Factors Impacting the Implementation of a Psychoeducation Intervention Within the Mental Health System: a Multisite Study Using the Consolidation Framework for Implementation Research

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Abstract

Background Despite a strong evidence base and policy recommendation supporting the implementation of psychoeducation interventions within the mental health system, equitable access for many service users and family members has not been achieved. To enhance translation, developing an evidence-base around the factors that influence implementation of interventions is critical.

Methods The aim of the study was to explore the factors influencing implementation of a group cofacilitated recovery focused psychoeducation intervention. The study design was explorative qualitative descriptive, involving the collection of data through individual and focus group interviews with key stakeholders (n=75) involved with the implementation within 14 mental health sites in the Republic of Ireland. The Consolidation Framework for Implementation Research (CFIR) was used as a conceptual framework to guide data collection and analysis.

Results Key enablers and barriers were identified across all CFIR domains of the framework with some factors (depending on context) being both an enabler and a barrier. National policy; structural stability with national systems; leadership at all levels; peer payment system; local champions and support from multidisciplinary team members; evidence strength and quality of the programme design; availability of resources; referral pathways; knowledge, beliefs and self-efficacy of facilitators, as well as local culture influenced implementation. While some were specific to the programme, many barriers reflected systemic and structural challenges within health services more generally.

Conclusion: Findings from this study provide an enhanced understanding of the different layers of determinants to implementation of an intervention. Overcoming challenges will involve positive and ongoing engagement and collaboration across the full range of stakeholders that are active within each domain, including policy and operational levels. The quality of leadership at each domain level is of crucial importance to successful implementation.

Background

In response to the global mental health policy aspiration of 'recovery-oriented care' [1, 2], the epistemological orientation of Mental Health Systems (MHS) are undergoing a period of tremendous change. Meaningful realisation of the recovery ethos into routine practice mandates systemic shifts at structural, organisational and practice levels. Entrenched traditional models of care in MHS are being reorganized to re-orient the service ethos towards the promotion of hope and self-determination, and strengthen competencies in developing egalitarian partnerships and co-production [3]. In some countries significant investment into developing, implementing and evaluating pro-recovery interventions has ensued including peer support services, advanced directives, Wellness Recovery Action Plans (WRAP), illness management and recovery programs (IMR) and so on [4–5]. A progressive portfolio of empirical research examining service and client outcomes, such as efficacy, efficiency, safety, and acceptability, have emerged to inform consensus appraisal of evidence-based practice and the development of

intervention manuals and best practice guides. However, like most human systems, mental health services are resistant to change and while this extensive empirical evidence-base is building consensus on best practice [6, 7], many countries continue to report that there “has been more progress made in envisioning a ‘recovery oriented system of care' than in implementing one” [8 p. 1094].

Two decades ago, Grol and Grimshaw [9] made a request for evidence-based practice to be complemented by evidence-based implementation, a plea arising from the notoriously lengthy time it took for research to be translated into practice and/or policy. Indeed, a recent review estimated that it takes 17 years for just 14% of original research evidence to be instituted into clinical practice [10]. The limited focus of research examining patient and provider outcomes of new health interventions has provided little evidence about why similar interventions succeed or fail in different settings. Consequently, lack of knowledge about key determinants that can inhibit or enable implementation can result in wide variations in the manner in which an intervention is implemented.

Despite these shortcomings, the science of Dissemination and Implementation (D&I) is advancing, with increased funding directed towards narrowing the longstanding phenomenon sometimes referred to as the “efficacy-effectiveness gap” [11]. Today there is a greater appreciation that demonstrating effectiveness is insufficient to promote adoption and sustainability of evidence-based interventions [12]. To enhance the uptake and embed innovations into everyday practice, a broader research focus is required, one that extends beyond effectiveness to encompass the inter-related and multi-level contextual factors (e.g. related to the intervention, individual, implementer/provider, organizational, policy levels) which dynamically interact in the real-world, natural environment of the health system [13, 14].

Similar to all non-pharmacological interventions in mental health care, the translation of psychoeducation’s proven efficacy into routine mental health care has endured a protracted and challenging path. Despite the strength of the evidence-base in relation to psychoeducation [15–20], and its successful integration into policy recommendation and clinical guidelines [21–24], equitable access for many service users and family members has still not been achieved [25]. Alongside nascent research exploring the implementation determinants of one to one psychoeducation [26–29], a recent scoping review [30] reported some participant, practitioner, intervention, organisational and structural barriers and facilitators to group psychoeducation. While the review provided useful insights, the authors noted several methodological limitations of the included studies which restrict the generalisability of their findings, including heterogeneity of study design and a narrow focus on one stakeholder perspective and one site of implementation. In addition, they highlighted the absence of studies informed by an implementation theory or framework, which resulted in limited cohesion in study findings and unexplored fields of inquiry.

In order to build a stronger evidence-base and thus facilitate the development and testing of implementation strategies, there is a need for more robust, larger-scale studies, informed by theories of implementation. Indeed, given the assertion that implementation is the bridge between the decision to adopt an intervention and its routine use in practice [31 p. 3], developing an evidence-base around the

factors that influence the implementation of group psychoeducation interventions is critical. To address this issue, with the support of grant funding, this study utilised the Consolidated Framework for Implementation Research (CFIR) [31] to examine determinants affecting the implementation of two group psychoeducation programmes for service users and family members, into mainstream mental health services in the Republic of Ireland.

EOLAS Intervention

The intervention (called EOLAS, which is the Irish word for knowledge) consists of two parallel structured psychoeducation information programmes (one for people who have been diagnosed with schizophrenia spectrum or bipolar disorders and a parallel programme for their family members or other supporters). Both programmes were developed in collaboration with service users and family members and are jointly facilitated by peers (service users and family members) and clinicians [32], thus combining lived experience with clinical knowledge and expertise. The programmes consist of 8 weekly sessions of approximately 90-minute duration, with some sessions being delivered by a guest speaker who has been selected in conjunction with the participants, (to date that is usually a psychiatrist). Potential participants are referred to the programme by members of the multidisciplinary Community Mental Health Team. All facilitators (clinicians and peers) undergo a four-day training programme, where they learn about the programme and are supported to develop co-facilitation skills. In addition to facilitators having a handbook to guide them through the programme, participants also receive a handbook, which they can take home and use as a resource of information after completing the programme. Maintaining fidelity of the programmes to the EOLAS model is overseen by a Steering Committee that is representative of relevant stakeholders, including service users, family representatives, clinicians, academics and funders. More detailed information on the co-design, content, facilitator training and impact of the EOLAS programmes has been reported previously (Inserted after review).

Methodology

Aim

The aim of this current aspect of the study was to explore the factors influencing implementation of the EOLAS programmes.

Methods

While a randomised control trial is considered a gold standard for evaluating the effectiveness of an intervention [33], it is limited in its usefulness in understanding factors that influence the implementation process for psychosocial interventions. Therefore, the study design for the current study was explorative qualitative descriptive, involving the collection of data through individual and focus group interviews. Qualitative descriptive research is directed at providing an in-depth description of an experience or event [34] and enables researchers to develop a deep understanding of the phenomena under study. The Consolidation Framework for Implementation Research (CFIR) [31] was used as a conceptual framework to guide data collection and analysis. The CFIR is a meta-theoretical framework designed to guide the

appraisal of implementation contexts, including the factors that might influence implementation. The framework consists of five domains: outer setting, inner setting, intervention characteristics, provider characteristics and implementation process. Table 1 provides an overview of the framework.

Data collection

Data were collected using semi-structured, audio recorded interviews (one to one and focus group). Due to limited resources and a desire to capture the views of as many participants as possible from services that were geographically spread, the research group decided to provide potential participants with the option of either a focus group interview or an individual interview. The option of a focus group also facilitated the collection of data from potential participants who were meeting as a group for other EOLAS related issues. The purpose of the interview was to explore participants' views on the factors they believed enabled or hindered the implementation of the intervention. The team developed an interview schedule to guide data collection which was based on the Consolidation Framework for Implementation Research (CFIR) [31]. The interview guides developed for this study are provided as supplementary materials (Additional Files 1-5). To ensure consistency in data collection the same schedule was used for both the individual and focus group interviews and reviewed by some of the research team after the first round of interviews. Two members of the research team (RM and JB), who were not well known to the participants, collected the data between late 2018 and 2019. Both interviewers were female; one was a postdoctoral researcher with extensive experience in qualitative research and the other had an academic education in psychology.

Recruitment

Using purposive sampling participants were recruited from 14 mental health services involved in delivering the intervention, ensuring a geographic spread, mix of health care areas, and urban and rural representation. Based on their ability to inform the study objectives, participants were selected from different groups of stakeholders and different sites, including sites where implementation had been more or less successful. For recruitment, potential participants who had previously provided consent to be contacted by the EOLAS project team were sent a letter of invitation and a participant information leaflet (PIL), together with an invitation to contact a member of the research team if they were willing to participate, in either an individual or focus group interview. The PIL contained aims of the research and information on data collection and consent process. Once a potential participant made contact all questions were answered and a time for either an individual or focus group interview was arranged. Interviews were either conducted face-to-face or by phone, depending on participants' preferences, and took place in a hotel, mental health service or university. Interview duration varied between approximately 30 minutes to one and a half hours. Fieldnotes were recorded after each interview.

Ethical approval and access to participants

The University's Research Ethics Committee (Reference Number 170901) and the ethics committees of the services involved provided ethical approval. The Director of Nursing at each site provided permission

to recruit participants within their service following communication with a member of the research team. Participants were given written and verbal information about the study and were required to provide written and verbal consent for the interviews. In addition, the principle of process consent was applied [35], thus the researchers sought verbal consent throughout each encounter. Participants were also informed that they could review the transcripts if they so wished, no participant took up the offer.

Data analysis

Interviews were transcribed and the transcripts were cleaned to remove any identifying information. All data transcripts were managed and analysed using NVivo version 12 [36]. Using framework analysis data were systematically coded to each of the domains of the CFIR framework [31]. The coding process moved through several iterative coding phases, paying particular attention to the 'goodness of fit' [37] between the data and the relevant construct and its definition within each domain. To enhance the rigour of the qualitative analysis, data were analysed by more than one person (RM, CD and AH) and findings compared. While definitions of each domain and construct within that domain was agreed prior to analysis, the authors acknowledge that in reality some of the constructs overlapped, which required discussion and agreement by consensus, to ensure consistency in data interpretation and avoid overlap in the final write up. Merging of data from different sources was feasible, allowing findings to emerge across all domains, although some groups of participants did speak in varying depth to a specific domain, depending on their role. The frequency of data recurrence and the absence of no new information, indicated that data saturation was reached.

Results

Participant characteristics

In total, exceeding the teams anticipated target, 75 people participated in the study, 42 in one-to-one interviews and 33 in focus group interviews. Participants included EOLAS co-ordinators (n=16), EOLAS facilitators (clinical n=12; peer n=25), programme participants (n=16) and other key stakeholders (n=6). The co-ordinators had been working in mental health services for 16 years on average (M=16, SD=11, Range= 3-40 years) and involved in EOLAS for approximately three and a half years on average (M=3.43, SD=1.89, Range = 1-7 years). Similarly, clinical facilitators reported working in mental health services for 16 years on average (M=15.58, SD=8.93, Range= 4-29 years), had been involved with EOLAS for four and a half years on average (M=4.5, SD=2.38, Range = 1-6 years) and on average had delivered programmes three times (M=3, SD=1.83, Range= 1-5). On average, the peer facilitators had delivered the EOLAS programme twice (M=2.29, Range = 0-7), with 18 peers reporting that they were facilitating EOLAS at the time of data collection. The majority of intervention participants had completed the programme within the previous year (n=8), while seven had completed the programme more than one year previously. The stakeholders consisted of EOLAS Steering Committee members (n=3) and project workers (n=3) who had been employed to support the development and roll out of the programme. In the interest of confidentially

no further information on the group was collected. A breakdown of the profile of interviewees is given in table 2.

