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**Exploring the implementation of Cognitive Behavioural Therapy for psychosis (CBTp), using the Normalisation Process Theory (NPT) framework**

And Clinical Research Portfolio

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BSc (Honours), MSc

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## **Chapter One: Systematic Review**

### **The implementation of Cognitive Behavioural Therapy for psychosis drawing on staff, service users and carers experiences: A meta-synthesis**

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## Abstract

**Objectives:** Despite the availability of national guidelines, evidence indicates limited implementation of Cognitive Behavioural therapy for psychosis (CBTp). The aim of this review was to identify and meta-synthesise current qualitative data regarding the experiences and perspectives of key stakeholders in relation to the routine implementation of CBTp. The meta-synthesis aimed to explore how key stakeholders make sense of the facilitators and the barriers to CBTp implementation.

**Method:** Systematic searches of Psychinfo, Medline, Pubmed, CINAHL, EMBASE, were completed up to March 2018. Examination of reference lists, citation searches, as well as, hand search of the Clinical Psychology Forum supplemented the search strategy. The methodological quality of the identified studies was also assessed. A meta-ethnography approach guided the synthesis of the data.

**Results:** Eleven studies were analysed. Three overlapping themes, each consisting of two subthemes were identified: *difficulties in seeking treatment* (motivation to engage, practical difficulties), *challenges of providing care* (professionals' confidence, practical challenges) and *service design* (lack of resources, conflicting needs).

**Conclusion:** Findings indicated that difficulties in seeking, delivering and investing in CBTp are interconnected. This suggests a systemic conceptualisation of successful implementation of CBTp, which relies on the collaboration of all key stakeholders.

## **Introduction**

Psychosis has a considerable impact on a person's quality of life, with evidence suggesting high rates of premature mortality and elevated levels of unemployment (Schizophrenia Commission, 2012). Further evidence suggests that although anti-psychotic medication improves symptoms, it results in a range of serious side effects including cardiovascular complications (Foley & Morley, 2011) and acceptance of antipsychotic medication can be poor. Additionally, even when people are on optimal doses of antipsychotic medication, residual symptoms and relapse remains a significant problem (Lally, Gaughran, Timms & Curran, 2016).

CBT for psychosis (CBTp) contributes to the reduction in symptoms (Turner, van der Gaag, Karyotaki, & Cuipers, 2014) and it is also associated with reduced risk of transition to psychosis for individuals with elevated risk (Hutton & Taylor, 2014). A systematic review of qualitative studies of service users' experiences of CBTp (Berry & Hayward 2011) reported that the ingredients of CBTp such as normalisation and offering an explanation to their symptoms were perceived as helpful in terms of the acceptance of symptoms. This was associated with adopting more helpful coping strategies and a reduction in reported distress. Similarly, Kilbride et al. (2013) reported that service users perceived normalisation and shared decision as important aspects of CBTp in their recovery journey. Furthermore, national guidelines, in the UK advise that CBTp should be offered to all individuals experiencing psychosis over the course of at least 16 sessions (National Institute for Health and Care Excellence; NICE, 2014).

Despite national guidelines recommending the use of CBTp, few individuals experiencing psychosis have access to this (Schizophrenia Commission, 2012). Over the recent years, studies have focused on exploring difficulties of implementing CBTp in routine clinical practice. A systematic review of the literature by Berry and Haddock (2008) reported

that barriers to CBTp implementation involved factors related to recipients of the services such as poor motivation, lack of family support and the severity of individuals' symptoms. Furthermore, a recent qualitative synthesis (Wood, Burke & Morrison, 2015) reported the challenges that service users experienced to engage with CBTp, which involved difficulties expressing emotions, managing distress and complying with homework assignments.

Additional factors which affected implementation were related to mental health professionals' reported lack of competence and pessimistic views on recovery in psychosis. Organisational barriers consisted of a lack of investment in CBTp which translated into lack of training, supervision and protected time for the implementation of CBTp (Berry & Haddock, 2008). Ince, Haddock, and Tai (2016) reported that organisation barriers were the most frequently reported in the literature followed by barriers related to professionals' and service recipients' attitudes.

A recent pilot study (Fornells-Ambrojo, et al., 2017) identified the role of clinical leadership (e.g. referral pathways, training, staff awareness, protected time) as crucial in CBTp implementation. Previous systematic reviews (e.g. Berry & Haddock, 2008; Ince et al., 2016) have described various barriers and facilitators to the CBTp implementation, without however attempting to synthesise and interpret qualitative data. Additionally, the data that were used were primarily related to professionals' experiences and views of CBTp. Systematic reviews of qualitative research have focused solely on service users' experiences of receiving CBTp without attempting to synthesise implementation from a range of stakeholders' perspectives.

## **Aim**

The aim of this systematic review was to identify and meta-synthesise current qualitative research investigating the experiences and perspectives of key stakeholders (including where



available mental health staff, service users, families and carers) in relation to the routine implementation of CBTp. This review will answer the following question: How do stakeholders experience/make sense of the facilitators and barriers to the implementation of CBTp?

## **Methods**

### **Search Strategy**

Before initiating the search, databases were searched for any existing reviews. No existing meta-syntheses of qualitative studies which explored the implementation of CBTp were identified. The main search strategy for this study included searching electronic databases (Psychinfo, Medline, Pubmed, CINAHL, and EMBASE), checking reference and citation lists of the included studies. A subject librarian was consulted on the development of the search strategy used. Boolean operators (OR and AND) were used to combine search strings. Title, abstract and keyword searches using the following terms were run (Appendix 1.5). The terms were tested to ensure that no problems with missing potential eligible papers were identified (e.g. the American spelling “behaviour”; “behavioral” did not increase the number of the final eligible papers)

1. Cognitive Behavioural Therapy or CBT or CBTp or Cognitive Behaviour Therapy  
AND
2. Schizophren\* or Psychos\*  
AND
3. NICE or “National Institute for Health and Care Excellence” or guideline\* or Implement\*

The search was carried out up to March 2018. Clinical Psychology Forum articles were also hand searched as previous systematic reviews have identified mixed methods audit reports which were relevant to the study’s aims. The reference list of a previous qualitative

synthesis review (Berry & Hayward, 2011) was also hand searched for any relevant papers and to improve the sensitivity of the search strategy.

### **Inclusion and exclusion criteria**

The following inclusion criteria were employed: Studies i) with adult population with a diagnosis of schizophrenia / psychotic symptoms/ experiences or individuals who had contact with this group (mental health staff, policymakers, carers), ii) including primary research information on the experience/perspective of stakeholders regarding the implementation of CBTp and/or CBT for people with psychosis, iii) in English language, iv) with full text available, v) which use qualitative methods (e.g. qualitative studies or mixed methods studies) , vi) quotations/excerpts reported, vii) published between the years 2002 to 2018.

Exclusion criteria included: i) studies not focusing on experiences of implementation of CBTp or CBT for people with psychosis, ii) studies not employing any qualitative methodology, iii) participants not having experienced psychotic symptoms, iv) absence of verbatim quotations being reported.

Inclusion and exclusion criteria were used to review the studies that were identified by this search. Initially, studies' titles were reviewed. Titles that were not meeting the inclusion criteria were excluded. Following this, the abstracts of the remaining studies were reviewed. Only studies whose abstracts indicated that the inclusion criteria were met, were reviewed by reading the full article.

### **Reflexivity**

At the time of this systematic review, the lead researcher was conducting a qualitative study which aimed to explore the implementation of CBTp based on mental health professionals'

perspectives. Moreover, the researcher had used CBTp in their clinical practice. This might have influenced the researcher's interpretation of the themes generated from the selected studies. Additionally, research supervision was used on a frequent basis to address potential biases that the researcher might have had when synthesizing the data.

### **Methodological critique**

The methodological quality of the identified studies was assessed with Walsh and Downe's (2006) framework of quality appraisal (Appendix 1.4). The selection of this framework was due to its focus on appraising qualitative studies that are included in meta-syntheses. Walsh and Downe's (2006) quality framework examines eight key domains in qualitative studies: namely scope and purpose; design; sampling strategy; analysis; interpretation; reflexivity; ethical dimensions; and relevance and transferability. A score of 0 was given for those domains that were absent. The domains that were partially met were given a score of 1 whereas a score of 2 was given to domains which fully met the criteria. To ensure the reliability of appraisals an independent rater, reviewed a subsample of studies. Although the methodological quality was assessed, this was not intended to provide a basis to exclude papers. Instead, studies were incorporated into the meta-synthesis in order of their total quality rating. Scores were used to identify the methodologically strongest studies to guide the initial steps of the meta-synthesis. The methodologically strongest studies were thematically analysed first to generate an initial set of themes before analysing subsequent studies. A priori, we decided not to report scores for the studies' quality as an outcome of this review, as it would conflict with the commitment to qualitative methods.

There was a 100% agreement between the lead researcher and the independent rater on the domains that were judged to be absent. Variation between ratings was noted for domains that were partially (score of 1) or fully met (score of 2) in the included studies.

Walsh and Downe (2006) noted one of the limitations of using a checklist approach is related to the difficulty of distinguishing the methodological quality from the quality of the write up which is likely to be affected by each journal's word limit criteria. Therefore, it was decided to comment on strength and weaknesses of each study rather than presenting a numerical representation, reinforcing our apriori decision not to present scores as outcomes. These are provided in Appendix 1.2 to ensure transparency in our conduct of this rating.

### **Data Synthesis**

The data from the studies were synthesised drawing on Noblit and Hare's (1988) method of meta-ethnography. Meta-ethnography is a type of meta-synthesis that was chosen to synthesise the qualitative data from the included studies due to its flexibility in synthesising data from various qualitative methods (Ring, Ritchie, Mandara & Jepson, 2011). The first stage of the synthesis involved reading each study to enable the researcher to immerse themselves in the data. A list of themes based on participants' and authors' quotations (and thematic analyses) was generated. Themes from the methodologically strongest studies were initially compared to understand how they were related to each other. The final step involved interpreting the themes that related to each other across the studies. Emerging coding frameworks were discussed in research supervision to refine codes and relationships. A comparison of matching codes to themes between the lead researcher and an independent rater suggested a 92.5% agreement.

### **Results**

The outcomes of the search strategy are displayed in Figure 1. A total of 11 papers were included in the meta-synthesis. Table 1 shows a summary of each study. Some of the selected studies involved only service users or staff participants, whereas others involved staff, carers

and service users. The studies included in the analysis also differed in the qualitative methods they used to analyse their data.

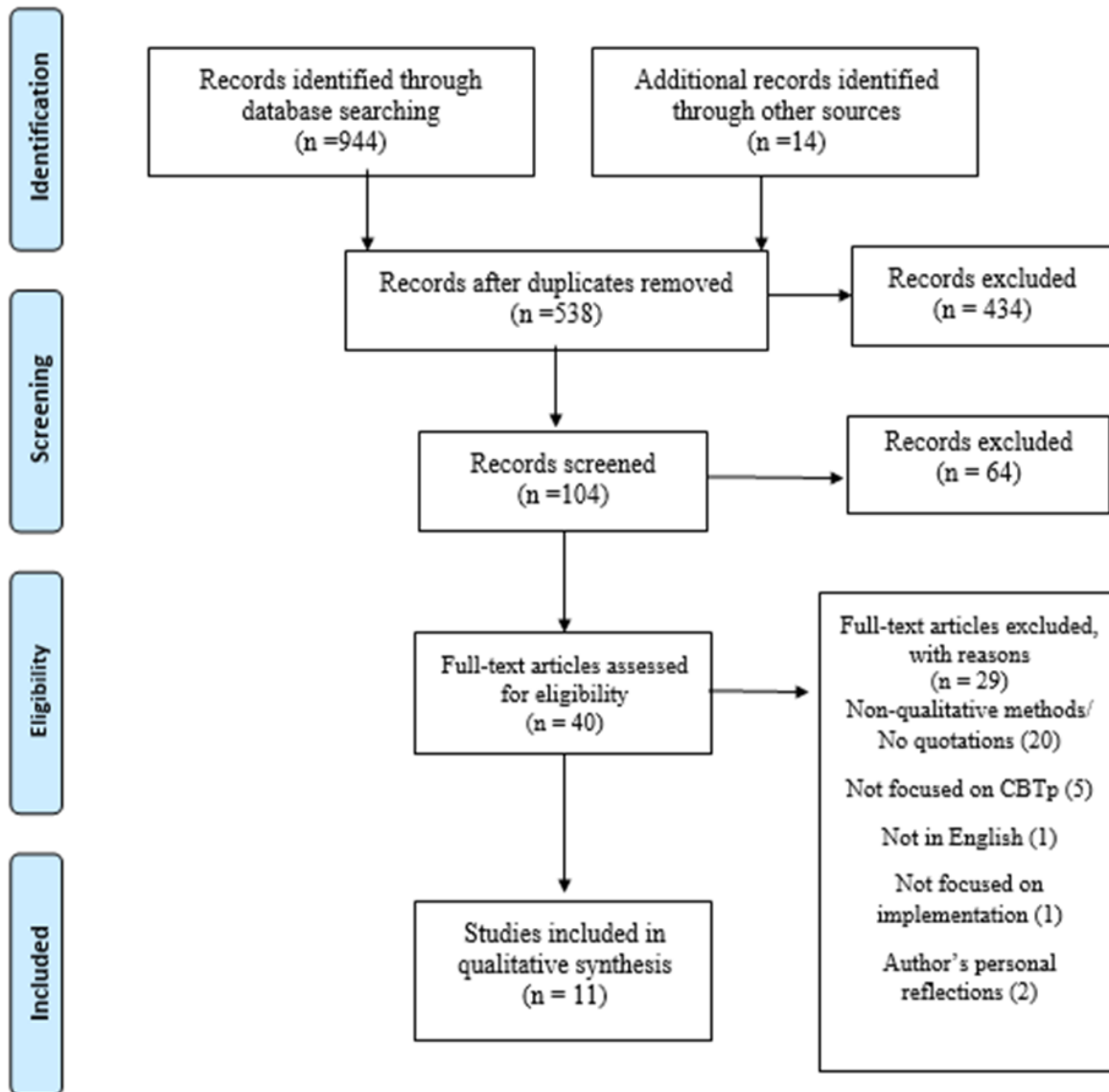


Figure 1. PRISMA flow diagram

Table 1

*Themes of the included studies that were used in data synthesis*

<b>Study (year) Country</b>	<b>Method of Analysis</b>	<b>Participants</b>	<b>Article themes related to the implementation of CBTp</b>
Dunn, Morrison & Bentall (2002) UK	Grounded Theory	10 service users (four female)	Themes: (1) motivation (2) memory (3) task difficulty (4) putting off (5) the need for a rationale (6) the perceived benefits of therapy (7) insight (8) the effort required to complete assignments and (9) the perceived relevance of the assignments to the patients' needs
Hazell, Strauss, Cavanagh & Hayward (2017) UK	Thematic analysis	21 service users 124 mental health clinicians	Themes: (1) Presenting problem, (2) Practical Barriers (3) The therapist
Iredale, Fornells- Ambrojo, & Jolley (2016) UK	Thematic analysis	10 service users (7 female) 12 Therapists (8 female).	Themes: (1) Access to psychological interventions, (2) experience of psychological interventions, (3) Motivation to engage with psychological therapy (4) Case complexities
Landau & Ruddle, (2017) UK	Thematic analysis	8 service users (4 male)	Themes: (1) Positioning of therapy, (2) To improve is to change (3) therapeutic alliance, (3) Frustrating findings
Li et al., (2017) China	Systematic Content and Question Analysis	15 Service users (7 female) 15 carers (12 female) 15 Psychiatrist (8 female).	Themes: (1) Culture and related issues, (2) Importance of language and communication, (3) Issues related to system and resources, (4) Understanding of illness and beliefs about its cases and its management, (5) Assessment, engagement and adjustments to therapy

McGowan, Lavender & Garety, (2005) UK	Grounded theory	4 Clinical psychologists 8 service users	Categories related to factors influencing outcomes in CBTp: (1) Ability to engage in clear and logical thinking, (2) Continuity in Therapy, (3) Remembering and Understanding therapy, (4) Therapeutic alliance-shared goal, (5) understanding, holding and engaging with the therapist's model.
Messari & Hallam (2003) UK	Discourse Analysis	5 service users (1 female).	Themes (1) CBT as a healing process, (2) CBT as an educational process, (3) CBT as a respectful relationship between equals (4) CBT participation as compliance with the powerful medical establishment.
Naeem et al., (2016) Pakistan	Systematic content and Question analysis.	33 Service users (15 female), 30 Carers (19 female) 29 Mental health professionals (15 female).	Themes: (1) Culture and religion, (2) Therapy issues, (3) Views about schizophrenia, its causes and its management (4) Awareness of illness and pathways to care (5) Management of illness
Newton, Larkin, Melhuish, & Wykes (2007) UK	Interpretive Phenomenological Analysis	8 service users (5 female).	Theme: (1) An inductive account of coping with auditory hallucinations.
Prytys, Garety, Jolley, Onwumere, & Craig (2011) UK	Thematic Analysis	20 Care coordinators (16 female)	Themes: (1) Understanding and beliefs about psychosis, (2) Beliefs about attitudes to clinical guidelines and psychological therapies, (3) Views on the role of care coordinator, (4) Factors affecting implementation
Waller et al., (2015) UK	Thematic Analysis	17 service users 7 mental health staff	Themes: (1) Positive aspects of the intervention (2) Challenging aspects of the intervention, (3) Future implementation into services, (4) Difficulties encountered during therapy (5) ideas for improvement

## Methodological review of the studies

All of the eleven studies documented the rationale, scope, and aims. Concerning the design, only three studies (Li et al., 2017; Messari & Hallam, 2003; Naeem et al., 2014) referred to the epistemological underpinning of their selected qualitative method. Some papers (e.g. Hazell, Strauss, Cavanagh, & Hayward, 2017; Prytys et al., 2011; Waller et al., 2015) provided detailed justifications for the use of qualitative methodology and their chosen method, without however mentioning the epistemology of their study.

