Let's not go there: exploring the delivery of trauma-focused

interventions in people with psychosis

Eleanor Chadwick

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name: Eleanor Chadwick

Date: 3rd July 2020

Thesis Overview

Post-Traumatic Stress Disorder (PTSD) is prevalent in people with psychosis. Trauma-focused interventions are increasingly supported for this group by research trials and clinical guidelines. However, in clinical practice, trauma continues to be under-recognised and under-treated. This thesis explores pertinent barriers and facilitators to delivering trauma-focused interventions for people with psychosis. It is presented in three parts.

Part 1: A Systematic Review

This review examines available qualitative data regarding staff perceptions of the barriers and facilitators to delivering psychological interventions in clinical practice. Findings from twelve studies are presented in a narrative synthesis. Results identify a number of common factors which inhibit the delivery of psychological interventions for mental health disorders. Clinical and research implications of findings are discussed.

Part 2: An Empirical Paper

This paper explores the barriers and facilitators to trauma-focused interventions for people with psychosis through a Grounded Theory approach. Interviews were completed with 18 individuals working in the commissioning and delivery of clinical services for people with psychosis. Analysis generated a three-factor conceptualization of the barriers and facilitators to treatment with this clinical population. Recommendations are made for strategies to increase access to trauma-focused interventions for this group.

Part 3: A Critical Appraisal

This chapter offers a critical reflection on the process of research and follows the journey of clinical research from study design, recruitment, and interview through to analysis and writing. It considers the context within which research takes place including philosophical and theoretical underpinnings as well as tempo-socio-cultural context.

Impact Statement

The use of trauma-focused interventions for the treatment of PTSD in people with psychosis is supported by both research and clinical guidelines. Despite this, PTSD in this population continues to be under-recognised and under-treated. This represents a significant translational gap between research and clinical practice.

The current body of research seeks to address this translational gap by developing a deeper understanding of the barriers and facilitators to trauma-focused interventions, from the perspective of staff working in the commissioning and delivery of clinical services. Through a greater understanding of these barriers, research seeks to identify tractable targets of intervention to increase equitable provision and access to treatment for this population.

These aims are consistent with UCL's strategic approach to impact which emphasises the translation of research for patient benefit. Key users and beneficiaries of the current research include:

1. **People with mental health disorders, in particular those with psychosis and symptoms of PTSD**: People with mental health disorders consistently report a preference for psychological treatments over their pharmacological counterparts. However, access to these treatments continues to be limited. Through increasing access to psychological interventions and reducing the barriers to treatment, current research will help to promote patient choice in treatment and care planning.

2. **Practitioners and clinicians working within clinical services:** It is anticipated that findings will have direct clinical implications which inform practitioners in care planning and engaging service users in treatment. Through a deeper understanding of these barriers, clinicians may be more able to anticipate and

mediate potential barriers, in order to streamline care pathways for people with psychosis within mental health services.

3. **Local, national and international healthcare providers:** The NHS Mental Health Implementation Plan 2019/20 – 2023/24 outlines a national commitment to increasing access to mental health care for adults with severe mental illnesses in the UK. Current research feeds directly into this commitment, helping to elucidate the barriers that prevent people from accessing appropriate treatment, and highlighting key areas of focus in order to increase access. Findings will inform strategic planning of services to meet ambitious access targets.

4. **Academics and researchers:** Insights will be invaluable to clinical researchers during the development of novel interventions to promote the dissemination of interventions into clinical practice.

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Part 1 Literature Review

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Part 1: Literature Review

Clinician Perceived Barriers and Facilitators to the Adoption of

Psychological Therapies in Clinical Practice: A Systematic Review

and Narrative Synthesis of Qualitative Data

Abstract

AIM: An extensive body of research supports the use of psychological interventions in the treatment of mental health difficulties. Despite empirical support, there is a significant discrepancy between evidence for the efficacy of these interventions and their delivery in clinical practice. In this systematic review, I sought to identify and summarise qualitative data regarding mental health clinicians' perspectives of the barriers and facilitators to the adoption of psychological treatments in clinical practice. METHODS: A systematic search of three electronic databases identified twelve studies that met inclusion criteria. The findings of these studies are presented in a narrative synthesis. RESULTS: Common narratives emerged regarding organisational barriers to psychological treatments including organisational culture, logistical barriers and barriers perceived to uniquely affect the clinical setting or environment of focus in included papers. Limited patient-level factors were identified by studies and no included studies discussed patient-level facilitators to psychological treatment. DISCUSSION: Results of the analysis may offer insights into efforts to increase access to and engagement with psychological interventions. The current literature has offered particular focus on perceived organisational level barriers to treatment. As such, findings may be of interest to managers and organisational leads within healthcare settings to guide strategic planning in this area. The current available literature regarding clinicians' perceptions of barriers and facilitators included limited discussion of patient-level factors. Further exploration is needed of these patient-level factors, as perceived by clinicians.

Introduction

Mental health disorders are extremely common around the world, are often disabling and have a significant economic and social impact. Worldwide, mental health disorders have an estimated annual prevalence between 9-19% and a lifetime prevalence between 18-36% (Kessler et al., 2009). In the UK, approximately one in four adults report experiencing a mental health disorder each year (McManus et al., 2009): this includes one in six adults (17%) who experience common mental health disorders such as depression and anxiety each year; one in seven adults (13.7%) who screen positively for Personality Disorders; one in twenty adults (4.4%) who experience PTSD each year; and one in 100 adults (0.7%) who experience psychosis each year (McManus et al., 2016). Mental health disorders are associated with a high level of disability (OECD, 2014; Whiteford et al., 2013), account for approximately 17.5 million sick days each year (Office for National Statistics, 2019) and are associated with a reduction in life expectancy of up to 20 years (Thornicroft, 2013). Mental health disorders account for approximately 28% of the national burden of disease in the UK (Department of Health, 2013) and are associated with significant costs including the direct costs of care and indirect costs related to reduced workforce productivity, impaired performance of children at school and associated costs within criminal justice and care systems (Kessler, 2012). Annually, the cost of mental health disorders to the UK economy is estimated at £70 billion (OECD, 2014).

A wealth of research now supports the use of psychological interventions in the treatment of a range of mental health conditions. Psychological interventions have been demonstrated to have equivalent, and in some cases superior, treatment outcomes when compared to pharmacological treatments in large controlled trials and meta-analyses (Barth et al., 2013; Butler et al., 2006; Cuijpers et al., 2011; Cuijpers et al., 2013; Cuijpers, Smit, et al., 2010; Cuijpers, van Straten, et al., 2010; Dutra et al., 2008; Fairburn et al.,

2009; Hoffman & Smits, 2008; Roth & Fonagy, 2005), as well as in evaluations of routine clinical practice (Franklin et al., 2000; Hahlweg et al., 2001; Organista et al., 1994; Persons et al., 1999; Tuschen-Caffier et al., 2001; Wade et al., 1998). Psychological interventions are cost-effective when delivered alone (Layard, 2006; McHugh et al., 2007), and when delivered in combination with pharmacological treatments (Byford et al., 2007; Domino et al., 2009; Miklowitz & Scott, 2009). Service users consistently report a preference for psychological interventions: a meta-analysis of 34 studies reported that 75% of patients expressed a preference for psychological treatments over their pharmacological counterparts (McHugh et al., 2013). A robust evidence base therefore supports the efficacy, effectiveness, and cost-effectiveness of psychological interventions, as well as highlighting patient preference for psychological treatments over pharmacological alternatives.

A significant gap, however, exists between the evidence base for psychological interventions and their availability in clinical practice (Cook et al., 2017; Layard, 2006; Insel, 2009; England, Butler, & Gonzalez, 2015; Marcus & Olfson, 2010). Psychological interventions for mental health difficulties are used less often than medication in the UK (McManus et al., 2016) and internationally (Marcus & Olfson, 2010). Within clinical services, clinicians report that evidence-based psychological treatments are under-utilized in the treatment of anxiety disorders (Becker et al., 2004; van Minnen et al., 2010), depression (Layard, 2006), eating disorders (Haas & Clopton, 2003; Mussell et al., 2000), psychosis (Jacobsen et al., 2018; Kuipers, 2011) and substance use disorders (Santa Ana et al., 2008). This disparity represents a significant translational gap between the evidence base for effective psychological treatments and their availability in clinical practice.

The need to understand and address the research practice gap in psychological interventions has been the focus of public health efforts locally, nationally and internationally (Berwick, 2003; Cook et al., 2017; Layard, 2006; US President's New

Freedom Comission on Mental Health, 2003; England, Butler, & Gonzalez, 2015; McHugh & Barlow, 2012). The Improving Access to Psychological Therapies (IAPT) program within the National Health Service (NHS) in the UK represents one of the largest initiatives worldwide to increase access to psychological interventions (Clark, 2011). The program has seen rapid expansion in the 12 years since it launched: IAPT services have been established in every area of England; more than 7000 new therapists have been trained (Clark, 2018) and by 2019 the service annually received 1.69 million referrals (NHS Digital, 2020). Ambitious access targets to psychological therapies, both within IAPT services and beyond, are central to the NHS Long Term Plan for mental health care (NHS England, 2019). Understanding the determinants of implementation outcomes will be central to ensuring the effective scaling up of psychological interventions throughout the NHS.

Implementation Science

The existence of a significant translational gap is not unique to psychological interventions. On average, it can take up to 20 years for clinical innovations to be adopted in clinical practice and more than 50% of clinical innovations are never widely adopted (Bauer & Kirchner, 2020). Recognition of the need for evidence-based procedures for the translation of evidence-based interventions into clinical practice has led to increased attention to the science of implementation (McHugh & Barlow, 2010). The determinants that define this gap are complex and likely include a variety of interacting barriers at multiple levels (Nilsen, 2015; Beidas & Kendall, 2010; McHugh & Barlow, 2010; Turner & Sanders, 2006). Determinant frameworks seek to describe the broad determinants, both enablers and barriers, that are believed to influence implementation outcomes (Nilsen, 2015). Reflecting the multiple levels of determinants, frameworks commonly describe barriers and facilitators at the level of the end users or patients; providers or

clinicians; and levels of context such as clinic, healthcare organisation or broader socio-cultural environment. Identification of the determinants that influence implementation outcome can then be used to inform and plan strategies for improving implementation outcomes. Frameworks may draw determinants from the synthesis of empirical studies of barriers and enablers; the personal experiences of the authors in implementation or existing theories and models such as social diffusion theory and organisational theory (Atkins, Rusch, Mehta & Lakind, 2016).

Identified Determinants

Barriers to treatment may exist at patient, provider and organisational-levels.

Patient-level barriers to treatment may include logistical barriers, attitudinal barriers, and the symptoms of mental health disorders themselves. Logistical barriers may make attending regular appointments for psychological interventions challenging and may include the physical accessibility, transport, cost, and time demands of treatment as well as the ability to identify a skilled therapist or available services (Harvey & Gumport, 2015; Mohr et al., 2010). Attitudinal barriers may reduce an individuals willingness to engage in therapies (Salyers et al., 2004) and include perceived stigma around mental health difficulties (Harvey & Gumport, 2015; Mohr et al., 2010), as well as beliefs about the usefulness or potential harm of talking about their difficulties (Harvey & Gumport, 2015; Mohr et al., 2010). Finally, symptoms of mental health difficulties, such as lack of motivation, anxiety or paranoid beliefs, may hinder engagement in treatment (Gairns et al., 2015; Harvey & Gumport, 2015; Mohr et al., 2010; Salyers et al., 2004).

Clinician-level barriers to use of psychological therapies may relate both to the therapists delivering psychological interventions, as well as to clinicians from other disciplines who are involved in the care-coordination of people with mental health difficulties and referrals for specialist psychological support. Clinician characteristics such

as theoretical orientation, level of education and clinical experience may all influence the openness of clinicians to learning about, referring people to and using novel interventions (Baer et al., 2009; Nelson & Steele, 2007; Salyers et al., 2004; Stewart et al., 2011). Clinician attitudes may be of particular importance in determining whether clinicians attend training in, and subsequently adopt or endorse an intervention in their clinical practice. Aarons and colleagues (2012) categorised these attitudinal barriers into eight areas: limitations to treatments; fit with patient need; monitoring of clinical work and outcomes; balance between scientific and flexibility in clinical practice; burden of interventions; job security; organisational support; and feedback from colleagues and patients. Clinician characteristics and attitudes may therefore be important determinants of access to psychological therapies.

Beyond the determinants that influence clinicians generally, there may be determinants that specifically influence psychological therapists in the adoption and implementation of interventions. Therapist attitudes are likely to be influential in the adoption of novel innovations including anticipated impact on the therapeutic relationship (Harvey & Gumport, 2015), anticipated exacerbation of distress or symptoms (Olatunji et al., 2009), and beliefs that treatments are contraindicated for clients with complex or severe difficulties (Becker et al., 2004; Olatunji et al., 2009; van Minnen et al., 2010). Therapist self-rated knowledge and self-efficacy have been positively associated with the likelihood of therapists implementing a novel intervention in clinical practice (Salyers et al., 2004; Shapiro et al., 2014), highlighting the importance of therapist knowledge and confidence in the implementation process. In contrast, anxiety sensitivity in therapists has been inversely associated with likelihood that a therapist reports using evidence-based treatments for anxiety in their routine clinical practice (Skutch et al., 2009). A range of clinician-related determinants have been described within the literature: some of these may apply to all clinicians involved in care-coordination and delivery of

psychological interventions, whilst others are described as applying specifically to psychological therapists.

Organisational characteristics may present environmental, cultural and attitudinal, and logistical barriers to adoption of psychological treatments: they may represent direct barriers to treatment or indirect influences on treatment decision-making by clinicians. The clinical setting itself may represent a determinant of the adoption of interventions: therapists working in hospital or university-based clinics are more likely to report use of evidence-based psychological therapies than colleagues in other clinical settings (Nelson & Steele, 2007) and the inpatient environment identified as a particular barrier to use of psychological therapies (Bailey et al., 2003). Organisational culture represents an important context for implementation of novel interventions: this may relate to general organisational characteristics such as leadership (McCann & Bowers, 2005) and openness to change (Baer et al., 2009; Nelson & Steele, 2007), managerial attitudes to an intervention (Bailey et al., 2003) and broader organisational support for clinicians (Shapiro et al., 2014, Harvey & Gumport, 2015). Logistical determinants at an organisational-level have been outlined relating to resources (Michie & Lester, 2005); time (Bailey et al., 2003; Harvey & Gumport, 2015; Michie & Lester, 2005; Shapiro et al., 2014; Sin & Scully, 2008); and sufficient and stable staffing (McCann & Bowers, 2005). Practical barriers may be exacerbated by the perceived failure of management to adress them (McFarlane et al., 2001). Conflicting workplace mandates (Shapiro et al., 2014) and absence of established procedures (Sin & Scully, 2008) may pose additional barriers to implementation of novel interventions. Thus, organisational characteristics may present environmental, cultural and attitudinal, and logistical to adoption of psychological treatments.

Determinant frameworks must capture the complex interplay of a range of determinants at patient, clinician and organisational level in order to inform effective interventions to improve access to psychological treatment. The views of clinicians

involved in the provision of mental health care may be of particular importance in understanding the determinants of intervention implementation: clinician-identified barriers have been shown to be predictive of the use of psychological interventions in clinical practice (Harned et al., 2013; Salyers et al., 2004). Given this, much of the available literature therefore centres the perspectives of clinicians to understand implementation determinants (Aarons, 2004; Aarons et al., 2012; Baer et al., 2009; Bailey et al., 2003; Becker et al., 2004; Gairns et al., 2015; McCann & Bowers, 2005; McFarlane et al., 2001; Michie & Lester, 2005; Nelson & Steele, 2007; Olatunji et al., 2009; Salyers et al., 2004; Shapiro et al., 2014; Sin & Scully, 2008; Skutch et al., 2009; Stewart et al., 2011; van Minnen et al., 2015). However, much of the empirical investigation of determinants has utilised quantitative methods to evaluate the relative impact of theoretically driven determinants (Barnett et al., 2017; Becker et al., 2004; Beidas & Kendall, 2010; Bruijniks et al., 2018; Harned et al., 2013; McFarlane et al., 2001; Nelson & Steele, 2007). In contrast, qualitative methods which explore the novel insights of practicing clinicians are used relatively infrequently within the literature, despite the strengths of these approaches and their ability to complement quantitative evaluations (Bauer & Kirchner, 2020).

Qualitative methods offer a valuable contribution to efforts to understand and improve the implementation of psychological interventions in clinical practice. Qualitative methods are well suited to describing what happens during the process of adopting novel interventions and exploring questions related to why and how these processes occur (Hamilton, 2019). By centring the experience and perspectives of key stakeholders such as clinicians, they may offer novel insights into the feasibility, acceptability and appropriateness of interventions (QualRIS, 2019). Finally, qualitative methods may help to capture the role of context on efforts to increase use of psychological interventions, across a diverse spectrum of settings (QualRIS, 2019). As such, qualitative methods can offer a rich exploration of the complex interplay of factors

that may influence the adoption of treatments in clinical practice.

In the current review, I sought to identify and synthesise available qualitative data to answer the question: What do clinicians identify as the barriers and facilitators to the use of psychological treatments in clinical practice?

The synthesis will contribute to a deeper understanding of the factors influencing the translational gap between research and clinical practice in psychological interventions. In turn, this understanding may provide important insights relevant to the development of interventions and implementation efforts to increase the accessibility of psychological treatments in clinical practice.

Methods

The review was prospectively registered with the International Prospective Register of Systematic Reviews (PROSPERO), protocol number 165308. It is reported in accordance with PRISMA guidelines and the ENTREQ guidelines for transparent reporting of qualitative syntheses (Toye et al, 2012).

Data Sources

I identified studies through searches of three electronic databases: PsycINFO, Medline and CINAHL. Initial scoping searches were completed between July 2019 and January 2020 and were used to develop and refine the search strategy. A final search took place on 20th February 2020.

The search strategy combined search terms relating to population (e.g. clinician; psychologist; therapist; counsellor); terms relating to the clinical context (e.g. mental health; depression; anxiety; psychosis; PTSD); terms relating to the intervention (e.g. treatment; intervention; therapy; psychotherapy); terms relating to the perceived barriers

and facilitators (e.g. barriers; facilitators; implement; inhibit); and terms relating to qualitative methodology (e.g. qualitative; interpretative; narrative; grounded). Medical Subject Headings, often referred to as MeSH terms, were adopted to ensure searches captured all relevant literature, and were adapted according to the MeSH terms used by the different databases. Terms included word stems and common abbreviations, as well as use of wildcards. The full search strategy is included in Appendix 2.

Changes to mental health care have occurred within the last two decades, significantly improving the treatment patients receive (Torjesen, 2016). As such, searches were restricted to papers published between 2000 and 2020, in order to represent current provision for mental health interventions and barriers and facilitators relevant to current provision.

Given the reported difficulties systematically identifying qualitative research (Atkins et al, 2008), I supplemented database searches by hand searching reference lists of included papers to identify additional potentially relevant studies. However, I identified no additional papers through citation searching which met the inclusion criteria for the review.

Selection Criteria

The inclusion criteria were that studies (a) used a qualitative research design, (b) consisted of a sample of mental health clinicians, (c) explicitly specified a study aim to the views of clinicians regarding barriers and facilitators to psychological interventions, (d) interventions were individual psychological interventions for mental health difficulties in adult clients (over 18 years old), and (e) were published in journal articles, theses or peer-reviewed reports. Studies were excluded where they (a) studies using mixed methods where qualitative and quantitative data were not reported separately, (b) were reported within a review paper or within the grey literature, book chapters, conference papers,

editorials, letters or general comment papers, (c) described generic unspecified support, 'treatment' or engagement with clinical services; service development models or design; or narrowly focused elements of intervention such as specific techniques, and (d) were not published in English.

Where studies included the views of service users or other stakeholders in addition to views of clinicians, I included only studies where the views of clinicians were clearly reported and analysed separately from views of other stakeholders.

Duplicate articles were removed and record titles and abstracts were reviewed for eligibility by two reviewers (EC & EP). The full text records of the remaining articles were then reviewed independently by two reviewers (EC & EP). All discrepancies between the reviewers were resolved through discussion.

