to stimulate qualitative discussion through interview, which is particularly valuable for smaller scale interventions such as this. Although THRIVE is a nationwide initiative, the local application in Greater Manchester, over a limited number of sites, makes this relevant here. Further research is needed to validate the model's applicability to other types of intervention when using it alongside qualitative methods.

6.5: References

Banwell, E., Humphrey, N., & Qualter, P. (2021). Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation. *BMC Medical Education*, *21*(1), 103. https://doi.org/10.1186/s12909-021-02530-0

Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC Psychology*, *3*(32). https://doi.org/10.1186/s40359-015-0089-9

Beidas, R. S., & Kendall, P. C. (Eds.). (2014). *Dissemination and implementation of evidence-based practices in child and adolescent mental health*. Oxford University Press.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Bowman, C. C., Sobo, E. J., Asch, S. M., Gifford, A. L., & the HIV/Hepatitis Quality Enhancement Research Initiative. (2008). Measuring persistence of

implementation: QUERI Series. *Implementation Science*, *3*(1), 21. https://doi.org/10.1186/1748-5908-3-21

Bridges, J., May, C., Fuller, A., Griffiths, P., Wigley, W., Gould, L., Barker, H., & Libberton, P. (2017). Optimising impact and sustainability: A qualitative process evaluation of a complex intervention targeted at compassionate care. *BMJ Quality & Safety*, *26*(12), 970–977. https://doi.org/10.1136/bmjqs-2017-006702

Chambers, D. A., Glasgow, R. E., & Stange, K. C. (2013). The dynamic sustainability framework: Addressing the paradox of sustainment amid ongoing change. *Implementation Science*, *8*(1), 117. https://doi.org/10.1186/1748-5908-8-117

Dababnah, S., Habayeb, S., Bear, B. J., & Hussein, D. (2019). Feasibility of a trauma-informed parent–teacher cooperative training program for Syrian refugee children with autism. *Autism*, *23*(5), 1300–1310. https://doi.org/10.1177/1362361318805368

Doyle, C., Howe, C., Woodcock, T., Myron, R., Phekoo, K., McNicholas, C., Saffer, J., & Bell, D. (2013). Making change last: Applying the NHS institute for innovation and improvement sustainability model to healthcare improvement. *Implementation Science*, *8*, 137. https://doi.org/10.1186/1748-5908-8-127

Engle, R. L., Lopez, E. R., Gormley, K. E., Chan, J. A., Charns, M. P., & Lukas, C. V. (2017). What roles do middle managers play in implementation of innovative practices? *Health Care Management Review*, *42*(1), 14–27. https://doi.org/10.1097/HMR.0000000000000090

Farr, J., Moore, A., Bruffell, H., Hayes, J., Rae, J. P., & Cooper, M. (2021). The impact of a needs-based model of care on accessibility and quality of care within children's mental health services: A qualitative investigation of the UK i-THRIVE Programme. *Child: Care, Health and Development*, *47*(4), 442–450. https://doi.org/10.1111/cch.12855

Filter, K. J., Sytsma, M. R., & McIntosh, K. (2016). A Brief Measure of Staff Commitment to Implement School-Wide Positive Behavioral Interventions and Supports. *Assessment for Effective Intervention*, *42*(1), 18–31. https://doi.org/10.1177/1534508416642212

Flannery, M., & Rotondo, L. (2016). Changing Practice: Frameworks From Implementation Science. *Oncology Nursing Forum*, *43*(3), 385–388. https://doi.org/10.1188/16.ONF.385-388

Forehand, R., Dorsey, S., Jones, D. J., Long, N., & McMahon, R. J. (2010). Adherence and Flexibility: They Can (and Do) Coexist! *Clinical Psychology: Science and Practice*, *17*(3), 258–264. https://doi.org/10.1111/j.1468-2850.2010.01217.x

Frakt, A. B., Prentice, J. C., Pizer, S. D., Elwy, A. R., Garrido, M. M., Kilbourne, A. M., & Atkins, D. (2018). Overcoming Challenges to Evidence-Based Policy Development in a Large, Integrated Delivery System. *Health Services Research*, *53*(6), 4789–4807. https://doi.org/10.1111/1475-6773.12986

Galdas, P. (2017). Revisiting Bias in Qualitative Research: Reflections on Its Relationship With Funding and Impact. *International Journal of Qualitative Methods*, *16*(1), 1609406917748992. https://doi.org/10.1177/1609406917748992

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, *13*(1), 117. https://doi.org/10.1186/1471-2288-13-117

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Greater Manchester Combined Authority. (2019). *Children and Young People's Plan*. https://www.greatermanchester-ca.gov.uk/media/2115/gmca-children-young-peoples-plan-2019-2022.pdf

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a Conceptual Framework for Mixed-Method Evaluation Designs. *Educational Evaluation and Policy Analysis*, *11*(3), 255–274. https://doi.org/10.3102/01623737011003255

Hasson, H., Villaume, K., von Thiele Schwarz, U., & Palm, K. (2014). Managing Implementation: Roles of Line Managers, Senior Managers, and Human Resource Professionals in an Occupational Health Intervention. *Journal of Occupational & Environmental Medicine*, *56*(1), 58–65. https://doi.org/10.1097/JOM.0000000000000020

Iden, J., & Eikebrokk, T. R. (2015). The impact of senior management involvement, organisational commitment and group efficacy on ITIL implementation benefits. *Information Systems and E-Business Management*, *13*(3), 527–552. https://doi.org/10.1007/s10257-014-0253-4

Jones, S., Hamilton, S., Bell, R., Araújo-Soares, V., Glinianaia, S. V., Milne, E. M. G., White, M., Willmore, M., & Shucksmith, J. (2019). What helped and hindered implementation of an intervention package to reduce smoking in pregnancy: Process evaluation guided by normalization process theory. *BMC Health Services Research*, *19*(1), 297. https://doi.org/10.1186/s12913-019-4122-1

Kaper, M. S., Sixsmith, J., Reijneveld, S. A., & de Winter, A. F. (2021). Outcomes and Critical Factors for Successful Implementation of Organizational Health Literacy Interventions: A Scoping Review. *International Journal of Environmental Research and Public Health*, *18*(22), 11906. https://doi.org/10.3390/ijerph182211906

Kelly, L. M., & Cordeiro, M. (2020). Three principles of pragmatism for research on organizational processes. *Methodological Innovations*, *13*(2), 2059799120937242. https://doi.org/10.1177/2059799120937242

Kroll, A., & Pasha, O. (2021). Managing change and mitigating reform cynicism. *Public Money & Management*, *41*(5), 395–403. https://doi.org/10.1080/09540962.2019.1683982

LaMontagne, A. D., Martin, A. J., Page, K. M., Papas, A., Reavley, N. J., Noblet, A. J., Milner, A. J., Keegel, T., Allisey, A., Witt, K., & Smith, P. M. (2021). A cluster RCT to improve workplace mental health in a policing context: Findings of a mixed-methods implementation evaluation. *American Journal of Industrial Medicine*, *64*(4), 283–295. https://doi.org/10.1002/ajim.23217

Lean, M., Leavey, G., Killaspy, H., Green, N., Harrison, I., Cook, S., Craig, T., Halloway, F., Arbuthnott, M., & King, M. (2015). Barriers to the sustainability of an intervention designed to improve patient engagement within NHS mental health rehabilitation units: A qualitative study nested within a randomised controlled trial. *BMC Psychiatry*, *15*. https://doi.org/10.1186/s12888-015-0592-9

Lennox, L., Maher, L., & Reed, J. (2018). Navigating the sustainability landscape: A systematic review of sustainability approaches in healthcare. *Implementation Science*, *13*(1), 27. https://doi.org/10.1186/s13012-017-0707-4

Lidchi, V., & Wiener, A. (2021). How can services be improved to effectively address the mental health of vulnerable children and young people? *Child Abuse & Neglect*, *119*, 104648. https://doi.org/10.1016/j.chiabu.2020.104648

Maher, L., Gustafson, D. H., & Evans, A. (2010). *NHS Sustainability Model*. https://improvement.nhs.uk/resources/Sustainability-model-and-guide/

Mazzucchelli, T. G., & Sanders, M. R. (2010). Facilitating practitioner flexibility within an empirically supported intervention: Lessons from a system of parenting support. *Clinical Psychology*, *17*(3), 238–252. https://doi.org/10.1111/j.1468-2850.2010.01215.x

McKay, V. R., Hoffer, L. D., Combs, T. B., & Margaret Dolcini, M. (2018). The dynamic influence of human resources on evidence-based intervention sustainability

and population outcomes: An agent-based modeling approach. *Implementation Science*, *13*(1), 77. https://doi.org/10.1186/s13012-018-0767-0

Morgan, D. L. (2014). Pragmatism as a Paradigm for Social Research. *Qualitative Inquiry*, *20*(8), 1045–1053. https://doi.org/10.1177/1077800413513733

Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: Understanding time lags in translational research. *Journal of the Royal Society of Medicine*, *104*(12), 510–520. https://doi.org/10.1258/jrsm.2011.110180

Moseholm, E., & Fetters, M. D. (2017). Conceptual models to guide integration during analysis in convergent mixed methods studies. *Methodological Innovations*, *10*(2), 1–11. https://doi.org/10.1177/2059799117703118

Mosson, R., Augustsson, H., Bäck, A., Åhström, M., von Thiele Schwarz, U., Richter, A., Gunnarsson, M., & Hasson, H. (2019). Building implementation capacity (BIC): A longitudinal mixed methods evaluation of a team intervention. *BMC Health Services Research*, *19*(1), 287. https://doi.org/10.1186/s12913-019-4086-1

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-Based Nursing*, *18*(2), 34–35. https://doi.org/10.1136/eb-2015-102054

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for Reporting Qualitative Research: A Synthesis of Recommendations. *Academic Medicine*, *89*(9), 1245–1251. https://doi.org/10.1097/ACM.0000000000000388

Ploeg, J., Ireland, S., Cziraki, K., Northwood, M., Zecevic, A. A., Davies, B., Murray, M. A., & Higuchi, K. (2018). A Sustainability Oriented and Mentored Approach to Implementing a Fall Prevention Guideline in Acute Care Over 2 Years. *SAGE Open Nursing*, *4*, 2377960818775433. https://doi.org/10.1177/2377960818775433

Proctor, E., Luke, D., Calhoun, A., McMillen, C., Brownson, R., McCrary, S., & Padek, M. (2015). Sustainability of evidence-based healthcare: Research agenda, methodological advances, and infrastructure support. *Implementation Science*, *10*(1), 88. https://doi.org/10.1186/s13012-015-0274-5

Rimehaug, T. (2014). The Ecology of Sustainable Implementation. *Zeitschrift Fur Psychologie*, *222*(1), 58–66. https://doi.org/10.1027/2151-2604/a000166

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), *Analyzing qualitative data* (pp. 173–194). Routledge.

Rocks, S., Fazel, M., & Tsiachristas, A. (2020). Impact of transforming mental health services for young people in England on patient access, resource use and health: A quasi-experimental study. *BMJ Open*, *10*(1), e034067. https://doi.org/10.1136/bmjopen-2019-034067

Scheirer, M. A., & Dearing, J. W. (2011). An agenda for research on the sustainability of public health programs. *American Journal of Public Health*, *101*(11), 2059–2067. https://doi.org/10.2105/AJPH.2011.300193

Shelton, R. C., Cooper, B. R., & Stirman, S. W. (2018). The Sustainability of Evidence-Based Interventions and Practices in Public Health and Health Care. *Annual Review of Public Health*, *39*(1), 55–76. https://doi.org/10.1146/annurev-publhealth-040617-014731

Slager, R., Pouryousefi, S., Moon, J., & Schoolman, E. D. (2020). Sustainability Centres and Fit: How Centres Work to Integrate Sustainability Within Business Schools. *Journal of Business Ethics*, *161*(2), 375–391. https://doi.org/10.1007/s10551-018-3965-4

Song, Y., MacEachern, L., Doupe, M. B., Ginsburg, L., Chamberlain, S. A., Cranley, L., Easterbrook, A., Hoben, M., Knopp-Sihota, J., Reid, R. C., Wagg, A., Estabrooks, C. A., Keefe, J. M., Rappon, T., & Berta, W. B. (2022). Influences of post-implementation factors on the sustainability, sustainment, and intra-

organizational spread of complex interventions. *BMC Health Services Research*, *22*(1), 666. https://doi.org/10.1186/s12913-022-08026-x

Spoth, R., Guyll, M., Redmond, C., Greenberg, M., & Feinberg, M. (2011). Six-Year Sustainability of Evidence-Based Intervention Implementation Quality by Community-University Partnerships: The PROSPER Study. *American Journal of Community Psychology*, *48*(3/4), 412–425. https://doi.org/10.1007/s10464-011-9430-5

Srivastava, A., & Thomson, S. B. (2009). Framework Analysis: A Qualitative Methodology for Applied Policy Research. *Journal of Administration and Governance*, *4*(2), 72–79.

Stirman, S. W., Kimberley, J., Cook, N., Calloway, A., Castro, F., & Charns, M. (2012). The sustainability of new programs and innovations: A review of the empirical literature and recommendations for future research. *Implementation Science*, *7*(1), 17. https://doi.org/10.1186/1748-5908-7-17

The Academy of Medical Sciences. (2020). *Transforming health through innovation: Integrating the NHS and academia*. https://acmedsci.ac.uk/file-download/23932583

Watt, J. D., & Piotrowski, C. (2008). Organizational Change Cynicism: A Review of the Literature and Intervention Strategies. *Organization Development Journal*, *26*(3), 23–31.

Whelan, J., Love, P., Pettman, T., Doyle, J., Booth, S., Smith, E., & Waters, E. (2014). Cochrane Update: Predicting sustainability of intervention effects in public health evidence: Identifying key elements to provide guidance. *Journal of Public Health*, *36*(2), 347–351. https://doi.org/10.1093/pubmed/fdu027

Wolpert, M. (2014). *Thrive: The AFC-Tavistock Model for CAMHS*.

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2016). *THRIVE Elaborated* (Second). http://implementingthrive.org/wp-content/uploads/2016/09/THRIVE-elaborated-2nd-edition.pdf.

Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2019). *THRIVE Framework for system change*. CAMHS Press. https://www.annafreud.org/media/9254/thrive-framework-for-system-change-2019.pdf.

Worton, S. K. (2020). Examining peer networking as a capacity-building strategy for Housing First implementation. *Journal of Community Psychology*, *48*(4), 1147–1162. https://doi.org/10.1002/jcop.22240

Chapter 7: Overall discussion

Each of the four studies that form the substantive research of this thesis (Chapters 3, 4, 5, and 6) include their own discussion sections. These sections detail the methodological considerations and limitations that are specific to each study, and explore the future directions and distinct contributions made to the field. Given the depth of those discussions, in this final thesis chapter I begin by providing a short reminder of each study's main details. After this, I examine the findings of each study in direct relation to the evaluation of GM i-THRIVE. I do this by focussing upon the contribution that this small body of research has made to the evaluation, dissected in terms of the initial thesis research questions. I then look at how successfully the gaps in the wider implementation science literature have been filled. The strengths and limitations of the overarching mixed-methodological approach to evaluation that was taken are discussed alongside any additional advantages and disadvantages that apply to all studies. This is followed by the indications for future research directions that have arisen from my research. The chapter ends with a brief concluding statement on the overall "picture" of GM i-THRIVE, and CYP mental health services at a wider level, that has been painted by the four studies. I explore what this tells us about the future of this type of service provision, particularly alongside England's socioeconomic backdrop that was outlined in Chapter 1.

7.1: Brief study recaps

7.1.1: Study 1: Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation

Study 1 (Chapter 3) was designed to gain a qualitative impression, from already-published studies, of the barriers and facilitators to the delivery and implementation of training that specifically related to the mental health of CYP. The primary motivation behind this study, from the viewpoint of the evaluation, was to develop an evidence base with which to drive the investigation into GM i-THRIVE's training practices (Study 2). To make this foundation as robust as possible, a

qualitative systematic literature review was produced. Through meta-aggregation, 19 summative statements were developed. This was done by synthesising studies that explored the training experiences of both mental health trained, and adjacent CYP-facing staff. This was to match GM i-THRIVE's pool of trainees as closely as possible. Whilst these concluding statements were used to develop Study 2's interview schedule, they can also be used as practical recommendations with which to guide the design, delivery, or implementation of similar training programmes. Example recommendations include in-training peer support, ensuring that training is suitable for all members of its target audience, and considering how new skills and knowledge fit in with already-held mind-sets.

7.1.2: Study 2: Barriers and facilitators to training delivery and subsequent implementation of a localised child and adolescent mental health initiative: A qualitative content analysis

Study 2 (Chapter 4) can be read and utilised as a standalone piece of original research. Yet it can also be considered a "part 2" to Study 1. This is because I converted the recommendations generated by the systematic review into interview questions, to investigate the extent to which the barriers and facilitators synthesised in Study 1 matched the experience of staff undergoing GM i-THRIVE training. Directed qualitative content analysis of interview data, using a mixture of deductive and inductive reasoning, revealed a good level of similarity with Study 1. However, some additional topics were raised that reflected both the nuances of GM i-THRIVE, and the impact of COVID-19 on the training. Six recommendations were made for further improvement of the GM i-THRIVE Academy training.

7.1.3: Study 3: Reformed child and adolescent mental health services in a devolved healthcare system: A mixed-methods case study of an implementation site

Study 3 (Chapter 5) was a comprehensive investigation of GM i-THRIVE's progress, which comprised three methodological components. I firstly concluded that the programme's implementation strategy and self-assessment tool were adequate. Then, visualisations built from GM localities' completions of the latter tool showed

that widespread implementation progress had been reported. These visualisations were compared to interview data from six young people who had received mental health support over the last four years. We found that CYP tended to agree with staff on where and if alignment to the THRIVE framework had occurred. Two themes were developed through thematically analysing the interview data: "qualities of the service", and "the mental health journey".

7.1.4: Study 4: Child and adolescent mental health services in a devolved healthcare system: A qualitative exploration of sustainable practices

Study 4 (Chapter 6) is centred on the important topic of implementation sustainability, which is both inconsistently and under researched. An interview was designed for staff working with GM i-THRIVE, based on the NHS Sustainability Model, to investigate the likelihood of a sustainable future for the programme. Data were analysed using inductive thematic framework analysis. Key points raised by the participants related to the importance of leadership, and having sufficient time to implement. Many participants appreciated the flexibility of the THRIVE model, but continued efforts should be made by the implementing team to ensure universal comprehension of its core elements. We concluded, with cautious optimism, that if effort is made to remedy the issues raised by this study's data, GM i-THRIVE can look forward to a long and sustainable future.

7.2: What does this thesis contribute?

7.2.1: Contributions to the evaluation of GM i-THRIVE

To consider how the four studies have contributed to a comprehensive evaluation of GM i-THRIVE, we must return to the original research foci for this thesis, that were set out in chapter section 2.1. These came, initially, in the form of four indicative research questions, which were provided by GMHSCP at the project's outset. However, once my immersion into the project fully began, I identified three additional pertinent areas of research interest, which added further inquiry to the evaluation. *Figure 2.1,* (Chapter 2, page 89) provides a visualisation of how each area of inquiry was addressed by the four studies; the current sub-section will directly explore these areas, and how they were resolved, in turn. This will allow

meta-inferences to be drawn from across the four studies, forming, in sum, a mixed-methods service evaluation. Each area below may, essentially, be regarded as a key conclusion of this thesis, given that the implications that the research has on the future of GM i-THRIVE are discussed. As the inferences made in this section inevitably raise their own questions, directions for future investigation will be briefly alluded to here. However, they will be discussed in greater depth, alongside the thesis's overarching conclusions, in section 7.4. You may notice that the narratives below that relate to the indicative research questions are more detailed than those for the additional areas. This is because the additional areas have broader foci, which have already been explored within the research questions of their respective journal papers. However, the indicative questions require some degree of novel analysis in this section, given their specificity, and the fact that they do not totally align with the research questions of the four studies.

Indicative research question 1: Has implementing GM i-THRIVE broadened the mental health offer to CYP?

My interpretation of the first indicative research question, given its emphasis on widening the options available for support-seeking CYP, was that it could be answered with the findings of Studies 3 and 4. A variety of mental health needs were represented by the participants of Study 3; needs which were met, in turn, by a diverse range of support provision. This support ranged from in-patient stays, to sessions with a school-based psychologist, to a course of therapy provided by a charity. Given that CYP who participated in previous qualitative studies (Biddle et al., 2006; Plaistow et al., 2014; Storey et al., 2005) reported an over-medicalisation of their concerns, which included, for example, the prescription of unwanted medication (Plaistow et al., 2014), it may be of note that none of Study 3's participants mentioned medication. This does not necessarily imply that the participants had no previous experience of psychotherapeutic medication. Indeed, I did not ask them about this. However, the fact that they neglected to mention medication, instead focussing predominantly upon the staff and the interactions they had, might tentatively suggest that any medicalised support they received was not the most memorable of their mental health journey. Further research to

investigate the nature of the link between the introduction of THRIVE and rates of medication prescribing is certainly warranted, however, because as it stands, this observation can only be described as tenuous at best. This is because of the cross-sectional nature of the CYP interviews of Study 3, and the sample size limitations that meant a broader range of experiences with support were not harnessed. Such exploration may clarify whether, in the time that has passed since these studies (Biddle et al., 2006; Plaistow et al., 2014; Storey et al., 2005) were carried out, initiatives like THRIVE have, or have not, successfully contributed to diversifying support options, reducing the likelihood of an individual CYP receiving medicalised care when they present with a mental health need. Furthermore, any evidence of broadened provision should not necessarily be considered at odds with the rise in CYP antidepressant prescriptions between 2015-2021 reported by Robinson (2021), which may relate, in part, to increased need (NHS Digital, 2022).

It is, however, undeniable that a greater demand for services equates to a strained provision of service. Staff who were participants in Study 4 reported that while THRIVE encouraged them to put more consideration into the choices they made, and to challenge decisions made by others, this did not necessarily change the outcomes for CYP. Indeed, another participant believed that the true downfall of the tiered model of CAMHS provision was poor investment rather than inherent flaws. If this is truly the case, broadening provision is not likely to help as much as the THRIVE model anticipates.

Indicative research question 2: Has implementing GM i-THRIVE improved access and accessibility to CYP's mental health service provision, including NHS CAMHS?

The second research question links closely with the first. This is because it also, technically, requires investigation into the broadening of support. However, rather than broadening *what* is on offer, this question deals with widening the pool of *who* can access mental health support and care. Studies 3 and 4, again, provided insight into this. The fact that a range of mental health needs were experienced by the CYP who participated in Study 3 was mentioned under the previous question. These findings are also relevant here, as they highlight how those with concerns that are considered milder, who are not eligible for NHS CAMHS support, have still been

able to gain helpful support, from a range of initial access points, ranging from schools to internet searches. One participant, although perceiving that the process could have been smoother, reported that they were signposted to alternative support when they aged out of CAMHS, despite ineligibility for adult NHS mental health services. Waiting times, however, remain a significant barrier to timely and appropriate access (England & Mughal, 2019), and this sentiment was echoed by Study 3's participants. Several participants reported that staff were honest about the length of the wait they could expect to face, and that they were usually given a "worst case scenario" to manage their expectations. But they still perceived the wait as too long, and that it was to the further detriment of their mental health. In terms of Study 3's staff accounts of adherence to those THRIVE principles (see *Table 5.1*) that relate to making support easier to access for more CYP, professionals across GM generally perceived that all agencies (education, health, social care, third sector) are involved in commissioning care (macro principle 2), and that these services worked closely with one another (macro principle 5). The match with CYP accounts was only moderate, but this nevertheless suggests that staff perceive the system that they operate within as interconnected, and that there are several means through which CYP can access support. It may well be the case that it is too early to assess the impact of efforts to boost inclusivity and diversify access points, particularly when we consider any effect that this might have on waiting times: an issue that has only been intensified by the COVID-19 pandemic and the backlog this has created across services (NHS Confederation, 2022).

