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The Staff Views About Assessing Voices Questionnaire: Piloting a Novel Socratic Method of Evaluating and Training Multidisciplinary Staff's Cognitive Assessment of Patients' Distressing Voices

Raune, D., Perkins, S., Paradisopoulos, D., Zsofia Bote, O., Skacel, P., Souray, J. and Hazell, C.M.

The Staff Views about Assessing Voices Questionnaire (SVAVQ): Piloting a novel Socratic method of evaluating and training multidisciplinary staff's cognitive assessment of patients' distressing voices.

1   Abstract:

Cognitive features of auditory hallucinations (voices) have important clinical significance and their assessment is vital for cognitive behaviour therapy to be more widely deployed by multidisciplinary staff. Using a new Socratic instrument - The Staff Views about Assessing Voices Questionnaire (SVAVQ) - we surveyed a community Inpatient Rehabilitation multidisciplinary workforce's ($N = 50$) assessment and attitude towards asking cognitive questions about patients' voices. We found that there were many clinically important gaps in what staff asked about in relation to cognitive features of voices. We identified a range of beliefs the staff hold that may prevent assessment of voice cognitive features. However, after attending the Socratic SVAVQ interview, 84% of staff said they planned to ask patients more questions about cognitive features of patients' voices. Research could now test if other psychosis services neglect the assessment of important cognitive features of patients' voices and if staff Socratic questioning improves their cognitive assessments.

1.1   *Abstract word count:*

150.

2   Keywords:

cognitive-assessment; cognitive-behaviour-therapy; auditory-hallucinations; voices.

3   Introduction:

Hearing distressing voices (also known as auditory verbal hallucinations) is common amongst patients using Psychiatric Rehabilitation services (Care Quality Commission (CQC), 2018). The experience is largely associated with psychosis disorders (American Psychiatric Association, 2013; World Health Organisation (WHO), 1992) with 60% of people with psychosis experiencing distressing voices (McCarthy-Jones et al., 2017); but voices also feature in a range of other serious mental illness (SMI) diagnoses (Waters et al., 2012). The distress associated with hearing voices can be understood in the context of a cognitive behavioural framework (P. Chadwick & Birchwood, 1994). That is, exploring what beliefs patients' attach to their voices (e.g. Birchwood & Chadwick, 1997) and understanding the voice-content and its meaning (e.g. Romme, Honig, Noorthoorn, & Escher, 1992) has therapeutic value.

Despite evidence for its effectiveness, access to cognitive behaviour therapy (CBT) for the symptoms of psychosis is poor (Haddock et al., 2014; Schizophrenia Commission, 2012); with one of the most consistently reported barriers to access being a lack of trained staff (Ince, Haddock, & Tai, 2015). Researchers have therefore explored ways of including the wider clinical team (i.e. staff other than clinical psychologists and qualified Cognitive Behaviour Therapists) in the delivery of such interventions. For example, training frontline staff (Naeem et al., 2016; Waller, Garety, Jolley, Fornells-Ambrojo, Kuipers, Onwumere, Woodall, Emsley, et al., 2013), and mental health nurses specifically (Malik, Kingdon, Pelton, Mehta, & Turkington, 2009; Turkington et al., 2006; Turkington, Kingdon, & Turner, 2002) to deliver brief forms of CBT for psychosis (CBTp) more broadly.

In line with the symptom-specific approach to psychosis (Chadwick, Birchwood, & Trower, 1996; Lincoln & Peters, 2018), similar brief CBT-based interventions specifically targeting distressing voices that are also delivered by non-Psychologist mental health professionals are currently being tested (Hayward et al., 2020). However, moving from interventions for psychosis more broadly to those for voices specifically brings the additional barrier of clinicians having difficulties talking to their patients about voices (Hazell et al., 2018).

