



Citation for published version:

Cowdrey, FA, Hogg, LI & Chapman, K 2018, 'Is there a choice to make? A pilot study investigating attitudes towards treatment in an Early Intervention for Psychosis Service', *Mental Health Review Journal*, vol. 23, no. 2, pp. 110-120. <https://doi.org/10.1108/MHRJ-09-2017-0038>

DOI:

[10.1108/MHRJ-09-2017-0038](https://doi.org/10.1108/MHRJ-09-2017-0038)

Publication date:

2018

Document Version

Peer reviewed version

[Link to publication](#)

The final publication is available at Emerald via <https://doi.org/10.1108/MHRJ-09-2017-0038>

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**Is there a choice to make? A pilot study investigating attitudes towards
treatment in an Early Intervention for Psychosis Service**

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Acknowledgements: We are grateful to the service-users and staff who
completed the survey. The authors report no conflicts of interest. No external
funding was received for this study.

Abstract

Purpose: This aim of this study was to investigate health care professionals' (HCPs) and service-users' (SUs) attitudes towards different treatment options in an Early Intervention for Psychosis (EIP) service as well as the topical issue of offering choice over treatment.

Methodology: Seven service-users accessing an EIP service and nine HCPs completed qualitative surveys about treatment for psychosis. Data was analysed thematically.

Findings: Both HCPs and SUs appeared to have a generally positive attitude to the range of interventions offered by the EIP service and SUs talked about the importance of all treatment options being explored. There was variation in attitudes towards SUs having choice over their treatment and a number of factors were identified as crucial in influencing attitudes including mental capacity, risk and level of engagement.

Research limitations: Small sample size and recruitment from only one EIP service limits generalizability.

Practical implications: HCPs working in EIP services should explore different treatment options fully with SUs but be aware that they may feel unable to make the decision themselves. Such discussions should be revisited throughout an individual's care as ability to make informed choices may change over time. Continuing Professional Development and clinical

supervision should be used to help HCPs reflect on the choice agenda and the implications of this for clinical practice.

Originality / value: Few studies have examined attitudes towards treatments for psychosis. This is an evolving and important clinical area that remains under researched. Recommendations for service-development, future research and clinical practice are made.

Key words: Psychosis, CBT, Antipsychotics, Early Intervention, Service-development

Background

Early Intervention for Psychosis (EIP) services aim to identify and engage people with a first episode of psychosis as early as possible to ensure timely access to evidence-based interventions and increase the likelihood of symptomatic and functional recovery. The UK's Access and Waiting Time Standards for Mental Health Services specify that more than 50 per cent of people experiencing a first episode of psychosis should be treated with a National Institute for Health and Care Excellence (NICE) approved care package within two weeks of referral (NHS England, 2015). NICE guidelines state that EIP services should aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions to service-users (SUs) and that oral antipsychotic medication should be offered in conjunction with psychological intervention for people with first episode psychosis (National Institute for Clinical Excellence, 2014). For those considered to be at increased risk of developing psychosis, psychological therapy without antipsychotic medication is recommended as the front line intervention.

Best practice guidelines have also stressed the importance of working in collaboration with SUs and carers, taking into account their needs and preferences, and enabling individuals to make informed decisions about their treatment (National Institute for Clinical Excellence, 2011). Such shared decision-making has been associated with an increase in treatment adherence, concordance and satisfaction across a range of settings. For people with first episode psychosis, treatment decisions might include the decision to try a

psychological intervention, such as Cognitive Behavioural Therapy (CBT), without antipsychotic medication for which there is emerging evidence (Morrison *et al.*, 2012a; Morrison *et al.*, 2014). Further, despite SUs valuing the positive effect of medication on psychotic symptoms and psychosocial functioning (Morant *et al.*, 2017), issues of non-compliance and aversive side effects are also well documented (for example, Lieberman *et al.*, 2005; Foley and Morley, 2011). Taken together, this has led some to argue that clinicians need to “*reappraise the assumption that antipsychotics must always be the first line treatment for people with psychosis*” (pg.84) (Morrison *et al.*, 2012b).