All studies provided detailed inclusion criteria and discussed sufficiently their sampling strategy. Regarding the analysis, all studies provided details of their chosen approach, steps they have taken to analyses and the inter-rater reliability for the selected themes. However, only three studies (Li et al., 2017; McGowan, Lavender, & Garety, 2005; Naeem et al., 2016) returned a sample of their transcripts to participants for comments and verification. In relation to the interpretation of findings, most of the studies discussed the decision trail to reach their conclusion, and all utilised participants' quotations to support their conclusions. Two studies (Li et al., 2017; Naeem et al., 2016) used field notes to capture the non-verbal communication of their participants during interviews.

Concerning researchers' reflexivity, all but two studies (Dunn, Morrison, & Bentall, 2002; McGowan et al., 2005) have referred to researchers' biases and the impact that this could have on the interpretation of their findings. Hazell et al. (2017) quote: *"the book is authored by two of the authors of this paper. Consequently, it is possible that our findings could be vulnerable to a positive research bias"* (p. 13) provides a good example of researchers acknowledging their parallel roles and the impact that this can have on data analysis.

All but two studies (Dunn et al., 2002; McGowan et al., 2005) demonstrated a degree of sensitivity to ethical issues by describing the process of obtaining consent from research



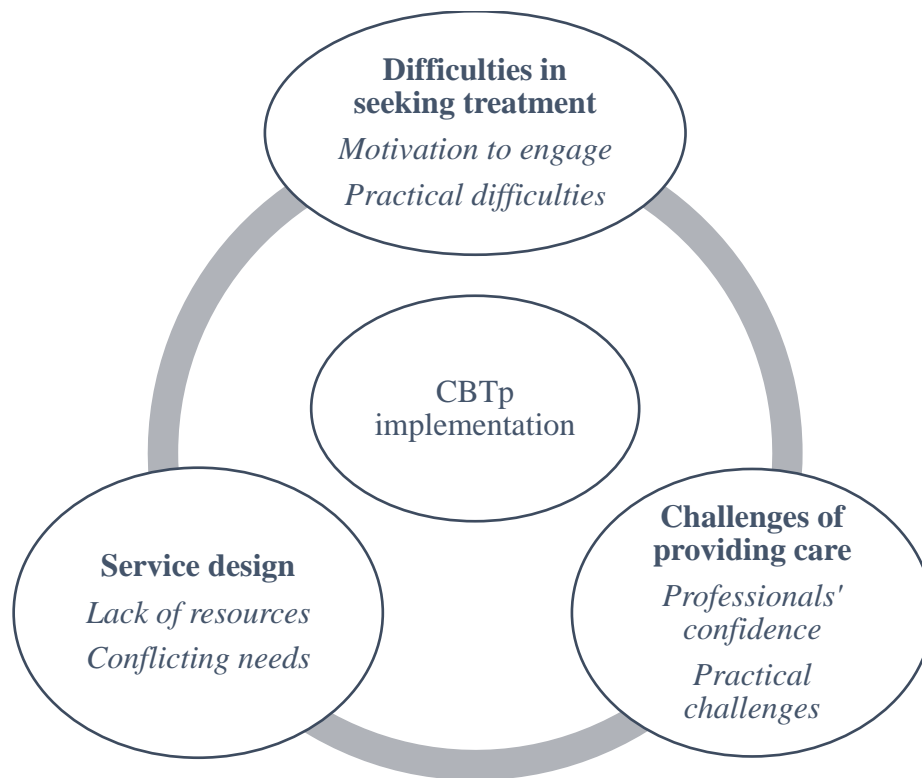
participants. Some papers even provided details of ethical approval (e.g. Hazell et al., 2017).

All papers reported the relevance of their findings to existing theories and knowledge.

The meta-synthesis started with the methodologically strongest studies (Hazell et al., 2017; Li et al., 2017; Messari & Hallam, 2003; Naeem et al., 2016; Prytys et al., 2011; Waller et al., 2015). Following this, the remaining studies were further analysed to search for new emerging themes or data that would disconfirm our initial themes.

### **Meta-synthesis**

Three overlapping themes, each with two subthemes, were identified. The themes summarised the perspectives of stakeholders regarding the barriers of implementing CBTp (see Appendix 1.3 for list of overarching themes). The ‘difficulties in seeking treatment’ theme consisted of the ‘motivation to engage’ and ‘practical difficulties’ subthemes. The ‘challenges of providing care’ theme consisted of the ‘professionals’ confidence and practical challenges’. The ‘service design’ theme comprised of the ‘lack of resources’ and ‘conflicting needs’ subthemes. Figure 2 demonstrates the interaction of the three themes which results in difficulties in implementing CBTp in services. The language used to describe the themes might need an adaptation overtime to improve the precision of the effects seen. For example, the “motivation to engage” subtheme might reflect at times approach or avoidance variants.



*Figure 2.* An illustration of the interactive and overlapping nature of the themes related to the implementation of CBTp.

### **Difficulties in seeking treatment**

All but one study (Prytys et al., 2011) contributed to this theme. The participants expressed their perspectives regarding the challenges that they faced to get access to CBTp. These challenges consisted of two subthemes: ‘motivation to engage’ and ‘practical difficulties’

#### *Motivation to engage*

Several factors affected service users’ motivation to engage with CBTp. Studies conducted outside the UK (e.g. Li et al., 2017; Naeem et al., 2016) reported the impact of culture and religion on illness attributions, which have influenced the treatment preferences: *“It usually starts with seeking help from non-medical healers at the initial stages of the illness. Before*

*coming to the psychiatric health facility almost everyone had seen a traditional/ faith healer”*  
(Author’s quote, Li et al., 2017, p. 5)

Furthermore, Newton et al. (2007) outlined that explanations that carers and service users gave to psychotic experiences affected the perceived sense of control over their symptoms, which in turn influenced their engagement with CBTp: *“In contrast, the religious beliefs in Mark’s family seem to have a negative impact on his coping with auditory hallucinations.”* (Author quote, p. 141). Li et al. (2017) study highlighted the impact of stigma on help-seeking: *“The stigma is a big problem; the patients are reluctant to come or even refuse to see psychiatrists.”* (Participant quote, p. 5).

Communication with mental health professionals and the ability to understand the concepts of CBTp were influenced by the socio-economic background of service users and carers and played a key role in their engagement:

*The low socio-economic level of the patients and their family members is the biggest barrier. Many patients and their family members have difficulty communicating with the doctors, and they do not want to spend time and energy in family therapy or CBT.*  
(Participant quote, Li et al., 2017, p. 6).

Studies which explored service users’ perspectives (Hazell et al., 2017; Waller et al., 2015) referred to individuals’ concerns regarding potentially increased distress or symptom deterioration when engaging with CBTp: *“If I’m focussing on something that is specifically about hearing voices and how to help that situation, my voices will not like that”* (Participant quote, Hazell et al., 2017, p. 7). Cognitive difficulties such as attention and memory affected the perceived gains of service users from therapy and thus their engagement with CBTp: *“I re-read the same thing so that could be a barrier to accessing the therapy”* (Participant

quote, Hazell et al., 2017, p. 7). This also had an impact on service users' compliance with homework tasks: *"Some people identified challenges with therapy. A common issue was difficulty in completing homework"* (Author quote, Landau & Ruddle, 2017, p. 38) and treatment materials: *"would have preferred a different format without that paperwork"* (Participant quote, Waller et al., 2015, p. 308,). The difficulty of engaging with treatment materials potentially limited the perceived benefits of service users from CBTp as illustrated by the following quote: *"Umm, there wasn't. I, I, I didn't get any help from it"* (Participant quote, Messari & Hallam, 2003, p.176). This might have affected the preference that some service users had for medication over CBTp: *"They only want medicines. They want quick cures. Some of them would say, how can you treat me by talking?"* (Participant quote, Naeem et al., 2016, p. 49).

### *Practical difficulties*

Studies referred to the lack of awareness of service users and families about the evidence base for CBTp and the ways that CBTp can help with their difficulties: *"Only a few had heard of psychotherapy. Other did not know what it means. Those who knew of psychotherapy, mainly considered it to be counselling"* (Authors quote, Li et al., 2017, p.7). Moreover, the lack of specialist care provision in some areas meant that even when families wanted to engage with CBTp they had to travel long distances to get access to it, which also had a significant financial implication: *"How can they come back for therapy if they are coming from Dera Ghazi Khan (2–3 days travel distance)?"* (Participant quote, Naeem et al., 2016, p. 49). Iredale, Fornells-Ambrojo and Jolley (2016) reported that psychotic symptoms, such as suspiciousness and anxiety, about leaving home environment deterred service users from accessing mental health services in the community: *"getting the bus [is] an incredibly stressful experience"* (Participant quote, p. 207). The houseboundness of people with

psychosis was further increased by comorbid physical health difficulties: “[*pain is*] worse when [*I’m*] moving around” (Participant quote, Iredale et al., 2016, p. 207).

### **Challenges in providing care**

All but two studies contributed to this theme (Messari & Hallam 2002; Landau & Ruddle, 2017). This theme comprised of professionals’ challenges of delivering CBTp. Such challenges were related to professionals’ confidence in delivering therapy and the practical challenges that they faced in providing CBTp.

#### *Professionals’ confidence*

Participants referred to the limits of CBTp effectiveness in the long-term, which affected their motivation to consider CBTp as a treatment option: “*What I have seen is that people find it quite hard to sustain*” (Participant quote, Prytys et al., 2011, p. 54). Increased workload along with experiences of limited benefits from CBTp impacted on professionals’ confidence in the evidence base and clinical guidelines, as they perceived them as not being realistic:

*the bodies that produce these guidelines and it can feel like, you know, something we need to know about but do they really know what it is like down on the ground level where we are struggling to just manage the vast number of people on the caseload* (Participant quote, Prytys et al., 2011, p. 54).

The severity of psychotic symptoms which was defined by limited insight, complexity, and chronicity, appeared to have shaped professionals’ experiences when delivering CBTp: “*These complexities appeared to impact on the staff members’ confidence and the service user’s engagement with the intervention*” (Author quote, Waller et al., 2015, p.304).

Professionals' confidence was further affected when the severity of symptoms was combined with a perceived lack of motivation from service users' side to engage with CBTp: *"As they did not perceive the tasks as relevant to solving their problems, they experienced low motivation to undertake the tasks and an increased tendency to put them off."* (Author quote, Dunn et al., 2002, p. 364). Such experiences led professionals to believe that receiving specialist training was essential to be able to deliver CBTp: *"Another important theme that emerged was the importance of having specialist workers in the team to offer a psychological intervention"* (Author quote, Prytys et al., 2011, p. 55).

### *Practical challenges*

Li et al. (2017) suggested that difficulties with attendance could increase the dropout rates when offering CBTp: *"Mental health professionals reported up to 80% drop-out from the follow-up"* (Author quote, p. 6). Additionally, difficulties in family relationships and subsequent lack of support seemed to further hinder the implementation of CBTp: *"Usually we find a family member who can act as a co-therapist. But if we can't do this then prognosis is poor"* (Participant quote, Naeem et al., 2016, p. 50). Mental health professionals referred to the challenges of implementing CBTp protocols which were not adapted to the cultural, educational and religious background of their clients: *"It is important to involve elements of religion and culture in therapy here. Then it becomes useful. If you don't understand religion and culture you can't give therapy"* (Participant quote, Naeem et al., 2016, p.48).

Additionally, cognitive difficulties that service users experienced, provoked feelings of frustration to professionals, which were mediated by the perceived benefits that they have from each session: *"Simply forgetting something that was blatantly obvious in the previous session. And it's almost as if every session is new ground."* (Participant quote, McGowan et al., 2005, p.521).

Hazell et al. (2017) reported that viewing psychosis solely as a medical illness affected the priorities that services have in managing referrals, which then influenced the support that professionals received in delivering CBTp: *“I think there will be resistance from practitioners who rely solely on the medical model.”* (Participant quote, p. 11).

## **Service design**

Seven studies contributed to this theme (Hazell et al., 2017; Iredale et al., 2016; Landau & Ruddle, 2017; Li et al., 2017; Naeem et al., 2016; Prytys et al., 2011; Waller et al., 2015). Participants in these studies referred to the service level barriers which consisted of the following subthemes: ‘lack of resources’ and ‘conflicting needs’.

### *Lack of resources*

Prytys et al. (2011) outlined that the combination of increased demand for mental health services and lack of resources impacted on the pressure that professionals experienced in daily clinical practice. This affected the priorities that professionals had when working with people with psychosis: *“we had this influx of, you know, a heavy caseload and the focus became more on keeping them stable, sort of, we are saying by, just compliance with medication and very little support”* (Participant quote, p. 55). Additionally, the pressure to assess more people within services limited the time that professionals had to attend supervision for CBTp: *“one-to-one social inclusion work you’re not used to group supervision really, so I can see the value of it ...it’s just finding the time really ...it was difficult”* (Participant quote, Waller et al., 2015, p. 304).

Professionals also referred to the pressure that they felt to deliver good outcomes in the least amount of time: *“All staff are asked to do unrealistic amounts of work, and this [guided self-help CBTv] may simply need too much time”* (Participant quote, Hazell et al.,

2017, p. 11). Furthermore, Prytys et al. (2011) outlined the importance of having staff trained in CBTp in order to facilitate referrals: *“Five referred to the beneficial effects of having specialist workers present in the team for easing referral for psychological therapies and communication regarding clients”* (p. 55). However, one of the consequences of limited resources was the difficulties of having staff trained in CBTp: *“CMHT workers in this study frequently highlighted the lack of such provision”* (Author quote, Prytys et al., 2011, p. 57).

### *Conflicting needs*

Investing in CBTp was perceived as producing limited outcomes: *“It seems to me that as psychosis does not produce results or turnover suitable to corporate organisations it [treatment provision] will remain the poor relation within services”* (Participant quote, Hazell et al., 2017, p.11). Hazell et al. (2017) outlined that CBTp was seen as a secondary option for services that needed to meet certain treatment and financial targets. This led staff to perceive that there were not adequately supported to deliver CBTp: *“I am dependent on managers who may be pressured to achieve targets and may not see interventions such as these as essential”* (Participant quote, p. 11). The long waiting lists for psychosis treatment in services created a sense of hopelessness amongst professionals:

*I am too frightened to tell them because they will want it then and there, so I will only tell people who are very suitable. I'm not doing anything to increase awareness, what's the point? When they will be on the waiting list for over a year?* (Participant quote, Prytys et al., 2011, p. 56).

This was also reflected amongst service users: *“People go round and round in circles, discharged too early”* (Participant quote, Landau & Ruddie, 2017, p. 38). Prytys et



al. (2011) reported the importance of clinical leadership in terms of providing clarity in professionals' roles in the implementation of CBTp: *"I think there also would be role confusion; you know, it would be very difficult slipping in and out of roles."* (Participant quote, p. 55). Another aspect of difficulties with clinical leadership reported in Waller et al. (2015) related to the confusion around referral criteria for CBTp and suitability for psychological intervention:

*This included discussion of how suitable service users would be identified and differentiated from those who might be better suited to other interventions, including a full course of CBT for psychosis. There were some contrasting views regarding who might be most suitable for brief, structured work.* (Author quote, p. 305).