Data Extraction and Analysis

I reviewed all the included studies and extracted key contextual and methodological data from each study. Key study information is reported in Table 1 and includes study country, sample size, methods of data collection and analysis, therapeutic approach, clinical population, and clinical setting. A second reviewer (EP) appraised a sample of the extracted data in order to promote credibility of the subsequent synthesis.

Methods for the synthesis of qualitative research are less well established than those used in quantitative reviews (Thomas & Harden, 2008) and continue to develop. Given that the current study is believed to be the first review of qualitative data in this area, I adopted a narrative synthesis to present the results. This approach is in line with guidance by Centre for Reviews and Dissemination at the University of York (2009). Narrative syntheses of this kind may inform methodological decisions about the conduct of a subsequent robust synthesis of data. I followed the methods described by Popay and colleagues (2006) to guide the analysis and reporting of findings from included studies.

In line with the methods described by Popay and colleagues (2006), I completed a preliminary synthesis by extracting the themes and subthemes of barriers and facilitators extracted from the reported results of included studies and listing these alongside the study characteristics in Table 1. In addition, I report a textual synthesis of the extracted themes identified by included studies. The textual synthesis is organised first by distinguishing barriers and facilitators, and sub-divided by the levels of patient, clinician and organisation in line with common reporting within the literature.

Quality Evaluation

The relevance of quality appraisal to qualitative studies continues to be debated (Dixon-Woods et al, 2005). As such, studies were not excluded based on quality. However, information regarding the quality of included studies are reported in order to aid the interpretation of studies with regard to their credibility, dependability, transferability and confirmability.

The quality of studies included in the review was assessed using the Critical Appraisal Skills Programme (CASP; 2017) Qualitative Research Appraisal tool. This tool comprises 10 questions including the appropriateness of the research design, justification of methods of data collection and whether there was sufficient awareness of the role of the researcher. Each question was coded using a traffic light scheme, where green represented yes, red represented no and orange represented ambiguity (not clear). Notably, these ratings reflect what is included in the available report of the study and may not necessarily reflect detail that was attended to in the research process but not necessarily written up in the presented paper.

The quality appraisal of included studies is reported in Table 2. I completed the quality appraisal for all studies and a sample of appraisals were examined by a second

reviewer to ensure the credibility of the assessment. We resolved all queries through discussion.

Results

Description of Included Studies

A total of 1237 records were returned by searches. After removing duplicates, the title and abstracts of 810 unique articles were screened for suitability. Of these, 756 were agreed not to be relevant to the research question. 54 full text articles were read in full by reviewers and 12 eligible studies were included in the final review. 42 studies were excluded at the full-text stage due to inclusion of non-mental health staff participants in the sample (n=7); use of quantitative methods (n=3); absence of aims or focus on barriers and facilitators to treatments (n=10); intervention of focus not individual psychological intervention for mental health difficulties in adults (n=20); or not being available in English (n=2). Citation searching did not identify any additional papers eligible for inclusion in the analysis. Twelve papers were included in the final synthesis. Results of the search strategy and screening process are reported in Figure 1: Study Selection Flowchart in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-analyses (Moher et al., 2009).

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┌─────────────────────────────┐
│ Records identified through  │
│     database searching      │
│         N =1237             │
└─────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐
│  Records after duplicates   │
│          removed            │
│          N =810             │
└─────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐       ┌─────────────────────────────┐
│     Records screened        │──────▶│     Records excluded        │
│        N = 810              │       │        N= 756               │
│                             │       │           =                 │
└─────────────────────────────┘       └─────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐       ┌─────────────────────────────┐
│ Full texts articles assessed│──────▶│ Full text articles excluded │
│       for eligibility       │       │          N =42              │
│          N =54              │       │       Sample (n=7)          │
│                             │       │     Methodology (n=3)       │
└─────────────────────────────┘       │     Aims/Focus (n=10)       │
              │                        │    Intervention (n=20)      │
              ▼                        │     Language (n=2)          │
┌─────────────────────────────┐       └─────────────────────────────┘
│   Studies included in       │
│        synthesis            │
│         N = 12              │
└─────────────────────────────┘
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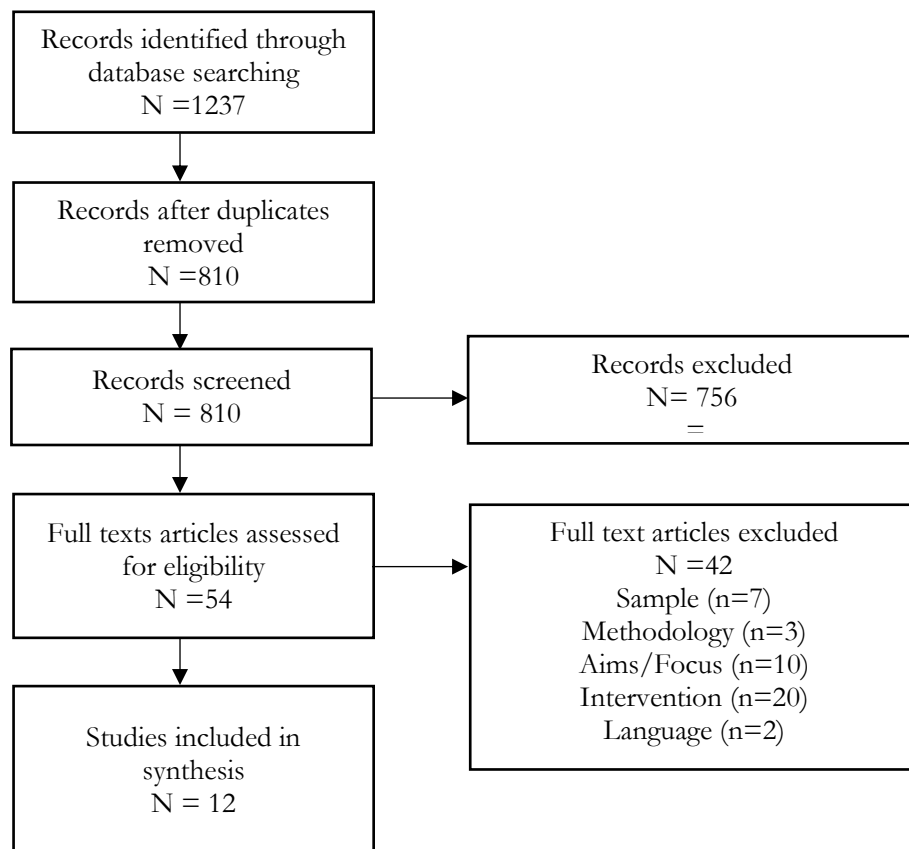
Figure 1: Study Selection Flowchart

The characteristics of the twelve included studies are reported in Table 1. In total, studies included 421 participants (sample sizes ranged from 6-95). Half of the included studies investigated use of Cognitive Behavioural Therapy (CBT) based interventions (N=6); with the remaining studies investigating the use of EMDR (N=1); Cognitive Therapy (N=1); and an indigenous intervention Mahi-A-Atua (N=1). Three studies did not name a specific intervention but addressed a broader concept of psychotherapy, evidence-based psychotherapy, or psychological interventions. Interventions were used for the treatment of PTSD (N=4), Psychosis (N=3), and Personality disorders (N=1). Four studies did not specify the target of interventions or considered trans-diagnostic interventions. Studies predominantly explored the use of psychological interventions in outpatient or community settings (N=9); two studies explored use of interventions within an inpatient setting and one study did not specify the expected setting of interventions. A range of analytic approaches were utilised including Thematic Analysis (N=3), Content Analysis (N=2), Grounded Theory (N=2), Explanation Building (N=1), Manual Coding (N=1), and Consensual Qualitative Research (N=1). Two studies did not state their analytic approach.

Research Quality

Overall, quality of the included studies was mixed and there were significant limitations to the transparent reporting of quality indicators for a number of included studies. As a result, it was not possible to assess whether these aspects of research quality had been attended to during the research process or not. Quality appraisals for individual studies are reported in Table 2.

Notably, the majority of included studies failed to report the nature of the relationship between researchers and participants, or to address the possible impact of

Table 1: Summary of Included Studies

Author (year) Country	Design / Data collection / Data analysis	Therapy model	Client group	Sample n=total no. of participants	Setting	Key reported themes
Cook, Biyanova & Coyne, (2009) USA	**Collection**: Semi-structured Interviews **Analysis**: Explanation Building	EMDR	Veterans PTSD	Specialist mental health clinicians n=29	Outpatient Clinics	• Storied History and the Influence of One • It's (Not) What We Do Here • Mechanism of Therapeutic Change • Perceived Characteristics of EMDR • Different Lens, Different Criteria • Aesthetics and Comfort Level
Kopua (2019) New Zealand	**Collection**: Hui (A Group Process) **Analysis**: -	Mahi-A-Atua	-	Clinicians incl. psychologists, social workers and nurses n=8	Community Mental Health Team	Facilitation of Mahi-a-Atua • Identity • Whakapapa and relationships • Wairuatanga (Spirituality) • Kaitakitanga (Guardianship) • Wananga and co-working • Critical mass • Validation Constraints to using Mahi-a-Atua • Confidence, training, integration of clinical and cultural knowledge, and resourcing
Sharp, Gulati, Barker & Barnicot (2018) UK	**Collection**: Focus Groups Semi Structured Interviews **Analysis**: Thematic Analysis	Emotional Distress Workbook (CBT / DBT based)	Trans-diagnostic	Nursing staff, Occupational therapists and Psychologists n=37	Inpatient	The 'fit' of the workbook • A stressful environment • A culture of emotional neglect • Adding structure and confidence to current nursing practice Conveying the workbook • Optimising the content • Delivering the content Getting the timing right • A gradual trajectory towards recovery • The eye of the storm

Doran, O'shea & Harpaz-Rotem (2019) USA	**Collection**: Focus Groups **Analysis**: Consensual Qualitative Research (CQR) coding system	Evidence Based Psychotherapies Cognitive Processing Therapy Prolonged Exposure	Veterans PTSD	Therapists n=8	Outpatient Clinics	1. EBP Strengths 2. EBP Weaknesses 3. Challenges Specific to the Veteran Population 4. Perceived EBP Effectiveness 5. Active Ingredients for Treating PTSD 6. Treatment Structure and Process 7. Suggested Changes/Improvements to EBPs
Hazell, Strauss, Cavanagh & Hayward (2017) UK	**Collection**: Questionnaire Free-Text Boxes **Analysis**: Thematic Analysis	CBT	Psychosis Auditory Verbal Hallucinations	Mental Health Clinicians n=124	-	Positive Attitude toward therapy • GSH in the context of IAPT • Staff willingness to be involved Negative attitude toward therapy • Not a stand-alone treatment • GSH not an equal treatment option Support for therapy with a caveat • Importance of clinician training • Need for evidence The presenting problem • Symptoms • Cognitive Abilities Practical Barriers • Lack of resources • Conflict with service priorities
Zubkoff, Carpenter-Song, Shiner, Ronconi, & Watts (2016) USA	**Collection**: Semi-structured Interviews **Analysis**: Manual Qualitative Coding	Evidence-Based Psychotherapies	Veterans PTSD	Psychotherapists n=22	Outpatient Clinics	Clinicians perspectives about their patient's readiness for treatment o Group to Educate Patients on PTSD and the Use of EBPs o Individual Motivational Interviewing or Psycho-Education o Promoting Patient Buy-In and Patient Willingness to Engage or Remain in Treatment o Stage of Change or Phased Approach

Stirman et al (2012)
 	
USA
	Collection:
	Questionnaire
	Free-Text
	Boxes
	Semi-Structured
	Interviews
	
	Analysis:
	Grounded
	Theory
		Cognitive
		Therapy
			-	Mental Health
				Clinicians and
				Supervisors
				
				n=95
					Community
					Mental Health
					Team
						Perception of the Ability of CT to Address Clients' Needs
						  o Fit with Client
						  o Reluctance to fully implement
						
						Organisation-Level Barriers
						  o Workload and productivity demands as barriers
						  o Reactions to change
						
						Organisation-Level Facilitators
						  o Attitudes towards training
						  o Fit with documentation requirements

Ayazi (2006)
 	
Gaza
	Collection:
	Semi-Structured
	Interviews
	
	Analysis:
	Grounded
	Theory
		Psychotherapy	-	Therapists
				
				n=6
					Community
					Mental Health
					Programme
						Cultural characteristics of Gazan Society
						  o The concept of mental illness
						  o The Gazan traditional healing system
						
						Impact of these characteristics on therapist work
						  • Faith in traditional healing
						  • Somatisation
						  • Reluctance towards disclosure
						  • Psychotherapist as a doctor
						  • Arabic time
						  • The psychotherapist as a part of the community
						  • Educating people

Carmel, Rose & Fruzzetti (2014) USA	**Collection**: Interviews **Analysis**: Content Analysis Approach	Dialectical Behavior Therapy (DBT)	Borderline Personality Disorder (BPD)	Clinicians n=19	Community mental health and substance abuse agencies.	Challenges with program development/staffing and recruiting clients appropriate for DBT: DBT requires a significant amount of training and that staff turnover, or insufficient numbers of staff to begin with, can jeopardize a program's ability to continue providing DBT services. Lack of administrative support or investment in DBT: A major barrier to implementing DBT was lack of support from clinic management, such as prioritizing other clinical teams, or minimal interest in providing evidence-based treatments of BPD. Time commitment of DBT and a lack of reduction in other clinical responsibilities: The time commitment required of DBT was a burden and that they had difficulty managing both DBT and their heavy caseloads.

Williams (2008) UK	**Collection**: Peer Audit **Analysis:** -	CBT	Psychosis	Clinicians (Team Representatives) n=28	Assertive Outreach Teams (AOT)	Organizational and culture barriers - Concerns over adaptation to groups with sensory impairments (e.g. people with hearing impairments); - Staff apathy/burnout; - Lack of investment from the organization; - Concerns regarding the level of CBT fidelity and flexibility over its use in an AO context; - Cost-effectiveness; - Structured nature of CBT with an AO client group will it work? - The predominance of the medical model within AOTs; - Clinicians understanding of CBTp and the time involved; - Elitist practice from CBT practitioners; - A lack of specialized training; - May be out of fashion in a few years. Will it be relevant? - Efficacy and effectiveness issues – what constitutes - CBT against what is measured in the research? - Purist views of the team approach and team approach practice. Managerial Barriers - A lack of understanding; - Time constraints (CPA vs. CBT); - Caseload management – the expectation to engage in crisis work; - A lack of a champion. Supervision barriers - Clarity of CBT practice; - Confidence in utilizing the approach; - Fidelity to the approach in an AO context; - Flexibility when engaging with clients that are difficult to engage; - A lack of dedicated time. Local Team Specific Barriers - The process of engagement; - Clients over medicated; - Social class (CBT/therapy seen as a middle class pursuit);

					- Adopting transactional analysis.
Wood, Williams, Billings & Johnson (2019) UK	**Collection:** Semi-Structured Interviews **Analysis**: Thematic Analysis	Individual Psychological Therapies	Psychosis	Psychological Staff n=12	Inpatient	Crisis-Focused Psychological Approaches • Discharge goals, distress reduction, and crisis planning • Developing a crisis narrative • Crisis and risk formulation development • Crisis-focused change mechanisms • Standalone group interventions • Stepped-care inpatient psychology • Working with complexity and high risk • Addressing distressing ward experiences. Working with and supporting the wider team • Formulation-informed team working • Communication and feedback • Formal and informal staff support • Discharge planning and community care • Supporting the family system • Marginalization, social deprivation, and trauma Environmental Adaptations • Inclusive engagement and advocacy • Working alongside the medical model • Brief interventions for brief admissions • Flexible sessions • Delivering psychology in a restrictive environment • Creative psychological provision with minimal resources

Frueh, Cusack, Grubaugh, Sauvageot, & Wells (2006) USA	**Collection**: Focus Groups **Analysis**: Content Analysis	CBT	PTSD Severe Mental Illness	Clinicians and Clinical Supervisors n=33	Outpatient Treatment Programs	1. Trauma has a major impact on the lives of persons with severe mental illness 2. Trauma has acquired a mystique that leaves clinicians fearful of addressing it, and clinicians have little confidence in their ability to help clients with PTSD 3. The proposal of a CBT approach for PTSD with this population was well-received 4. Miscellaneous implementation issues were considered to be important for the feasibility and acceptability of the proposed cognitive-behavioural treatment program.

Table 2: Quality Appraisal of Included Studies

Authors (Date)	Clear Statement of aims	Qualitative methodology appropriate?	Design appropriate to aims?	Recruitment appropriate to aims?	Data collection addresses research issue?	Relationship between interviewer and participants considered?	Ethical issues considered?	Data analysis rigorous?	Clear statement of findings?	Value of Research
Cook, Biyanova & Coyne (2009)	Red	Green	Green	Green	Green	Orange	Orange	Orange	Orange	Orange
Kopua (2019)	Green	Green	Green	Orange	Orange	Red	Green	Orange	Green	Red
Sharp, Gulati, Barker & Barnicot (2018)	Green	Green	Green	Green	Green	Orange	Green	Green	Green	Green
Doran, O'Shea & Harpaz-Rotem (2019)	Green	Green	Orange	Green	Green	Orange	Green	Green	Green	Green
Hazell, Strauss, Cavanagh & Hayward (2017)	Green	Green	Orange	Green	Orange	Green	Green	Green	Green	Green
Zubkoff, Carpenter-Song, Shiner, Ronconi & Watts (2016)	Red	Orange	Orange	Orange	Green	Green	Orange	Green	Green	Green
Stirman et al (2012)	Green	Green	Orange	Green	Orange	Orange	Green	Green	Green	Green
Ayazi (2006)	Green	Green	Green	Orange	Green	Orange	Orange	Red	Red	Red
Carmel, Rose & Fruzzetti (2014)	Green	Orange	Orange	Green	Green	Orange	Orange	Orange	Green	Green
Williams (2008)	Green	Green	Green	Green	Green	Orange	Green	Orange	Orange	Green
Wood, Williams, Billings & Johnson (2019)	Green	Green	Green	Orange	Green	Green	Green	Green	Green	Green
Frueh, Cusack, Grubaugh, Sauvageot, & Wells (2006)	Green	Green	Green	Green	Green	Orange	Green	Green	Orange	Green

investigator within the participant sample, without discussing the potential implications for the findings of the analysis. A number of studies also failed to provide a clear account of the analysis process beyond a statement of the analytic approach. A lack of transparent reporting in these areas, inhibits readers from being able to independently assess the impact of these on the resulting analysis.

Barriers to Adoption of Treatment

Patient-level Barriers

Patient-level barriers to interventions were explored by a number of the included studies. Themes within the described patient-level barriers included the timing of treatment, patient readiness for treatment and the clinical presentation of patients.

Multiple studies reported barriers relating to patient readiness and the timing of treatment (Sharp et al., 2018; Wood et al., 2019; Zubkoff et al., 2016). Analysis by Zubkoff and colleagues (2016) reported clinicians' assessment of patient readiness for treatment as an important theme not addressed by existing theoretical models of implementation. Clinicians also described 'getting the timing right' as a major barrier to delivery of psychological interventions during inpatient admissions (Sharp et al., 2018). Studies reporting barriers created by the timing of, or patient readiness for, treatment also reported strategies used by clinicians to overcome these barriers. These strategies included contrasting approaches of adapting psychological therapies for the acute needs of service users (Wood et al., 2019) and preparatory strategies to promote patient readiness including psychoeducational groups, individual motivational interviewing and use of the stages of change model (Stirman et al., 2004).

The clinical presentation of patients has also been identified as a key barrier to treatment, although different aspects of the clinical presentation of clients were emphasised across studies. The presenting problems of patients were described as a

significant barrier in analysis by Hazell and colleagues (2017) and the differential impact of positive and negative symptoms of psychosis was presented as subordinate themes. Positive symptoms such as auditory hallucinations were described as distracting and making it difficult for people to concentrate. Negative symptoms such as cognitive impairments and reduced motivation were described by clinicians as impeding patient engagement with treatment. Both positive and negative symptoms of psychosis were therefore anticipated to present barriers to people with psychosis accessing treatment. In contrast, clinicians working with veterans identified the complexity of clinical presentations in this population as a significant barrier to treatment for this group (Doran et al., 2019).