In light of guidance emphasising the importance of involving SUs in treatment decisions, the emerging evidence-base for psychological interventions (Morrison *et al.*, 2012a; Morrison *et al.*, 2014) and concerns about antipsychotic medication, there seems to be a rationale for providing choice to SUs over their treatment for psychosis. Whilst the idea of shared decision-making and offering choice over treatment appears to be broadly accepted in mental health care, in practice it remains a complex issue.

As offering choice is dependent on health care professionals (HCPs) perceiving this as a useful thing to do, ultimately HCPs’ attitudes will determine what is offered, how it is offered and optimism about prognosis. A number of studies have been conducted examining HCPs’ attitudes in this respect. Carter and colleagues investigated beliefs about the causes of psychosis in a mixed group of mental health professionals and how these related to their opinions on the helpfulness of different types of treatments (Carter *et al.*, 2017a). Significant associations between aetiological beliefs and perceptions about the

helpfulness of different treatments were found. For example, a belief that antipsychotics were helpful was positively associated with biological causes and negatively associated with psychosocial causes and vice versa for psychological treatments. It therefore seems that causal explanations are associated with, and may influence, beliefs about treatment efficacy in professionals. This is an empirical question that needs investigation. Interestingly, this pattern of results was not replicated when SUs were asked to complete a similar set of questions. Whilst SUs had a preference for a psychosocial explanation for their difficulties this was not related to their perception of how helpful different treatments were (Carter *et al.*, 2017b). Therefore, unlike HCPs, SUs formulation of their difficulties may not alter their beliefs about different types of treatments suggesting for example, that even if a patient holds a biological view of their illness, they may still be open to exploring psychological treatments. What remains unclear from the existing literature is whether HCPs' beliefs about the causes of psychosis and effectiveness of treatments predict behavior in clinical practice and could pose a barrier to offering choice over treatments to SUs with psychosis.

From a HCPs' perspective, a number of others barriers to offering patients choice over their treatment have been identified in a recent qualitative study examining the process of prescribing antipsychotic medication. These factors included a patient's lack of understanding of symptoms or recognition of illness, a perception that the patient prefers professionals to make the decision, the setting (i.e inpatient versus outpatient) and a concern that giving choice undermines professionalism and perceived competency (Harris *et al.*, 2017). Despite this, generally professionals in this study viewed the process of

prescribing antidepressants to be as collaborative as it could be. This was in contrast to the majority of SUs and carers who were interviewed in the study who experienced the process as hostile, paternalistic and not incorporating their views. This suggests that there is difference in the experience of collaborative decision-making between professionals and SUs and carers.

As well as investigating the extent to which HCPs' attitudes are important in the choice agenda, it is essential that SUs' attitudes are also considered. Day and colleagues investigated the relationship between SUs' attitudes toward antipsychotic treatment and adherence (Day *et al.*, 2005). As well as confirming that attitudes toward treatment as well as insight predicted adherence to medication, they identified a number of variables that were important in forming SUs' attitudes. These included therapeutic alliance, lack of coercion and involvement in treatment decisions. These results are supported by a recent qualitative study which found that perceived lack of involvement with decisions about commencing or changing antipsychotic treatment was associated with poor adherence (Yiesen *et al.*, 2017). These studies therefore suggest that SUs' attitudes are shaped in part by their interactions with HCPs which in turn may have an influence on their behaviour.

Given the apparent importance of the relationship between HCPs and SUs, several studies have highlighted how the power imbalance between professionals and SUs can influence the process and experience of treatment decisions. One study found that generally SUs felt powerless to influence decisions about their medication and felt that choices were limited due to the nature of their illness and perspectives of other people (Morant *et al.*, 2017). As

highlighted by Quirk and colleagues, if SUs feel coerced or feel that they have little real influence over their treatment, then the potential benefits of shared-decision making are lost (Quirk *et al.*, 2012).

Further research into attitudes and experiences of treatments for psychosis is needed to help understand the barriers to shared decision-making and offering choice over treatment. Using a qualitative methodology, this pilot study aims to explore HCPs' and SUs' attitudes toward different treatment options for psychosis as well as the topical issue of offering choice over treatment to SUs in an EIP service.