Consequently, the lack of clarity concerning the referral suitability criteria deterred professionals from referring people. Hazell et al. (2017) reported that the pessimism that staff experienced regarding implementing CBTp was likely to affect the perceptions of the organisation around psychosis treatment and lead to a vicious cycle: *"While this attitude remains, commissioners are unlikely to invest in CBTp"* (Author quote, Hazell et al., 2017, p. 12). On the other hand, using the medical model to guide the treatment of psychosis was perceived as something which assisted services in meeting their targets: *"It appeared that some felt an intervention like this conflicted with the priorities of services on two main fronts: firstly, a conflict with the dominant treatment model, and secondly the need to meet targets"* (Author quote, Hazell et al., 2017, p. 11).

### **Composition of meta-synthesis**

Most of the data from each study were used in the meta-ethnography and contributed to the development of the themes in this study. Table 2 illustrates the contribution of each study to the development of each theme in this review. The themes: ‘this is truly happening’, and ‘I am ill’ (Messari & Hallam 2003) were not used in this review as they mainly referred to service users’ attempts to make sense of their psychotic experiences. Additionally, the theme ‘a place to explore shared experiences’ (Newton et al., 2007) referred to the positive aspects of a group therapy and thus was also not included in the current review.

Table 2

*The contribution of each study to final themes*

Studies	Themes					
	Difficulties seeking help		Challenges providing care		Service Design	
	<i>Motivation to engage</i>	<i>Practical difficulties</i>	<i>Professionals' confidence</i>	<i>Practical challenges</i>	<i>Lack of resources</i>	<i>Conflicting needs</i>
Dunn et al., 2002	X		X	X		
Hazell et al., 2017	X	X	X	X	X	X
Iredale, Fronells-Ambrojo, & Jolley, 2016	X	X	X	X	X	X
Landau, & Ruddell, 2017	X	X				X
Li et al., 2017	X	X	X	X	X	X
McGowan et al., 2005	X	X	X	X		
Messari & Hallam, 2003	X	X				
Naaem et al., 2014	X	X	X	X	X	X
Newton et al., 2007	X	X	X			
Prytys et al., 2011			X	X	X	X
Waller et al., 2015	X	X	X	X	X	X

## **Discussion**

The aim of this meta-synthesis was to explore key stakeholders' experiences and views in relation to the routine implementation of CBTp. 'Difficulties in seeking treatment', 'professionals' challenges of delivering CBTp' and 'services design' were the three interlinked and overlapping themes which were constructed from the data during the synthesis. Each theme consisted of two subthemes which mainly described the motivational and practical challenges that professionals, service users and organisations faced in implementing CBTp.

Consistent, with previous systematic reviews (e.g. Berry & Haddock, 2008; Ince et al., 2016) our findings suggest that barriers to CBTp implementation are related to recipients (service users, carers) as well as providers (organisation, staff) of CBTp. Given the exploratory nature of meta-synthesis (Noblit & Hare, 1988), our findings attempt to formulate the interplay between various barriers to implementation of CBTp, rather than simply provide a descriptive summary of the literature. Several factors affected service users' motivation and ability to engage with CBTp. These factors, in turn, had an impact on professionals' confidence and capacity to deliver CBTp. The difficulties with engagement and delivery of CBTp influenced the organisational priorities which were not in favour of investing in CBTp, maintaining thus difficulties in implementation.

Similar to a recent systematic review which explored pathways to care in psychosis (Gronholm, Thornicroft, Laurens, & Evans-Lacko, 2017) the results indicated that stigma and perceived discrimination influence help-seeking behaviours and often deter service users from engaging with CBTp. However, evidence has shown that adapting CBTp to specific cultures can reduce feelings of stigma, improve symptom reduction and attendance (Rathod et al., 2013). Another finding was that the travelling distance, in combination with difficulties leaving the house due to comorbid mental and physical health problems, can

affect the implementation of CBTp. This finding potentially highlights the importance of increasing services' flexibility, in terms of time and location of appointments. Given the importance of homework tasks in CBTp (Morrison, 2017), our findings suggest that these should be adapted to match the specific needs of service users and to ensure a user-friendly experience of CBTp.

The lack of clinical leadership translated into confusion about professionals' roles in the implementation of CBTp and resulted in unclear referral pathways. Additionally, the lack of protected time was frequently mentioned in our findings as a crucial barrier to CBTp implementation following training. This finding is supported by a recent pilot study which reported consistent clinical leadership to be an important predictor of successful CBTp implementation during the pilot period (Gray, Stevens, Motton, & Meddings, 2017).

### **Methodological strengths and weaknesses**

To our knowledge, this is the first meta-synthesis, which incorporates professionals', carers' and service users' views on the implementation of CBTp. This meta-synthesis involved studies conducted in and outside of the UK and aimed to explore barriers to implementation in various mental health systems and cultures. Additionally, although our aim was to synthesise qualitative data, we did not exclude studies with mixed-methods design to increase the inclusivity of our search strategy.

The aim of the meta-synthesis was to explore both facilitators and barriers to CBTp implementation, however, most of the studies that met our inclusion criteria focused on barriers to implementation. Additionally, the exclusion of grey literature and government reports might have limited the scope of our findings. Similarly, we included only studies conducted from 2002 to 2018. However, in order to increase the sensitivity and the scope of

our search strategy we checked reference lists and conducted citation searches of the included studies.

Given the interpretive nature of our meta-ethnography (Noblit & Hare, 1988), our findings might have been affected by researchers' biases. To address this, all the sources of potential bias were discussed prior to the search of the studies. Additionally, during data synthesis a reflective log was kept by the researcher and used in supervision to discuss potential sources of bias in interpretation. Quality appraisal of the included studies was used to analyse in a hierarchical order the studies, starting with the methodologically strongest ones. To minimise potential bias, an independent rater was used for the quality appraisal as well as to compare emerging themes across the studies.

## **Implications**

One of the benefits of qualitative meta-synthesis is that by comparing and identifying common themes across qualitative studies, it offers a deeper understanding and interpretations of the literature (Sandelowski & Barroso, 2007). The results of this synthesis produced a model which aims to portray an interaction between barriers in seeking, delivering and investing in CBTp. This model suggests that the barriers encountered on service user/carer level (e.g. houseboundness, illness attributions, cognitive difficulties, severity of symptoms) can interact with professional level factors by reducing the confidence that professionals have to deliver CBTp and thus increase their requirements for training and supervision. These factors in turn interact with the organisation level variants as health boards are required to increase investment (e.g. supervision, protected time, defined roles) and adapt their approach (e.g. flexibility in appointment times, outreach support) while trying to meet treatment targets and financial targets.

We consider that future quantitative studies could explore the utility and validity of this model when exploring stakeholders' experiences of implementing CBTp. Our findings also suggested that families' and carers' perceptions and support affected service users' engagement with CBTp. However, only two of the included studies explored family and carers' views (Li et al., 2017, Naeem et al., 2016). This highlights the importance of involving this stakeholder group in the future CBTp implementation research.

The results of this meta-synthesis could be used by service managers and clinicians to predict and address potential difficulties in implementation when developing training agendas for staff. Another implication of our findings is that they offer a systemic conceptualisation of successful implementation of CBTp, meaning that the responsibility in implementing CBTp relies on the collaboration of all key stakeholders. This highlights the importance of involving service users and carers in service design and delivery.

## **Conclusion**

To our knowledge, this is the first meta-synthesis of implementation of CBTp in services. The synthesis of qualitative studies produced a cyclical model of barriers to CBTp implementation. Barriers to help-seeking (e.g. motivation, symptom severity, illness attribution, cognitive difficulties, attendance) pose specific challenges to professionals who offer CBTp (e.g. confidence, requirements for supervision, training, protected time). These, in turn influence the organisational priorities (e.g. medical model, ethos) when trying to meet targets with limited resources. Future studies can use the model of this synthesis to formulate and address potential barriers to CBTp implementation in their localities.

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## **Chapter two: Major Research Project**

### **Exploring the implementation of Cognitive Behavioural Therapy for psychosis (CBTp) using the Normalisation Process Theory (NPT) framework**

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Submitted in partial fulfilment for the Doctorate of Clinical Psychology  
(DClinpsy)

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## Plain English Summary

**Title:** Exploring the implementation of Cognitive Behaviour Therapy for psychosis, using the Normalisation Process Theory framework.

**Background:** Cognitive Behavioural Therapy for psychosis (CBTp) is an individually tailored talking therapy which aims to help people with psychosis develop helpful coping strategies for specific psychotic symptoms (e.g. hearing distressing voices). National clinical guidelines recommend CBTp to be offered to any person experiencing psychosis. However, only a small minority of service users (5-10 %) have access to CBTp. Normalisation Process Theory (NPT) attempts to explain the processes for a successful implementation of interventions in routine clinical practice.

**Aims/ Questions:** This study used NPT to explore the experiences and views of NHS mental health staff regarding the implementation of CBTp. Specifically, (a) how do mental health professionals working with people experiencing psychosis make sense of CBTp implementation and (b) can professionals' perspectives be understood within the NPT framework?

**Methods:** A total of 14 mental health professionals from different professional backgrounds attended either a focus group or an individual interview and provided their experiences of implementation of CBTp. Interviews were audio recorded and transcribed verbatim. Transcriptions were analysed using thematic analysis. Subsequently, the initial themes were mapped onto the constructs of NPT.

**Main Findings:** Themes consisted of the perceived benefits of CBTp, the challenges of implementing CBTp routinely, and ways to address difficulties in implementation. All but two subthemes mapped onto the NPT framework. NPT analysis of themes suggested that professionals had difficulties in agreeing about the purpose and benefits of CBTp. This was translated into the service's lack of confidence in investing in CBTp.

**Conclusion:** Professionals were willing to support the wider implementation of CBTp however, difficulties in making sense of CBTp among professionals and a lack of collective action from services hindered the implementation. The findings suggested that strong clinical leadership could increase professionals' awareness and service investment in CBTp.

## **Abstract**

**Objective:** Evidence suggests that only a minority of service users experiencing psychosis have access to Cognitive Behavioural Therapy for psychosis (CBTp). Normalisation Process Theory (NPT) is a theoretical framework which focuses on processes by which interventions are implemented and normalised in clinical practice. This study explored the views and experiences of mental health professionals regarding the implementation of CBTp. Barriers and facilitators to implementation were explored using the NPT framework.

**Design:** A qualitative methodology was adopted involving semi-structured focus groups and individual interviews.

**Methods:** A total of 14 members of staff working in the community and crisis mental health teams were recruited. Thematic analysis was used to generate initial themes. The Framework approach was utilised to map initial themes to the NPT framework.

**Results:** Inductive coding generated five overarching themes consisting of 15 individual subthemes which captured the perceived barriers to engagement; contextual barriers to implementation; optimisation of implementation; positive attitudes towards implementation; and expectations of implementing CBTp. All but two subthemes mapped on to the NPT framework. The deductive analysis suggested that difficulties in making sense of CBTp among professionals were reflected as service level barriers which impeded wider implementation.

**Conclusion:** The results of this study suggested a mixture of barriers and facilitators to CBTp implementation. Interpreting our findings within an NPT framework indicates the importance of strong clinical leadership to address difficulties in sense-making and service investment in CBTp.



## **Introduction**

Cognitive Behavioural Therapy for psychosis (CBTp) is an individually tailored talking therapy which aims to increase an individual's coping with specific psychotic experiences (e.g. hearing distressing voices) by modifying associated thoughts, physical sensations, behaviours and emotions (Morrison, 2017). A recent Delphi consensus study reported that the essential aspects of CBTp involve collaboration, formulation, normalisation and change strategies (Morrison & Barratt, 2010). These ingredients and processes were perceived by service users to improve engagement and reduce stigma, as reported in a recent synthesis of qualitative studies (Berry & Hayward, 2011).

Evidence from randomised controlled trials (RCTs) indicates that CBTp results in a reduction of positive symptoms (Wykes, Steel, Everitt, & Tarrier, 2008) and comorbid difficulties (Turner, van der Gaag, Karyotaki, & Cuipers, 2014). Additional evidence suggested that CBTp may also prevent the onset of psychosis in people who were at risk of developing psychosis (Hutton & Taylor, 2014). National Institute of Clinical Excellence (NICE, 2014) guidelines in England and Wales and the Scottish Intercollegiate Guidelines Network guidelines (SIGN (131), 2013) recommended that CBTp should be offered to all individuals who either experience or are at risk of experiencing psychosis over the course of at least 16 sessions.

Although national guidelines have increased professionals' awareness (Fadden, 2006) regarding the benefits of CBTp this has not been followed by successful implementation of CBTp into routine care (Rowlands, 2004). A recent national audit in the UK estimates that only one in ten people with psychosis have access to psychological interventions (Schizophrenia Commission, 2012). Ince, Haddock and Tai (2016) reported that the rates of implementation of CBTp varied significantly across studies and this was attributed to differences in the methodological quality of the studies. Berry and Haddock (2008) suggest

that barriers can be classified into three main categories, which involve service recipients' factors such as poor engagement and family support. The second set of barriers related to professionals' negative perceptions of CBTp and lack of competence in delivering CBTp (Prytys, Garety, Jolley, Onwumere, & Craig, 2011). The third cluster of barriers was associated with organisational factors reflecting difficulties with access to training, supervision and having protected time to implement CBTp (Ince et al., 2016). Arguably, the small effect sizes of CBTp that were reported in a recent meta-analysis (Jauhar et al., 2014) have also provoked a debate among clinicians about its perceived efficacy (McKenna & Kingdon, 2014), which may have affected the consensus regarding the prioritisation of resources.

Studies which investigated facilitators to CBTp implementation reported that high intensity training improved the competency of the staff which resulted in increased implementation. However, this depended on whether the staff had protected time to implement CBTp following training (Jolley et al., 2012). Similarly, Gray, Stevens, Motton, and Meddings (2017) highlighted the benefits of the availability of trained staff to participate in team meetings to increase professionals' awareness of CBTp.

The longstanding difficulties with the implementation of physical and mental health treatments in routine clinical practice have led to the development of theoretical models which aim to understand and aid the process of implementation. Normalisation Process Theory (NPT; May et al., 2009) is one of the theoretical frameworks that focus on the implementation of interventions, their embedding in routine practice and the processes by which interventions are sustained or normalised. NPT consists of four components which define distinctive processes that have been found to predict successful implementation. The first component, *Coherence* refers to the extent to which stakeholders involved in implementation have a sense of clear and common purpose of the intervention. *Cognitive*

*Participation* refers to the degree to which stakeholders perceive the potential benefits of the intervention and the willingness to support the implementation. *Collective Action* relates to the service level pragmatics involved in successful implementation. The fourth component, *Reflexive Monitoring* refers to an agreed plan of how the implementation would be evaluated. NPT predicts that implementation processes need to satisfy these four components to become normalised in routine practice. Additionally, NPT suggests that these components are linked with each other and thus changes in one part can affect the others.

Previous qualitative studies have used NPT framework to explore and formulate the barriers to implementation of evidenced-based psychological interventions for depression (Gunn et al., 2010) and bipolar disorder (Moriss, 2008). These studies suggested that the use of NPT allowed them to assess, formulate and develop an intervention plan based on the components of NPT to facilitate the implementation (McEvoy et al., 2014). Recently, Hazell, Strauss, Hayward and Cavanagh (2017a) explored the views of mental health clinicians on brief CBTp intervention using an NPT based questionnaire. Exploratory factor analysis of the responses found support for all but one (collective action) construct of the NPT. Although Michie and colleagues (2007) applied a theoretical framework to interpret barriers to implementation of national guidelines for psychosis, this was focused on family interventions and not CBTp. Additionally, previous studies exploring CBTp implementation have used only one professional group (care co-ordinators; Prytys et al., 2011) rather than a mixture of diverse professional backgrounds. This may have limited the understanding of the interaction between experiences and perspectives of stakeholders, which subsequently restricted the production of an intervention plan based on the theoretical model used, to overcome such barriers.

## **Aims**

The first aim of this study was to explore the experiences and perspectives of mental health professionals concerning the implementation of CBTp in NHS Ayrshire & Arran (A&A). A second aim was to apply the NPT framework to interpret potential barriers and facilitators to implementation.