What did Study 4 contribute to this research question? Although the findings appear less closely connected to this research question than those of Study 3, valuable insights into the wider embedding process of GM i-THRIVE were gained. It is easy to make links between the points raised by participants, and the knock-on effect they are likely to have on access and accessibility for CYP. The sustainability-related interview questions of Study 4 showed that participants valued the THRIVE framework's provision of a sector-wide shared language. In an ideal situation, this means that mental health support is allocated in the same way across GM. This unanimity is, again, likely to foster a more accessible system where both professionals and CYP are aware of the range of services that are on offer, both

within and outside of CAMHS. It was, however, reported that the major culture and mind-set shift needed to fully unite the sector to a degree that the outcomes for CYP are maximal, is yet to occur. Continued monitoring of the embedding of THRIVE's core ethos is needed.

Indicative research question 3: Do CYP feel like they have a choice in what, where, and how they access support for their mental health?

Given that CYP voice feeds into this question so significantly, it was solely answered with Study 3. Several themes that were developed using this study's interview data are relevant here. The topic of shared decision-making was raised by several young people, although experiences were mixed. One participant said they had a flexible appointment system with their psychologist, and that they could choose to meet him, or conversely *not* meet him, whenever they wished. Given that they mentioned this favourably, this set-up is likely to have emerged based around a discussion of their therapeutic wants and needs. Some participants felt, on the other hand, that they actively wanted decisions to be made for them. One had reached a stage where having full control was no longer desirable, whereas another felt that more professional input into the trajectory of their sessions would have made them more productive. It is clear from all these views that it is not only important to give CYP a choice, but to also "give them a choice about having a choice", so to speak.

To use THRIVE terminology, this would be considered a form of "needs-based support", where help is given equitably rather than equally. This demands that professionals carefully listen to and assess what the individual both requires and wants. According to THRIVE principles, this process should be iterative, as needs are dynamic rather than uniform. Study 3's participants gave varied accounts of whether they felt listened to. One participant felt that their professional was unwilling to budge on the agenda that they had, which led to their eventual disengagement. However, others reported that they were taken seriously, that they were treated as an individual, and that support progressed at their pace. Continuing to promote the idea of needs-based support, where decisions are made with an

appropriate level of input from all involved parties, will continue to improve this already developing outcome of GM i-THRIVE.

Indicative research question 4: Are CYP and those who care for them reporting an improved experience in access and receiving care?

The first part of this question has been covered under research question 2. Since a predominantly qualitative approach was taken across the thesis, evidence for improved access, including that of waiting times, cannot be captured statistically. Thus, I relied on CYP testimony to capture this. Since the topic of access was repeated across two indicative questions, GMHSCP may have hoped for an analysis of this kind. However, as discussed in chapter sub-section 2.2.2, quantitative exploration was judged unsuitable given the complexity of GM i-THRIVE, especially since most implementation procedures occurred during the COVID-19 pandemic and its aftermath. The time phase cannot be meaningfully compared to the period before the pandemic without acknowledging this context.

Considering the above, findings relating to access will not be repeated here. However, Study 3 revealed crucial insights into how CYP perceive the overall process of getting care and support, from first to last contact. Participants discussed the early days of receiving support. The professionals they saw took the time to get to know them, to build rapport and develop a trusting therapeutic environment. They appreciated the personalised approach taken, and that professionals remembered basic details in subsequent sessions. When different providers were involved in the mental health journey, one participant reported that their school had good connections with helpful services. However, another participant perceived their transition to further support once they reached 18 years old as rather abrupt and challenging to navigate. As the final part in the support process, participants discussed the time that their help came to an end. This was frequently described as an anxious time. Although some participants felt that their professionals had prepared them well for the termination of their sessions, others described this ending as sudden. They were not signposted well towards alternative services, despite asking for this. Finally, when asked about their overall satisfaction with support, all participants said that they would recommend their support to

another young person. For some, however, this accolade came with the caveat that they perceived their good experience as an exception rather than the norm for most young people. This shows that CYP are aware of the wider systemic problems with mental health support access, and they tend to share their experiences with their friends. Improving reputation may be key to building trust in support services and encouraging CYP to seek support.

Additional key area 1: The GM i-THRIVE Training Academy – what are the barriers and facilitators that underpin the effectiveness of this training programme?

Studies 1 and 2 were designed, in combination, to conduct an evidence-based investigation of the GM i-THRIVE Academy training programme. The core findings of these studies can be found in sub-sections 7.1.1, and 7.1.2, but their implications for this part of the evaluation will be explored here. The 19 action points noted in Study 1 were generated by pulling together topically relevant barriers and facilitators from the literature. The study can therefore be treated as an accessible guidance document against which future iterations of GM i-THRIVE's training can be developed. However, while Study 1 can also be considered broadly applicable to other similar mental health training programmes, Study 2 was used to create six tailored recommendations for the evaluation. Facilitating peer support within and around training, and ensuring relevance for attendees and their job roles, are two examples of these recommendations. Overall, the evidence base developed by Study 1, combined with the qualitative investigation and recommendations produced in Study 2, provided the evaluation with an all-encompassing view of GM i-THRIVE's training in the present, as well as looking to the future as it develops.

Additional key area 2: What is the value of taking CYP insight into consideration when inferring implementation success from plans and tools?

Although the indicative research questions were investigated in Study 3, it was designed with this important area in mind. The study was built on the premise that implementation progress cannot be fully evaluated without harnessing the opinions of the target recipients of an intervention. It is only once this information has been generated, that can success be inferred from any quantitative measures of progress

completed by professionals. Although disagreements were noted, I concluded that CYP agreed with professional staff, to a reasonable level, on how mental health care and support were provided during the initial implementation period. This conclusive statement, together with the more intricate findings detailed in the study (Chapter 5), fashioned a methodologically original exploration into GM i-THRIVE's progress: an undeniably vital part of this evaluation.

Additional key area 3: Has THRIVE been implemented sustainably within Greater Manchester?

Studies 1, 2, and 3 looked at the retrospective and present situation to make recommendations for future action. Study 4 took a similar approach, on the grounds that recommendations were made, yet the study's fundamental aim was to predict the future longevity of GM i-THRIVE by researching the steps taken, in the past and present, to make the programme sustainable. The depth of inquiry facilitated by the qualitative interviews with staff produced rich understandings of how well the principles of the THRIVE framework were embedded and disseminated, whether staff perceived any implementation barriers, and the overall reputation of the framework. These points were explored by adapting an established survey measure, the NHS Sustainability Model (Maher et al., 2010), into a semi-structured interview schedule. This use of an NHS-focussed measure enhanced the relevancy of the study's methods yet allowed the nuances of GM i-THRIVE to be explored. Study 4's recommendations are vital outcomes of the evaluation, particularly as GM i-THRIVE is further embedded into CYP mental health provision in Greater Manchester. These recommendations included closer monitoring of knowledge dissemination by senior staff; and sustaining sector-wide commitment to GM i-THRIVE.

7.2.2: Contributions to knowledge, and strengths of the broader methodological approach

In the previous section, I briefly revisited the term "mixed-methods service evaluation", which was first discussed in Chapter 2. This research design, given the thesis's wider aim of assessing GM i-THRIVE in its current state for the purpose of

future decision-making (Watkinson et al., 2021), most accurately describes this work's principal identity. I will now discuss the extent to which I have adhered to this design. Within this thesis, I have not only interspersed my predominantly qualitative approach with quantitative measures, but across the four studies, several ways of collecting and analysing data, from each methodological strand, were used. A mixture of inductive and deductive reasoning was also applied throughout, and already-held knowledge was used to develop the understanding of novel findings. In sum, the multiplicity of the inquiry meant that the most suitable method, or set of methods, could be pragmatically selected for each study. They were chosen based on their suitability, rather than because of my preference for, or experience with, a certain research method. The strengths of each have contributed to the development of a comprehensive service evaluation.

The weaknesses of each methodological approach, which were discussed individually in Chapters 3, 4, 5, and 6, are essentially offset in this production of meta-inferences. What could not be found out in one study, could be found out in one of the others. This combined contribution follows the ethos of true mixed-methods research: that methods and the inferences drawn from them are properly integrated, rather than simply undertaken alongside each other as "parallel play": an approach perhaps better described as "multimethod" rather than "mixed-method" (Palinkas & Cooper, 2017). To ensure, therefore, that the thesis conformed as closely as possible to the definition of a mixed-methods service evaluation, inferences from each study were used to explore, in sub-section 7.2.1, each of the seven areas of enquiry. These will be combined once more, to form the thesis's key "take-home" messages in section 7.4. This strategy makes this thesis is a strong service evaluation, enhanced by the benefits of mixed-methods inquiry. The next part of this sub-section will discuss the wider application of the research, the implications of the production of meta-inferences, and how the thesis fits into, the implementation science field.

Generalisability or transferability are not typically aims of service evaluations. After all, they are designed to investigate and develop the specific service that is being evaluated (NHS Health Research Authority, n.d.; Watkinson et al., 2021). However, I would argue that it is exceedingly rare for a piece of research

to have absolutely no value or usefulness outside of its own aims. Each individual study chapter of the thesis detailed its own contributions, and the unique positionings within the bodies of literature they related to. However, here I will provide examples of how the key findings of each study can be applied beyond GM i-THRIVE as their intervention of focus. Study 1, the systematic review, provided practical recommendations for those designing, delivering, or implementing training. The evidence base that these recommendations were drawn from related purely to mental health training that pertained to CYP, therefore it is clear that they can be applied to other training programmes within this topic. However, provided that a reader hoping to utilise the review considers the intricacies of their own training programme, the recommendations should be applicable to training of any nature. They are phrased in a broad way, so that any reader can consider the relevance of recommendations (such as enhancing peer support, being mindful of one's target audience, and stimulating interest), when applying them.

A similar observation can be made for Study 2, where I concluded that findings such as the value of unstructured peer interaction during training (a deeper insight developed from the use of the online format during COVID-19) and a wish to discuss the nuances of workplaces where training will be applied, can benefit other implementors. The range of job roles and levels of professional knowledge represented in Studies 1 and 2, despite the focus on CYP mental health, bolsters this applicability.

Aside from those that relate to methodology, the key wider contribution messages of Study 3 relate predominantly to the interviews with CYP. The richness of the insights they provided, and the fact that they aligned well with staff perceptions of service improvement, suggests that other services utilised by young people can benefit from developing an ongoing programme of discourse, to embed and improve said services. The identified themes translate well to a range of other health services, not only mental health. For example, clear communication, and CYP's active participation in decisions, at a level of their choosing, can also be beneficial within physical healthcare (Quaye et al., 2019). Whilst the nuances of mental health are discussed within the themes, many of the discussions, especially

those relating to trust and openness, likely indicate what CYP expect from a health service of any kind.

Whilst Study 4 focussed on sustainability practices within GM i-THRIVE, points identified from the interview data, such as ensuring flexibility and adaptability, learning from reflection, and demonstrating evidence of change mirrored, and consequently added support to, the implementation science literature. This, in combination with the methodological consistency provided by this study, mean that this research can act as a case-study example of evaluation of sustainability, from which the conclusions can be transferred to others.

When these contributions are considered as components of the wider service evaluation, several strengths are evident that make the thesis a competent example of how an implementation can be evaluated. Firstly, the thesis combined data in a range of novel or underutilised ways. The interconnectedness of Studies 1 and 2, in terms of study design and analytic method, not only demonstrated the practical utility of systematic review evidence, but also gave my empirical research a sound evidence base. In Study 3, I linked staff and CYP voice to provide a holistic view of implementation progress. Similar approaches have been taken previously. For example, a study by Macleod et al. (2017) corroborated CYPs' testimonies of their own mental health with presenting issues and diagnoses recorded by professionals, ultimately finding a good level of clinical accuracy. However, the process of actively engaging young people in implementation evaluation, especially when their opinions are provided independently to those of healthcare professionals, remains in its infancy.

Whilst novel research approaches are excellent ways of exploring and combining ideas, sometimes a more "tried and tested" approach is needed. This is especially true when methodological consistency has been noted as a direction for future research, as is the case for the field of implementation sustainability (Proctor et al., 2015; Stirman et al., 2012), an important area of implementation science. Although Sciacca (2021) acknowledges that the source of the quote in its original form is unclear, their amusing version "frameworks are like toothbrushes. Everyone has one, but nobody wants to use someone else's" (Sciacca, 2021, p. 1), is applicable when discussing implementation theories and frameworks in the

sustainability field. Researchers developing their own frameworks, that are ultimately only used once, has led to inconsistent measurement and outcomes of both sustainability itself, and overall implementation progress. All three original studies in this thesis responded to this limitation in some form. Study 4, given the direct focus on sustainability, provided a clear response to this research dilemma, in that an existing sustainability measure was used to guide the study and analyse the data. Whilst not relating directly to sustainability, Study 3 was similarly guided by existing foundations, making use of both GM i-THRIVE's own implementation tools and a well-established implementation framework measure. Even Study 2 can be said to show consistency. Despite taking an underutilised approach, this was done by closely referring to a reliable evidence base.

To end this section by looking more broadly, implementation science has been defined as "the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services" (Eccles & Mittman, 2006, p. 1). The field goes beyond the relative simplicity of quality improvement studies, and generally utilises a mixture of qualitative and quantitative methods, to take a wide range of perspectives into account (Bauer et al., 2015). Service evaluations form an important part of the implementation science process, in their assessment of how, and how successfully, the changes have been adopted. These processes are crucial if the time lag between research finding and full clinical implementation (Morris et al., 2011) is to be minimised, and research funding is to be used effectively and appropriately (Bauer et al., 2015). By evaluating the implementation of THRIVE, a carefully designed evidence-based framework, in Greater Manchester, at a temporally relevant juncture, I have provided insight into how effective efforts have been thus far, and pinpointed areas for development through which the precision of future funding decisions can be improved. This approach is easily transferable to other similar service evaluations and implementation studies.

7.3: A holistic critical analysis

This section of the discussion will cover the criticisms that can be made at a broader, more "macro" level than those discussed within each study chapter. The thesis covered a range of topics that were chosen and investigated pragmatically. This meant that whilst the studies are individual pieces of research that can be utilised on their own, in their sum, they provided a comprehensive response to the most significant evaluative needs of GM i-THRIVE. Having carried out the research, this approach to topic identification is one that that I would recommend to other researchers tasked with conducting similar service evaluations. However, despite the practical and informed nature of this strategy, it must be noted that this approach can still be considered subjective. It can be argued that a *complete* service evaluation, covering *every* important facet, cannot be completed in just four studies that are conducted within a relatively short time frame. Even though the aims and methodologies of the four studies were agreed by both my supervisory team, and the GM i-THRIVE team, it may be the case that a different PhD student who was given the same task may well have approached it differently. It would, therefore, be erroneous to detach pragmatism from the humans who ultimately decide that a certain way of conducting a piece of research is the "most suitable" way. No overarching "best" approach truly exists, and we as researchers must consider ourselves core parts of pragmatic decision-making. Our individual capabilities and interests inevitably play into this, no matter how much we advocate for putting the needs of the project above these. Evaluating more than a handful of implementation areas was well beyond the scope of this thesis, however it is nonetheless important that this small battery of studies was conducted. Their findings have provided a strong empirical foundation upon which to develop the rest of the implementation period.

The four initial indicative research questions provided the first level of guidance as to what GMHSCP hoped that the thesis would cover. I hope that I have managed to provide some form of resolution to these questions within the four studies. However, it is undeniable that without recourse to measures that provide some level of longer-term comparison, these questions, that fundamentally focus on whether things have improved since GM i-THRIVE was introduced, could only be answered tenuously. Whilst it was vital to harness CYP voice in this thesis, to gain

their insights and experiences into the care they received, through this, a true sense of *improvement* cannot be gained. Simply owing to their young age, most CYP have only been in receipt of support for a relatively short period of time. Even if they have received this over several years, they are unlikely to remember the intricacies of far earlier support, and their emotions surrounding it, with as much detail as that which they received more recently. Their parents, as well as the professional staff who provide support, are perhaps better equipped to provide testimonies of what the situation was like previously, especially prior to 2018 (when GM i-THRIVE was introduced). Interviewing these individuals for Study 3, however, would have added further complexity to a study that already contained several methodological components. Including these insights in an additional study would have been the most ideal way to make these comparisons qualitatively, however, this, again, was beyond the scope of the thesis. As a critique of the indicative research questions themselves, I would argue that the three additional areas that were added to the thesis's aims *(Figure 2.1)* added a level of precision to the investigations, and a richness that would not have been possible without them. As is clear from the nature of the four studies, this meant that these three areas were used, to a greater degree than were the original indicative research questions, to develop the methodologies. Yet, within these studies the research questions have still been addressed.

A point that was noted in all three original studies was that the sample sizes were smaller than that I had initially hoped for. The main reason that larger samples are desirable in qualitative research is that the chance of encompassing as wider range of experiences, to be converted into themes, is maximised. The number of participants needed to do this is widely known as subjective (Marshall et al., 2013), and I would be inclined to agree with the notion that a one-size-fits-all ideal does not exist: thematic saturation should be defined within the context of a study's research aims, the methods used, and the theoretical standpoint (Braun & Clarke, 2021; Saunders et al., 2018). With this in mind, I have discussed the extent to which a small sample was a true limitation within each paper.

The discussion of sample size also links in with the question of why further qualitative lines of enquiry were not added, as discussed above. It is worth

mentioning that trying to enlist additional groups of participants would have made the recruitment process even more difficult and lengthy than it already was. The use of gatekeepers, whilst necessary, meant that this process was mostly beyond my control. However, I believe that whilst the number of participants that I managed to recruit to each study was small, the number would have been even smaller had I been responsible for doing this myself. My main gatekeeper was a familiar name to the professional participants (and to secondary gatekeepers when recruiting CYP), which meant that her emails were likely taken more seriously than if I, an unknown researcher, had contacted them directly. It is difficult to truly establish the motivations behind the professional participants responding to the gatekeeper email to take part. From the conversations I had during the interviews, it appeared that most simply wished to help the evaluation, which is how their potential participation was framed in this email. It is, however, undeniable that those who took part are likely to have had more outgoing personalities, and/or a good deal of opinions, either positive or negative, that they wished to express about their work with GM i-THRIVE. They are also likely to have had better working knowledge of THRIVE and the intervention, given that they felt confident to discuss it in an interview, than those who did not volunteer. Whilst a "working with the willing" approach was necessary to ethically (it would not have been appropriate to target specific individuals) gain a sufficient sample, this undoubtably means that certain opinions and familiarity levels were not captured. This is a particularly important consideration for Study 4 where, even though a broad range of localities and professional levels were represented in the sample, a true first-hand picture of the reach of GM i-THRIVE's practices may not have been captured.

It would have not only have been impossible due to lack of access to a relevant sample, but it would also have been unethical for me to have recruited CYP participants for Study 3 without the use of a gatekeeper. This is because the gatekeepers, who were professionals who had worked with and knew the CYP, had insight into their mental health progress, and emotional ability to take part, that I did not. This does, however, mean that those CYP who were approached to, and agreed to, take part are likely to have a stronger therapeutic relationship with their support provider, and to have had an overall better experience of support than

those who were not approached to take part, or who may have disagreed. The small size of the sample makes it even more likely that more homogenous experiences were represented These points were given as limitations within Study 3's paper.

The issues raised around sample size should be taken into consideration when engaging with the conclusions of this thesis, and the individual study chapters within. Notwithstanding these, the difficulties I had with recruiting larger samples may reflect a wider issue, within the NHS and allied services, of a lack of engagement with research. The strain felt within the NHS, as was discussed in depth in Chapter 1, has meant that health research has taken a "back seat" whilst more time-critical priorities understandably take priority (Sheard & Peacock, 2020). A lack of time, competing clinical caseloads, and a lack of senior advice, were all quoted as barriers to engaging in research in a study conducted within the NHS (Gilbert et al., 2016), whereas the allocation of protected time for such activities was quoted as a facilitator. Similar barriers, including a lack of professional backfill, were given in a similar study, which concluded that the future of healthcare innovation depends upon these issues being remedied (Rodrigues et al., 2022). These issues are particularly true for qualitative research, and patient voice is often captured through satisfaction surveys, complaint reports, and patient-reported clinical outcome measures (Barker, 2015). Barker (2015) reported that qualitative research is an important way of harnessing first-person opinion, especially when NHS services are designed and commissioned. These insights (Barker, 2015; Gilbert et al., 2016; Rodrigues et al., 2022; Sheard & Peacock, 2020) suggest that whilst I *have* been able to capture these voices within my studies, eventually collecting a minimally sufficient number of participants for each piece of research, the difficulties I faced in doing so highlight the current extent of this issue within CAMHS and CAMHS-adjacent services. The need for a more effective structure for research engagement is clear.

In sub-section 7.2.2, I referred to the notion that transferring findings to other settings, and to produce generalisable statements, is not a goal of service evaluations (NHS Health Research Authority, n.d.). Whilst I concluded that my four studies did provide useful contributions to the literature, some limitations

regarding their wider applicability should be discussed. The first of these relates to the use of the Greater Manchester region as a case study. Participants from all locality boroughs within Greater Manchester were included in the studies, which, given the diversity of the city region, should mean that a broad range of perspectives and experiences with services were included. However, although the THRIVE model allows for variations in implementation depending on the needs of staff and service-users, GM i-THRIVE was fed down to all boroughs through the same core implementing team. This, combined with the locality boroughs being located within the same geographic region in the North-West of England, means that the localities are likely to have more broad similarities than they do differences. These similarities may then translate into how GM i-THRIVE is delivered by each locality. This point is consistent with a previous multi-site evaluative study. Stainbrook et al. (2015) found that, despite differences in how a model was used across sites, the experiences of, and outcomes for, the recipients (in Stainbrook et al. (2015)'s case, those who were involved with both the justice system and who suffered from trauma), were very similar. I suggest that, even though the thesis's take-home messages can be used by other areas of the UK that are also implementing THRIVE in their CYP mental health services, this should be done by considering their area's unique demographic and economic statuses as relative to Greater Manchester, which, for all intents and purposes, can be considered a singular entity despite consisting of ten distinct boroughs.

A final critical point that should be made relates to the temporal positioning of the thesis. I started work on the thesis in the summer of 2019, and I am writing these final conclusions in early 2023. This spans the entire early implementation phase of GM i-THRIVE. Whilst this period was reasonably large, it examined GM i-THRIVE at a critical point in the implementation process. This means that the conclusions drawn are only from this point. Song et al. (2022) made the distinction between peri- and post-implementation factors. Peri-implementation factors are those that are salient *during* the implementation process, and post-implementation factors are those issues that become important to the continued usage of an intervention after supports (e.g., human, financial, time) are withdrawn. Whilst peri-implementation factors are protective and facilitative of ongoing progress and

sustainability, post-implementation issues, such as unforeseen internal demands and workforce instability, are prohibitive barriers to its continued use (Song et al., 2022). Due to the scope of my work, I was only able to cover the peri-implementation of GM i-THRIVE. GM i-THRIVE-specific future directions in relation to this issue will be presented in sub-section 7.4.1.