Enablers and Barriers of Implementation based on CFIR

All participants described a highly complex range of factors that mapped to the domains as follows: outer setting (180 code units); inner setting (408 code units); characteristics of the intervention (345 code units); provider characteristics (299 code units) and the implementation process (519 codes units). All groups identified issues across all five domains, bar the programme participant group who mainly contributed to the 'characteristics of the intervention' domain. Figure 1 provides a breakdown of the number of enabler and barrier codes per domain.

Analysis of the data identified enablers and barriers across all five CFIR domains, with some of the factors identified as being both an enabler and a barrier depending on context. Figure 2 provides an overview of the findings per domain and Table 3 provides data to support findings in each domain.

Domain A: Outer Setting

The Outer Setting focuses on the socio-cultural and infrastructural context in which an organisation resides [31]. Within this domain four key factors were identified; policy, instability intrinsic to the statutory agency, payment, and infrastructure.

In terms of policy there were mixed views, with some participants expressing the view that EOLAS' compatibility with the national recovery agenda, and the fact that it was referenced in national mental health documents were an endorsement which gave the programme legitimacy and facilitated its promotion within local services (A1-A2). In addition, some contributors viewed the independence of EOLAS as critical to its success, being developed and co-ordinated by a steering group independent of the Health Service Executive (HSE), and ensuring ongoing fidelity to the EOLAS model (e.g. in training, co-production and co-delivery). This group expressed concern that full assimilation of EOLAS into HSE structures would result in a loss of fidelity to its ethos (A3-A4). On the other hand, other contributors commented on the fact that the external positioning of EOLAS potentially led some stakeholders to consider it to be an 'addendum' programme and made the EOLAS Programmes more vulnerable if choices were to be made regarding funding (A5-A8).

The second factor identified as a barrier to implementation related to the structural and personnel instability intrinsic to the Health Service Executive (HSE), the statutory agency tasked with the delivery and management of the public health services in Ireland, and who were the funders of the programme. Senior personnel within the HSE who were key to supporting the implementation transitioned out of roles and as a consequence the EOLAS steering group were constantly building and renewing relational ties with funding decision makers and educating them about the unique features and benefits of the programme (A9-A10).

The third factor identified was the payment of peer facilitators. All participants agreed that payment of peers was an important enabler as it valued their contribution and ensured they were not out of pocket; however, they were adamant that the model of payment operated by the health service for peer delivered programmes (including EOLAS) was a significant barrier. In their view it was causing significant distress to some service users and family peer facilitators, due to its unwieldy nature, and as a consequence had adversely affected social welfare payments, (including cuts to social welfare and other entitlements or incorrect and untimely payments) and added to the workload of local co-ordinators (A11-A14).

The fourth factor impacting implementation related to the infrastructural context in which the mental health service operates. The lack of public transport, particularly in rural areas, was identified as a barrier to people accessing EOLAS (A15-A16). Clinical facilitators and coordinators emphasised the importance of taking people's transport needs and their fears of going out in the evenings into account when arranging the location and timing of the programmes (A17-A19).

Domain B: Inner setting

Inner Setting is defined as the internal socio-cultural context of the organization in which an innovation is being implemented (e.g. cultural, leadership, values, innovation climate, organisational capacity) [31]. Within this domain the following issues were identified: culture, implementation climate and readiness for implementation.

From a cultural perspective, the degree to which a recovery approach to mental health service provision was embedded within the organisational culture and practice was viewed as a critical factor (B1-B2). As co-production and co-facilitation represented a significant cultural shift, where services were promoting service user participation there was a greater openness and willingness to implement the programme (B3-B4). In contrast, in those services that had not fully integrated recovery principles, and where the medical model was perceived to dominate, the pace of implementation was slower (B5-B8).

In terms of implementation climate, there were mixed views on the degree to which the programme's alignment and compatibility with the principles and values of recovery facilitated its acceptance and smooth integration into work plans. Some people believed EOLAS was an efficient way to fulfil the organisation's local commitments to delivery recovery-oriented care (B9-B10). However, others considered that its recovery orientation was a barrier in some settings, such as acute inpatient care. In this context EOLAS was not viewed as a natural fit, as the emphasis within such services was on containment rather than recovery (B11).

In terms of implementation readiness, there was a consensus that organizational leadership and resources were critical. In services where senior nursing and medical personnel proactively promoted the EOLAS programmes, this greatly facilitated implementation (B12-B13). These key stakeholders not only leveraged their managerial position to promote integration of EOLAS into services' plans and operational processes (B14-B15), but they enabled information about the programmes to be transmitted through services, increasing buy-in at local level (B16). In addition, they adopted a flexible approach to time

management, which facilitated clinical staff to manage the demands of their workload, while contributing to EOLAS implementation e.g. time in lieu (B17). In contrast, where there were difficulties in engaging the support of senior clinicians, programmes were delivered in a more ad hoc manner and not fully embedded within services (B18-B19). Similarly, where there was a consensus among Multidisciplinary team (MDT) members around the importance and value of the programme, support for implementation was achieved across teams (B20-B21). However, implementation was hindered in teams were there was a lack of buy-in among team members (B22), and particularly consultant psychiatrists (B23), or where there was an over-reliance on one discipline or individual champions to implement the programme (B24-B25). Where this occurred, there were significant challenges in generating referrals and enlisting MDT members as guest speakers.

Another aspect of implementation readiness is resources. In terms of resources, where few competing programmes existed, the allocation of resources to support the delivery of EOLAS was straightforward (B26). However, as the number of recovery-oriented programmes increased, competition between programmes emerged. This decreased the availability of support, and personnel to EOLAS (including potential programme participants, as many of the same services users/family members were being targeted for participation in other programmes e.g. Behavioural Family Therapy, WRAP, Early Intervention in Psychosis Program) (B27-B28).

The level of human resources dedicated to implementation was also an issue. In some services a surplus of facilitators existed which enabled services to accommodate unexpected facilitator absences (B29-B30). Other services experienced difficulties because facilitators (clinical and peer) dropped out due to changes in circumstances (B31-B32). In addition, the availability of time was consistently reported to be a key factor influencing implementation. Some were of the view that their co-ordination or facilitation roles didn't impact greatly on their current workload, either because the programme operated outside of clinical hours or they had a sufficient degree of flexibility within their roles to enable them to manage their schedules, including receiving time in lieu (B33-B34). In contrast, others reported difficulty in finding adequate time for the planning and preparation required by the programme, either due to the lack of protected time or because the role was considered an add-on to an already cumbersome workload (B35-B36). In similar vein, some reported challenges in securing protected time for staff to attend the EOLAS training programme.

Some services provided venues from within their existing room complement, whereas others, who wished to run the programme in a community setting, experienced difficulties securing venues (B37-B38). The final resource issue was an absence of a system of data management, which prevented teams from being able to systematically identify individuals and families who might be eligible to participate in EOLAS (B39-B40).

Domain C: Intervention domain

The intervention domain focuses on aspects of the intervention. Within this domain six key factors were identified: design; evidence strength; relative advantage; trialability; adaptability; and complexity.

In terms of design, participants reported that the 'ready-made' manualised programme was an important enabler for a number of reasons. Where participants perceived they had deficits in service provision or had limited resources to develop programmes to respond to the needs of people with severe mental health problems and/or family members they reported finding the 'ready-made' nature of the programme appealing (C1-C3). In addition to the handbooks being perceived as well-written and user friendly (C4-C5), they were deemed to be a comprehensive source of information for service users and family members (C6-C7). The Facilitators Handbooks were viewed as providing structure, support and guidance on delivering the programme as well as aiding facilitators to open communication with participants (C8-C11). While the handbooks were appraised as effectively bypassing the time and resource challenges participants encountered when trying to establish similar initiatives, there were mixed views around the referral aspect of the design. Participants understood the rationale for referral through the Multi-Disciplinary Team (MDT) e.g. to ensure that only people with the relevant diagnoses were referred and that participants had ready access to support from the MDT if needed (C12-C13). However, some contributors felt that the referral pathway (through Community Mental Health Teams) contravened the ethos of recovery, on the basis that all recovery education needs to be embedded within community facing initiatives, such as recovery colleges (C14-C16). In addition, some perceived the referral pathway as limiting the opportunity to advertise and promote the programme outside of local services, in-turn impeding recruitment of sufficient numbers to sustain the programme on an ongoing basis (C17-C18).

Participants noted that the information within the handbooks was strongly evidence-based, which enhanced their legitimacy and credibility and buy-in within services (C19-C20), with many viewing the piloting and evaluation of the programmes as an enabler. In their view, these ensured that key informants were consulted about the content, structure and delivery of the programme and the information gleaned in turn informed the ongoing development (C21).

The programmes were also perceived to have a number of relative advantages compared to other interventions, including filling an educational void in relation to psychosis and severe mental illness (C22); being suitable for people recently diagnosed and starting their recovery journey (C23); and having the potential to run alongside other interventions (e.g. Behavioural Family Therapy, WRAP), thus providing service users with a stepped pathway to recovery (C24). In terms of adaptability, there were mixed views. While some facilitators were of the view that by its nature, a manualised programme was rigid and lacked a certain amount of flexibility (C25-C26), most were of the view that the programmes offered a fair degree of flexibility which enabled them to be responsive to the needs of programme participants (C27-C28) as well as enabling them to harness different theoretical perspectives (C29). Some were of the view that the duration of the programme acted as a barrier, with the 8 weeks being a considerable commitment for participants (C30-C31).

The extent of work involved in organising programmes acted as a barrier, as participants perceived it as a complex intervention to implement. Co-ordinators recounted the numerous tasks that had to be fulfilled in order to advance implementation, including recruiting and training facilitators, relationship building with and between facilitators, securing venues and guest speakers, promotion and awareness raising amongst

their colleagues, prompting colleagues to refer, assisting with payment difficulties, assisting with the research evaluation and reporting progress back to managers (C32-C33). Although each task in isolation was not particularly onerous, cumulatively they were time-consuming in the context of coordinators and facilitators existing workload (C34-C35).

Domain D: Provider Level

Provider is defined as 'Aspects of the individual provider who implements the innovation with a patient or client'. In the context of EOLAS this included both the clinical and peer facilitators. Within this domain three key factors were identified: Beliefs about the Intervention; Self-efficacy; and Other Personal Attributes.

While some participants were of the view that some members of the mental health teams still lacked knowledge about the programme which impeded their ability to promote it (D1-D2), participants themselves highlighted the need for such programmes (D3-D5) and had a belief in their own ability (self-efficacy) to deliver them (D6-D7). Facilitators' self-efficacy was attributed to the Facilitator training programme, regular practice, and prior facilitation experience or clinical experience (D8-D10). In terms of other personal attributes, facilitators were of the view that having the ability to communicate compassionately and engage group programme participants, manage group dynamics, manage dual identities (as facilitator and as clinician/peer), negotiate potential tension between content delivery and time constraints, and navigate a non-hierarchical co-facilitation relationship, were important for effective facilitation (D11-D14). While some facilitators felt they successfully expressed these competencies, others recounted challenges. Clinical facilitators recalled struggling with letting go of their 'expert' status and hierarchical position (D15), while some peer facilitators reported struggling with managing their dual identity of co-facilitator and service user, and in establishing an equal partnership with clinical co-facilitators (D16-D17). Job flexibility and family support enabled some family facilitators to participate (D18-D19), while conflicting commitments and ill-health limited the availability of some service user facilitators (D20-D21). Finally, participants considered that a key enabler was the personal motivation and commitment of each individual involved. Facilitators who were motivated and committed were deemed to continuously promote the programme, follow-up on recruitment efforts, engage with and support potential programme participants and make themselves available to deliver the programme when needed (D22-D24). However, some participants noted that motivation was limited to a core group of dedicated individuals (D25-D26).

