Recovery Budgets in a Mental Health Service

Evaluating recovery budgets for people accessing an Early Intervention Service and the impact of working with Self Directed Services on the team members within a North West of England NHS Trust

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“I’d just like to thank yourself for coming out and giving us the opportunity to tell my story and as I say I can only thank the people Imagine from the recovery budget and the Early Interventions Team …without them I wouldn’t be where I am in life.”

(Participant of Individual Recovery Budget pilot)
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Introduction and executive summary
Introduction

This report follows a 12 month pilot of implementing Individual Recovery Budgets (IRBs) within an early intervention service across Mersey Care NHS Trust.

Executive summary

The following key findings and recommendations are derived from the analysis of interviews with participants of the Individual Recovery Budgets pilot between April 2008 and March 2009. The investigator undertook two focus groups with staff from the three early intervention teams serving the Mersey Care catchment area covering inner city and outer suburbs of Liverpool. The work was commissioned by a partnership of Mersey Care NHS Trust and the Care Services Improvements Partnership (CSIP), since April 09 part of the Department of Health.

The findings and recommendations should be seen in the light of the overwhelming drive for public services to modernise their delivery in line with a personalisation agenda. This report, and the findings and recommendations, should be seen as part of the process of listening and learning about what is important to and for people with mental health problems, assisting and facilitating their journey towards recovery.

The findings and recommendations are not presented in any rank order and should be read as a whole. In transforming public services, and specialist mental health services in particular, the complexity of delivering effective,
efficient and empowering agencies cannot be underestimated. Therefore the following is to be seen as a guide and not a prescription.

Findings and recommendations

• The use of support planning has positive effects in augmenting the approaches used within the early intervention teams.
  
  The staff group reported that the processes of being able to access additional sources of funding to facilitate recovery prompted a different way of thinking about service user need.

• The recovery budgets have enabled individuals to access support or items that may not have been open to them in any other way.
  
  The recovery budgets accessed activities and items that may not have been possible through other means. The effect on users has been shown to be overwhelmingly positive. The recovery budgets enabled users to positively develop recovery strategies. The process of elimination of other funding means for the service providers has also been positive.

• The staff group report a positive experience in being able to support people effectively.
  
  The staff group found the use of the recovery budgets provided effective and tangible outcomes for participants. The work undertaken by the early intervention teams is by definition practical, and these recovery budgets promoted engagement and facilitated recovery. The positive experience reflected on satisfaction the workers felt using the IRBs.
• The process of obtaining resources for production of support plans needs to be quick in order to be effective.

One of the most positive aspects of this pilot has been the deliberate simplicity and speed of the process. The production of support plans and brokerage time has been flexible depending on participant need, and has been efficient in the main.

• Means of payment for recovery budgets need to be efficient allowing brokers to purchase effectively.

Early delays in signing off monies slowed initial payments down. The broker accessing direct means of payment improved efficiency, though thought needs to be given to limits placed on the purchasing capacity. Governance procedures need to be placed alongside the aims and processes of an IRB scheme.

• It has been possible to utilise a range of creative media through the support planning process that fit well with statutory or other forms of planning (such as the care programming approach, CPA).

The varied forms of participant developed support plans have fitted in with statutory processes. The outcomes identified in CPA documentation have been met, though not necessarily in ways traditional services would recognise, as the process facilitated different ways of interpreting the needs being expressed. There are issues of storing non-paper or standardised format support plans alongside statutory requirements.
• **Training and development need to build on the skills, knowledge and attitudes within the services.**

    *Training and support is required in creating person centred support plans. A balanced and facilitative approach to this development should acknowledge the excellence that exists in services supporting people with mental health problems, along with the expectations and aspirations of recipients of these services. Support planning training should help staff to work towards outcomes rather than processes, allowing practitioners to support individual recovery plans, and balancing positive risk enablement with empowerment and growth.*

• **Capability building systems in accessing services should be part of training and development.**

    *Training and development needs to encourage practitioners to look beyond traditional responses in order to provide services. The work of mental health practitioners should be in partnership with wider communities, harnessing and facilitating resources from diverse sources. This is particularly challenging in some ways, as it sometimes encourages the user to use specialist mental health services less.*

• **Developing confidence in accessing available funds, support and services will be central in maintaining an individual recovery plan.**

    *The lessons from this pilot suggest that working creatively with individuals supporting recovery may not be as financially difficult as previously*
thought. Barriers in accessing resources can be overcome, and with experience and support, direct payments and other resources should be accessed. The transforming social care agenda today should facilitate widening access to available grants. Mental health services should develop their capacity and skill in this area.

- The processes of working creatively, considering alternative means of obtaining resources within the service user's life, is central to the process.

  Focusing on the user's aim of getting a life rather than getting a service is central to successful support planning and recovery. The early intervention teams were excellent in supporting participants creatively and in working alongside users.

- Governance issues require development to maintain the recovery approach and probity of public monies.

  The IRB used a panel process to scrutinise applications via support plans over a modest ceiling. Additionally this pilot used the panel for potentially contentious or potentially difficult requests. The panel approach was reported positively, combining safeguards with the ethos of the pilot. When considering scaling up the approach, care and consideration should be given in maintaining the flexibility of approach, and balancing risk and probity without creating bureaucratic and limiting processes.
• Other areas of mental health service delivery could be encouraged to develop person centred individual budgets.

One of the key challenges for the service is creating capacity for supportive planning within wider mental health services. The experience of participants within this pilot suggest a wider adoption could have positive benefits for other client groups. Within this pilot, the approach of listening and learning from the person at the centre has been received well. Creating capacity within teams should be a priority within the wider mental health services. The direction of service delivery across the service is not altogether out of place with the ethos of support planning – however there are key differences of approach. The challenge for service managers is to harness the excellence that exists in the many innovative developments which are already a part of Mersey Care with the approaches highlighted in the following report.
Background
Background

Increasing consumer choice and autonomy in the delivery of public sector services under the umbrella term of personalisation in services has emerged to describe a move toward individually tailored services from public and third sector services (Leadbeater et al 2008). A range of names are used to describe the approaches used within a personalisation framework; an explanation of these may be found in appendix 1. The increased government commitment to the provision of health and social care services tailored to the wishes and needs of the individual places the user at the heart of service delivery and sets out a blueprint for organising care services for the future NHS (DH 2007).

The government has been committed to developing individualised support based on choice and responsibility within the NHS since the publication of Our Health, Our Choice, Our Say (DH 2005, DH 2006), and maintains the impetus to create the means by which packages of individualised funded care can be developed (DH 2009), as it has done with the social care sector.

The NHS Act (1998) made it possible for health and social care providers to work together with shared budgets and staff, and to overcome barriers created when individuals receiving support from more than one agency require them to collaborate. Health and social care trusts and multi-agency working practices have sought to create a joined up or cohesive approach in supporting people.
Within social care, budgets devolved to users are not new. The Independent Living Fund has been providing grants to assist people with physical impairments to have flexible packages of care that enable them to live with degrees of independence that would be inconceivable within large public bodies (Henwood and Hudson 2007). Direct payments for people with physical and cognitive impairments, as well as people with mental health problems, have been a part of the mixed economy of care with both the current and previous administrations for many years, with mixed success and varied levels of uptake. The Department of Health has committed itself to increased financial autonomy for users of the health service (DH 2006), though to date such autonomy for users has not occurred within health service delivery.

In social care person centred planning, (Sanderson et al 1997, DH 2001, Sanderson 2003, DH 2006, Thompson et al 2008), it is clear that decisions about what is *important to* and *important for* the individual are central for enabling the user to achieve the life they want, and in obtaining support and assistance. Person centred approaches have been used with good effect within learning disabilities services (Robertson et al 2005), and it would be fruitful to explore the potential for this approach within mental health services. There is reason to suggest that combining person centred approaches with the power of flexible self directed services through individual budgets could be a potent force for empowerment (Bates 2004).
The government has sought to strengthen the mechanisms by which people create packages of care with direct payments. Direct payments have had a lower than hoped uptake, with a reported 42,000 being administered since their inception (Alakeson 2007). The payments are often seen as bureaucratic and inflexible. They have also been criticised by some as being insensitive to users' needs (Duffy 2005, Duffy 2007). Person centred approaches aim to increase inclusive lifestyles for people vulnerable to social exclusion, and the means by which this may be realised could lay in self directed services.

However, one criticism is that professional expertise and the role care management has in accessing and allocating monies through the methods above, has meant that power to decide on what is important for a person lies very much with the services themselves (Alakeson 2008). Choices and decisions about how to utilise available funding may differ between the user and a care manager: one perspective from a user may seek to find support from within their community, families and through ordinary means to overcome social isolation whilst another, from a professional, may attempt to meet identified need through traditional services with which they are more familiar (Bird and Wooster 2008).

While the sometimes transitory nature of mental distress in the main is accepted by all professionals, as is the notion of working with a recovery goal (DH 2006b), the issue of capacity and choice for users trying to change their lives is moot. The are many predisposing and precipitating factors leading to mental distress in individuals, and a tacit recognition that ecological elements
beyond the individual have a strong bearing on wellness (Coyle 2009). Nevertheless, in spite of understanding the roles of education, poverty, exclusion and discrimination, treatment responses and traditional services focus on a pathogenic model of diagnosis and medication i.e. a psycho-medical construct of psychological problems fitting with a nosological understanding (McDonald 2006). Self directed services through recovery budgets may be seen as a means to unlock barriers for an individual, enabling them to access the places that define ordinary living. Through such access, the recovery budget pilot hoped that for some an increased engagement within their communities and enhanced inclusion would arise.

*Putting People First* (DH 2007) represented a watershed in government collaboration. It represents a concordat across health and social care outlining a radical new approach to delivering public services. The focus on empowering people through individualised budgets is apparent throughout this document, and it is predicted to fundamentally change the relationship between health and social care providers and the recipients of these services (Bamber and Flanagan 2008).

**Recovery as a mainstream aim**

Recovery approaches have been used within mental health services for many years, after being championed within the United States by Deegan (1996) and Copeland (2007) whose influence on the development of recovery within the UK is clear. The prominence of recovery as a means to support people with mental health problems is now evident, with the approach sanctioned as a
mainstay of mental health interventions (DH 2006b). The Future Vision Coalition (2008) highlighted the importance of recovery as a means by which mental health can break free of traditional biogenic dominance, resulting in better outcomes for recipients of services.

**Problems for recovery**

Problems for recovery include deciding on precisely what it means and what it might look like within a service, how the service interacts with it, and the relationship between the service user and those supporting them. Bonney and Stickley (2008) note that there are:

> “…multiple definitions of the concept of recovery in mental health; it remains a contested concept.”

(p.140)

The purpose of recovery is to enable people experiencing mental health distress to develop resources that will facilitate positive life experiences and develop skills that may support growth of the person.

**Purpose of the evaluation**

The availability of funding to support an early intervention team with Mersey Care meant that monies could be used as part of a support planning process to enable people to access items, services or facilities that would not be accessible within existing services. The project enabled £100,000 to be used to allocate resources, and administer and evaluate the project, over a 12 month period. The project was seen as an opportunity to work in a more
recovery focused way, enabling participants to access means and experiences that may not have been otherwise available.

The pilot was used to explore the processes required in order for an NHS service to deliver highly personalised, yet safe opportunities for people with a serious mental health disorder. Rather than studying more institutionally-based teams, the early intervention teams were selected as a subject, as they have as their primary function a remit of working in ways that keep people with psychosis within their communities.

This evaluation has been produced using funding from Mersey Care NHS Trust and the Care Services Improvement Partnership between April 2008 and March 2009. The aim of the evaluation was to focus on the use of 'recovery budgets' in early intervention teams within Mersey Care NHS Trust. A recovery budget for this project meant a payment that can be used by the service user to acquire or purchase an item/service/access that would enhance their life, meet agreed goals and contribute to their place within their community. The budget for the pilot was considered a reasonably small amount, given the overall funding available and the expressed aim of seeking to reach approximately 100 users.