However, I will summarise this criticism by suggesting that implementation research should continue for as long as possible, to investigate ongoing progress, and to identify protective solutions to new challenges and detrimental external factors that appear further down the line (Song et al., 2022). This point is applicable to all four studies in this thesis, and all stakeholders, professionals, and service-users should continue to be consulted on a range of outcomes as the programme develops. Nonetheless, the topic of sustainability is especially relevant here, given how it relates directly to GM i-THRIVE's future. A systematic literature review on sustainability approaches in healthcare (Lennox et al., 2018) found that 66% of reviewed studies saw sustainability as an ongoing process, rather than as a single outcome or a definitive end goal. This is an optimistic finding, suggesting that many health researchers recognise the importance of continuous outcome monitoring. The timing of my studies has allowed insight into the "mechanisms of action" (Burchett et al., 2020, p. 1). This means that not only *what* has occurred has been recorded, but also some pointers on *how* improvements can be made in the future have been developed. However, considering the above, I accept that the limited time frame of the research, along with the lack of ability to cover more topics as discussed earlier, has inevitably restricted the potential comprehensiveness of this service evaluation.

7.4: Where do we go from here?

7.4.1: Overall conclusions and future directions

In sub-section 7.2.1, meta-inferences taken from the four studies were used to develop summative remarks in response to each of the thesis's seven research areas. These inferences can and should be treated as valid "take-home" conclusions, in their own right. However, the current section will go one step further, by essentially "zooming out" and considering these inferences as part of a

unified whole. To do this, I will now explain what I perceive to be *the* most important messages of this thesis. I arrived at these core deductions by appraising each of the granular inferences made in sub-section 7.2.1, alongside the research limitations and methodological criticisms outlined in section 7.3. The conclusions will therefore be presented, where relevant, in terms of the directions for future research, and recommendations for the future of GM i-THRIVE, that have been stimulated.

Key conclusion 1: A wide-reaching programme of research should continuously accompany the use of THRIVE principles in Greater Manchester's CYP mental health services.

This recommendation is, in part, necessitated by the inevitable obstacles and challenges that will appear for GM i-THRIVE as time goes on, as mentioned earlier (Song et al., 2022). Many of these challenges were referred to in Chapter 1, and include widespread changes in the financial situation of families in the region because of the cost-of-living crisis, and the continued effect of the pandemic. The full effect of the impact of these factors on the mental health of CYP is not yet clear. GM i-THRIVE will need to develop a reliable method of predicting and identifying such issues, and quickly employ strategies to respond to and accommodate them within the ongoing implementation programme. Additional research will also be needed to identify the longitudinal effects of all changes initiated by GM i-THRIVE. This should be done with a broad and long-term scope in mind: one that extends well beyond the temporal limits of this thesis. My discussions with staff and CYP implied evidence of services going beyond medicalisation, to provide a more personalised and caring support service. Their reports suggested that services are becoming more connected, with a wider range of access points available through which help can be obtained. However, further investigations, particularly where quantitative methods are available, should investigate the extent to which these changes have made a real, tangible difference to waiting times and referral acceptance. Additionally, it will be important to consider how cost, time, and resource effective a broadened, diversified mental health support offer is under the context of the ever-increasing mental health needs of CYP. It is important to note

that just as the tiered model was well received when it was originally devised, before falling out of favour for a number of reasons (see section 1.2), this monitoring must ensure that THRIVE is still the most suitable framework in years to come.

Key conclusion 2: The direct outcomes of the implementation for CYP should be monitored closely.

This conclusive point follows on smoothly from the first. Study 3 demonstrated that CYP, through their rich and detailed testimonies, are reliable informants of mental health services and their personal experiences with them. The GM i-THRIVE team should therefore continue to work in consultation with CYP, to gain temporally representative impressions of their experiences with support that is, ideally, becoming more and more "THRIVE-aligned" as implementation progresses. The clinical outcomes for CYP should also be monitored and aligned with the availability and accessibility of services at each timepoint. The recent increase in the prescription of psychotherapeutic medication to CYP (Robinson, 2021) is an example of where such monitoring could be beneficial. It is important to state here that the use of medication should not be stigmatised. Demonising its use can discourage help-seeking, and it neglects the complexity of the recovery process (Abrams, 2018). Indeed, such medication is necessary in some cases, so that distressing symptoms are reduced to a level where the individual can meaningfully engage with other forms of therapy. However, it would nonetheless prove interesting to identify the reasons behind this increased prescribing for CYP. Does it simply reflect the general increase in need, or does it relate to poor availability of other services, similar to reports from doctors in a study by Barnett et al. (2020) in the USA? Has medicine been carefully identified as the best option for everyone who is prescribed it? Might interventions such as GM i-THRIVE change these statistics? These questions should all be investigated to gain a complete picture of the outcomes of broadening and improving access.

Regardless of the answers, GM i-THRIVE should not underestimate the importance of ensuring that every CYP-facing professional is aware of the full range of support options that they can signpost and refer to, and under which

circumstances. Detailed documentation of why such decisions have been made will allow for rectification if a support option turns out to be unsuitable. It would also add a universally understood level of consistency to the process. As in my previous point, outcomes should be monitored in terms of social change, and the nuances of each CYP's life. As demonstrated in Study 3, it is vital that support should be carefully tailored to individual wants and needs. This is true even when a procedure is deemed "best practice", such as shared decision-making. The participants taught us that whilst full input into decisions surrounding support should be offered, this is not desirable or helpful for all. Many factors such as age, capacity and insight, where they are in their therapeutic journey, and most importantly simple preference, should impact how much control or professional steering is eventually given to each CYP.

Key conclusion 3: Implementation should be treated as an ongoing process

This summative point relates closely to the first two. Underlying the idea that implementation and outcome research should be continuous is the very essence that implementation itself should be treated as ongoing, and not a singular "end goal" (Lennox et al., 2018). Study 4 optimistically concluded that GM i-THRIVE can reasonably expect a long and sustainable future, provided that certain considerations are made. These considerations showed that ongoing senior support, training, and overall good communication of THRIVE principles will be vital. To enhance the reputation of GM i-THRIVE, and to align working mindsets and practices with the framework to a stronger degree, it is important that key ideas are repeated and embedded as much as possible. This may happen through, for example, refresher training, or simply through using the language of the framework as much as possible in everyday workplace dialogue. Dissemination of knowledge, particularly of training, should also be monitored, to assess implementation spread, and to identify knowledge gaps across localities.

Key conclusion 4: The impact of alternative forms of support warrants research attention

The final conclusion-recommendation was not directly stimulated by my research and is more of an observation based upon the limited scope of what I was able to cover. Most CYP in Study 3 had received support that was provided either by CAMHS, or through adjacent voluntary organisations that provided traditional form of therapy. I would suggest that research into the outcomes, both systemic and for CYP, of services that provide distinctly alternative forms of support, such as the arts and culture-based mental health programme that is currently in ongoing implementation based upon THRIVE principles. Preliminary feedback has shown that this programme, that aims to harness the benefits or art, music, drama, and cultural engagement, has been received well by CYP (Implementing THRIVE, n.d.). Nevertheless, more direct research into the nature of this work and its longer-term outcomes, perhaps through ethnographic case-study of one form of support, is warranted.

7.4.2: The future of mental health service provision for children and young people

The key question inevitably raised at this point is "has GM i-THRIVE achieved, at this stage, what it has set out to do?". Chapter section 7.3, and sub-section 7.4.1, raised limitations to our ability to fathom this from the thesis alone, and a range of ways to enhance this knowledge in the future were suggested. Considering this, the most definitive answer that can be derived from the four studies is that a number of positive changes have been, and are being, made. These changes have been instigated to improve and broaden access to mental health services for CYP residing in Greater Manchester, and to ultimately ameliorate the problems related to the tiered model of provision. It is hoped that as more localities across the UK choose to align their CYP mental health support services to the THRIVE framework, these improvements will become more widespread, and overtake the tiered model as the default model of practice. However, for this to become a reality, the localities that have already adopted the framework must clearly demonstrate the benefits of doing so. Therefore, the most important messages of this thesis lie in the future directions that have been unearthed from discussion with CYP and professional staff, and the fact that research and monitoring must form a key feature of any

continued or novel use of the programme. This thesis, despite its temporal constraints, provides a pragmatic and comprehensive examination of the most important implementation factors of GM i-THRIVE; it highlights the current socio-economic issues faced by CYP and health services today, a context that was, ideally, considered at all stages of reading.

7.5: References

Abrams, A. (2018). Why We Need to Stop Demonizing Antidepressants. *Psychology Today*. https://www.psychologytoday.com/gb/blog/nurturing-self-compassion/201806/why-we-need-stop-demonizing-antidepressants

Barker, K. L. (2015). How can qualitative research be utilised in the NHS when re-designing and commissioning services? *British Journal of Pain*, *9*(1), 70–72. https://doi.org/10.1177/2049463714544553

Barnett, E. R., Trepman, A. Z., Fuson, H. A., Acquilano, S. C., McLaren, J. L., Woloshin, S., & Leyenaar, J. K. (2020). Deprescribing psychotropic medications in children: Results of a national qualitative study. *BMJ Quality & Safety*, *29*(8), 655–663. https://doi.org/10.1136/bmjqs-2019-010033

Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC Psychology*, *3*(1), 32. https://doi.org/10.1186/s40359-015-0089-9

Biddle, L., Donovan, J. L., Gunnell, D., & Sharp, D. (2006). Young adults' perceptions of GPs as a help source for mental distress: A qualitative study. *The British Journal of General Practice*, *56*(533), 924–931.

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, *13*(2), 201–216. https://doi.org/10.1080/2159676X.2019.1704846

Burchett, H. E. D., Kneale, D., Blanchard, L., & Thomas, J. (2020). When assessing generalisability, focusing on differences in population or setting alone is insufficient. *Trials*, *21*(1), 286. https://doi.org/10.1186/s13063-020-4178-6

Eccles, M. P., & Mittman, B. S. (2006). Welcome to Implementation Science. *Implementation Science*, *1*(1), 1. https://doi.org/10.1186/1748-5908-1-1

England, E., & Mughal, F. (2019). Underprovision of mental health services for children and young people. *British Journal of General Practice*, *69*(680), 112–113. https://doi.org/10.3399/bjgp19X701381

Gilbert, A., Steel, J., Rachel, D., & Jaggi, A. (2016). Identifying barriers and facilitators to engaging in clinical research within an NHS Therapies Department: Results of a listening exercise. *Physiotherapy*, *102*, e179. https://doi.org/10.1016/j.physio.2016.10.214

Implementing THRIVE. (n.d.). *Greater Manchester i-THRIVE Arts, Culture and Mental Health Programme*. Retrieved 3 February 2023, from https://implementingthrive.org/greater-manchester-i-thrive-arts-culture-and-mental-health-programme/

Lennox, L., Maher, L., & Reed, J. (2018). Navigating the sustainability landscape: A systematic review of sustainability approaches in healthcare. *Implementation Science*, *13*(1), 27. https://doi.org/10.1186/s13012-017-0707-4

Macleod, E., Woolford, J., Hobbs, L., Gross, J., Hayne, H., & Patterson, T. (2017). Interviews with children about their mental health problems: The congruence and validity of information that children report. *Clinical Child Psychology and Psychiatry*, *22*(2), 229–244. https://doi.org/10.1177/1359104516653642

Maher, L., Gustafson, D. H., & Evans, A. (2010). *NHS Sustainability Model*. https://improvement.nhs.uk/resources/Sustainability-model-and-guide/

Marshall, B., Cardon, P., Poddar, A., & Fontenot, R. (2013). Does Sample Size Matter in Qualitative Research?: A Review of Qualitative Interviews in is Research. *Journal of Computer Information Systems*, *54*(1), 11–22. https://doi.org/10.1080/08874417.2013.11645667

Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: Understanding time lags in translational research. *Journal of the Royal Society of Medicine*, *104*(12), 510–520. https://doi.org/10.1258/jrsm.2011.110180

NHS Confederation. (2022). *Hidden waits: The lasting impact of the pandemic on children's services in the community*. https://www.nhsconfed.org/publications/hidden-waits-lasting-impact-pandemic-childrens-community-services

NHS Digital. (2022). *Mental Health of Children and Young People in England 2022—Wave 3 follow up to the 2017 survey*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey/data-sets

NHS Health Research Authority. (n.d.). *Is my study research?* Retrieved 20 January 2023, from https://www.hra-decisiontools.org.uk/research/glossary.html

Palinkas, L. A., & Cooper, B. R. (2017). Mixed Methods Evaluation in Dissemination and Implementation Science. In R. Brownson, G. Colditz, & E. Proctor (Eds.), *Dissemination and Implementation Research in Health: Translating Science to Practice* (2nd ed., Vol. 1). Oxford University Press. https://doi.org/10.1093/oso/9780190683214.003.0020

Plaistow, J., Masson, K., Koch, D., Wilson, J., Stark, R. M., Jones, P. B., & Lennox, B. R. (2014). Young people's views of UK mental health services. *Early Intervention in Psychiatry*, *8*(1), 12–23. https://doi.org/10.1111/eip.12060

Proctor, E., Luke, D., Calhoun, A., McMillen, C., Brownson, R., McCrary, S., & Padek, M. (2015). Sustainability of evidence-based healthcare: Research agenda, methodological advances, and infrastructure support. *Implementation Science*, *10*(1), 88. https://doi.org/10.1186/s13012-015-0274-5

Quaye, A. A., Coyne, I., Söderbäck, M., & Hallström, I. K. (2019). Children's active participation in decision-making processes during hospitalisation: An

observational study. *Journal of Clinical Nursing*, *28*(23–24), 4525–4537. https://doi.org/10.1111/jocn.15042

Robinson, J. (2021). *Peaks in number of young people prescribed antidepressants coincide with lockdowns*. The Pharmaceutical Journal. https://pharmaceutical-journal.com/article/news/peaks-in-number-of-young-people-prescribed-antidepressants-coincide-with-lockdowns

Rodrigues, J. C. L., O'Regan, T., Darekar, A., Taylor, S., & Goh, V. (2022). Current pressure on the UK imaging workforce deters imaging research in the NHS and requires urgent attention. *Clinical Radiology*, *77*(12), 913–919. https://doi.org/10.1016/j.crad.2022.07.015

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Sciacca, J. (2021). A useless history of the "Frameworks are Like Toothbrushes" quote. *LinkedIn*. https://www.linkedin.com/pulse/useless-history-frameworks-like-toothbrushes-quote-jonathan-scaccia

Sheard, L., & Peacock, R. (2020). Fiddling while Rome burns? Conducting research with healthcare staff when the NHS is in crisis. *Journal of Health Organization and Management*, *34*(1), 77–84. https://doi.org/10.1108/JHOM-04-2019-0105

Song, Y., MacEachern, L., Doupe, M. B., Ginsburg, L., Chamberlain, S. A., Cranley, L., Easterbrook, A., Hoben, M., Knopp-Sihota, J., Reid, R. C., Wagg, A., Estabrooks, C. A., Keefe, J. M., Rappon, T., & Berta, W. B. (2022). Influences of post-implementation factors on the sustainability, sustainment, and intra-organizational spread of complex interventions. *BMC Health Services Research*, *22*(1), 666. https://doi.org/10.1186/s12913-022-08026-x

Stainbrook, K., Penney, D., & Elwyn, L. (2015). The opportunities and challenges of multi-site evaluations: Lessons from the jail diversion and trauma recovery

national cross-site evaluation. *Evaluation and Program Planning*, *50*, 26–35. https://doi.org/10.1016/j.evalprogplan.2015.01.005

Stirman, S. W., Kimberley, J., Cook, N., Calloway, A., Castro, F., & Charns, M. (2012). The sustainability of new programs and innovations: A review of the empirical literature and recommendations for future research. *Implementation Science*, *7*(1), 17. https://doi.org/10.1186/1748-5908-7-17

Storey, P., Hurry, J., Jowitt, S., Owens, D., & House, A. (2005). Supporting young people who repeatedly self-harm. *Journal of the Royal Society for the Promotion of Health*, *125*(2), 71–75. https://doi.org/10.1177/146642400512500210

Watkinson, F., Dharmayat, K. I., & Mastellos, N. (2021). A mixed-method service evaluation of health information exchange in England: Technology acceptance and barriers and facilitators to adoption. *BMC Health Services Research*, *21*, 737. https://doi.org/10.1186/s12913-021-06771-z

Appendix 1: Supplementary materials relating to Chapter 3/Study 1: Delivering and implementing child and adolescent mental health training for mental health and allied professionals: A systematic review and qualitative meta-aggregation

Example search strategy:

The list of search terms is divided into the following categories. Three example terms have been provided below for each**:**

1) Population:

a) *Roles of trainees*, e.g. nurses; psychologists; police

b) *Conditions/disorders focussed on,* e.g. depression; anxiety; psychosis

c) *Condition/disorder associated terms,* e.g. disorder; difficulty; condition

d) *Population training focusses on,* e.g. children; teenagers; pupils

2) Focal areas:

a) *Training,* e.g. course; professional development; awareness

b) *Focus of literature,* e.g. opinions; effectiveness; evaluation

3) Data generation methods, e.g. qualitative; interview; audit

Terms will be truncated where necessary, e.g. child* to cover child; child's; children; children's; childhood.

Example search using Scopus (ordered by specificity of fields searched):

Focus of training:

TITLE(child* OR teen* OR adolescen* OR youth* OR "young people" OR "young person*" OR "young adult*" OR young OR CYP OR minor* OR juvenile* OR school OR college OR pupil* OR student* OR "you* offend*" OR paediatric* OR "looked after*" OR toddler* OR bab* OR boy* OR girl* OR LGBT*)

Training:

AND TITLE(training OR traine* OR "learning package*" OR course* OR "learning resource*" OR skills OR "skills development" OR "professional development" OR

“staff development” OR knowledge OR education OR awareness OR “policy change”)

Roles of trainees:

AND TITLE-ABS(“mental health professional*” OR “allied professional*” OR “professional*” OR staff OR employee* OR nurse* OR paediatric* OR doctor* OR practitioner* OR GP* OR psycholog* OR psychiatr*OR teacher* OR counsell* OR “social worker*” OR “youth worker*” OR “support worker*” OR police OR paramedic* OR “prison officer*”)

Conditions/disorders focussed on:

AND TITLE-ABS(depress* OR anxi* OR schizophreni* OR bipolar OR psych* OR mental* OR OCD OR obsessive-compulsive OR “obsessive compulsive” OR self-harm* OR emotion* OR “self harm*” OR suicid* OR “eating disorder*”OR “disordered eating” OR anorexi* OR bulimi*OR autis* OR ADHD OR “attention deficit hyperactivity” or hyperactive* OR hyperkinetic OR conduct OR panic)

Condition/disorder associated terms:

AND TITLE-ABS(“mental health” OR wellbeing OR disorder* OR illness* OR crisis OR difficult* OR condition* OR problem*)

Focus of literature:

AND TITLE-ABS(barrier* OR facilitat* OR implement* OR sustain* OR intervention* OR effective* OR success* OR evaluat* OR apprais* OR assess* OR review* OR reflect* OR view* OR observ* OR perspective* OR perception* OR opinion* OR experience* OR story OR stories OR narrative* OR theme*)

Data generation methods:

AND ALL(qualitativ* OR “mixed method*” OR interview* OR “focus group*” OR observation* OR ethnograph* OR “case stud*” OR “action research” OR “document review” OR audit

Table 3.2: *Key characteristics of studies included in the SLR*

Reference	Country	Type of professional	Sample (*mixed methods studies. N reflects the number of participants involved in the qualitative element)	Training programme aim(s)	CYP population training focusses on	Study aim(s)	Qualitative data collection method	Qualitative analysis method	JBI Critical Appraisal Checklist score out of 10 and (classification)
Adelman (2014)	USA	Allied	Pre-kindergarten special educators (new to the field - either newly applying for jobs or in first or second year in the field) (*n* = 7)	To improve teachers' observation skills in social responsiveness of preschool children with ASD.	Preschool children aged 4–5 years, with ASD.	To examine the potential learning outcomes for teachers using the tool to learn.	Interviews	Grounded theory coding and analysis	7 (moderate)
Askell-Williams & Murray-Harvey (2016)	Australia	Allied	Early childhood educators (*n* = 1148*)	Initiative to promote mental health in young children.	General population of under 5 s.	To analyse perspectives of early childhood education and care educators about their professional learning.	Open ended questionnaire	Thematic analysis	7 (moderate)

Bassilios et al. (2017)	Australia	Mixed	Mental health professionals (psychologists, social workers, mental health nurses) (*n* = 8); Medicare administrators (*n* = 20)	To up-skill mental health professionals to meet required skills/competencies to deliver CMHS (a new service in Australia beginning 2010).	CYP aged 11 and under who have, or are at risk of developing, psychological disorders.	To explore the utilisation of implementation processes (of which the outlined online training is one) for those CMHS that will help deliver its objectives.	Structured interviews	Theoretical semantic analysis	8 (high)
Bazyk et al. (2015)	USA	Mental health	Paediatric occupational therapists and occupational therapy assistants (*n* = 117*)	A capacity building process designed to promote knowledge translation of a public health approach to mental health.	CYP having occupational therapy.	Explore the meanings and outcomes of the training.	Written reflections	Phenomenological analysis	8 (high)
Blackburn et al. (2016)	Australia	Mental health	Clinical staff at a youth acute mental health inpatient unit (*n* = 18*)	To teach sensory modulation techniques to de-escalate violence and aggression in CYP mental health inpatients.	CYP aged 15–24 years, in inpatient mental health units.	To evaluate the effectiveness of the intervention in transferring knowledge to staff, and translating this knowledge into practice.	Focus groups	Thematic analysis	7 (moderate)

Bond & Dogaru (2019)	UK	Mixed	Police officers, teachers, "CYP professionals", trainee teachers, social work students, health professionals, youth workers, probation officers, family support workers, hate-crime officers, therapists, and charity Chief Executive Officer (CEOs) (n = 114*)	To develop professionals' competence and confidence when responding to the needs of children and their families after online sexual abuse.	CYP who have been sexually abused online.	Evaluate the outcomes of the training.	Open-ended questionnaire	Thematic analysis	5 (moderate)
Bryson & Ostmeyer (2014)	USA	Mental health	Social skills group leaders for children with ASD (*n* = 15*)	Group management of CYP with ASD attending social skills group.	CYP between 4 and 12 years old, who have ASD.	To look at the changes in behavioural management skills of the group leaders.	Electronic survey with free text options	Thematic analysis	7 (moderate)
Christie et al. (2013)	New Zealand	Mental health	CAMHS workers (*n* = 37*)	Training to use an adolescent alcohol and drug screening and intervention.	Adolescents involved with CAMHS for whom alcohol or drugs might be an issue.	To evaluate the utility and acceptability of the training package, and its impact on relevant attitudes, skills and knowledge.	Focus groups	General inductive approach - thematic analysis	5 (moderate)