Clinician-level barriers

Clinician-level barriers identified within the analysis of included studies related to clinician attitudes and confidence.

Negative clinician attitudes were characterised by multiple studies as a major barrier to the adoption of interventions. Doran and colleagues (2019) described negative clinician attitudes as comprising several subthemes including perceived weaknesses, disadvantages or shortcomings of treatment; views about limitations to treatment effectiveness; and perceptions that manualised treatments would impede the flexibility and individualised administration which were important to effective treatment. Negative clinicians' attitudes to treatment were also reported in analysis by Hazell and colleagues (2017) and included a subtheme regarding clinicians' concerns about the credibility of interventions. Clinician attitudes to treatment were also described by Cook and colleagues (2009) with researchers interpreting clinicians' perceptions about EMDR to be key distinguishing factor between a clinic which had widely adopted EMDR and a second clinic which had not. Analysis by Cook and colleagues (2009) extended the discussion of

clinicians' attitudes by linking attitudes to clinician comfort delivering interventions in clinical practice.

Kopua (2018) characterised a lack of clinician confidence in their own knowledge and skills as a key barrier to delivering treatment. Researchers inferred that this lack of confidence contributed to clinicians' ambivalence towards treatment and fear about the use of an intervention (Kopua, 2018).

Organisational-level barriers

Organisational-level barriers to the delivery of psychological interventions were widely explored by the included studies. Themes within the discussed organisational-level barriers included: organisational culture; management investment; and logistical barriers related to workload and productivity pressures, supervision, training, resources and staffing. Finally, several studies reported barriers perceived to be unique to specific clinical settings or environments.

Several studies described barriers to treatment relating to the organisational culture including: the 'fit' between an intervention and the organisational culture; the influence of individual stakeholders in shaping organisational culture; and organisational responses to change. Strong clinician narratives were reported within the included research regarding the goodness-of-fit between an intervention and the specific organisational culture, customs and practices (Cook et al., 2009; Sharp et al., 2018; Williams, 2008). This theme represented a strong and common narrative across these diverse clinical settings including community clinics for veterans with PTSD (Cook et al., 2009), as well as both assertive outreach and inpatient services for people experiencing psychosis (Sharp et al., 2018; Williams, 2008). Individual key stakeholders were understood to play an important role in shaping organisational culture and attitudes towards treatment both through their presence (Cook et al., 2017) or absence (Sharp et

al., 2018). Finally, the nature of organisational change was characterised as a subtheme of organisational barriers reported by Stirman and colleagues (2004) and this reflected both the manner in which changes were implemented by the organisation and the reactions of clinicians to change.

A second theme within the reported organisational-level barriers related to clinicians' expectations that treatment would not be supported by service managers and administrators within organisations (Carmel et al., 2014; Hazell et al., 2017; Williams, 2008). Clinicians' perceptions that alternative treatment programs were prioritised was characterised as a major barrier to the implementation of a DBT programme (Carmel et al., 2014). The perception that treatments conflicted with the dominant treatment model and service targets (Hazell et al., 2017) and a lack of managerial understanding or organisational champions for interventions (Williams, 2008) also represented subordinate themes within organisational-level barriers to treatments for people with psychosis.

A third theme within the reported organisational-level barriers related to logistical barriers to delivering interventions. This theme captured a wide range of described barriers including workload and productivity demands, supervision, training, resources and staffing. Workload and productivity demands were frequently cited as barriers including a lack of time (Stirman et al., 2004; Williams, 2008); high caseloads (Williams, 2008); competing clinical responsibilities (Carmel et al., 2014); and demanding workloads, paperwork and evidencing productivity (Stirman et al., 2004). In particular, clinicians described two distinct mechanisms by which these high workloads inhibited use of novel interventions: by limiting opportunities for staff to engage in training, supervision or exploring novel approaches (Stirman et al, 2004) and by clinicians' tendency to 'default' to mainstream practices in the context of high demands placed upon them (Kopua, 2018). High workloads and productivity demands may create barriers to delivering treatment by distinct mechanisms. Logistical organisation-level barriers also included a lack of

resources (Hazell et al., 2017; Kopua, 2018); a lack of and high turnover of qualified staff within services (Carmel et al., 2014; Kopua, 2018; Stirman et al., 2004); a lack of specialist training (Kopua, 2018) and a lack of clarity, fidelity, confidence and dedicated time for the development of therapy skills within supervision (Williams, 2008). Numerous logistical barriers were identified by the included studies which presented organisational-level impediments to adoption and sustained use of psychological interventions.

Clinicians also described organisational barriers that were considered unique to the clinical setting or environment in which treatment was delivered (Ayazi, 2006; Sharp et al., 2018; Williams, 2008; Wood et al., 2019). These unique contextual barriers represented dominant themes within the selection of studies that reported them and included barriers related to the cultural context of the local society in which services were based (Ayazi, 2006); the challenges specific to assertive outreach settings (Williams, 2008); and barriers relating to the physical environment of inpatient services (Sharp et al., 2018; Wood et al., 2019).

Facilitators to Adoption of Treatment

Patient-level Facilitators

None of the included studies reported patient-level facilitators to the delivery of psychological therapies.

Clinician-level facilitators

Clinician-level facilitators to the delivery of psychological interventions were explored broadly by the included papers. A prominent theme within the reported clinician-level facilitators related to positive clinician attitudes towards treatment. Studies also described facilitators relating to clinician confidence and the cultural identity of clinicians.

The importance of positive clinician attitudes towards treatment was identified as a significant facilitative theme both within individual studies and across the studies included in the review. Studies captured the multi-facetted nature of positive attitudes including perceived benefits of treatment (Doran et al, 2019); perceived usefulness of treatment for patients (Frueh et al., 2006); perceptions that interventions would increase access to treatment (Hazell et al., 2017); and subjective assessment of the validity of interventions (Kopua, 2018). Doran and colleagues (2019) further reported a number of subordinate themes comprising positive attitudes including relevance and face validity of treatments, and the available evidence base for treatment. Comparison of two clinics which had and had not widely adopted EMDR described the aesthetics or observability of treatment outcomes as an important influence on clinician attitudes towards treatment (Cook et al., 2009).

Sharp and colleagues (2018) identified the use of structured and manualised interventions as building the confidence of clinicians to deliver a novel intervention. This confidence offered by a structured intervention facilitated what researchers characterised as the 'fit' between the intervention and the clinical context, highlighting the inter-relation between clinician and organisational-level factors.

Finally, analysis by Kopua (2018) emphasised the cultural identity of clinicians as facilitating the delivery of an indigenous intervention, Mahi-A-Atua. Clinicians described a special relationship with the local community created by a shared cultural identity: this relationship facilitated their use of the intervention. Clinicians also self-identified as guardians of indigenous knowledge and expressed feeling responsibility for passing this on as related to their use of the intervention. As such, the cultural identity of clinicians was conceptualised as a central facilitator to the use of the intervention (Kopua, 2018).

Organisational-level Facilitators

Studies exploring organisational-level facilitators to psychological therapies described two common narratives. Firstly, the endorsement of key stakeholders was important to increasing the acceptability of interventions through the organisational culture. In addition, co-working and training were perceived to facilitate clinicians learning new interventions.

Organisational endorsement was identified to be facilitative of the adoption of new interventions (Cook et al., 2009; Kopua, 2018). Cook and colleagues (2009) described dominant clinician narratives regarding the importance of a single influential clinician in shaping organisational endorsement of EMDR in a clinic where it was widely adopted. They also described similarly strong narratives regarding the importance of another key stakeholder in the organisational rejection of EMDR within another clinic. In contrast to these descriptions of a single influential stakeholder, clinicians delivering the Mahi-A-Atua intervention described organisational endorsement relating to reaching a 'critical mass' of staff buy-in (Kopua, 2018). Thus, clinicians described contrasting influences of individual or collective attitudes towards treatment in shaping organisational endorsement of interventions.

Finally, clinicians discussed the way in which co-working and organisational engagement with training supported adoption of novel interventions. Agency and system-level policies including required documentation were identified mechanisms to increasing engagement with training (Stirman et al., 2004): these policies were defined as an important organisational-level facilitator to treatment. Similarly, clinicians' descriptions of the availability of training and encouragement of clinicians to attend training were central distinctions between a clinic where EMDR had been adopted and another clinic where it had not (Cook et al., 2017). Co-working and the presence of specialist clinicians were also identified as facilitative of staff learning how to use an intervention (Kopua, 2018).

Discussion

Summary of Findings

This systematic review synthesises the currently available qualitative data regarding the barriers and facilitators to psychological therapies, from the perspective of mental health clinicians. Across the twelve included studies, there existed common thematic narratives within the identified barriers to psychological treatments described by clinicians. In addition, a number of barriers and facilitators were uniquely discussed in relation to specific clinical settings, populations or interventions.

There was a notable emphasis on barriers to psychological therapies within the literature, with limited discussion of factors that facilitate delivery and engagement in treatment. While multiple patient-level barriers to treatment were identified, none of the included papers discussed patient-level facilitators to treatment. This represents a potentially significant gap in available literature, whereby limited attention has been focused on the factors that promote patient engagement in psychological therapy compared to the factors that impede engagement.

Studies reported organisational level barriers which could be distinguished into those related to organisational culture and logistical barriers to implementation such as competing pressures of workload and productivity. These barriers were mirrored in the facilitators identified within the literature relating to organisational endorsement and implementation of policies promoting staff engagement with training. That these themes were reported across both reported barriers and facilitators in the literature supports confidence in the significance of organisational culture and endorsement in influencing the use of interventions in clinical practice. The organisational-level determinants described are consistent with those findings in previous empirical studies (Baer et al., 2009; Bailey et al., 2003; Harvey & Gumport, 2015; McCann & Bowers, 2005; Nelson & Steele, 2007; Shapiro et al., 2014) and the distinction of support barriers and process

barriers in determinant models (Nilsen, 2015). Current findings extend the literature by highlighting the multiple interacting aspects of organisational culture including narratives surrounding the 'goodness-of-fit' between an organisation and intervention, the influence of key stakeholders or champions, and the development of organisational momentum when support reaches a 'critical mass'.

Clinician attitudes to treatment were frequently identified by studies as important to understanding clinicians' adoption and use of psychological interventions and were characterised both as possible barriers and facilitators. Analysis extends on Aarons (2004) characterisations of clinicians' attitudes regarding limitations and fit by highlighting the multi-facetted nature of clinician attitudes: acceptability of an intervention related to judgements regarding the face validity, credibility, effectiveness including the observability of outcomes, appropriateness, usefulness and relevance to the needs of clients. Identification of attitudes within both reported barriers and facilitators strengthens confidence in the importance of clinician attitudes in shaping adoption and use of treatments in clinical practice. In the consideration of the role of healthcare professionals, individual adopters or users of a novel intervention, determinant models emphasise the characteristics of the individual such as clinical experience or training (Nilsen, 2015). Current findings indicate that greater attention is needed to clinician attitudes towards a treatment in order to maximise use of the intervention.

Patient-level barriers were not as commonly discussed in the included studies compared to therapist and organisational-level barriers. This is perhaps not surprising given that the current review emphasised the perspectives of clinicians who may be more attuned to the barriers that affect them personally and within their organisational context. Whilst a multitude of patient-level barriers are identified elsewhere in the literature (Gairns et al., 2015; Harvey & Gumport, 2015; Mohr et al., 2010; Salyers et al., 2004), they are frequently neglected within determinant frameworks of implementation (Nilsen,

2015). The relatively limited discussion of patient-level factors represents a limited understanding of what patient-level factors clinicians are aware of and attend to in their practice.

The impact of broader cultural context was discussed with regards to both potential facilitative effects (Kopua, 2018) and inhibiting effects (Ayazi, 2006). Notably, the two studies that included discussion of the impact of cultural context were the only included studies written and published outside of the UK and United States. It is important to acknowledge the absence of reported discussion of cultural context within the included research conducted within the UK and United States, although it is not clear whether culture was discussed during the conduct of the studies but not included in the written reporting. Culture is not limited to settings beyond the Euro-American context, but is invisible within the included body of research: this mirrors a broader invisibility of White and Euro-American culture within psychological research and theory described elsewhere (Sue, 2004). Greater research attention is needed to address the role of culture within the implementation of psychological therapies in the UK and USA.

Clinical Implications

Findings emphasise the perceived importance of organisational context to implementation of novel psychological interventions by clinicians. Common narratives existed regarding the importance of both organisational culture and logistical mechanisms. Whilst determinant frameworks commonly situate the organizational context as integral to implementation, they differ in whether this context is conceptualized as a passive environmental setting in which implementation occurs or having a more active role in the success of implementation. The findings of the current synthesis align with a more active conceptualization of the role of organizational context. As such, organizational leads and managers must attend to organizational determinants

in order to maximize implementation outcomes: this applies both to aspects of organisational culture that support and encourage innovation, as well as concrete logistical determinants such as clinician time, workloads and staffing levels that influence the uptake of novel approaches. Within implementation efforts, attention is needed to create the organizational context which facilitates training in novel interventions being translated in clinical practice.

Findings highlight the importance of clinician attitudes to treatment in determining whether an intervention is adopted into routine clinical practice. Recognising clinicians' attitudes to treatment may enable researchers to improve the acceptability of treatments by actively emphasising positive attitudes and actively addressing negative attitudes. There were many subthemes described relating to the multi-facetted nature of clinician attitudes including effectiveness, face validity, relevance, appropriateness, credibility and usefulness of an intervention for the needs of clients. Efforts to increase the acceptability of interventions for clinicians must therefore reflect the multi-facetted nature of clinician attitudes. Training providers may benefit from this nuanced understanding of clinician attitudes in order to tailor training to emphasise theoretical, technical or practical components to effectively address clinicians' perceptions of intervention credibility or harm expectancies (van den Berg et al, 2016).

Consultation and collaboration with clinicians throughout the research pipeline may improve the acceptability of novel interventions and, in turn, reduce the barriers to implementation in clinical practice (Green, Ottoson, Garcia, & Hiatt, 2009; Hayes et al., 1999) Consultation with practicing clinicians may take varying forms, including discussion of proposed interventions within focus groups comprising of practitioners or recruitment of a clinical advisory board to review proposed protocols of novel interventions. The opportunity for staff to work across clinical and academic roles may also enable insights from clinical practice to be further incorporated into the development of novel

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interventions. Increased opportunities for clinicians' insights to be incorporated into development of treatments will allow barriers to be identified and addressed and could promote successful translation of interventions into clinical practice.

While a number of common themes were identified within the reported barriers and facilitators, a number of unique factors were identified that influenced adoption of and engagement in psychological treatments for specific populations, in specific settings and for specific interventions. For example, the cultural identity of clinicians in New Zealand represented the dominant facilitator of clinicians delivering the Mahi-A-Atua intervention grounded in indigenous practices. In contrast, the specific needs and challenges of working with a veteran population including the complexity of clinical presentations and multiple experiences of trauma represented a challenging barrier to delivering treatments for PTSD to this population. Findings therefore highlight that determinants may have varied applicability to be individual implementation efforts. The understanding of common determinants may offer an important framework for considering the process of implementation. However, frameworks must be applied flexibly to tailor implementation interventions to the context in which they will occur. Implementation outcomes are likely to be most effective when they are grounded in an assessment of the relative importance of different determinants in the local context.

Limitations

There are a number of limitations inherent in the papers included and in the current review itself. This review highlights a relatively small body of qualitative research exploring clinicians' perceptions of the barriers and facilitators to psychological treatment, despite the wealth of quantitative investigation and commentary in this area. Clinicians represent key stakeholders in understanding the translation of interventions from research into clinical practice and clinician reported barriers have been demonstrated to

directly predict clinical practice (Salyers et al., 2004). Therefore, limited attention to this area of research represents a significant gap in our understanding of this process.

The quality of included studies was mixed and limited by a lack of transparent reporting in some areas. Few papers explicitly acknowledged the position of the investigator and the potential role this had in the collection and analysis of data and several studies failed to report a clear description of the analysis process. It was often unclear in written reports whether these features had been considered during the research process and were simply not reported. This prevents readers from being able to independently consider the impact of the researchers' position and process on the credibility and validity of research findings. Confidence in the findings of the review is therefore limited by the mixed quality of reporting of included studies.

There are also some limitations of the current review. The search strategy was focused and terms captured a discrete selection of mental health difficulties: the final review therefore included no studies of treatments for eating disorders, bipolar affective disorder or neurodevelopmental disorders. Published research relevant to the review question including that relating to the barriers specifically experienced by minority or marginalized groups were not captured by the inclusion criteria. As a result, discussion of these important barriers is missing from the analysis of the review. While research from across the world has been included within this review, studies not published in English and those within the grey literature were excluded. The review may therefore be subject to some publication bias and reflects a dominant Euro-American perspective. Whilst the use of narrative synthesis was appropriate to the scale and exploratory nature of the current review, the analysis could be strengthened by the use of systematic qualitative analysis of the findings through meta-ethnographic methods. These methods were beyond the scope of the current review but would provide a richer exploration and more nuanced understanding of the available literature. The review focused on the three most

commonly discussed levels of determinants: service user or patient-level determinants, provider or clinician-level determinants, and organizational-level determinants. It did not directly examine or address determinants at the level of either the characteristics of the interventions nor the impact of broader socio-cultural and geographical contexts. Of the included studies, more were conducted outside of the UK than within the UK: services delivered internationally may not operate in comparable ways. A more detailed examination of the broader socio-cultural and geographical context would enable a clearer assessment of the applicability of the findings to a UK health service context.

Future Research

A number of the themes identified in the current review could benefit from further investigation. In particular, the review provides convincing evidence that clinician attitudes to treatment are an important factor in whether clinicians describe adopting an intervention in clinical practice. However, less is known about how clinicians weigh up the multiple considerations that comprise clinician attitudes to treatment such as effectiveness, credibility, validity and usefulness. Little is also known about the factors that may contribute to or facilitate changes in clinician attitudes. Further attention is therefore needed to understand mechanisms for change in clinicians' attitudes towards treatments in order to improve adoption of interventions in clinical practice. Evaluations of the impact of training programmes may offer one opportunity to investigate the impact of training on both clinician attitudes to treatment and implementation outcomes.

There was relatively limited discussion in the current literature regarding patient-related barriers and facilitators and it was unclear whether this reflected the emphasis of researcher or clinicians. Where patient-related barriers were identified in relation to timing of treatment or readiness for treatment, clinicians also described the use of strategies to overcome these barriers such as motivational interviewing or adaptations to the focus of

treatment. However, no study in the included research identified patient-level facilitators to treatment. Further exploration of patient-level influences on access to treatment may allow the development and dissemination of strategies to overcome the barriers and promote facilitators, thus enhancing access to treatment.

This paper reports a systematic review and narrative synthesis of available qualitative data on the barriers and facilitators to use of psychological interventions, from the perspective of clinicians involved in delivering mental health treatment in clinical practice. Results highlight common narratives regarding the perceived influence of organisational culture and logistical barriers within organisations to adoption of psychological interventions. Clinician attitudes and confidence were also commonly described as both potential barriers and facilitators. However, more high-quality qualitative research is needed in order to better understand the perspectives of mental health clinicians who represent key stakeholders in the delivery of psychological interventions in clinical practice. Greater attention is needed to patient-level barriers and facilitators, as understood by clinicians, in order to understand strategies employed by clinicians to overcome these barriers and foster facilitators.

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Part 2: Empirical Paper

Let's not go there: exploring the delivery of trauma-focused

interventions in people with psychosis

Abstract

BACKGROUND: There is evidence of high rates of comorbidity of psychosis and PTSD. Individuals with psychosis who also experience symptoms of PTSD have worse outcomes, with higher symptom levels, poorer social functioning and lower quality of life. Trauma-focused interventions have been shown to be effective for symptoms of PTSD, and since 2014 NICE has recommended their use with people with psychosis. Despite this, trauma-focused interventions are still used relatively infrequently in this population. There could be many reasons for this, including staff attitudes and understanding, patient behaviours and organisational barriers. AIMS: This research sought to investigate staff perceptions of what impedes or facilitates the treatment of PTSD among people with psychosis. METHODS: Semi-structured interviews were conducted with 18 individuals working within the commissioning and delivery of clinical services for people with psychosis. Constructivist grounded theory was used in the collection and analysis of data. RESULTS: A range of inter-related barriers to the clinical use of trauma-focused interventions were identified and clustered into three themes: Coherent Understanding; Structural Support; and Safe Space. CONCLUSIONS: In order for trauma-focused interventions to be integrated into routine clinical practice, we need to address the processes, pathways and organisational culture surrounding the assessment and treatment of trauma in clinical practice. Skills-based training would enable staff to translate knowledge about the prevalence of trauma in this client population into routine clinical practice.