The evaluation had at its core three broad questions, answers to which were collected by individual interviews and two focus groups. The individual interviews were conducted between the lead researcher and up to ten service
users (n=7) on two occasions, and with representatives of three early intervention teams in Mersey Care NHS Trust. The areas focused upon were:

- What is the experience of individuals using financial support in the form of personal budgets to make changes in their lives?

- Does the experience of having control of resources impact on social inclusion, choice and autonomy?

- How does using recovery budgets in this way impact on the early intervention teams’ ways of working?

The interviews were digitally recorded with consent, then transcribed verbatim and subjected to narrative analysis. The sample provided rich stories of how participants had regained some of what had been lost in the course of their mental health problems, and how the recovery budgets had facilitated action that could not have occurred in any other way.
Methodology
Methodology

The section that follows will outline the basis of the approach used in analysing and understanding the data gathered as part of the investigation. It will also detail the processes of data generation with the service user sample and the Early Intervention Team (EIT) members. The safeguarding process of ensuring ethical practice will also be described in relation to both sample groups.

The method used in research must be capable in principle of answering the research question (Avis 1995, Silverman 2000, Bryman 2008, Bowling & Ebrahim 2005, Parahoo 2006). The analysis of data within this evaluation will use a narrative approach (Holloway and Freshwater 2007). As Edwards (2006) points out, narrative or story can offer more than simple chronological accounts: it can provide the person’s experience and their explanation of mental distress, experience of community and support. Narrative research for this evaluation is defined by Chase (2003) as:

“…a major way in which people make sense of experience, construct the self, and create and communicate meaning.”

(p.80)

The definition of narrative therefore framing this evaluation is offered by Murray (2008) as:

"A narrative can be defined as an organized interpretation of a sequence of events. This involves attributing agency to the
Narrative methodology has been chosen for this study as it allows the investigator to identify individual constructs and understanding of the user’s situation and others roles within the support process. Narrative analysis is inherently social (Chase 2003) requiring a teller, listener and story rendering it suitable to detail the interactions between the service user and supporters. In the words of Murray (1999), narrative – in particular for mental health users’ experience in this evaluation – allows us to elicit:

"...meaning through the stories we tell about it. In diagnosis, during its course, and after the illness has ended or at least subsided, we attempt to bring order to the crisis by constructing a story. This story integrates material from our life history with information about the current situation and future prospects. It is a dynamic construction which is rooted in the social and cultural context."

Narrative accounts do not fit comfortably into orthodox research frameworks (Josselson et al 2003) as the methodology generates no hypothesis nor seeks to control factors; instead it seeks to reveal the personal and social worlds of the subjects. The generation of generalised data was beyond the resources of this evaluation, with other larger national projects developing data sets (Individual Budgets Evaluation Network project, Glendinning et al at 2008); therefore, the evaluation aimed to provide an account of the service users'
understanding of their experiences and their use of recovery budgets. Narrative methodology has been used to reveal the users' perspective across a range of health related fields (Charmaz 1999, Bury 2001), including in mental health (Foster 2007, Cohen 2008). It is important to recognise that narrative research can have its limitations, and caution must be used to avoid an uncritical or idealised version of illness and suffering (Atkinson and Silverman 1997).

Equally, the researcher's desire to elicit the core story (Bury 2001) may unduly shape data, and strategies will be employed to guard against this. Similarly such risks of idealising suffering or constructing a story occur in reading the material. Holloway and Freshwater (2007) discuss the interactive nature of reader and story inherent in the process. Readers of the narratives presented should bear in mind their responses to the stories, characters and plot in forming their understanding of the people described and their lives.

Narrative approaches support the researcher to map events within sequences experienced by the users and others, allowing the story to be revealed. The interviews were recorded whenever possible, supported by the researcher's contemporaneous field notes.

Narrative methodologies are widely used within healthcare settings offering a means to capture data rich in personal experience (Murray 2008). The narrative method clearly sits within the qualitative paradigm, and epistemologically is a constructivist approach and should be undertaken in a
flexible non-schematic way (Murray 2008). It does not, therefore, adhere to a positivist ontological perspective (Mishler 1999).

Narrative methodology permits an understanding into the person's inner world, and into the identity they create for themselves and others and the place of action within the temporality of action. In the evaluation, the person’s constructions may be revealed via an ontological narrativity, as might their social understanding and expectations through a public narrativity. Broad cultural and historical contexts of community and family can be explored via a master narrativity (Somers 1994, cited Williams and Keady 2008).

Narrative offers a methodology for obtaining contingent narratives (explanatory), moral narratives (blame or punishment attributions), and core narratives (central narratives aligned to classic narratives such as heroic, tragic etc.) (Bury 2001). Although other qualitative or quantitative approaches could elicit interesting perspectives, they were not selected as they could not produce such rich data within the constraints of the study.

Narrative inherently consists of multiple perspectives, constituting many constructions of similar or the same events. Methodologically, there is no difficulty with collecting multiple or layered data to describe the place of people with mental health problems, their world and the world of those around them, and in obtaining stories from service users, participants within the IRB pilot, representatives of the early intervention teams, team managers and core brokers we have obtained such layered stories (described in later sections).
The three early intervention teams serving Mersey Care NHS Trust were asked to approach service users who were in the process of applying for or who had received a recovery budget, who might be interested, and who were willing to meet an investigator from the University of Chester. These individuals were provided with an information sheet outlining the nature and process of the evaluation (see appendix 3). Prospective participants were also provided with a consent form (see appendix 2) to sign and return to the investigator in pre-paid envelopes.

The data were collected in appropriate environments in accordance with the national guidance that early intervention teams engage with users outside traditional mental health facilities. For this service evaluation, data were collected in the settings where the user engages with the EIT. This could have been mental health facilities, or facilities within the user's local community such as health centres, community centres or public places. In all interviews, the service user chose the most convenient location. In most instances, data were collected in the service user's home, though one interview was in a service user's local pub and one in the local EIT service’s offices.

Where the investigator was meeting service users, irrespective of setting, best practice for lone worker guidance was used in accordance with the host Trust’s policy, with the early intervention team being fully aware of when and where the interview was taking place.
The evaluation aimed to identify ten recipients of recovery budgets who would be met on two occasions during the evaluation period. The meetings would be recorded and then transcribed. Following transcription, these data would be subject to narrative analysis following the modifications of Bury (1982) and Murray (2008).

In addition to individual meetings with recipients of recovery budgets, the evaluation involved arranging two focus groups with members from each of the three teams, again on two separate occasions. The investigator met with members of the three early intervention teams on three occasions, providing information and an opportunity for team members to ask any questions regarding the evaluation. Copies of consent forms (appendix 2), and evaluation information sheets (appendix 3) with stamped addressed envelopes were left in each of the EIT offices for willing participants to sign and return to the investigator. The focus group sessions were transcribed (Robinson 1999), and subject to textural analysis following the MAXQDA interpretive software (2007) methodological format. Dates for the focus groups were negotiated and sessions held at the most convenient time for team members.

As the sample of service users was smaller than planned (discussed later), an additional aspect of data collection was arranged with the third party broker, to offer an additional perspective to the development, administration and management of the pilot scheme. This interview was also transcribed and
subjected to textural analysis. This interview will be discussed fully in a later section, as many key lessons emerged.

The evaluation recruited seven recipients, four of whom were interviewed on two separate occasions, initially in months seven and eight of the pilot with the second interviews occurring in months ten and eleven. Two of the follow up interviews could not be arranged within the time frame, as both users were busy with commitments supporting their recovery. One follow up interview was cancelled as the participant was unwell, and it was felt inappropriate to hold the interview.

The focus groups were similarly designed to collect experiential data at two points in the pilot to elicit the impact on the EIT’s ways of working and of lessons learned from the pilot. The first group was held in month seven of the project with five members of the EIT attending. Representatives of all three teams attended (South = 2, North = 1, Sefton = 2). The group were offered the opportunity of a closed group (no new participants for the second focus group), or an open one. The group opted for an open group for the second meeting to allow as many views and experiences as possible to be elicited.

The location of the focus group meetings was negotiated on the basis of convenience, parking and access. The second focus group was scheduled to occur in month ten of the pilot. However, the date clashed with core training where many of the EIT staff would be attending. A second date was offered, and although many of the members might have been able to attend (details
having been disseminated though team meetings), only two members were able to do so. Both respondents in this second interview had perspectives of the pilot that were unique.

A decision was taken at the time to focus of issues of administration and supervision rather than continue with the initial focus group aim. Whilst the original aim would be compromised by the representation of the group, the decision of the initial focus group was that the second meeting would be an open meeting. The second meeting with only two respondents, each with quite unique roles, was therefore within the agreement.

The methodology described earlier was selected, as the process of narrative or of making sense of experience and the stories of recovery and hope ran in parallel with the operational ethos of the early intervention service in maintaining normalcy and hope of recovery.

**Ethical considerations**

The evaluation aimed to establish the impact of receiving recovery budgets and how working within a support planning and recovery budget approach would affect the workers within the EIT. The evaluation was felt to satisfy the service evaluation criteria of the Clinical Governance department within the host Trust. As such, the Trust would not require the proposal to be subject to National Research Ethics Scrutiny (NRES). In order to promote a safe framework and support scrutiny of the investigation, the investigator used the processes of the Ethics Committee within the Faculty of Health and Social
Care, University of Chester to subject the proposal to peer and expert review. The committee gave full approval to the evaluation in May 2008. The evaluation throughout was cognisant of guidelines and considerations of the potential vulnerability of the client sample (Department of Health 1997, Department of Health and Welsh Office 1999).
Narratives
Narratives from the service users interviewed (Participant narratives)

The following stories are summaries from the interviews of the participants from the IRBs, representing two of the three early intervention teams. These narratives are offered as a means for the reader to begin to understand the situations and experiences of the service users. Each story is presented as a brief biography, outlining salient events leading to or arising from their developing psychosis and subsequent contact with the early intervention teams.

Detailed analysis will follow on from this brief section. The length of time each person had been in contact with the early intervention teams was entirely random, and no inclusion or exclusion criteria were used in this open approach. In accordance with the Nursing and Midwifery Council Code (2008), names have been changed to ensure anonymity. Identifying details have also been altered where appropriate to protect the identities of the participants.

Narrative 1: James

Before James experienced his first episode of psychosis he had been fit, very fit. As a instructor working in a gym, James had spent most days working out, usually for around two hours a day. As his psychosis developed and anxiety mounted, James was less and less likely to leave his house, fearing unspecified frightening things would happen to his parents. Subsequently James’ situation meant that he stopped going to the gym. This, combined with his antipsychotic medication, had consequentially caused James to put on
weight, and he developed poor sleep hygiene (as he was unable to sleep due
to worrying), and was not getting out of the house. The recovery budget
process identified that a positive hope for James would be for him to
reconnect with a previous ability, by going back to the gym. Social prescribing
was considered, but in James’s view the gyms used through the General
Practitioner referrals were “chocker” and as a result would be a most
threatening experience.

The recovery budget was used to buy membership to James’ old gym where
he would receive support in attending, initially from a relative. James had from
the outset set himself a goal of regaining fitness, and in addition expressed a
desire to give something back by helping to support people within the acute
mental health setting with fitness instruction. The health and social benefits for
James would be manifested in raising activity levels, and potentially be of net
benefit for others too. James had arranged for support in getting to the gym,
and had recruited a friend to provide him with the impetus to get to the gym.
Initially James suffered a minor physical injury, but in spite of this setback
James resumed his attendance. James now has a paid role researching peer
support in a regional project investigating physical health in people with
mental health problems.