Coiro et al. (2016)	USA	Mental health	Graduate student clinicians in clinical psychology, or speech-language pathology (n = 11)	To expose graduate students to inter-professional collaborative practice centred on enhancing children's social communication.	USA school-aged CYP in an outpatient mental health setting.	To get feedback from the graduate students on the programme.	Email survey	Categorising answers under the 4 competencies of the training.	5 (moderate)
D'Oosterlinck et al. (2009)	Belgium	Allied	Staff working in residential facilities for children with emotional and behavioural disorders (*n* = 71*)	Empower the staff to handle conflict.	CYP with emotional and behavioural disorders who are in crisis in a therapeutic setting.	To evaluate whether the training was effective in empowering the staff members to handle the conflict.	Semi-structured questionnaire with open ended questions	Hermeneutic analysis with frequency coding and categorisation	3 (low)
Dababnah et al. (2019)	Turkey	Allied	Teachers (n = 8)	To teach ASD knowledge, behavioural management, social support, and how to advocate for services and support in the community.	Syrian refugee CYP in Turkey, who have ASD, in addition to trauma.	To test the feasibility and acceptability of the training intervention.	Semi-structured interviews	Constant comparative method	9 (high)
Dame (2016)	USA	Allied	Teachers (*n* = 9*)	Teach about childhood anxiety.	Anxious USA elementary school-aged children.	To evaluate changes in self-efficacy as result of the training, and to gauge perception of the training.	Focus groups	Classic transcript based analysis	8 (high)

David & Schiff (2018)	Israel	Mental health	Clinicians practicing psychotherapy (*n* = 77*)	Training clinicians to use a bottom-up evidence based intervention for traumatised children and their families.	Young children with trauma.	To obtain information regarding whether, how, and where clinicians are using the intervention after training.	Open-ended questionnaire	Thematic analysis	8 (high)
Davies & Ray (2014)	USA	Mental health	School psychologists (*n* = 19* at two-month follow-up; n = 18* at 1 year follow-up)	To increase awareness of TBI, better identify students with TBI, and improve education for students with TBI.	School-aged children with traumatic brain injury.	To evaluate the efficacy of a half-day traumatic brain injury training in school psychologists' knowledge and skills.	Longitudinal survey	Content analysis	3 (low)
Donald (2015)	USA	Allied	Residential care workers in psychiatric inpatient unit (n = 3*)	Child-teacher relationship training.	Can be used with general or clinical groups, aged 6–10 years.	To investigate training effects and experiences.	Semi-structured interviews	Thematic analysis	10 (high)
Drahota et al. (2014)	USA	Mental health	Therapists (*n* = 13)	Train staff to deliver EBP programmes to reduce challenging behaviours in children with ASD.	CYP with ASD	To examine feasibility of implementation, from the perspectives of those receiving training on, and delivering, the EBPs.	Semi-structured interviews	A coding, consensus, and comparison methodology (an iterative approach rooted in grounded theory).	7 (moderate)

Dunsmuir et al. (2017)	UK	Mental health	Tutors of school psychologists (n = 13)	Using problem based learning (PBL) with trainee school psychologists.	General school-aged population.	To evaluate strengths and weaknesses on PBL from different trainers.	Telephone survey	Thematic analysis	7 (moderate)
Eustache et al. (2017)	Haiti	Allied	Teachers (*n* = 12*)	To prepare teachers to respond to student mental health needs.	A general school population.	To evaluate the feasibility and acceptability of this scope of training content and format of delivery, as well as its effectiveness in improving knowledge and attitudes relevant to school mental health.	Open-ended questionnaire and focus group discussions	Thematic analysis	8 (high)
Gonzalez et al. (2019)	USA	Mental health	Trainers on school psychology training programmes (*n* = 327)	Teach about evidence-based assessment and intervention.	A general school-aged population	To conduct a more comprehensive and descriptive study of trainers' instruction.	Online survey	Conventional content analysis	6 (moderate)
Grant et al. (2016)	UK	Mixed	Medics, nurses, occupational therapists, radiographers, clinical and health psychologists (*n* = 31)	To teach about how having a very sick parent can impact CYP development, resilience, and family functioning.	CYP with a parent who has cancer.	To evaluate the implementation of training programme, and begin to establish its efficacy.	Semi structured open ended questionnaire	Framework analysis	7 (moderate)

Harris (2013)	USA	Allied	PE teachers (n = 13*)	To improve confidence of PE to teachers include autistic children.	School-aged CYP with ASD.	To determine the effects of a 1 day in-service workshop on the self-efficacy and content knowledge of general physical educators.	Focus group	Reflexive analysis	9 (high)
Heyeres et al. (2018)	Australia	Allied	Service manager, teachers, guidance counsellors, youth mentors (*n* = 21)	To support the wellbeing of indigenous students at boarding school, including mental health literacy and resilience training.	Australian Aboriginal children transitioning to boarding school at age 10–11 years.	To investigate whether the training influences the capacity of education staff to advocate for and support Indigenous student wellbeing.	Reflective group discussions, interviews	Thematic analysis	7 (moderate)
Jolivette et al. (2014)	USA	Allied	Various school staff (n = 9*)	Train staff in a positive behavioural intervention, decreasing problem behaviours.	CYP between 7 and 17 years old, who have emotional and behavioural disorders.	To describe the training, and implementation effectiveness and fidelity.	Focus group	Constant comparative method	3 (low)

Jones & Howley (2010)	UK	Allied	Local authority, teachers, SENcos (n = not stated)	To promote interactive skill building with children on the autism spectrum.	CYP with ASD	To investigate a system of training designed by a Local Education Authority support service.	Multi-method case study including semi-structured narrative approach interviews, and questionnaires.	Thematic analysis	7 (moderate)
Killick & Allen (2006)	UK	Mixed	Staff on an adolescent psychiatric inpatient unit (nurses, psychologists, psychiatrists, social workers, teachers, family therapists) (*n* = 27*)	To manage aggressive and harmful behaviour in the adolescent psychiatric unit.	Psychiatric inpatient adolescents aged 11–18 years.	To evaluate effects of training - confidence increase, knowledge increase, good practice, staff satisfaction.	Survey	Grouping of comments - "informal analysis"	5 (moderate)
Lee (2016)	UK	Allied	School pastoral support staff (n = 10*)	Increase knowledge of self-harm, identify risk factors, help CYP develop coping strategies, and develop a protocol for the school.	"Low-risk" self-harming secondary school aged CYP.	To explore each participant's experiences of the workshop, and the meaning/psychological processes at work.	Semi-structured interviews	Interpretative phenomenological approach	6 (moderate)

Leventhal et al. (2018)	India	Allied	Teachers (*n* = 24)	To help teachers improve mental health and other outcomes for youth in Low and Middle Income Countries.	A general school population of CYP, with a mean age of 13.5 years.	To describe key findings of the training and identify focus areas for the implementation going forward/scaling up.	Participatory action research - observations, focus group discussions, interviews, advisory groups.	Thematic analysis	2 (low)
Lusk et al. (2018)	USA	Mental health	Psychiatric mental health nurse practitioner students (*n* = 107*)	To teach child/adolescent CBT to those on graduate nursing programmes.	CYP with mental health problems.	To evaluate the feasibility and acceptability of the model for advanced practice PMH students.	Open ended questionnaire	Thematic analysis	4 (moderate)
Manassis et al. (2009)	Canada	Mental health	Practitioners from community mental health agencies (*n* = 22*)	To teach cognitive behavioural therapy for use with CYP.	CYP with internalising disorders	To evaluate the training	Interviews	Thematic analysis	5 (moderate)

Manning et al. (2017)	UK	Allied	Children's nurses (n = 8*)	Understand self-harm, effective communication with admitted CYP, assessing risk.	CYP who have self-harmed.	To determine the impact of the intervention on the knowledge, attitudes, confidence and behavioural intention of the staff, and to explore the perceived impact, suitability and usefulness of the intervention.	Semi-structured interviews	Thematic analysis	7 (moderate)
McAllister et al. (2019)	Australia	Allied	Teachers, guidance officers, school nurses, indigenous school officer, chaplain, youth worker (n = 27*)	To develop knowledge and understanding of best practice in youth mental health promotion and to increase confidence in delivering the programme.	A general school population of Australian secondary school age CYP.	To report the results of the training.	Open-ended questionnaire	Thematic analysis	7 (moderate)
Omigbodun et al. (2007)	Nigeria	Mixed	Multidisciplinary health professionals (nurses, doctors, psychologists, and community health workers) (*n* = 38*)	To provide a basic CAMH course.	Clinical population of CYP	To develop and evaluate the basic course with a multidisciplinary audience, to inform future training.	Open-ended questionnaire	Thematic analysis	6 (moderate)

Post et al. (2020)	USA	Allied	Kindergarten teachers (n = 4)	Child-teacher relationship training.	USA kindergarten aged children.	Report findings of training in terms of teachers' experiences.	Semi-structured interviews	Thematic analysis	6 (moderate)
Sherwin (2014)	USA	Allied	Para-educators (n = 4)	Assist working with autistic children.	CYP with ASD.	To determine how para-educators respond to the training.	Interviews, questionnaire, focus groups	Organising into themes and building a theoretical model	9 (high)
Srivastava et al. (2015)	India	Allied	Primary school teachers (*n* = 79*)	Improve attitudes and knowledge of special educational needs.	Primary school aged children with SEND.	To implement a teacher training program and evaluate its effects and appropriateness.	Open ended questionnaire	Thematic analysis	5 (moderate)
Suldo et al. (2010)	USA	Mental health	School psychologists (*n* = 41*)	To improve knowledge and confidence with regards to suicide prevention for CYP.	A general school population, aged 5–18 years.	To evaluate the professional development intervention on youth suicide.	Open-ended questionnaire	Thematic analysis	5 (moderate)
Tchernegovski et al. (2015)	Australia	Mental health	Mental health clinicians (nurses, social workers, psychologists) (n = 8*)	To provide clinicians with skills to empower parents with mental illness to support their family.	CYP of parents with a mental illness.	To examine clinicians' views on the acceptability of the resource, and assesses its effectiveness.	Post-training interview	Thematic content analysis	7 (moderate)

Tilahun et al. (2017)	Ethiopia	Allied	Community health workers (n = 11*)	A general CYP mental health course for community health workers.	CYP with mental health problems.	To examine training needs and perspectives in relation to providing child mental health care in rural Ethiopia.	Interviews	Framework analysis	8 (high)
Wu et al. (2019)	Canada	Allied	Teachers, principals, plus one educational assistant (*n* = 23)	Train teachers to deliver PAX-GBG - a classroom-delivered mental health promotion intervention.	A general school population, up to 17 years old.	To gain a greater understanding of how the training was viewed by school personnel, in order to improve implementation in remote/indigenous communities.	Semi-structured interviews	Line-by-line analysis, grouping into categories, then themes	7 (moderate)

Appendix 2: Supplementary materials relating to Chapter 4/Study 2: Barriers and facilitators to training delivery and subsequent implementation of a localised child and adolescent mental health initiative: A qualitative content analysis

Semi-structured interview schedule including prompts:

Hi, how are you? I'm Emily, a PhD student at the University of Manchester, and I'm working on an evaluation of i-THRIVE in Greater Manchester. Thank you for agreeing to speak to me today. As you'll be aware, I'm going to run through an interview with you about your experiences with the THRIVE training academy. The questions won't be too taxing, but we're just keen to get your thoughts on it so that we can feed back to the team ways which it can be improved going forward as part of my evaluation of i-THRIVE. The first few questions will be about the training itself, what you thought about it, and the following ones will be about how, and to what extent, you have utilised the training in your job.

Try not to divulge any confidential information about anyone that you mention, if you do mention another person in whatever context. If you do mention any names though, they will be anonymised in the transcript. I just want to make it clear that even though I am working on an evaluation of i-THRIVE which is funded by them, my position is completely impartial, so please feel free to be as honest as you can with your experiences: we want to hear the good and the bad, and there won't be any negative consequences of you doing this!

I just want to reinstate that you are free to stop and/or withdraw from the study at any time, if you just let me know, we can stop. If you do decide to continue, this Zoom call will be recorded. Zoom also automatically transcribes our conversation, and once I've used your recording to check this generated transcript for accuracy, this recording, both audio and visual, will be deleted. But, if you do want to turn the camera off now so that your face isn't recorded at all, you can do that if you wish? It's up to you. I'll also set up the pseudonym feature on Zoom. Do you have any questions?

Are you happy to begin? I will start the recording if so.

***

What is your job title?

(If unclear from job title) what does your role involve, in a nutshell?

Which Greater Manchester borough do you work in?

Would you describe the area you work in as urban, suburban, rural, etc.?

Which THRIVE academy training modules have you attended?

1. *Getting advice/signposting*
2. *Building Confidence in Letting Go and Managing Difficult Endings*
3. *Risk Support*
4. *Using i-THRIVE Grids to Improve Shared Decision Making*
5. *The THRIVE Framework: Leading system wide transformation*

When did you undertake the training approximately? (If after first lockdown, clarify that they did training online)

Overall, what were your motivations behind attending the training?

- Did you choose to attend it, or was it mandated?
- What did you hope to gain?

***

Now I would like to talk to you about the set-up of the training.

Can you describe the general set-up of the training? For example how many people were leading, and how was the event structured? Things like that!

Also…

- Did you feel that the training was suitable and appropriate for you?
- How did your prior knowledge of CYP mental health prepare you for the training, i.e. did they assume too much prior knowledge? Was it too basic? Or perhaps just right?
- How relevant was the training to your job?

- How easy was it to imagine yourself using the training, when the leader was explaining it?

Was the training accessible for you and your colleagues?

- Perhaps think about access, location, use of technology…
- How did you feel about the length of the training session(s)…
- …and the amount of content that was covered?

Can you tell me about the support you received, both during and after the training?

What qualities did the person/people leading the training have?

- What did you feel they did that was helpful?
- Was there anything that you disliked about the approach taken by the training leader/leaders?
- Is there anything that they have done to be more helpful?
- If you can remember, what mechanisms were in place for you to ask questions, get feedback, etc. from the trainers?

Thinking about the other people who attended the training…

- Did you get a chance to meet them?
- How much time was given to meeting and working with other people?
- Was this useful?
- Why?
- (Depending on tone of answer) would you have preferred more of a chance to interact with them?
- Why?
- Have you kept in contact with any of the people who attended the training with you? How so/why/why not?

Thank you! Thinking about the bigger picture in terms of your experience:

- How did your hopes/expectations match up to the actual experience?
- Which parts exceeded them?
- What were you disappointed by?

***

Thinking now about taking the training back to your work, how did people generally feel about the training in your workplace?

- (If good or bad) what did people have to say about it?
- Did this impact your enthusiasm?

To what extent has the training been useful to you?

- Have you used any of the skills that you learned?
- Can you give some examples?
- What do you think would encourage you to use the training more regularly?
- If you have applied the training during your interactions with CYP, how did you find this?
- Was it easy? Why?
- What would have made it easier to apply the training?
- For example, was the training relevant enough to your role to use it properly? Was it flexible enough to use with the range of young people that you help?
- What challenges were there?
- If give vague/generic/too broad answers, give tailored example based on person's job role and the training they did (e.g. can you give an example of how you gave advice to/signposted a young person based on what you learned? How have you made a joint decision with a young person about their ongoing care? Remember not to divulge anything about the young person that would make them identifiable).

To what extent have the skills you learned in training replaced old ways of working?

- Which skills/what have they replaced?
- Could you explain whether things have changed in terms of the way you do things as a result of the training? Is there a big difference/a small difference? If so, how do things differ…

- For example, has it changed the way that you signpost/give advice/make decisions alongside CYP/deal with the end of a CYP's treatment (use appropriate example)
- **(If not much replaced),** why do you think this is? How did it compare to the old way that you did things?
- **If so,** why do you think this is? How did it compare to the old way that you did things?

To what extent do the new knowledge/skills you gained fit in with your day to day role? For example, do you have time to use the skills you gained in an average interaction with a CYP?

- What would make the new skills fit in better with your day to day activities? E.g. more time, a change in how the skills fit in with what you did already?

Do your colleagues know about THRIVE?

- Did many of them also go to the training?
- Do you think this has influenced the extent to which the training is used back at work? How? How do you think having your colleagues on board has affected you/your utilisation of the training?

How closely have you followed the specific guidance that you were given in the training? Why/why not?

Do you have any other observations or experiences about the training itself, or about its impact on your work, to share that you think we might find interesting?

Appendix 3: Supplementary materials relating to Chapter 5/Study 3: Reformed child and adolescent mental health services in a devolved healthcare system: A mixed-methods case study of an implementation site

Ethical decision letter from the University of Manchester's Ethics Research Committee:

Research Governance, Ethics and Integrity
2nd Floor Christie Building
The University of Manchester
Oxford Road
Manchester
M13 9PL
Email: research.ethics@manchester.ac.uk

Ref: 2021-11033-18945

17/05/2021

Dear Miss Emily Banwell, Prof Neil Humphrey, Prof Pamela Qualter

Study Title: Implementing i-THRIVE in Greater Manchester: A mixed-methods case study

University Research Ethics Committee 2

I write to thank you for submitting the final version of your documents for your project to the Committee on 11/05/2021 15:28 . I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

COVID-19 Important Note

Please ensure you read the information on the Research Ethics website in relation to data collection in the COVID environment as well as the guidance issued by the University in relation to face-to-face (in person) data collection both on and off campus.

A word document version of this guidance is also available.

Please see below for a table of the title, version numbers and dates of all the final approved documents for your project:

Document Type	File Name	Date	Version
Data Management Plan	DMP new	15/02/2021	1
Participant Information Sheet	Info sheet for parents 13-15	19/04/2021	4
Participant Information Sheet	PIS 13-15	19/04/2021	4
Participant Information Sheet	PIS 16+	19/04/2021	4
Consent Form	Consent form 16+	19/04/2021	2
Consent Form	Consent form parent (1)	19/04/2021	2
Consent Form	Assent 13+	19/04/2021	2
Default	Paper 3 questions (2)	26/04/2021	2
Distress Protocol/Debrief Sheet	DistressProtocol	09/05/2021	4
Additional docs	Ethics revision letter	11/05/2021	1

This approval is effective for a period of five years however please note that it is only valid for the specifications of the research project as outlined in the approved documentation set. If the project continues beyond the 5 year period you will be required to submit a new ethics application.

If you wish to propose any changes to the methodology or any other specifics within the project, including the dates of data collection, an application to seek an amendment must be submitted for review. Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

1. Amendments: Guidance on what constitutes an amendment
2. Amendments: How to submit an amendment in the ERM system
3. Ethics Breaches and adverse events
4. Data breaches
5. Notification of progress/end of the study

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a **UREC Feedback Form**. Instructions for completing this can be found in your approval email.

We wish you every success with the research.

Yours sincerely,

Mrs Genevieve Pridham

Secretary to University Research Ethics Committee 2

Semi-structured interview schedule including prompts:

Hi [name], how are you/how was your trip here today/weather/have you come out of school/college to come here/what do you have planned for the rest of your day…

Thank you for coming along to do this interview with me today. I would just like to ask you a few questions about your experiences with getting help from [CAMHS/HYMS/other]. If you don't want to answer any of the questions, that's no problem at all. Please just say, and then we can skip it. We can also stop the interview at any time, there is absolutely no pressure, so just let me know. Also, please shout up if something I ask doesn't make sense, or you don't understand a question. Everything that you say today is completely private and confidential, unless I become worried that any harm or danger will come to you, then I would need to speak to [gatekeeper name] about this. Apart from this, nothing at all will be told to anyone outside of this room. I will use a voice recorder to record your interview, so that I can listen to it and type it up, but I won't use your name at all during this recording, so that what you say can't be matched to you. As I said before, we can stop at any time you wish, and please do interrupt at any time if you have any questions. I will turn the recorder on now…

1. So, to begin, it would be great if you could tell me a little about yourself, and how you came to need a bit of help with your mental health?
2. Which services have you got help from in the past?

   Prompts:

Did you go to CAMHS appointments? Did you have any help at school on top of this?

3. For how long was this? You can give a rough guess if you can't remember exactly!
4. I'd like to know what it was like when you first started receiving help at [xxx].
   a) If you can remember back to your earliest appointments, do you feel like you were allowed to make some of your own choices about the help you got?

      Prompts:

      Did you have the option to tell the staff what times or places were good, or not so good, for you to attend?

      Were you allowed to choose whether you had sessions on your own, or in groups?

      If you said you didn't like the idea of a certain thing, how much do you feel like they listened to you? What other options did they give you?

      If gives positive answers:

      Could you tell me how being able to make some of these choices made a difference to you? Prompt: Did it help much?

      If gives negative answers:

      If you had been given a bit more freedom to get involved in these decisions, how do you think this would have changed things for you?

   b) Thinking back to the beginning, were you happy with the length of time you waited in between any of the stages of, for example, first being referred by your doctor or your school, to when you managed to get an assessment? Or between getting an assessment and starting treatment?

      Prompts:

      Do you think it took a long time, or was it quite quick?

      Can you remember roughly how long it was you waited to [get referred/get assessed/start treatment]?

5. If you saw any new people during your time, to what level did you feel that they knew about you before seeing them?

Prompts:

Did you ever have to repeat your story to several people, or tell them why you were there? Or do you think they knew, or remembered, a little bit about you before each session?

6. I would now like to hear about the time when your sessions finally came to an end.
   a) Why did your sessions end? (Age, i.e. transfer to adult services, improvement, etc.)
   b) When they did finally stop, did you feel ready for this?

      If yes: Could you tell me a little bit about what they did to prepare you for them ending? Prompts: For example, did your sessions become more spaced out, happening less regularly?

      If no: Has any alternative help been put in place for you?
   c) Who was involved in the decision for you to stop attending?
   d) Do you think anything could have been done to make the end of your time feel smoother?
   e) To what level do you think you were listened to at this time?
7. Thinking right the way across your time with the services, what do you think could have made the help better, or more suitable, for you?
8. Overall, did you feel like your thoughts and opinions were listened to?

   Prompts (if doesn't expand on this):

   Could you tell me about a time during your sessions where you felt like your feelings were taken into consideration?/Could you tell me about a time where you think they could have listened to you a bit better?
9. Would you recommend getting this type of help, to another young person who might need it? What do you think could be improved to make it better for them?
10. Ask depending on whether they have offered up info/been proactive with answering before:

    Does anything else come to mind that you were really impressed with during your time, or on the other hand, was there anything that you found really frustrating? It would be interesting for me to hear about it.

Responses from me:

That sounds like that was really frustrating.

How did that make you feel?

It's okay/don't worry/take your time/you're doing great/everything you've said so far has been brilliant.

We can leave that question out if you like?/We can come back to that one later if you like?

Debrief:

Participant were thanked for their participation and given a further opportunity to ask questions.