Introduction

People with psychosis have an increased risk of traumatic experiences and post-traumatic stress disorder (PTSD) compared to people in the general population (Varese et al., 2012). Comorbid diagnoses of PTSD and psychosis are associated with higher symptoms levels (Grubaugh et al., 2011) and worse outcomes from treatment (Insel, 2009). Trauma-focused interventions for people with psychosis have been recommended by clinical guidelines since 2014 (National Institute of Health and Social Care Excellence (NICE), 2014). Despite this, PTSD continues to be under-recognised (de Bont et al., 2015) and under-treated (Becker et al., 2004) in this group. Understanding the barriers to treatment experienced by staff working with people with psychosis may inform efforts to increase access to treatment.

Post-traumatic stress disorder (PTSD) is characterised by re-experiencing the traumatic event, cognitive and behavioural avoidance of reminders of the traumatic event, increased arousal and a negative impact on mood and beliefs (American Psychiatric Association, 2013). Lifetime prevalence of PTSD is estimated at 1.9-8.3% (Breslau, 2009; Breslau et al., 1998; Frans et al., 2005), and the diagnosis is associated with distress, social and functional impairment and increased use of healthcare (McLaughlin et al., 2015; Swan et al., 2017).

Individuals with psychosis are 2.78 times more likely than others to experience adversity and traumatic events (de Bont et al., 2015; Varese et al., 2012). Childhood and multiple experiences of trauma are also amongst the most robust environmental risk factors for the development of psychosis (Gibson et al., 2016; Varese et al., 2012). The experiences of psychosis, psychiatric treatment, and hospitalisation may also be traumatic (Berry et al., 2013). Given this increased exposure to traumatic events, individuals with psychosis are at increased risk of developing PTSD (Achim et al., 2011; Buckley et al., 2009; de Bont et al., 2015; Grubaugh et al., 2011). There are large variations in the

estimated prevalence of PTSD in people with psychosis, but meta-analyses estimate the prevalence at 12.4% (95% Confidence Interval 4.0-20.8%; Achim et al., 2011). Comorbid diagnoses of psychosis and PTSD are associated with higher symptom levels, and poorer social functioning and quality of life (Grubaugh et al., 2011; Mueser et al., 2010), with higher use of and worse outcomes from healthcare (Insel, 2008; Switzer et al., 1999). These difficulties are increasingly recognised as a clinical priority. Clinical guidelines recommend that individuals presenting with first-episode psychosis should be assessed and receive treatment for traumatic experiences and PTSD, and call for research into safe and effective interventions for this group (NICE, 2014).

Trauma-Focused Interventions

Trauma-focused psychological interventions including Cognitive Behavioural Therapy (tf-CBT) and/or Eye-Movement Desensitisation and Reprocessing (EMDR) are cited as first-line interventions for PTSD by clinical guidelines (NICE, 2018). These trauma-focused interventions should be distinguished from broader trauma-informed approaches to care. Trauma-informed approaches refer to a broader organisational awareness of, and attendance to, the prevalence of traumatic experience within people who engage with services: these have been written about extensively over the last decade (for a review, see Reeves, 2015; Sweeney et al., 2016), but are not the focus of this paper.

Both tf-CBT and EMDR have been shown to reduce symptoms and overall distress in individuals with a diagnosis of PTSD (Bisson & Andrew, 2007). People with psychosis are commonly excluded from research trials evaluating the effectiveness of trauma-focused interventions in order to reduce heterogeneity and risk of harm (Swan et al., 2017). As a result, the efficacy of recommended treatments for people with psychosis is uncertain. Although guidelines report no contraindication for treatment (NICE, 2014), recommendations were based on a single trial that was notably underpowered for the

planned analysis (Jackson et al., 2009). Guidelines therefore represent an absence of evidence rather than evidence of either benefit or harm. In order to address the limitations of current guidance, interventions for PTSD symptoms in people with psychosis are identified by authors as a key research priority (NICE, 2014).

Despite growing clinical interest, research regarding the effectiveness of trauma-focused interventions for people with psychosis is an emerging and limited field. Results from three recent meta-analyses do not consistently support a positive benefit of trauma-focused interventions on symptoms of PTSD or symptoms of psychosis which are sustained at follow up (Brand et al., 2018; Sin & Spain, 2017; Swan et al., 2017). Discrepancies between analyses may be partially accounted for by differences in the analytic strategies employed by research teams. However, heterogeneity in the interventions and participant samples included within trials may also contribute to difficulty drawing conclusions across current research.

Therapy modality may be an important moderator of treatment outcome (Brand et al., 2018). Most trials with people with PTSD and psychosis have evaluated a Cognitive Restructuring intervention and early trials reported positive treatment outcomes on symptoms of PTSD in a sample of participants with PTSD and Severe Mental Illness (SMI; Mueser et al., 2015; Mueser et al., 2008). However, people with a primary diagnosis of psychosis formed the minority (15-36%) of the participant sample in these trials. Subsequent trials with people with PTSD and psychosis found no significant group differences compared to a treatment-as-usual control group (Steel et al., 2017). A prolonged exposure (PE) intervention and EMDR have been evaluated in one randomised controlled trial (RCT; van den Berg et al., 2015): both treatment groups showed significantly greater reductions in symptoms of PTSD compared to a waiting-list control group. Secondary analysis of results also reported significantly less exacerbation of symptoms and fewer adverse events during treatment for participants in the

intervention groups compared to controls (van den Berg, de Bont, et al., 2016). Although findings regarding PE and EMDR are promising, results come from a single trial and require replication. Emerging research therefore remains inconclusive regarding the efficacy of trauma-focused interventions and further research is clearly needed. Anecdotally, harm expectations regarding trauma-focused treatments contribute to hesitance by ethical boards to support the conduct of such trials.

Clinical Practice

Trauma continues to be neglected in clinical practice, despite well-established evidence regarding the prevalence of traumatic experiences and PTSD in people with psychosis and emerging research into trauma-focused interventions. Trauma is frequently un-recognised (de Bont et al., 2015; Lommen & Restifo, 2009) and, even when identified, individuals are rarely offered trauma-focused treatment (Becker et al., 2004). Given the potentially detrimental consequences of failure to identify and treat PTSD in this population (Álvarez et al., 2012), it is important to understand this discrepancy between research and clinical practice.

So far little research has directly examined the barriers specific to trauma-focused treatment with people with psychosis. Staff perspectives may be of particular importance in understanding this translational gap between current research and clinical practice. Clinician attitudes towards treatment, knowledge about treatment and self-efficacy delivering treatment have been shown to predict adoption of psychological interventions in clinical practice (Harned et al., 2013; Salyers et al., 2004). Thus, better understanding staff perceptions may be central to understanding the barriers to adoption of trauma-focused interventions in clinical work with people with PTSD and psychosis.

Two studies have previously explored clinician perspectives towards trauma-focused interventions for people with SMI (Frueh et al., 2006; Salyers et al., 2004).

Clinicians identify a number of client-related barriers including symptoms of SMI interfering with treatment, client unwillingness, cognitive impairment and difficulty communicating symptoms or events (Salyers et al., 2004). Identified clinician-related barriers to treatment included clinician fearfulness of addressing trauma (Frueh et al., 2006); a lack of knowledge and experience; perceived competence and confidence delivering interventions; perceived usefulness of interventions; and perceived agency support (Salyers et al., 2004). Clinicians' attitudes to treatment, and specifically their perceived competence and confidence treating trauma/PTSD and perceived usefulness of interventions, were predictive of whether clinicians had assessed, documented and treated trauma and PTSD with clients (Salyers et al., 2004). This research has examined barriers within people with SMI, rather than specifically people with psychosis. Given the heterogeneity of the SMI population, the barriers that apply specifically to people with psychosis may differ significantly from the wider population.

Only one study has previously examined clinician perspectives towards trauma-focused interventions for people with psychosis (Gairns et al., 2015). Clinicians identified additional barriers to treatment that existed when working with people with psychosis specifically, including perceived mental health risks to clients, workload pressures and poor client engagement. However, findings also highlighted the complex and apparently contradictory variables that may influence the use of trauma-focused interventions with this population. Despite identifying mental health risks to clients as a key barrier to treatment, 68.8% clinicians endorsed trauma-focused treatments as safe (Gairns et al., 2015). Further research is clearly required to explore and unpack these complexities and apparent contradictions within clinician reports.

There are methodological limitations within the current literature which may limit the depth of our understanding of the barriers to delivering trauma-focused interventions for people with psychosis. Research studies have included analysis of surveys and

questionnaires dominated by forced-choice Likert scales (Gairns et al., 2015; Salyers et al., 2004). These methodologies have allowed the quantification of how widely perspectives are endorsed (Gairns et al., 2015) and statistical analysis of the relationships between different variables of interest (Salyers et al., 2004). They do not, however, facilitate a deep exploration of identified barriers or consider the complex interaction between them. Research has also utilised focus groups to facilitate a richer exploration (Frueh et al., 2006; Gairns et al., 2015; Salyers et al., 2004). However, social dynamics within focus group settings may inhibit clinicians from discussing barriers perceived to be less acceptable or inconsistent with the views of colleagues and supervisors. The literature may therefore be extended and enhanced by individual qualitative interviews which allow a more open exploration of complex processes such as the barriers to delivering trauma-focused psychological therapies for people with PTSD and psychosis.

Treatment decisions can be complex, influenced by clients, clinicians, organisational and treatment variables. Detailed understanding of barriers and facilitators to use of trauma-focused therapies in clinical practice is important to increase access to treatment and ensure equity of provision for people with psychosis and PTSD. Staff perspectives may offer an initial understanding of the variables that influence the assessment and treatment of trauma for this group of service users. In the current study, I sought to explore staff perceptions of the barriers and facilitators to using trauma-focused interventions for people with psychosis. I interviewed key staff involved in the commissioning and delivery of services for people with psychosis. I adopted a constructivist grounded theory approach to develop a preliminary model of the factors described by clinicians. This may provide valuable insights to inform efforts to improve provision.

<center>**Methods**</center>

Design

I conducted individual, semi-structured qualitative interviews with staff working in the commissioning and delivery of clinical services for people experiencing psychosis. My analysis was guided by constructivist ground theory methods (Charmaz, 2014).

Grounded Theory

First described by Glaser and Strauss as 'the discovery of theory from data', grounded theory is an inductive methodology with systematic guidelines for collecting and analysing qualitative data (Glaser & Strauss, 1967). The methodology seeks to discover and abstract theoretical models from data through iterative processes of data collection and analysis.

Constructivist grounded theory (Charmaz, 2014) asserts that the researcher's position and perspective plays an active role in the social construction of theory from data. The researcher is not considered a neutral, value-free observer and their role is not 'discovery' of theory from data.

A range or constellation of different methods are described within the grounded theory literature (Charmaz, 2014). Constructivist grounded theory methods, as described by Charmaz (2014), typically commence with purposive sampling of data or participants who can offer insights into actions and processes of interest and searches for variation in perspectives elicited. Data collection and data analysis occur iteratively and coding progresses through open and focused stages through the constant comparison of similarities and differences within the data. Codes are collapsed into increasingly abstract categories and memos are used in the development of new conceptual categories and theory. Theoretical sampling is employed whereby emerging concepts are examined by

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repeated interviews with participants or by including new lines of enquiry in later interviews.

Treatment decisions within clinical contexts are social processes involving a number of stakeholders with differing experiences of and perspectives on the process. Given this, constructivist grounded theory methods (Charmaz, 2014) were well-suited to the exploration of the understanding of staff regarding the barriers and facilitators to delivery of trauma-focused interventions to service users with psychosis.

Procedure

Participants

Grounded theory involves purposive sampling of a range of differing perspectives (Rohleder & Lyons, 2015). Care and treatment planning within clinical services for individuals with psychosis involve multi-disciplinary clinicians, supervisors, and managers and is informed by decision-making by a clinical commissioning group (NICE, 2014). The sampling strategy purposefully aimed to capture the experiences of the diverse staff involved in commissioning and delivery of clinical services for this population.

I contacted potential participants via emails to professional contacts within a range of clinical services across the Greater London area, and on social media by Twitter. Snowball sampling allowed me to maximise the diversity of the sample by asking all participants to identify colleagues or other members of staff who may hold interesting, different or conflicting views from their own (Charmaz, 2014).

Data Collection

When individuals expressed interest in participating in the study, I contacted them to provide a participant information sheet (Appendix 3) and schedule the interview for a mutually convenient time and location. No payments were offered for participation, but

a small charitable donation per participant was made to Haringey Suicide Prevention Group. This charity was selected following participant recommendation that the organisation is doing valuable work supporting people with psychosis in London.

Of the 18 individual interviews completed, I completed 15 face-to-face at the place of work of the participant, one face-to-face at University College London and two via telephone interviews. Consent forms (Appendix 4) were completed in person at the time of the interview for face-to-face interviews and digitally prior to telephone interviews. All interviews were audio-recorded using a digital voice recorder. In addition to the interview, participants were asked a limited number of questions regarding their demographics and professional experience in order to characterise the participant sample. These questions were not audio-recorded.

Interviews ranged from 25 to 57 minutes. Within the interviews, I aimed first to briefly elicit participants' knowledge about trauma-focused interventions and then explored their experiences of using these interventions in clinical services, including the barriers and facilitators to doing this. I conducted interviews in line with Charmaz' (2014) definition of *Intensive Interviewing*. I used a semi-structured interview schedule (Appendix 6) as a prompt guide whilst promoting a primarily one-sided conversation exploring participants' experiences. The schedule was developed following discussions with an external expert in the field of trauma and psychosis and reviewed by the supervisory team. I designed the schedule to keep questions deliberately broad to minimise biasing responses, and used participants' words in follow up questions to elicit expansion on ideas. The interview schedule was not piloted, but evolved during the data collection process in line with emerging themes and memos from previous interviews as demonstrated below.

Data Analysis

I transcribed interviews using Express Scribe Pro software and a VEC-Infinity USB pedal controller. This process aided immersion in the data. I transcribed the first five interviews before completing further interviews. I used memo-writing to record key themes and relationships emerging within the data. Following reflections after these initial interviews, I altered the interview schedule to include a statement of the definition of trauma-focused interventions. This statement was given after participants had described their understanding of the term and ensured that all participants answered subsequent interview questions with a shared understanding of the central concept. Although repeated interviews with the same participants were not completed, purposive sampling for later interviews and integration of emerging concepts into the interviews allowed for further exploration and clarification of emerging concepts, consistent with theoretical sampling (Charmaz, 2014).

An initial cross-section of five interviews, selected for their diversity of perspectives, were selected for initial line-by-line open coding, with each line or segment of text assigned a code or descriptive label. Initial codes were kept close to the data and attempted to capture a mix of actions and adjectives. At this stage, I developed categories through repeated comparison of individual codes to identify frequent and common concepts. Gradually, this generated focused codes which grouped similar open codes into more abstract higher order codes. Identified patterns and relationships between codes allowed organisation of the codes into an initial coding framework.

I then coded the remaining interviews using the initial coding framework. Where text was consistent with pre-existing codes, it was coded accordingly. Where text contrasted, or added a new understanding to the analysis, I generated novel codes to reflect this and to develop the complexity of the model. This iterative process of open and focused coding stages continued until I had coded all eighteen interviews. I used memos to define, refine and elaborate coding decisions and to provide rationale and

definitions of higher order coding. All coding was completed using NVivo 11 software for Mac.

Reporting of the Model

I have reported the themes generated by my analysis in a narrative form. To enhance the credibility of analysis, tables have been included to summarise the theme structures and associated illustrative quotations. I have chosen not to report the number of participants who reported each theme and sub-theme. Constructivist grounded theory adopts an interpretative stance towards the development of knowledge from research (Charmaz, 2014). Findings are viewed as constructions of reality developed jointly by the participants and researcher through the research process. Findings are therefore not considered objective, universal truths. In grounded theory, we also seek to include as diverse a sample of people as possible in order to explore the widest possible range of views on a topic. In so doing we are not seeking a representative sample from which we can draw inferences about a wider population. In this study, interviews were semi-structured and all participants were asked five common questions. However, questions were kept deliberately broad and interviews prioritised exploration of the experiences and perceptions described by clinicians over ensuring standardisation of the interview content. As a result, the focus of the interviews varied. That a participant did not speak about one of the themes does not indicate that they do not share those ideas, rather that those ideas did not arise during the interview process.

Quality Assurance

In line with guidance on the conduct of good qualitative research (Henwood & Pidgeon, 2003), I have endeavoured to maximise the credibility of the analysis through transparent reporting of the research processes, researcher reflexivity and a statement of

researcher's position and the use of validity checks. Explicit and transparent reporting of these strategies aims to increase the credibility of findings and enable readers to assess the applicability of findings to their own context.

Reflexivity

It was important to recognise early in the research process that as a researcher, I was not an unbiased observer and came to the research question with my own prior personal and professional experiences (Charmaz, 2014). At the start of the project I therefore began a reflective log beginning with a preliminary consideration of my expectations and beliefs about trauma-focused interventions for people with psychosis. I summarise the key ideas from this process in the position statement below. I continued to use this reflective log to document the process of recruitment and data collection, including reflections following interviews and the role of my own knowledge and experience in shaping the interview.

Researcher's Position

A statement of positionality is an important opportunity for researchers to acknowledge their own perspective and offer readers the opportunity to consider how this position may influence their interpretation of the data (Elliott et al., 1999).

I write from the perspective of a 27-year-old, white female with no personal lived experiences of either PTSD or psychosis. My interest in trauma and psychosis arose from professional experiences prior to clinical training, and in particular my experiences as a research assistant working with adults with paranoid beliefs and psychosis. Within this role, I became aware of the significant histories of trauma of service users I worked with, and how inter-linked these experiences were with their anomalous experiences and paranoid beliefs. Through these experiences I came to the belief that trauma-focused

interventions could be clinically valuable to individuals experiencing psychosis. However, prior to conducting the research I had limited experience delivering trauma-focused interventions and no experience of either working in NHS services for, or delivering trauma-focused interventions to, individuals experiencing psychosis. This could be valuable in limiting my pre-conceptions regarding the research question.

Validity Checks

I completed the coding and model development with consultation from the supervisory team. Two transcripts from the initial cross-section were reviewed by a supervisor who contributed initial themes to the analysis. The development of focused codes and the theoretical model was generated through iterative processes involving use of exploratory memos and discussion with the supervisory team to ensure credibility and face validity of the emerging framework. This process of consultation with the supervisory team aimed to facilitate the validity and applicability of the analysis (Henwood & Pidgeon, 2003). However, the 'fit' of the analysis will ultimately be assessed by the reader.

Ethical considerations

The study was approved by the Joint Chair of the University College London Research Ethics Committee (Application ID: 15035/001).

Results

Participants

I interviewed a total of eighteen individuals. To protect their anonymity, I have reported their demographic data in summated form. Participants' ages ranged from 33 to 58 years with from 3 to 34 years of experience working in mental health services.

Participants were 11 Clinical Psychologists, three Psychiatrists, two Social Workers, one Nurse, and one Occupational Therapist. Participants currently worked primarily within clinical teams: four in inpatient settings; three in Early Intervention for Psychosis; two in Recovery and Rehabilitation; one each in Community Mental Health and a specialist psychological therapies service; six were in senior positions across clinical teams and one in a Clinical Commissioning Group.