Historically, clinicians were actively discouraged from talking to their patients about voices (Woods, 2013).Voices were not considered to be real, and that talking about voices would only encourage the patient and prolong their symptoms (Martin, 1987).This issue is still pervasive in services today. Patients report feeling frustrated with mental health teams who refuse to ask questions about their voices (Coffey & Hewitt, 2008). Even in specialist psychosis services, like Early Intervention Services (EIS), staff do not routinely discuss voices with their patients, and generally lack confidence in having such conversations (Bogen-Johnston, deVisser, Strauss, & Hayward, 2020). The stigma associated with hearing voices means that patients are unlikely to volunteer information about voices (Bogen-Johnston, de Visser, Strauss, Berry, & Hayward, 2019; Vilhauer, 2017). The fear of disclosure and reluctance from clinicians to ask about voices can prevent access to the appropriate treatments (Hazell et al., 2018) and prolong the distress associated with voices (Bogen-Johnston, Strauss, Hayward, Strauss, & Hayward, 2019).

Assessment of voices is vital to inform cognitive behavioural and psychosocial interventions to treat and care for patients who hear them (NICE, 2014). Working in Psychiatric Rehabilitation settings involves high levels of patient face-to-face contact and are therefore well-placed to talk to patients about their voices. It is therefore important to learn about these clinicians' current behaviour when it comes to talking about voices, as well as understanding their attitudes towards such discussions and whether they are open to improving their behaviour with patients.

3.1   Objectives:

The present project had the following objectives: (1) identify what cognitive questions clinicians currently ask their patients about their voice-hearing experiences; (2) identify how important staff think it is to ask about each aspect of patients' voices; (3) determine whether staff experience or profession is associated with the frequency of questions or importance of asking; (4) identify what are the perceived benefits and the barriers preventing clinicians from asking their patients about their voices; and (5) ascertain whether asking clinicians about their current practices leads to improved willingness to conduct more comprehensive voice-hearing assessments in the future.

4   Method:

4.1   Setting:

The setting was a 24-hour staffed Community Inpatient Psychiatric Rehabilitation service that spanned two sites in Harrow, London, United Kingdom. The service accepts patients aged over 18 who have a psychiatric diagnosis given by a qualified Psychiatrist, have shown a treatment resistance course (at least two years), and experience functional deficits in everyday life management. Patients typically spend at least two years in the service.

4.2   Design:

The present project used a structured interview design. Data was collected over a 10-month period. The interviews were guided by the Staff Views about Assessing Voices Questionnaire (SVAVQ). Interviews were conducted one-on-one with a member of the Audit team and a staff clinician.

4.3   Participants:

We sought to interview all the clinicians working in the Harrow Community Inpatient Psychiatric Rehabilitation mental health service within CNWL Trust. In total we interviewed 50 clinicians (out of a possible 52, 96%); 32 of which were female (64%). On average, clinicians were aged 41.16 years (SD = 12.00), had worked in CNWL for 4.56 years (SD = 4.30), and had 8.19 years (SD = 7.96) experience of working with voice hearers. The staff sample were ethnically diverse (including Black 54%, White 22%). The sample includes clinicians working in a range of professions, but most were working in nursing (nursing: n = 25 (50%); occupational therapy: n = 8 (16%); healthcare assistant/support worker: n = 13 (26%); management: n = 2 (4%); other: n = 2 (4%)).

We obtained the sample characteristics of all 53 patients who heard voices in the service as identified via their health records and staff consultation. On average, these patients were aged 51.47 years (SD = 14.94). Most of the patients were male (n = 34 (62%), White (n = 34 (64%), and had a diagnosis of Paranoid Schizophrenia (n = 35 (66%); Schizophrenia: n = 9 (17%); Schizoaffective Disorder: n = 2 (4%); Other Schizophrenia subtype: n = 6 (11%); Other: n = 1 (2%)).When clinicians were asked if

the patient(s) they were involved with were currently actively hearing voices, 37 (70%) were definitely currently active (probably active: $n = 5$ (9%); not active: $n = 9$ (17%); unknown: $n = 2$ (4%)).