## **Research questions**

1. How do mental health professionals working with people experiencing psychosis make sense of CBTp implementation?
2. Can professionals' perspectives be understood within the NPT framework?

## **Methods**

### **Design**

This study adopted a qualitative design to explore individuals' experience as a phenomenon, within the context and social reality of participants (Holloway, 1997). Focus groups with participants from the same professional background and semi-structured individual interviews were employed. The interview topic guide (Appendix 2.8) was developed to reflect the research aim and questions. Additionally, the NPT framework was used to prompt, guide and structure the questions of the topic guide and permit participants to reflect on the NPT constructs. The epistemological positions behind this study followed the critical realist and post-positivist paradigms, suggesting that the experience of participants and the researcher is influenced by the social, structural and political context in which the study is conducted (Danermark, Ekström, Jakobsen, & Karlsson, 2002).

## **Ethical considerations**

Data were anonymised and stored in a password protected computer in line with University of Glasgow guidelines on confidential data. The Research Proposal (Appendix 2.1) and proposal amendments (Appendix 2.2) for this study were approved by the local Research and Development Department and ethical approval was granted by the University of Glasgow College of Medical, Veterinary and Life Sciences (Appendix 2.3 -2.5).

## **Procedure**

Study adverts and introductory information (Appendix 2.6) were provided to the Community Mental Health Teams (CMHTs) and Crisis Team (CT) leaders to circulate to their team members. The lead researcher attended the team meetings to introduce the study and explore interest. After obtaining verbal consent from participants, participant information sheets were provided (Appendix 2.7). Prior to the interviews, the researcher explained issues of confidentiality, anonymity, and the voluntary nature of participation and participants provided written informed consent (Appendix 2.10). All interviews were conducted by the lead researcher and took place in NHS A&A settings. Field notes were recorded after each interview.

## **Participants**

The experiences and views of several staff groups were sought as NPT assumes that everyone has a role in successful implementation. The sample consisted of 14 participants, ten of whom were female. Eligible participants have worked with individuals who have experienced psychosis in NHS A&A CMHTs or CTs across the three geographical regions in A&A (East, South, North). The average number of years of clinical experience of participants was 17.2 years. Participants consisted of mental health nurses ( $n=5$ ) consultant psychiatrists ( $n=2$ ),

clinical/counselling psychologists ( $n = 2$ ), CBT therapists ( $n = 2$ ), an occupational therapist ( $n = 1$ ), a team leader ( $n = 1$ ) and a senior adult mental health manager ( $n = 1$ ). Two focus groups (a nursing staff and a psychology focus group) and six individual interviews were completed. The interviews lasted between 29 to 65 minutes.

## **Data Analyses**

The first stage of analysis involved inductive thematic analysis (Braun & Clarke, 2006) as our aim was to capture common patterns of experiences of CBTP implementation across a variety of staff groups and to avoid forcing themes to the predetermined constructs of the NPT. This helped us to identify deviant or new themes that might not be adequately captured in the deductive framework. Previous qualitative studies in NPT research have successfully used this approach to analyse data (MacFarlane & O'Reilly de Brun, 2012)

The inductive stage of analysis was conducted in line with Braun & Clarke's (2006) six stages of thematic analysis. Interviews were audio-recorded and transcribed verbatim. The lead researcher initially immersed themselves in the data by reading the transcribed interviews and noting down how participants made sense of their experiences. Complete coding by analysing all the meaning units related to the research questions and aims was used (Appendix 2.11). As the coding progressed, codes describing common experiences were translated into themes. Once themes from each interview were identified, a list of overall themes common across the dataset was developed. This phase involved discussing the themes with an independent researcher and reaching a consensus regarding the definition and the composition of each overarching theme by adding and subtracting the subthemes. The final phase of inductive analysis involved selecting participants' quotes to illustrate the identified themes.

The deductive coding was completed using a framework analysis approach (Ritchie & Spencer, 1994). This involved developing a list of all the subthemes that led to the composition of the overarching themes. Following this, the lead researcher and an independent researcher attempted to map these themes to the four constructs of the NPT.

## **Reflexivity**

The lead researcher is a trainee clinical psychologist who has worked in a CMHT in NHS A&A and in the past has used CBT with people experiencing psychosis. This provided the researcher with an insight into barriers and facilitators to CBTp implementation. Additionally, the lead researcher completed a systematic review of the literature concerning the implementation of CBTp, which might have influenced their interpretation when generating codes and themes. Potential sources of bias to data interpretation were discussed in research supervision before the data collection and an independent researcher was involved in data synthesis to minimise the risk of bias. A reflective log was kept during the data collection process to reflect on sources of bias during interviews with participants.

## **Results**

Inductive thematic analysis of participants' experiences of CBTp implementation resulted in five overarching themes (Appendix 2.9). Table 1 illustrates the subthemes that contributed to the development of each of the overarching theme. Participants' quotations which illustrate each of the themes are presented in italics.<sup>1</sup>

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<sup>1</sup> In quotations, material that has been omitted is indicated by ellipsis points (...). Words inserted for clarity are represented by square brackets [ ]. Professional background, transcript page and line number are provided for each quotation

Table 1

*Overarching themes and subthemes of thematic analysis*

<b>Overarching themes</b>	<b>Subthemes</b>
Perceived barriers to engagement	Symptom severity Lack of attendance Social environment
Contextual barriers to implementation	Lack of resources Lack of staff awareness of CBTp Difficulties with referral pathways The dominance of the medical model Outcome driven services
Optimisation of the implementation	Increasing professionals' awareness Supporting clinical leadership Improving professionals' communication
Positive attitudes to implementation	Perceived benefits to service users Perceived benefits to the professionals'
Expectations of implementing CBTp	Objective outcomes Subjective outcomes

**Perceived barriers to engagement***Symptom severity*

Participants referred to their experiences of attempting to implement CBTp. Applying a structured treatment to address psychotic experiences which were chronic in nature meant that recovery was difficult to achieve: “...you just know there’s these particular really fixed beliefs that have been there for years and years and really there’s probably limitations in what we can really do” (Nursing staff, p.5,105-108). Apart from chronicity, professionals also referred to the severity of psychotic symptoms, such as lack of insight, that further hindered the implementation of CBTp: “Sometimes is hard, but it’s a battle, is a long battle, because it’s whether they’re accepting it’s their acceptance of their illness as well...” (Nursing staff, p.5, 100). Difficulties managing any potential increase in distress of service users when using CBTp further complicated the implementation: “...the last man that I dealt



*with we did decide to put a hold to it, because he had reached a point where his tolerance of the distress was as much as he could take” (Occupational Therapist, p.16, 352-354).*

#### *Lack of attendance*

Service users’ motivation to accept the offered sessions affected professionals’ capacity to deliver CBTp. For service users who initially engaged with CBTp the difficulty was the lack of consistency in attendance rates and their ability to prevent possible drop outs: *“Well someone with psychosis tends to be less inclined to be seen and that’s the worry is that they’re going under the radar because to have the time to pursue these patients is really difficult” (Consultant Psychiatrist, p.21, 512-514).*

#### *Social environment*

Professionals reported that social deprivation can determine service users’ preferences regarding treatment: *“...don’t really either see or feel motivated to engage in work that would require some effort. That’s not true for everyone but perhaps is a little bit more true in a deprived area” (Consultant Psychiatrist, p.4, 86-88).* Family support in the recovery journey of service users was a crucial element in the successful implementation of CBTp: *“and the family support as well, I think people who tend to do better, tend to be people who got stable family and that support there as well” (Nursing staff, p.14, 311-313).* Furthermore, attitudes of peer groups affected service users’ lifestyle choices which impacted on their engagement with services:

*...but a bit like I was saying some of them are quite kind of chaotic life style, so they come in they get a bit better but the go back out and it’s just kind of cycle with them so, again to get them to engage it’s a bit trickier (Nursing staff, p.14, 269-271).*

## **Contextual barriers to implementation**

### *Lack of resources*

An increase in workload was perceived as an indication of reduced resources. This induced a feeling of pressure which affected professionals' perceptions regarding the service's priorities when working with people with psychosis: *"...I would get ripped over the course of not doing their depo but nothing would happen to my registration if I didn't offer that particular intervention that we know can be as helpful as well"* (Nursing staff, p.26, 582-585). A lack of service investment in CBTp not only translated into a reduction in training opportunities but also a lack of provision for supervision and protected time for staff that were already trained: *"...lots of people been training and they never use it because they weren't supervised, there's no formal mechanism for them to have the confidence to try it"* (Consultant Psychiatrist, p.27, 664-666). Limited protected time impacted on professionals' confidence when applying CBTp training into clinical practice, thus maintaining the difficulties with implementation: *"...I've got some skills in it, but I don't always feel as confident in using them"* (Nursing staff, p.3, 63).

### *Lack of staff awareness of CBTp*

Some participants described difficulties in understanding CBTp processes and how they differentiate from a traditional CBT approach: *"I am not entirely sure what is about to be honest, other than I know what CBT is, and I know what psychosis is"* (Senior manager, p.11, 251). This limited staff awareness of the potential benefits of CBTp: *"I have only been in the team for a year, I don't know how effective CBT is with psychosis cause is not something I've been involved in"* (Nursing staff, p.26, 601). A lack of clarity around CBTp reinforced professionals' reluctance to refer people with psychosis, as illustrated by the following quote:

*“it’s no an intervention that springs to mind when a patient comes up and they’re discussed”*  
(Nursing staff, p.25, 570).

#### *Difficulties with referral pathways*

Increasing demands for other mental health presentations had an impact on referrers’ attitudes towards prioritising other patient groups that also needed psychological interventions: *“...I think because our services are so overwhelmed with emotional dysregulation, these are the patients that are causing the problems and they are the ones that we tend to refer on”* (Consultant Psychiatrist, 11.257-259). Various factors such as demand, service targets and resources shaped the referral suitability criteria for psychological interventions for psychosis:

*...when you get small resource people wanted to be targeted to the people that are most likely to benefit and that’s understandable but our patient population like everywhere it’s not like that, you know they are not very many patients who will fulfil all these criteria* (Consultant Psychiatrist, p.24, 577-581).

Feelings of frustrations and hopelessness emerged when referrals for psychological intervention for psychosis were not successful: *“...they were not considered suitable and I suppose I felt just a whole mixture of negative emotions about that”* (Consultant Psychiatrist, p.18, 432). This deterred professionals from continuing to refer other people from their caseload: *“The problem is like they’re saying we probably wouldn’t refer cause you know they wouldn’t be accepted”* (Nursing staff, p.27, 622). As a result, some professionals reported a gradual decline in referrals for CBTp over the years: *“...but the referrals are still aren’t made, although I am not sure maybe there just not, maybe just these referrals aren’t to made to team at all”* (CBT therapist, p.13, 283). Additionally, actively seeking referrals for

psychosis was a challenging decision as participants reported the importance of meeting service targets:

*...we're trying to meet the HEAT target, so we would never be going out to create demand; I think that's something we would never do but what we're saying is that the demand that's coming to us is the demand that we're meeting. (Clinical/Counselling Psychologist, p.20, 467-469)*

#### *The dominance of the medical model*

Participants reported the difficulties of challenging the perceptions of other professionals' regarding the available treatment options in psychosis:

*So I suppose it's more to trying to help people not to just focus on the medical model cause I think quite often in crisis especially that initial kind of referral period and the initial appointment they referred; I think quite often we can; we'll look to medication for helping the person to. (Team Leader, p.5, 122-125).*

Increase in workload, combined with time restraints reinforced the medical model of psychosis as professionals tended to revert to practices they were more confident in: *"Again it comes down to simply when people are under pressure or busy emmm..they will just stick with what they usually do rather than implementing change"*(Occupational Therapist, p.11,240-242).

#### *Outcome driven services*

Limited resources combined with pressure to meet targets meant that professionals had to make decisions about what needed to be prioritised in terms of service investment: *"...but the*

*reality is that when you then introduce something else, another bit of the service has to be, has to go if there is not an additional investment”* (Consultant Psychiatrist, p.18, 430-432).

This meant that resources were allocated to interventions with the best evidence base for the least required amount of sessions: *“I think there has been a shift in emphasis towards well good evidence, we can help people whose illnesses are shorter duration”* (Consultant Psychiatrist, p.10, 235). The need to achieve outcomes meant that CBTp was offered only to service users with the best chances of benefiting from it: *“But what we’ve seen is perhaps a move certainly in psychology and perhaps even from other colleagues away from a process model to an outcome model...”* (Consultant Psychiatrist, p.4, 100).

### **Optimisation of the intervention**

#### *Increasing professionals’ awareness*

Increasing competence in CBTp assessment was perceived as something that would help participants decide the suitability for the intervention: *“and if we get more information how to assess people properly if they’re suitable for CBT with psychosis, you know”* (Nursing staff, p.32, 737). Some participants referred to the benefits of integrating awareness of CBTp at the pre-qualification training: *“So psychiatrist should by through their exams and by the end of the training be very clear that they can recognise patients and scenarios in which a CBT approach would be helpful...”* (Consultant Psychiatrist, p. 23,533-535).

#### *Supporting clinical leadership*

Participants referred to the importance of having professionals with specialised training to promote CBTp: *“I don’t know it made people, it made everybody in the team think about it, be enthusiastic about it”* (Nursing staff, p.12, 272). Personal attributes such as enthusiasm and actively seeking referrals for psychological intervention were also perceived as

facilitators to CBTp: “...*I think you need a role or somebody in the position that is driving that forward, somebody with enthusiasm for for intervention, for the principles*” (Team Leader, p.24, 574). To ensure the continuity of the implementation, it was important that service structures supported clinical leadership by having a professional role in the assessment and overview of the implementation: “*so you need them to have erm kinda not to sit in the side or the periphery of the line management structure to be involved in that and be involved in a kinda central level*” (Team Leader, p. 25,592-593). Another aspect of clinical leadership that could facilitate the implementation was the development of referral protocols adapted for CBTp: “...*but I suppose maybe kind of the education and and how, how, good they need to be how stable, how well would you need to have them before you can ever consider*” (Nursing staff, p.28, 628).

#### *Improving communication*

Improving communication in teams was an important facilitator to the implementation of CBTp. Increasing inter-professional dialogues could increase trust and help professionals understand different views and approaches:

*I think, the more we have conversations with each other the more we've got good relationships the more we understand what we should do the better can be for patients and I think it doesn't take much to start affect relationships* (Consultant Psychiatrist, p.23, 567-569).

Establishing effective inter-professional relationships could further facilitate collaboration and consistency during the transition of service users from other services: “...*if you were lucky enough you would be passing over to someone that's done the PSI training or*

*CBT training then that was great that was brilliant” (Team Leader, p.21,492-494). Another aspect of communication and consistency was reflected in having clarity in professional roles: “I think the psychology department think the CPNs are doing that but I don’t think the CPNs know what that is or two feel confident in doing these things, so we’ve got this real gap” (Consultant Psychiatrist, p.9, 210-212).*

## **Positive attitudes to implementation**

### *Perceived benefits to service users*

Aspects of CBTp such as formulation were viewed as having a crucial role in engaging service users: *“So I do think that building a therapeutic rapport and the formulation is useful parts of that approach which is definitely helpful...” (Clinical/Counselling Psychologist, p.10, 220). CBTp was perceived as an approach that empowers recipients and increases the sense of shared responsibility between the therapist and the client: “It is about people feeling empowered to manage their own health, I think CBT allows that self-management and emm It gives people quite concrete strategies” (Occupational Therapist, p.7,140-142).*

### *Perceived benefits of CBTp to professionals*

The benefits of CBTp were not limited only to recipients, but they also expanded to team functioning. The structured approach of CBTp, as well as, the simple language encouraged staff to use it in their clinical practice: *“I think for me when I try to explain CBT and the kinda I try to explain to the individual I think I feel that most people get the principles of it...” (Team Leader, p.11, 262-263). Formulation was one of the processes of CBTp that was perceived as valuable in increasing interprofessional understanding when working with service users: “even if they’re just not ready or they don’t want to engage in treatment, but I*

*think a formulation, is really, really valuable in terms of informing all parts of care not just the psychological treatment”* (Consultant Psychiatrist, p.6, 139-141).

## **Expectations around the efficacy of CBTp**

### *Objective outcomes*

Participants referred to their expectations as sources of engagement and motivation in delivering CBTp to service users. In order to evaluate these expectations, it was essential to document outcomes of CBTp: *“For example it’s not something that I see reported on so I am not aware or getting stats on this number of interventions that we’ve delivered...”* (Senior Manager, p.12, 293). Indicators that CBTp was achieving its purpose involved a reduction in psychosis symptoms, relapse and readmission rates: *“From my service perspective you’re looking at potentially less referrals to crisis team or less admissions for individuals experiencing psychosis, less kinda erm maybe as well less medication...”* (Team Leader, p.26, 628-630).