Domain E: Implementation Process

In terms of implementation key factors identified included planning, engaging key stakeholders and champions, and evaluation.

In terms of planning, identifying formal leaders was of key importance. The hiring of project workers to coordinate the overall project and the establishment of local steering groups within services was viewed as critical. The role of the project worker was not only critical in introducing services to EOLAS and

encouraging them to adopt it, but they provided ongoing support to co-ordinators and facilitators on day to day issues (E1-E2). Having a local steering group that comprised all stakeholders was also central, as this group mapped the local pathway to rolling out EOLAS and addressed issues and concerns related to resources, recruitment, and promotion (E3-E5). Many services also appointed a coordinator to oversee local implementation. Having a coordinator with status, credibility and who was capable of influencing and persuading key influential people (E6-E7), was vital to getting EOLAS off the ground. While the coordinators' activities varied from service to service, coordinators who linked with, and supported clinical facilitators was a key enabler (E8-E9), as successful implementation depended on them working together to plan advertising, dates, venues, guest speakers, and secure and follow up on programme participant referrals (E10-E11).

Successful implementation also involved recruiting and engaging key stakeholders, such as consultant psychiatrists. Securing buy-in from consultant psychiatrists was critical, as they were perceived as a powerful group with significant influence on a team's approach to care (E12-E13). Coordinators and clinical facilitators spoke of using a number of strategies to engage this group, including presenting evidence from evaluations to having family members and service users make presentations about EOLAS at medical fora (E14-E15). When support (beyond verbal tokenism) was not achieved, referrals to the programme were not forthcoming (E16-E17). In addition to consultant psychiatrists, the recruitment of facilitators was considered critical. While recruitment of clinical facilitators was through word of mouth within services, recruitment of peer facilitators was more challenging. Factors that supported recruitment of peer facilitators, included clinicians having well established connections within community settings and knowing which service users and family members might be interested in becoming a facilitator (E18-E19). From a peer perceptive, a key enabler was the credibility and nature of the interaction they had with the clinician or project worker who issued the invitation (E20-E21). Once recruited and trained, part of successful implementation involved co-facilitators (and sometimes coordinators) meeting prior to and after each session, to plan sessions and foster collaborative, non-hierarchical working relationships (E22-E24). Clinical facilitators and coordinators also described the importance of supporting the wellbeing of peer facilitators (E25-E26), as well as ensuring that all trained peers got opportunities to facilitate programmes (E27).

Successful implementation was also attributed to having multiple dedicated and active local champions (coordinators, clinical facilitators, mental health nurses) within teams who constantly kept EOLAS on the agenda by promoting it at meetings, and continually engaging and following up with colleagues to create an awareness and understanding of EOLAS and to increase referrals (E28-E30). In contrast, in services that depended on a single champion, the loss of this person through turnover or role change threatened implementation (E31-E32) and succession planning for staff turnover was felt to be needed (E32-E33).

The formal evaluation and feedback processes that was built into the EOLAS process were also perceived as an enabler, as this enhanced buy-in among clinical and management personnel (E34-E35), and enabled participants to identify ways in which EOLAS implementation could be improved (E36). While the evaluation process was an enabler, the time-consuming nature of producing and updating the

programme handbooks was an unanticipated barrier, as delays in the availability of up-to-date handbooks slowed down implementation within sites for a time (E37-E38).

Discussion

The purpose of this study was to explore the factors mediating the implementation of recovery-oriented psychoeducation interventions. Using the Consolidation Framework for Implementation Research (CFIR) [31], key enablers and barriers were identified across all five domains, with some factors (depending on context) being both an enabler and a barrier. To our knowledge, this is the first study that used an implementation theory to explore factors influencing implementation of a group psychoeducation intervention.

Introducing a new intervention into a mental health service is not just a local phenomenon [38], but an endeavour that taps into the 'complex relations between the healthcare system and the outside world….' [39]. To date, examination of determinants (such as mental health policy and national health system governance) on the adoption and implementation of psychoeducation is limited. In this study, the epistemological alignment of EOLAS to national recovery-oriented mental health policy [40, 41] and other HSE recovery documents [42, 43] proved to be a strong enabling factor to local service adoption, as local decision makers perceived EOLAS to be apt model for the effective integration of recovery-oriented care into local service provision.

While the presence of a National policy on recovery [40, 41] has a major influence on programmes such as EOLAS, policy alignment is not always sufficient, as policy is constantly evolving in response to changing societal and political expectations. In addition to this natural evolution in social and political priorities, the Health Service Executive (the body charged with the implementation of national health policy) has also been subject to recurring phases of structural and personnel change (e.g. moving from the delivery of mental health services through a National Division for Mental Health, to new localized structures). This flux in health service structures and personnel, as identified by participants in this study, also added significant challenges, such as the need for repeated engagement to build relationships of trust and credibility with newly appointed decision-makers who controlled the allocation of financial resources.

In addition, the nature of the governance of the programme was also an issue as it was perceived to be independent of national and local service structures. Whilst independent governance has advantages, such as enhanced control of fidelity, it can introduce vulnerability, particularly when competing initiatives emerge which are fully integrated into national as well as local governance structures. In this landscape, an independently governed intervention such as EOLAS can ultimately be perceived as an 'optional extra' to service provision and consequently experience challenges in securing financial and personnel prioritization from senior health service managers. This finding highlights some of the challenges in achieving a balance between independent governance and sustainable integration of an intervention within existing statutory services, an area that has received scant attention in the literature and is worthy

of further study. Of note, the independent governance of some programmes, such as Behavioural Family Therapy (BFT) and Wellness Recovery Action Plan (WRAP), both located outside of Ireland, do not appear to cause similar concerns for contributors. The reason for this disparity in organisational attitudes to domestic as distinct from programmes originating overseas is unclear.

While these findings highlight how factors in the outer domain of policy influenced adoption, within the inner setting, the importance of strong and credible leadership across all levels of the mental health service to the implementation of EOLAS emerged as a central theme. This leadership helped to successfully negotiate inter-organizational relationships and supported the cultural shift towards recovery and, by extension, inclusion of co-production and co-facilitation strategies. Where influential and engaged leaders existed at senior level within organisations, other key stakeholders were brought on board to support and deliver the programmes, champions of the programmes were facilitated at lower levels, and resources (including flexible work practices) were made available. This lends credence to findings from other studies who report on the centrality of synergistic leadership and managerial support across mental health services when implementing psychoeducation programmes [44–46]. It also highlights how the success or failure of implementation can rest on leaders' ability to navigate vertical and horizontal inter-organizational relationships [47–48].

The implementation of any complex intervention and transition from initial adoption to routine practice is "a nonlinear process characterized by setbacks and unanticipated events" [13 p. 610). Similar to other studies, the efficacy of the intervention was cited to be a critical facilitator to implementation [30]. The intervention's rigorous development, piloted feasibility, tested efficacy, and evidence-based handbooks convinced many stakeholders of its value. Of equal importance was the intervention's ability to integrate harmoniously with ongoing efforts to develop a recovery focussed ethos within local services, which supported its adoption. However, there were elements of the EOLAS programme structure that were felt to hinder implementation, such as the referral process. The challenges of securing referrals and the importance of engaging continually with clinician providers, especially consultant psychiatrists, to normalise the referral process within work practices has also been a challenge in other programmes [45, 49, 50]. Contributors in this and other similar studies report that some consultant psychiatrists harnessed their position as team leaders to support multidisciplinary teams to adopt recovery-oriented approaches such as EOLAS. On the other hand, where the psychiatrist was not on-board, obstacles ensued. In this regard, the recent publication of the Position Paper on recovery published by the College of Psychiatrists of Ireland in 2020 [51] is welcome, as not only does it outline how psychiatrists can embrace recovery principles but highlights the role of the EOLAS Programmes (e.g. including a psychiatrist as a 'guest speaker') as an example of the collaborative approach that is fundamental to recovery, and one that supports the diffusion of recovery principles in clinical practice [52].

Consistent with other studies that have explored barriers to implementation of group psychoeducation, issues such as access to resources (e.g. of time and venues), operation outside existing work patterns/shifts or over-reliance on a single 'champion' contributed to the difficulties in local implementation [46, 53, 54]. While these are not unique or specific to the EOLAS programmes and reflect

systemic and structural challenges within health services more generally, they once again highlight the importance of strong leadership within mental health services to address these issues.

The study findings also bring into sharp focus the supports required to implement a co-produced and co-facilitated intervention. Despite the positive appraisal of the facilitator training, both clinical and peer facilitators noted challenges in developing genuinely equitable partnerships in practice, revealing that at times they slipped back into their traditional hierarchical roles of 'patient' and 'provider'. Given that the implementation of co-production is in its infancy in mental health services [55–58], this is not a surprising finding and highlights the importance of support during intervention implementation (in the form of informal mentoring or clinical supervision), as well as endorsement by service leaders and senior managers. In the context of coproduction, the availability of a streamlined and hassle-free payment system for peers is of critical importance. Study findings indicate that many peer facilitators experienced challenges around payments. If we are to meaningfully enact parity of esteem between service users and clinicians, the necessary bureaucratic infrastructure needed to achieve it must be firmly embedded. Failure to do so risks imposing undue stress and break down of trust between peers and services, alongside the potential attrition of peer partners. An additional concern identified in the inner domain is the reliance on a small cohort of 'champions' (mostly from the disciplines of nursing and social work) to drive the implementation of EOLAS locally. This highlights the importance of viewing the implementation of change as a 'whole team' challenge, where each discipline and individual shares the responsibility to actively seek out and implement recovery oriented programmes such as EOLAS, rather than allowing this responsibility to be 'siloed' to a particular discipline (such as nursing). Where responsibility is widely shared across the MDT, it is more likely that the experiential learning arising from implementation and the move to recovery orientated practices will be enhanced.

Equally, the findings highlight the challenges of overcoming local interpretation of national policy in relation to recovery. In some services, recovery-oriented care was viewed by contributors as situated in and facilitated exclusively through the community, e.g. as something that must be underpinned by the principal of self-referral, and not overly influenced by the "medical model". Consequently, some staff appraised EOLAS as not 'fitting' with their view of recovery-oriented care. This finding demonstrates that for optimal adoption into routine clinical practice there is a need to move beyond the narrow lens of simply emphasising the value and efficacy of the intervention, towards understanding views, preferences, needs, or demands of potential adopters [12]. The finding is also important, in that the more narrow concept of recovery has the potential to leave people who are at an early phase of their recovery journey without critical information necessary to engage positively with mental health services and has the potential to sideline those who do not have the self-confidence to self-refer to community based resources. These views also continue, perhaps inadvertently, to perpetuate the positioning of the recovery perspective in opposition to psychiatry. A discourse suggesting it is either/or as opposed to both/and, is a perspective that closes debate as opposed to exploring contradictions with an openness to new possibilities and perspectives.

Limitations

The CFIR, which informed data collection and data analysis helped capture both the breadth and depth of implementation determinants and ensured that they were systematically captured and appraised across all domains, thus strengthening the efficiency, generalisability, and interpretability of the findings. In addition to helping the authors to tell a story in an organised and comprehensive manner, by using the CFIR framework and its underpinning constructs, we have contributed to an implementation science evidence base and enabled future researchers to replicate and compare findings from other studies and contexts. However, using the CFIR is not without challenges. Capturing enough depth and specificity across all CFIR constructs within the time limitation of a single interview is difficult to achieve. As a result, nuanced data within a construct, which may be critical to implementation, may have been missed. The number of constructs within each domain also induced complexity during data analysis, particularly in the write up as some constructs appeared to overlap, suggesting a need for further exploration of the CRIF. In addition, further studies are required to identify the most relevant CFIR constructs required for successful implementation as well as longitudinal studies into how an implementation process evolves over time.