A Conceptual Representation of Results

Across the diverse participant sample, there were strong common narratives regarding the barriers and facilitators to delivering trauma-focused interventions for people with psychosis. Analysis resulted in three dominant themes being represented by the conceptual model: (i) coherent understanding; (ii) structural support; and (iii) safe space (see Figure 1). They have been diagrammatically represented as over-lapping to emphasise the inter-relation between themes, and these links will be demonstrated through the below description.[1]

Every participant recognised the prevalence of traumatic experiences in people with psychosis and potential lasting consequences including post-traumatic stress. Despite this, they acknowledged that trauma and its sequelae were frequently neglected in assessment and treatment planning by the clinical team. Participants articulated the identification of trauma as a crucial pre-cursor to trauma-focused interventions and each of
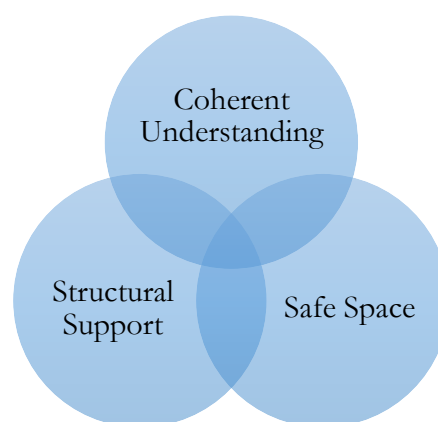
Figure 1: Key variables influencing the use of Trauma-Focused Interventions in Psychosis

[1] Quotations are accompanied by the participant ID and professional training.

the themes described appeared to offer barriers both to the initial identification of trauma and subsequent delivery of trauma-focused interventions. In order to ensure clarity, the identification of traumatic experiences and PTSD will be distinguished from the delivery of trauma-focused interventions throughout the reported results.

Coherent Understanding

Participants perceived that for many clinicians, knowledge about the role of trauma in psychosis could be difficult to integrate into existing models of understanding and treating people experiencing psychosis. This difficulty integrating knowledge with existing models created a barrier to knowledge being translated into clinical practice through routine identification of trauma by all clinicians. This barrier included three aspects.

Firstly, clinicians described the dominance of the medical model of illness within services and resistance to considering psychosocial perspectives. Secondly, I observed significant variations in understanding of trauma-focused interventions and this indicated significant ambiguity about the role of interventions in treatment planning. Thirdly, participants described specific clinician characteristics which they believed were associated with how much value individual clinicians placed on the identification of trauma and delivery of trauma-focused interventions. Illustrative quotations for each of the subcategories are included in Table 1.

Identification of trauma and the dominant medical model

Identification of trauma and delivery of trauma-focused interventions within a dominant medical model was frequently identified as a barrier by participants. While participants made reference to the value of a biopsychosocial model to think holistically

about their patients, they reflected that medical or biological explanations dominated the clinical discourse within services. As one psychologist described it:

'the overwhelming presence of the medical model, the overwhelming presence and the overwhelming faith to chemistry' (P5, Psychologist)

Participants reflected that research regarding trauma and psychosis was perceived to be incoherent with, and therefore difficult to integrate into, a medical understanding of psychosis as an organic brain disorder. I understood this incongruence as a barrier that prevented staff knowledge regarding trauma from being translated into meaningful increases in the identification of trauma in clinical practice.

In order to identify a history of trauma and the clinical appropriateness of trauma-focused interventions, participants emphasised the importance of these being included within standardised assessments. However, in the context of this medically dominated understanding, participants reflected that questions about trauma could be perceived by their colleagues as a tick-box exercise and frequently lost from assessments. The result of this, participants acknowledged, was an increased risk that a history of trauma was not identified or followed up.

Service users' own narratives about their mental health were also shaped by this clinical discourse. Participants described how the absence of questions about trauma, or failure to follow up on disclosures about trauma, fostered a mutual understanding that these experiences were not relevant to their mental health treatment.

'...so they get into a narrative of talking about psychosis-related symptoms rather than talking about their trauma 'cause they assume that's not what they're here for, that's not what's available, that's not what can be treated' (P2, Psychologist)

Table 1: Sub-categories and illustrative quotes of Theme 1: A Coherent Understanding

Sub-category	Illustrative Quotes
Attending to trauma and a dominant medical model	*'the research on trauma and psychosis is a difficult one for those who believe that psychosis is an organic, degenerative brain disease' (P11, Psychologist)*
	'it's looking at the social model when we're in a medical team' (P17, Social Worker)
	'psychiatric professionals were always quite reluctant to acknowledge trauma and that kind of drive of having trauma introduced into the, the debate very often regularly came from outside' (P4, Psychiatrist)
	'there's rarely, only in a minority of cases, any evidence that people have been offered, um, er, a comprehensive trauma screening so that they've really been asked, in the standardised way, about um, their experience of kind of common traumatic events' (P16, Psychologist)
	'a client's narrative may be shaped, very well shaped by what clinician's routinely ask them, so they get into a narrative of talking about psychosis-related symptoms rather than talking about their trauma 'cause they assume that's not what they're here for, that's not what's available, that's not what can be treated' (P2, Psychologist)
Awareness of and perceptions about psychological interventions	*'it means different things to different people and I think that does cause um, some confusion sometimes, the lack of clarity' (P16, Psychologist)*
	'I think the psychodynamic therapy offers someone to talk about their losses and their traumas and the difficulties from their past and it can be quite deep work' (P17, Social Worker)
	'everyone should be offered um, psychological assessment and CBT for p, um, it's the, is the stated intervention' (P3, Occupational Therapist)
	'I don't sense here that there's any, sort of, deep work here, with the CBT' (P17, Social Worker)
	'I ask about trauma and I can see that it can affect mental state, but actually what I can do' (P15, Psychiatrist)
	'there is something that is counter-intuitive isn't it, that...that we are asking people to believe that you get better by diving into the depths of the worst thing that ever happened to you' (P13, Psychologist)
	'I think pretty much everywhere now you have to have a discrete, you offer people discrete therapy contracts that are far too short for what they actually need because that's the NHS context' (P1, Psychologist)
Clinician characteristics	*'you need a lot of compassion, but you need compassion in such a way that you can also work out when you've got compassion fatigue and that you're burning out' (P1, Psychologist)*
	'there are some people who within the team, who just have um, more of an acute sensitivity to people's experiences and some who don't, some who are able to um, ask enough, and not necessarily, over and unpack at an assessment point um, and um, some who don't' (P3, Occupational Therapist)
	'because I have a very intensely, intense psychodynamic background, I'm not very much in favour of this' (P5, Psychologist)

Awareness of and perceptions about psychological interventions

There were significant differences between participants' awareness of and perceptions about psychological interventions: these differences indicated confusion and ambiguity about the role of interventions in care planning by clinical teams. Participants held diverse definitions of the term 'trauma-focused interventions', and some used it interchangeably with the term 'trauma-informed approaches'. For some, trauma-focused interventions were conceptualised as specific psychological therapies focused on the processing of traumatic memories. For others, the term captured a broader approach to working with clients whereby the experience of trauma was assumed or explicitly acknowledged in the clinical formulation but might not be the focus of treatment. In line with this variability, a broad range of interventions were conceptualised as trauma-focused including Eye-Movement Desensitisation and Reprocessing (EMDR), trauma-focused Cognitive Behavioural Therapy (tf-CBT), Narrative Exposure Therapy (NET), Acceptance and Commitment Therapy (ACT), Body-based psychological therapies, CBT for psychosis, Dialectical Behaviour Therapy (DBT), Psychodynamic psychotherapy, Peer Support groups and medication.

Participants' beliefs about the restricted provision and accessibility of psychological therapies within services, and trauma-focused interventions in particular, appeared to contribute to a sense of futility in the identification of trauma and PTSD needs that could not be addressed by the service. Limited numbers of psychological therapists, a restricted range of available interventions, and service pressures to deliver work within brief, time-limited therapy contracts were identified by participants as specific barriers. This indicated that clinicians widely felt that provision was inadequate to meet the complex needs of this population.

Participants identified that endorsement of trauma-focused interventions by both themselves and their colleagues was linked to positive beliefs about treatment. In contrast,

staff recognised that many clinicians and service users reported that interventions lacked face validity: this lack of face validity could make it difficult to engage colleagues or patients in the value of trauma-focused interventions. As one participant summarised:

'there is something that is counter-intuitive isn't it, that…that we are asking people to believe that you get better by diving into the depths of the worst thing that ever happened to you' (P13, Psychologist)

Participants identified training, combined with clinical experience and positive outcomes from treatment, as building the credibility of re-living interventions and therefore facilitating their adoption in clinical practice. When discussing the early phase of treatment, psychologists emphasised the importance of psychoeducation prior to embarking on treatment in order to support the credibility of the intervention for service users, promoting service user engagement in treatment.

Clinician characteristics

Participants commonly described clinicians' characteristics as influencing individual differences in the adoption of trauma-focused interventions. These characteristics were perceived to influence how valuable clinicians perceived interventions to be, as well as how sensitively and effectively they were able to identify traumatic experiences and consider trauma-focused interventions. A number of participants specifically identified their own experiences, including experiences of trauma, as influencing them to integrate assessment and treatment of trauma and PTSD into their clinical practice. These experiences, in themselves and their colleagues, were also credited with contributing to clinicians having greater aptitude for talking about traumatic experiences and ability to empathise with service users' experiences. However, one participant highlighted that clinicians' own experiences of trauma could, for some clinicians, cause difficulty talking about trauma and make this feel potentially re-traumatising:

'many professionals have traumatic experiences, and actually are as vulnerable as clients are to re-activating traumatic experiences, and talking about trauma and talking about their own take on trauma is very likely to do exactly that' (P4, Psychiatrist)

Clinicians also identified personal qualities of the clinician and some psychologists described these as being as important as a therapist's clinical skills and techniques to delivering trauma-focused interventions. In particular, courage and compassion were identified as key qualities to enabling clinicians to work with emotionally evocative content within trauma-focused interventions.

Many participants also described psychotherapeutic modality or theory as informing whether they adopted or endorsed trauma-focused interventions. One psychologist with a psychodynamic orientation simply stated that trauma-focused interventions were incongruent with the way they worked with service users. Other psychologists, with a systemic orientation, reported focussing on indirect ways of working with the system over direct, individual clinical work.

Structural Support

Significant systemic or structural factors, including service configuration and communication between stakeholders, impacted on the use of trauma-focused interventions. Routine identification of trauma and delivery of trauma-focused interventions required endorsement at multiple levels of the system, including community awareness, organisational culture and the environment of the clinical team. Both top-down and bottom-up endorsement of the importance of identifying trauma and offering treatment were needed to sustain system-wide practices. Illustrative quotations for each of the subcategories are included in Table 2.

Service Configuration

The configuration of services was commonly described as representing a barrier

to accessing trauma-focused interventions for service users. Participants described how

Table 2: Sub-categories and illustrative quotes of Theme 2: Structural Support

Sub-category	Illustrative Quotes
Service Configuration	*'I mean I do think this is a barrier, so, we…we're a psychosis service, so in terms of what we should be offering as a service, it's much, you know, much more it's CBT for psychosis, as such' (P8, Psychiatrist)*
	'I think it's a very traumatic experience to have touched on the emotional struggles that you have, and then, you're told 'you're not for us though, you're not the right kind of distress, we don't do that sort of distress'' (P3, Occupational Therapist)
	'you can then kind of get into a situation of playing bat and ball with another service' (P2, Psychologist)
	'I think it's just, probably sometimes you know, you sort of know the response you will get, the push back that you're going to get and you know, you are struggling sometimes, so, I think that was the main factor really, in terms of preventing, me from referring' (P7, Nurse)
Communication	*'a certain level of understanding and knowledge that they were able to […] speak the same language that the psychologist would've been speaking. So you have synergy in terms of how people would operate and intervene' (P7, Nurse)*
	'We've referred patients there instead, but I must say the difficulty then is, the people who are accepted for treatment, I must say I don't get much feedback' (P8, Psychiatrist)
	'don't see the services coming back to me and saying…we need to put in place trauma-focused therapies for psychosis in a very specific way' (P14, Commissioner)
Barriers at multiple layers	*'there is the, pervasive kind of silencing in our communities of trauma, so you know there's… there's barriers to disclosure from a service user side' (P16, Psychologist)*
	'there's so many different um, KPI's linked with the national template, if you like, of what EIS services should provide, that it's actually quite difficult to think in the round about what really ought to be sort of more fundamental training needs within the team, um, given the amount of trauma that people experience who are on our caseload' (P3, Occupational Therapist)
	'I looked at the…what we had in terms of psychological therapies at the time, and about 6% of our work was going on with people with psychosis, so the whole Trust had bought into this idea, this wasn't a group for whom psychology… ' (P11, Psychologist)
	'a high level of, of, um, need, which, um, essentially undermines our capacity to engage and maintain people within um, a psychological aspect of the pathway' (P3, Occupational Therapist)
	'So if you've got somebody who has a special interest in trauma, maybe a national expert, you may get services that developed in a better way or a different way to services in a different area that maybe didn't have that local expertise or interest' (P2, Psychologist)
	'when I'm training psychologists people say oh the team are very resistant, the team don't want me to do, they just wanna up the meds' (P10, Psychologist)
Training	*'there's probably a training need within the team, uh, around the assessment of trauma and actually understanding the impact of trauma on psychosis' (P3, Occupational Therapist)*
	'We have real problems getting specialist supervision…particularly in relation to EMDR, so I would like um, to have all the psychologists in my service training in EMDR and to have supervision, um, for delivering that with a…psychosis population. No chance.' (P9, Psychologist)
	'you would run a training and if it was an opt-in option for staff, then it would very much depend on how busy staff felt they were, and if staff were over run with other things, it was, managers weren't insisting they go, they just wouldn't come […] it would feel like a luxury to go to training on something like that.' (P2, Psychologist)

clinical services for people experiencing PTSD were typically differentiated from services for people experiencing symptoms of psychosis. Many participants reflected that this differentiation resulted in uncertainty about whether trauma-focused interventions for people with psychosis should be delivered by specialists within trauma services or services for people with psychosis. This uncertainty indicated unclear pathways for service users to access these interventions.

Referral pathways between services were portrayed as challenging for both clinicians and service users. Clinicians described experiencing push-back from teams to whom they made referrals for trauma-focused interventions and debate about the appropriateness of these referrals. Differences in clinical opinions; rigid, changing and ambiguous service thresholds; and individual differences in how referrals were written and interpreted all contributed to variable referral outcomes. As a result, clinicians lacked confidence that referrals would be accepted and acknowledged being discouraged from making future referrals.

Participants reflected that these transitions could also be distressing and difficult to manage for service users. They recognised that the referral process could be experienced by service users to be a rejection or their difficulties having been judged to be '*not the right kind of distress*' (P3, Occupational Therapist.) Participants expressed concern that experiencing the referral process to be traumatic or distressing could damage service user engagement with treatment and services generally.

Communication

Participants talked about the importance of communication in facilitating access to trauma-focused interventions. Effective communication between clinicians within the multi-disciplinary team (MDT) was described as important to ensuring that all clinicians were working from a shared understanding of service users' difficulties and facilitating

joined-up care. In contrast, a number of non-psychological clinicians described limited communication and a lack of shared terminology creating difficulty in collaborative working between psychological staff and their colleagues from other disciplines. This seemed to create a barrier to effective communication between psychological staff and the wider team. Participants described training, supervision or team formulation sessions as helping to develop communication between psychological staff and other members of the MDT.

Clinicians also emphasised the importance of communication between services and with commissioners for shaping future decision-making regarding treatment planning, referrals and service development. Clinicians' decision-making regarding treatment planning and referrals were influenced by the feedback, or lack thereof, regarding the outcome of referral, assessment and treatment with other clinical services. Participants acknowledged that this feedback was often absent and expressed therefore feeling uncertain about whether referral to trauma-focused interventions in other services had been appropriate or effective. One commissioner also emphasised how important it was that they received feedback from clinical services in order to inform service development and planning. Commissioners were only aware of and able to address gaps in service provision, such as unmet needs for trauma-focused interventions for people with psychosis, when services brought these to the attention of commissioners.

Multi-Level Thinking

Participants expressed that routine identification of trauma and use of trauma-focused interventions required structural support across multiple levels of the organisation and wider socio-political context. Several highlighted how of the broad socio-political context fed into community awareness of trauma and supported or silenced

disclosure of traumatic experiences. Some participants described elements of the current socio-political climate, such as the rise in feminism and 'Me too' movement, as having contributed to greater awareness of and attention to trauma in society more generally. Other clinicians highlighted different aspects of the socio-political culture, such as poverty and austerity, which increased the likelihood of people experiencing traumatic events and reduced the funding to and availability of services to support people through these experiences.

Many participants discussed the role of national policy and implementation guidance in informing how services promoted the routine identification of trauma. Participants from managerial positions expressed recognition that training and clinical focus on the identification of trauma and delivery of trauma-focused interventions would be of significant clinical value to the quality of care provided by their teams. However, they described it as challenging to prioritise these training needs in the context of extensive and demanding Key Performance Indicators set nationally. Resources developed by NHS Scotland around trauma-informed care were identified as examples of how national policy and guidance could facilitate services building skills in the identification of trauma in service users.

Participants talked about the importance of senior leadership endorsement in supporting the development of an organisational culture where trauma and trauma-focused interventions were routinely considered. Participants described how expertise or interest in trauma by senior managers translated into greater organisational emphasis the assessment of trauma and delivery of trauma-focused interventions, including staff training. Leadership expertise also appeared to contribute to differences between NHS trusts regarding resourcing of specialist trauma services and psychological and trauma-focused interventions for people with psychosis.

Participants described how the configuration of clinical record systems impaired clinicians' ability to integrate identified traumatic experiences into their clinical practice. Experiences of trauma, once documented, were described as being lost from service narratives about the service user by patient record systems which fragmented these experiences into symptoms, contacts and episodes. As a result, there was a sense that this narrative context was often felt to be lost or forgotten. Accessibility of trauma-screening tools, through their integration onto clinical record systems, was identified by participants as promoting their routine use in clinical practice.

Endorsement of trauma-informed approaches within the team culture and individual clinicians comprising the MDT appeared to provide valuable support to therapists delivering trauma-focused interventions. Conversely, clinicians acknowledged feeling pressure not to undertake trauma-focused interventions with service users when trauma-informed approaches were not endorsed by their colleagues.

Sustaining the routine assessment of trauma and consideration of the suitability of trauma-focused interventions therefore appeared to be facilitated by endorsement and structural support at multiple levels of the organisational hierarchy and broader cultural and societal factors.

Training

The need for and impact of training to increase the routine identification of trauma and consideration of the suitability of trauma-focused interventions within clinical teams was described by several participants. Participants described the importance of management and organisational endorsement of training. Funding and protecting time for staff to attend training were seen as important indicators of managerial endorsement and enabled clinicians to engage with it. Participants also stated that training needed to be

supplemented by on-going supervision to sustain clinician confidence and competence in conducting assessments and delivering interventions.

Safe Space

Safety was prominent in clinicians' minds when thinking about disclosure of trauma and trauma-focused work. The name for this theme is taken from one interview where a participant described this as *'creating the safe space' (P4, Psychiatrist)*. I understood from this that achieving sufficient safety was an important precursor to asking about trauma or offering trauma-focused interventions. Anxieties about the possible risk of harm resulting from trauma-focused interventions, with possible negative consequences for both service user and clinician, were also commonly expressed by participants. Finally, clinicians talked about having sufficient skills to safely ask about trauma and deliver trauma-focused interventions. Illustrative quotations for each of the subcategories are included in Table 3.

Achieving Sufficient Safety

Clinicians' talked about what they conceived to be pre-requisites for it to be sufficiently safe to ask about trauma or start trauma-focused interventions. The timing of interventions was important and treatment might be delayed until someone reached this pre-requisite of sufficient safety. Determining whether it was the right time to start treatment was a clinical judgement for which there were no definitive criteria. Clinicians described considering service users' affective regulation skills and coping strategies; the acuteness or chronicity of their clinical presentation; the existence of a supportive environment including supportive social networks, community and clinical resources; and the relational safety of the therapeutic relationship. These factors appeared to be

subjectively weighed-up by clinicians to inform their judgement regarding whether trauma-focused interventions could be safely facilitated and contained.