Narrative 2: Tim

Tim had been experiencing both physical and severe mental health problems
for a number of years. He was working in a dissatisfying job, which
contributed to his physical problems. Still living at home and approaching 40,
his sense of being stuck was clear. Tim had been working with the EIT for some time, receiving help to overcome the barriers in his life that prevented him from leading the happy and fulfilling time he felt he should be having. He was asked if he could go with a relative for a week's break in Spain. As this relationship was an important one, the opportunity presented by the offer to go on holiday appeared to ensure that Tim was a brother, and not either a service user or carer.

The sum required was beyond Tim’s means and his prospect of travelling was unlikely. Tim’s support worker set the IRB process in action, and the recovery budget was used to fund the holiday. Given the change of environment, different perspective and space the holiday provided, Tim made a number of decisions. On his return he put his plan into action: he resigned from his job, began looking for a further education course suitable for his previous educational attainment, and has been actively seeking alternative accommodation.

The effect on Tim has been that he now has a plan that is realistic and which he is working towards completing. Without the budget, the decisions may have been arrived at; however, the efficiency of space and location provided a perspective that made the changes possible. Tim is realistic about the pace of change he can expect, and whilst this pace may be slow and dependent in many ways on the actions of others and their ability to identify appropriate resources which allow his goals to be realised, he is hoping that within the forthcoming year he will have achieved the goals set. He recognises that the
biggest goal for him is to achieve paid work; however, he is actively seeking to engage in some voluntary work so that he might give back something to the community.

Narrative 3: Norman

Norman, a young man with a passionate interest in music, had been with the early intervention team since his first episode of psychosis. Norman had attended the first semester of a university course during which he had been increasingly using cannabis and MDMA. Over a period of two months, Norman had begun to experience strange and increasingly distressing thoughts involving supernatural and spiritual ideations, and ultimately auditory hallucinations resulting in self harm. Norman spent time with the early intervention team following an acute admission. Since then Norman had been withdrawn, though with input from the support time recovery worker he had been using his music as a means to promote recovery.

Norman had made contact with a scheme that was part of the European Capital of Culture activities, and began regularly making music with an established artist. The recovery budget for Norman meant that he would be able to purchase specialist music making software to enable his music to reach a new level.

Although at the time of both interviews Norman was still awaiting delivery of the software, even the imminent arrival was having a positive effect on his view of himself and the opportunities that he saw for himself. Norman was
making plans to return to university, and to begin working in a voluntary
capacity with music and young people. He was also in contact with an
employment agency specialising in supporting people with mental health
issues to get back to work. Although the past two years have been traumatic
for Norman, he was hopeful and possessed a degree of optimism for the
future.

Narrative 4: Ted

Ted had been in contact with the EIT for six months following a psychotic
episode, having been experiencing psychological distress for four years. Ted
had been experiencing suicidal ideation and reported an affective disorder
(depression). He had had been increasingly isolated, finding social situations
stressful, and used work as a way to avoid people. In addition, Ted had a
history of regular abuse of multiple illicit substances and alcohol. Ted was
made redundant upon his return to work, though his employer stated that his
episode of mental health had no bearing on the decision. Ted attributes his
loss of employment to both his mental health problems and that he was
undertaking a job that he held no formal qualifications to do.

The recovery budget was used to pay for a course which was hoped to help
Ted return to work, though in a qualified capacity and therefore in a stronger
and potentially more secure position. The budget was paying for a course that
Ted had begun paying for himself out of the small sums of benefit he
received.
This course was challenging in a number of ways, in that it subjected candidates to rigorous assessment and that as a mature student Ted was the oldest person in the group. Ted was succeeding very well academically, which provided a source of great personal satisfaction, providing evidence of worth and accomplishment which would not have been achieved any other way. Ted reported that the course provided him with aspirations, which had been absent prior to the course commencing. With the support received from the EIT and the course he was undertaking, he felt that it allowed him to have a future for the first time.

Spending time with other people was challenging for Ted, though he knew that with his history of substance abuse he would not at present be comfortable to meet with his cohort outside the course. Ted felt that because of the budget, he had a plan and a goal to support recovery. He knew what worked and what did not, and felt a part of his local community as he had routines to get him regularly out of the house, something that had previously been missing. Ted felt that without the course there would be a negative and compounding effect on his life.

**Narrative 5: Vicky**

Vicky, aged 19, had experienced a psychotic episode resulting in her admission to an acute psychiatric service and subsequent contact with the EIT. I met Vicky on a single occasion where she described her episode of psychosis and subsequent period of hospitalisation. Vicky had some clear plans of where she wanted to be, though she felt that she was being held
back because she was unable to drive, resulting in her being less able to see her family and reducing the chances she had of securing the paid employment she wanted.

Vicky had used the opportunity of support planning to consider her long term goals and promote her sense of recovery. Her goals centred around obtaining a job and pursuing a career in sales. A central contribution to Vicky’s recovery was her learning to drive. Following her discussions with the recovery broker, the broker arranged for driving lessons to be banked so that Vicky could begin her journey when she was able to do so.

*Narrative 6: John*

John is a young man who is living at home with his parents, and has been in contact with the EIT for over 18 months. His episode of psychosis was exacerbated for some time by using cocaine and crack. The house was busy, as two other children also lived there, which could cause stress to John. He had been struggling to attend college, although he was a very able and bright student. Central to John’s success or otherwise in maintaining attendance was submitting work on time. John found that trying to access the family's computer situated in a communal room was a source of continual and fractious tension as he found busyness difficult, preferring instead to work in his room away from the busy family milieu. Being unable to undertake his college work, John got behind with his work resulting in him avoiding teachers and lessons, leading to further stress and conflict.
Clearly, John needed access to a computer that he alone could decide where and, equally importantly, when it was used. The meeting with the recovery budget broker was quickly arranged, and in partnership with John’s EIT key worker the support planning process was undertaken. John acquired a laptop to facilitate the learning needs previously expressed. Interestingly, John expressed some degree of guilt at being provided with this equipment, stating that there would be other people who were needier and therefore more deserving of the laptop. This sentiment was expressed by John to both the recovery broker and key worker who replied with an apposite comment that:

“…no amount of money can replace the last two years of your life that have been lost through mental illness and this is just an addition, an additional resource for us to use such as medication and talking therapies.”

Since receiving the laptop, John has caught up with his college work and is able to attain grades which reflect his ability. He still experiences aural hallucinations in the form of voices, but importantly he can use his college work to provide distraction and crucially can choose where this work is undertaken.

**Narrative 7: Kate**

Kate had been involved with the early intervention team since her diagnosis of schizophrenia 18 months before. Kate had become increasingly distressed over a prolonged period of time, becoming anxious and finally psychotic, experiencing distressing commands from her television. A young person who
became increasingly isolated experiencing lengthy periods of inactivity and exclusion, she was invited by her support time and recovery worker to apply for an IRB. Kate was successful and used the money to access a local gym. Kate now goes to the gym around three times a week, increasing her time out of the house and maintaining a much healthier lifestyle. Additionally, the gym membership permits access to classes and other activities that Kate has tried, enhancing the opportunities for her to interact with other people and thereby increasing her opportunities for recovery.

**Narrative frames**

This section describes the process of categorisation leading to the core narratives describing the experiences of both participants and service personnel.

In order to create the narrative for this evaluation, the transcriptions from the interviews were read and re-read. In addition, the reading was augmented by listening to the digital recordings from the individual interviews and focus groups. The purpose of this activity was to familiarise the investigator with both the content and tone of the story, and to check the transcripts for accuracy. The transcription then became a permanent record (Cameron 2001 cited Coffey 2009) of the interview which could be referred to again and again. This process of revisiting original data has been invaluable, as issues and core themes have become apparent after reading and re-reading the data several times.
As explained in the methodology section, the investigator used an adaptation of narrative methodology described by Bury (2001) where three key areas are offered as a map to understand the participants’ experience. The explanation of each is explained with an example for the evaluation:

- **Contingent narratives**: understanding the event and causes or contributory factors leading to the illness. Goes beyond bio-medical understanding into lay knowledge.

- **Moral narratives**: understanding an attributional component of morality in chronic illness of self in and against societal factors. Ideas of self harming, worthiness and punishment exist here.

- **Core narratives**: understanding that narrative conforms to classic scripts (such as tragic, comedic, heroic, parody).

The stories of the user's experience are coded from an experience that frames their understanding of their situation, from one or more of three further narratives based on a development by Robinson (1990 cited Bury 2001) of the work of Gergen and Gergen (1986). Firstly the participants may have seen their experience and/or situation in a negative or downward construction, moving away from the person’s desired goal. The characteristics of such a narrative are one of low expectation and one where hope seems distant. This is known as a **regressive narrative**.
**Progressive narratives** show movement towards a valued aspiration or direction, a place where the person wishes to be. It is overwhelmingly this type of narrative that is clearly expressed within the data.

We also need to consider two further aspects. Firstly, we need to recognise the idea of stable narratives, which are characterised by a process of homeostasis where tensions maintain a static narrative. These story sections move neither towards nor away from a desired or valued goal. And whilst these narratives may not be entirely positive, they may not be negative. Secondly a narrative may shift during its telling, switching or pausing from static to regressive or from positive to static. The storyteller might use these devices to accentuate their retelling or point to their role in the story.

All transcripts were inputted to MAXQDA (2007) textural analysis software. This method of data handling enabled a large amount of verbatim accounts to be compared and themed for the purposes of evaluation. The transcriptions led to the categorisation of experience from participants as well as professionals interviewed either singly or as a focus group.

Overwhelmingly, the views from the participants were progressive narratives. The stories show that having the experience of being in crisis and often admitted to inpatient mental health services can be countered; following the work of the EIT, the recovery budgets resulted in a positive change.
**Progressive narratives**

An example of a progressive narrative is offered by the following excerpt from one of the transcripts:

“To be honest it’s worked exactly as I’d hoped it would, to be truthful with you. Coz I’m no longer…before I got it I was so far behind. I know it meant that I was getting teachers ringing up me Mum. I was getting like always getting dragged in to subject warning. I got it for lack of homework and that. And now I’ve completely caught up and me attendance is improved dramatically …..it’s just helped a lot of things come together really and stopped a lot of things from going downhill.”

(John)

Another example of a progressive narrative is given here by a different participant of the recovery budgets:

“It’s given me some sort of goal to head towards. It’s also allowing me to meet other people er… Er….so again it’s given me something to aim for in life er…hopefully er…it will give me a lot more security when I go into the job market and try and look for employment.”

(Ted)

Again, this time from the first participant expressing their new found direction:

“And all this is progress all the time. There’s that…and also I’m looking to do some volunteer work at some point in time as well so er…so this is all things, you know, that erm…then its all…come about just coz of the new found confidence that I have.”

(John)
A progressive narrative was found to be alluded to or directly shown on 22 occasions within the interview group. The quantity of recipients shows a large number of people who wish to make changes that would not otherwise have been possible. Often users would make sense of their story by setting it against their past or events that have in some way shaped their present day existence. In this sense the two other categories of regressive and stable narratives were seen only in a past tense. The use of a negative narrative should not be discarded.

This segment from the interview with Ted shows the journey to a more hopeful and progressive place:

“I’d say very bright. The sky’s the limit. I can’t foresee what’s going to happen in the future but I can only imagine, hope and believe. And I believe it’s going to be a much brighter future for myself, having gone through all this I feel I’m a lot better person erm… I wish I hadn’t of had to go through it erm… but I’ve learnt quite a lot from what I have gone through. It’s put me in good stead for the future. Hopefully I won’t find them pitfalls ever will bother me again, so…I didn’t enjoy it but I will get some use from the situation I was in.”

(Ted)

The progressive narrative was clearly articulated throughout the evaluation. Participants (and staff) found the access to and effect of the IRB to have been entirely beneficial. It would seem unlikely that any service development resulting in funding allowing participants to access previously inaccessible
facilities such as gyms or enabling a participant to acquire computer software or hardware without a lengthy process or a means-based assessment would be negatively viewed.