### *Subjective outcomes*

Using quality of life measures was considered an important aspect of CBTp effectiveness: *“but actually how about how do we look at it a bit closer and say well what’s that person’s quality of life like in between the relapse”* (Nursing staff, p.35, 812-813). Receiving feedback from the wider network of service users was another way to measure aspects of functioning following a CBTp course: *“and the referrers and carers and that type of thing so you’ve got feedback from outside people, the person itself and outcome measures”* (CBT therapist, p. 25, 579-581). For some participants, subjective measures of success were perceived as stronger reinforcers for continuing to use CBTp: *“We can look at studies we hear all the evidence but*

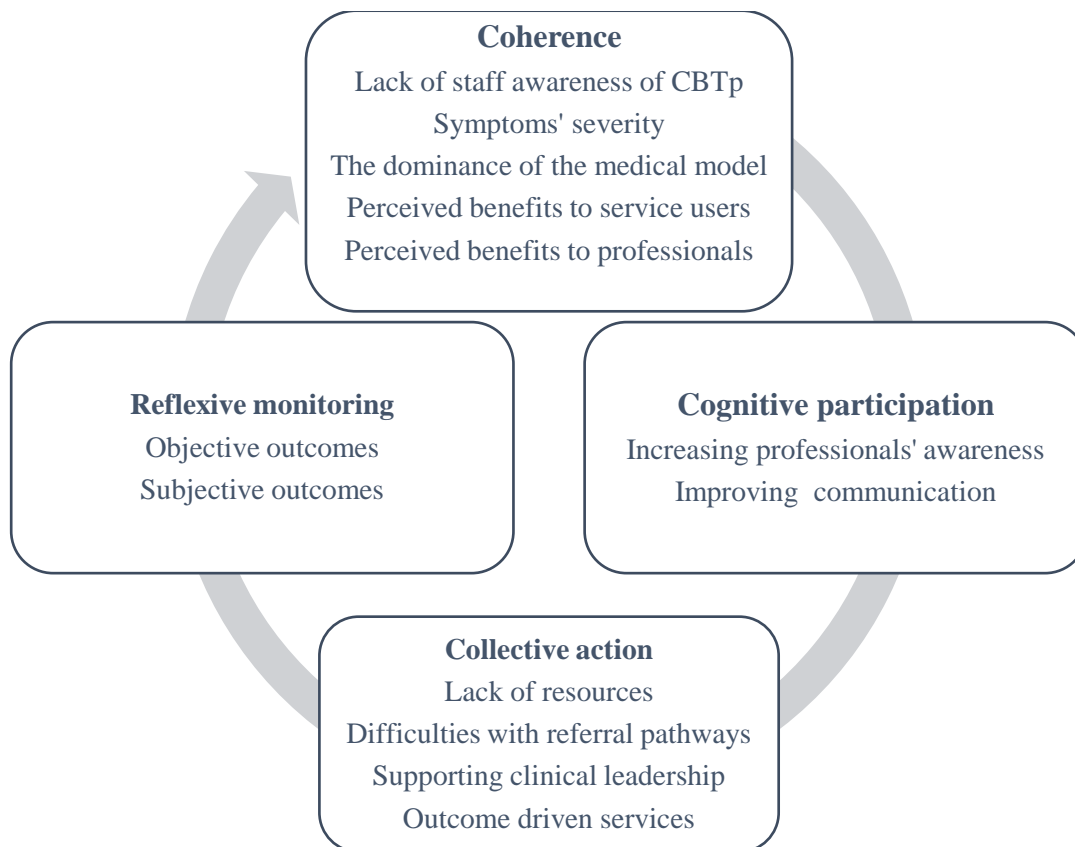


*ultimately is once you start referring and you see people benefiting or engaging better”*

(Consultant Psychiatrist, p.23, 555-557).

### **Framework Analysis**

Thirteen out of the 15 subthemes were mapped to the four constructs of the NPT. Given that NPT suggests that these constructs are linked with each other, a continuous cycle representation of deductive coding was selected (see Figure 1). The construct of *coherence* consisted of themes related to professionals’ views of CBTp. *Cognitive participation* comprised of themes related to professionals’ willingness to support the implementation of CBTp. The construct of *collective action* was mapped to the views that professionals had about organisation level structures that were related to the feasibility of the implementation. Professionals’ expectations of implementing CBTp were mapped to the *reflexive monitoring* construct. The two themes which emerged from the inductive analysis and did not match the NPT framework were: i) lack of attendance and ii) social environment. The inter-rater reliability of mapping themes to NPT constructs was 86%.



*Figure 1.* Deductive coding of subthemes using the NPT framework

## Discussion

The first aim of this study was to explore the experiences and views of mental health professionals regarding the implementation of CBTp. Five overarching themes consisting of 15 subthemes captured a mixture of barriers and facilitators to CBTp implementation. Overall, participants referred to the lack of provision of CBTp in their teams which confirms reports from a recent systematic review regarding the low rates of CBTp implementation (Ince et al., 2016). Similar to previous studies (Hazell, Strauss, Cavanagh, & Hayward, 2017b; Prytys et al., 2011) our findings indicate the difficulties that clinicians face when implementing CBTp, which include the severity of symptoms and reported lack of insight of people with psychosis. In addition, challenges with consistent attendance increased the pessimistic attitudes of professionals regarding the feasibility of recovery and reinforced the

lack of implementation. In line with a previous study (Kingdon & Kirschen, 2006) this finding indicates that certain clinical groups might not be offered access to psychological therapies due to a disbelief that they would benefit from them.

Another perceived barrier to engagement which has been reported in previous studies (Naeem et al., 2016) was related to social factors such as peer and family support. In line with Braehler and Harper (2008), our findings suggest that psychological needs are often overlooked or perceived as secondary when professionals are faced with high caseload and a pressure to achieve treatment targets. Consistent with previous systematic reviews (Berry & Haddock, 2008; Ince et al., 2016) our findings suggest that high caseload, lack of protected time and supervision prevent professionals from implementing CBTp even when training has been provided (Jolley et al., 2012).

The role of clinical leadership is perceived as crucial in facilitating changes in service structures responsible for effective implementation of CBTp which is corroborated by a recent pilot study (Fornells- Ambrojo et al., 2017). Similar to previous studies (Gray et al., 2017; Jolley et al., 2012), the findings highlight the championing nature that clinical leadership can take in order to facilitate CBTp implementation. This would involve training the current workforce, ensuring protected time is defined in job roles for delivery, in addition to increasing other professionals' awareness of the nature and purpose of CBTp. Interestingly, participants' reports regarding the use of quantitative as well as recovery orientated qualitative outcome measures in measuring the effectiveness of CBTp is supported by the recent shift in developing a CBTp adapted outcome measures (Greenwood et al., 2010) which examine the quality of life and subjective sense of control over symptoms.

The second aim of our study involved adopting a deductive approach utilising the NPT framework to interpret the subthemes generated from inductive coding. The subthemes which were mapped to the construct of *Coherence* suggested mixed views and experiences in

the sense-making of CBTp. For example, although participants referred to the positive experiences of using CBTp with clients and teams, findings suggested that the awareness of these benefits was limited across different professional roles. Additionally, the challenges of implementing CBTp with individuals experiencing chronic and severe distress gave rise to the medical approach and further complicated the sense-making process.

According to Hazell et al. (2017b), professionals' lack of belief in the efficacy of CBTp reinforces commissioners' lack of investment in CBTp. Similarly, the lack of *Coherence* in this study might have reinforced the service level barriers which reflected the lack of *Collective Action*. Furthermore, participants perceived the lack of CBTp training and supervision as a consequence of limited service investment. Additionally, the pressure to achieve outcomes and difficulties with referring people for psychological interventions hindered the normalisation of CBTp. Interestingly, effective clinical leadership was perceived as an important service level facilitator to overcome such barriers. The construct of the *Cognitive Participation* indicated that participants are willing to support CBTp implementation by increasing the inter-professional communication and consistency. Furthermore, the *Reflexive Monitoring* construct suggests that participants considered important to use a variety of outcome measures to examine the efficacy of CBTp, once it is implemented.

Overall, the framework analysis found support for all of the constructs of the NPT. Participants were willing to support the implementation of CBTp. However, the lack of clarity around the purpose of CBTp among professionals and organisational level barriers seem to impede the wider implementation and normalisation of CBTp in teams. The two subthemes which did not map onto the NPT framework were the perceived difficulties of people with psychosis attending consistently and the impact of the social environment. Although these themes might be related to the lack of *Coherence* and *Cognitive Participation*

from the service users/carers side, it was decided not to map them to NPT constructs since these were the perceptions of professionals rather than an experience that service users reported themselves.

### **Methodological strengths and weaknesses**

One of the strengths of this study was the inclusion of professionals from different backgrounds across different levels of seniority. This was in line with NPT which intends to capture a systemic view of implementation processes, involving both individual and collective action. The flexibility in data collection methods increased stakeholders' representation by providing an alternative to participants who did not wish to participate in a focus group and vice versa. To our knowledge, using both inductive and deductive coding was unique in CBTp implementation research. Applying NPT analysis to the subthemes improved our understanding of the interactions between themes which were generated from thematic analysis. To minimise the risk of forcing themes to NPT constructs, inductive coding was completed first.

This study recruited clinicians and managers from one Health board. Thus, the experience and views towards CBTp might vary significantly across different Health boards. Additionally, this study recruited only participants from CMHTs and CTs. This might have limited the generalisability of the findings as specialised services for psychosis, such as Early Intervention (EI) teams might have different experiences regarding the implementation of CBTp. Furthermore, the purposive sampling method in this study might have led to further biases, as the participants who volunteered in this study might hold specific views about the barriers and facilitators to CBTp implementation. Although attempts to minimise researchers' bias were made, it is possible that researchers previous knowledge and experience have affected the interpretation of themes. Given the critical realist position of this study, it is

plausible that other researchers might have interpreted the data differently and identified different themes.

## **Implications**

The findings of this study have implications for both research and clinical practice. Although we recruited a variety of professionals, we did not compare their views based on their role. Thus, future studies could explore the views and experiences of CBTp implementation based on the different role of professionals in teams. Furthermore, future research could examine the validity of the NPT framework across different samples and psychological interventions. Given that no service users and carers were recruited in this study, future studies could analyse the perspectives of these stakeholder groups using NPT.

In terms of clinical implications, our findings could be used by local managers to understand the several factors that impede the normalisation of CBTp in their teams. The use of a theoretical framework could potentially be translated into informing training agendas and improving clinical leadership in teams. It is important to highlight that the findings might only reflect the Scottish context of data collection and commissioning. In particular, the NPT model of implementation in this study might need to be refined when examining funding pathways to reflect the key stakeholders responsible for this in other mental health systems. Based on our findings an effective clinical leadership should operate on an individual level by improving professionals' competence and attitudes towards CBTp. On a service level, clinical leadership should be reflected in defined referral pathways and professional roles in CBTp. Moreover, our findings regarding the perceived barriers to engagement highlight the role that service users and carers have in the successful implementation of CBTp, such as

setting research priorities relevant to their needs, shaping research questions and sharing knowledge to other relevant stakeholders (Gray-Burrows et al., 2018).

### **Conclusion**

To our knowledge, this is the first study which explores the implementation of CBTp by applying an existent implementation framework. Participants had clarity over their expectations from using CBTp and willingness to support the wider implementation. However, mixed views concerning the benefits and the purpose of CBTp amongst staff hindered the implementation on an individual level. Difficulties of making sense of using CBTp routinely were reflected on a service level by a lack of investment into CBTp, thus maintaining the low rates of implementation. The findings further highlight the importance of strong clinical leadership to address difficulties in sense-making and service investment in CBTp.

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## **Appendices**

### **Appendix 1.1: Journal Submission Guidelines**

#### **Psychology and Psychotherapy: Theory, Model and Research submission guidelines**

##### **Author Guidelines**

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in Psychology and Psychotherapy: Theory, Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

##### **1. Circulation**

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

##### **2. Length**

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

### **3. Brief reports**

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

### **4. Submission and reviewing**

All manuscripts must be submitted via [Editorial Manager](#). The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the [terms and conditions of submission](#) and the [declaration of competing interests](#). You may also like to use the [Submission Checklist](#) to help you prepare your paper. If you need more information about submitting your manuscript for publication, please email Melanie Seddon, Senior Editorial Assistant at [papt@wiley.com](mailto:papt@wiley.com) or phone +44 (0) 1243 770 108

### **5. Manuscript requirements**

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use [this](#) template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the [Project CRediT](#) website for a list of roles.
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

- All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.
- Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (<http://www.consort-statement.org>).
- Manuscripts describing systematic reviews and meta-analyses must be submitted in accordance with the PRISMA statement on reporting systematic reviews and meta-analyses (<http://www.prisma-statement.org>).

For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association.

## **6. Multiple or Linked submissions**

Authors considering submitting two or more linked submissions should discuss this with the Editors in the first instance.

## **7. Supporting Information**

PAPT is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at <http://authorservices.wiley.com/bauthor/suppmat.asp>

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## **9. Colour illustrations**

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded [here](#).

## **10. Pre-submission English-language editing**

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at [http://authorservices.wiley.com/bauthor/english\\_language.asp](http://authorservices.wiley.com/bauthor/english_language.asp). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

## **11. OnlineOpen**

OnlineOpen is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For the full list of terms and conditions, see [http://wileyonlinelibrary.com/onlineopen#OnlineOpen\\_Terms](http://wileyonlinelibrary.com/onlineopen#OnlineOpen_Terms)

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## **12. Author Services**

Author Services enables authors to track their article – once it has been accepted – through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit <http://authorservices.wiley.com/bauthor/> for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

## **13. The Later Stages**

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site: <http://www.adobe.com/products/acrobat/readstep2.html>. This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

## **14. Early View**

Psychology and Psychotherapy is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

Further information about the process of peer review and production can be found in this document. [What happens to my paper?](#) Appeals are handled according to [the procedure recommended by COPE](#).