Participants described being able to address some of these barriers within clinical work to build a greater sense of safety and stability before embarking on re-processing work. Some psychologists valued utilising a stabilisation phase of treatment during which a service user's emotional regulation skills could be strengthened using grounding, self-soothing, and mindfulness techniques. Other clinicians described focussing on engagement and building a strong therapeutic relationship during early sessions, ensuring sufficient relational safety was established before proceeding to trauma-focused

Table 3: Sub-categories and illustrative quotes of Theme 3: Safe Space

Sub-category	Illustrative Quotes
Achieving Sufficient Safety	'I would…very much…use that principle that the processing comes when safety has been achieved' (P12, Psychologist) 'there are also things about the containment of the environment that actually, in some ways make it easier, so from session to session, there's more people around to help people stay safe, and support them in promoting their own safety' (P13, Psychologist) 'if she or he has the resource to deal with that during the, the trauma therapy' (P15, Psychiatrist) 'people need to first of all trust the team they work with and the professionals they work with enough […] so it's creating the safe space' (P4, Psychiatrist) 'it's important that she got a sense that she could trust me, and that we could work together, I thought we shouldn't start with the trauma, and that we should do some work on the social anxiety first' (P9, Psychologist) 'people might struggle more to accept a service from a service which has already traumatised them at their point of entry' (P3, Occupational Therapist) 'it was felt that the person would not have been able to, because of how chronic they are with their symptoms and how long-standing their illness has been' (P7, Nurse)
Potential for harm	'people worry that the process of talking through the trauma will raise so much distress that people with psychosis in particular won't be able to manage that, and therefore that it will have a knock on effect on their other symptoms say' (P10, Psychologist) 'that can have real consequences for that person's career and you know, perhaps they'll be viewed as negligent and perhaps it'll impact whether they can continue to practice' (P1, Psychologist) 'They're then self-harming and you did that…that's your fault, and there's bound to be a bit of a narrative about that' (P13, Psychologist) 'I think there's quite, a kind of naïve understanding for some care coordinators, um, that any exp- emotional expression is very dangerous and wrong, […] and um, you know, people should avoid talking about things that upset them' (P9, Psychologist) 'you've got a staff group that are also terrified of, you're gonna open up a can of worms, don't go back there either' (P18, Psychologist) 'there's something about working with trauma…um, that is…quite hard going, um and it's quite draining and there, there is a risk of vicarious traumatisation' (P10, Psychologist) 'we can only help them if we're not burnt out ourselves' (P17, Social Worker)
Clinician Skills	'we don't have the skills to contain, to handle, to respond safely, to a patient perhaps telling us something' (P17, Social Worker) 'when we've actually asked staff they've just said well yeah, we, we, we feel like we don't know how to do this' (P16, Psychologist) 'they may not therefore have the training, have the supervision, have the know-how how to do it, and…and therefore you know, none of us are gonna be doing work if we, or we shouldn't be doing work if we're not competent to be doing it, it's important that we have those competencies to be doing the work' (P10, Psychologist) 'he sits within a psychosis service, so there is always a slight kind of concern that maybe my competencies aren't there' (P2, Psychologist)

interventions. Participants recognised that developing relational safety could take time and described focussing on other aspects of a service users' distress, such as social anxiety or voice-hearing, to allow this safety to be developed.

However, clinicians acknowledged that it did not always feel possible to achieve sufficient safety. Perceived limitations to community and clinical service provision appeared to contribute to the concerns that service users were unsupported between therapy sessions and therapeutic work lacked an important safety net. Participants also acknowledged that achieving relational safety could be challenging in the context of services which had themselves been experienced as traumatic and harmful.

Potential harm

Anxieties that trauma-focused interventions could cause harm were described by many participants. Whilst anxieties expressed by service users were recognized, participants accounts emphasised the anxiety experienced by clinicians and clinical teams and this appeared to be a more prominent barrier to offering trauma-focused treatment.

Participants recognised both their own and colleagues' fears that trauma-focused interventions could cause additional distress to service users, resulting in service users becoming destabilised and their mental state deteriorating. At its most severe, clinicians expressed concern that treatment could exacerbate both symptoms of psychosis and risk of suicide. These fears appeared to be exacerbated by an incongruence between trauma-focused interventions and clinicians' conceptualization of mental health treatment (Theme 1).

The potential harm or risks to clinicians themselves appeared to confound anxieties about the risk of causing harm to service users. Participants talked to the significant emotional burden on therapists created by the evocative content and process of trauma-focused interventions: this could pose an increased risk of vicarious

traumatisation of clinicians. In addition to the emotional and psychological impact of trauma-focused interventions, some clinicians described potentially catastrophic professional and reputational consequences for clinicians if service users' mental health deteriorated or a patient attempted suicide during treatment, as described by one psychologist:

> 'that can have real consequences for that person's career and you know, perhaps they'll be viewed as negligent and perhaps it'll impact whether they can continue to practice'
> (P1, Psychologist)

Whilst these anxieties were acknowledged by all psychologists who delivered trauma-focused interventions, only two reported that these worries prevented them from offering the treatment. Research findings and personal clinical experience were identified as helping clinicians to maintain a belief in the safety and effectiveness of the intervention and tolerate these anxieties. Being supported and encouraged in delivering this work by other psychologists working in this way, as well as support from MDT colleagues, supervisors and managers, were identified ways clinicians felt enabled to deliver interventions in spite of this anxiety.

Clinician Skills

Clinicians' skills were identified by participants as important to them being able to manage and respond helpfully to disclosures of traumatic experiences. Some participants described not believing they had the skills to manage disclosures or respond in a safe, helpful and therapeutic manner. This suggested that clinicians' self-evaluations of their clinical skills may inhibit them from enquiring about and identifying traumatic experiences.

Within psychological therapy provision, clinicians described questioning their own competence in delivering trauma-focused interventions, as well as the competence of trauma-specialist clinicians in working with individuals with psychosis. Whilst some

clinicians described developing confidence in their skills over time and with increasing experience, others remained uncertain of their competencies. This suggested that clinicians' lack of confidence in their own (and other clinicians') competence working with trauma in the context of psychosis prevented service users from being offered the intervention in either clinical context.

Discussion

This study captured the unique view of eighteen members of staff and provided novel insights into the barriers and facilitators that influence the delivery of trauma-focused interventions for people with psychosis. Staff identified numerous barriers and facilitators and analysis generated a conceptualisation of three dominant themes: i) coherent understanding; ii) structural support; and iii) safe space. These themes are consistent with prior research exploring clinicians' perceptions of barriers to trauma-focused interventions in people with SMI (Salyers et al., 2004) and first-episode psychosis (Gairns et al., 2015). Findings extend the depth of our understanding of these barriers and explored the inter-relation between themes. Findings also highlight the importance of coherent understanding in translating research and theory into clinical practice within services.

Despite awareness of the prevalence and potential impact of trauma and PTSD in the lives of clients, staff reflected on limited identification of trauma and delivery of trauma-focused interventions within clinical teams. This discrepancy was understood to relate to difficulty in coherently integrating trauma, and other psycho-social factors, into a dominant medical model of illness that guided routine clinical practice within services. Clinicians' perception that trauma continues to be under-identified in clinical practice is consistent with previous findings (De Bont et al, 2015). Salyers and colleagues (2004) have previously reported that clinician knowledge about the prevalence of trauma in people

with SMI does not predict how likely they are to have discussed or documented traumatic experiences or referred clients for treatment of trauma or PTSD. Current analysis may therefore offer one explanation for why clinician knowledge regarding trauma and PTSD does not appear to predict assessment and treatment of these difficulties in clinical practice. Researchers have previously recommended that adoption of trauma-focused interventions can be enhanced via training to increase staff knowledge (Frueh et al., 2006; Salyers et al., 2004). van den Berg and colleagues (2016) previously reported that theoretical training in trauma-focused interventions was associated with a significant increase in therapist-rated credibility of the intervention and reductions in harm expectancies. However, the training package included subsequent phases of technical training and practical, supervised clinical practice. It may therefore be that theoretical training must be consolidated through practical skills development in order to embed learning and sustained use of trauma-focused interventions. Whilst staff in the study identified training as an important facilitator, it may be that training focused on increasing knowledge must be delivered in conjunction with the development of skills and a framework for integrating theory into their clinical practice in order for novel practices to be sustained.

Consistent with the previous research within early intervention services for people with psychosis (Gairns et al, 2015), safety was prominent in the minds of staff and they described needing safe space to be able to offer trauma-focused therapies. This sense of pre-requisite safety existed throughout clinical work with service users and determined whether clinicians considered it safe enough to enquire about experiences of trauma, offer trauma-focused work, and manage concerns about the potential for the treatment to cause harm. The current analysis extends the understanding of these clinical anxieties about the safety of treatment, by recognizing staff anxieties about potential harm for clinicians. The emotional burden of trauma-focused work and potential for reputational or professional

damage if a service user's mental health deteriorated during treatment further inhibited clinicians from offering treatment.

Staff described being able to tolerate anxieties about the potential for harm to themselves and service users where they felt supported by their colleagues, supervisors, managers and clinical context. This is consistent with previous findings that ongoing, high quality clinical supervision was associated with reduced therapist harm expectancies (van den Berg, van der Vleugel, et al., 2016) and that lack of perceived agency support was a barrier to trauma-focused interventions (Salyers et al, 2004). The current analysis extends previous literature to highlight that clinicians may be supported to tolerate anxieties associated with delivering these interventions by a variety of professional relationships beyond supervision. Clinicians emphasised support from colleagues across multiple professional disciplines, from management attitudes and perceived organisational culture. These supports helped clinicians to contain anxieties about patient risk in order to offer clinically-indicated treatments.

Finally, staff emphasized the importance of trauma-focused interventions being supported by structural and organizational factors such as service configuration, communication within and between clinical teams, multi-level thinking and facilitation of training. Staff in the current sample were motivated to integrate the assessment and treatment of PTSD into their clinical work with people with psychosis. However, in the absence of formalized structures and pathways to support clinicians in doing so, numerous barriers emerged to extending these practices beyond the individual or small clusters of clinicians. Previous studies have also described organizational barriers to trauma-focused interventions (Gairns et al., 2015; Salyers et al., 2004) including workload pressures, training, professional guidance and agency support. The current analysis extends these findings to consider the multiple levels at which organisational culture also influences clinicians' clinical decision making with regard to routine screening for trauma

and identification of individuals requiring trauma-focused treatments. Clinicians making treatment decisions described the influence of multiple layers of context from team, service, organisational and broader cultural context which play an active role in use of trauma-focused interventions. As such, efforts to increase the implementation of interventions need to recognise and address the active role of context in implementation outcomes, rather than conceptualise it as the passive environment in which implementation occurs (Nilsen, 2015).

Previous studies have emphasised the client-related barriers to trauma-focused interventions in people with severe mental illness (Salyers et al, 2004; Frueh et al, 2006) and psychosis (Gairns et al, 2016). These include the interference of symptoms of mental illness; client unwillingness or poor engagement; cognitive impairment or difficulty communicating symptoms and experiences. Whilst clinicians in the current analysis acknowledged the role of these barriers for some people with psychosis, they were not conceptualised to be the primary barriers to treatment. The organisational culture, structural processes and shared conceptualisation of mental illness were instead centred within clinicians' understanding of the determinants of identification of trauma and delivery of trauma-focused interventions.

Limitations

The study was successfully able to include the views of staff working in a diverse range of clinical disciplines, clinical contexts and with diverse perspectives with regard to the barriers to trauma-focused treatments for people with psychosis. Despite this, the sample was limited by the notable difficulty of including a substantial sample of commissioners and limited social work and nursing staff who traditionally fulfil the role of co-ordinating care for people with psychosis in MDTs. Further, while efforts were

made to recruit and include clinicians with diverse views regarding the clinical value of trauma-focused interventions, it is likely that positive views of treatment were dominant while negative views of treatment were voiced less. This is perhaps unsurprising in a sample of busy clinicians who volunteered their time to participate in research. As such, the narrative developed reflects a partial understanding of the barriers to the use of trauma-focused interventions for people with psychosis.

Grounded theory is a naturally iterative research methodology. The current theoretical understanding would undoubtedly be enhanced by the inclusion of perspectives from service users, carers and other key stakeholders. Staff placed significant weight on structural mechanisms that underpin their clinical practice, which service users themselves are unlikely to be aware of. Efforts were made to ground the focus of individual interviews in the experience of individual clinicians and emerging themes from memos maintained during the interview and analysis process. No questions were asked directly and explicitly enquiring about staffs' perspectives of the perspectives of people with psychosis and these did not emerge during the interview process. The silence of the voice and perspectives of people with psychosis themselves within the analysis is therefore important to acknowledge. Integration of the perspectives of service users in particular may therefore contribute to building a multi-faceted understanding of the key barriers and facilitators to this work.

Clinical and Research Implications

There are a number of clear clinical and research implications from the current findings. Staff identified a number of barriers and facilitators to delivering trauma-focused interventions to people with psychosis in clinical practice, which clustered into three areas. In order for traumatic experiences and symptoms of PTSD to be routinely identified, it is important that the clinical relevance of trauma for people with psychosis can be

coherently integrated into routine clinical practices within services. Staff have also emphasized the importance of structural factors including endorsement of management and clear pathways in facilitating ease of access to trauma-focused therapies for this population. Taken together, this suggests that increasing adoption of trauma-focused interventions requires attention at an organisational level. Valuable organisational strategies may include the provision of policy or guidance, development of service pathways, strategic emphasis on joint working and enhancing communication within and between teams. In the absence of a standardized process and pathways for the treatment of PTSD in service users with psychotic experiences, the identification of trauma continues to be left to the individual clinician. This creates a significant risk that, in the context of multiple competing clinical targets and foci, trauma is under-recognized and treated in clinical practice.

Organisational leaders and managers hoping to increase access to trauma-focused interventions within clinical services for people with psychosis need to consider both the mechanisms by which the organisation facilitates this as well as to the organisational culture to is perceived to facilitate or inhibit this. Organisational structures such as standard processes and service pathways, and the availability of screening tools to aid the routine identification of trauma (de Bont et al, 2015) may be valuable mechanisms by which practices can be embedded. Organisations must also attend to the development of a service and organisational culture that emphasises the importance of an understanding of trauma in clinical work within services. The NHS Long Term Plan (NHS England, 2019) emphasises the importance of mental health services developing towards becoming 'trauma-informed': such a cultural shift within services may be integral to services increasing the identification of trauma in this population and increase access to trauma-focused interventions moving forward.

Many clinicians described doubts about their clinical skills to safely assess

traumatic experiences and PTSD or to deliver specialist trauma-focused interventions. Given this, clinicians could be supported to develop confidence and competence through training, and staff expressed interest in doing so. Delivery of teaching in the theoretical rationale for identification of trauma and use of trauma-focused interventions could be delivered in conjunction with technical training and practical, ongoing supervised practice in order to embed learning and novel practices (van den Berg et al, 2016). Increasing clinician confidence in their skills would support staff to routinely enquire about traumatic experience and increase identification of people with psychosis who may benefit from trauma-focused interventions. Training may be helpfully delivered by colleagues from different disciplines, to develop communication between clinicians and disciplines and the development of shared language and understanding.

The proposed model offers a valuable first step in understanding the barriers to delivering trauma-focused interventions to people with psychosis. The model could be strengthened by empirical evaluation on a larger scale with a broader sample in order to explore the applicability of the model beyond the current participant sample. Quantitative methods could be utilised to investigate the relative contribution of each of the aspects described by the model in determining clinical decision making, in order to develop further insights and understanding of the how the adoption of trauma-focused interventions in clinical practice can be maximised. This may inform the development of more tailored efforts to promote the adoption of trauma-focused psychological therapies for this under-served population.

This study offers a rich exploration of the experiences of staff in delivering trauma-focused therapies to people with psychosis. Within a diverse sample of professionals, there existed a marked commonality and shared narrative regarding widespread and numerous barriers to treatment. As a result, access to these interventions continues to represent the exception rather than the rule. Attention is needed to address

the conceptual, organisational and safety-related barriers in order to increase the equitable

access to and provision of trauma-focused treatments for people with psychosis.

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Part 3: Critical Appraisal

Introduction

This critical appraisal primarily focuses on my personal reflections throughout the process of completing this doctoral thesis. It is organised in a broadly chronological manner, to represent and follow the journey through research. It starts by setting the research in context: drawing out the wider socio-political context in which the research, and my clinical training, took place and the impact of this context on me as the researcher and the research produced. The contents then proceed to parallel those documented in the reflective log I maintained throughout this research process, albeit in a more polished and intellectual manner, to document my thoughts, uncertainties, frustrations and dilemmas as a researcher.

The Context for Research – An (Extended) Statement of Positionality

Reflexivity is increasingly recognised as a key component in the conduct of high quality qualitative research (Berger, 2013). A statement of positionality offers an explicit acknowledgement of the unique perspective of researchers and is a frequently used strategy for incorporating reflexivity into the written reporting of research (Elliott et al., 1999). Such a statement offers consumers of research the opportunity to consider how this position may influence their interpretation of the data. A brief statement of researcher's position is included within the empirical component of this thesis. However, given the significant role of the researchers' position in qualitative research, this positionality is expanded upon here.

At the time of writing, I am a 27-year-old cis-gender heterosexual woman close to completing my professional doctoral training in clinical psychology. Beyond mild long-sightedness in one eye, I have experienced no disabilities either developmental or acquired. I am White British and was born and raised in a rural village in Oxfordshire

where 90% of the local population also identified as White British (Service, 2013). I come from a middle-class family, although my father would wish to emphasise his own working-class roots. As my supervisor prior to training advised me: the biggest challenge I faced being accepted onto training was to sound less like a stereotypical candidate.

The characteristics outlined above shape my experiences, my perspectives and my approach to the conduct of this research. They have offered me a privileged position whereby I am less likely than others to experience traumatic events or the daily traumas and micro-aggressions associated with being a member of a minority or marginalised community in the UK. This creates attentional biases, whereby I am less likely to be attuned to the systemic discrimination of marginalised groups and consequential experiences of trauma. As a trainee clinical psychologist, I am also likely to privilege psychological responses to distress over social, community or medical responses. Whilst I have endeavoured to be reflective and mindful to these biases in the conduct of the project, it remains important to recognise the way in which these inevitably frame the body of research.

Whilst some of the facets of my identity and perspective described above are fixed or static, others have shifted within the context of the current series of study. In particular, the qualitative research presented in this thesis represents a marked shift in epistemological position from that which I occupied when I began my doctoral studies. I entered training from a predominantly research background: I had been involved in the conduct of quantitative investigations alongside my undergraduate studies and later joined a research team examining the effectiveness of novel CBT interventions for people with paranoid beliefs and or anomalous experiences associated with psychosis. I would likely have described myself as a scientist-practitioner and would certainly have valued numbers, statistics and hard scientific evidence. I endeavoured to understand a reality that

was universal, objective and quantifiable. That is to say, my beliefs and attitudes aligned strongly with an empiricist, positive stance.

Over the course of training, I have come to appreciate the strong influence of social context on our sense of identity and our experienced reality. Through teaching, reading, reflective practice and my experiences in clinical practice I have become familiar with frameworks for considering the impact of these aspects of cultural identity (Burnham, 1993; Hays, 2008). I have valued using these in my clinical practice. This emphasis on understanding as a process of sense-making, framed by socio-cultural influences on our experience, represents a social-constructionist position. I was therefore also keen to explore how this social-constructionist position could be reflected in the conduct of research in order to capture the diversity and complexity of human experiences. Developing and furthering this understanding of how we as humans reach complex decisions seems integral to our clinical work as psychologists, and I wanted to reflect this in the conduct of my major research thesis.

Beyond my own context, this research is embedded within a wider socio-politico-cultural context. It was completed during a period of significant change, both locally within the UK and internationally. While it is not possible to capture all of the changes and their impact on the current body of research, some pertinent factors will be addressed in order to ground the research in the relevant context.

In 2010, the coalition government in the United Kingdom introduced a programme of austerity measures which resulted in a slowdown in the funding to NHS services. These measures have required decision makers to make often difficult choices in order to balance budgets, sometimes referred to as 'rationing decisions' (Kings Fund, 2017). Although an end to austerity policies was announced in 2018, the impact of this decade of measures had a profound and lasting impact on patient care (Kings Fund, 2017) as well as broader impact across social care and education services. As directly described

by some participants within the empirical paper, this extended period of austerity impacted on the experience of clinical staff working on the frontline of services and in their efforts to deliver high quality care.