GM i-THRIVE's Initial Implementation Plan:

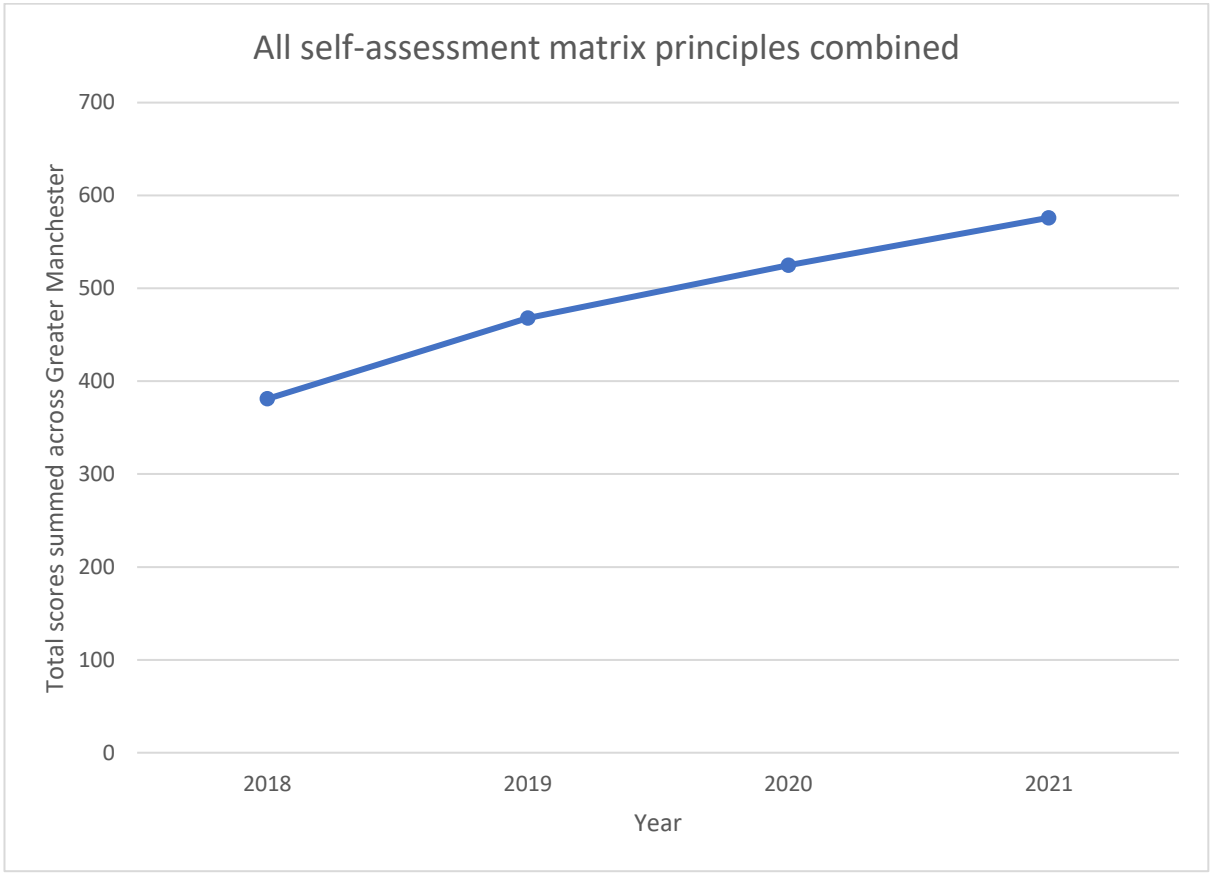
Point	i-THRIVE Approach to Implementation Phase 0: Set Up
0.1	Establish cross sector approval to proceed with i-THRIVE
0.2	Have a named lead for implementing THRIVE
0.3	Set up multi-agency Programme Board (include senior leadership from CCG, health provider(s), local authority, education, third sector)
0.4	Undertake stakeholder mapping
0.5	Create communications and engagement plan based on stakeholder analysis
0.6	Multi-agency working group established
0.7	Site leads/sponsors identified (where i-THRIVE delivered across multiple sites)
0.8	Establish communications functions (contact databases, shared folders, website)
0.9	Create high level project plan
0.10	High level project plan approved by Programme Board
1.0	**i-THRIVE Approach to Implementation Phase 1: Engagement, Understanding and Planning**
1.1	Key messaging for i-THRIVE project established - goals, aspirations, local context
1.2	Whole system stakeholder engagement event
1.3	Pathway mapping workshop
1.4	Staff consultation
1.5	Young people and families consultation
1.6	Review Quantitative data and fill gaps
1.7	Qualitative review of feedback collected
1.8	Service performance review (including population need, demand, flow, experience of service, participation levels, clinical outcomes, efficiency, current shared decision making practice etc)
1.9	Mapping of current outcome measures used across health, social care, education and voluntary sector
1.10	Understanding your data workshop
1.11	THRIVE Assessment Tool workshop
1.12	Engagement with wider system re THRIVE-like baseline score
1.13	Prioritisation and gap analysis workshop
1.14	Redesign workshop
1.15	Creation of local model for i-THRIVE
1.16	Finalise implementation plan

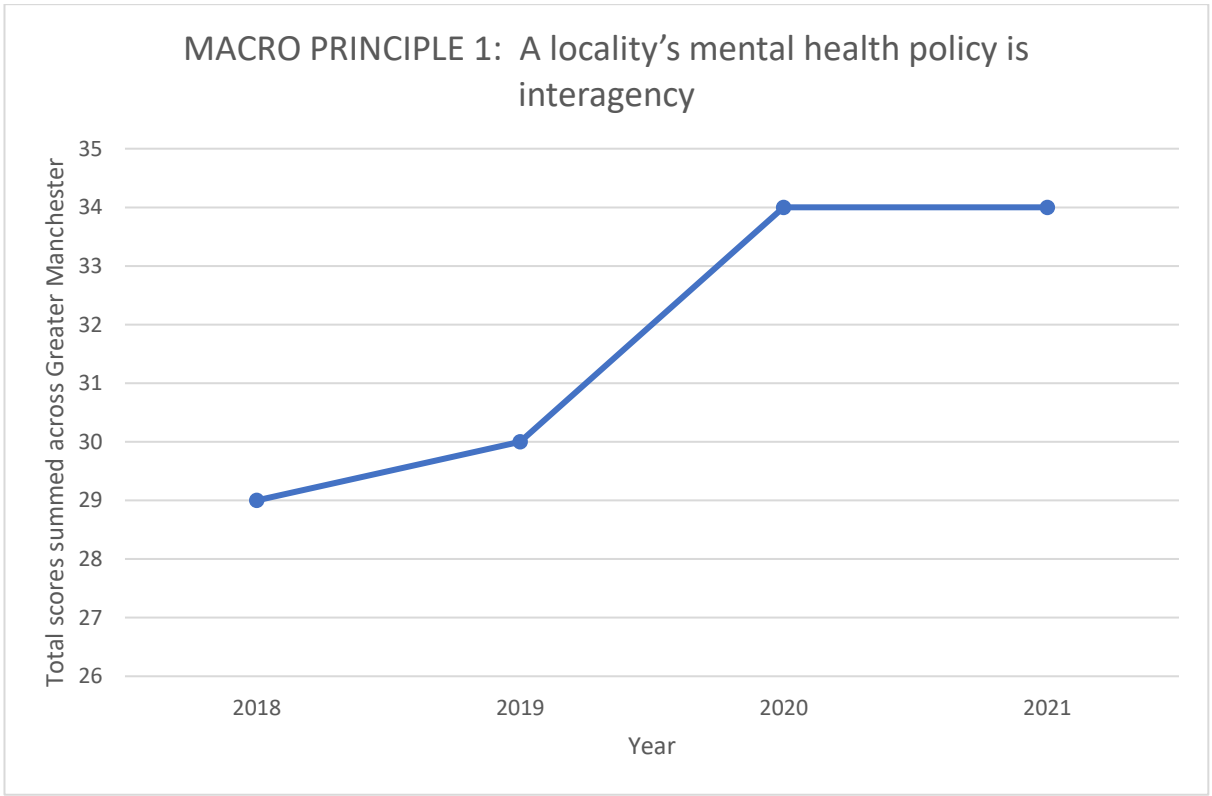
2.0	**i-THRIVE Approach to Implementation Phase 2: Building Capacity**
2.1	Review of staff skills for THRIVE-like working
2.2	Review of staff capacity for delivery of new model
2.3	Plan for recruiting to deliver new model
2.4	Review of training opportunities available across all organisations
2.5	Creation of workforce development plan
2.6	Development of new commissioning specification
2.7	Identification and creation of local champions and implementation leads
2.8	Training for implementation leads (knowledge of change management, i-THRIVE Approach to Implementation and QI)
2.9	i-THRIVE Academy training for multi-agency front line staff and managers
	- Shared decision making
	- Getting Advice and Signposting
	- When to stop treatment
	- Risk Support
	- i-THRIVE Grids
	ACE / Trauma training
2.10	Multi-agency workshop event to reflect on learnings from i-THRIVE Academy and other training
2.11	Delivery of other training and development as set out in workforce development plan
2.12	Review of workforce development delivery and plans for ongoing work
3.0	**i-THRIVE Approach to Implementation Phase 3: Implementation**
3.1	Ongoing review of implementation plan agreed at end of phase one
3.2	Detailed implementation planning finalised with lead for each project identified
3.3	Delivery of implementation plan as specified *import detailed implementation plan into this section* ***The implementation plan should include - as a minimum - the following elements which are required in order for a site to be assessed as 'THRIVE-like' in line with the THRIVE Assessment Tool:***
	> Children and young people's mental health is included in the LTP and the STP and implementation plan is in place for delivering outcomes
	> Multi-agency strategy and policy for delivering improved outcomes for children and young people's mental health operational with clear and measureable goals
	> Multi-agency commissioning board operational with joint accountability for delivering strategy
	> Shared outcome framework for the multi-agency commissioning board is in place

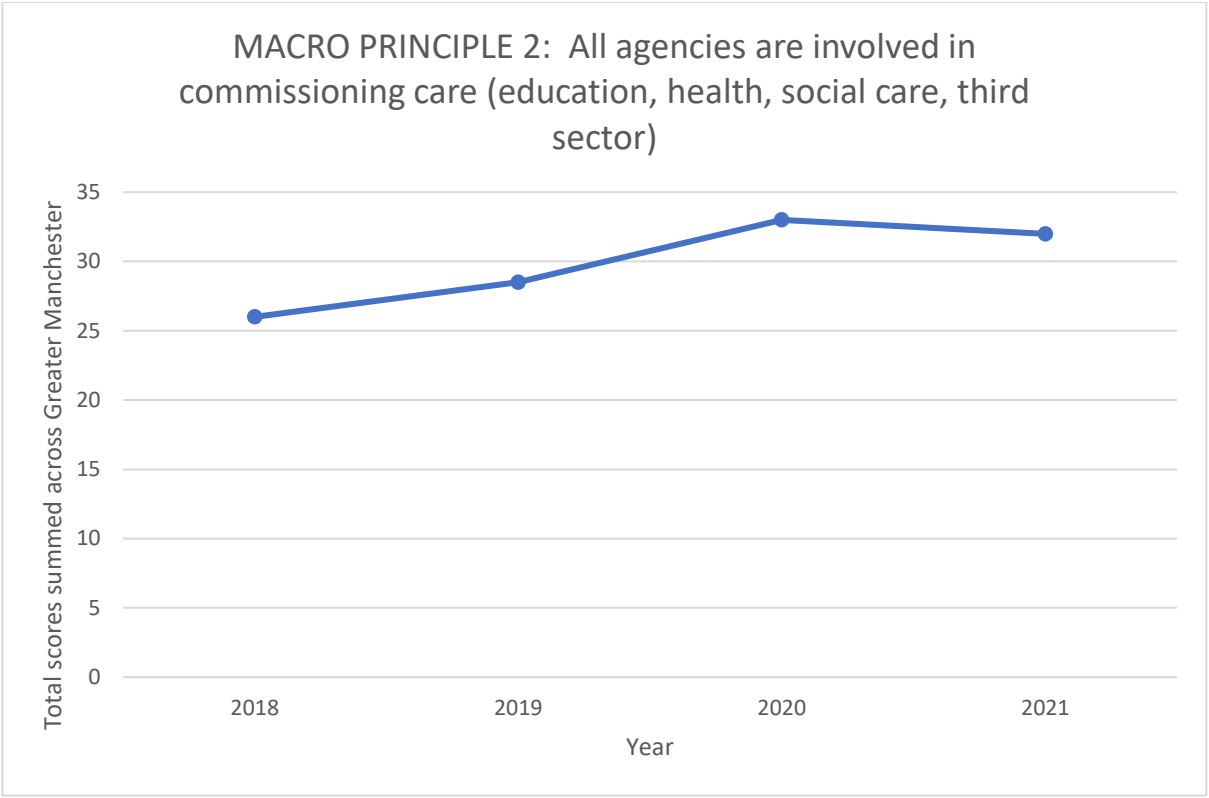
	> Annual commissioning cycle (multi-agency) operational supported by formal mechanism for service performance, outcome and preference data to inform the process
	> Joint budgets to support delivery of strategy established with processes in place across all involved agencies
	> Protocols established for regular sharing of performance and outcomes data across all agencies and commissioners
	> Introduction of systematic preference data collection across all agencies and sectors
	> All QI projects are undertaken using recognised methodology
	> Outcomes and process measures are collected routinely and this data is used to help shape service provision, manage performance and deliver interventions **full list of measures is available from i-THRIVE programme team
	> Local pathways structured to deliver care according to five THRIVE needs based groups
	> Multi-agency assessment that categorises children and young people into the THRIVE needs based groups is operational
	> THRIVE needs based group recorded for all cases
	> Implementation of i-THRIVE Grids to support shared decision making
	> Record of shared decision making documented for all cases
	> Population health and wellbeing offer available to all children and young people
	> Targeted prevention and resilience building offer available to children and young people who we know are more likely to require support with their mental health and wellbeing
	> Digital front end is available for children, young people and their families
	> There is a self-help and peer support offer available to children, young people and families
	> Senior mental health practitioners (band 8 or above) involved in all advice and signposting
	> Digitally enabled database of full range of community providers is operational
	> In reach from CAMHS to schools is operational
	> In reach from CAMHS to primary care is operational
	> CAMHS outreach to hard to reach groups is operational
	> Evidence of families being involved in development of care plans in all cases
	> Evidence of therapy being aligned with NICE guidance for all cases
	> Recorded note of treatment goals and expected outcomes for all cases
	> Children, young people and their families are managed within the recommended number of therapy sessions
	> Reasons for ending proforma completed for all cases with treatment
	> Multi-agency structures and protocols for providing risk support

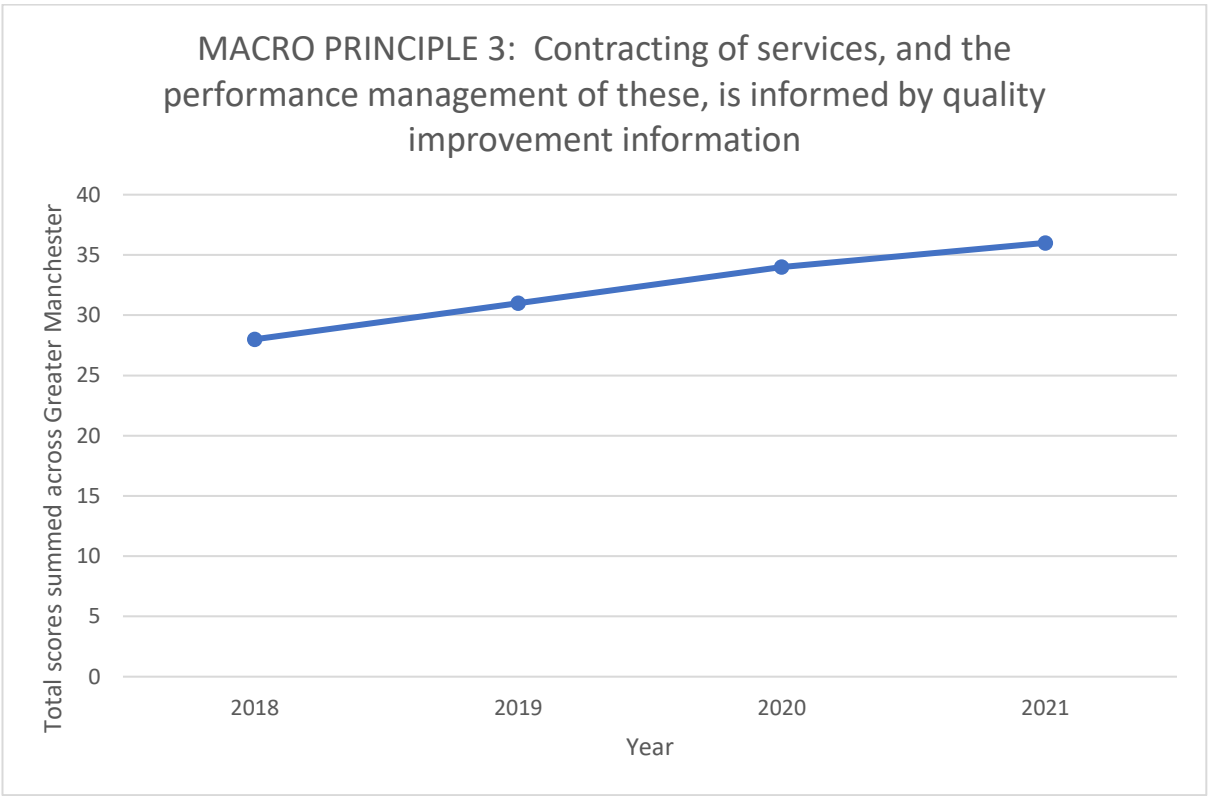
	> Multi-agency THRIVE plans documented for all risk support cases
3.4	Year one of implementation (details to be added)
3.5	Year one progress review and refine plan for year two
3.6	Year two of implementation (details to be added)
3.7	Year two progress review and refine plan for year three
3.8	Year three of implementation (details to be added)
3.9	Year three progress review and refine plan for year four
3.10	* Continue as necessary in yearly cycles*
4.0	**i-THRIVE Approach to Implementation Phase 4: Embedding and Sustaining**
4.1	Establish learning collaborative
4.2	Learning collaborative
4.3	Embedding and sustaining year one implementation projects
4.4	Embedding and sustaining year two implementation projects
4.5	Embedding and sustaining year three implementation projects

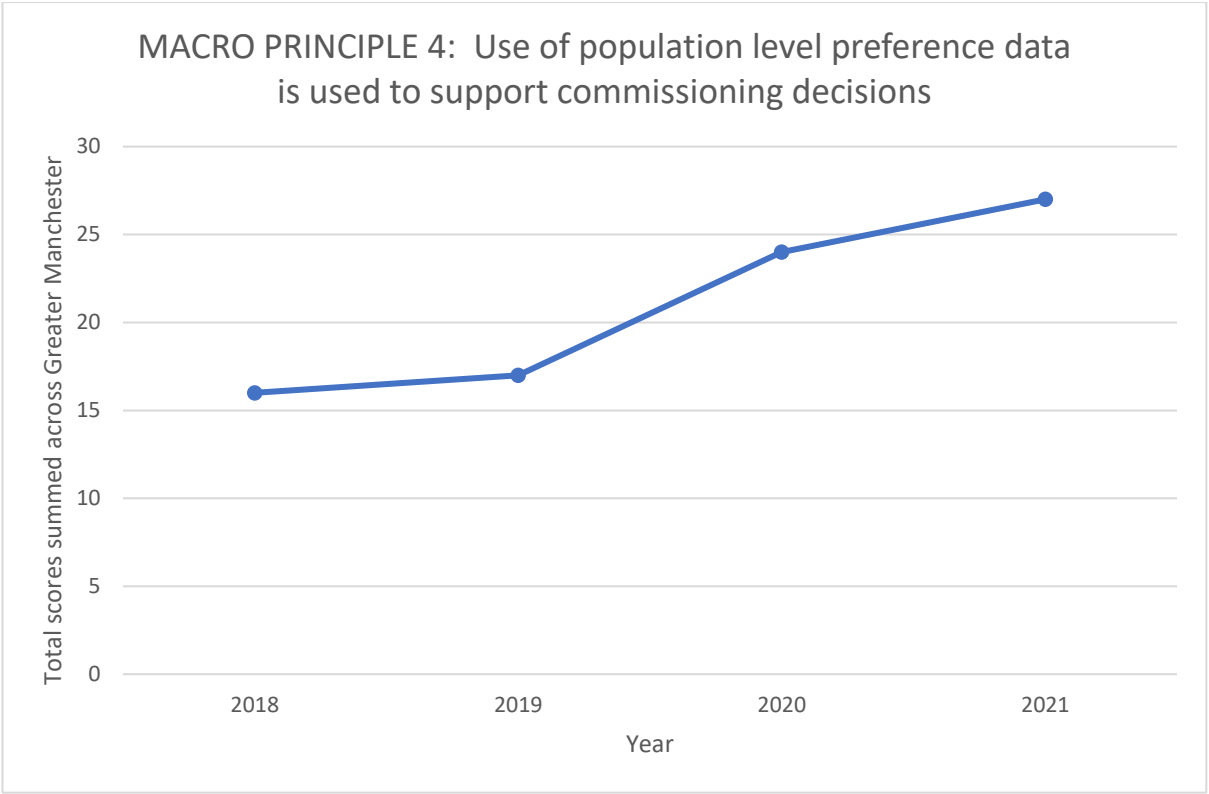
Line graph visualisations of Greater Manchester's self-reported adherence to GM i-THRIVE's core principles from 2018-2021.