While the inclusion of multiple sites and different cohorts of stakeholders provided a triangulated and deepened understanding of factors in real-world settings [10, 59–61] and thus addressed some of the methodological issues identified in previous studies [30], there are several limitations that need to be acknowledged. First the self-selection nature of the sample may have resulted in recruitment bias, with those who were more assertive, confident, and articulate and with strong views opting to participate. As a result, it cannot be assumed that the views and experiences presented represent all of those who were involved in the implementation process. Secondly, the focus of recruitment was on participants directly involved with the programme, thus other opinion leaders such as service managers, consultant psychiatrists or Directors of Nursing not directly involved or those tasked with developing other recovery-oriented initiatives were not involved. The findings are also a result of interviews as opposed to observation of practice and may be influenced by both recall and social desirability bias. In addition, while the researchers endeavored to minimise interpretative bias during the analysis by using the constructs underpinning CFIR and by having more than one person complete the data analysis, there is always the potential for misinterpretation as qualitative data analysis has a subjective element.

Conclusion

The implementation of recovery-oriented change faces considerable challenges and obstacles to sustainability, with change theorists advocating for comprehensive pre-implementation planning, including adequate consideration of how the intervention can be delivered with high fidelity whilst also harmoniously integrating it into existing systems, structures, and workflows. Findings from this study provide an enhanced understanding of the different layers of determinants to implementation of a recovery focused intervention across the range of domains and help illuminate why setbacks may occur. Overcoming these challenges will involve positive and ongoing engagement and collaboration across the

full range of stakeholders that are active within each domain. The quality of leadership at each domain level is of crucial importance to a successful outcome, including at Multidisciplinary Team level, Mental Health Engagement, Service User fora and within professional bodies for mental health disciplines. However, health service management at both policy and operational level have a particular responsibility to find ways of positive engagement with all stakeholders in developing effective implementation strategies that truly respect the value of collaboration and partnership in achieving positive change.

Abbreviations

CFIR: Consolidation Framework for Implementation Research; MHS: Mental Health Systems; WRAP: Wellness Recovery Action Plans; IMR: Illness management and recovery programs; HSE: Health Service Executive; MDT: Multidisciplinary team; BFT: Behavioural Family Therapy (BFT).

Declarations

Ethics approval and consent to participate: Ethical approval was granted by the Faculty of Health Sciences Research Ethics Committee, Trinity College Dublin [Reference Number: 170901] and the ethics committees of the services involved. Participants were provided with verbal and written information about the study, and gave both verbal and written consent to participate in the study. In addition, the principle of process consent was applied by the researchers at each encounter.

Consent for publication: Not applicable

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Tables

Table 1
Overview of the Consolidation Framework for Implementation Research

Domain	Meaning
Outer setting	The wider social/political/economic context in which the organisation is embedded. The focus of this domain is on the organisation's/service's understanding of, and responsiveness to, patient needs, its links with other external organisations, and its competitiveness with peers who have already implemented the intervention as well as the influence of external policies, regulations and incentives designed to promote the intervention.
Inner setting	The structural and cultural characteristics of the organisation/service where the intervention is implemented. This domain addresses the constructs of: culture, leadership, mentoring, networking, communication patterns, the implementation climate in terms of whether practitioners collectively work towards implementing the intervention and the implementation readiness of the service in terms of leadership engagement and resource availability.
Intervention	Intervention refers to the characteristics of the intervention, and focuses on stakeholders' views about the quality of the evidence about the intervention, the quality of the design, its ability to adapt to local needs, how it compares to other interventions and how difficult it is to implement. Also includes costs associated with the intervention and its ability to be piloted.
Provider	The constructs within this domain include: a person's knowledge and beliefs about the intervention, their self-efficacy in relation to providing the intervention, their commitment to their organisation/service, and other personal attributes that may impact implementation, such as motivation, competence, nature of work contract, and past experiences.
Implementation process	The implementation domain addresses activities undertaken as part of the implementation process and includes the constructs of planning, engagement of appropriate individuals, the quality of the execution process and evaluation methods.

Table 2
Overview of interviewees by method of data collection and role in EOLAS

Role in EOLAS	Gender		Individual interview	Focus group
EOLAS Clinical Facilitators	F = 10 M = 2	Nurses = 6 Social worker = 4 Occupational Therapist = 2	2	10
EOLAS Peer Facilitators		Family = 11 Service user = 14	11	14
EOLAS Coordinators (12 with experience of facilitating the programmes)	F = 11 M = 5	Nurse = 8 Social Worker = 7 Psychiatrist = 1	7	9
EOLAS Participants	F = 11 M = 5	Family Members = 12 Service Users = 4	16	
Other Key Stakeholders	M = 4 F = 2	EOLAS steering group n = 3 Project worker (former and current) n = 3	6	

Table 3
Data to support each domain

Domain A: Outer Setting	
A1	They [National Office] put EOLAS in the service plan, you know. And I suppose at a national level that has made a difference. That we can go into services and say look, we're part of the service plan. You know EOLAS is part of that. She [Director of the National Office] has promoted us at conferences; you know all of those things make a difference. They give you a legitimacy. SH2 (II)
A2	There has been a general crystallising of a commitment at senior administrative level [in the HSE] towards recovery and recovery framework. And towards that being an important principle in the development and shaping of services into the future […]. And obviously that is very much a facilitator of maintaining the standing of EOLAS with the senior management structures, within the HSE. Because EOLAS fits so well with that ethos. SH1 (II)
A3	There is an argument for the importance of EOLAS staying outside, as from outside, we can ensure its quality framework and training, we can maintain an independent voice of advocacy, we can ensure the primacy of the coproduction with the inclusion of the EOLAS peer facilitator. SH7 (II)
A4	[...] training in here [EOLAS] is not the same as recovery training over here [ARI's (Advanced Recovery in Ireland) 'train the trainers' training]. And that actually the skills aren't transferable. And if you kind of superimpose one on the other you'll lose potentially…. **Fidelity integrity.** All of those things. The core essence of what makes it EOLAS, exactly. And that they don't transfer. SH1 (II)
A5	I think EOLAS being separate and it remained separate to the actual recovery program within the HSE, began to become more of an issue. Because it was always an add on as oppose to an integral part of. So I think that remains an issue and I think that will also be the downfall of EOLAS unfortunately […] CO5 (II)
A6	And what makes it doubly difficult for EOLAS is […] it's actually outside of the system […]. So I think that outsider piece is very significant to EOLAS in terms of how it actually gets embedded in. And I think there's been an ambivalence about whether there's a wish to have it embedded in or not, all right. SH5 (II)
A7	[…] it's [EOLAS] one single project with two part time workers with no staff employed by the HSE. It's vulnerable I think it's slightly isolated and slightly vulnerable no one questions the ethos of it and I think it's very, very strong it's a fairly kind of strong programme but it's not really kind of embedded I think across the HSE the way some of the other strands are. And because it's a single project no HSE staff I think it makes it a little bit vulnerable and I am not sure everybody sees that yes. SH3 (II)
A8	[…] it's [EOLAS] not translating from management team to front line. And I don't think that's anything to do with anyone in terms of not wanting to do it, but it's not under a program. So if it's not under a program it doesn't then, on a very basis level it doesn't then tick any boxes in terms of your operational planning […] CO5 (II)
A9	And a lot of the influencing is done through human relationship. And not through a formal structure… We put a lot of work into establishing the human relationship with important decision makers… getting access {to senior policy people] is not easy …And we had managed to get ourselves invited to a meeting in the national mental health division last year and made a presentation. And it went swimmingly. Then the structure was changed. The person that you've been cultivating a relationship with is moved. And all of that work in terms of interpersonal work is gone. Because none of it [learning, relationship] stays behind with the post. Only the structures are left. And essentially you've to start all over again. So that's been a real challenge. ISO1
A10	We had a meeting with [Director of Mental Health – HSE]. And [names person] learned about EOLAS and gave us our backing. And they [HSE] put EOLAS into the recovery focus, so that was a huge, huge thing, hugely helped, but then the person moves on. … and every year we have to see if it's going to get the contract [funding], or if it's going to be renewed. IS06
A11	FF6 (FG): So the first say course that we facilitated was this time last year say from September to November. And I got paid just this August gone; I got half of it in July and half in August, or something. **Q: So it took months.** FF6 (FG): Yea now I did, I you know I didn't want to be begging for it. But you know I told my coordinator and she was back and forth the whole time with someone on payroll.

Domain A: Outer Setting	
A12	[…] there was no information about whether doing this course would affect me disability allowance, social welfare. I was kind of led to believe it probably wouldn't affect it but then it did affect it. Now I'm at the stage were social welfare are docking at euros off me, it's very difficult. I've put in an appeal and they said it takes months, but it's been months now since I put in the appeal. SF2 (II)
A13	I've had horrendous experience now with a service user co-facilitator now who had their social welfare cut because they did EOLAS and I've had to appeal that with them and it's just been an absolute nightmare to the point where like they're turned off, and that's a, that's a client of mine that I, I really try to mind through the process, I identified as being a very good resource as somebody who would be brilliant, and they were, they were absolutely fantastic through the facilitator process so much and all this additionality has become a major headache, so the likes of that in terms of actually supporting the, the, your co-facilitators and making sure that they're minded and looked after and that it's a good experience for them has been hugely problematic. CO15 (FG)
A14	[…] it was causing an awful difficult time more so for them, but also for me trying to navigate the system to help them. And at the end of the day I had no background in it [social welfare] and it was really, really disappointing that aspect of it […] CO4 (II)
A15	So I suppose again you come in to a transport issue for people getting from [Large town] up to I suppose where we ran it was [2nd town]. That's [transport] where we felt the greater need was. So that's a 40 minute drive and if you're not driving its 2 buses, so that in itself is a headache. CF1 (II)
A16	And then the challenge of a rural service, you know, getting people in to one location at eight o'clock in the evening on the country roads in November is a challenge I suppose. CO13 (FG)
A17	[…] but then transport links in to [large town] – there's a lot to take on board with it, you know, because we're conscious of that then when we're running it [programme], where people are coming from, bus times, school times, holiday times, there's a lot of stuff. CO1 (II)
A18	I suppose socially and economically in [2nd town in ES07], unemployment is so, so high, access to public transport is very, very poor. So ergo then, if your initiatives are very centralised in [Large town in ES07] or [City in Southern Ireland] it's very hard for people to access anything. So I suppose that was my own personal agenda to get something running in [2nd town in ES07] that people can access easily on their doorstep. CF1 (II)
A19	Yea and it just can be hard to, also to get the timing right. Like so do you run it in the day time, do you run it in the night time? Like people are working during the day. So it's better to run it at night time. But then at the same time it can be hard to get travel you know, to get buses and the dark in the evening, the weather, all of that. So there's a lot of especially in the country, where there isn't that kind of availability of transport you know. CO8 (FG)
Domain B: Inner Setting	
B1	I was just going to say I think it depends on how lucky you are in your area if it is a recovery culture and if your consultant buys in, if you're team is recovery focused […] CF9 (FG)
B2	It depends on how I suppose to be honest how convinced they [senior management] are about the principles of recovery because it's a shift away from just a clinical or kind of medical approach. The approach of having people at the centre of their own recovery and the ethos of EOLAS is that they operate as equal partners in the training and then the delivery of local programmes. SH3 (II)
B3	[…] it wasn't the traditional sort of service. It was very outward looking and recovery focused sort of service, you know what I mean. So that's where the initial programmes were launched, was in [ES12] SH6 (II)
B4	I think in that sense this whole idea of co-facilitation, there was something kind of a little scary about it at the start and […] people are fine with it now because they are so used to it, whereas I think at the start everyone was like oh, I don't, you know, it was, you hadn't done it before and they were, we were like I don't even know what I would say, […] it's just because it was, really we came, you know, like we came from a completely institutionalised hospital based service out to this whole, you know, we were thrown in to this recovery model and it was just such a huge change and it was, it took a while but - it actually didn't take that long – I think people adapted really quickly, once it started coming in to the service people were fine with it and, you know CO1 (II)
B5	No because our team definitely it would be more medically led. You know and it would, like EOLAS would be at the very bottom [of priorities]. CF3 (FG)
B6	[...] the medical model is so entrenched that it's not going to be moved that easily. So any of the recovery work that goes on, it's almost seen as peripheral or extra. And that is the biggest difficulty [...] SH2 (II)