Method

Setting

The study was based in an EIP service located in an inner city locality and took place over a 7-month period commencing in June 2013. Consistent with an EIP model of care, the service provides care for people from the age of 14 years who are experiencing a first episode of psychosis, or where there are concerns that this may be developing. The service provides a range of interventions, based on NICE guidelines, which aim to facilitate recovery. At the time of conducting the study, the service had a caseload of around 75 SUs and the staff team consisted of a part-time clinical psychologist, a part-time staff grade psychiatrist, a support worker, three nurse prescribers, three nurses without prescribing rights, an occupational therapist and a psychology student.

Participants

HCPs

All team members working clinically within the EIP service during the study period were invited to take part. The survey was discussed and described at a team meeting before the study started.

Service-Users

SUs were invited to take part by a member of the EIP team if their case was currently open to the EIP service during the study period and the clinician involved in the case deemed it to be appropriate to approach the SU regarding the study. No exclusion criteria were applied.

Procedure

Survey Development

Two surveys were created, one for HPCs and one for SUs. The surveys were divided into two sections; a section that elicited quantitative data, and a qualitative survey section¹. Only the data drawn from the qualitative surveys will be reported here. Qualitative surveys are a relatively novel method for data collection. They have unique advantages for qualitative researchers including being a relatively cost-effective and efficient way of collecting data, providing increased anonymity for participants and addressing a range of types of research questions (IBraun and Clarke, 2013). Qualitative surveys are particularly useful when investigating sensitive topics and questions related to views/ perspectives and practices as was the case with this study.

HCPs' Survey

¹ The survey proforma is available from the corresponding author.

Based on a review of the extant literature on treatment options for first episode psychosis, a draft survey was created for the team. A team member from the EIP service, who was not directly involved in the study, provided feedback on the draft survey and further revisions were made. The final survey had 13 questions and broadly aimed to examine attitudes towards different treatments for SUs with psychosis and SUs being offered choice over treatment. Survey items included: 'How much choice do you believe service-users should have over commencing antipsychotic treatment?', 'What methods do you routinely use to ensure informed choice and shared decision making occur before commencing antipsychotic treatment?' and 'Under what circumstances would you feel most confident about not recommending antipsychotic medication to service-users?'. Five items required participants to comment on whether they agreed with a particular statement (e.g., '*How much do you agree with the following statement "All service-users with psychosis require antipsychotic medication in order to recover"*'). The final two items asked about their awareness of recent research on treatments for psychosis and whether this research had influenced their clinical practice. After each question there was space for free text. Copies of the survey were provided to all team members and they were invited to complete all items.

SUs' Survey

In order to develop the survey for SUs, a focus group was convened with four SUs who had been discharged from the service (Three males and one female). After the aims of the project were detailed, topics that the SUs deemed significant based on their experiences were discussed. At the end of the focus

group, the themes of the discussion were summarised. A draft survey was constructed by the researchers based on the themes and circulated to members of the focus group for feedback. Further modifications were then made. The final survey had a total of 15 questions that focused on the process and experience of being prescribed medication (where applicable) and general attitudes towards different types of treatments and having choice over treatment. Survey items included: 'How much choice do you feel you had over which medications were prescribed?', and 'How much choice do you believe people with a first episode of psychosis should have over starting antipsychotic treatment?'. As with the HCP survey, five items required participants to comment on whether they agreed with a particular statement and there was space after each question for free text.

The University of Bath gave ethical approval for the study before the SU focus groups took place.

Data Collection

Following an EIP staff team meeting, hard copies of the survey were provided to all attendees. All members were invited to complete the survey and return the completed survey to one of the named researchers. To ensure all members of the team received a copy of the survey, it was also circulated electronically. For SUs, information sheets about the project were given to team members for circulation to SUs. If the SUs provided consent, they were sent either an electronic or hard copy of the survey, depending on preference. Once the survey had been completed and returned, SUs were thanked and entered into a draw to win a gift voucher.