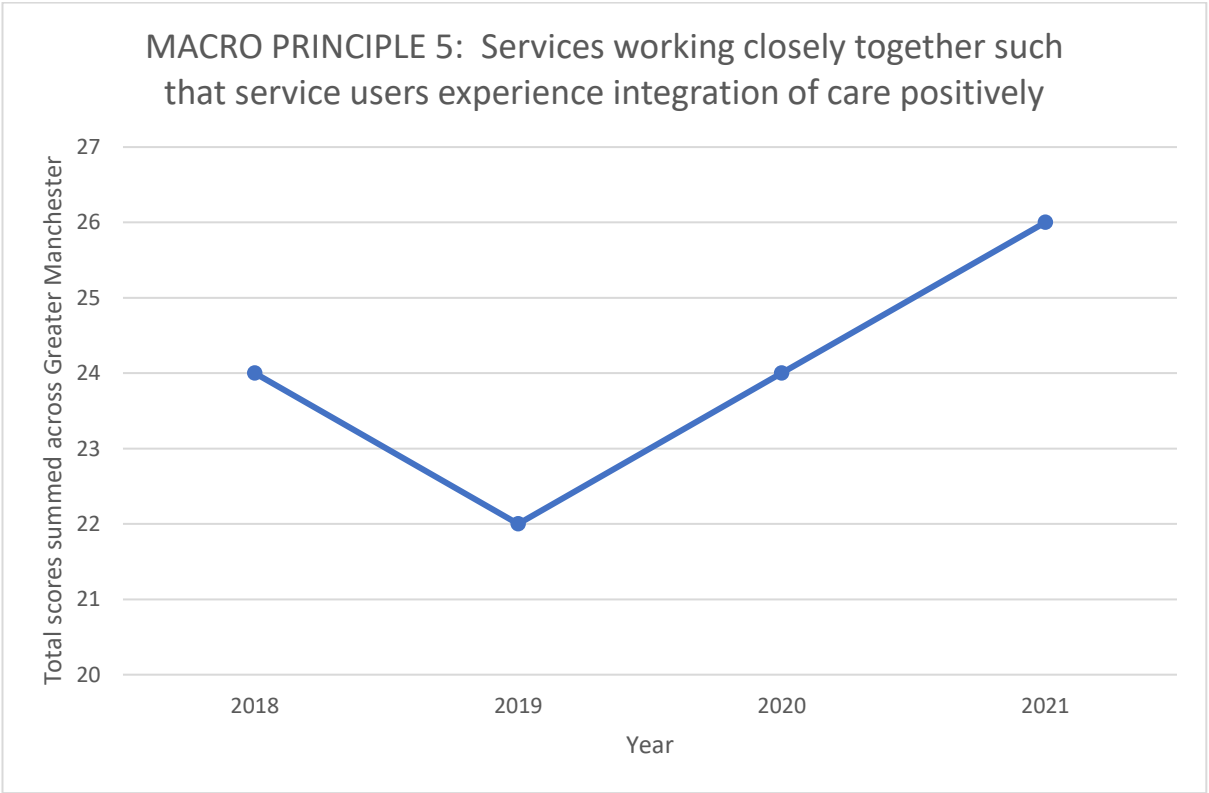


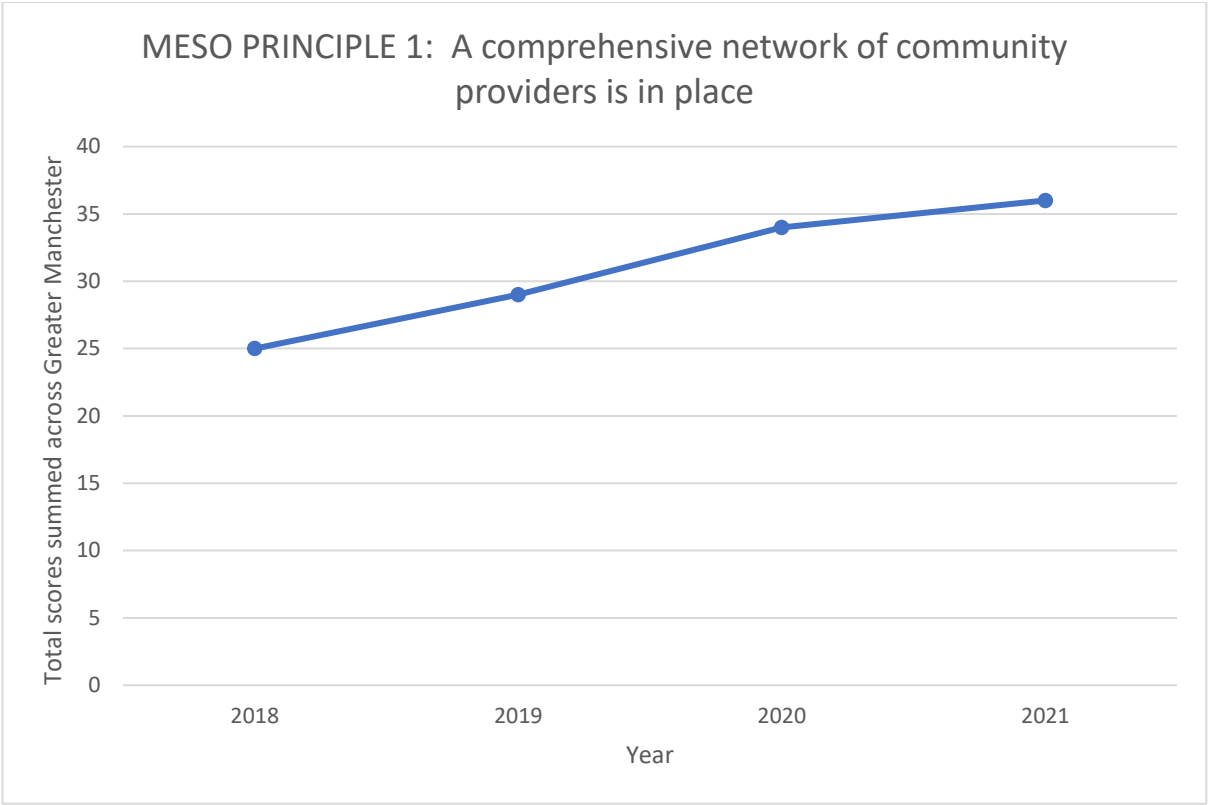


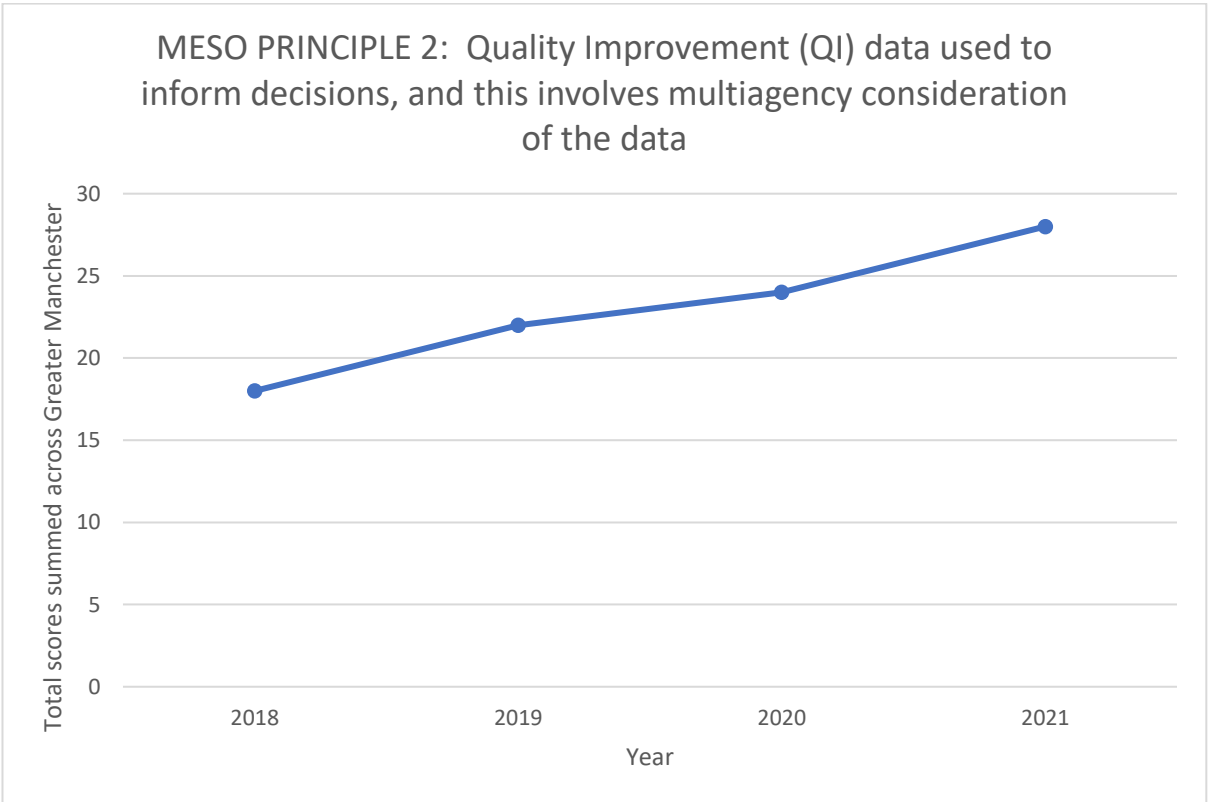

MACRO PRINCIPLE 2: All agencies are involved in commissioning care (education, health, social care, third sector)
Total scores summed across Greater Manchester
35
30
25
20
15
10
5
0
2018
2019
2020
2021
Year

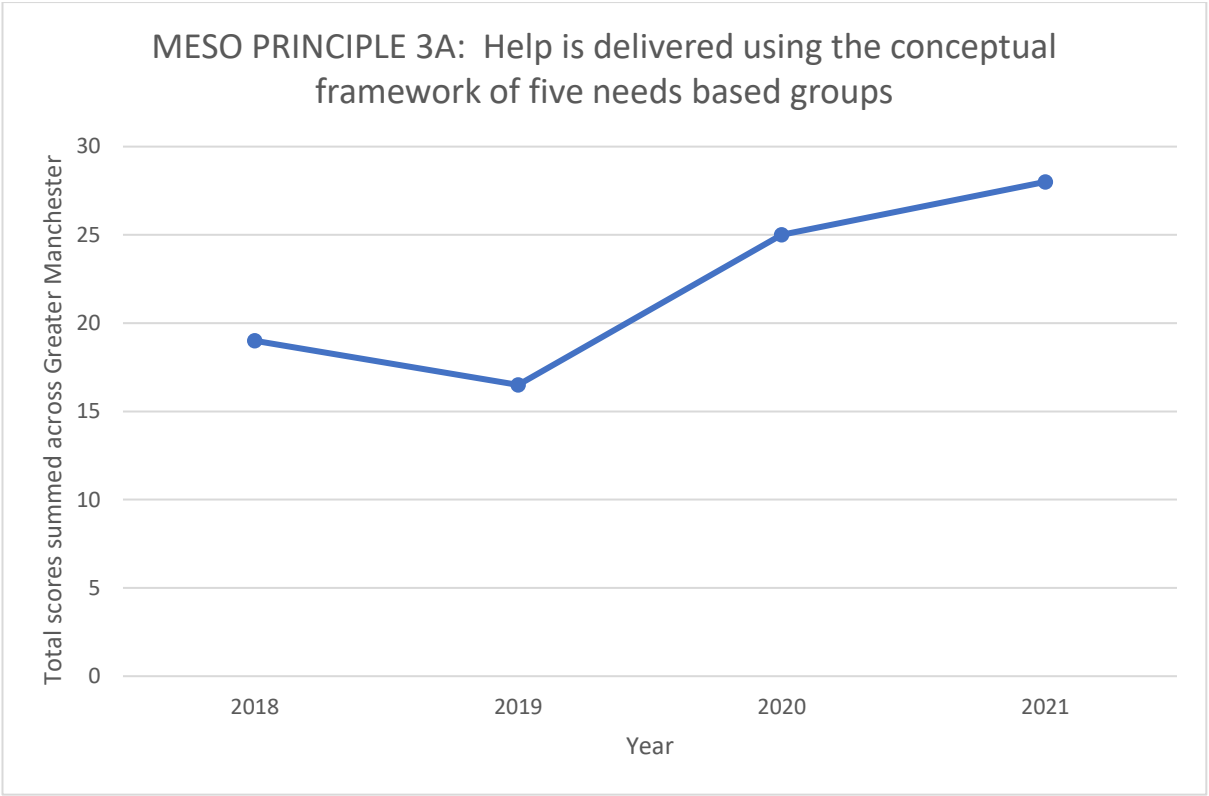

MACRO PRINCIPLE 3: Contracting of services, and the performance management of these, is informed by quality improvement information
Total scores summed across Greater Manchester
40
35
30
25
20
15
10
5
0
2018
2019
2020
2021
Year

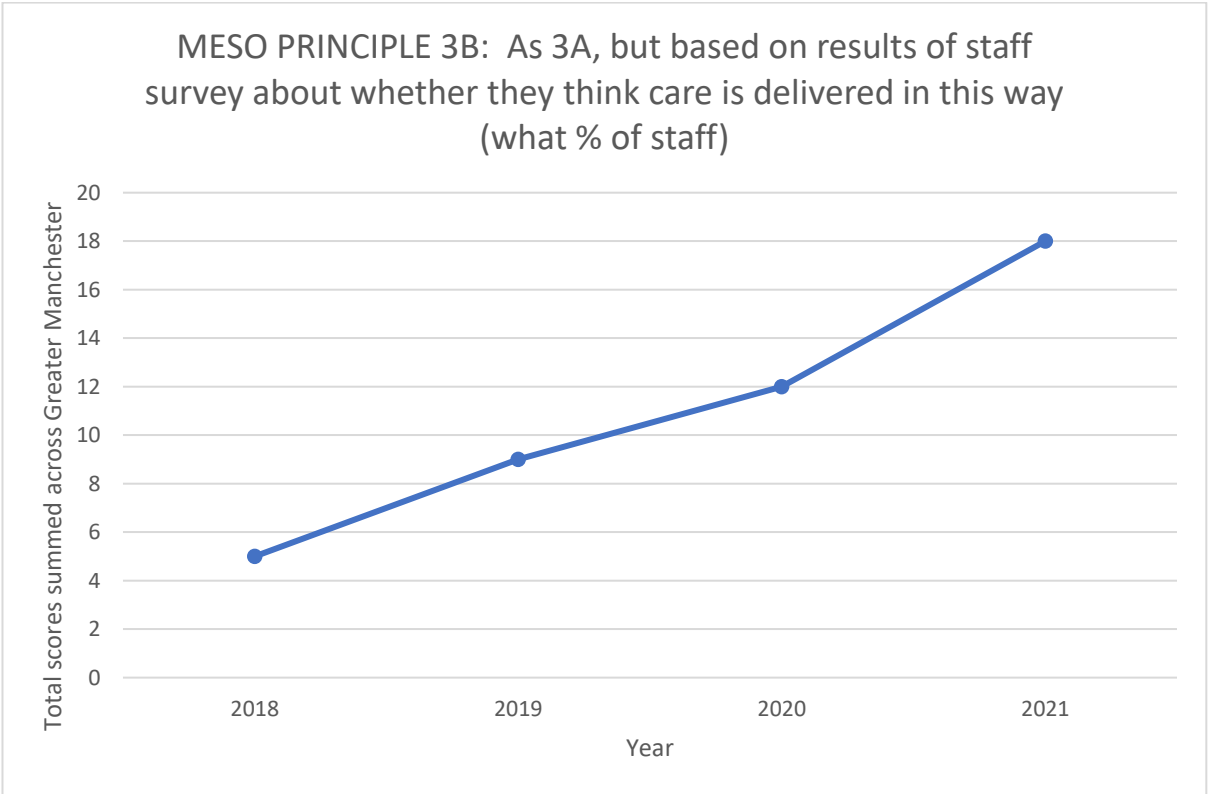

MACRO PRINCIPLE 4: Use of population level preference data is used to support commissioning decisions
Total scores summed across Greater Manchester
30
25
20
15
10
5
0
2018
2019
2020
2021
Year

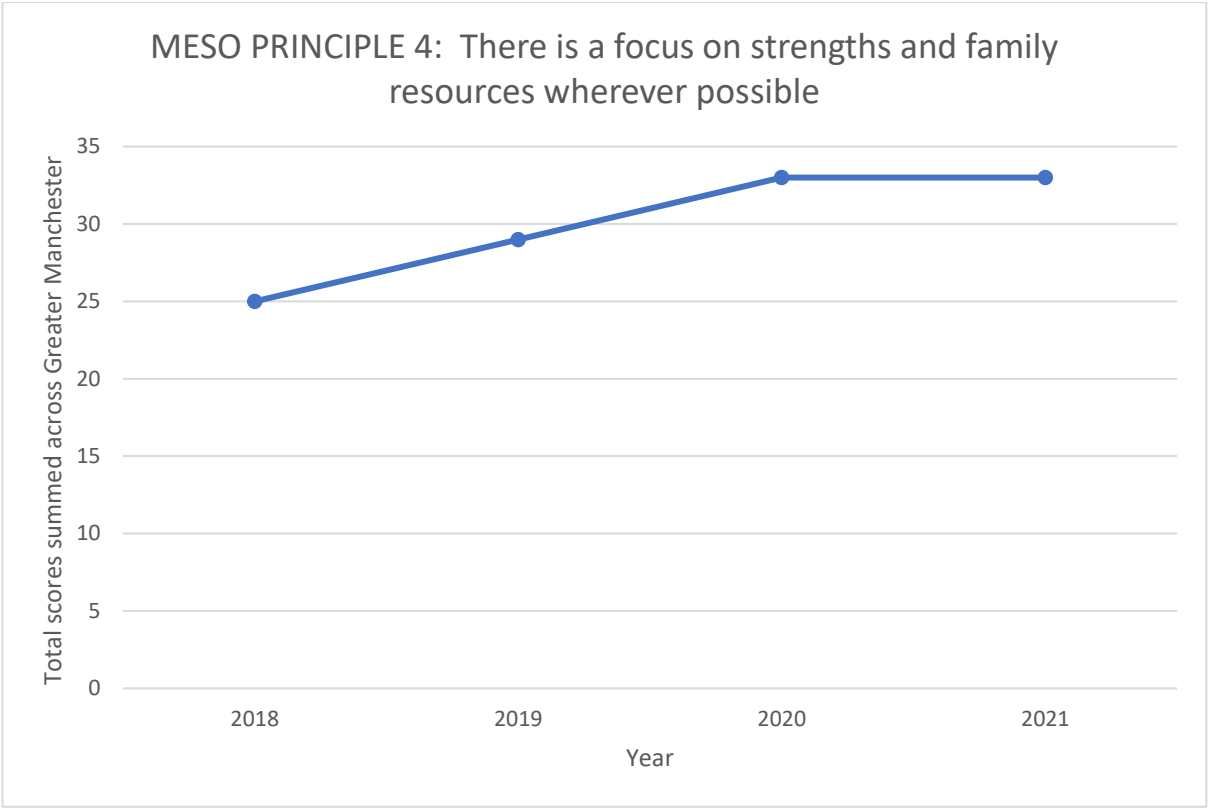

MACRO PRINCIPLE 5: Services working closely together such that service users experience integration of care positively
Total scores summed across Greater Manchester
27
26
25
24
23
22
21
20
2018
2019
2020
2021
Year

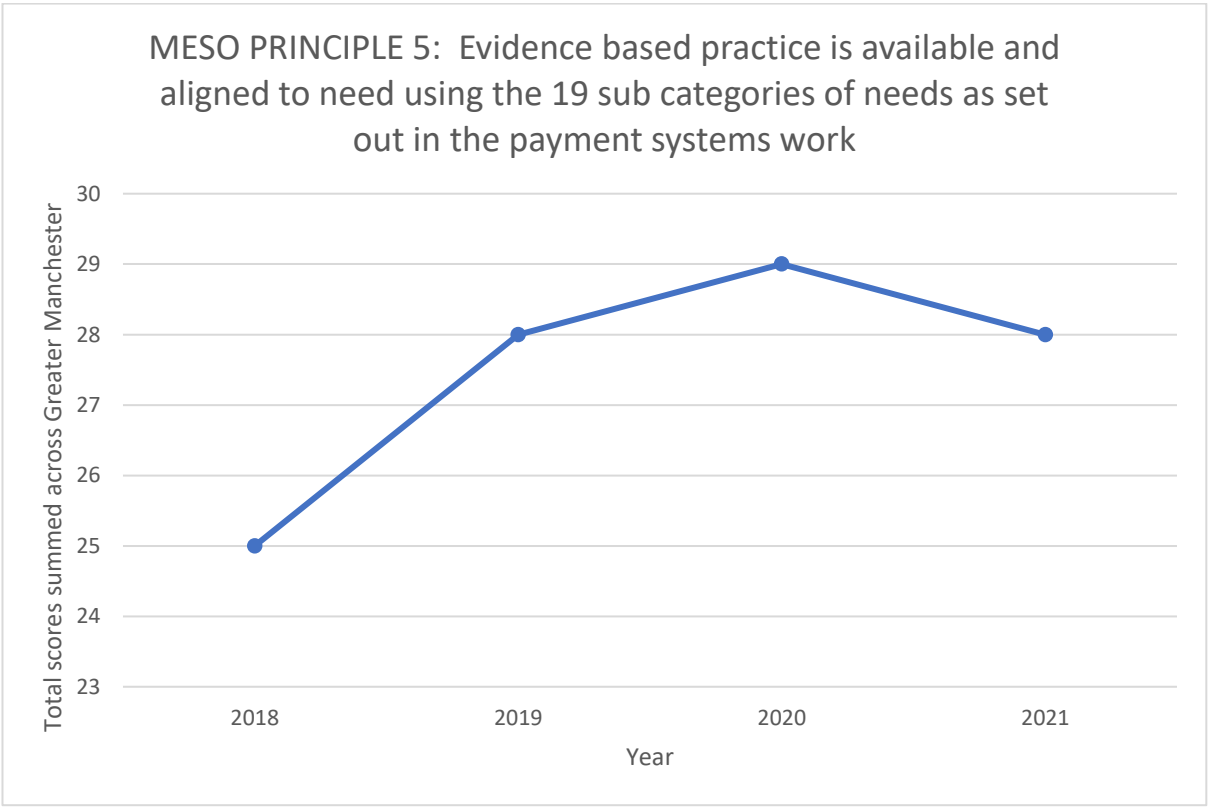

MESO PRINCIPLE 1: A comprehensive network of community providers is in place
Total scores summed across Greater Manchester
40
35
30
25
20
15
10
5
0
2018
2019
2020
2021
Year

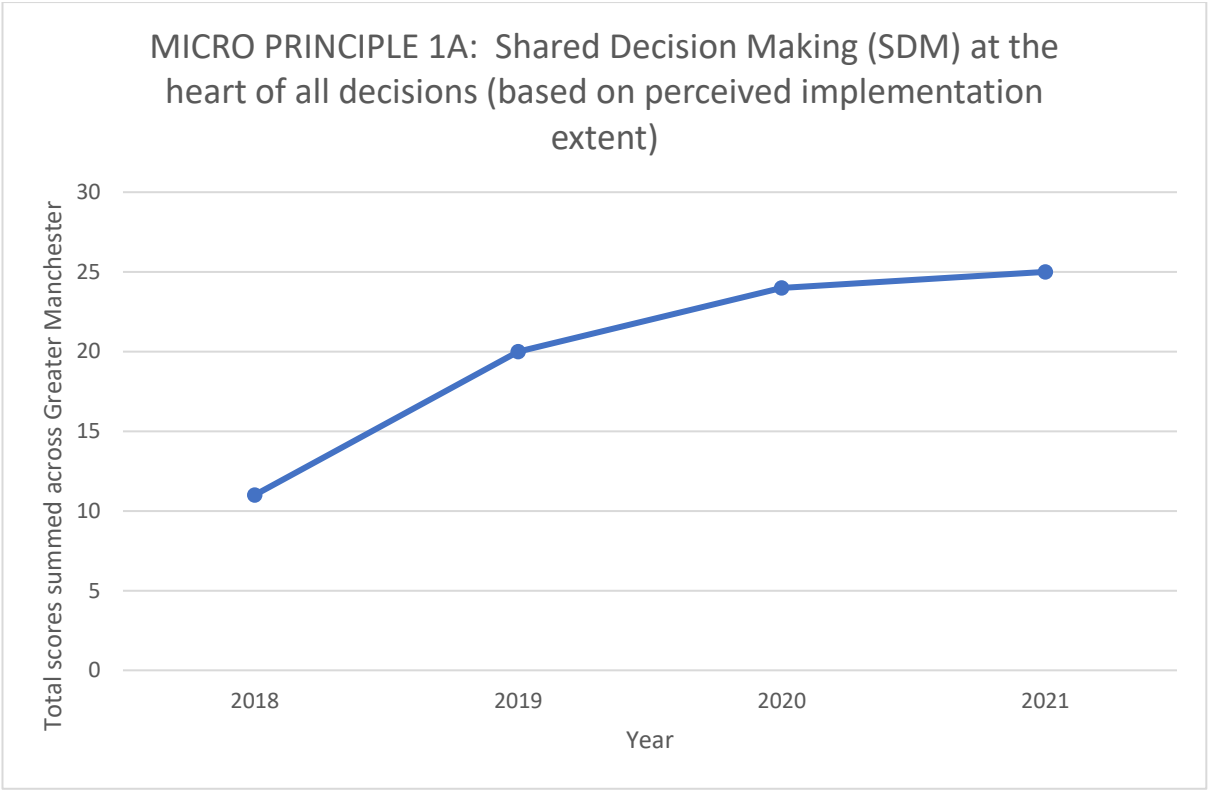

MESO PRINCIPLE 2: Quality Improvement (QI) data used to inform decisions, and this involves multiagency consideration of the data
Total scores summed across Greater Manchester
30
25
20
15
10
5
0
2018
2019
2020
2021
Year