Domain A: Outer Setting	
B7	[…] there's pockets of where it's, it's [EOLAS], you know, very accepted and they're very recovery focused […] and I think it is, there is pockets of a kind of a deeply entrenched cultural attitudes that, that, while they might say they're recovery focused, the practice says something different […] CO14 (FG)
B8	[…] I do hear of other sectors who don't have a recovery ethos and that can be a barrier [to implementation]. Don't mess with my patients or come with your new fangled [intervention/approach}.Yeah, it just depends on I think the areas understanding. CF9 (FG)
B9	We were looking at our IMROC [Implementing Recovery through Organisational Change], which were the IMROC challenges at the time and we were adopting some of the challenges and bringing recovery focus care and recovery focus practice to the way, to the organisation of changes. And we were thinking well there you have a very set piece of coproduced, co-facilitated piece of work that's, you know has been established so there has to be merit in it. CO4 (II)
B10	I suppose there was a big push towards the recovery and really adopting it in to the service, especially when we moved in to our new building, and it just really fit in with everything that we were doing at the time […]. CO1 (II)
B11	[…] it's really difficult to get staff in the acute services interested in what's happening with EOLAS […] So there is a lot of disinterest I would say from our acute staff to engage with things that might actually prevent somebody coming back in and that's a huge problem. CO3 (II)
B12	I do think you know clinical leadership in a team is you know, is very important. Because it does set the tone. And I suppose it's about buy in and attitudes and I suspect that you know every team is different. And you know I know that in our team like [name of psychiatrist] would be very enthusiastic about it. CF5 (FG)
B13	Well we did get that buy in quite early on. But probably as well, for me because I suppose [Consultant Psychiatrist] was very supportive of it as well. That was our immediate link into the area management team from that level. Because I suppose I'm not of senior. CO7 (FG)
B14	[…] people were identified and they were told they were doing it, you know that kind of, I don't mean told they were doing it, but we were all identified and then you know It was expected and you know you had to provide your figures and you had to do it and you had to get your cohort, you worked with your community nurse, you know there was a better level of commitment towards it. CO16 (II)
B15	Depending on who is doing the, the consultant and writing and having the conversation with the person. And often, yeah and once they're discharged it could be, no I've seen it, refer for EOLAS on discharge, refer to EOLAS, I have seen that on their discharge plans when I was working in the area. CO4 (II)
B16	So coming back to the referrals, if you know, first of all you get your executive management team saying; yes we want this in our area. And this message gets out to the local sector teams. That they need to refer and this is the referral process. And this is the person that's going to take the referrals. Then things happen at a reasonable pace. SH2 (II)
B17	We just go into our managers. I don't know who's involved in our sector, we just went to our manager and said we're going to be running an EOLAS in the evening, can we have the time back – **Q: Okay, and managers went "yes".** Sure. CF9 (FG)
B18	[...] but the biggest challenge we have from the EOLAS programme perspective, is in persuading services that this is something we really need to do. You know because you will find pockets of interest in lots of places and there's some great people who really want to do it but you know they're not supported then by the key decision makers within the service to prioritize this as a programme that can really make some difference. FF1 (II)
B19	I have to say in terms of, although initially I'd say like buy-in from senior management was excellent it began to kind of decrease as we moved along yeah. […] The resources really weren't there at that moment in time you know. So I kind of felt that definitely had an impact kind of mid flow of the programmes being rolled out but you know resources certainly weren't as plentiful you know and management kind of saying it's probably a luxury we can't afford really at the moment you know. CF2 (II)
B20	[..] even though there was only a certain few of us within the team going to do it. To be honest everybody kind of bought into it. You know because it did bring a sort of an energy to the place. And you know okay well what about this. So like our colleagues were very willing. **Q: To get onboard as well and buy in?** Yea which suggested you know, such a person might benefit from this. Or I know somebody, or what do you think. So it did bring a whole different energy within the place. CF12 (FG)

Domain A: Outer Setting	
B21	[…] we had lots of support from medical colleagues. We had lots of support from our senior nurse managers and everyone kind of came forward around, you know that this programme [EOLAS] was a tripartite kind of approach to mental ill health. I suppose we would have had, we would have been lucky in the sense, I suppose we were such a new community service at the time that you know, everyone bought into EOLAS and what it could do. […] CF2 (II)
B22	So some teams were slower in fairness [to refer to EOLAS], to you know buy in, or maybe I don't know what it is. But I suppose maybe it's to do just with the characteristics of the team. Or the maybe the consultant [...] CF5 (FG)
B23	But there is other consultants unfortunately that avoid it and just you know, I would've been, like when I went out to sell it initially, I was kind of asked, well how much will I get paid to do this. That was the one question. I got another question, why does a service user have to know what they're diagnoses is. CO11 (FG)
B24	There was just one discipline involved, which was social work. […]. I think that one discipline is not sufficient. You need an active coordinating team to make things happen. SH2 (II)
B25	[…] you will find the dedicated few who actually buy into that. But when we're, we're speaking to the converted. We're working with the converted all the time. So it's to try and get to the people who have, for whatever reason, lost or are fatigued by all of this and just don't believe that it can be done […] FF1 (II)
B26	So there was great excitement and actually got off the ground very quickly, got buy in very quickly because it was the only thing. […] everybody was like let's do this and let's all get excited and the, the clinicians were excited as excited about it as the services and the carers so at the time it worked out brilliantly. CO13 (FG)
B27	Again, I suppose to increase peoples' buy-in because for like the majority of people you know we're all so busy. You know there's 10 different programmes running across the service and it's hard to keep you know EOLAS to the forefront of peoples' minds when you've got 4 different OT groups, WRAP [Wellness Recovery Action Plan] everything else happening as well. CF1 (II)
B28	[…] But the service user's programme I would say, has competed more so with I suppose other programmes that are up and running in that sense that we're drawing out of the same people all the time. CO7 (FG)
B29	Yeah, a lot of our team, the rehab and recovery team, are trained, so it's very easy to get swaps with people […] CF10 (FG)
B30	We do have a couple of OTs [Occupational Therapists] that haven't done full groups for me […] so I would use them to step in if, you know the facilitator needed a night off or couldn't make it or whatever, step in. CO2 (II)
B31	[names local service] more than [names local service] was particularly good at the start. They had some very large groups. Very dependent on nursing and there were issues around release of staff. So that caused problems there. SH2 (II)
B32	I suppose we had just the three [facilitators] and then one girl that was, she just wasn't in a position to do it, and then, she had been doing it, it was just personal circumstances, and then I was on maternity leave, so we seem to have been down to one facilitator, then when I came back the other girl left and it was back down to one, so it's just the, that seems to be the issue everywhere, talking to the other coordinators. CO1 (II)
B33	Yea one of my facilitator was in the evening times, it was outside work hours. So in that sense it didn't eat into clinical time, except you know preparation work might have a bit. […] It was just really managing your own workload really. That you balance it all out at the end of the day. **Q: Well I suppose you all felt that you had the flexibility to manage your own workload?** Yea we did. CF4 (FG)
B34	I suppose we're quite lucky in the independence that we're given in our role to follow the initiatives that we feel is worthwhile to our service users really. So I suppose the only conversation I would have had with my direct line manager about it would have been, being released for the training days and obviously the subsequent time that it was going to take out of my clinical time rolling it out, facilitating groups and all that stuff. […]. I mean there was no issue around time allowed for training days, travel, even being approved to travel to training is you know increasingly becoming more difficult if it's out of area. So yeah very supportive in terms of that. I suppose the logistical side of it. CF1 (II)

Domain A: Outer Setting	
B35	Well I think, again going back to time, like so we're doing this as an add on to our clinical work and I suppose we're exceptionally busy anyway, so finding the time to even, like we're having a, a meeting today just, again just the, the three social workers, about this, that's probably being cancelled three or four times because of our workload, you know, so we don't have any protected time for EOLAS […] CO6 (II)
B36	[…] we still have our day hospital to run. And all our clients that are attending. So to do our working week and then find space to fit EOLAS in CF11 (FG)
B37	[…] we do use our own mental health, our own building, you know, in the evenings, […] And it works, yeah, it works quite well, we don't have those kinds of issues in terms of safety and security CO15 (FG)
B38	So there's always battles about resources, finding even rooms and places to deliver EOLAS. There was hope that EOLAS would be delivered outside HSE premises. Because of the clinical connection, but no money, no nothing. SH6 (II)
B39	There's no app, or you know. System or excel or anything like that for maintaining a database. So we don't have such. So that's the thing. So that's the practical thing. So if you ask the CNS [Clinical Nurse Specialist] who's eligible to do EOLAS within your patient load. They won't know. And how many of them have actually done EOLAS so far, well again they'll be. They won't necessarily be keeping track. SH1 (II)
B40	[…] really it needs a dedicated coordinator, it needs protected time, I think you could easy allocated half a day a week in terms of like maintaining a database, promoting it, seeking, sourcing referrals, the prep of the group, you know, all that administration, the, you know, the planning for it [...] CO6 (II)
Domain C: Intervention Characteristics	
C1	I suppose prior to EOLAS we would have been running family education for years, in [names service]. And both the co-ordinator [and I actually were involved in that. I suppose I felt personally that we needed something more, something with more guidance which was what the EOLAS has given us, in the structure to the programme. CO10 (FG)
C2	[…] it's something we aspired to do but in terms of time commitments we weren't able to kind of get that off the ground or weren't sure what that would look like and how we could involve, particularly family and friends I suppose, but also service users, so it was a very structured way to do it. […] this was like a readymade package, if you like. Yeah. So it, it, that was definitely the most appealing part to it. CO6 (II)
C3	[…] somebody else has already kind of put together for us and kind of let's go with that rather than kind of trying to reinvent the wheel. […] CO13 (FG)
C4	[...] I think the book [the handbook] was written too for people who don't have a background [in clinical practice]. So the book I think was good. It wasn't a difficult, well for me it wasn't you know, it wasn't difficult for me to understand what is in the book. SF11 (FG)
C5	[…] it's [the manual] in layman's terms I suppose, it's all very black and white, you know that kind of way, it's not kind of the doctors spiel on it, it's written for people to be able to understand, yeah, it's great, a bit of everything in it. FP7 (II)
C6	[…] the actual books [the manuals] are very good. They explain a lot and they're you know well divided up and that. CF3 (FG)
C7	Like there's a lot packed into it [the manual] but it's not too much and there's a lot of information that is helpful. I found the booklet very good to have just to breeze over in my own time. SP (II)
C8	**Q. Would you find it difficult doing it I suppose if there was no guidance there or no manuals [EOLAS training manuals]?** A. I would find that difficult yeah because I would probably lose my track of, I find it hard to focus you know and keep to the point like. SF2 (II)
C9	It [the manual] gives you guides you know, that you can let a room take off on its own you know. FF8 (FG)
C10	And you can use kind of parts of it [the manual] to help get a conversation started. SF6 (II)
C11	It [the manual] opens up the conversation in the EOLAS group. FP12 (II)
C12	So we need to probably look at the referral process. I know it's for a specific diagnosis and that's very important and the programme is aimed for people like that. So you can't just self-nominate or self-refer at the moment but maybe there could be some way of because I know people who would love to do the programme and have never even heard of the programme and I might just mention it and it's complete news to them. FF1 (II)