4.4 Procedure:

The Steering Group for the Clinical Audit comprised the Clinical Psychologist (DR), the Consultant Psychiatrist (PS), and Rehabilitations Managers (GB and SN). The Steering Group were not interviewed themselves as the audit was focused on the multidisciplinary team who spend many hours in face to face contact with the patients. All non-Steering Group staff working face-to-face in the Harrow Rehabilitation service in CNWL Trust were told by Management to complete a structured interview discussing their experiences of working with voice-hearers on their current caseload as part of this mandatory Clinical Audit. Staff participation in this Clinical Audit was therefore compulsory, but permission to publish the staff results was optional, as was agreement to audiotape a subsample of staff for inter-rater-reliability purposes. The interview was based on the Staff Views about Assessing Voices Questionnaire (SVAVQ) developed specifically for the purpose of this Clinical Audit. The SVAVQ was completed by clinicians during their working hours at their place of work.

4.5 Staff Views about Assessing Voices Questionnaire (SVAVQ):

The SVAVQ was developed by the first author (see Appendix for a copy of the full measure). The instrument uses a Socratic questioning method to assess and train staff. By including questions about staffs' views on the importance of asking about each aspect of voice hearing, and then asking if the clinician believed assessing the feature was important, the interview schedule created the potential for a cognitive dissonance staff training component within clinicians i.e. highlighting differences between their *actual* work performance versus their beliefs regarding their *desired* staff practices. In addition to learning about clinicians' assessment of voices, the goal of the SVAVQ is to encourage staff to improve the consistency and completeness with which they assess voice-hearing in their patients. Interview items required both yes/no responses ("do you ask patients about this") and for clinicians to rate their agreement about the importance of asking, using a 5-point Likert scale (0 = strongly

disagree; 4 = strongly agree). The SVAVQ began with demographic questions, followed by 4main subsequent sections.

4.5.1   Staff demographics:

Staff were asked about their personal demographics, as well as information about their role in the service and clinical experience.

4.5.2   Staff views about barriers to themselves asking patients about voices:

In the first SVAVQ section, clinicians were asked the extent to which they agree with a set of barriers to talking with patients about their voice-hearing experiences. Clinicians were asked for the patient names they had asked about voices and to identify where in the patients' health records this conversation would have been officially recorded. The purpose of collecting this information was to be able to potentially verify the responses given by staff, and thereby encourage staff to give accurate responses.

4.5.3   Staff behaviour and attitudes about each voice aspect:

In the second SVAVQ section, clinicians were asked about 36 different aspects of voice hearing, divided across 5 topic areas (i.e. factors that influence voices, topographical characteristics, voice content, beliefs about voices, and reactions to voices). The 36 aspects were based on the common themes included in patient-focussed hallucination measures (Waters & Stephane, 2015). They were asked: (i) whether they usually ask their patients about that aspect of voice hearing with a yes or no response; and (ii) irrespective of what they are currently doing, the extent to which they agreed that they should be asking patients about this.

4.5.4   Staff views about benefits of themselves asking patients about voices:

Similar to the first part of section one, clinicians were asked to rate the extent to which they agreed with a series of possible benefits associated with talking about voices.

4.5.5   Future staff work:

In the final section, clinicians were asked what tools/paperwork could help them to consistently discuss voices with their patients. Staff were also asked if they did or did not plan to make any changes to their practice after completing the SVAVQ, and if so, what these changes would be.

4.5.6   Psychometric properties:

4.5.6.1   Validity:

The aspects of voice-hearing included in the SVAVQ were selected based on an examination of the international literature of reviews and instruments and are consistent with the current evidence base (Waters & Stephane, 2015). The SVAVQ therefore has good face validity and high construct coverage and relevant validities.

To further improve the validity of the findings of this particular Clinical Audit, clinicians were told that all of their responses would be collected anonymously and no one other than the Audit staff would know whom gave what response (i.e. management would not be told who said what). Questions were asked in a neutral manner and feedback was never given on the clinicians' answers as to approval or disapproval of any answer. Also, clinicians were asked to identify up to three specific patients who they had worked with so that their responses regarding current assessment behaviour could be verified via health records if needed.

4.5.6.2   Reliability:

To assess inter-rater reliability, authors SP and DP double coded a 20% (n = 10) convenience sub-sample of interviews. This assessment revealed only 3 item discrepancies out of approximately 4500 responses (0.07% discordant), all of which were attributed to poor quality of the audio-recording. Where discrepancies occurred, we used the original rating.