Data Analysis

The primary researcher transcribed written feedback verbatim. Data was coded and analysed using NVivo software. The thematic analysis procedure described by Braun and Clarke was used (Braun and Clarke, 2006). The HCPs' and SUs' data were coded and analysed separately. All transcripts were read and re-read to aid familiarisation with the data. Key words or phrases were highlighted and used to develop initial codes. Codes were then compared and organised into potential overarching themes and subthemes. The analysis used an inductive approach meaning that the themes characterised participants' experiences rather than coding for the specific research question. The provisional themes were then reviewed to check (a) the themes worked in relation to the coded extracts, and (b) the themes reflected the data set as a whole. At this stage, two independent researchers were given a randomly selected sample of the transcripts to code. One researcher coded three of the SU transcripts and the other coded four HCP transcripts. The independent researchers were psychologists who had previous experience in thematic analysis but were unfamiliar with the specific aims of the study to encourage data-driven analysis. There was close agreement in terms of codes applied to the text.

Interpretation of the data and the conclusions drawn were made in a meeting between the authors. As two of the authors worked in an EIP service, it was particularly important that during this meeting the researchers were able to reflect on their positions in relation to the data and how this may influence their interpretation of the data. Where possible the words used by participants were

included in the theme title.

Results

HCPs

Nine team members who were working clinically self-selected to participate; equating to an 82% response rate. Professions represented included nursing ($n = 4$), psychology ($n = 2$), occupational therapy ($n = 1$) and support work ($n = 1$). One participant did not specify profession. Two of the nine participants stated that they had prescribing rights. The mean duration of time working in EI was 4.4 years (range = 9 months - 7 years 6 months).

The coding scheme included six related overarching main themes. Each theme is presented and supported by verbatim excerpts.

Attitudes towards different interventions

All HCPs commented on their attitude towards antipsychotic treatment as well as other non-pharmacological approaches offered by the service. The majority of participants reflected on the effectiveness of antipsychotics generally.

“I have seen medication work when other options have failed and vice versa but I would always offer medication as one option.” [HPC 6]

Three HCPs commented more specifically on the effectiveness of antipsychotics in reducing distress so that other interventions could be accessed.

“Sometimes get a sense that need to ‘calm things down’ or smooth out thinking to engage in other work.” [HPC 5]

“Antipsychotics are sedating. Sometimes this is really helpful to minimise distress so that psy [psychological] work can be effective. However, sedation can be achieved by short-term benzos.” [HCP 2]

As well as recognising the effectiveness of antipsychotic medication, four HCPs recognised how well some SUs do without any medication. Specific benefits of psychological interventions were also identified.

“I believe that some service-users can benefit from just challenging their beliefs and CBT, especially if they have had a short DUP [duration of untreated psychosis] and if there isn’t as much conviction behind their beliefs.” [HCP 8]

However, there was a sense from three HCPs that psychological interventions were generally thought of as a second line intervention after medication.

“The reality is that it [CBT] usually comes as second wave.” [HCP 1]

“Medication is still the ‘default’ treatment for ‘psychosis’ –still sold as a more exact science re dopamine etc than actually is.” [HCP 5]

Decision-making regarding treatment with medication

HCPs identified that in some circumstances the decision-making regarding treatment with medication would be more led by the clinician, but other times it would be led by the SU. Related to this, two HCPs also highlighted that sometimes SUs do not want to make a choice.

“Some people want to have us choose, some don’t. ” [HCP 9]

Five HCPs highlighted that informed choice was an essential part of the decision-making process.

“Where they [SUs] have capacity, they should have 100% choice, but sometimes we think it [medication] is needed despite the service-user not being keen. If we can offer choice regarding an alternative to antipsychotics, that is ideal (e.g., benzos).” [HCP 5]

“I don’t advise on medication but always promote the service users right to ask questions and research their medication if they wish.” [HCP 9]

Factors influencing prescribing

Eight HCPs commented on factors that influenced prescription of antipsychotic medication including the SUs’ capacity to make treatment-decisions, the DUP, individual characteristics of the person and their presentation, the role of third parties, engagement with service and professional’s knowledge about the effectiveness of antipsychotic medication.