Domain A: Outer Setting	
C13	And it just seems to be that EOLAS seem to have these constraints around it. Being referred only through the mental health teams, which is fine. Because you don't want people coming incorrectly to the wrong course, or whatever. But I still don't see why you can't have posters up in GP [general practitioner] surgeries. Saying what the programme is, to contact the local coordinator […] FF10 (FG)
C14	[…] if we're focusing on say recovery education, service user, family engagement to a specific area and if EOLAS isn't fitting the criteria as in the referral, go back to the referral process. It will get lost in that. So the design is that we have one centre engineering and driving all education information for service users and family members, that it's sort of a centre and it spreads out. So if EOLAS isn't, if the referral thing is catch, if it doesn't fit in there and it's a standalone project, that it doesn't come up for the recovery framework or our local education, recovery education plan […] CO4 (II)
C15	[…] it's [EOLAS] not accessible through self-referral and that is extremely outdated, out moded and its anti-recovery in my view and it's not recovery education at all, it is just not. CO5 (II)
C16	[…] if it's [EOLAS] supposed to be recovery orientated and we're trying to break the traditional way of doing things, it shouldn't really be referral based. I know people, there'd be people who are discharged from the services who would love to do this programme you know and to give them a chance as well. SF4 (II)
C17	And the, and one of the dilemmas about EOLAS being a referral only system and it being, and not being advertised because it is for a very particular group, is that people don't hear about it in the way that they would hear about other programmes. SH5 (II)
C18	[…] if it [EOLAS] was more kind of advertised, advertised in your local shop, or in the local parish. Or that kind of thing that even your local GAA club that kind of, you know each side of the pitch. A lot more people in the community, to be able to come in and do a programme, like the EOLAS. SF6 (II)
C19	And I think the key to it was that this [EOLAS] programme was evidence based. It had quite a bit of work already done and people were more enthused by that. […] I think they [executive management] realised that it had credibility as well. CO11 (FG)
C20	Very much the fact that EOLAS was welcomed into service was the fact of the scientific research that was done on it. Because that impressed the clinicians. Because there was evidence of the benefits of the programme for family members, for service users and for the research also was very good on the impact on clinical people. And how they benefit from it. SH6 (II)
C21	We arranged focus groups around [Irish county] for service users, for family members and service providers. Which was an opportunity for the project workers to just ask questions around like what do you think of this. What, how would you like it to run, what do you think would be most effective. What sort of information, learning material would be useful? You know how do you feel about you know facilitation and how do you think this facilitation should be done. How long should the meetings be for? What sort of venues would suit you best, all that sort of thing? So and likewise service providers you know, what do you think about education for service users. Would you be interested in facilitation? How do you think it should run all that sort of thing? So they did the initial scouting around of, to get the feedback from the ground. SH1 (II)
C22	There's a lot of other good programmes and they might be more specific to people. But EOLAS was only ever meant at the present time for people with psychosis. There is nothing else actually addressing people with psychosis and at that hopefully at that early stage. SH6 (II)
C23	I think EOLAS would almost be the first stage before people start going in to recovery, I think they need that education piece before they start going in to other recovery programmes. CF9 (FG)
C24	I would see it as a complementary thing to say, ARI [Advancing Recovery in Ireland] or WRAP [Wellness Recovery Action Plan]. And I think there's no reason why somebody who's done EOLAS cannot do ARI [Advancing Recovery in Ireland] and also do WRAP [Wellness Recovery Action Plan] also. SF1 (II)
C25	[…] you know when it's so structured to that style, I find that can be counterproductive. Because something could come up that is week 3 or week 6 in week 2, but we'll get to that but no they want the answers there and then. And that's just from my own personal, I suppose delivering or facilitating groups, when I have set my aims, my agenda, my objectives for when people leave here they will have X, Y and Z, and that's fine. That was where I was at until I sat down and stopped and listened to the groups of people that I was facilitating and going, the question is what is it you want to get from this group, what is it and you know whether its sessional pieces, whether it's a full program or a stand-alone piece. I think we need to be more flexible in how we can deliver EOLAS. […] you know sometimes we'd be talking about how else can we deliver it here. […] CO4 (II)

Domain A: Outer Setting	
C26	And unfortunately I do have an issue then with the information as in it's too static, the amount of work that goes into […] but that information is out date already. […] It's a very one, you know it's a one-dimensional information which again it's just too static, it doesn't fit everyone's experience. […] CO5 (II)
C27	Like each EOLAS event is slightly different due to the different participants. So there is a format there and there are topics that are covered but there is a lot of room to sway what exactly is discussed in each EOLAS session due to the people that are there. SP (II)
C28	I think we did probably adapt it, like we found it really useful to have the booklets, to have a kind of preordained, as to this is what we're going to do. But definitely, like the first couple of weeks anyway that I did with the families. We'd a lot of families who were really in the thick of it; you know their loved one was really unwell […]. We'd a lot of emotion; there was a lot of people just in tears you know. So you had to manage that and address it. But you couldn't kind of by the way we have to; this is what's in the booklet. So we now we still got through the stuff. But you know we just had to balance it, as to we had to deal with what was going on in the room. And then once the group kind of formed and settled, it was easier. CF11 (FG)
C29	[…]we felt it [the guest speaker psychiatrist session] was very medication focused. And if you have this, this is your diagnosis and this is the treatment. So at the end, we would always close off with these are other treatment options and these are things. So we kind of managed it that way. CF11 (FG)
C30	I think it's the idea of an eight-week programme. Yeah, it sounds very long and people are saying, oh, you know, on Monday I like to do this or I'm going to be missing a, you know, I'm going on holidays or... or there's something coming up, I'll miss a week […] CO1 (II)
C31	I felt it was a long programme, it was long because it was at the time of day for me, you know, and it clashed with my work days, do you know, so it seemed like every week for eight weeks, it seemed like – and then there was, I think then there was Easter I think in between, so it was a bit of this is forever. FP9 (II)
C32	It means for me as an ADON [Assistant Director of Nursing], like I hate when this group is on because I'm trying to, you know the way (laugh), there's a huge amount of work, there's a huge amount of work anyway because you're trying to get the names, get them organised, organise the rooms, teas, coffees you know I do all that and I just really ask the facilitators to turn up and look after the clinical piece on the night. CO2 (II)
C33	[…] I coordinate it, and, like even though it doesn't take a huge amount of time, but it takes a huge amount of time getting it up and running and I know we're going to be talking about that, but the coordination of it, keeping the names and getting the speakers and that, but it's not a huge amount, but at the same time if you're very busy it is a lot, you know, when you break it down you sort of say Oh God, no, there's not a lot, but when you try to keep it going it is. […] CO14 (FG)
C34	[…] the real challenge is the time pressures in terms of coordination pieces with their other role, that's really the biggest problem for us […] it's the stuff really around, you know, with our co facilitators maybe, you know, getting them set up, you know, in terms of getting our co facilitators set up, […]and making sure that they're minded and looked after and that it's a good experience for them has been hugely problematic. Some of the follow up stuff as well, just in terms of like I suppose the stats and research and stuff like that, like again that that creates, you know, […] it's, it's extra, it's extra work after, like on top of, of the kind of core thing, which is you wanting to deliver that service, so, so that's been, that's been our kind of main issue. CO15 (FG)
C35	I think the challenges for the time that it actually takes. And not that I, I have managed it like on top of a very busy workload. CO7 (FG)
Domain D: Provider Level	
D1	You know there is a kind of a threat in the CPNs [Clinical Nurse Specialists], or that nurse feeling threatened by oh my god, I have to tell people about this. And if they ask me two questions about it I'm not going know the answer, I'll look like an eejit. So maybe I just won't bother mentioning it to them or something. CO8 (FG)

Domain A: Outer Setting	
D2	[…] I suppose to tell a family or to advise a family that there is a group for. You have to know what the group is about. You have to kind of have done your own. And I suppose if the community nurse for example, was kind of, or wasn't involved in the training. Wasn't involved in direct kind of maybe didn't, maybe there was a kind of a reluctance, or unconsciously. Not to maybe. I mean I suspect that if the facilitator was a community nurse. And they were out there, they would be selling it big time, you know. Whereas, I think and I don't have any, I don't blame the nurses, the community nurses. But when you're hard pressed, to sit down with a family and to talk to them about the benefits. And the philosophy even and what kind of, what [is] this. CF5 (FG)
D3	I just loved the whole concept of it and idea of it from the very beginning. So that's kind of what, and I just felt there was such a gap there. CO14 (FG)
D4	And I suppose my interest in EOLAS came about because there was nothing there. I could recognise that there was absolutely no support there for families. No information even certainly and as I say that's from my experience you know. FF10 (FG)
D5	Also, as the weeks went on also I've seen the value in it as well because especially having the lived experience there with the professional knowledge because you can see the lads, we do it actually in this room, and you can see the lads and they light up and they're kind of saying, yeah that sounds very familiar that's happens to me too. SF4 (II)
D6	I would've done facilitation in a previous life kind of you know, in other roles and stuff like that. So I suppose I felt fairly confident in going forward for it. FF10 (FG)
D7	[…] I've worked in mental health for, God, I don't know, eleven years or something, so, do you know, like for me, like I'm fairly confident in terms of that [facilitation] CO6 (II)
D8	Were we ready? I suppose it's only in the doing really that you really learn an awful lot. Very nervous the first few sessions, the first session in particular but in doing it the confidence rose and you know you become better at it. FF1 (II)
D9	You see I worked as a HR person in the private sector. So I would have done facilitation skills and interviewing skills and coaching, you know and developing things. […]. So I would have had that experience and then yeah so and being involved in groups and running groups and I mean I would have done a bit of training in my role as well in my HR role. FF1 (II)
D10	[...] so what they did in the facilitation [training] for the three days, it was like putting us into groups and you know then eventually towards the end, it was you yourself probably getting up and being able to facilitate with the little group that you'd been in or just directing the conversation and you know, or taking charge of maybe being the one that would get up and explain what you've discussed in the group. And that over the three days, gave you that encouragement. SF3 (II)
D11	Then you're sharing with others really what worked for you and you actually do create a very good rapport with people and it helps the group to participate then and that's great. FF1 (II)
D12	I think, again this particular lady was fantastic in terms of the group dynamics and I think was, it was, it came quite natural to us and we worked well together, but, I mean we had some people get upset and some people, and the co-facilitator was very able to manage that, or we were able to manage that […] CO6 (II)
D13	I think it's the content and you have to have a skilled and experienced facilitator that will be able to look at it and be able to probably amend it or adapt it to the group whilst getting the content delivered. I think that's probably the key to it, knowing that to leave in or leave out or you know and trying to stay true to it as well I suppose is the thing, trying to stay true to the program you know. […] CO16 (II)
D14	Well I'm definitely conscious of it that you know that there's kind of the requirement for anybody who's coming into an EOLAS group. To either give a talk or facilitate, is that you give up your power. You know you actually accept that these are human beings, you know, struggling with you know. And you have to be compassionate and you have to at least be able to empathise and relate to people where they're at. CF5 (FG)
D15	No. I tried very hard not to be the nurse. Not to be the manager within the facilitation. But I struggled in that. Because if someone didn't show, if somebody wanted to stop their medication or whatever. My co-facilitator would be encouraging of that. And I found it very hard to stay in my role as a facilitator. And not as the nurse. CF12 (FG)