Other socio-cultural changes contribute to an atmosphere of significant social change within the United Kingdom at the time of the conduct and writing of the research. Following a referendum in 2016, the United Kingdom officially left the European Union on 1st January 2020 and entered a transitionary period. At the time of writing, the terms of the continued relationship between the UK and EU are not publically known. At the time of writing, the world is also experiencing the prolonged impact of the worldwide pandemic of a novel Coronovirus-19. The pandemic has resulted in high levels of excess morbidity and many people have been personally affected by the illness. In order to control the spread of this virus, international borders have been widely closed and emergency legislation has driven lockdowns in many countries and fundamental changes to 'normal' society. The requirement for social distancing has resulted in significant changes in the way in which people work and spend their leisure time. These changes have also caused financial hardship for many individuals and organisations. There has also be a significant increase in recent public discourse surrounding systemic racism, both within the profession of clinical psychology and the growth of the Black Lives Matter movement and international protests following the death of George Floyd. All of these facets of the socio-cultural background to the current research contribute to an over-arching sense of an unsettled and shifting global and national context, which it is important to acknowledge here.

Epistemology and Research Design

The above statement of positionality is an important pre-cursor to discussion of the choices about the methodological design on my doctoral thesis. Prior to this stage of my training, the relationship between epistemology and method has been elusive and rarely discussed. However, understanding the relationship between the epistemological foundations and the methods employed are critical to the conduct of high quality, meaningful research (Darlaston-Jones, 2007).

In my empirical investigation, I sought to extend the current understanding of the use of trauma-focused psychological therapies in clinical practice with people with psychosis. The majority of research in the area involves the empirical evaluation of whether these interventions are effective in reducing symptoms of post-traumatic stress disorder (PTSD) and psychosis (Mueser et al., 2015; Steel et al., 2017; Swan et al., 2017; van den Berg et al., 2015) or whether they are used by clinicians (van Minnen et al., 2010). These studies have provided important evidence that these interventions may effectively reduce symptoms of PTSD and psychosis in this population, but that they are not frequently used in practice.

Understanding the reasons that treatments are not used is a complex issue: there are multiple influences on clinical decision making with regard to treatment for mental health difficulties such as PTSD and psychosis. Within a clinical team, decisions are indirectly influenced by the perspectives of individual clinicians, the interaction between different clinicians within the team, and between clinical staff and the people with psychosis themselves. Each of the numerous people involved in these decisions are influenced by the type of person that they are, their experiences from clinical and academic training and beyond, their culture, background, social and economic status. As such, each individual brings a unique position and perspective to the decision making process. Meaningful understanding of this process needed to emphasise the subjective

experience behind the decision to use or not to use trauma-focused treatment. Given this, answering the research question required an exploration of the experiences and perspectives of individuals rather than by quantifiable, object facts. A social constructionist position was indicated, and this informed the choice to use qualitative methods to explore the topic.

I was keen to move beyond the description of this complex process in order to develop a theory of how these decisions were navigated and understood by staff. I hoped that the development of theory or model which captured many of the barriers and facilitators to offering treatment would offer additional insights and inform efforts to increase access to trauma-focused interventions for people with psychosis. It would allow other staff involved in the commissioning and delivery of services for people with psychosis to consider how transferable results were from the context of the sample of participants and researcher, to their own settings and experiences. I therefore felt constructivist grounded theory offered a good fit with both the research question and my aims of developing a provisional theory from the research. The approach utilises a constellation of methods (Charmaz, 2014) to generate theory grounded in the experiences and perspectives of a range of stakeholders within a process. It therefore emphasises the inclusion of a diverse spectrum of perspectives, in order to characterise the complex interactions that exist within processes.

Constructivist grounded theory also emphasises the inclusion of a diverse range of participants and perspectives within the research process in order to address the complexities and tensions within the interactions. I felt that this approach therefore held particular resonance with the process of clinical decision making within mental health services in that it mirrored the confluence of multiple diverse perspectives in the decision making process. Care planning and treatment decisions are rarely developed in isolation by a single individual, and are informed by the input of a range of clinicians and non-

clinical stakeholders. This reinforced the decision to use constructivist grounded theory within the investigation.

During the initial stages of research design, the decision was made to focus on the perspectives of staff involved at different stages of the commissioning and delivery of clinical services. It was considered important to extend this sampling beyond the psychological practitioners delivering therapies within services because, as previously discussed, care planning involves clinicians from a range of clinical disciplines. As a result, only a limited proportion of people with psychosis are referred for and receive psychological assessment or treatment at all. Non-psychological clinicians were therefore able to elucidate the processes which may prevent individuals from being referred to psychological therapies. This would enrich the analysis by bringing insights into different stages of care planning, as well as the diversity of clinical training. It was also felt important to include staff at all levels of the care-planning process, including commissioners and senior managers within NHS Trusts. The decision making of senior managers and commissioners directly influences the care-planning process through the set up and development of services including development and monitoring of care pathways. Their views and experiences therefore offered a contrasting position in the care planning process, to further extend the richness of the data generated. The inclusion of staff involved throughout the service commissioning and delivery and care planning process would enrich the resulting theory of this process.

In contrast to the broaden range of staff I hoped to include in the sample, the sample did exclude other key stakeholders including most notably, the perspectives of people with psychosis themselves and their carers. In part, the decision to do so was a pragmatic decision in order to contain the work within the scope of a major research project. In part, this decision was also a methodological one whereby the perspectives of staff might be a good start to developing an understanding of this process. The theory

could be built upon and extended by future investigation of the perspectives of other key stakeholders in order to develop to enhance the richness of the theory. This is consistent with the iterative process of constructivist grounded theory (Charmaz, 2014) and the process of theoretical sampling in order to enrich data. Finally, this decision was influenced by contact with other researchers in the area. Through these conversations, I learnt that research into the use of trauma-focused psychological interventions from the perspective of people with psychosis had recently been undertaken and would shortly be disseminated. Focussing on the perspectives of clinicians was therefore considered the most appropriate for the current investigation.

Recruitment of Participants

Recruitment of a diverse sample of individuals and perspectives was considered critical to generating a meaningful analysis. This diversity could be achieved by consideration of a number of features conceptualised to be potentially important influences on staff perspectives on the topic. This could relate to the clinical training and professional disciplines participants identified with. It could also relate to the service setting: both the dichotomy of inpatient and community settings as well as the range of typical services for people with psychosis including Early Intervention services, Assertive Outreach Services and Community Mental Health teams among others. Diversity within the sample was also created by the inclusion of individuals with positive, negative and mixed attitudes towards trauma-focused interventions and those with limited understanding or experience of these interventions alongside others whose academic and clinical roles were focused on delivering them. It could relate to where staff were situated in the chain of clinical decision making: delivering psychological interventions; the coordination of care for people with psychosis; leadership of clinical teams; and within more senior leadership and commissioning roles which focused more on the wider

context surrounding clinical decision making. It could also relate to social and cultural diversity between individual people including gender, sexuality, race, nationality, religious faith. Notably, while it was important and appropriate to enquire about some of these defining characteristics, such as professional training and clinical context, it was not possible or desirable to enquire and record all aspects of diversity, including personal characteristics. It was important that when aiming to maximise the diversity of perspectives during recruitment, and reporting these during dissemination, not to provide a reductive understanding of these factors. Therefore, simple aspects of clinical training and experience were reported in order to demonstrate the diversity within the sample and help readers to make decisions regarding the transferability of findings. It was hoped that the narrative reporting of the analysis would contribute to an understanding of the diversity, as well as marked dominance of some narratives, within the perspectives of participants.

Capturing diversity in the sample therefore required me to attend to multiple aspects of diversity simultaneously, and redirect recruitment efforts to focus on amplifying absent or less heard perspectives. These efforts have generated a diversity of voices within the sample, but there are perhaps aspects where this diversity could have been strengthened. Whilst clinical staff came from a diverse range of clinical settings and services, psychologists comprised a significant proportion of the sample. While I had hoped to include a strong voice of commissioning staff in the investigation, only one agreed to participate. A second commissioner initially agreed to be interviewed, while declaring a lack of knowledge about trauma-focused interventions and later stopped responding to attempts to organise an interview. Further, all but one of the participants in the sample endorsed that trauma-focused therapies could be valuable for people with psychosis, indicating that negative or ambivalent perspectives towards treatment were less voiced in the current sample. This is perhaps not a surprise, given that busy staff who do

not consider trauma-focused interventions to be valuable are less likely to engage in and participate in research on the subject. The resulting limitation within the diversity of participants' perspectives may be reflected in the strength of shared narratives within the current analysis whereby many participants described common experiences and perspectives. Greater inclusion of lesser heard perspectives may contribute to a richer and more complex understanding of the barriers and facilitators to treatment.

Data Collection and Analysis

While completing the interviews and analysis I became particularly aware of the importance of language in the construction and communication of meaning. It appeared that participants often used the same words to discuss different ideas. At times, this conflation of terms resulted in confusion and ambiguity about key concepts. At other times, people used terms with distinct meanings inter-changeably and without apparent awareness of these discrepancies. I began to wonder about the role of language within group identities and how silos of clinical specialties could be created by the development of a shared language that excluded others. Finally, I was mindful of the power of silence within the analysis and how meaningful these silences could be.

The current research involves a wealth of inter-woven terminology and relies, to a certain extent, on general consensus with regard to the definition of terms. At the core of the research is the concept of trauma. In medical use, the term trauma is often used to refer to physical injury whilst in mental health and common parlance it is often used to refer to experiences causing extreme distress. Even within psychological writing, references to trauma can have diverse definitions and be understood in different ways. Some people, including participants within current research, distinguish between little 't' traumas and big 'T' Traumas. Big 'T' Traumas are events most commonly associated with PTSD including events that are life threatening or pose a risk of serious injury or sexual

violence. Little 't' traumas typically refer to a broader category of highly distressing events which may or may not be life threatening. I became increasingly aware of the diverse use of this central term, as well as others, during the interviews and subsequent transcription and analysis. This highlighted how much meaning is communicated (or miscommunicated) through language. When people held different understandings of the words used to understand and discuss a topic, this created the opportunity for ambiguity and uncertainty, as well as complete misunderstanding between individuals. This also contributed people's understanding of the concept of trauma-focused care, which was frequently used interchangeably with trauma-informed approaches, despite key differences highlighted by the definition of these terms in the literature (See empirical paper for more detail). Thus, ambiguity and disconnect could be created by the absence of widely-held and well-defined understandings of the central terminology. Clearly defined and widely-held definitions of key terms is therefore pivotal to the progress of research regarding clinical concepts. When I became aware of this during the interview process, I decided to include a statement defining the term 'trauma-focused interventions' during the interview. I hoped that doing so would help to ensure interviews with different participants to have shared terms of reference. However, in order to continue to capture this diversity of definitions, and on consultation with the supervisory team, I chose to include this after participants had described their own definition of the term. It was important that me offering a common definition was framed as ensuring a common term of reference to ensure that participants did not feel they had been 'corrected'. Despite this, participants continued to appeared to proceed with varied definitions of trauma-focused interventions.

In thinking about the diverse use of language, I was aware that to some extent, I shared a common language with psychologists within the current study sample more than participants from other professional disciplines. As a result, I found myself more often

feeling that I understood the nuances that they articulated during interviews and inferred that they equally understood the nuances in my questions. This likely influenced the interview process itself, as I was less likely to follow up or enquire about what phrases meant with psychologists within the sample. For example, I noticed a tendency to ask psychological participants 'can you tell me more about that?', whilst I was more likely to ask non-psychological staff 'what do you mean by that?'. The slight shift of emphasis in these two questions undoubtedly influenced the information elicited between interviews conducted with psychologists and other professionals.

My awareness of these differences in language were highlighted to me during an interview with one participant in particular, approximately half way through the process of recruitment. During the interview, this participant reflected on the language barrier which prevented some people with psychosis from accessing trauma-focused psychological therapies. When we explored this idea further, he reflected on the dual meaning of this statement. He described the barrier created by the spoken language of people with psychosis whereby if they did not speak English they were less likely to be referred, accepted or engage in psychological interventions within the service. In addition, he expressed experiencing differences in the language used by psychologists compared to other clinicians within the team. While all the clinicians in his team spoke English, he was making reference to the use of terminology and shared framework held by psychologists that other clinicians found difficult to decipher. There was a sense that the professional training of different groups of clinicians created silos of practice, where each professional group had only a partial understanding of the work of the others. As such, both differences in the language, and the use of language, could inhibit effective communication between clinicians and with people with psychosis. Both therefore represented barriers to accessing trauma-focused therapies.

Finally, the process of analysis highlighted the power of silence in constructing meaning. I reflected that difficulty recruiting commissioners into the study, and subsequent lack of a strong voice of commissioners in the analysis. I felt that this left their voice and influence ambiguous and uncertain. This appeared to parallel my experiences during the clinical placements whereby I had rarely spoken to or actively engaged with commissioners, despite their defining role in shaping services. When I had enquired about attending meetings with commissioners during a leadership placement, I had been discouraged by my supervisor and informed that the local commissioners *'aren't very friendly'*. A disconnect appeared to exist between clinicians and the commissioners involved in the design and delivery of services, whereby the perspective of commissioners was muted within the clinical context. This appeared to reflect the relatively limited input of commissioner perspectives in the current analysis, which in itself appeared to have a powerful meaning.

Conducting the Systematic Review

The decision when to complete a review of pertinent literature continues to be problematic and debated within the field of grounded theory (Dunne, 2011). In their original writing, Glaser and Strauss (1967) explicitly advised against completing a review of the literature prior to conducting a grounded theory analysis. They argued that in order for analysis and theory to be truly grounded in the data, analysis should be free from existent theory and pre-conceptions. Whilst Glaser continued to uphold this perspective, Strauss later advocated for an early review of the literature (Dunne, 2011) in order to inform the direction of recruitment and investigation. In constructivist grounded theory, Charmaz (2014) advises that delaying the literature review may prevent pre-conceived ideas being imposed on analysis and encourage researchers to articulate their own ideas and novel insights.

I have adopted a pragmatic approach in the current study. An initial scoping review of the literature enabled me to develop an understanding of the gaps and limitations existing within the field. This then informed my decisions regarding methodology and helped me to articulate the proposed body of research for approval by the university and ethical boards. However, I chose to delay the full systematic review regarding the broader literature around the topic until after the analysis had been completed. This allowed me to first articulate the core insights and implications truly grounded in the original analysis. The later conduct of the literature review highlighted common narratives across the literature, without these being artificially imported into the analysis.

Despite this decision to delay the full review of the current literature, it is important to acknowledge that the literature will still have influenced the current study and analysis. Many participants either personally interested in or a component of their professional role included active efforts to increase access to trauma-focused interventions for people with psychosis. As such, many participants were well aware some of the existing literature surrounding the topic, and many drew upon a range of theoretical frameworks in describing their experiences and perspectives. Existing theories and hypotheses therefore likely entered into the current analysis by means of participants discussing these during interviews. While this may confound the analysis with pre-existing theoretical understandings, it also contributes to a richness within the data. Participants discussion of theoretical models that influenced their practice or work may draw attention to which theory is valued and adopted into clinical and managerial thinking, in contrast to other writing which was less considered within the data collection process.

Conclusions

This critical appraisal has described some of my reflections and dilemmas during the conduct of the doctoral research, in the style of a reflective log. It has considered the impact of my own cultural identity, as well as my beliefs and experiences, in shaping the research process and product. Further, it has grounded the work within the current socio-politico-cultural context, which may be important to aid the understanding of research by readers within different cultural contexts and time periods. It has discussed the links between the epistemological positioning of current research and decisions about the design and methods adopted during the process. It has also considered the challenges of recruiting a truly diverse sample and the impact of that on the resulting theory. It has considered the use of language to create and communicate shared meaning, both between individuals and communicating concepts more generally. Finally, it has considered the timing of the systematic literature review in relation to the generation of truly grounded theory. I hope these reflections offer insights to others embarking on the research process, as well as helping to give additional context to the research product beyond that which can be included in the earlier chapters.

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Appendices

Appendix 1: List of Commonly used Abbreviations in Paper 1 and 2
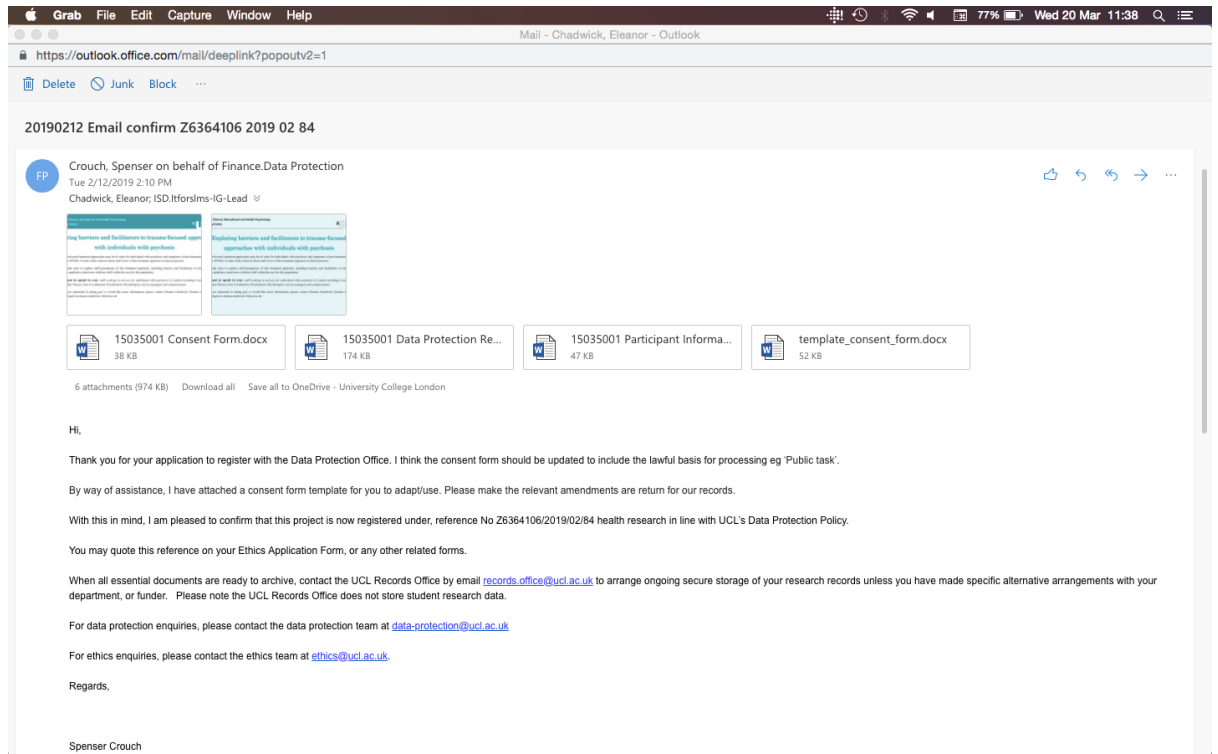
EMDR …………………………..Eye Movement De-sensitisation and Reprocessing

MDT…………………………………………………….Multi-Disciplinary Team

NICE…………………………..The National Institute for Health and Care Excellence

PE………………………………………………………...Prolonged Exposure

PTSD…………………………………………… Post-Traumatic Stress Disorder

RCT …………………………………………..Randomised Controlled Trial

SMI………………………………………………………… Severe Mental Illness

Tf-CBT ………………………….Trauma-focused Cognitive Behavioural Therapy

Appendix 2: Literature Review Search Strategy

1. (intervention* or treatment* or treating or therap* or psychotherap* or psycholog*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

2. (qualitative or formative or depth or structured or interpretative or phenomenological or narrative or experiential or grounded or discourse or preliminary).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

3. ((clinician* or psychologist* or psychotherapist* or therapist* or physician* or 'mental health personnel' or counselor* or 'health care professional*') adj7 (perspective* or perception* or experience* or description* or interview*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

4. (anxiet* or anxious or depress* or psychosis or schizophrenia or psychotic or 'post traumatic stress disorder' or 'mental health' or 'mental illness' or obsessive or OCD or PTSD).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

5. exp Implementation Science/

6. (implement* or barrier* or facilitat* or challenge* or constrain*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

7. 5 or 6

8. 1 and 2 and 3 and 4 and 7

Appendix 3: Confirmation of Ethical Approval

Project Registration with Data Protection Officer

Email screenshot:

20190212 Email confirm Z6364106 2019 02 84

Crouch, Spenser on behalf of Finance.Data Protection
Tue 2/12/2019 2:10 PM
Chadwick, Eleanor; ISD.Itforslms-IG-Lead

Attachments:
- 15035001 Consent Form.docx — 38 KB
- 15035001 Data Protection Re... — 174 KB
- 15035001 Participant Informa... — 47 KB
- template_consent_form.docx — 52 KB

6 attachments (974 KB)   Download all   Save all to OneDrive - University College London

Hi,

Thank you for your application to register with the Data Protection Office. I think the consent form should be updated to include the lawful basis for processing eg 'Public task'.