“I think the DUP is the crucial bit- the longer the DUP the more likely it is that medication will be required.” [HCP 6]

“If people will engage in other treatments – i.e. psy [psychological interventions], are supported well by family/friends, and are able to occupy themselves, not offering meds is a realistic option. For people who are unable /unwilling to the above it is not a realistic option to not offer meds.” [HCP 3]

Process of prescribing medication

HCPs reflected on the process of introducing medications to SUs. Some suggested that certain HCPs, particularly those with prescribing rights, should undertake initial conversations with SUs regarding medication. However, one HCP commented on how some professionals introduced a more biological explanation of psychosis when discussing antipsychotics..

“Medics often sell TREATING psychosis- like it is an underlying thing rather than a state of mind.” [HCP 5]

Provision of services

Five HCPs highlighted that the EIP service in which they worked offered a range of interventions, other than just medication, and that SUs are rarely offered just one type of intervention. However, some HCPs felt that a medical model, emphasising biological factors, still dominated in the service, which meant that the first line intervention was medication. In some cases, it was felt that this was necessary in order to make other interventions accessible.

Conversely, one HCP attributed the order of interventions to ‘service-level factors’ although the nature of these was not expanded on.

“EI research and team discussions ensure the team approach reflects varied interventions of which medication has its place.” [HCP 7]

“Always advocating for CBT- some service level limitations re early detection stuff.” [HCP 5]

Research influencing practice

There was evidence that HCPs were aware of recent research on the effectiveness of antipsychotic medications and non-pharmacological interventions (with and without medication). However, a number of HCPs referred to limitations of using the research to guide practice including overstated effects, poor quality and employing inappropriate measures.

“Research is poor, contradictory or badly interpreted. Also not measuring good quality med management.” [HCP 1]

SUs

Seven SUs out of eight approached took part (5 men, 2 women). The mean age of the SU was 26.1 years (age range = 22 - 39 years). Five SUs described themselves as White British, one as White Irish and one did not respond to this question. The mean length of time supported by the EIP service at the point of completing the survey was 33 months (range = 6 - 48 months). One of the SUs had their first contact with the EIP service following admission to hospital. All SUs reported that they had taken medication for psychosis; the majority had been prescribed antipsychotic medication ($n = 6$). All SUs who had been prescribed antipsychotic medication had also been prescribed at least one other type of medication including antidepressants ($n = 3$), anxiolytics ($n = 3$) or Z drugs ($n = 2$).

The final coding scheme for SUs included six main themes.. Each theme is presented in the paragraphs that follow and supported by verbatim excerpts.

Choice over treatment

The majority of SUs commented on their attitude towards having choice over treatment, and more specifically, having input into decisions around starting or changing their medication regime. There seemed to be a divide in terms of whether SUs wanted choice over their treatment. Some were happy to follow whatever treatment was recommended, others felt they should have choice over their treatment but be guided towards a decision by HCPs. One SU felt strongly that they wanted medication and therefore they did not feel that there was a choice to be made.

"I believe that people experiencing first episodes of psychosis should obviously have a choice in their treatment but also should be helped in the right direction."

[SU 1]

"Totally wanted medication as I was sure it was best for the condition I thought I had." [SU 5]

"If feel that if the recipient has fairly good control over their mental state, they should be able to choose whether they go on drugs no matter their age or gender." [SU 6]

There was evidence from five SUs that they did have input into changes in their medication regime, both in terms of dose and type of drug, or felt able to contribute to such decisions should they want to.

"I remember being given the choice of switching from Olanzapine to Aripiprazole." [SU 7]

"If I felt I wanted to change or stop taking medication I would inform [Name of EIP worker] ASAP." [SU 1]

However, two SUs felt that they got what they were prescribed without having much input into the process. One SU said that they did not get on with the clinician who was prescribing them medication and felt as though they did not have any choice in seeing anyone else.