Domain A: Outer Setting	
D16	[…] the service user facilitator has a much, it's much harder for them to position than it is for us I think because there is, straddling that line between being a, being, receiving a service and facilitating within that service as well. And sometimes that, sometimes the difficulty of riding that line becomes really obvious, do I, am I here to tell my own story, am I here to, to be a, you know, here's what you could be, kind of thing. And there's one young woman who I've facilitated with a couple of times who, who finds that really, and she's said it to me, she finds that really difficult. About where she, where she pitches herself I suppose, it's, it is a really, really hard thing to do. CF7 (FG)
D17	Well initially I would have kind of maybe taken a little bit of a back step. Because I would've considered that the, you know the, like the co facilitator being a health professional. Would have a certain set you know of knowledge obviously that I wouldn't have. And I would've kind of you know, being, felt a little bit subordinate. FF9 (FG)
D18	I suppose I'm self-employed, so I'm flexible. Otherwise I couldn't do the middle of an afternoon, like you know and that's the reality of it. FF10 (FG)
D19	Yea well actually yea, well I've a good husband, if he wasn't there I couldn't do, go to these places you know like. Because my daughter can't be left on her own, yea. FF4 (FG)
D20	I had lined up for a course there in October, but then I got a job so I had to bow out you know. But I was kind of looking forward to doing it. And I thought at one stage I might be able to do it. But just the work schedule didn't allow it. So I told [EOLAS Coordinator] that. SF10 (FG)
D21	I've already lost a few service users […] lost from EOLAS […] I'd say for some of them, their own mental health probably deteriorated, one in particular mid one of the programmes and he hasn't reengaged with EOLAS [….] A few family members have gone through very difficult times and pulled away from EOLAS. Not that EOLAS has been a trigger for anything. But just their lives have been difficult at different periods of time, so. […] CO7 (FG)
D22	[…] the other social worker trained, again was really motivated and found referrals herself.. CO5 (II)
D23	And the success, I have to put down to the work from the facilitators around the table you know the key people, the contact people just keeping it on the agendas. CO4 (II)
D24	I've had some very, very good and strong family members who came onboard from the very beginning and they're still onboard. […]. I have been very lucky with particular family members. I have that one or two of them could've been the coordinator of EOLAS themselves. You know it's just you know they really have always been there and always ready to deliver and you know. CO7 (FG)
D25	There's only 1 or 2 [MDT members], it's like what I said about the service users, there's only 1 or 2 I suppose who would be dedicated and would be committed. Yeah, so everybody else kind of, you wouldn't get much of a response you know. CO16 (II)
D26	[…] there's a core of us who are very committed, you know, and have a passion for it but most other people just it's a job, they've got families, they have, we have to recognize that. SH4 (II)
Domain E: Implementation Process	
E1	Yeah, they're [EOLAS], like they are very good, your, you know, they're very accessible, if there's every a question, you know, you can get through to [EOLAS project worker 1], [EOLAS project worker 2]or [EOLAS project worker 3] previously, when he was there, they were very good, very accessible […] CO1 (II)
E2	[…] we berate ourselves all the time but support from the national, you know from [EOLAS Project Worker 1] and [EOLAS Project Worker 2] in the past and [EOLAS Project Worker 2] and [EOLAS Project Worker 3] is great, I mean they're always contactable or always there you know really are, they're great. CO4 (II)
E3	And we had meetings outside the EOLAS to plan when we're going to have the next one. And we were all invited and organised who would be available to do it. FF8 (FG)
E4	[…] we set up a steering group. With [CO8 (FG) – Consultant Psychiatrist] was on it, and there was team coordinators from each area. Because what have we five, five areas, five teams within our area. So we had kind of the key people, in terms of. Yea from each area and straight off with myself and then with one or two of the clinicians. And one or two of the family members and the service users, were part of that steering group as well. CO7 (FG)
E5	And I would have initially set up a meeting I suppose with the people who were trained, the lived experience people, the family carers and the service providers and to see what had been done to date I suppose, just a planning meeting. And to see where could we go and where were we going to take it, what were our plans for this few months going forward, how were we going to capture our cohort. So a usual, I suppose a normal kind of a planning meeting. CO16 (II)

Domain A: Outer Setting	
E6	So I think the, in terms of the coordinators, they have to have that seniority, they have to have the time and the commitment to do it and the actual dedication and the belief in EOLAS to do it. The belief in the value of it. They also need to be really good organizers and persuaders because a big part of this role is persuading people to do things for you, whether it's either making a referral or even just teams having EOLAS on their agenda or its facilitators being available or sorting out the [payment] register, there's a lot of negotiation and moving that actually needs to happen. SH05 (II)
E7	So I think what we realised is that whoever that coordinator is going to be, needs to have some status. Whether it's a senior social worker, assistant director of nursing, senior OT whatever it is. But they need to be influential […] they need to have that ability and that experience of managing people and if you don't have that experience of managing people and managing resistance. Then you're going to find it really, really difficult. And that was the case, basically everywhere you know. SH02 (II)
E8	I organise all the bits, all the pieces, I organise the docs, the manual, all that sort of stuff. Because I think people are really, really busy, the clinician are really, really busy and its enough for them to get to the group and deliver the group and do all the bits with their other facilitators. […]. It means for me as an ADON [Assistant Director of Nursing], like I hate when this group is on because I'm trying to, you know the way (laugh), there's a huge amount of work, there's a huge amount of work anyway because you're trying to get the names, get them organised, organise the rooms, teas, coffees you know I do all that and I just really ask the facilitators to turn up and look after the clinical piece on the night. CO2 (II)
E9	The coordinator does most of it [recruitment of attendees] like, within our team we would ask people ourselves who we were working with, but with regards to the, I'm on a rehab and recovery team, so the community teams, the coordinator would be contacting those teams. But I found that really helpful and I think there's a lot less pressure when it's just turning up basically.. CF10 (FG)
E10	Yeah so I suppose I took on the role of getting the referrals you know talking to the team, getting buy-in from the team, finding a venue, that kind of logistical side. I did that for the area. I suppose the EOLAS coordinator took on the challenge of getting a service user and family member from [Large town in ES07] signed up to travel to [2nd town in ES07]. CF1 (II)
E11	We'd probably have a bit of both, the coordinator would send out the kind of overall email to the whole service and would organise the guest speakers, would prompt, kind of this is the date, and then it's the ground work then of kind of collating all the referrals and the organising the stationary and that kind of stuff. So it's a bit of both. CF6 (FG)
E12	It seems to be psychiatry, that's where the power is so we've got to get psychiatrists on board with it and how do you do that? FF1 (II)
E13	I just remember one conversation with a, a consultant and she told me that [EOLAS steering committee member – Consultant Psychiatrist] had come in and spoken to the consultant group and it was like a light bulb moment for her, even though I had spoken to the group as well, but, I don't know whether I was talking French or German or something but […] I think by [EOLAS steering committee member – Consultant Psychiatrist] coming in it gave it the stamp of approval. CO14 (FG)
E14	[…] what we did after our first EOLAS experience, we asked, you know the way the trainee doctors and the consultants have their forum every week where they have to present something, we asked could we come in with the family members and the service users and give a presentation on the experience - to kind of sell it to them for the coming years, and that seemed to work a treat […] CF9 (FG)
E15	[…] I did up a summary of activity and, so he's [consultant] going to bring it to the consultants' meeting and I asked him just to look over it and see what he thought of it and he gave me suggestions as to what to change, because they all love stats, and it's really quantitative, what happened, and what happened to the people, you know, that you sent out the letters that you didn't hear anything from, you know, and what was the result, so I did that, but I haven't had anything back as yet. […] I included also, I mean some lovely qualitative stuff that we'd got from the service user experience […] CO12 (FG)
E16	The consultant wasn't leading it, or were, they were giving it the nod. But not actually proactively giving it the nod. Because I had to go back to those areas and say, listen if you don't put in the referrals, we are going to scrap this. CO11 (FG)
E17	I think the psychiatrists haven't just got it yet if that makes sense. I just think but then you see when you go in to see a psychiatrist they have a set amount of questions right and they might come to the 6th one or whatever and somebody might have said to him maybe somebody might need EOLAS but I'd say that's way down their list of priorities. SF8 (II)

Domain A: Outer Setting	
E18	[…] it was all nursing actually who were delivering and co facilitating the programmes. And they were able to recruit facilitators because they had engaged in the community. They knew family members and service users to come, to the facilitation training. SH06 (II)
E19	I was on a community team at the time so it was to get service users and family members from my director who I knew and I knew might either benefit from EOLAS or be interested in it or who would have expressed an interest in you know giving back or doing something more because they had gotten, you know whatever the reason was they had experience or they wanted to do something. CO5 (II)
E20	[…] the particular individual who actually came with the invitation or asked me to get involved, she's a service provider and I would have a lot of faith in her and she described it really well. So that would be number 1 why I said, right I trust this individual and if there's anything she particular promotes well then it's worthwhile. FF1 (II)
E21	I would've done some work with the nurses and stuff that were involved with ARI [Advancing Recovery in Ireland]. So it was them that kept kind of pushing me to do it. Because obviously they saw, kind of something in me. But it was great to have I suppose that bit of a push SF6 (II)
E22	We do meet every two weeks and we would go through say the number one, number two. And we'd talk about right, who's going to do that who's going to do that role. FF11 (FG)
E23	So for the first session that we did, we met up probably half an hour before we went into the session. And [Name of cofacilitator] would say, well I'll take this would you like to take that. And we shared taking each part. And then what we would do after every session after that we would stay behind probably for about fifteen, twenty minutes. And we'd go through the same pattern. And we'd say and then we'd go away and we'd take that part of it. And you know we'd structure it ourselves. So that it was ready for the next week. SF3 (II)
E24	And then I suppose the planning meetings then as a whole group, meeting beforehand, before the groups were even ran at all, making sure that we all met beforehand and that everybody was comfortable with it. And that people were happy to work together and all that kind of stuff. You know and then just being really clear to try and keep everything as balanced as possible, so encouraging the facilitators and especially the clinicians to be open and to divide the work and to kind of, you know offer to take the bits that maybe are more difficult, like literally access to buildings, you know sending out you know invitation letters that obviously the clinician should do that because they can get the postage paid for and all the rest. But making sure that you know the letter is actually drafted by both facilitators so making sure it is as equal as possible and coproduced as possible. CO5 (II)
E25	[…] I checked in enough that if somebody wasn't doing well because like do you know after maybe the first few years there was a point where, you know 1 or 2 people either wanted to step back as in the peers or became unwell or whatever it was, that I checked in enough that I caught those things […] CO5 (II)
E26	I suppose the service user that I am co-facilitating with […] I suppose he was experiencing quite a bit of anxiety about taking the lead on certain activities and that. […]. So yeah like even before groups when we would meet and you know discuss the content and all of that. I suppose because of his anxiety I felt a little bit more, well you don't worry about that I'll look after that. So you know I feel like maybe I've been doing more than a 50/50 split in terms of the workload I suppose. CF1 (II)
E27	[…] there's a bit of politics involved in some sense because people are eager to do it, you know, people are interested in it and also then there is the payment with it, so we are very conscious that you don't, you know, that, I suppose it's fairly done.....that it's done with, you know, and especially when training or anything comes up and, you know, you are always conscious that this person has done it before and maybe this person would like to do it and, you know, so there's, there's that type of just basic, they're kind of like nearly housekeeping type things CO1 (II)
E28	I think there's a good awareness [of EOLAS] in [urban town] because [clinical facilitator] champions it so well. I know there's a few other people that really champion it really, really well [Assistant Director of Nursing] and a few people like that. SF8 (II)
E29	Having staff in the area is very important, like I have two social workers and a nurse, or two nurses in that central sector. And then in that other sector I have actually two nurses, two community mental health nurses. One CMN2 sorry and a community mental health nurse. And because they are at the meetings, they're kind of bringing it up regularly. The conversation gets had. Whereas, in the other places it's not there. So that not having the ongoing conversation around it and saying, well listen have we any referrals or whatever. And it keeps the focus of attention. CO11 (FG)