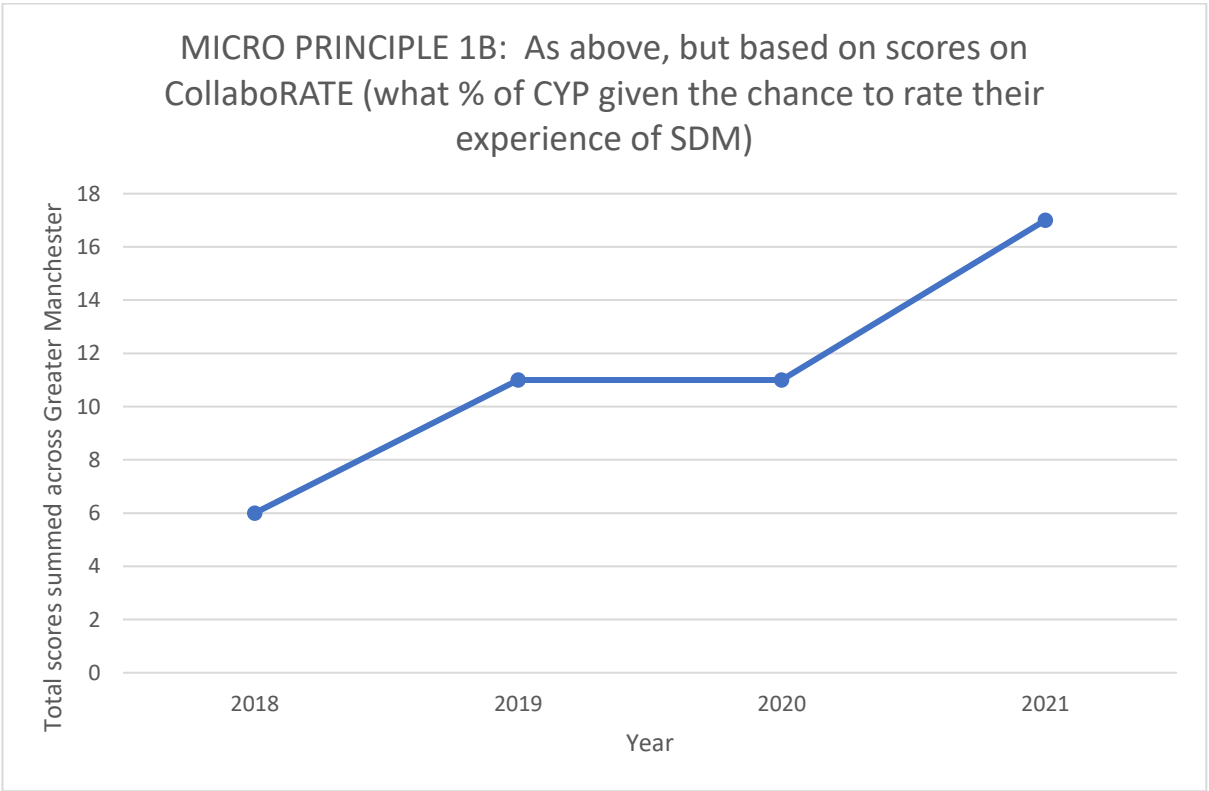

MESO PRINCIPLE 3A: Help is delivered using the conceptual framework of five needs based groups
Total scores summed across Greater Manchester
30
25
20
15
10
5
0
2018
2019
2020
2021
Year

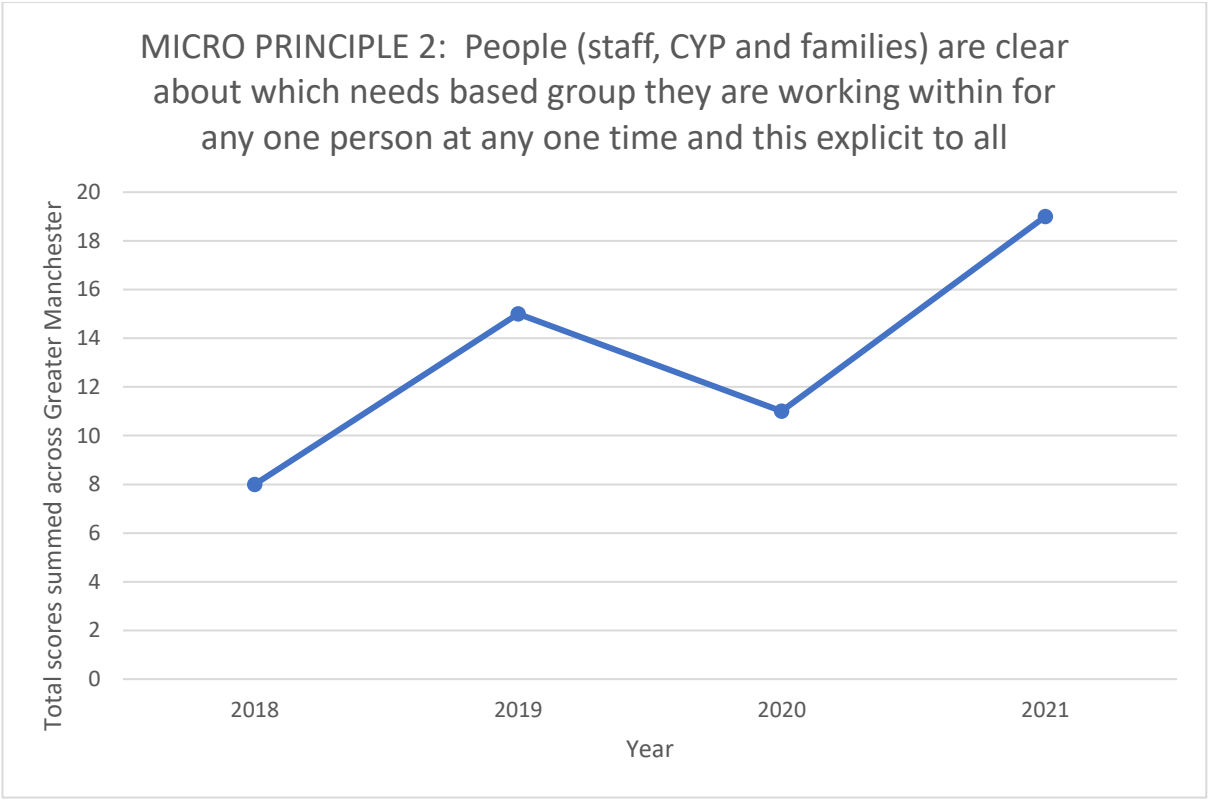

MESO PRINCIPLE 3B: As 3A, but based on results of staff survey about whether they think care is delivered in this way (what % of staff)
Total scores summed across Greater Manchester
20
18
16
14
12
10
8
6
4
2
0
2018
2019
2020
2021
Year

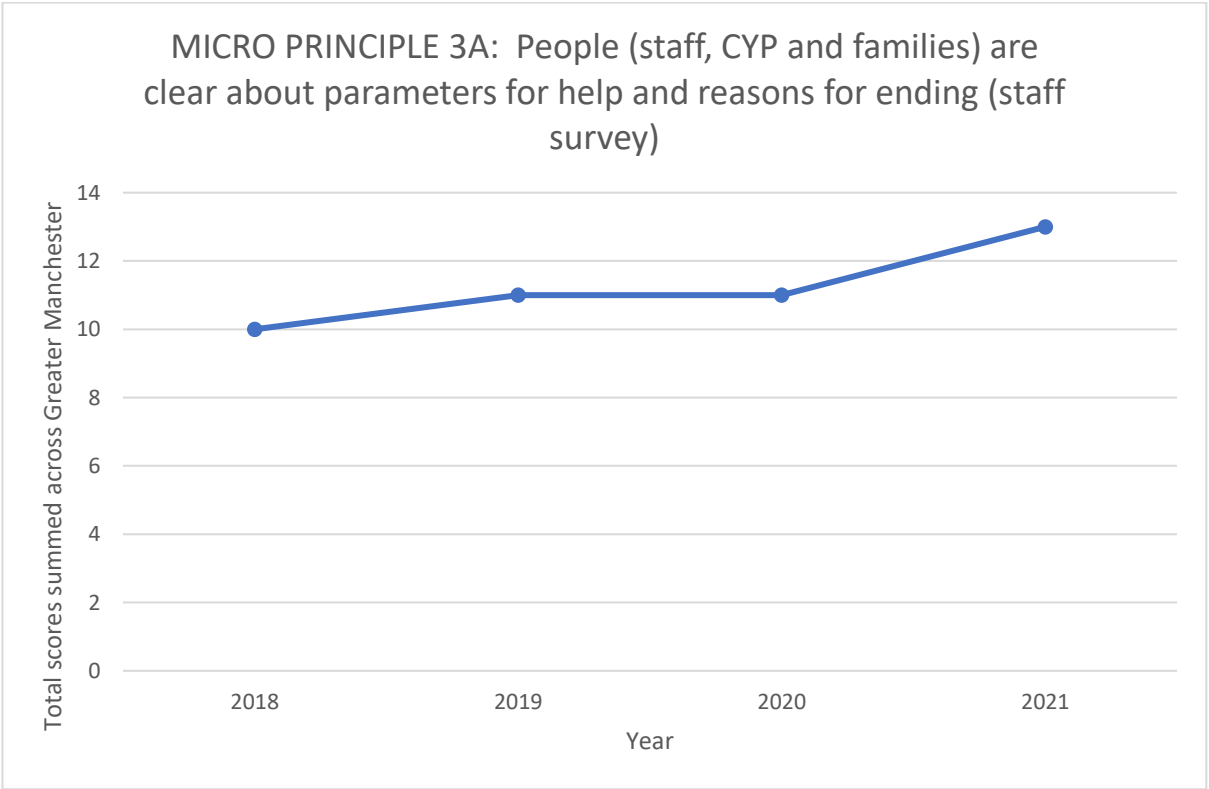

MESO PRINCIPLE 4: There is a focus on strengths and family resources wherever possible
Total scores summed across Greater Manchester
35
30
25
20
15
10
5
0
2018
2019
2020
2021
Year

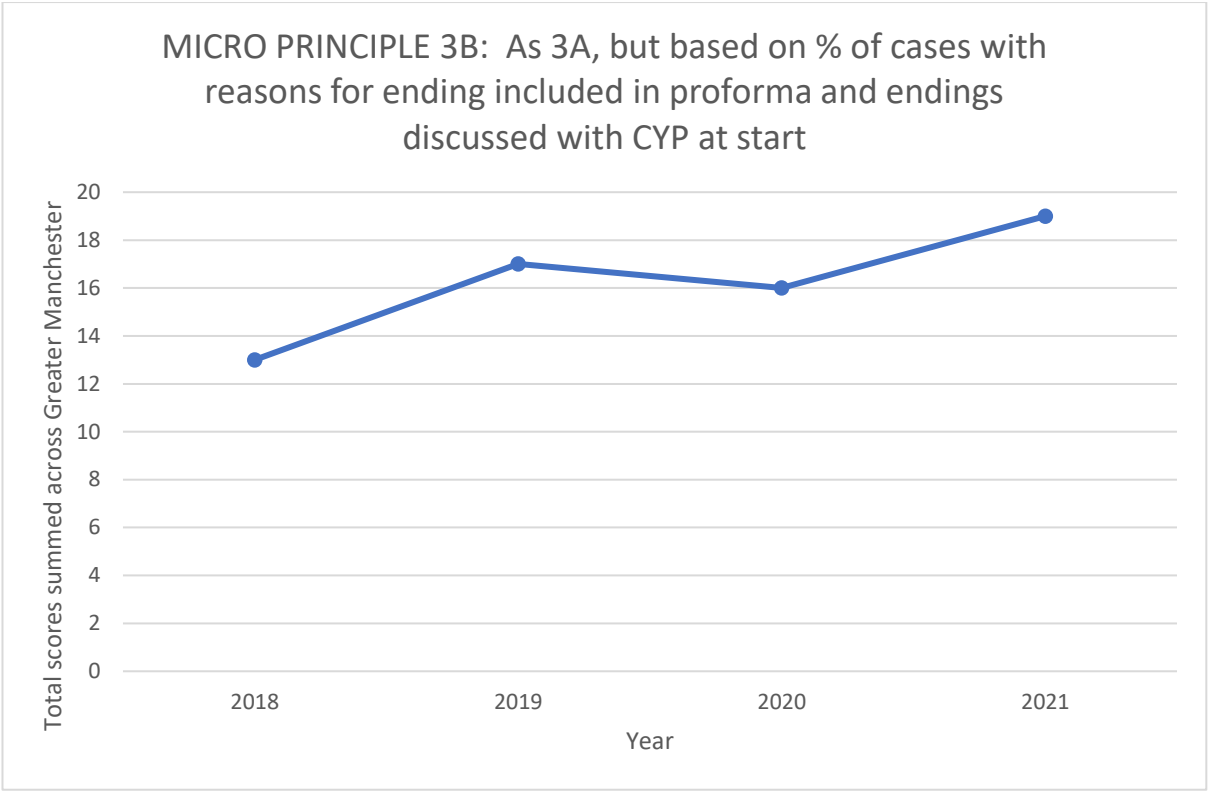

MESO PRINCIPLE 5: Evidence based practice is available and aligned to need using the 19 sub categories of needs as set out in the payment systems work
Total scores summed across Greater Manchester
30
29
28
27
26
25
24
23
2018
2019
2020
2021
Year

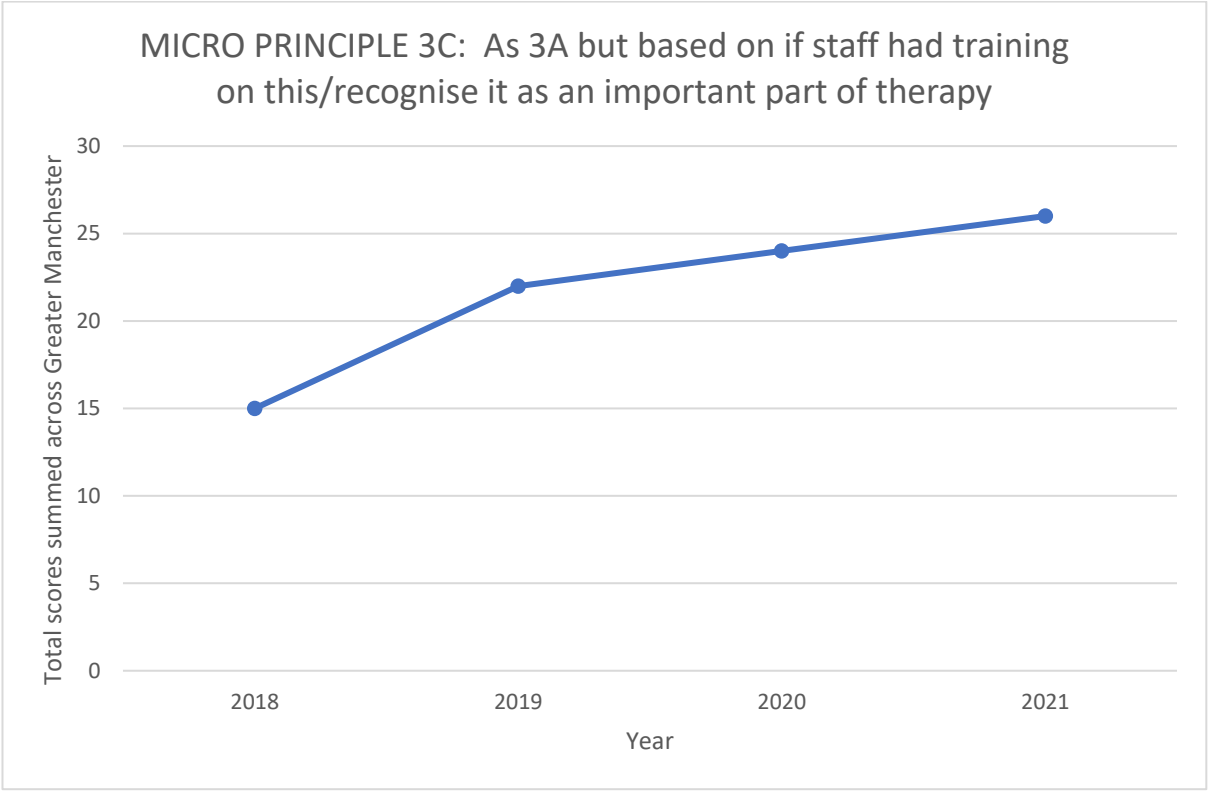

MICRO PRINCIPLE 1A: Shared Decision Making (SDM) at the heart of all decisions (based on perceived implementation extent)
Total scores summed across Greater Manchester
30
25
20
15
10
5
0
2018
2019
2020
2021
Year

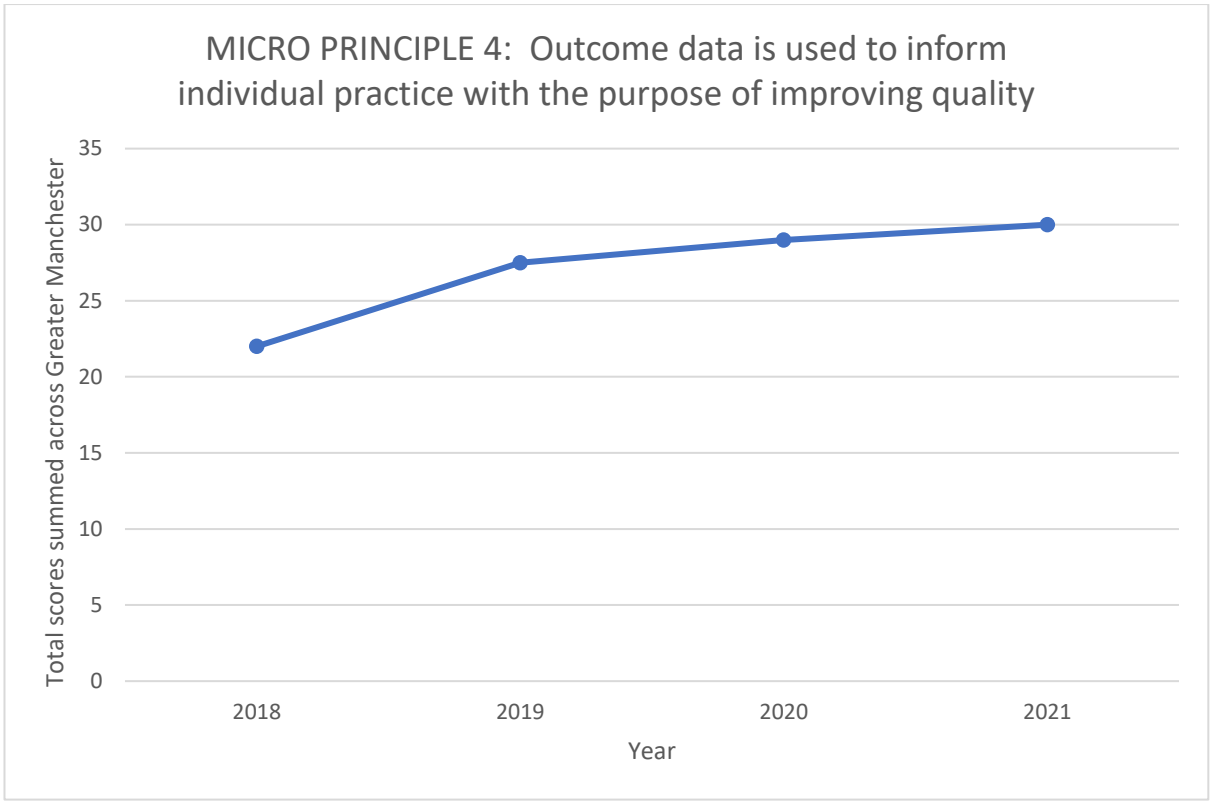

MICRO PRINCIPLE 1B: As above, but based on scores on CollaboRATE (what % of CYP given the chance to rate their experience of SDM)
Total scores summed across Greater Manchester
18
16
14
12
10
8
6
4
2
0
2018
2019
2020
2021
Year

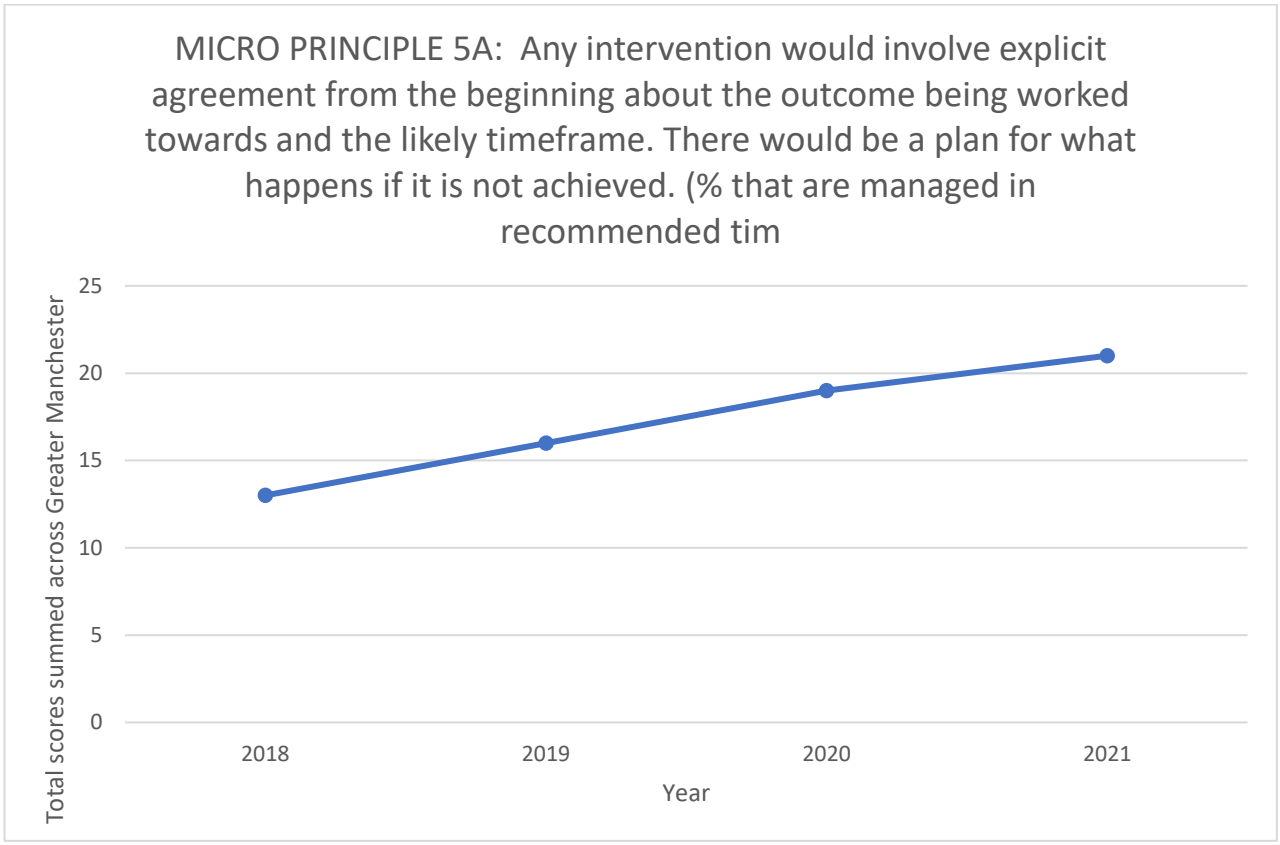

MICRO PRINCIPLE 2: People (staff, CYP and families) are clear about which needs based group they are working within for any one person at any one time and this explicit to all
Total scores summed across Greater Manchester
20
18
16
14
12
10
8
6
4
2
0
2018
2019
2020
2021
Year