"I got prescribed what I was given." [SU 2]

"I didn't like [HCP name] and had no choice in seeing others for meds". [SU 6]

Informed decision-making

SUs talked about the different ways in which information about treatment options was provided to them. Methods mentioned included leaflets and discussion. However, there was evidence from two SUs that their mental state at the time made it difficult to process and understand the information that was provided.

"At the time of starting meds I wouldn't have had any capacity to read information." [SU 2]

"I was told it was a neuroleptic but I still don't really know what it does."

[SU 4]

Attitude towards taking medication

The majority of the SUs commented on their attitude towards taking medication for their symptoms. Some SUs felt strongly that medication was the best option; others felt it was best used in combination with other approaches, such as talking therapies.

"I have a science background and I feel I am biased in favour of medication."

[SU 5]

"The medication definitely helps when used in conjunction with other techniques e.g. CBT, psychology work." [SU 7]

A minority of SUs indicated that they were not in favour of medication. Reasons were given for this and included not finding that they alleviated the symptoms that they were experiencing and knowing that people can recover with other, non-drug treatments.

"Didn't really want to take meds in first place and didn't make much difference...some people can be alright with CBT or other means without drugs." [SU 6].

Others input into treatment decisions

Three SUs commented on their experience of having family members or significant others involved in conversations around treatments. There was a split between those who thought this was helpful due to their mental state at the time, and others who felt that family members did not need as much input as they had.

"I personally think they [family members/ significant others] didn't need quite as much input." [SU 7]

“One may not be thinking straight so may need to be persuaded to take medication until they feel well enough to make a reasonable choice.” [SU 5]

Individualised treatment

The majority of SUs identified various person and illness-related variables which should influence the treatment plan and determine whether an individual can have choice over their treatment. SUs talked about mental state, risk to self and others and insight. There was also reference to personal situations and circumstances influencing a person’s treatment.

“I think it all depends on the personal situation and how that particular person is being affected.” [SU 1]

“I thought I was in the FBI during my first episode of psychosis and I had no awareness at all. Should depend on how aware a person is.” [SU 5]

Intervention in EIP services

SUs highlighted that there are a range of different treatment options available in EIP services and that all possible options should be explored. Three SUs indicated that they believed that people can recover without medication and also that individuals may have their own ideas about what will help them.

“I think people may have their own ideas on how to get better as well.” [SU 7]

Two SUs commented on the order of different interventions, specifically whether medication should come before, after or at the same time as other approaches.

“From my experience with [Name of EIP worker] I believe the initial problem should be sourced before medication is prescribed.” [SU 1]

“Don’t think psychological understanding is separate to using medication.” [SU 4]

Discussion

The aim of this study was to examine the attitudes of SUs and HCPs towards treatment options for people with psychosis and crucially the issue of SUs having choice over their treatment in an EIP service. Both HCPs and SUs appeared to view the range of interventions offered by the EIP service as broadly acceptable and SUs talked about the importance of all treatment options being explored. A number of factors were identified as crucial in influencing HCPs’ and SUs’ attitudes towards SUs having choice over their treatment. Reservations about using research to guide practice were also raised by HCPs.

Comparison of the current findings to other qualitative studies highlights similar themes. For example, Carrick and colleagues also found that the process of making decisions about treatment, as well as the treatment itself, need to be individualised as there are various factors which might influence how active a person can be in treatment decisions and also how much choice or control is ‘*enough*’ for a given individual (Carrick *et al.*, 2004). Whilst SUs and HCPs in this study generally acknowledged the importance of SUs having choice over treatment, particularly medication, a number of variables were identified which influenced their perspectives including capacity, duration of untreated

psychosis, risk and engagement. Some HCPs felt that SUs should have choice over treatment if they retained capacity to do so and had adequate insight. However, capacity and insight are dynamic variables suggesting that the degree to which SUs are involved in treatment decisions should be re-considered at different time points. The data was mixed with regards to whether SUs felt that they had input into discussions around changing type of medication or the dose after medication had been prescribed. This finding is similar to that reported in a recent qualitative study with longer term SUs in which some participants reported feeling powerless to initiate conversations about changing their medication or lowering the dose even though they were not happy and wanted a change (Morant *et al.*, 2017). Further, there is evidence that lack of involvement may reduce trust in professionals and adherence to medication (Yiesen *et al.*, 2017). Therefore, a clear recommendation for clinical practice following on from these findings is that discussions about treatment options should be revisited by HCPs throughout a SUs involvement with EIP services.