However one should avoid any simplistic reduction. This would be to miss the point or meaning of progressive narrative. For all of the participants, their recent history and experience of psychosis resulted in their world being dominated by distress, confusion and a realisation that mental ill health would be part of their life possibly for the rest of their entirety, and certainly for some considerable time to come. Those participants who would have investigated psychosis would have no doubt seen poor prognosis around schizophrenia. Indeed, the eminent psychologist Richard Bentall has likened receiving a diagnosis of schizophrenia to that of being told of a terminal disease or in his words of “psychiatric cancer”.

**Regressive narratives**

The positive direction evident through progressive narratives could not tell a story without the existence of a darker place. The journeys experienced by all those participants interviewed were all characterised by instances of distress and of intolerable situations. In addition to the personal distress of psychosis, societal prejudice creates a stigma and negative associations of mental health. The idea of mental disorder being a wholly negative experience and sometimes creating a life defining change, the progressive narrative articulated by all of the participants can be seen in some perspective. The contrast between the participants’ story before the IRB and after is clear. The
narrative reporting their experiences prior to receipt of the IRB can clearly be seen as *regressive*. The following accounts describing the participants’ experiences show their negative experiences and poor prognostic outlook, and therefore fall into the *regressive narrative* category:

“When I was unwell I was really unwell. Things were very bad for me. I was very isolated. Very alone. I felt like I was dealing with me problems all alone. I had no-one to speak to, no-one to turn to, no-one to off-load on. Er so, things were very bad for me. The only thing I had in life was me full-time job. Er…that was my only way of er…socialising or meeting with the outside world so to speak because I don’t put meself in situations where, in social situations. I’ve got very low self-esteem, er…not very confident.”

(Ted)

The feelings of poor prognosis and lack of control are further exemplified by the next respondents who highlight their feeling of being lost, being somewhere they would not wish to be without recourse to change, and experiencing a single choice of direction:

“…Yeah. For the longest time I think I’ve been really at the wrong pace and it’s been frenetic and it’s been….dictated by outside forces and things like that and when you are in that sort of a rut you lose focus.”

(Tim)

“Yeah. Because of the mental state I was in, if I knew a teacher was really going to have a go at me because of, I hadn’t done me homework, which I wouldn’t have done without the laptop with a lot of
them, coz I can’t deal with conflict blah de blah. But erm…but it stopped me going into a downward spiral. I was taking a day off college which would leave me [with] anxiety and [feeling] depressed…”

(John)

The disruption in ordinary living patterns caused by the onset of mental ill health is a common experience, and conforms to the notion of regressive narrative where the experience prevents the person living the life they would wish, or creates barriers in the person’s life where their continuance of ordinary life or of progression will not be realised.

The regression is often not of the persons own doing, but is often attributed to others or fate, or forces outside their control (Bury 2001). Participants reported the disruption to either their life as it was or to their plans, where the diagnosis of psychosis would severely interfere with college or early careers (remembering that the EIT delivers services to young people, 14–35). The following excerpts show clearly this process of inhibition of dreams or progress:

“Before, before…before I got ill I was in college and stuff like that so me plans had to be put on hold, well obviously because I couldn’t carry on working or going to college or anything like that with things like that happening…so…I don’t know, it was just strange.”

(Vicky)
In an interview with Norman, the following narrative of disruption by psychosis was given. (The interview was not recorded as they chose to go to their local pub where it was inappropriate to use the fairly large recording equipment, but extensive notes were taken followed by contemporaneous field notes.)

The regressive narrative for Norman was reported to begin with a physiological problem and repeated visits to their General Practitioner. The continued use of MDMA and cannabis over a two month period led to an increasingly depersonalised psychological state, a situation where Norman was tormented by ideas of witches and by a vision/hallucination of a winged demon appearing to him in a mainline railway station. This was the precursor to crisis, beginning for Norman with the sight of a dead young woman in his student flat. Terrified, Norman cut himself with glass and was discovered by his flatmates, and this was the beginning of his involvement with specialist mental health services and the early intervention team.

Bury (2001) shows how a third dimension of narrative can be understood in relation to the participants’ experiences. This level of understanding or narrative is called the contingent narrative and, by Gergan and Gergan, a moral narrative. In some ways the narrative can be a reflection of how the person in wronged by others or how others have contributed to their situation, but it can equally be a point where the person understands that their own actions can in some ways contribute to their situation.
As mentioned, the story a person creates around their situation is wholly interpretive. The individual determines their situation as being in some way caused by or directly a result of fate (prophetic narrative), bad luck (tragic or ironic narrative), absurd misfortune (comedic narrative), or as a supreme challenge (heroic narrative). The moral narrative is evident in some accounts where participants’ previous lifestyles and, in particular, their use of illicit and other substances contribute to the onset of their psychosis:

“I’ve always had, well I’ve not always had, but for a portion of my life from the age of about 20 ‘til I was about 27 I was addicted to alcohol, cocaine and cannabis. It usually started, the alcohol would spiral into the cocaine use and the cannabis so I do have a lot of worry, fear based around going out because er…”

(Ted)

Responding to a direct question from the investigator enquiring about a comment from Ted who stated that, at the time of his crisis, he was and had for a numbers of years been using some substances, Ted answered by saying:

“Class As yeah. Cocaine, cannabis and alcohol all at the same time. So it started off, as I say, 10 or 15 years ago on the cannabis and then maybe 10 years, sorry 5 years later I er…upgraded to er…cocaine at the same time with the alcohol and they all took over me and got a grip of me, yeah. So, for I’d say, for following 4 or 5 years I was addicted to cocaine. As I say, I was still using the cannabis and the alcohol erm…and I realised, you know, that I’d had so many near death experiences while being under the influence of the drugs that I realised that it wasn’t the right thing that I was doing.
It was certainly not good. It didn’t sit right with me. Erm…you know, the person I wanted to be certainly wasn’t me anymore.”

(Ted)

John, who had also been using substances for some time, also attributed his onset in part or in whole to persistent use of chemicals:

“About a year and a half ago when I first got in touch with the early intervention team coz me mum and dad had noticed that I was like erm, a lot more withdrawn, wasn’t quite right…I mean I had a drug problem at the time which they got onto.”

(John)

This investigator enquired to the nature of the ‘drug problem’:

Investigator: “What were you taking? Do you mind me asking?”

John: “Crack. Cocaine.”

Investigator: “Right OK.”

The role of the substance in this participant’s narrative was clear, in that their use of substances was directly relevant in both the construction of the problems and the point where their narrative began to change (what is sometimes called a narrative turn) (Reissman 1993).
Only the IRB could do this

One of the key features of the IRB pilot was a perception that the recovery budgets were doing something that could not have happened by any other means. The category showed that recipients and staff were aware of the resource’s usefulness in creating opportunities where previously lengthy processes might have not been able to elicit the results of the IRB.

One of the criteria in the IRB process was to ensure that the item, service or access could not be obtained by other means. This meant that all applications via support plans would have eliminated local grants, social prescribing, educational or charitable grants, and finally direct payments. Therefore when the IRB had been allocated, it should have been explicitly unique. However, the transcripts show the participants highlighting the way the IRB has shaped their experiences and expectations. The material content of what the IRB had purchased was as important as the experience of receipt for the participants.

Examples of the process in action can be seen below where many people have identified change that is attributable to the IRB and where no other approach could have achieved the ends experienced.

“I feel very lucky to get something like that and erm…it’s very, very nice to be able to look forward to something that’s gonna help me throughout each day and you can practise all you want, whenever you want. It’s just brilliant so it’s really nice to just be able to have something to get up for if you know what I mean.”

(Norman)
"I’d been thinking about getting driving lessons for a little time before…a little time. Because erm…like the jobs I’ve been looking for at going and stuff, it would really help if I had like driving lessons and stuff like that because they ask for like, like for accessibility reasons like if you could have a driving licence and stuff like that and also because it would make it easier to get around and stuff like that like for meself like socially and work wise because like I rely on public transport."

(Vicky)

The point of change and process of growth through a medium where only the IRB could have done what occurred is important, as it is directly linked to the process of recovery and engagement. The means by which hope is conveyed to the participants or recipients of a service is important, as it becomes a demonstrable measure of trust and success. The following excerpts show the process of growth clearly:

“…this funding by ------ ,[support worker], and ------ ,[broker], and I didn’t even know about this organisation until I was informed about it and it was like for me it was sort of, I don’t know, it was almost like a miracle to me at that time that I really needed something…that somebody and something was there and that I will never forget and since that holiday I’ve come back and I’m a totally different person now because I’m more focused and more tuned into what I wanna achieve and what I wanna do”.

(Tim)

Tim expands this point further in the clearest terms in the following passage.

Reflecting on the efficacy of the approach, his view is clear:
“It’s helped me decide what I wanna do and now that I’m not in… I’ve sort of gone past that process now of what I wanna do, how do I decide what I wanna do, I’ve now decided what I wanna do and just go on courses and try and find work in the media and how I got past that point was being able to reflect on it away from me surroundings and that was only made possible by the funding I received.”

(Tim)

The IRB shows itself to be effective as a quick and efficient means of overcoming a difficult situation. In the following instance John, who was missing out at college because of problems in getting access to the family computer, states how the IRB meant he could maintain college in as stress-free manner as possible.

“…to get me a laptop coz that will just completely solve all the problems. I’ll stop, I’ll get all me homework and come in here, put a laptop down… do all me work, get everything done and it’ll stop missing days of college where I’m ducking and diving and trying to avoid teachers…”

(John)

The work that the early intervention team carried out was appreciated by the participants spoken with. Separating the work of the team from the perceived benefits of the IRB is difficult, as one result probably could not occur without the other. This phenomenon was well articulated by Ted who recognised the value of support from the early intervention team combined with the IRB:
“...as I say, I would have had to look round for monies that weren’t there. Me family, er...whilst I’ve been off, getting the sick pay, they’ve bailed me out and bailed me out and it come to a certain point where they could bail me out no more. So I wouldn’t have asked for it meself, er...from me family. I think it was just a bit too much and to be honest with you, they didn’t have it. Erm...I did go down that route once and it wasn’t, the funds weren’t available. So I was very lucky to come into contact with the EI team, not just for...obviously the recovery budget, there’s a lot more er...to the EI team but one of the things they did do is put me in touch with the recovery budget which did enable me to sit and er...sit the course.

(Ted)

Contribution to social capital

From the beginning, a feature of the evaluation has been consideration of how the IRB would contribute to the recipients’ perception of inclusion and connectedness within their local communities. The experience of mental ill health is often accompanied by social isolation and difficulty with relationships. The aim of the early intervention team is ostensibly to maintain people within their local communities, keeping relationships and networks as intact as possible; however, the experience of users is often characterised by experiences of social distance (Forster 2007).

Tim showed a strong sense of civic mindedness in his narrative prior to his engagement with the early intervention team. Being part of his local community and contributing to wider philanthropic activity was central to how he lived his life. Social capital as defined by Putnam (1995) describes the nature and strength of social networks the person engages with. Clearly,
where a person is engaged with a group of people from within their local community their experience of isolation is potentially reduced. Woolcock (1998) makes the point that when people are rich in the kind of relationships where they meet others outside their immediate families (bridging links), they do better in terms of having increased opportunities to find their own way to a satisfying life.

The subject of social capital arose directly in two interviews, with the other meetings being inappropriate to pursue the questions directly. This decision was taken by the investigator in part because of the age of the participants and potential fragility in respect to social networks.