## Appendix 1.2: Quality Appraisal of included studies

Table

*Quality appraisal of included studies. Red colour = domain absent, Yellow =domain partially met, Green = domain fully met*

	Scope & Purpose	Design	Sampling Strategy	Analysis	Interpretation	Reflexivity	Ethical Dimensions	Relevance and Transferabi lity
Dunn et al., 2002	Green	Yellow	Green	Yellow	Yellow	Red	Red	Green
Hazell et al., 2007	Green	Yellow	Green	Yellow	Yellow	Green	Green	Green
Iredale et al., 2015	Green	Yellow	Green	Yellow	Yellow	Green	Yellow	Yellow
Landau, S & Ruddle, A. (2017)	Green	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Li et al., 2017	Green	Green	Green	Green	Green	Yellow	Yellow	Green
McGowan et al., 2005	Green	Yellow	Green	Yellow	Yellow	Red	Red	Yellow
Messari & Hallam 2003	Green	Green	Green	Green	Yellow	Yellow	Yellow	Green

Naeem et al., 2016								
Newton et al., 2007								
Prytys et al., 2011								
Waller et al., 2015								

### Appendix 1.3: List of overarching themes

Codes	Subthemes	Overarching themes
<ul style="list-style-type: none"> <li>• Culture &amp; Religion beliefs about mental health</li> <li>• Stigma</li> <li>• Fear of deterioration</li> <li>• Sense of control/ attributions</li> <li>• Cognitive difficulties</li> <li>• Disbelief in recovery</li> <li>• Family's perceptions</li> </ul>	Motivation to engage	Difficulties in seeking treatment
<ul style="list-style-type: none"> <li>• Accessible language of treatment materials</li> <li>• Awareness of treatment options</li> <li>• traveling distance/expenses</li> <li>• Housebound</li> </ul>	Practical difficulties in accessing treatment	
<ul style="list-style-type: none"> <li>• Lack of training</li> <li>• Pessimistic views about psychological interventions</li> <li>• Pessimistic views about recovery</li> <li>• Professional's confidence in delivering therapy</li> <li>• Lack of sustaining benefits from treatment</li> </ul>	Professionals' confidence in delivering therapy	

<ul style="list-style-type: none"> <li>• Challenges of working with complex and chronic illness</li> <li>• Difficulties of working with comorbidity</li> <li>• Difficulties in managing endings</li> <li>• Challenges of sticking to the treatment protocol</li> </ul>		
<ul style="list-style-type: none"> <li>• Cultural/ Religious awareness</li> <li>• High Dropout rates</li> <li>• Family's engagement</li> <li>• Engagement with therapy (attendance, compliance with homework, sense of control that patients have)</li> <li>• Dominance of the medical model</li> <li>• Disbelief in clinical guidelines</li> <li>• Lack of clarity around suitability criteria</li> <li>• Lack of defined professional roles</li> <li>• Need for a specialised trained therapist</li> <li>• cognitive difficulties</li> <li>• Lack of common agenda between therapists and client</li> <li>• Therapist becoming incorporated into the delusional system of the client</li> </ul>	Practical difficulties	Challenges of providing care
<ul style="list-style-type: none"> <li>• Time restraints</li> <li>• Lack of training availability</li> </ul>		

<ul style="list-style-type: none"> <li>• Long waiting list</li> <li>• Supervision</li> <li>• Lack of specific job roles</li> </ul>	Resources	Service design
<ul style="list-style-type: none"> <li>• Unclear pathways</li> <li>• Target driven services</li> <li>• Lack of confidence in investing in CBTp</li> <li>• Deciding suitability</li> <li>• Medical model dominance</li> </ul>	Conflicting needs	

#### Appendix 1.4: Walsh & Downe (2006) Quality Appraisal Framework

Scoring key: Not present = 0 Partially present = 1 Present = 2

Stages	Essential Criteria	Specific prompts	Score
Score and Purpose	<p>Clear statement of, and rationale for, research question/aims/purposes</p> <p>Study thoroughly contextualised by existing literature</p>	<ul style="list-style-type: none"> <li>• Clarity of focus demonstrated</li> <li>• Explicit purpose given, such as descriptive/explanatory intent, theory building, hypothesis testing</li> <li>• Link between research and existing knowledge demonstrated</li> </ul>	
Design	<p>Method/design apparent, and consistent with research intent</p> <p>Data collection strategy apparent and appropriate</p>	<ul style="list-style-type: none"> <li>• Rationale given for use of qualitative design</li> <li>• Discussion of epistemological/ontological grounding</li> <li>• Rationale explored for specific qualitative method (e.g. ethnography, grounded theory, phenomenology)</li> <li>• Discussion of why particular method chosen is most appropriate/sensitive/relevant for research question/aims</li> <li>• Setting appropriate</li> <li>• Were data collection methods appropriate for type of data required and for specific qualitative method?</li> <li>• Were they likely to capture the complexity/diversity of experience and illuminate context in sufficient detail?</li> <li>• Was triangulation of data sources used if appropriate?</li> </ul>	

Sampling Strategy	Sample and sampling method appropriate	<ul style="list-style-type: none"> <li>• Selection criteria detailed, and description of how sampling was undertaken</li> <li>• Justification for sampling strategy given</li> <li>• Thickness of description likely to be achieved from sampling</li> <li>• Any disparity between planned and actual sample explained</li> </ul>	
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Analysis	Analytic approach appropriate	<ul style="list-style-type: none"> <li>• Approach made explicit (e.g. Thematic distillation, constant comparative method, grounded theory)</li> <li>• Was it appropriate for the qualitative method chosen?</li> <li>• Was data managed by software package or by hand and why?</li> <li>• Discussion of how coding systems/conceptual frameworks evolved</li> <li>• How was context of data retained during analysis</li> <li>• Evidence that the subjective meanings of participants were portrayed</li> <li>• Evidence of more than one researcher involved in stages if appropriate to epistemological/theoretical stance</li> <li>• Did research participants have any involvement in analysis (e.g. member checking)</li> <li>• Evidence provided that data reached saturation or discussion/rationale if it did not</li> <li>• Evidence that deviant data was sought, or discussion/rationale if it was not</li> </ul>	
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Interpretation	<p>Context described and taken account of in interpretation</p> <p>Clear audit trail given</p> <p>Data used to support interpretation</p>	<ul style="list-style-type: none"> <li>• Description of social/physical and interpersonal contexts of data collection</li> <li>• Evidence that researcher spent time ‘dwelling with the data’, interrogating it for competing/alternative explanations of phenomena</li> <li>• Sufficient discussion of research processes such that others can follow ‘decision trail’</li> <li>• Extensive use of field notes entries/verbatim interview quotes in discussion of findings</li> <li>• Clear exposition of how interpretation led to conclusions</li> </ul>	
Reflexivity	<p>Researcher reflexivity demonstrated</p>	<ul style="list-style-type: none"> <li>• Discussion of relationship between researcher and participants during fieldwork</li> <li>• Demonstration of researcher’s influence on stages of research process</li> <li>• Evidence of self-awareness/insight</li> <li>• Documentation of effects of the research on researcher</li> <li>• Evidence of how problems/complications met were dealt with</li> </ul>	

Ethical Dimensions	Demonstration of sensitivity to ethical concerns	<ul style="list-style-type: none"> <li>• Ethical committee approval granted</li> <li>• Clear commitment to integrity, honesty, transparency, equality and mutual respect in relationships with participants</li> <li>• Evidence of fair dealing with all research participants</li> <li>• Recording of dilemmas met and how resolved in relation to ethical issues</li> <li>• Documentation of how autonomy, consent, confidentiality, anonymity were managed</li> </ul>	
Relevance and transferability	Relevance and transferability evident	<ul style="list-style-type: none"> <li>• Sufficient evidence for typicality specificity to be assessed</li> <li>• Analysis interwoven with existing theories and other relevant explanatory literature drawn from similar settings and studies Discussion of how explanatory propositions/emergent theory may fit other contexts</li> <li>• Limitations/weaknesses of study clearly outlined</li> <li>• Clearly resonates with other knowledge and experience</li> <li>• Results/conclusions obviously supported by evidence</li> <li>• Interpretation plausible and ‘makes sense’</li> <li>• Provides new insights and increases understanding</li> <li>• Significance for current policy and practice outlined</li> <li>• Assessment of value/empowerment for participants</li> <li>• Outlines further directions for investigation</li> <li>• Comment on whether aims/purposes of research were achieved</li> </ul>	
<b>Total score</b>			

## **Appendix 1.5: Search terms for Systematic Review**

### EMBASE (n=132) and Psycinfo (n =233)

(CBTp or CBT or Cognitive Behavioural therapy or Cognitive Behaviour Therapy). ab. OR  
(CBTp or CBT or Cognitive Behavioural therapy or Cognitive Behaviour Therapy). kw. OR  
(CBTp or CBT or Cognitive Behavioural therapy or Cognitive Behaviour Therapy). ti.

AND

(schizophren\* or psychos\*).ab. OR (schizophren\* or psychos\*).kw. OR (schizophren\* or  
psychos\*).ti.

AND

(NICE or “National Institute for Health and Care Excellence” or implement\* or guideline\*)  
ab OR (NICE or “National Institute for Health and Care Excellence” or implement\* or  
guideline\*) kw. OR (NICE or “National Institute for Health and Care Excellence” or  
implement\* or guideline\*). ti.

### CINAHL (n =60)

CBTp or CBT or Cognitive Behavioural therapy or Cognitive Behaviour Therapy).ab. OR  
(CBTp or CBT or Cognitive Behavioural therapy or Cognitive Behaviour Therapy).ti.

AND

(schizophren\* or psychos\*).ab. OR (schizophren\* or psychos\*).ti.

AND

(NICE or “National Institute for Health and Care Excellence” or implement\* or  
guideline\*).ab. OR (NICE or “National Institute for Health and Care Excellence” or  
implement\* or guideline\*). ti.

Pubmed (n= 172)

CBT[Title/Abstract] OR CBTp [Title/Abstract] OR Cognitive Behaviour Therapy  
[Title/Abstract] OR Cognitive Behavioural Therapy [Title/Abstract]

AND

Schizophren\* [Title/Abstract] OR psychos\*[Title/Abstract]

AND

NICE[Title/Abstract] OR “national institute for health and care excellence” [Title/Abstract]  
OR implement\* [Title/Abstract] OR guideline\*[Title/Abstract]

MEDLINE (n =347)

TOPIC: (CBT OR CBTp OR Cognitive behavioural therapy OR Cognitive behaviour  
Therapy)

AND

TOPIC: (schizophren\* or Psychos\*)

AND

TOPIC: (NICE OR “national institute for health and care excellence” OR implement\* OR  
guideline\*)

## **Appendix 2.1 Major Research Project Proposal**

### **Abstract**

**Background:** In contrast to national guidelines, evidence suggest that only a minority of service users experiencing psychosis have access to Cognitive Behavioural Therapy for psychosis (CBTp). Although previous studies identified various barriers to implementation of CBTp, they did not use a theoretical framework to interpret them.

**Aims:** This study aims to utilize Normalisation Process Theory (NPT) to explore the experiences and perspectives of stakeholders regarding the implementation of CBTp in NHS A&A.

**Method:** The sample will consist of Community Mental Health Team (CMHT) managers and professionals working with people who experienced psychosis, service users with lived experience of psychosis and their carers. This study will adopt a qualitative design using focus groups and semi-structured individual interviews with nursing staff, occupational therapist, clinical psychologists, psychiatrists, service users and carers. Transcribed interviews will be analysed using Framework Analysis (deductive) and Thematic Analysis (inductive methods).

**Applications:** To our knowledge the use of a theoretical framework and the participation of recipients and providers of CBTp to explore the barriers to implementation, constitutes an innovative feature of this study in comparison with previous studies. Potential implication of this study would involve the generation of a plausible intervention plan to overcome implementation barriers in service and individual level.

## **Introduction**

Psychosis constitutes a spectrum of mental distress which is often classified into positive and negative symptoms (American Psychiatric Association [APA], 2013). Positive symptoms, refer to experiences such as hearing voices or seeing things that others cannot see or hear ('hallucinations'), speaking in a way that others find hard to follow ('thought disorder') and holding firm beliefs that seem unusual to others ('delusions'). Negative symptoms refer to lack of enjoyment (anhedonia), motivation (apathy) and diminished emotional expression (APA, 2013).

Cognitive Behavioural Therapy for psychosis (CBTp) is an individually tailored talking therapy which aims to increase an individual's coping with specific psychotic experiences (e.g. hearing distressing voices) by modifying associated thoughts, physical sensations, behaviours and emotions (National Institute of Clinical Excellence; NICE, CG178, 2014). Recent meta-analyses indicate that CBTp not only contributes to the reduction in positive symptoms, improves medication adherence and general functioning (Turner, van der Gaag, Karyotaki, & Cuipers, 2014; Wykes, Steel, Everitt, & Tarrier, 2008) but it is also associated with reduced risk of transition to psychosis for individuals with elevated risk (Hutton & Taylor, 2014)

Wykes et al (2008) meta-analysis of CBTp Randomised Control Trials (RCTs) estimated the mean effect size for specific psychotic experiences, depression and social anxiety to be in the medium range; it also indicated that low quality trials had inflated effect sizes. Main contributor to effect size inflation was lack of blinding. However, a more recent meta-analysis (Jauhar et al. 2014) reported that the effect sizes of CBTp further reduced from medium to small range by controlling for the blinding bias. Jauhar et al (2014) argued that

design quality scales and effect size calculation methods used in previous meta-analysis of CBTp (e.g. Wykes et al, 2008) had contributed to inflated effect sizes.

For context, a recent meta-analysis (Leucht et al. 2009) of first and second generation antipsychotic medication estimated the effect sizes to range from small to medium range for overall symptoms. As with CBTp studies, the effectiveness on positive symptoms was less, with effect sizes ranging from small to moderate range. Furthermore, both NICE (2014) and the Scottish Intercollegiate Guidelines Network (SIGN (131), 2013), recommend CBTp to be offered to all individuals experiencing psychosis over the course of at least 16 sessions. However, evidence suggest that even low intensity CBTp (mean number of session was 9), has medium effect sizes post intervention and at follow up (Hezell, Hayward, Cavanagh, & Strauss, 2016)

Despite the national guidelines for CBTp, evidence indicates limited accessibility, estimating that only five to nine percent of service users has access to CBTp (Berry & Haddock, 2008; Haddock et al. 2014; Prytus, Garety, Jolley, Onwumere & Craig, 2011). Previous studies reported lack of training, allocated time and supervision as barriers to CBTp implementation (Berry & Haddock, 2008). Even when the rates of staff training increased, the provision for allocated time and supervision continued to affect negatively the implementation of CBTp (Jolley et al. 2012). Prytus et al. (2011) identified increased caseloads, lack of resources and staff attitudes towards the efficacy of psychological therapy as the most significant barriers to CBTp implementation. A recent systematic review (Ince, Haddock, & Tai, 2016) indicated organisational barriers (e.g. lack of resources, protected time, supervision and specialist training) as the most commonly reported followed by barriers met by staff (e.g. biological model of psychosis, lack of clarity of who should be offered treatment, disbelief in psychological interventions) and service users (e.g. poor engagement, overly medicated or symptomatic to take part in therapy). Furthermore, the reduced effect sizes that were found in



the latest meta-analysis, provoked a debate among clinicians regarding the efficacy of CBTp (e.g. McKenna & Kingdon, 2014), which has affected the consensus regarding prioritisation of resources.

Normalisation Process Theory (NPT; May et al, 2009; Murray et al, 2010) is one of the theoretical frameworks that were developed as an attempt to explain the gaps observed in applying evidenced based treatments in routine practice and influencing health related policies (Murray et al, 2010). The theory focuses on the implementation of interventions, their embedding in routine practice and the processes by which interventions are sustained or normalised. NPT consists of four components which attempt to explore the implementation, embedding and incorporation of interventions among stakeholders. The first component, *coherence* refers to the sense of clear and common purpose of the intervention between the stakeholders. *Cognitive participation* refers to the degree to which stakeholders perceive the potential benefits of the intervention before it is implemented. Consequently, *collective action* refers to stakeholder's readiness to change their current practice due to the implementation of the intervention. The fourth component, *reflective action* refers to the potential experience of the stakeholders after the intervention has been applied (May et al 2009; Murray et al; 2010).

Although previous studies identified various implementation barriers of CBTp, none of them utilised an existent m interpret and formulate such barriers in organisational and individual level. This might have limited the understanding regarding the interaction between experiences and perspectives of stakeholders, which subsequently restricted the generation of an intervention plan based on theoretical model used, to overcome such barriers.

## **Aims/Hypotheses**

The proposed research aims to utilize NPT to explore the experiences and perspectives of stakeholders (NHS mental health managers and staff, service users and carers) regarding the implementation of CBTp in NHS Ayrshire and Arran (A&A).

### **Research questions**

1. How do the managers and staff working with people experiencing psychosis make sense of CBTp implementation?
2. What are service user's experiences of accessing CBTp?
3. What are carers' experiences of their loved one's access to CBTp?
4. Can stakeholder's perspectives be understood within the NPT framework?

### **Methodology**

#### **Design**

This study will adopt a qualitative design, as we aim to examine individuals' experience as phenomenon, within the context and social reality of participants (Holloway, 1997). Focus groups and semi-structured individual interviews will be employed, and analysed using both deductive and inductive methods.

#### **Epistemology**

The epistemological positions behind this study follow the critical realist and post-positivist paradigms, suggesting that the experience of participants is influenced by the social, structural and political context in which the study is conducted (Danermark, Ekström, Jakobsen, & Karlsson, 2002). We invite participants to take perspectives based on their roles either as potential referrers for CBTp, providers of CBTp or consumers of CBTp. Stryker (2008) proposes that individuals take on 'positions', which are recognized social categories. The concept of 'role' is then defined as the set of expectations attributed to those positions.

Thus, we assume that the context of 'role' will be an important social factor which affects the experience and the perspectives of the participants (Appendix D).

## **Participants**

The sample will consist of nursing staff, occupational therapist, clinical psychologists and psychiatrists working with people who experienced psychosis, service users with lived experience of psychosis and their carers. Staff will be recruited from CMHTs across the three geographical regions in NHS A&A (East, South, North). Service users and carers would be recruited from third sector organisations in Ayrshire.

Inclusion and exclusion criteria will be applied flexibly to get a heterogeneous sample, as we are aiming to get a broad perspective of experiences. CMHT's staff must have worked with individuals who have experienced psychosis. Service users, must have an experience of psychosis which led to CMHT involvement and reside in Ayrshire to participate; carers must have/had a caring role for someone with lived experience of psychosis.