It will be important for future research to also investigate possible barriers to HCPs exploring all treatment options with SUs. Studies have demonstrated that the explanatory framework employed by an individual regarding mental health influenced their views of treatment options and recovery from mental illness (Lam and Salkovskis, 2007; Lam, Salkovskis and Hogg, 2016). More specifically in the context of psychosis, it has been shown that the aetiological model held by a professional is associated with beliefs about the efficacy of treatments for psychosis (Cater *et al.*, 2017a). The results of the current study

suggested that SUs' and HCPs' attitudes on treatment options and choice may in part be influenced by the explanatory framework they have. This in turn, may be influenced by the psychoeducation HCPs provide for SUs or more general education about the causes of mental illness. For example, if a SU has a more biological understanding of their 'mental illness' they may be more likely to view medication as crucial. Similarly, if the HCP has a more psychological understanding of psychosis, they may have a more positive attitude towards offering CBT for psychosis without medication. It may also be important to consider whether wider cultural explanations of mental illness impact on SUs' attitudes towards support and recovery (Larsen, 2004), although the current study does not specifically address this issue. Thus, it is possible that the explanatory framework either SUs or HCPs hold could influence attitudes towards different treatments. This may in turn affect the way in which different treatments are discussed and the order in which they are offered by the HCP or accepted by the SU. This is an area which warrants further investigation as these factors may act as one barrier to exploring all treatment options.

The implementation of robust research findings into clinical practice is critical for increasing the overall standard of care for SUs and improving outcomes (Geddes and Harrison, 1997). Interestingly, HCPs indicated that they were aware of recent research in the field of treatment for psychosis, such as studies indicating that CBT may be effective for SUs who are medication naïve, yet for some, responses indicated that such research did not influence their attitudes. As more research is completed in this area, it will be important for HCPs' knowledge of the evidence-base for different treatment options to

be updated regularly and barriers to integrating this knowledge into their clinical practice explored. Regular CPD as well as discussion of issues related to the choice agenda in supervision may aid this. Increasing clinicians' knowledge base through these means may in turn contribute to attitudinal and behavioural change.

Limitations

Whilst the small homogenous sample and recruitment from one EIP service limits the generalizability of the data, the results suggest the value of extending this type of research to larger and more diverse samples from other EIP services. It was not possible to explore within group differences due to the size of the sample, for example whether attitudes differ depending on the profession or the explanatory framework of the HCP. Further research with a larger sample size may enable exploration of such questions. Lastly, due to the method of data collection used in this study (qualitative surveys), it was not possible to explore themes in further depth. This is a recognised limitation of the qualitative survey method.

Future directions

The attitudes of the HCPs reported in this study may not necessarily directly map onto clinical practice and so whether attitudes affect practice needs to be investigated. Similarly, it would be important to establish whether SUs' attitudes towards treatment and their experience of being offered choice over treatment influences adherence to their treatment and other relevant clinical outcomes. Lastly, the study was conducted before the UK Access and Wait Times

standards were published. It would be interesting to repeat the study now that the standards have been implemented and assess whether increased staff training has been effective in changing HCPs' attitudes and practices.

Conclusions

There is variation in SUs' and HCPs' attitudes towards treatments for psychosis and also their views on how much choice SUs should have over treatment. There are a number of factors that influence HCPs' and SUs' attitudes about treatments and choice. HCPs working in EIP services should explore different treatment options fully with SUs but be aware that they may feel unable to make the decision themselves. Such discussions should be revisited throughout an individual's care as ability to make informed choices may change over time. The results of this pilot study have implications for further research in the area of attitudes towards treatments in psychosis and SUs having choice over treatment.

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