By way of assistance, I have attached a consent form template for you to adapt/use. Please make the relevant amendments are return for our records.

With this in mind, I am pleased to confirm that this project is now registered under, reference No Z6364106/2019/02/84 health research in line with UCL's Data Protection Policy.

You may quote this reference on your Ethics Application Form, or any other related forms.

When all essential documents are ready to archive, contact the UCL Records Office by email records.office@ucl.ac.uk to arrange ongoing secure storage of your research records unless you have made specific alternative arrangements with your department, or funder.   Please note the UCL Records Office does not store student research data.

For data protection enquiries, please contact the data protection team at data-protection@ucl.ac.uk

For ethics enquiries, please contact the ethics team at ethics@ucl.ac.uk.

Regards,

Spenser Crouch

18th June 2019

Dr Amanda Williams
Clinical, Educational and Health Psychology
UCL

Dear Dr Williams,

Notification of Ethics Approval with Provisos
Project ID/Title: 15035/001: "Exploring barriers and facilitators to trauma-focussed approaches with individuals with psychosis"

I am pleased to confirm in my capacity as Joint Chair of the UCL Research Ethics Committee (REC) that I have ethically approved your study until **18th June 2020.**

Ethical approval is also subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'
http://ethics.grad.ucl.ac.uk/responsibilities.php

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report
At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

Appendix 4: Participant Information Sheet

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Participant)Information)Sheet)for)Research)Studies)

UCL Research Ethics Committee Approval ID Number:

Title of Project	**Exploring barriers and facilitators to trauma-focussed approaches with individuals with psychosis**
Department:	Department for Clinical, Educational and Health Psychology
Name, Address and Contact Details of Researcher:	Eleanor Chadwick 1-19 Torrington Place, WC1E 7HB Eleanor.chadwick.14@ucl.ac.uk
Name, Address and Contact Details of Principal Researcher:	Dr Jo Billings Division of Psychiatry, Maple House, 149 Tottenham Court Rd, W1T 7BN j.billings@ucl.ac.uk
	Dr Amanda Williams Department for Clinical, Educational and Health Psychology 1-19 Torrington Place, WC1E 7HB Amanda.williams@ucl.ac.uk

We would like to invite you to take part in a research project. Before you decide it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the aim of this research?

This research seeks to better understand staff perceptions regarding the use of trauma-focused approaches with individuals with psychosis including the barriers and facilitators to such work.

Individuals with psychosis have an increased risk of experiencing traumatic events and meeting the diagnostic criteria for post-traumatic stress disorder (PTSD). Trauma-focused approaches including psychological therapies may be of value for individuals with psychosis and a co-morbid presentation

What if something goes wrong?

If you are unhappy with anything that happens during the course of your participation in this study, you can raise this with the researcher or Principal Researcher. The Principal Researcher for this study is Dr Jo Billings. She can be contacted via email at j.billings@ucl.ac.uk

If you do not feel that your concerns have been adequately addressed by researchers, you can contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk

Will my taking part in this study be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential.

In order to ensure the identity of participants is protected, we use a technique called peudonymisation. This means that, when you consent to take part, you will be assigned a participant number. This number is used to replace identifiable information (in this case your name) and only the research team will be able to identify participants.

Transcriptions will be completed by researchers listed above and research staff bound by a data protection agreement. Audio files will be deleted at the end of the research project (no later than September 2020) and written transcriptions will be deleted following publication of the research (no later than September 2021). You can also request that your data including these files are deleted at any stage by making a request to the research team.

You will not be able to be identified in any ensuing reports or publications resulting from this research. Short quotations from interviews will be used to help to show that the themes identified by researchers during analysis are a true reflection of the views of participants. Where quotations are selected for use, these quotations will be referred to using participant number and professional background (e.g. pt 6, social worker). Quotes will not be selected where their content may indicate the identity of the participant. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

To help us maintain the confidentiality of yourself and your clients, we ask you not to reference any personally identifiable details of yourself and your clients during the interview (e.g. names or addresses). We will remind you of this at the start of the interview.

Please note that confidentiality will be maintained as far as it is possible, unless during our conversation I hear anything which makes me worried that someone might be in danger of harm, I might have to inform relevant agencies of this.

What will happen to the results of the research project?

The current research is undertaken as part of the researcher's doctoral training in clinical psychology. The results will therefore be written up for submission by the summer of 2020. The results are intended to be submitted for publication in an academic journal after this.

The thesis will be available once completed via the UCL discovery website. Please inform the researcher if you would like a copy of this sent to you by email or post.

Local Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice click here

The categories of personal data used will be as follows:

> **Name**
> **Email address**
> **Age**
> **Professional Training**
> **Clinical Focus of Current Team**

The lawful basis that would be used to process your *personal data* will be performance of a task in the public interest.

Your personal data will be processed so long as it is required for the research project. We will undertake pseudonymisation of data in order to protect your confidentiality and endeavour to minimise the processing of personal data wherever possible.

All data collected during the study will be deleted following the publication of the research and no later than September 2021.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Thank you for reading this information sheet and for considering to take part in this research study.

Appendix 5: Informed Consent Form

Consent Form for Participants

Title of Project	Exploring barriers and facilitators to trauma-focussed approaches with individuals with psychosis
This study has been approved by:	UCL Research Ethics Committee
Project ID Number:	**15035/0018**

Participant's Statement

I .... agree that I have

- Read the information sheet and/or the project has been explained to me orally;
- Had the opportunity to ask questions and discuss the study; and
- Received satisfactory answers to all my questions or have been advised of an individual to contact for answers to pertinent questions about the research and my rights as a participant and whom to contact in the event of a complaint.

I understand that I am free to withdraw from the study without penalty if I so wish.

I consent to my interview being audio recorded and understand that brief quotations from the interview may be included in subsequent publication of this research. I understand that any quotations will be presented anonymously but in connection with my generic professional role (e.g. psychiatrist, social worker). Identifiable quotations will be excluded from dissemination.

I understand that my personal data will be handled in accordance with the General Protection Regulations (2016) as outlined in the information sheet and that according to data protection legislation, "public task" will be the lawful basis for processing personal data. I consent to the processing of my personal information for the purposes of this study only and that it will not be used for any other purpose.

Signed: Date:

Investigator's Statement

I .... confirm that I have carefully explained the purpose of the study to the participant and outlined any reasonably foreseeable risks or benefits (where applicable).

Signed: Date!

Appendix 6: Demographics Questions

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Demographics Form

Participant ID ……………………………………….

Interview Date ……………………………………….

Age ……………………………………….

Professional Affiliation
- ! Psychiatrist
- ! Psychologist
- ! Psychotherapist
- ! Social Worker
- ! CPN – Psychiatric Nurse
- ! Care Co-ordinator
- ! Commissioner
- ! Manager

Other (please specify) …………………………….

Current Team
- ! Early Intervention
- ! Recovery and Rehabilitation
- ! Community Mental Health Team
- ! Assertive Outreach
- ! Commissioning

Other (please specify) ………………………………

Time in Current Role (Yrs) …………………………………………

MH Experience (Yrs) …………………………………………

!

Appendix 7: Interview Schedule

Thank you for agreeing to meet with me today to talk about 'trauma-focussed approaches in psychosis'. Maybe I could start by asking what you understand is meant by the term 'trauma-focused approaches in psychosis'?

In your experience, what factors influence whether you (or your service) adopt this approach with clients?

I wonder if you can give me an example of where you or your service have used this approach:

- -! What influenced your decision to use this approach?
- -! What made it possible to do this?
- -! Were there any barriers/issues which arose in trying to do this?

Are there times when you/your service have chosen not to use this approach?

- -! What influenced your decision not to use this approach?
- -! Were there any barriers/issues which stopped you from using this approach?

Are there any considerations that make you more or less likely to adopt this approach in your work?

Possible additional prompts (areas identified in previous research)

- ☐! Are there any aspects about a **client** that would influence whether you use this type of approach with them?
- ☐! In your experience, do you feel that other **clinicians** are more/less likely to take this type of approach? Why do you think that might be?
- ☐! Is there anything about the level of team, service, trust, national health service or wider socio-political level that feeds into these treatment decisions?
- ☐! Are there any factors about the **treatment** itself that influence whether you adopt this type of approach with clients?

NB: The research adopts a Grounded Theory methodology: as a result, this initial interview schedule is anticipated to evolve during the course of the research. However, the provisional schedule below is anticipated to indicate the core focus of the interview.

Line-by-Line Open Coding

on how um, growing up in adversity causes problems for populations. And if we use that widely, the ACES study being one of them which has kind of come over to the UK but kind of it was like, this is from the eighties, and it takes so long, um, for things to penetrate. Which is fine, that's the cycle. I think that means that we are having to pay a bit more attention and do things differently...

Interviewer: Okay

Participant: ...than we were, um, the same with the move towards understanding the impact on our bodies which is, I think now why things like yoga and tai chi and QiGong and things like that are more popular. Um...than talking, that just talking therapy, but that all of those things can be incorporated into talking therapy and what psychologists do and that's definitely the direction that I've moved in.

Interviewer: I wonder, moving on then in terms of using trauma-focused approaches in your ...um, clinical practice, in your experience what factors will influence whether you do use those approaches or don't?

Participant: Hmmm, um, so [pause] obviously, kind of client engagement and the therapeutic relationship, and people having a level of kind of, functioning and stability in their life, somewhere, their social support, relationships, [breath] Um...I'd be thinking about their capacity to manage their emotions, whether they have some of that capacity or not, and you know, otherwise, how to build it, how long will that take, those kinds of things, I mean, yeah, 'cause they all feed into kind of the safety in terms of considering whether somebody is in a safe place to be able to...um...actually collaborate in and make use of a trauma-focussed intervention.

Interviewer: Can you tell me a bit more about that safety...

Participant: Well, a good..um... [gestures inverted commas] good [laughs] approach with trauma is three-phased. There's kind of establishing safety, um, which we call stabilisation, which basically involves anything that helps the person prepare for therapy and live a meaningful life in whatever way they can ...um... so that can, I mean it can literally be, it can be grounding...um...exercises, it can be behavioural activation, it can be getting them more in touch with their values, it can be...um... many things...

Participant: Connecting a bit more with their, you know whatever support, mobilising their support network, anything like that. Um, so that they've got some internal sense that the world is not all awful, and that they can cope a little bit. I work at the severe and

SOURCES ▸ Internals ▸ Transcription 01260719

Socio Political Context
Good support networks for clinicians
System level approaches
Clinician characteristics
Coding Density
Sufficient Safety
Percieved Risks
Phased Treatment Model
Stabilisation Phase

...criteria, refer to a locality team for care coordination, um whilst referring to a separate pathway for trauma-related work...

Interviewer: Okay, so is there, there's something about the system that makes that difficult?

Participant: Yeah, yeah the system in Haringey and the system generally but yeah, um, 'cause essentially the way mental health services are configured within the current NHS is uh, because of the functionalisation of services, there are kind of numerous barriers to uh, a smooth treatment pathway for people. So you might have someone who you've engaged through an assessment and it turns out that really their main need is trauma-related, um, and because of the pressure on an EI team to work to the EI standards with a very narrow focus, um, we're unable to help them, um and we effectively burn the, um, the value of the engagement. We effectively light a flame to it 'cause you've spent maybe an hour talking to someone and engaging with them, um, in a compassionate collaborative way, only to tell them, to go next door, and start again. So there, there, it's it's probably the um...biggest challenge, most distressing painful aspect of our work is um, we spend a lot of time really trying to support people to give us some sense of understanding of what um, you know, um what part of the service they need and in doing so, we um, we waste that engagement early on, and we re-inforce trauma by doing it.

Interviewer: Can you tell more about what you mean by you 'reinforce trauma by doing that'

Participant: I support, I, in relation to help-seeking, I think you know when people are asking for help and support, um, and sharing their story, um, if that is something that they've maybe struggled with, and I think most of us struggle with sharing our experiences, um, to be told following that investment or during that investment that they're not going to be worked with by you or by someone close to you, that they're going to be referred on, um, is in itself I think, you know I think it's a very traumatic experience to have touched on the emotional struggles that you have, and then, you're told 'you're not for us though, you're not the right kind of distress, we don't do that sort of distress

Interviewer: Mhmm

Participant: Um, and you might wait for six months before you see a therapist.

Interviewer: I wonder if there are any factors that kind of, any differences you've noticed in terms of how easy or difficult different clinicians within the team find it to ask about

SOURCES ▸ Internals ▸ Transcription 03230819

Clinician characteristics
Training
Training need
We're unable to help them
functionalisation of services
Clinician skills
Coding Density
Relational Security or Relationship to Help
GOOD QUOTES

Focused Coding – Building a Framework

Name		Sources	Refere…	Created On	Created By	Modified On
▼ ◯ (In-) Coherence	🗂	3	4	29 Feb 2020 12:39	EC	19 Mar 2020 18:32
▼ ◯ A Dominant Narrative		6	6	18 Feb 2020 13:54	EC	9 Mar 2020 23:10
◯ Barriers to thinking…		2	2	24 Feb 2020 14:44	EC	9 Mar 2020 22:20
▶ ◯ BioPsychoSocial M…		7	13	18 Feb 2020 13:53	EC	19 Mar 2020 18:32
▶ ◯ Focus of treatment		9	15	18 Feb 2020 09:43	EC	19 Mar 2020 18:43
◯ If you get upset, th…		7	15	29 Feb 2020 16:11	EC	19 Mar 2020 18:32
▶ ◯ Making sense of ps…		9	34	18 Feb 2020 16:24	EC	9 Mar 2020 22:50
▶ ◯ models of care		3	3	17 Feb 2020 19:02	EC	2 Mar 2020 22:48
▼ ◯ Overwhelming pres…		9	22	19 Feb 2020 19:13	EC	19 Mar 2020 10:30
▶ ◯ Diagnosis		6	10	8 Jan 2020 21:16	EC	19 Mar 2020 18:32
▶ ◯ Diagnosis Treatm…		3	5	17 Feb 2020 20:26	EC	9 Mar 2020 21:07
◯ diagnostic overs…		2	3	9 Mar 2020 21:01	EC	9 Mar 2020 21:42
▶ ◯ it's looking at the…		2	2	18 Feb 2020 12:49	EC	9 Mar 2020 22:03
▶ ◯ Medical treatment		5	11	18 Feb 2020 09:50	EC	19 Mar 2020 18:43
◯ therapeutic work…		3	5	8 Mar 2020 17:51	EC	9 Mar 2020 21:41
◯ Perception of deficit		2	2	8 Jan 2020 18:57	EC	20 Feb 2020 20:54
▶ ◯ Service set up and l…		10	16	8 Jan 2020 18:45	EC	19 Mar 2020 18:32
◯ The pervasive silen…		4	16	6 Mar 2020 10:58	EC	19 Mar 2020 18:32
▶ ◯ Transdiagnostic		2	7	5 Jan 2020 10:04	EC	19 Feb 2020 13:49
▶ ◯ Clinician characteristics		19	252	18 Feb 2020 20:47	EC	19 Mar 2020 18:32
▶ ◯ Shift in Approaches		6	15	5 Jan 2020 10:03	EC	19 Mar 2020 18:32
◯ Being lucky		7	18	24 Feb 2020 14:51	EC	19 Mar 2020 18:32
▼ ◯ Creating a safe space to…	🗂	8	18	17 Jan 2020 17:24	EC	19 Mar 2020 18:32
◯ Being in someone's h…		1	1	20 Feb 2020 20:31	EC	20 Feb 2020 20:31
◯ Clinicians feeling cont…		2	2	6 Mar 2020 14:36	EC	9 Mar 2020 14:22
▶ ◯ Coping Skills		9	25	5 Jan 2020 10:37	EC	19 Mar 2020 18:32
◯ Functioning		3	3	5 Jan 2020 10:32	EC	19 Mar 2020 18:32
▶ ◯ Good support networ…		16	79	17 Feb 2020 21:15	EC	19 Mar 2020 18:39
◯ Interfering factors		4	5	17 Jan 2020 17:26	EC	9 Mar 2020 14:53
◯ More staff around		3	5	20 Feb 2020 20:01	EC	19 Mar 2020 18:32
◯ People are trying to sa…		2	5	6 Mar 2020 13:09	EC	19 Mar 2020 18:39
▶ ◯ Percieved Risks		18	268	18 Feb 2020 12:00	EC	19 Mar 2020 18:39
▶ ◯ Relational Security or…		16	171	18 Feb 2020 16:14	EC	19 Mar 2020 18:32
◯ Safety Net		3	8	6 Mar 2020 12:53	EC	19 Mar 2020 18:32
◯ Sense of Safety		8	14	20 Feb 2020 20:36	EC	19 Mar 2020 18:32
▶ ◯ Service Context		11	30	18 Feb 2020 17:59	EC	25 Mar 2020 14:45

Memo-Writing

Annotations ☐ Edit

Having completed coding a week ago and given myself time to process the information generated, my sense of an emerging model is as follows.

A three-factor venn diagram where each condition is necesary but insufficient to enable the delivery of trauma-focussed interventions to clients with psychosis. Each of these sit within a socio-polotical context and change/shift over time.

A Coherent Understanding
- Recognition of the relevance and importance of trauma in understanding a this client population presenting distress fits uncomfortably within a dominant medical model of illness. Clinicians talked of the difficulty of holding a biopsychosocial understanding of this population within 'an overwhelmingly medical model'. This also touches on how the medical model of illness informs the conceptualisation of what treatment is and the task and/or focus of both the team and individual clinicians (link with structural factors below)
        Relevant quotes include
            'the overwhelming presence of the medical model, the overwhelming presence and the overwhelming faith to chemistry' p5
            'with psychosis, the path has always been kind of, antipsychotics first, and then psychological interventions second' p14
            'psychiatric professionals were always quite reluctant to acknowledge trauma and that kind of drive of having trauma introduced into the, the debate very often regularly came from outside' p4
            'I think a trauma-informed model, just the research on trauma and psychosis is a difficult one for those who believe that psychosis is an organic, degenerative brain disease' p11
            'I sometimes feel it's a bit like when you quantum physics you need more than one model to describe what's happening in full, you need to use the particle model and a wave model, and in a way that's how I would say is a, that's happening in psychiatry in general, but also very much in the connection between trauma and psychosis' p4
            'I discovered about how trauma can affect mental health and how sometimes, er, we just label people with, with a diagnosis but actually, maybe it's just an expression of the traumatic experience' p15
            'So I think some psychologists have felt very much like lone soldiers, fighting a...um, a different formulation, different story that what the rest of the team are, are saying, you know and I hope that's changing' p10

- At an individual client-centred level, this factor refers to a full, comprehensive

SOURCES ▸ 📝 Memos ▸ 📄 Coherent Understanding, Structural Factors and a Safe Space for Trauma

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Annotations ☐ Edit

In order to offer trauma-focussed treatment, the team need to identify the need for trauma-focussed work.
    - Requires identification of trauma
    - Coherence/perceived relevance to treatment (and therefore consistent with model of illness)
    - Skills and time to ask about trauma
    - Definition of terms - ambiguous use of terms

Once the presence of trauma has been established, the team must have the clinical skills and resources to offer a trauma focussed intervention

All of this sits within the interacting contexts of service delivery models/pathways and models of illness (medical vs psychosocial understanding).

Key fears to asking/identifying trauma include:
    - clinicians feeling out of their depths, (the safety of encouraging disclosure).
    - clinician skills to ask/manage (we're only as good as the skills we have)
    - what to do with the information (once asked, we never start the conversation).

Systemic barriers to offering appropriate trauma focussed interventions often overlooked. Discussions normally centre around client barriers, but there are extensive barriers PRIOR to this.

Key emerging idas:
    - a lack of understanding
        - ambiguous and diverse definitions of trauma
        - ambiguous and diverse definitions of key terms - trauma focussed, trauma informed