Third sector organisations will be informed about the aims of the study, and consent to contact their members will be sought. Carers and service users will be provided with introductory information sheets from third sector organisation, which will briefly outline the aims and eligibility to participate in the study. Following contact with the researcher, potential participants will receive a participant information sheet. Before taking part, participants will provide written informed consent. Participants will then provide their contact details to the researcher to arrange the date, time and location of the focus group or interview as appropriate.

In order to recruit CMHT staff and managers, study information will be sent via email to the CMHTs managers to circulate to team members . This will be followed by a telephone call to

arrange for the researcher to attend team meetings to introduce the study and provide participant information sheets. Before taking part, participants will provide written informed consent.

Based on previous studies (e.g. Bird et al. 2014) with similar research design we estimate that we will need seven focus groups with six to eight participants per group to reach thematic saturation and ensure stakeholder's representation. Potential barriers to recruitment involve lack of motivation to attend group contexts and time restraints (see Appendix E).

## **Materials**

Data collection will involve: a) The completion of basic demographics questionnaire (e.g. age, gender, occupational status etc.) b) separate focus groups with nursing staff and occupational therapists, psychiatrist, clinical psychologist, service users and carers which will last approximately one hour. Secondary option of individual interviews will be available for participants who have difficulties attending a group context, as previous study has recommended this to increase participation (e.g. Farrelly et al, 2015).

## **Analysis**

Framework Analysis (FA; Ritchie & Spencer, 1994) will be used for the data analysis given that a theoretical framework (NPT) will be utilised in this study to explore the experiences of stakeholders. The interview topic guide will be designed to permit participants to reflect on the NPT components, related to experiences of accessing (service users/carers) /implementing (staff) CBTp. Subsequently, themes generated from the analysis of the transcripts will be compared and then matched with the NPT components (deductive coding).

Thematic Analysis (Braun & Clarke, 2006) will be also used to identify deviant or new themes that might not be adequately captured in the deductive framework. Thus, the inductive coding will limit the possibility of themes not fitting the NPT framework, being reframed or undetected.

The analytic process will follow the five-stage model (Ritchie & Spencer, 1994), which involves familiarisation, thematic framework development, indexing data, charting and mapping. Anonymised transcripts will be imported to Nvivo (version 7, QRS international) for analysis. The produced coding manual will be given to a colleague to examine differences in coding (inter-rated reliability).

### **Health and Safety issues**

Participants will have the right to withdraw at any point during the interview. The researcher will not be directly responsible for the care of those being recruited. As part of the informed consent process, participants will be informed of how to access support should they experience distress following the interview.

Interviews with service users and carers, will take place at third sector organisation grounds during working hours. The location and the estimated time of the interviews will be documented in advance so that research team can contact the researcher before and after the estimated end. Researcher will have access to risk minimisation procedures of the settings that the interviews will take place (Appendix B)

### **Ethical considerations**

Participants will be asked to read an information sheet, which will summarise the procedure of the study, the right of withdrawal and confidentiality. Before taking part, participants will provide written informed consent. Although, participants will have the right to withdraw at

any stage of the study, anonymised data already collected will be retained. Participants will be informed that if the research team is concerned for their safety or the safety of other people, they may be required to break confidentiality after informing and explaining them the reasons for this decision.

Interviews' transcripts will be stored in encrypted files in a password protected computer in line with the University of Glasgow and NHS A&A data protection guidelines. Anonymity will be kept by changing the names mentioned in the interviews while confidentiality issues will be managed by the destruction of the audio material after the completion of the study. Favourable ethical approval will be sought via the University of Glasgow, Ethics Committee and NHS A&A Research and Development Department.

### **Time-Line**

<b>Time</b>	<b>Major Task/s</b>
January	Submission of MRP proposal.
May 2017	Submission for University Ethics approval
June 2017	Ethics Meeting Submission for NHS A & A Research and Development Department approval
August 2017-January 2018	Recruitment of participants
February – April 2018	Transcriptions of interviews. Data analysis.
April– July 2018	MRP write up

### **Financial cost**

Participation in this study is voluntary. Financial expenses involve stationary cost, postage, travel expenses for participants and the software for the analysis of the data (Appendix A).

The digital recorder for the interviews will be borrowed from the University.

### **Practical application**

To our knowledge, the use of a theoretical framework and the participation of recipients and providers of CBTp, constitutes a distinctive feature of this study in comparison with previous studies in this research field. Potential implication of this study would involve the generation of a plausible intervention plan to overcome implementation barriers in service and individual level.

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## **Appendix 2.2: Rationale for amendments to initial research proposal**

Although, the initial aims of the study were to recruit service users, professionals and carers, researchers decided to focus recruitment on mental health professionals only. The rationale for this decision was related to the feasibility of completing the study within the given timescale. Additionally, focusing on one stakeholder group helped us to reach thematic saturation and get perspectives from a variety of professional groups. The receipt of further feedback from key stakeholders (including clinical psychology) which was not forwarded to the researcher by NHS Ayrshire and Arran clinical psychology governance committee suggested further amendment to initial proposal. The overall feedback advised that researchers should consider broadening the scope of the focus groups and include a discussion around the provision of psychosocial interventions in general for people with schizophrenia while retaining the focus on CBTp specifically.

## Appendix 2.3: MVLS ethics committee approval

Dear Professor Andrew Gumley

### MVLS College Ethics Committee

**Project Title:** *Exploring the implementation of Cognitive Behavioural Therapy for Psychosis using Normalisation Process Theory Framework*

**Project No:** 200160151

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. We are happy therefore to approve the project, subject to the following conditions:

- I note the response from NHS REC. The study will now exclusively focus on staff. Consent and information sheets for service users and carers are still on the system but will not be used.
- The applicants have been advised by NHS REC to submit IRAS paperwork to facilitate local Research and Development approvals. While not mandatory for ethical approval, these documents should be submitted to MVLS ethics.
- Project end date as stipulated in original application.
- The data should be held securely for a period of ten years after the completion of the research project, or for longer if specified by the research funder or sponsor, in accordance with the University's Code of Good Practice in Research:  
([http://www.gla.ac.uk/media/media\\_227599\\_en.pdf](http://www.gla.ac.uk/media/media_227599_en.pdf))
- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely



Dr Terry Quinn

## Appendix 2.4: Research and Development Department Approval



Research & Development  
58 Lister Street  
University Hospital Crosshouse  
Kilmarnock  
KA2 0BB

Mr Nikos Xanidis  
Trainee Clinical Psychologist  
NHS Ayrshire & Arran  
Psychological Services  
North West Area Centre  
Kilmarnock

Date 19 October 2017  
Your Ref  
Our Ref AG/KLB/NM R&D 2017AA077  
Enquiries to Karen Bell  
Extension 25850  
Direct line 01563 825850  
Fax 01563 825806  
Email Karen.Bell2@aapct.scot.nhs.uk

Dear Mr Xanidis

*DISCO: Exploring the implementation of Cognitive Behaviour Therapy for Psychosis (CBTp) using the Normalisation Process Theory (NPT) Framework*

I confirm that NHS Ayrshire and Arran have reviewed the undernoted documents and grant R&D Management approval for the above study.

### Documents received:

Document	Version	Date
SSI form	Version 5.5.2	19/10/17
Protocol	Version 1.3	12/09/17
R&D Form	Version 5.5.2	19/10/17
Demographics Questionnaire Staff	Version 1.1	11/08/17
Staff Consent Form	Version 1.3	11/09/17
Interview topic guide for participant groups	Version 1.2	11/09/17
Staff Participant information Sheet	Version 1.2	11/09/17
Staff Information Leaflet	Version 1.1	11/08/17
Staff Study Advert	Version 1.2	11/09/17

The terms of approval state that the investigator authorised to undertake this study within NHS Ayrshire & Arran is: -

- Nikos Xanidis, Trainee Clinical Psychologist, NHS Ayrshire & Arran

With no additional investigators.

The sponsors for this study are NHS Ayrshire & Arran.

This approval letter is valid until 19 January 2019.

Regular reports of the study require to be submitted. Your first report should be submitted to Dr K Bell, Research & Development Manager in 12 months time and subsequently at yearly intervals until the work is completed.

Please note that as a requirement of this type of study your name, designation, work address, work telephone number, work e-mail address, work related qualifications and whole time equivalent will be held on the Scottish National Research Database so that NHS R&D staff in Scotland can access this information for purposes related to project management and report monitoring.

In addition approval is granted subject to the following conditions: -

- All research activity must comply with the standards detailed in the Research Governance Framework for Health and Community Care [www.cso.scot.nhs.uk/publications/ResGov/Framework/RGFEdTwo.pdf](http://www.cso.scot.nhs.uk/publications/ResGov/Framework/RGFEdTwo.pdf) and appropriate statutory legislation. It is your responsibility to ensure that you are familiar with these, however please do not hesitate to seek further advice if you are unsure.
- You are required to comply with Good Clinical Practice (ICH-GCP guidelines may be found at [www.ich.org/LOB/media/MEDIA482.pdf](http://www.ich.org/LOB/media/MEDIA482.pdf)), Ethics Guidelines, Health & Safety Act 1999 and Data Protection Act 1998.
- If any amendments are to be made to the study protocol and or the Research Team the Researcher must seek Ethical and Management Approval for the changes before they can be implemented.
- **Monitoring Auditing and Inspection:** The Researcher and NHS Ayrshire and Arran must permit and assist with any monitoring, auditing or inspection of the study by the relevant authorities. Since A&A Sponsor this study the researcher must be available to meet and complete any relevant documents. The R&D office will make contact to establish this process. The researcher and project team are required to engage with the auditing and monitoring process during the set-up and life of the project. Failure to engage with this process at any stage for a period of more than one month will lead to escalation to the Head of R&D/Clinical Director for the Service. If unable to resolve; the process will then be escalated to the Nurse or AHP Director/ or Medical Director which may lead to the suspension or close down of the research study.
- **Steering Group:** Since Ayrshire and Arran are the Sponsor for this study a Steering Group should be convened of which a member of the R&D team will attend. A record of these meetings should be kept in the Master Site File for the study
- The NHS Ayrshire and Arran Complaints Department should be informed if any complaints arise regarding the project and the R&D Department must be copied into this correspondence.
- The outcome and lessons learnt from complaints must be communicated to funders, sponsors and other partners associated with the project.
- As custodian of the information collated during this research project you are responsible at all times for ensuring the security of all personal information collated in line with NHS Scotland policies on information assurance and security, until the secure destruction of these data. The retention time periods for such data should comply with the requirements of the Scottish Government Records Management: NHS Code Of Practice. Under no circumstances should personal data be stored on any unencrypted removable media e.g. laptop, USB or mobile device (for further information and guidance please contact the Information Governance Team based at University Hospital Crosshouse 01563 825831 or 826813).

If I can be of any further assistance please do not hesitate to contact me. On behalf of the department, I wish you every success with the project.

Yours sincerely



**Dr Alison Graham**  
**Medical Director**

c.c.

Dr John Taylor, Associate Medical Director, Mental Health Services, NHS Ayrshire & Arran  
Derek Barron, Associate Nurse Director, Mental Health Services, NHS Ayrshire & Arran  
Libby Mullings, Senior Research Advisor, R&D, NHS Ayrshire & Arran (sponsor contact)  
Professor Andrew Gumley, University of Glasgow (CI and Academic Supervisor)  
Information Governance, NHS Ayrshire & Arran  
Lesley Douglas, Finance, Ailsa Hospital



## Appendix 2.5: Amendments approval from R&D

Research & Development Office  
58 Lister Street  
University Hospital Crosshouse  
Kilmarnock  
KA2 0BB



Professor Andrew Gumley  
University of Glasgow  
Mental Health and Wellbeing  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow  
Scotland  
G12 0XH

Date	13 December 2017
Our Ref	AG/KLB/CI R&D 2017AA077
Enquiries to	Karen Bell
Extension	25850
Direct line	01563 825850
Fax	01563 825806
Email	<a href="mailto:Karen.bell2@aapct.scot.nhs.uk">Karen.bell2@aapct.scot.nhs.uk</a>

Dear Professor Gumley

**DISCO: Exploring the implementation of Cognitive Behaviour Therapy for Psychosis (CBTp) using the Normalisation Process Theory (NPT) Framework**

I have received the undemoted documentation, relating to proposed changes to the above study:

- Notification of Substantial Amendment
- Interview\_topic\_guide\_for\_participant\_groups\_Version\_1.3
- Participant Information Sheet Version 1.3
- Staff information leaflet Version 1.2
- Staff\_Consent\_Form\_Version 1.4
- Staff\_Study\_Advert Version 1.3

I can confirm that the above amendment has been approved.

Please contact the R&D Office if you have any queries. On behalf of the department, I wish you every success with the project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'A. Graham', written over a horizontal line.

**Dr Alison Graham**  
Medical Director

Cc Nikos Xanidis

## Appendix 2.6: Information leaflet



### **DISCO: Discovering Implementation in health Services of COgnitive Behaviour Therapy for psychosis**

Volunteers are needed for a research study which would involve a focus group regarding your experiences of referring or offering psychosocial interventions and CBTp to people who experience psychosis. The focus group is expected to last one and half hours and will take place at NHS Ayrshire & Arran grounds, at a time convenient for you.

If you have any queries and/or are interested in participating contact us directly by email [n.xanidis.1@research.gla.ac.uk](mailto:n.xanidis.1@research.gla.ac.uk) to arrange a time and a place convenient for you to attend.

## Appendix 2.7: Participant Information Sheet



### Participant Information Sheet (Version 1.3, 13<sup>th</sup> of November 2017)

## Discovering Implementation in health Services of COgnitive Behaviour Therapy for psychosis (DISCO)

### Part 1 What does my participation involve?

#### 1 Introduction

You are invited to take part in this research project because you are currently an adult mental health operational manager, occupational therapist, a member of nursing staff, nursing assistant, clinical psychologist or psychiatrist working in Community Mental Health Services (CMHT) or Crisis Team (CT) in NHS Ayrshire & Arran (NHS AA).

This Participant Information and Consent Form outlines the details of the research project, including the procedures involved, and will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you do not understand, or would like to learn more about. Before deciding whether or not to take part, you might want to talk about it with a colleague. Participation in this research is voluntary. If you don't wish to take part, you don't have to. Your employment at NHSAA will not be affected whether you take part or not.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to the use of your personal information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

## **2 What is the purpose of this research?**

The project is funded by the University of Glasgow, Institute of Health and Wellbeing and NHS Ayrshire & Arran Research and Development Service.

Psychosocial interventions (e.g. psychoeducation, social skills training) can assist individuals experiencing psychosis to cope better with their symptoms and improve general functioning. One of the psychologically informed intervention for psychosis is Cognitive Behavioural Therapy for psychosis (CBTp). Cognitive Behavioural Therapy for psychosis (CBTp) is a talking therapy which aims to increase coping with distressing psychotic experiences (e.g. hearing distressing voices) by changing the way that someone interprets, feels and reacts to them. Evidence suggests that CBTp is effective in reducing distressing psychotic experiences and improves general functioning.

The aim of this study is to understand the perspectives of mental health staff that might influence our understanding of the implementation of psychosocial interventions and CBTp . This potentially will help us improve the accessibility of psychosocial interventions and CBTp, which has shown to be effective for people experiencing psychosis and is recommended by national guidelines. Participants will be invited to share their views and experiences of psychosocial interventions and CBTp being offered to service users with psychosis.

## **3 What does participation in this research involve?**

Participation in this study involves: attending a focus group with other mental health staff members. We expect that the focus groups would have maximum 6-8 participants. In case you are unable to attend group settings, an option for individual interviews will be available. The focus groups are planned to take place in NHS AA grounds in East, South and North Ayrshire.

Professional mental health care staff who partake in the study will be asked about their experiences/views of psychosocial interventions being offered to people with psychosis. Additionally, participants will be asked about their experiences of CBTp being offered (e.g. referring people for CBTp, their experience of delivery of CBTp by others or their experience of offering CBTp themselves). It will also include their views regarding implementation of CBTp in NHSAA.

It is expected that the interview will require about 1 – 1.5 hrs of your time.

## **4 Other relevant information about the research project**

We will invite mental health staff of all disciplines from CMHTs and CT's of NHS AA to participate in separate focus groups.

The allocation to focus groups will be based on your professional grouping. For instance, if you are a member of a nursing staff you will be allocated to a focus group which consist only of nursing staff professional, if you are clinical psychologist, you will be allocated to psychology focus group and if you are psychiatrist you will allocated to a psychiatry focus group. This is so that we can capture distinctive perspectives based on professional roles within the organisation. In case you are unable to participate in group settings, option for individual interview will be also available.