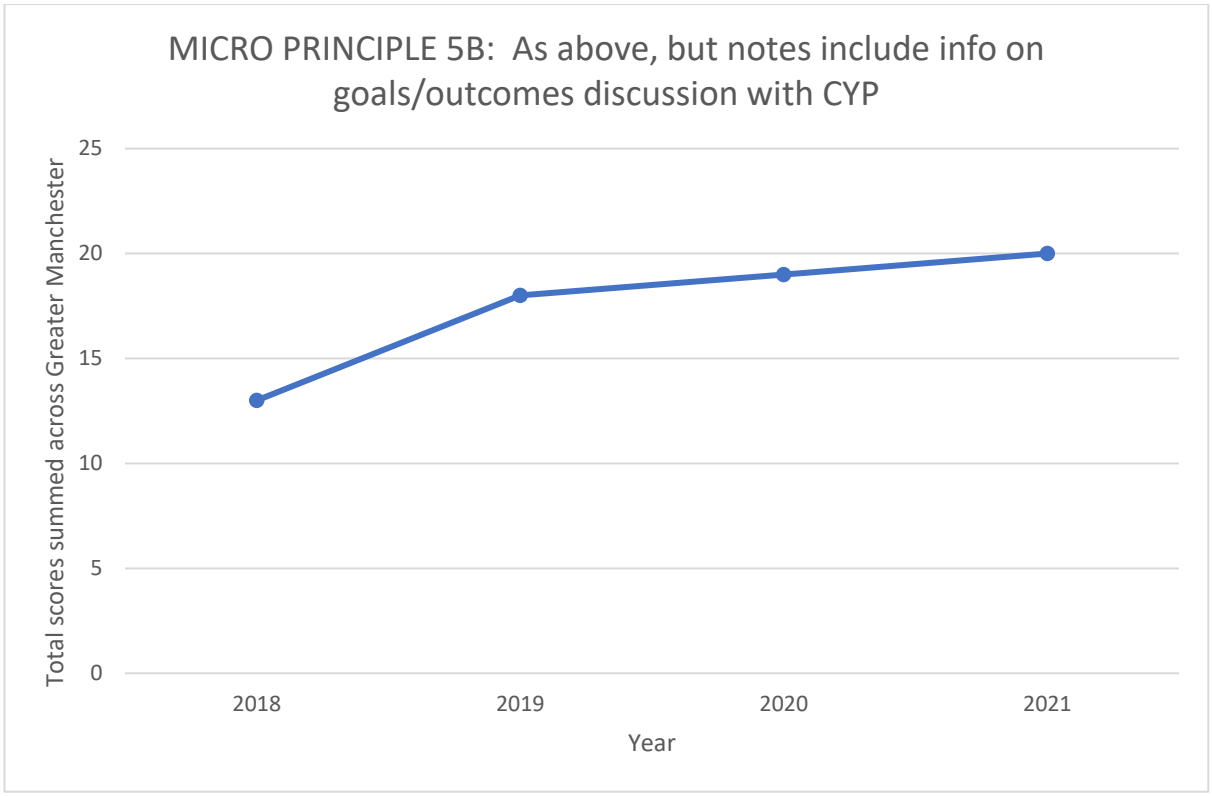

MICRO PRINCIPLE 3A: People (staff, CYP and families) are clear about parameters for help and reasons for ending (staff survey)
Total scores summed across Greater Manchester
14
12
10
8
6
4
2
0
2018
2019
2020
2021
Year

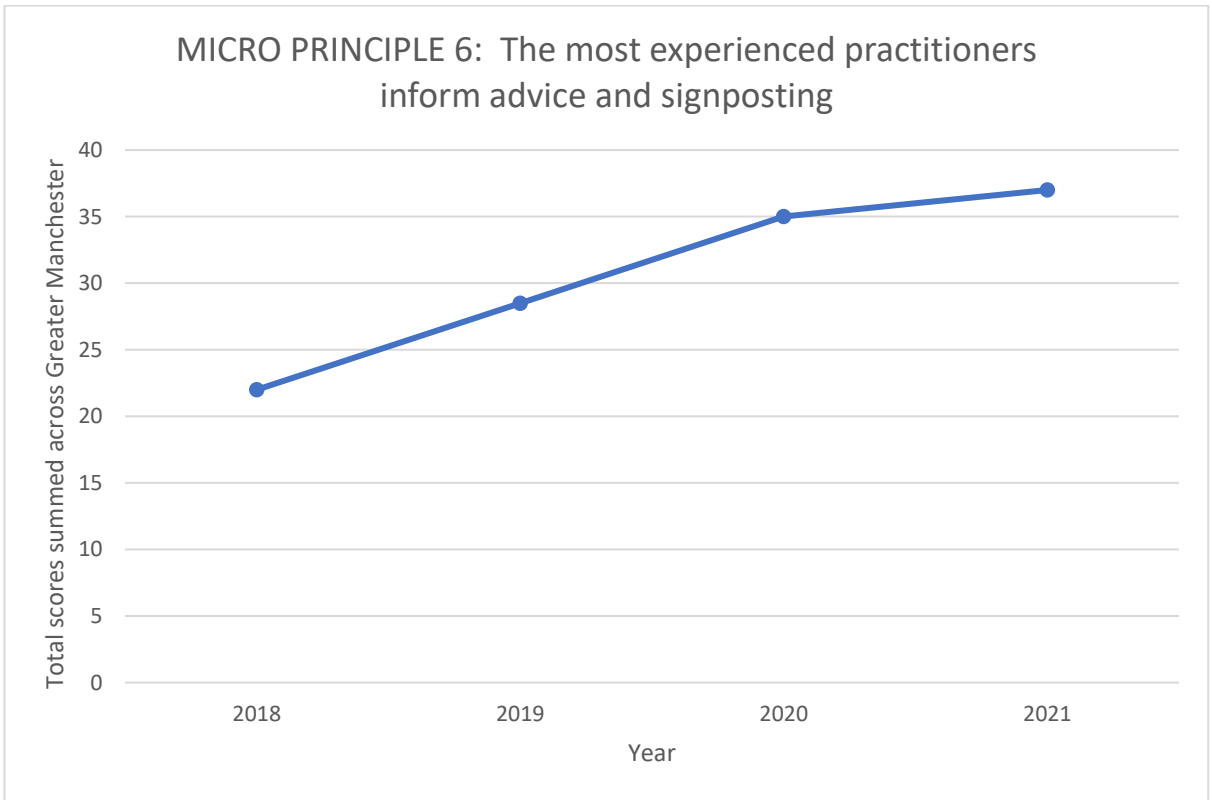

MICRO PRINCIPLE 3B: As 3A, but based on % of cases with reasons for ending included in proforma and endings discussed with CYP at start
Total scores summed across Greater Manchester
20
18
16
14
12
10
8
6
4
2
0
2018
2019
2020
2021
Year

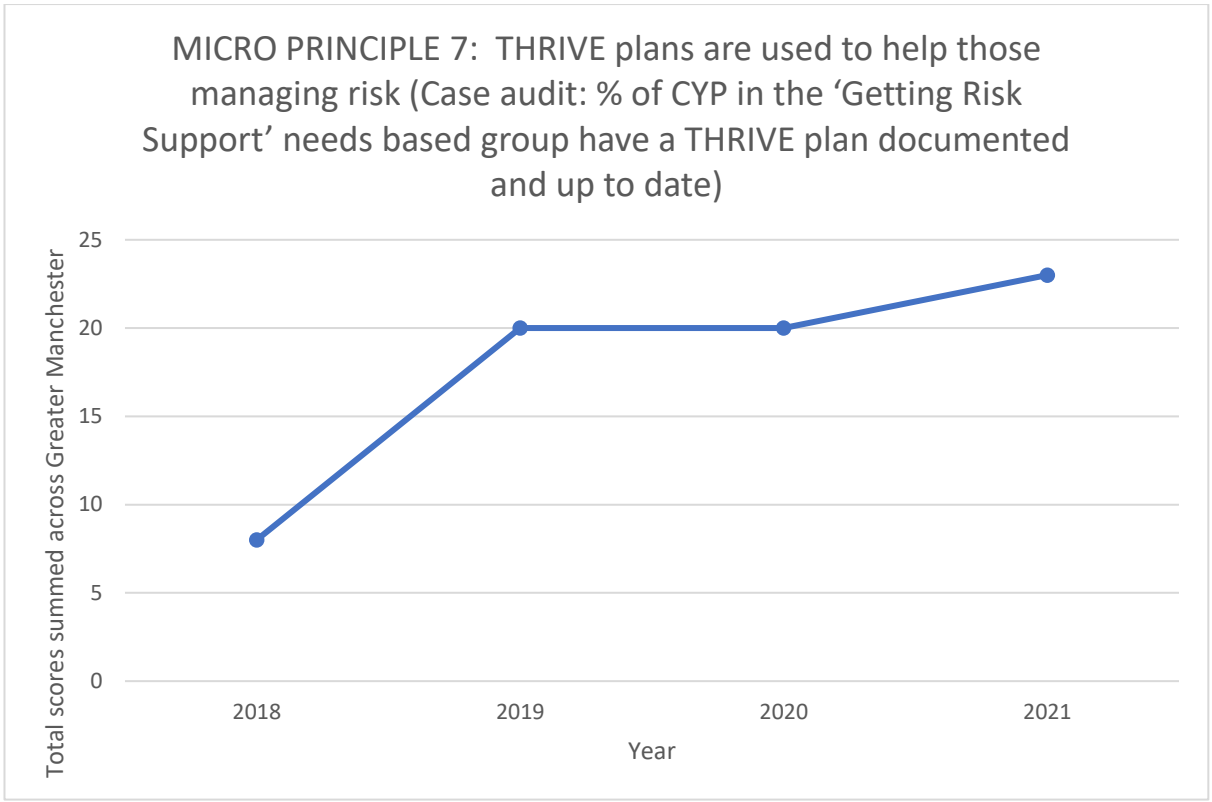

MICRO PRINCIPLE 3C: As 3A but based on if staff had training on this/recognise it as an important part of therapy
Total scores summed across Greater Manchester
30
25
20
15
10
5
0
2018
2019
2020
2021
Year


MICRO PRINCIPLE 4: Outcome data is used to inform individual practice with the purpose of improving quality
Total scores summed across Greater Manchester
35
30
25
20
15
10
5
0
2018
2019
2020
2021
Year


MICRO PRINCIPLE 5A: Any intervention would involve explicit agreement from the beginning about the outcome being worked towards and the likely timeframe. There would be a plan for what happens if it is not achieved. (% that are managed in recommended tim
Total scores summed across Greater Manchester
25
20
15
10
5
0
2018
2019
2020
2021
Year


MICRO PRINCIPLE 5B: As above, but notes include info on goals/outcomes discussion with CYP
Total scores summed across Greater Manchester
25
20
15
10
5
0
2018
2019
2020
2021
Year


MICRO PRINCIPLE 6: The most experienced practitioners inform advice and signposting
Total scores summed across Greater Manchester
40
35
30
25
20
15
10
5
0
2018
2019
2020
2021
Year


MICRO PRINCIPLE 7: THRIVE plans are used to help those managing risk (Case audit: % of CYP in the 'Getting Risk Support' needs based group have a THRIVE plan documented and up to date)
Total scores summed across Greater Manchester
25
20
15
10
5
0
2018
2019
2020
2021
Year

Appendix 4: Supplementary materials relating to Chapter 6/Study 4: Child and adolescent mental health services in a devolved healthcare system: A qualitative exploration of sustainable practices

Semi-structured interview schedule including prompts:

Top-down implementors:

Hello, thank you for agreeing to do this interview. As you've probably gathered, the main focus of the interview is to talk about how well THRIVE is setting itself up to be sustainable in the long run, and the processes that are in place to do this. Your perceptions of how things are going will be really useful to hear, so your honest opinions about how things are going, and your suggestions for what you feel can be improved will be really appreciated.

I'm sure you won't, but try not to divulge any confidential information about anyone that you mention, if you do mention another person in whatever context. If you do mention any names, they will be anonymised in the transcript. And obviously for the evaluation I want to hear the good and the bad, so feel free to be as honest as you can be about your experiences!

I just want to reinstate that you are free to stop and/or withdraw from the study at any time, if you just let me know, we can stop. If you do decide to continue, this Zoom call will be recorded. Zoom also automatically transcribes our conversation, and once I've used your recording to check this generated transcript for accuracy, this recording, both audio and visual, will be deleted. But, if you do want to turn the camera off now so that your face isn't recorded at all, you can do that if you wish? It's up to you. Do you have any questions? Are you happy to begin? I will start the recording if so.

Others:

Hello, thank you for agreeing to do this interview. The main focus of this interview is to talk about THRIVE – what you know about it, what you think about it, and how it's influenced your daily procedures at work – that kind of thing, really. Your honest perceptions of how things are going on the ground will be really useful to hear, and your suggestions for what you feel can be improved going forward will be really appreciated.

Try not to divulge any confidential information about anyone that you mention, if you do mention another person in whatever context. If you do mention any names, they will be anonymised in the transcript. I just want to make it clear that even though I am working on an evaluation of i-THRIVE which is funded by them, my position is completely impartial,

so please feel free to be as honest as you can with your experiences: we want to hear the good and the bad, and there won't be any negative consequences of you doing this!

I just want to reinstate that you are free to stop and/or withdraw from the study at any time, if you just let me know, we can stop. If you do decide to continue, this Zoom call will be recorded. Zoom also automatically transcribes our conversation, and once I've used your recording to check this generated transcript for accuracy, this recording, both audio and visual, will be deleted. But, if you do want to turn the camera off now so that your face isn't recorded at all, you can do that if you wish? It's up to you. Do you have any questions? Are you happy to begin? I will start the recording if so.

Staff:

Top-down implementers:

- So, could you start by outlining your job title and role?
- What is being done to ensure that locality staff, at all levels, feel involved in the roll-out of i-THRIVE?
- Which types of professionals, in terms of both job roles and seniority levels, have been involved in the design and planning of new ways of working?
- **Prompts for the above two questions:** what has their involvement looked like? To what extent have the different levels across services been involved? Do you feel that this level of involvement has been sufficient across all levels? Why/why not?
- **Only ask if not covered above:** How are staff encouraged to express their ideas or concerns throughout the change process, and how is their input being taken on board?
- **Prompt**: are there, for example, any regular meetings where staff can express their thoughts, and have actioned/un-actioned changes fed back to them? Are there also any, perhaps more informal mechanisms by which feedback can be given?
- How were the THRIVE leads chosen? In what ways are they "visible", approachable, and well known to those on the ground?
- **Prompt:** Do staff know who the lead is? How to contact them?
- To what extent do you feel that the THRIVE leads feel a sense of personal responsibility for the change process in their locality?
- **Prompt:** Can you give an example of how a lead has shown that they do/do not? (Do/do not depends on response to the above question)

THRIVE leads:

- What is your main job role/other work-related responsibilities, aside from being the THRIVE lead for your locality?
- In your own words, what does being a THRIVE lead entail?
- How are staff in your locality encouraged to express their ideas or concerns throughout the change process, and how is their input being taken on board?
- **Prompt**: are there, for example, any regular meetings where staff can express their thoughts, and have actioned/un-actioned changes fed back to them? Are there also any, perhaps more informal mechanisms by which feedback can be given?
- What steps do you take to ensure that you are "visible", approachable, and well-known to the staff implementing THRIVE in your locality?
- **Prompt:** Do staff know you and your role? Are there mechanisms by which they can contact you?
- How satisfied do you feel with the support that you have been given as a THRIVE lead? Is there anything in particular that has really helped? Or, what do you feel could help you more?
- **If not made clear above:** Do you feel you have actively had to seek support yourself, or are there formal processes or meetings that actively offer you it?

Other staff members:

- What is your job role?
- Tell me about how you have been involved with the implementation of i-THRIVE?
- **Prompt:** How has it changed your daily working practices?
- Are you able to express your ideas and concerns about the i-THRIVE implementation process? How? Do you feel that these are taken on board?
- **Prompt**: are there, for example, any regular meetings where you can express your thoughts, and have changes fed back to you? Are there also any, perhaps more informal mechanisms by which you feel you can give feedback?
- On a related note, has a system been made clear to you through which you can approach someone with any concerns or queries that you have about the implementation?
- **Prompt:** Do you know who to contact?
- In your opinion, how has i-THRIVE changed the way you do things, compared to before it came about?

- **Prompt:** Personally, do you feel that it is worth preserving? **(If not)** what changes do you think could be made to make it a worthwhile intervention to keep?

Process:

Top-down implementers:

- In your opinion, what are the most important elements of THRIVE that you feel should be kept and sustained?
- **Additional:** What barriers do you foresee to being able to sustain them?
- In addition to the outcomes of THRIVE that directly relate to supporting CYP, what other changes, particularly in workplaces and within teams, have you seen as a result of implementing THRIVE? **Prompt:** for example has it made people's jobs easier or harder? Have processes been streamlined? Has duplication been avoided? **Ask to give examples if says yes or no.**
- From your perspective, what are the key differences that you think staff notice, or will notice, in their working lives as a whole?
- Do you believe that THRIVE is overall well-placed to meet the ongoing needs of CYP? How are the changing needs of GM currently being monitored and how is this monitoring acted upon?
- More importantly, since we're talking about sustainability, what mechanisms will be in place to monitor changing needs of CYP, localities, and staff, *beyond* the formal implementation phase? This can be both formal and informal mechanisms.
- More generally, what long terms plans are in place for sustaining and/or widening the programme?
- To what extent has i-THRIVE been impacted by COVID-19? Do you think, realistically, that it has impacted how well the principles of THRIVE have been delivered? How so?
- **Prompt:** Tell me about what changes have been made to the training academy.

THRIVE leads:

- In addition to the outcomes that directly relate to supporting CYP, what other changes, particularly in workplaces, and within your teams, have you seen as a result of implementing THRIVE? **Prompt:** for example has it made people's jobs easier or harder? Have processes been streamlined? Has duplication been avoided? **Ask to give examples if says yes or no.**

- From your perspective, what differences do you think staff notice, or will notice, in their working lives as a whole?
- Are you optimistic that THRIVE will continue to meet the ongoing needs of CYP, in particular, beyond the formal implementation phase?
- More generally, do you know of any long terms plans that are in place for sustaining and/or widening the programme?
- To what extent has i-THRIVE been impacted by COVID-19 in your locality? Specifically, do you think, realistically, that it has impacted how well the principles of THRIVE have been delivered? How so?

Other staff members:

- What differences in your working life have you noticed, that you could attribute to the introduction of THRIVE? **Further question**: if none, do you think you will in the future?
- Has patient care/interactions with CYP (change depending on person's specific role) changed much as a result of THRIVE? What do you think has changed the most? What has stayed the same?
- In addition to the outcomes that directly relate to CYP, what changes have you seen in your workplace as a result of THRIVE? **Prompt:** for example has it made people's jobs easier or harder? Have processes been streamlined? Has duplication been avoided? **Ask to give examples if says yes or no.**

Organisation:

THRIVE leads:

- Could you tell me how the specific goals of THRIVE are communicated to teams on the ground? I can give you some examples if you've gone blank!
- **Prompt:** Needs-based approach, not diagnosis/severity, shared accountability, communication between services, no wrong door…
- How satisfied do you feel with the structure of any implementation plans or timelines that you have been given? For example, do you feel that they are too rigid, too unstructured, or about right?
- **Prompt:** Is there anything you'd change about the plans? Why?

Others:

- How confident do you feel in your knowledge of the goals of THRIVE? How are these being communicated to you? **Further question:** Has this been sufficient?
- What new policies and/or procedures have been implemented in your workplace as a result of THRIVE?
- How well does everything you have learned about THRIVE fit in with your everyday duties? **Prompt:** do you have enough time/training/equipment?

Other questions (elements of these have been captured with the NHS Sustainability Model, the below are additional questions that have not been covered):

Adaptability:

Top-down implementers:

- I know you are conducting a number of surveys, with CYP about the service, and with staff about the training. Will the findings of these be actively used to make changes to develop and improve THRIVE? Will they be used to mould guidelines for the ongoing implementation?
- **Prompt:** How?
- Do you think, as a whole, THRIVE is a system that is adaptable and flexible, in the sense that it is open and responsive to new information, be it changing CYP needs, or feedback given by staff?
- **Prompt:** Can you give an example of how issues that arise are used to shape the system going forwards?
- Are guidelines/requirements adapted if significant barriers come up that are preventing staff from carrying them out?
- **Prompt:** How?
- What are the key elements of THRIVE that make it suitable for use with such a diverse population of CYP, and such a diverse range of services?

Reflection:

Top-down implementers:

- What do you think makes THRIVE different from other implementations that the NHS has been involved in?

- Have you had insight to any past implementations, that you have been able to use to guide the implementation of GM i-THRIVE?
- What were the key differences, or indeed similarities, between CAMHS processes and THRIVE principles that stood out to you when you began your role? What has been done to align these processes to THRIVE thus far? How successful do you think this has been?
- Do you have any examples of how the changes that have been made so far have been embedded into long-term policy?
- Have there been any negative or unintended consequences of implementing THRIVE, that you've seen in either formally through things like survey results, or from word of mouth?
- To what extent do you believe that the effort being put into implementing THRIVE matches, or will match, any benefits that will be seen in the long run?

THRIVE leads:

- What do you think makes THRIVE different from any other implementations that the NHS has been involved in?
- What were the key differences, or indeed similarities, between your locality's previous processes and THRIVE principles that stood out to you when you began your role? What has been done in your locality to align these processes to THRIVE thus far? How successful do you think this has been?
- Do you know of any examples of how the changes that have been made so far have been embedded into long-term policy?
- Have there been any negative or unintended consequences of implementing THRIVE, that you've seen in your locality? Either formally, or through word of mouth?
- To what extent do you believe that the effort you are putting into implementing THRIVE matches, or will match, any benefits that your locality will see in the long run?

Others:

- In what ways does THRIVE feel different from other implementations or new ideas that you've experienced at work?
- Thinking back to how things were before THRIVE came along, what are the main things that have changed for you? **Prompt:** did you have any frustrations or problems

that THRIVE has resolved? Are there any frustrations that still exist that you wish THRIVE had have resolved?

- Have you witnessed any negative consequences of THRIVE? **Prompt:** For example, reports from other staff or CYP/families, or perhaps any statistical changes that you know of?
- To what extent do you believe that the effort you are putting into implementing THRIVE matches, or will match, the benefits that your institution will see in the long run?

Training:

Top-down implementers:

- From your perspective, how does the i-THRIVE training academy actively promote the aims of GM i-THRIVE?
- How well do you think that the message is getting across? Could you give some examples of where you have seen sustainable practices taking place?
- How are gaps in staff's knowledge and skills being identified? Is this process ongoing?
- Do you feel that there is enough staff capacity and support to carry out the new requirements? And have the new requirements altered job descriptions in any way?

THRIVE leads:

- From your perspective, how does the i-THRIVE training academy actively promote the aims of GM i-THRIVE?
- How well do you think that the message is getting across? Could you give some examples of where you have seen sustainable practices taking place?
- How are gaps in staff's knowledge and skills being identified? Is this process ongoing?
- Do you feel that there is enough staff capacity and support to carry out the new requirements? And have the new requirements altered work schedules and job descriptions in any way?

Others:

- Did you take part in any of the GM i-THRIVE training academy sessions? Which one(s)?
- Did you find them useful? In what ways?

- **If did attend:** have you been able to share your knowledge from the training with your colleagues? Has much time been dedicated to this?
- **If didn't:** what knowledge or information have you received from others who have attended some sessions? Was much time given to feeding this information down to you?
- Do you feel that you have enough capacity and support to carry out the new requirements? To your knowledge, has your work schedule and/or job description been altered at all as a result of the new requirements?