Domain A: Outer Setting	
E30	**Or have you seen sites that you think actually what they have done has been really clever, what they've done has been an integral part of how they've got this up and running?** Number one – there's a champion. All right. And that there are probably multiple champions in that you've a coordinator who's a champion and is really taking a management role in the delivery of it so they're actually seeing it as a project to be delivered in its complexity. And that where it really works is then where that person has the support of the other clinicians so that there's buy-in from the teams in terms of that this is a resource that they're using. SH05 (II)
E31	It is champion lead. And that is a sustainability risk, you need to build the teams around you. It's not, you need to have people who know about EOLAS, who are willing to do EOLAS. To refer, send people on to you automatically. SH06 (II)
E32	For EOLAS to sustain itself there has to be champions in each area. So there has to be some sort of succession planning. And I suppose, I can give you an example, in we'll say one particular area where a director of nursing was the champion for EOLAS. And retired and now there's no champion in the area. SH02 (II)
E33	I suppose people are constantly moving as well in terms of staff. You know there's people moving into different roles, there's people moving out of area into different roles. So I mean if I was to take a job somewhere else next year, as it stands if we didn't have someone else on the team trained it probably wouldn't happen. So I suppose it's kind of planning for that as well. CF1 (II)
E34	[…] when I circulated it [evaluation] everybody on the teams knew who referred in to EOLAS. Who was the person that actually did it? So you were kind of saying, well listen you know You're getting credibility for doing that (Laughs) and that was a good idea. Because right away and I circulated it widely kind of I just let it go. And plus the fact the feedback on, it was qualitative and quantitative right. So right away people, even the consultants themselves were getting an understanding and direct feedback. As to what the families were saying and what service users were saying. Which in turn, actually, increases the potential possibility of them referring in, having more engagement with it and seeing the benefit of it. CO11 (FG)
E35	But I know after our first program [name of coordinator ES08] done an evaluation actually in [ES08] and presented the feedback to the management team. And you know broke it down and just people's comments and you know it was done anonymous and just our numbers and things like that and sent that down through the system. And it definitely generated more referrals for like you know, we ran a spring program and now an autumn program and it definitely generated more numbers and more information and you know because there's lots of programs happening. SF14 (FG)
E36	I'm one of these people who likes to prepare and it's important to prepare and then, so you do learn from one session to the next or what happened. So you might have a little bit of feedback and it's great to be honest with each other. If you can do that to be honest with each other you know; what did I do that I shouldn't have done or is there something that I could have done to make it easier for you? FF10 (FG)
E37	And then there was the evaluation. Which is you know, just getting surveys, exactly feedback and focus groups again, just to get feedback. And then we, so that was the first kind of year really. So then it was a matter of sitting down with the feedback and rewriting the whole thing again for publication. The actual handbooks weren't prepared until after that initial round. So that was another, I won't tell you, I won't tell you how much time it took to do it. SH01 (II)
E38	Do you know that who knew the handbooks were going to take so much longer? And we didn't know and we couldn't know that until we started it. And low and behold it took longer than planned. And that completely compromised the possibility of proceeding with the train the trainers as planned. And there was no way around that that's just the way it was. So that task had to be deferred. SH01 (II)

Figures

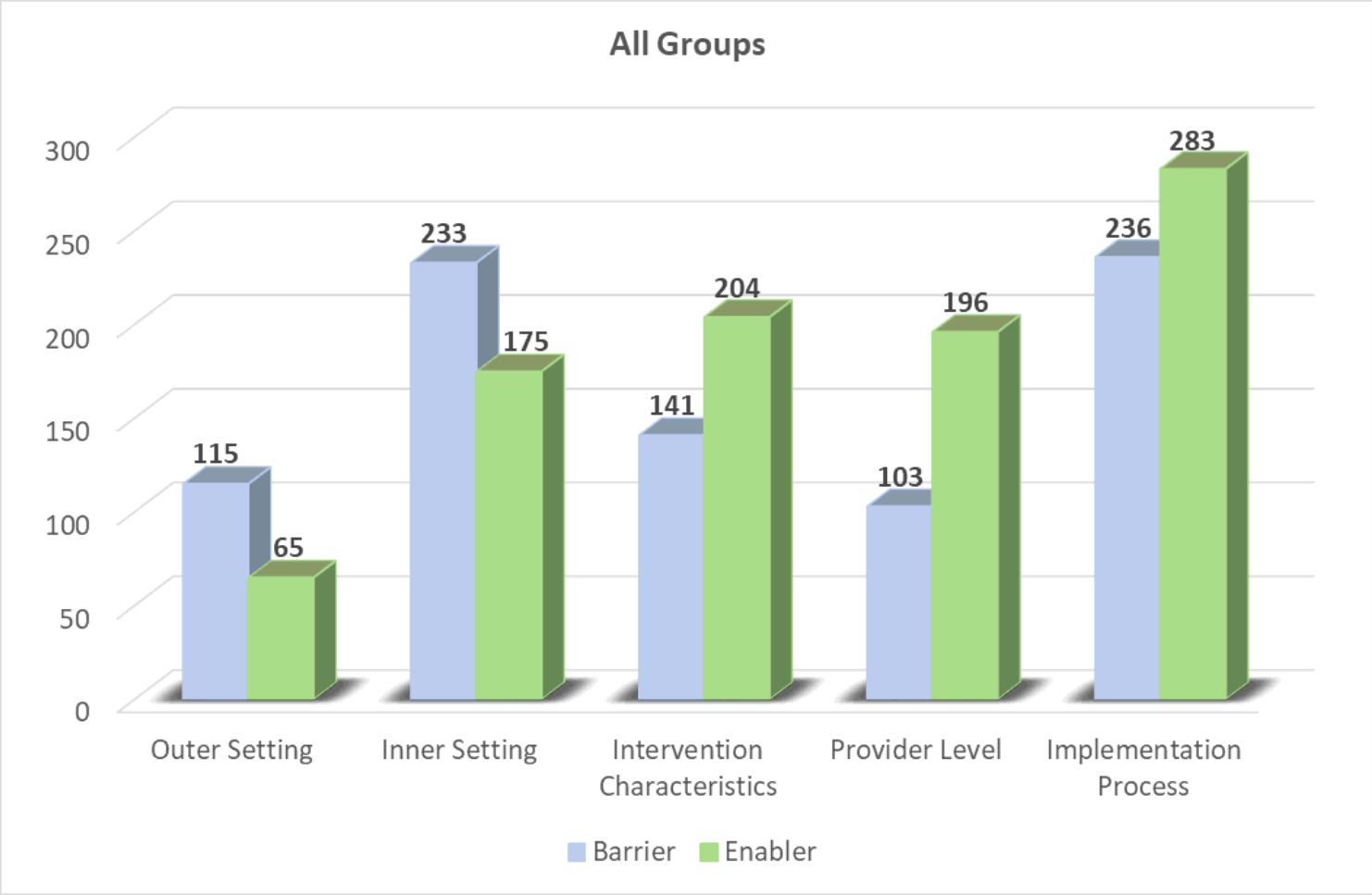

Figure 1

Number of enabler and barrier codes per domain

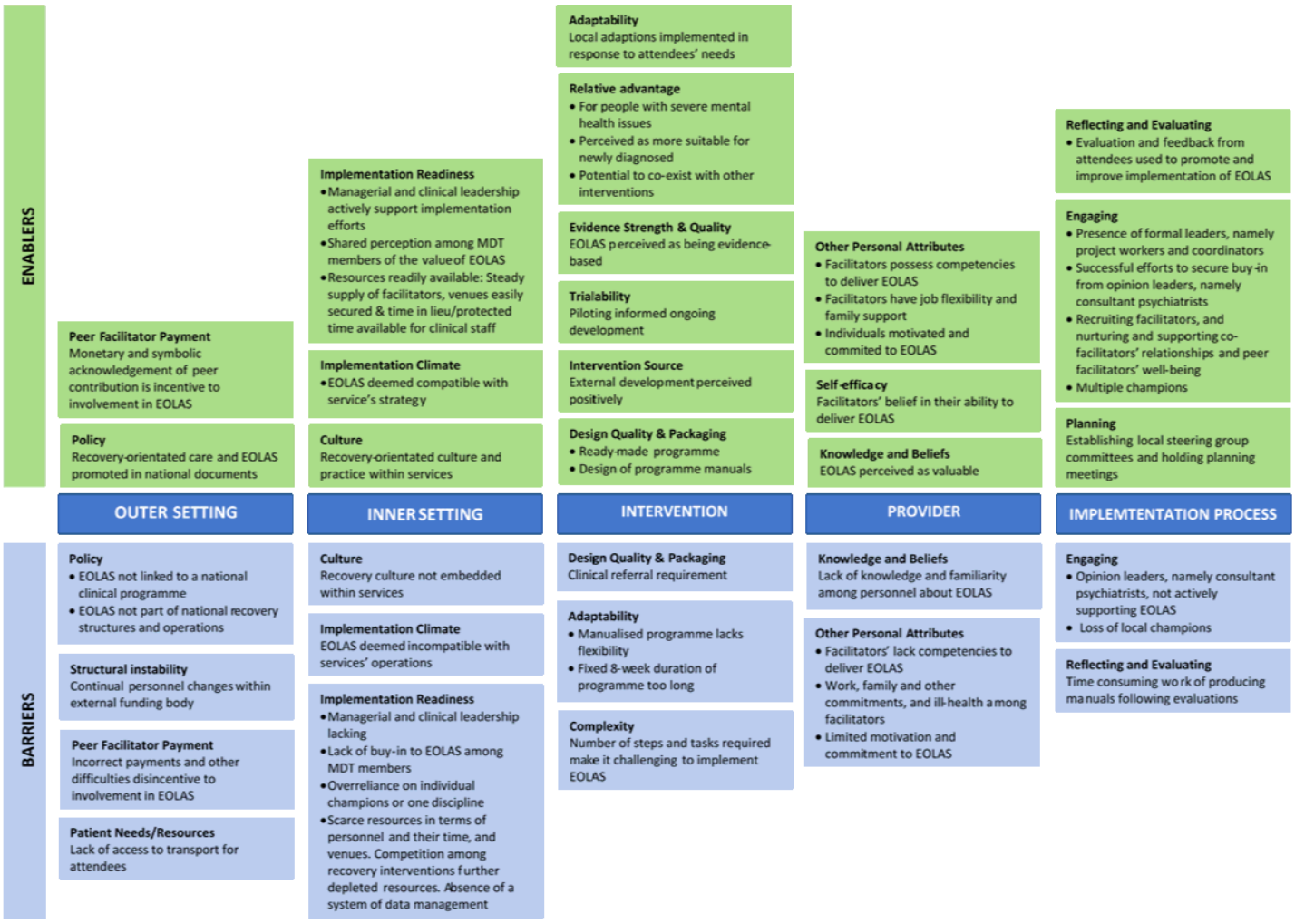

Figure 2

Summary of barriers and enablers

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- CoreqChecklist5thAugust.doc
- AdditionalFile5InterviewGuideEOLASAPAAttendees.docx
- AdditionalFile4InterviewGuideEOLASAPASUFFS.docx
- AdditionalFile3InterviewGuideEOLASAPACFs.docx
- AdditionalFile2InterviewGuideEOLASAPACoOrd.docx
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