Where the question relating to social capital was directly asked, the responses were illuminating. Ted had been isolated from his community by his need to be present at work for over 60 hours a week. The place he lived in was considerably less important than his sense of work. Since his enforced time at home, being off sick, he did not necessarily spend time in his locality. His psychological state meant he felt safer within his home, though since his attendance on the accountancy course made available by the IRB, he reports a connectedness with his locality, not previously experienced whilst in the midst of his psychiatric episode:

“…And as you’re saying, living in such an isolated world I didn’t come across very much of it or I didn’t think I did. Maybe that was just the way I was feeling at the time er…maybe it was more apparent than I let anyone know. But at the time I was feeling er…I didn’t feel
connected at all er…to the outside world. I felt very much the opposite, disconnected.”

(Ted)

Tim summarised the notion of contribution to the social capital of their locality by remarking on his perception of being connected with their community:

“It’s own reward to be honest you know, especially if whatever you’re doing is having a good effect on someone else or in the community and how you can help out in any sort of way.”

Core narratives
Bury (2001) discusses the notion of core narrative where a story can be identified with the classic narratives or muthos (plots) where a protagonist is subject to challenge, struggle, irony or fate. These plots are present in most of the understanding we have of others’ stories. The core narratives for the participants of the IRB were found in their stories of recovery. The participants told of how their lives had been shadowed by the distressing experience of mental ill health and psychological disorder. The experiences would be seen and expressed as places where they did not wish to be and where they had moved from to a better place.

The stories were not, however, complete. The participants would not state that their battle had been won, nor that their journey was over. Instead their core narrative was one of a continuing journey, subject to a fragile state of being. The participants would not wish to tempt fate, nor boast a success. The narrative was one of an adversary against an enemy, psychosis. Their
successes were significant, though incomplete. The work that had been undertaken was significant, though by no means complete. The IRBs were a key to their current success, though their journey was not finished. The process of change and wellness can therefore be seen within the frame of recovery.

**Recovery**

Recovery was a key theme for the respondents who received the IRBs, and for the staff group. Recovery as a concept is difficult to define precisely, as it often relates to a feeling or perception held by either the person at the centre or by those supporting them. Recovery within the construct of this evaluation should fit under a *progressive narrative*, highlighting the process of growth or change towards a desired goal.

It seems entirely appropriate to include the themes here, illuminating in explicit ways the direction and change experienced by participants within the pilot. Recovery will be shown in the following excerpts as being entirely positive and potentially changing the way participants perceived their problems. Hope as a *core narrative* is the message from the recipients of IRBs, the notion of an individual on a journey, having navigated difficult and threatening terrain, who now has a direction and tangible support to sustain a hope for change.

“Well I’m going out more and I’m not staying stuck in the house like I used to before I went in hospital.”

(Kate)
Additionally, recovery focuses on the idea of confidence – a key loss for many people when they experience mental health problems. This respondent shows the aim of the IRB being as much about regaining a physical well being absent since the onset of their mental health problems, as about regaining a psychological one:

“It’s to bring me confidence back and er it’s just gonna get me back into mingling with people as well coz I don’t know how they go out or nothing like that and it’s gonna help me start going back out again properly and help me start to mingle with people which I haven’t done.”

(James)

This respondent continued the idea of recovery and regaining what might have been lost, in that the IRB held out the possibility of re-engaging with people they knew before their episode of mental ill health:

“Yeah. Coz I do know a lot of people that train there. I know loads that go there. Coz when I used to go it’s still the same old people that used to be there when I used to go. Coz I went…last time I was there must have been about four years ago but it’s still the same people that go.”

(James)

“I guess you know, er…it gave me the impetus to think and reflect why I was away on vacation and this sort of, it did it just…it helped tremendously so…it made me realise that what I wanna do and yes the four things I put down on the page, how I want them to change
and move on and really get a grip of things again and get my life back in order and this really helped and from there on in I’d be…------ - and ------- [support workers], who’s also part of my health team as well, they’ve all test tried it and since then I’ve improved dramatically on how I am and all that and it’s been really, it’s been really good since the holiday.”  

(Tim)

In the second interview with Tim, following opportunities for him to undertake more work in respect to his plans for recovery, one of his final comments when reflecting on the process was a summation of his feelings where he defines what recovery means for him and its impact on hope and optimism for the future:

“I know I’ll be able to do it you know, it’s hard to describe, the feeling you get inside when you feel so positive you know, the feeling that you’re moving in the right direction. You’re getting better all the time and your life is on the right path, the feeling you get from that is unbelievable. Yeah.”  

(Tim)

Early intervention team perceptions

The staff group reported that the recovery budget had resulted in reflection on how they supported people enabling autonomy and positive change. The staff group recognised that the use of support planning and the flexible nature of the plans provided a valuable tool for the early intervention team to use. Finally, the teams learned that fears of financial abuse were not realised, and
that modest sums had the potential to develop large and unpredicted positive results.

The narratives garnered from interviewing participants of the IRB show the positive effects of using the process to support recovery approaches. The participants reported feeling able to do something towards recovery, something that reflected their individual situation, needs and aspirations. The monies were accessed quickly and efficiently, and provided the participants with tangible and rewarding experiences which are proving to be foundational in building their personal recovery plans.

The services were also part of the evaluation. In particular, the evaluation was interested in what ways, if any, the early intervention teams' ways of working had changed, or whether specific learning had occurred as a result of using the IRB. The following section highlights some of the key messages arising from the two focus groups, and is followed by the interview with the recovery broker.

The use of recovery budgets revealed important lessons about how the process of support planning and managing recovery budgets might be enhanced. Key areas of learning were that a **quick and simple process** helped the participants. Several experiences showed that only a process such as the individual recovery budget could have resulted in the participants accessing the purchase.
A key theme emerging from the meeting was that the IRBs were a new and helpful tool. The experience of working with support plans towards IRBs raised the issue of whether the approach was a different way of approaching the person. Some debate arose over whether the early intervention team were doing anything different from what they would have ordinarily undertaken. The decision to include the category was made because sufficient staff felt that using support plans and working with outcomes involved working in a different way, even if that difference was attitudinal.

The staff group discussed the potential of the IRBs for recipients as being a method to develop means to possible futures. There is a resonance between the use of possible futures for the staff group and the notion of recovery from the recipients of the IRBs. The idea of possible futures shows a relational meeting of hope between the work of the early intervention worker and the aspirations of the service user.

Some staff articulated a view that IRBs and potentially personalisation would not necessarily suit everybody. For these individuals an IRB would not support the person’s recovery plan. This theme was termed not for everyone.

Additionally, one of the aspects arising from the support planning process highlighted two aspects of learning. Firstly, the sometimes unorthodox use of media in creating support plans could easily be incorporated into statutory
systems of planning and governance; this was called *fitting in with regulatory forms* or working in parallel with existing requirements. Secondly, the outcomes identified at the outset of the plan were only a part of the overall change associated with the IRB. This category was termed *unanticipated outcomes*, and can be seen in a number of stories. One story shared by three staff in separate interview settings, though not an interview by this investigator, is given on page 73.

It is this last point that seems in some ways the most interesting, as it highlights the importance of focusing on outcomes, a central tenet of self directed support and personalisation, but also makes clear the importance of serendipity and unpredictability in providing opportunities for individuals. The notion of *making it work* was important for the staff group, as reported by the three different perspectives sampled. The teams were, it seems, under pressure to respond to development and initiatives from the Trust and wider agendas. A way of working that supported positive interventions was one to be welcomed, though any progress or success would need to be supported by some key mechanisms ensuring work was undertaken.

A strongly articulated issue focused on the assessment of need and subsequent allocation of funds, although the focus group where this issue was mostly articulated centred around discussion of an equitable distribution of IRB monies across teams and, most importantly, individuals highlighted an issue of measurement of need.
Within larger projects where individual budgets have been administered, a central tenet has been a self assessment questionnaire and the Resource Allocation Schedule. Neither has been used in this pilot. The issue of parity and equity are central to the processes of self determination. The coding for this evaluation was termed **fairness and parity**.

An issue always related to financial probity and governance is that of abuse and fraud. The concern exists that some individuals will abuse whatever funds they receive, and as a result the service will in tangible ways be seen as culpable for the actions of others. Concern to protect public monies will be even more acute with impending financial constraints.

Within this pilot there have been no reported incidences nor concerns that participants or applicants had in any way sought to exploit the process of IRBs. In fact, the staff group commented on how they had been moved and touched by the participants' modesty in asking for IRBs. The participants could had identified the most expensive item to buy, such as a computer, though the experience of the team was that this did not happen.

Alakeson (2007) makes the point that in the Florida 'cash for counselling' scheme, the most financially needy families and individuals did not fritter the meagre resources away. On the contrary, it seemed that those people with the least money to draw on were in some ways the most frugal. They understood the value of money, unlike many others, whose experience of
handling money was greater. A later section, *Modesty of request*, will briefly highlight the surprise of the early intervention teams.

The final section in analysing the narrative transcripts focuses on the effect of training.

*A new and helpful tool*

The focus group felt that IRB gave them as an early intervention team more approaches than were available without them. The teams were supportive of the use of IRBs and the approaches that underpinned their achievements:

“There’s been some positive trade-offs because of the budget has been used when other areas have been exhausted. So in some cases we’ve actually found other streams of funds that perhaps we weren’t as aware of before or as comfortable accessing. So quite often we’ve found other ways. So that the budget highlighted it but there was actually other things there and that was quite positive I thought.”

(Early intervention worker)

“I thought it was a fabulous idea in fact, um, to be able to access funds to help people improve their lives and to me that’s something I’ve never had access to in the health service and it’s nice and new and it’s been absolutely fabulously beneficial for those clients who’ve accessed it.”

(Worker, Sefton)

“I think graphic in as much as people have sometimes got a lot more of an idea now of what recovery would mean to them and we’re able
to capture that within the care plans. I’m not saying that we…
perhaps always have, but we never quite had that depth of detail
sometimes as we’re getting now.”

(Early intervention worker, North)

“I suppose you could say given the sort of um the theoretical
construct around STR work is and personalised budgets. There’s a
direct correlation though isn’t there. Put down recovery, personality
recovery budgets, that correlation I think. Maybe, you know…”

(Early intervention worker, South)

A different way of approaching the person

“I think sometimes, yeah, if you were close, obviously we’re all
acutely aware of the money situation plans so I think it would
probably change what you said to them in the way of, if you had it in
the back of your mind that you could get them a bike to get fitter and
ride round the park then it would change the suggestions you make
to them because you know you could help them buy that bike…so
maybe, yeah. It does change a little bit.”

(Early intervention worker, South)

For others a change of working practice was more noticeable. The change
was as much to do with creative approaches as it was with helping people
think of novel responses to their situations:

“In some instances it’s probably put more depth in some of the care
planning aspects now. From what I’ve…coz sometimes I suppose we
look at certain activity…and we’ve almost got like a stock, it sounds
terrible doesn’t it, we’ve got a stock answer of what we want to do
and that seems to be getting a lot richer now.”

(Early intervention worker, North)
"...I think its changing the dynamics of discussions that we have around things sometimes but that is...it is different for most people, the way that you work, isn't it?"

(Early intervention worker, South)

**Fitting in with regulatory forms**

"How can you link ---- [IRB participant] getting golf clubs to his care plan and John’s recovery? Well quite simply, if you have a look at...if the careplan, if the CPA and careplan have been done properly then there are certain outcomes within that that will link nicely to ---- [IRB participant] playing golf. Such as to improve social skills or to spend more time away from home doing things. Er...to get fit for example. So as long as we could link those things back to the CPA I knew that Mersey Care would be happy."

(Recovery broker)

The sentiment above challenges modern mental health service delivery in so far as it is making clear the relationship of support planning to mandatory or statutory care plans, for instance the Care Programme Approach.

“I think most uh...the most amazing one was ---- [IRB participant], who came up with his own CD. They was asking for some music software for their laptop and er...I’ve worked with about half a dozen young people now who’ve asked for some sort of recording equipment...---- [IRB participant] put their support plan together yeah? They created a CD, er...I don’t know, it was a real sort of cutting edge dance track really, that they had put together. And it was all about themselves. It involved many of the questions that we’ve talked about and erm...we suggested that they did an album
cover for the CD as well and that’s where they wrote some of the things down that were important to him, for the software.”