## **5 Do I have to take part in this research project?**

No, participation in any research project is voluntary. If you do not wish to take part you do not have to. If you decide to take part and later change your mind that is also OK. You have the right to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information Sheet and a Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not, or to take part and then withdraw, will not affect your employment with NHS AA.

## **6 What are the possible benefits of taking part?**

There are no particular benefits to you in taking part. The research is led by a research group with a track record of research and training in psychological therapies for recovery from psychosis. We hope that these data will be used to inform policy and practice development both locally and more broadly in NHS Scotland.

## **7 What are the possible risks and disadvantages of taking part?**

We do not anticipate any significant risks associated with participation in this project.

## **8 What if I withdraw from this research project?**

You can withdraw from the study at any time. You do not have to provide a reason and if you withdraw your employment will not be affected.

If you do withdraw from the study, any personally identifiable information about you will be destroyed. However, anonymised data already collected will be retained to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected by the research team up to the time that you withdraw will form part of the research project results. If you do not want them to do this, you should choose not to participate in this study.

## **9 Could this research project be stopped unexpectedly?**

We do not expect this research project to stop unexpectedly. However, if this situation arose the research team would communicate with you.

## **10 What happens when the research project ends?**

Transcribed anonymised interviews will be analysed by the research team using the Normalisation Process Theory Framework. Please let us know if you would like a summary of the results of this study shared with you by endorsing/ ticking the *Yes* response option on the Consent Form

## **Part 2 How is the research project being conducted?**

## **11 What will happen to information about me?**

By signing the consent form you consent to the relevant research staff collecting and using information about you for the research project. Any information obtained for the purpose of this research project can identify you will be treated as confidential and securely stored. It will be disclosed only with your permission, or as required by law.

Your demographic information (e.g. sex, profession, duration of employment) and your contributions in the interview regarding your experience of psychosocial interventions and CBTp will be collected. The interview will be audio-recorded. The recording and your demographic information will be stored on a password-protected computer at the University of Glasgow. Any paper files will also be stored securely at the University of Glasgow. The audio recordings will only be accessible by select members of the research team for the purpose of coding the specific responses of participants. After the completion of the study codings will be entered in a re-identifiable (i.e., coded) format into a databank, which will be stored securely at the University of Glasgow.

All of the investigators listed on this Participant Information Sheet/ Consent Form will have access to the de-identified study data (i.e., demographic information, interview codings).

Your information will only be used for the purpose of this research project, and it will only be disclosed with your permission, except as required by law.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission. Information that is published from this study will only include summary information that describes the whole group of participants in this study and not to any individual participant. We will use quotations taken directly from interviews. However, you or your service and its users will not be identifiable based on these quotations.

## **12 Who is organising and funding the research?**

This research project is being conducted by University of Glasgow Doctorate in Clinical Psychology training programme. This study will contribute towards an educational qualification (Doctor of Clinical Psychology; DClinspy) of the student, Mr Xanidis. Therefore, the findings of this study would be included in Mr Xanidis' thesis as well as publications. Investigators for the study are:

1. Mr Nikos Xanidis (email: [n.xanidis.1@research.gla.ac.uk](mailto:n.xanidis.1@research.gla.ac.uk))
2. Professor Andrew Gumley (email: [Andrew.Gumley@glasgow.ac.uk](mailto:Andrew.Gumley@glasgow.ac.uk); tel: **01412113939**)

The sponsor of this study is NHS AA (Research and Development Service). No financial benefits are expected to arise from the conduct of the research.

### **13 Who has reviewed the research project?**

The research has been reviewed by University of Glasgow Doctorate in Clinical Psychology and NHS Ayrshire and Arran Research and Development Department. Professor Rory O'Connor who is not involved in the study but has reviewed the study is the independent reviewer. The research has been approved by the University of Glasgow College of Medical, Veterinary and Life Sciences Ethics Committee.

### **14 Can I speak to someone who is not involved in the study?**

Yes, you can speak to Professor Rory O'Connor who is not involved in the study but has reviewed the study. He can answer questions or give advice about participating in this study. His telephone number is 0141 211 3927.

### **15 What will happen if there is a problem or if I want to make a complaint?**

If you have any concerns about the study or the way it is conducted or if you want to complain about any aspect of this study, please contact Prof. Andrew Gumley, Institute of Health and Wellbeing, Gartnavel Royal Hospital, 1<sup>st</sup> Floor, Admin Building, University of Glasgow, Glasgow G12 0XH, or the Research & Development Service, NHS Ayrshire & Arran on 01563 825850. The normal NHS complaint mechanisms will also be available to you.

**Thank you for reading this Participant Information Sheet**

## Appendix 2.8: Interview Topic Guide

What	Questions
<b>Grand tour question</b>	<ul style="list-style-type: none"> <li>• I am really interested to hear about your experience of supporting people with psychosis from your role a psychiatrist/psychologist/OT/therapist?</li> <li>• What a day to day work with people with psychosis involve?</li> <li>• Do you have an example?</li> </ul>
<b>Opening discussion: Introducing Psychosocial interventions</b>	<ul style="list-style-type: none"> <li>• How would you describe your experiences of psychosocial interventions being offered to service users with psychosis?</li> <li>• I am interested to know more about your psychosocial practice, and especially ways that you support people with psychosis stay well?</li> </ul>
<b>Introducing CBTp</b>	<ul style="list-style-type: none"> <li>• What are your views of CBT for psychosis?</li> <li>• I am interested to hear your views of CBT as a treatment option for people with psychosis.</li> <li>• How is CBTp different compare to other interventions for psychosis?</li> </ul>
	<ul style="list-style-type: none"> <li>• How would you describe your experiences of CBTp being offered/delivered?</li> <li>• What are your experiences of referring people for CBTp?</li> <li>• What are your experiences of witnessing CBTp? How people with psychosis respond?</li> </ul>
	<ul style="list-style-type: none"> <li>• What are the advantages of having CBTp?</li> <li>• What are the challenges /disadvantages of CBTp?</li> </ul>
	<p>Do you think that CBTp should be implemented more widely? /What are the challenges of implementing CBTp more widely?</p> <p>If yes/What would need to change?</p> <p>If not Why not?</p>
	<ul style="list-style-type: none"> <li>• What would help you as a psychiatrist/ot/nurse/therapist/psychologist to successfully implement/use/refer CBTp?</li> <li>• How do you think OT/Psychology/ Psychiatry in Ayrshire can be involved with CBTp or PSI implementation? What are the skills that you could be use to achieve that?</li> <li>• What would keep you involved/committed?</li> <li>• What do you think the role of OT/psychiatry/nursing/ psychology in Ayrshire can be in the implementation of CBTp?</li> </ul>
<b>Overall and concluding thoughts</b>	Thinking of CBTp overall and thinking ahead how would you know it's worth the effort?



## **Appendix 2.9: A list of the overarching themes**

### **Perceived barriers to engagement**

Severity of symptoms  
Chronicity of symptoms  
Better outcomes with early intervention  
Insight  
Comorbidity  
Medication side effects  
Drop outs  
Potential of increase in distress  
Life style factors  
Peer influences  
Family involvement/support  
Social deprivation

### **Contextual barriers to implementation**

Lack of resources  
Waiting times  
Referral criteria/ suitability of intervention  
Focus on outcomes  
Rejected referrals frustration  
Lack of referrals for CBTp  
Lack of documented outcomes  
Clinical priorities  
medical model  
Meeting targets  
Professionals' roles  
Demand for other clinical presentations

### **Optimisation of the implementation**

Importance of managerial support (allocated time, supervision)  
Raising awareness around CBTp  
Change in Culture  
More flexibility / Outreach work  
Supporting staff with specialist interest  
Having people with specialist interest (clinical leadership)  
Referral pathway protocol (clinical leadership)  
Importance of measuring long term outcomes  
Importance of supervision  
Having the same framework-Integration of psychology in teams-  
Need for more training in CBTp  
Service user involvement

**Positive attitudes towards CBTp**

Using CBTp to improve engagement

Using CBTp to liaise with staff

Ways to support implementation

CBT and self-management

CBT and quality of life

CBT formulation

CBTp shared responsibility

CBTp easy to understand

**Expectations of implementing CBTp**

Reduction in admission

Reduction in medication

Reduction in relapse severity

Quality of life

Self report measures

Feedback from family and carers

Less referrals to crisis teams

Direct feedback from service users

## Appendix 2.10: Consent Form

### Participant Consent Form



#### CONSENT FORM

Identification Number for this study:

**DISCO: Discovering Implementation in health Services of COgnitive Behaviour  
Therapy for psychosis**

Chief Investigator: **Professor Andrew Gumley**

Name of Researcher: **Mr Nikos Xanidis**

**Please initial box**

I confirm that I understand the nature of the study proposed, having read and understood the information sheet provided, DISCO Participant Information Sheet Version 1.3, 13<sup>th</sup> of November 2017. I have had opportunity to ask questions and am satisfied with the answers I received.

☐

I understand that my participation is voluntary, and that I am free to withdraw from the study at any time. Should I wish to withdraw, I understand that I can do so without giving reason, and without my employment being affected.

☐

I agree to take part in the study.

☐

I agree that you may audio tape sessions as required.

☐

I agree that fully anonymized quotations may be used in publications and other materials arising from the study

☐

I would like to receive a copy of the study results.

☐

Subject Name

Date

Signature

.....

... / ... / .....

.....

Researcher

Date

Signature

.....

... / ... / .....

.....

**1 copy for participant; 1 copy for researcher**

## Appendix 2.11: Sample of thematic analysis coding

DISCO, Participant ID: 2, Woodland View, 12/02/2018, Researcher ID: 1 Duration: 40.47min

1 Researcher 1: So once again thanks a lot for taking part in  
2 this research {{Name of the participant}}. First of all I  
3 would be just interested to hear about your experience of  
4 supporting people with psychosis from your role as a  
5 psychiatrist. What does this involve?

Reduced demand

6 Participant 2: Emmm. Being very honest we are not seeing as  
7 many patients with psychosis, a lot of our job is taken up a lot  
8 of other conditions but obviously we do have psychosis as part  
9 of that. Emm. I mean for a new first presentation. {{pause 2

Demand for other clinical presentation

10 sec}} primarily the treatment will be psychiatrist and CPN  
11 {{community psychiatric nurse}} would very rarely asking  
12 psychology to see to be honest. emm. because there has been a  
13 shift in services here away from being involved in those  
14 patients, whereas previously when I first came here they would  
15 be expected ...a first presentation of psychosis to be referred to  
16 psychology as part of that process [ Researcher: Hmmm]

Care pathways in psychosis

Changes in service structures and priorities throughout years

17 emmm it tends to be much more kind of medical model and its  
18 at psychotics and CPN as a main point of contact emm.. which  
19 works ok but there are some patients who certainly even further  
20 down the line express an interest...maybe more patients that  
21 have an affective psychosis rather than a schizophrenic illness.

Dominance of the medical model approach in treating psychosis

Limitations of the medical model approach

22 Emmm we maybe would be more inclined to to look at more  
23 psychosocial interventions or psychological interventions for  
24 them emm. I wouldn't say in Ayrshire in general we are overly  
25 well resourced to be honest in terms of what options there are

Limited resources for psychosocial interventions in psychosis

26 in the community even for just more general interventions. So I  
27 think unfortunately we are fairly limited even most severe  
28 patients in what we can offer emm they are not even  
29 psychological but just in terms of resources within the  
30 community we might be slightly with integration a little with  
31 more easier access to {{ pause 2 sec }} support workers and that  
32 kind of thing , but it is still a very limited resource so ...yeah

Limited resources  
in community  
settings

33 Researcher 1: I see, you said that there's a shift compare to  
34 the past. Would you like to tell me a bit more about that?

35 Participant 2: Well when I first was here emm we had a few  
36 clinical psychologists, can't remember how many, certainly  
37 two within the North team. The north team when I started was  
38 divided into two then we combined not long after that into one

Differences in  
team structures  
and management

39 big team. So we had at least two clinical psychologists who  
40 were..who actually if anything maybe prioritised the CBT for  
41 psychosis and psychotic patients, which was good for those  
42 patients and they would certainly ...see them for a long time and  
43 emm give very really helpful formulations, but I think the  
44 problem was that other areas were then not getting access to  
45 psychology, so waiting list were ridiculous length of waiting  
46 list. I mean several years emm and there was a real shift then

Benefits of past  
psychology  
service structure

Benefits of strong  
clinical leadership  
in CBTp

Importance of  
actively seeking  
referrals for CBTp

Prioritising  
psychosis in the  
past added more  
pressure in waiting  
lists

Increase in  
referrals and  
assessment in  
psychology

47 with the organisation that psychology now sees more patients,  
48 assesses a lot more patients, ~~I wouldn't think of referring~~  
49 someone with psychosis now to be honest, it wouldn't be  
50 something I would consider cause I don't think that most of the

Challenges  
referring people  
with psychosis for  
psychological  
interventions

Lack of  
confidence in  
delivering CBTp

51 psychologists that we have now are {{pause 2 sec}} overly  
52 interested in it or don't necessarily see that as as as there are  
53 not the people that necessarily can help as much as maybe [

Perceived lack of  
interest for staff to  
offer  
psychological  
intervention for  
psychosis

54 Researcher : Hmmm] the ones that... To be fair they are seeing  
55 more of which is an emotional dysregulation and personality  
56 issues and who obviously seek couple of services so.. there s  
57 been a shift maybe in terms of how psychology have emm

Increase in demand  
of other clinical  
presentation for  
psychology

Psychology  
service structure  
changes

58 → organised their service, but also to be fair that is partly because  
59 there has been a huge shift in what we are seeing now which is  
60 really dominated by trauma [Researcher: Hmmm] and emotional  
61 dysregulation, some of which obviously can have psychosis as  
62 part of that but it's not not like the schizophrenic patients,  
63 whereas previously the psychologist were quite interested  
64 particularly in first presentations and would want to be [  
65 Researcher : hmmm] seeing those patients

Perceived shift in  
the interest of  
psychologist for  
CBTp

66 Researcher 1: Do you have any experience of trying to refer  
67 people ..eee to psychology and what was this experience that  
68 led you think maybe..

Limited referrals  
for CBTp

Experiences of  
successful  
referrals for CBTp

69 Participant 2: I mean I must admit that I haven't referred  
70 recently. I have one patients I've referred recently who was  
71 very much a depressive psychosis, so he had psychotic features  
72 as part of his condition but they very much were seeded as in  
73 the background as very fearful of becoming unwell again and  
74 they accepted the referral for him, without any difficulty and  
75 I.I as long as he engages I think he'll do quite well, so certainly

76 that is absolutely fine but we've left with him until his really  
77 quite well recovered from the [Researcher: Hmmm] the sort of  
78 acute illness and his ..his now just at a stage where he has a  
79 better understanding, so I've to say that psychology was very  
80 happy to discuss any referrals and the North team {{ North  
81 CMHT}} there seems to be, there is differences between the  
82 teams{{ meaning EAST and SOUTH CMHT}}. I think quite  
83 mark differences how the psychology fits in to the team, but in  
84 north, I've always found that ..they are happy to discuss  
85 emmm...they are certainly assessing a lot more patients but not  
86 necessarily take on very many for treatment and certainly  
87 psychosis {{pause 2 sec}} . I just...it is a rare thing to see now  
88 a first presentation psychosis . I mean I have just somebody  
89 right now at the ward, but I can't imagine how engaging ..this  
90 is always as feeling if they are insightful {{ not having  
91 insight}} they would probably see that as somebody that  
92 wouldn't be really suitable because if they are not  
93 ..insightful...they wouldn't see that as a role of trying to get  
94 somebody at a point where they are more motivated, that  
95 doesn't seem to be psychology's role to ...if people are not  
96 motivated they don't see them, whatever the condition  
97 ..whatever the diagnosis..emm..  
98 Researcher 1: I see, Thanks very much. Going back to your  
99 role as a psychiatrist supporting people with psychosis, you  
100 referred to medication reviews and generally primarily the

Impact of  
psychology  
integration in  
teams on CBTp  
implementation

Challenges of  
progressing from  
assessment to  
treatment

Reduction in  
demand for first  
episode of  
psychosis

Importance of  
good insight to  
get benefit from  
psychological  
intervention=  
Suitability  
criteria= Lack of  
referrals

Importance of  
motivation to  
engage for  
successful  
referrals for  
psychological  
interventions=  
Suitability criteria