(Recovery broker)

One of the main differences between traditional care planning and the methods promoted through person centred support planning is that the latter relies far less on process and form; instead, the person at the centre should have ownership of both the process and outcome. This is done using standardised formats, mostly developed by service professionals, which meet the system’s governance regulations as well as attempting to be a useful document for service users.

In a personal communication from a peer advocate/researcher, the tension between users and professionals was succinctly articulated:

“…You can be more creative and accountable with what we have but requires thinking differently about what really makes a difference. They always want us to think outside of the box but won’t allow you to colour outside of the lines…”

(Fudge 2009)

Ownership is achieved by supporting service users to develop their support plans using media and approaches that make most sense to them. One of the support workers within a focus group felt that the creativity shown by the service users had a positive effect on their approach in a reciprocal way:
"We’ve had people who have, due to their computer skills, have done a presentation and we’ve had some people who’ve wrote a letter. We’ve had people who’ve taped things as their medium, you know, to explain what things meant and I’ve kind of enjoyed the fact that it was for anybody at any level and it was up to us to interpret that and I thought that that was one of the really positive things for me."

(Early intervention worker, North)

The worker here is alluding to the interpretive action required when trying to understand what the service user is expressing. Unlike professional assessments where the frame is set, or scores lead to firm conclusions, the process of inviting a personalised support plan demands engagement from the professionals. It requires a curiosity at both professional and human levels to find out what that plan means to the service user. In itself this is quite different from traditional service systems, though it is central in support planning.

“That’s been quite good and I think the way that it’s been done it may have seemed to people that this is something that is accessible rather than a really strong paperwork trail that means that you’ll be jumping through hoops to do this. It allows you to, I suppose, express yourself in the manner that you are most comfortable."

(Early intervention worker, North)

Unanticipated outcomes

A key feature of mental health services is the identification and assessment of need or deficit, followed by skilled formulation and planning interventions. The outcomes of this process are evaluated and judgements made as to their
efficacy. The legislative framework for supporting people with mental health problems demands clear statements amounting to objectives of a care plan. Indeed, the Care Programme Approach is a means by which care delivered across interagency boundaries can be co-ordinated.

The IRBs were meant from the outset to be an outcome led initiative. The purpose of the budgets was to create opportunities that would directly support activities identified as being important to and for the participant, and would thereby be beneficial to the process of recovery.

The evidence from this small group of individuals shows good results in achieving goals identified within the support plan. What was less expected was that after receiving the IRB, unforeseen and unanticipated outcomes followed. For one young man, a bicycle to enable him to get to school in a stress free manner resulted in him meeting similarly aged local friends and using the bicycle to go for long cycle rides, like many young people of his age. The young man’s support worker states:

“So he said I want a bike, you know, ’I want to get to school on a bike’. You know, and he has and you know, and he’s doing other things that young people do, football coaching, you know.”

(Early intervention worker, South)

The recovery broker who supported the early intervention team worker and young man in developing the support plan reflects on the process and unexpected nature of the outcome:
“...It was during the summer holidays and actually he started biking with a friend who lived on the same street. For one of the first times he was getting out for more than, you know, more than just to go to an appointment or with a family member or with a member of staff. He was going, packing a lunch and going with his friend for a day’s long bike ride. So, er...being able to provide something for somebody often has consequences beyond what we planned for, you know.”

(Recovery broker)

An £800 holiday met the support plan of one participant; being with their near relative, supporting them and being a friend to strengthen that important relationship gave the participant space and time to evaluate their situation, and to decide their future in terms of work, education and housing.

A young man sought to improve his health, sleep hygiene and social contact, and to recover some things which his psychosis had deprived him of. Following a successful application for membership of a gym which he had previously frequently attended, and with an aspiration to provide some physical education to people within acute mental health services, the man now has a role peer supporting people with mental health problems to access physical health as part of a large funded research project.

A young man who wished to go to university obtained an IRB for computer hardware and software and broadband internet access to make access to learning materials easier; he was also able to maintain contact with friends in
spite of a relapse pattern being shown. The laptop and internet connection allowed him to use instant messaging software when he was otherwise unable to engage with others outside his accommodation. The evidence of maintaining contact through messaging was contributory in deciding to take a positive approach to risk management and not to admit him to acute services:

“On this occasion he didn’t and it was a totally different outcome. That person was able to maintain contact with ourselves, with other people and in that instance that person didn’t come into hospital. Whereas given the risks and the concerns that we would have had in the set circumstances he would have done.”

(Early intervention worker, North)

The point of extrapolating to this finding from the very small number of people interviewed is that the predicted goal of service intervention was generated by users initially stating what was important to them and then identifying what would make a difference to their life and contribute to a process of recovery. What could not be predicted were the consequences or happy coincidences which resulted in more change and positive growth.

**Fairness and parity**

One of the central and potentially contentious issues facing the use of individual budgets today is the allocation of resources on the basis of need, ensuring that allocation is measured on that basis, and on that basis alone. The Resource Allocation System (RAS) (Duffy 2007) is the means by which this process occurs. As previously mentioned, this pilot did not use a RAS as the sums involved were small and its scope was limited to the early
intervention team. The sums allocated through the IRBs were not subject to a process of allocation other than a support plan request and scrutiny by a panel should the request exceed £400 or be contentious.

The IRBs were therefore more akin to spot purchasing than individual budgets. That said, issues of parity and fairness were raised in the focus group, though the issues were not universally held to be a problem. Nevertheless, the issue was one that echoes the wider question of how resources are allocated within a service.

The support worker below articulated their concern that monies could have been allocated on what they describe as a more fair system rather than on what was requested:

“I actually thought it should have been shared out more evenly…Like maybe with the care co-ordinators getting so much money and then looking at what their clients need and doing it out that way, more sort of equal.”

(Support worker EIT, South)

The support worker went on to suggest that monies could have been allocated across teams equally, rather than being based on need, and suggested a ceiling of £200 per person to ensure equity. This position was qualified on the basis of the pilot being for a limited period only, suggesting their views may be slightly different were the scheme to be permanent.
This view was countered by another member of the focus group who expressed support for the way the IRB had been allocated. Whilst acknowledging the perspective of their colleague, their support for the system adopted was clear:

I take sort of ----- [support worker EIT South] point about it being distributed differently. My worry with that though is if you allocate per head a sum of money and then if you think about, we’ve got maybe two hundred clients per team who’ve got about twenty grand per team to spend, that would come down to a couple of hundred quid each. That’s not going to make a difference for a lot of people but if there are some who don’t need it and some who need more then to me it’s much better that you can have no cap on that.

(Support worker, EIT Sefton)

The idea of fairness was extended to the perceptions of the service users outside the early intervention team’s pilot, where users from other services within the Trust’s remit noticed what some other users had received:

“\text{I don’t know if I told you this, I attended one of the football games recently and it was one of the service users from early intervention…was quite upbeat about a course they were going on and that the recovery budget that had helped to fund that. There were three service users from the community mental health team who just were amazed that this.}”

(Support worker, EIT North)

The difficulties around fairness and equity were acknowledged within the focus group, but the members could not agree how a system of allocation
should be managed. Simple capping of monies available to service users was felt to miss the point of working with individuals and their unique needs and aspirations. However, the amount of money requested by an individual could use a significant amount of monies available, lessening the amount available for others to access.

One member recognised the inevitability of a resource driven system where services are inherently limited by the amount of resources at their disposal. This member was sanguine about their professional situation, stating:

> There will always be a finite amount of money. No matter how we sit round here. We’re never going to deal with endless pots are we?”

(Support worker, EIT Sefton)

**Modesty of request**

“I said at the beginning the modesty of what people have received having an impact on their lives and that’s been perhaps one of the nicest outcomes of this. Nobody’s asked for the moon. So many people have looked at what things could just have a…if you like a gentle impact in making recovery and I think that’s been reflected in…”

(Support worker, EIT North)

This respondent further articulated the point by considering the role of the IRB panel:

“I think the gentle use of a panel over this set amount of money has um…has been a good, if you like, a good mediator and…but in many
respects the panel has been under-used because people have been asking for very modest sums.”

(Support worker, EIT North)

**Training and preparation of services**

The training and preparation of services in supporting people with mental health problems is central to transforming services. Training represents an investment of time and resources for service managers, and the trainees take time from their clinical duties to undertake preparation or training. It is crucial that this time is beneficial to the service users’ experience. For the service personnel, training and development should have clear relevance to their work, facilitating and assisting in their undertaking of tasks. Additionally, when training for transformation, the culture of the service setting and even profession may create challenges for the commissioned training and development.

With this in mind, the following section highlights some of the experiences reported during the evaluation, and indicates some directions for any subsequent provision to learn from. In order to promote a balanced view of the training, the framework of what worked and what didn’t will be used.

When respondents were asked directly what advice they would give to another service if they were considering setting up a recovery based service using individual budgets and person centred approaches, one respondent stated:
“I think it would help us all... really and useful training days. And I think it was... 'cause people obviously..., because there's more and more that's being put upon care co-ordinators provided by other professionals is that could be worse than... alleviating those fears first for you and actually really giving a good explanation of actually what individualised budgets, recovery budgets are all about really.”

(Support worker, EIT South)

There is an indication that training should have some shared professional identity, as well as recognition that any training introducing a new approach or way of working will be received in the context of the existing perception of the workload of that person or team. The importance of good, clear explanation is highlighted as a way to circumvent reticence, professional or otherwise.

Part of the perception of the service personnel interviewed was that the IRB was a pilot, with a finite lifespan. This was highlighted as a potential barrier in earlier comments from some workers, who suggested that they worked with a partial mindset that the resource should be used to its full extent, as it would cease after April 2009.

When responding to questions about the training and preparation for the pilot, it seems that the approaches covered may not have been incorporated into the practitioners’ work. It was clear that the focus group had not used the tools delivered within the initial training.

There appears to be some mismatch between the materials taught and the fidelity of that piece of training. There may be some significant learning
required to support successful integration of person centred approaches into wider specialist mental health services.

**Narratives from the service users not interviewed, but referred to by focus groups**

*Peter's story*

A 14 year old person was travelling to school on public transport where younger children were frequently smoking cannabis. Peter had very strong views about drugs as he had a goal of becoming a police officer, and as a result he had got into conflict with these children resulting in threatening behaviour towards Peter. The situation deteriorated and Peter was choosing not to go to school.

The recovery budget process was undertaken. Following a suggestion from his key worker at the EIT, a means of maintaining his attendance in school and avoiding physical threats was to access the IRB to purchase a bicycle so that Peter would be able to get to school, maintain his studies and avoid a particularly stressful part of his day. The bicycle was brought, though by the time he received the bike the summer holiday had begun. The positive view was that Peter could get used to the bike in readiness for the recommencement of the school term.

As an unforeseen consequence, Peter used the bike in and around where he lived and for the first time in a very long time, Peter and a friend decided to go
off for a day’s ride with a packed lunch. This was quite unexpected, but nevertheless fulfilled key components of his care plan. Additionally, Peter has begun using his re-found confidence to become involved with football coaching.

_Darius’s story_

Darius used his recovery budget to obtain a laptop and broadband as a means to prepare for and undertake an educational course. Some months later and due to the fluctuating nature of his mental health, Darius began to show definite relapse signs: he was distancing himself from social settings, commencing a relapse signature of withdrawal and isolation.

The concern of the early intervention team was that Darius was withdrawing socially and retreating into his room. In the past, this had been a clear indicator that things were getting very bad for Darius. A visit to Darius’s accommodation was arranged to determine whether a hospital admission would be required. The psychiatrist and nursing clinician knew that should they be compelled to compulsorily admit Darius under the Mental Health Act, something that had been done before, then many of Darius’s suspicious ideations would focus on him being observed and monitored – clearly, being admitted would involve such experiences, for appropriate clinical reasons.

Although Darius was withdrawn and not going out, the laptop and broadband brought with the IRB was sited in the corner of the room and instant messages were flashing up on the screen. Although in cyberspace, these
messages were taken by the clinicians as evidence that Darius was in fact still in contact with the outside world. Darius had also used mobile text messaging with his worker in the early intervention team. Although this form of communication was somewhat unusual within traditional mental health services, the communication was recognised as a means of contact.

This was a factor in the clinicians’ decision not to recommend an admission. This was reported as a difficult decision to make, as the type of evidence being used to partly inform the judgement was unusual. The clinicians regarded the decision not to compulsorily admit Darius as positive risk enablement. Without such evidence, an admission may have been the only option.

The cost saving obtained by avoiding a compulsory admission, coupled with the likely ongoing costs of acute care versus the cost of laptop and peripheral equipment, seems clear. However, the financial equation is only part of the story, as Darius was not admitted. His mental health and well being was maintained through the continued work of the early intervention team and their supportive interventions. Darius continued with his recovery process and was to access the IRB a second and third time. He is now on a course gaining qualifications in translation which it is hoped will enhance his opportunities for employment.

Darius’s story shows us a number of points that exemplify the IRB pilot and the flexibility of approach it offers. Firstly, in very real ways the early
intervention team were able to support his application to a higher education institution by providing him with technical means to access learning through a laptop. Additionally, the early intervention team learned to access broadband on a pay as you go basis, a process they have subsequently used with other recipients of IRBs. This has been particularly useful as it avoids complications of line rental and fixed installations. Darius has also used the IRB for a second time when his original application to higher education was rejected on the basis of prohibitive costs arising from his citizenship status, aiding him to access a course appropriate to his skills and interests.
Patterns of spending within the budgets
Patterns of spending within the budgets

The following data representing referral, access and spend from the three early intervention teams in Mersey Care show some differences between the teams in how often and how much they have spent, and how many of their staff have used IRBs. The teams were each set up to support 150 individuals within their geographical area with first episode psychosis. The teams were set up in a phased way, and have as a result different characteristics in the number of service users they support.

Table 1: Characteristics of EITs

<table>
<thead>
<tr>
<th>Team</th>
<th>Intake cycle</th>
<th>Number of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Liverpool</td>
<td>2\textsuperscript{nd} year</td>
<td>150</td>
</tr>
<tr>
<td>North Liverpool</td>
<td>3\textsuperscript{rd} year</td>
<td>150</td>
</tr>
<tr>
<td>Sefton and Southport</td>
<td>4\textsuperscript{th} year</td>
<td>163</td>
</tr>
</tbody>
</table>

Figures of cycle and caseload

Chart 1: IRB spending (on participants) July 1st 2008 – 31st March 2009

(My thanks to Antony Dowell for providing access to funding and some of the following charts.)
The budget for IRB spending on clients in 2008–09 was £66,798.00. The total amount spent by the three teams was £48,003.00 in that period. This left £22,795.00 to be carried over to the 2009–10 IRB budget. The average spending per client request was £545.50 in 2008–09.

**Chart 2: Numbers of people accessing the Individual Recovery Budget 1st Jul 08 – Mar 31st 09**

- Overall 79 people have accessed the IRB (Individual Recovery Budget) in the nine months of operation (between 01/07/08 and 31/03/09).

- 88 opportunities/activities have been bought for those 79 individuals. (8 people have accessed the scheme more than once.)
- The number of purchases has been 106 (some items and activities have required more than one purchase e.g. sports kit and gym membership are two purchases for one person, and are counted as one above).

Table 2: What the IRB money has purchased in 2008–09

<table>
<thead>
<tr>
<th>Item</th>
<th>Numbers purchased</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT equipment</td>
<td>13</td>
</tr>
<tr>
<td>Annual gym membership</td>
<td>11</td>
</tr>
<tr>
<td>Driving lessons</td>
<td>10</td>
</tr>
<tr>
<td>Bike</td>
<td>7</td>
</tr>
<tr>
<td>Course</td>
<td>7</td>
</tr>
<tr>
<td>Home furnishings/decorating/improvements</td>
<td>6</td>
</tr>
<tr>
<td>Musical instruments</td>
<td>4</td>
</tr>
<tr>
<td>DJ/sound recording equipment</td>
<td>4</td>
</tr>
<tr>
<td>Activity budget</td>
<td>3</td>
</tr>
<tr>
<td>Broadband</td>
<td>3</td>
</tr>
<tr>
<td>Sporting gear</td>
<td>3</td>
</tr>
<tr>
<td>Holiday/weekend break</td>
<td>3</td>
</tr>
<tr>
<td>Clothing</td>
<td>2</td>
</tr>
<tr>
<td>Travel to college/bus pass</td>
<td>2</td>
</tr>
<tr>
<td>Freezers</td>
<td>2</td>
</tr>
<tr>
<td>PAYG mobile phone &amp; top-up budget</td>
<td>2</td>
</tr>
<tr>
<td>Pet related</td>
<td>1</td>
</tr>
<tr>
<td>Car tax &amp; insurance</td>
<td>1</td>
</tr>
<tr>
<td>Study book voucher</td>
<td>1</td>
</tr>
</tbody>
</table>

(A. Dowell)
The following chart shows the proportion of spend to items. There is a clear diversity and flexibility shown in the spending pattern. There is also a clear emphasis on the use of the budgets on equipment or access aimed at a direct health improvement.

Computer or other technologies are also used to a large extent by participants within the scheme. There appears to be a strong link between the accessing of IRB resources and the participants’ aspirations of undertaking further study or training to further their recovery.
Chart 3: Items bought with budget by proportion 2008 – 2009
If we compare the spending patterns in Mersey Care over the short period of the pilot with the more established services of SDS from Florida, then even allowing for the different rules applied to SDS, we can see the emphasis on using the grant to access or purchase items that enhance recovery for the individual.

Chart 4: Number of purchases made by category in District 8 Self-directed Care Program, July 2008 – March 2007 (Number of requests for reimbursement)

Data by kind permission from Vidhya Alakeson

The rules governing spending in the US are not consistent from state to state, creating differences in how individual budgets can be used. The systems used in Oregon are most similar to those applied within mental health services in the UK. In this we can see the use of more socially orientated budgets.
In the Mersey Care pilot, it was explicit from the outset that there was no bar on what the budget could be used for, other than the mantra:

“No limits were put on the amount of money that was to be spent on somebody. No limitations apart from it should be safe and legal.”

The pilot employed a ceiling of £400, but if a request exceeded that then a panel system would be employed. The panel was comprised of the recovery budget broker, a senior member from the EIT and a service user representative; these would scrutinise the support plan proposal and decide whether to support the application or to ask the applicant to amend the application in some way. The panel used for reviewing possible controversial or expensive purchases was used about 30 times for expensive purchases.
The panel was also set up as discussed to listen to and make judgements for unusual or potentially difficult support plan proposals. The panel was called upon four times to discuss these unusual/controversial requests. Each of these applications was accepted, such as buying a dog for a service user, and decoration of a spare bedroom so that a mother separated from her child might be able to have her child stay with her. Both of these instances raised ethical issues, in terms of wellbeing of an animal in the former case and hope beyond reality in the latter instance. This was seen as an important and necessary level of scrutiny, ensuring best practice was maintained throughout.

There were two cases where the panel needed to be reassured that all other areas of potential funding had been explored to achieve the decorating and furnishing requested. The panel’s decision was that no other areas of funding were available and therefore the payment could be made.

This aside, the spending patterns are clearly set against making a difference for the person and the life they wished to lead. Most of the spending had some direct change associated with it. The spending could not be said to have been either excessive or inappropriate. It was noted by one of the interviewees that they were very much taken with the modesty of the requests emanating from the support plans. There has been no suggestion that any of the budgets have in any way abused or exploited the seemingly open system
adopted by the pilot sites. This finding is consistent with other studies that clearly show that monies have been appropriately used (Alakeson 2007).

This is an important point as much opposition to SDS is centred about the idea that public monies will be spent in ways that would be hard to justify in the light of harsh scrutiny – even more so today with a focus on probity to allay misuse of precious funds in increasingly restrictive settlement rounds.

When examining the patterns of access team by team, it is clear that differences between access and spending exist between the different bases of the early intervention teams. The figures show that with available data, the team with, at that point, the lowest uptake of budgets had the highest rate of access with the least number of staff. This would suggest that the team did not at that point have wide usage of the IRB. The data tells us that South had eight practitioners access the budgets over the period, whereas North had approximately 16 members of staff using the budgets. The Sefton team had approximately 12 workers facilitating the budgets. These figures are approximations as some of the applications for the IRB are unclear as to their origins. Also, as can be seen from the chart below, the South team experienced a slight lag in uptake between the months of July to October 2008.
It would appear that in the final quarter of the pilot, the discrepancy in referral between the three teams had evened out to some degree. Interestingly, the number of IRB spends from the South team was greater than those of the other teams. It would appear that the South team used the budgets a great many times, but used them for smaller amounts.
The final spend patterns within the pilot at the end of the financial year show that the different teams spent differing amounts in the budget as the charts below show.

**Chart 8: Percentage of budget spent by each team**

![Chart 8: Percentage of budget spent by each team](chart8.png)

**Chart 9: Average number of items requested by team member**

![Chart 9: Average number of items requested by team member](chart9.png)
Chart 10: Number of items requested

- Liverpool North Central: 45
- Bolton: 30
- Liverpool South: 20
Conclusion
The work undertaken over the past year has provided opportunities for recipients of the IRBs to progress their recovery paths in ways that would not have been possible without the recovery pilot. The opportunities provided to the early intervention teams have also been a means to progress working practices in the way the teams utilise their skills in listening to and supporting the service users.

The aims of the evaluation were to consider:

- What is the experience of individuals using financial support in the form of personal budgets to make changes in their lives?

- Does the experience of having control of resources impact on social inclusion, choice and autonomy?

- How does using recovery budgets in this way impact on the early intervention teams’ ways of working?

In respect of the first question, there seems little doubt that by providing participants with support in identifying what is important to and for their recovery, the recipients of the IRBs have benefited, sometimes in surprisingly positive ways.

Where the participants did not have opportunities to access appropriate local resources because of financial limitations, the IRBs have provided a bridge to
create the opportunities. Where participants have had some control, choice and autonomy, the IRB has strengthened the degree to which the person can exercise their control. And where the participants’ control or recovery was threatened because of funding difficulties, the IRB has defended the person’s ability to access the course/service/item.

The IRBs have had an impact on the way the early intervention teams operated in relation to their reach and options. There is less evidence to suggest the workers were practising in different ways because of the IRBs and/or training. The indication from workers is that the approach taken by the early intervention team is quite person centred to begin with. The IRBs provided a way to access the previously inaccessible, and offered opportunities to service users in ways that were efficient and effective. Not having to apply for direct payments was seen as a boon, however there does appear to be a need for skill and experience in accessing resources through the panel.

Work should be undertaken on utilising some of the tools being used in support planning if a person centred approach is to be adopted beyond the working of the pilot. Much of the positive attitude towards the scheme felt by the service personnel was in part due to the knowledge that funding would be available and the funding was finite, and the feeling that whilst the monies were accessible, they should be used to the full.
The pilot will end in 2010 following an extension. Should the processes inherent within person centred approaches and support planning be continued within the early intervention teams and scaled up within the Trust, work on consolidating community connecting and creative support planning should be maintained.

The use of creative approaches to users developing their support plans is one that has potential to assist in listening better to the voice and choice of the consumer. The importance of shifting the balance of power to the consumer in partnership with paid professionals should be recognised, though the challenges created by the need to merge plans with statutory recording in a meaningful way should not be underestimated.

This evaluation has produced some progressive narrative demonstrating the learning and development of choice and autonomy using relatively small sums of money. The impact of attending a gym or obtaining driving lessons or computers would be great to most people in need, however the impact for the service users accessing the early intervention team is greater. Without the financial support that accompanied the IRB, it is unlikely that many of the positive events would have happened. The challenges are for the service to maintain its commitment to recovery processes, and to find ways to further develop the personalisation agenda for people with mental health problems and those who support them.
References
References


Appendices
Appendix 1: Defining individualising of care services across health and social care

Personalisation:
The process by which state provided services can be adapted to suit you. In social care this means everyone having choice and control over the shape of their support, along with a greater emphasis on prevention and early intervention.

Self directed support:
A change to the way the social care system operates to give you choice, control and power over the support you receive.

Individual budgets:
A clear up-front allocation of money that can combine several funding sources that you can use to design and purchase support, from the public, private or voluntary sectors.

Personal budgets:
Like an individual budget, but solely made up of social care funding.

Direct payments:
“A cash payment paid directly to you so you can acquire your own support, rather than having it delivered by the council. One of a range of options for
people getting individual or personal budgets – other choices involve you having someone else manage your support for you.”

(from Department of Health 2008)
Appendix 2: Consent form (service user)

Title of Project: Recovery Budgets in a Mental Health Service

Name of Researcher:
David Coyle, Senior Lecturer, Faculty of Health and Social Care, University of Chester
Research assistant TBC

Please initial box

1. I confirm that I have read and understand the information sheet dated ………….for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason or legal rights being affected.

3. I agree to take part in the above study.

___________________                _______________   _____________
Name of participant Date Signature

________________________________  ____________________
Name of person taking consent (if different from researcher) Date Signature

________________________________  ____________________
Researcher Date Signature

Contact details for participant:
Telephone no. ____________
Email address: ____________

Please return in stamped addressed envelope or hand to support worker
(1 copy for participant, 1 copy for researcher)
Appendix 3: Participant information sheet (service user)

Recovery Budgets in a Mental Health Service

You are being invited to take part in an evaluation of a new part of the Early Intervention Team. Before you decide, it is important for you to understand why the evaluation is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others if you wish. Contact me to ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the evaluation?
The evaluation aims to find out what people who use the Early Intervention services experience is of receiving recovery budgets. These are the small sums that you might have used to purchase something that could not be obtained by the EIT or through direct payments, or other means. The budget could have been used to acquire a thing or access a service. The recovery budget process may have found a way for you to access a course or opportunity that did not require money, but that you got because of the recovery budget process. This evaluation wishes to listen to your story and to what the experience was like for you, and in what ways, if any, getting the budgets or process have made a difference to you. We will be asking members of the EIT what their experience of working with the budgets was like too.

Why have you been invited to take part?
You have been approached because you are in contact with the Early Intervention Team and are using the recovery budget component. This evaluation is only open to people using the Early Intervention Team’s service and who have been part of the recovery budget process between summer 2008 and spring 2009.
Do I have to take part?
No, participation within this evaluation is completely voluntary. If you choose to be a part of the evaluation you will be interviewed by an experienced researcher on two occasions, in the autumn and again around February 2009. The interview should take around an hour and will be at a place where you feel happy to talk.

Are there any risks or disadvantages to participating?
No, there should be no risks or disadvantages to participating; rather we hope the things we learn will help other services listen better to what people want and to provide more individual services.

Will the evaluation be confidential and anonymous?
Yes, the interviews will be confidential. We will record the interview using the University’s digital equipment. These recordings will then be transcribed. You will not be identifiable in this or any written report. All data will be stored in accordance with the Data Protection Act and kept within a locked facility within the University, accessible to only the research assistant and lead researcher. All digital recordings will be destroyed after 3 years (2011). All transcripts of the recording will be destroyed after 3 years (2011).

What will be the benefit of participating?
We hope that the results of the evaluation will be published and that the lessons learned by services will be shared with a wider audience through conferences. We hope this might help more people use self directed support more easily and provide the opportunity to get things from mental health services that really help the person.

Who is paying for this evaluation?
This evaluation is being funded by Mersey Care NHS Trust and the Care Services Improvement Partnership and will run between Spring 2008 and Spring 2009.
How can I find out more?
If you would like more information or have any questions please contact:

David Coyle

At the Department of Mental Health and Learning Disability, Faculty of Health and Social Care, University of Chester

Tel: 01244 511652
e-mail: d.coyle@chester.ac.uk

Thank you for your interest in this evaluation.
Appendix 4: Consent form (service provider)

Title of Project: Recovery Budgets in a Mental Health Service

Name of Researcher:

David Coyle, Senior Lecturer, Faculty of Health and Social Care, University of Chester

Research assistant TBC

Please initial box

1. I confirm that I have read and understand the information sheet dated …………. for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason or legal rights being affected.

3. I agree to take part in the above study.

___________________                _________________   _____________
Name of participant Date  Signature

______________________________             ________________
Name of person taking consent (if different from researcher) Date  Signature

______________________________             ________________
Researcher  Date  Signature

Contact details for participant:

Telephone no.  ____________

Email address:  ____________

*Please return in stamped addressed envelope

(1 copy for participant, 1 copy for researcher)
Appendix 5: Participant information sheet (service provider)

Recovery Budgets in a Mental Health Service

You are being invited to take part in a service evaluation. Before you decide, it is important for you to understand why the evaluation is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The evaluation is in two parts. It aims to find out what staff within the Early Intervention Teams experience using recovery budget processes. The study wishes to find out what this experience is like for the people working in the Early Intervention Team. A separate part of the evaluation is asking service users what their experience of the budgets has been.

Why have I been approached?

You have been approached because you are part of the Early Intervention Team within Mersey Care. You may have also been involved in Support Plan training and have been working alongside the budgets and their facilitator for some months.

Do I have to participate?

No, participation within this evaluation is completely voluntary. If you choose to be a part of the evaluation, you will be invited on two occasions by an
experienced researcher to a focus group. The group will comprise of representatives across the 3 Early Intervention Teams within the Trust.

**Are there any risks or will I be disadvantaged by participating?**

No, there should be no risks or disadvantages to participating, rather we hope the things we learn will help other services listen better and provide more flexible and responsive services.

**Will the evaluation be confidential and anonymous?**

Yes, the interviews will be confidential within professional limitations. We will record the interview using the University’s digital equipment. These recordings will then be transcribed. You and the service you work within will not be identifiable in this or any written report. All data will be stored in accordance with the Data Protection Act and kept within a locked facility within the University, accessible to only the research assistant and lead researcher. All digital recordings will be destroyed after 3 years (2011). All transcripts of the recording will be destroyed after 3 years (2011).

**What will be the benefit of participating?**

We hope that the results of the study will be published and the lessons learned will be shared with a wider audience through conferences.

**Who is paying for this evaluation?**

This study is being funded by Mersey Care NHS Trust and the Care Services Improvement Partnership and will run between Spring 2008 and Spring 2009.
How can I find out more?

If you would like more information or have any questions please contact:

David Coyle

at Department of Mental Health and Learning Disability, Faculty of Health and Social Care, University of Chester

Tel: 01244 511652
e-mail: d.coyle@chester.ac.uk

Thank you for your interest in this research.
Appendix 6: MAXQDA Code Browser

**MAXQDA code frequency recording**

<table>
<thead>
<tr>
<th>Frequency of themes within data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Working in people’s homes</strong></td>
</tr>
<tr>
<td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td><strong>Recovery</strong></td>
</tr>
<tr>
<td>0 1 3 0 1 0 1 2 0 0 0 0 7 0</td>
</tr>
<tr>
<td><strong>Others might need this process more</strong></td>
</tr>
<tr>
<td>0 0 0 0 0 0 0 1 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td><strong>Narrative turn</strong></td>
</tr>
<tr>
<td>0 0 0 0 0 0 0 1 2 2 0 0 0 0 0</td>
</tr>
<tr>
<td><strong>Contributing to social capital</strong></td>
</tr>
<tr>
<td>0 0 0 0 2 0 0 0 0 1 0 0 0 0 0</td>
</tr>
<tr>
<td><strong>Regressive narrative</strong></td>
</tr>
<tr>
<td>0 0 0 0 1 0 0 1 1 4 0 0 0 0 0</td>
</tr>
<tr>
<td><strong>Moral narrative</strong></td>
</tr>
<tr>
<td>2 0 0 0 0 0 0 0 2 3 0 0 0 0 0</td>
</tr>
<tr>
<td><strong>Progressive narrative</strong></td>
</tr>
<tr>
<td>2 0 1 0 4 3 3 5 2 2 0 0 0 0 0</td>
</tr>
<tr>
<td><strong>Only the budget could do this</strong></td>
</tr>
<tr>
<td>1 0 2 0 1 1 1 8 5 3 0 0 0 0 0</td>
</tr>
<tr>
<td><strong>Consequences beyond what we planned</strong></td>
</tr>
<tr>
<td>0 0 0 0 0 1 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>Headline</td>
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<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Simple process</td>
</tr>
<tr>
<td>Starting a positive process</td>
</tr>
<tr>
<td>What’s essential or what they actually want or need</td>
</tr>
<tr>
<td>Final thoughts</td>
</tr>
<tr>
<td>Modest requests</td>
</tr>
<tr>
<td>Possible futures</td>
</tr>
<tr>
<td>Fitting in with regulatory forms</td>
</tr>
<tr>
<td>Making it work</td>
</tr>
<tr>
<td>Composite story 3 laptop at home</td>
</tr>
<tr>
<td>Composite story 2 laptop broadband fees</td>
</tr>
<tr>
<td>Preparation and training for recovery budgets</td>
</tr>
<tr>
<td>Composite story 1 bike</td>
</tr>
<tr>
<td>Use it now because it is just for a year</td>
</tr>
<tr>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Different way of approaching the person</td>
</tr>
<tr>
<td>Not for everyone</td>
</tr>
<tr>
<td>A new and helpful tool</td>
</tr>
<tr>
<td>Fairness and parity</td>
</tr>
<tr>
<td>Unanticipated outcomes</td>
</tr>
</tbody>
</table>
Appendix 7: Flow diagram of process of IRB from initiation to receipt
(taken from PowerPoint presentation given at Network for Psychiatric Nursing Research, September 2008)

What is happening in a NW NHS Trust

Meeting between user/RB worker/EIT

What’s important TO and FOR user

link payment with outcomes

Support plan written, users doing as much & creatively too

Can this need be met by...

Broker & team manager agree payment?

Yes

Broker arranges for payment

No

Person gets item/access/service etc.

Panel

Existing Education DP/other

Plan re-written with users

IRB received
Appendix 8: Examples of materials from training and preparation undertaken with early intervention teams

Meeting map led us through the two days
**Important To/For**

- Understanding 'important to' and 'important for' is the key to the review process.
- 'Important to' refers to individuality and quality of life.
- 'Important for' refers to keeping the person healthy and safe.

**Doughnut**

This was used to explore:

- Core responsibilities
- Where we can use judgement and creativity
- What is not our paid business
Acknowledgements

I would like to express my thanks to all those who have supported the evaluation and allowed me into their experience of this pilot. I am indebted to the participants who gave their time and stories so freely, answering my sometimes clumsy questions with good grace and humour. Without the willingness of these people, there would be little to tell.

I should also like to express my appreciation to the members of the early intervention teams who took time from their very busy schedules to introduce me to potential participants and especially to the support, time and recovery workers who ferried me to some of the interviews. My thanks to the community psychiatric nurses and the early intervention team managers whose commitment to the IRBs and their teams was inspiring. Finally, my thanks to Carey for starting the project and thanks as well to senior managers in Mersey Care, especially Jenny, for their support and patience.