4.6   Ethics:

The present project was classified as a service evaluation by the Central North-West London (CNWL) NHS Foundation Trust and registered as a Clinical Audit/Quality Improvement project. Research ethical approval was therefore not required. All the clinicians who completed the SVAVQ gave their

written informed consent conforming to standard Trust guidelines for their anonymous responses to be published, and for their interviews to be audio-recorded for the purposes of assessing inter-rater reliability.

4.7   Analysis:

The categorical data collected via the SVAVQ (i.e. yes/no items), was reported as frequencies and percentages. The continuous data collected (i.e. Likert scale ratings), was reported using descriptive statistics. The subgroup analysis utilised chi-square analysis, t-tests (or Mann-Whitney-U tests where data were non-normal), and correlations to determine whether there were any significant differences or relationships between questionnaire responses, and clinicians' profession and level of experience.

5   Results:

5.1   What voice-related questions do clinicians currently ask their patients?

Table1 shows the frequency with which staff reported asking patients about different aspects of voices. The most frequently asked questions by clinicians were whether the voices patients heard issued commands (82%) and whether the content of the command was related to harming oneself or another (82%). Equally as common were questions related to patients' voice-related coping strategies (82%). The questions asked least frequently were related to the clarity of the voice (28%) and beliefs about the factors maintaining voices (28%). Most staff asked at least one question within each topic area. The most neglected area of questioning were items related to the factors influencing voices, whereas the topic that received the most comprehensive assessment was the content of voices.

5.2   What voice-related questions do clinicians believe they should ask their patients?

Clinicians generally agreed that they should ask their patients all of the questions included in the SVAVQ (see Table 1). That is, all average scores were above 3 (slightly agree). The items most strongly endorsed were questions related to whether the patient heard commands ($M = 3.92$; $SD = 0.34$), and whether these commands ($M = 3.98$; $SD = 0.14$)or voices ($M = 3.98$; $SD = 0.14$)more generally contained any harm-related instructions/content. These three items were also the only

questions where none of the clinicians disagreed with their inclusion in voice-related assessments (i.e. zero disagreements). The items with the least agreement were related to maintenance factors (M = 3.42; SD = 0.84), the perceived benefits of voices (M = 3.28; SD = 1.07), and how optimistic they were that voices will improve in the future (M = 3.12; SD = 1.22).Similarly, when asked which items they should not ask their patients, items related to maintenance factors and the benefits of voices were the most frequently identified, in addition to asking about the volume of voices. All staff thought that at least one question should be asked from each of the topic areas. The topic with the largest number of clinicians supporting its use was the 'influences' section.

5.3   Sub-group analysis:

5.3.1   How does clinicians' current behaviour and beliefs about asking questions vary according to profession?

We compared the frequency with which questions were asked between nurses (n = 23) and all other professions (n = 27). The results of chi-square analyses revealed that, compared to other professions, nurses were significantly more likely to ask patients about the number of voices heard (B4; $\chi2$ = 5.06, p = .02), whether multiple voices are heard simultaneously (B10; $\chi2$ = 5.06, p = .02), the gender of the voices (B11; $\chi2$ = 4.18, p = .04), beliefs about the cause of voices (B18; $\chi2$ = 5.27, p = .02), whether there are any delusional beliefs related to the voices (B24; $\chi2$ = 5.06, p = .02), and voice-related coping strategies (B30; $\chi2$ = 5.38, p = .02). In terms of beliefs, nurses reported a stronger agreement that questions around voice clarity should be asked (B8; Z = -2.66, p = .01). All other analyses were non-significant (p > .05).

5.3.2   How does clinicians' current behaviour and beliefs about asking questions vary according to experience?

5.3.2.1   Experience of working in a rehabilitation service:

Currently asking patients about the identity of the voice they heard was significantly associated with working in the rehabilitation service for a longer duration (B23; t = 4.39, p < .001).Also, there was a negative correlation between years of experience working in rehabilitation services and agreeing that

patients should be asked about whether voices are stopping them from achieving their goals (B36; r = -.31, p = .03). That is, those with greater experience were less likely to support asking patients how voices are preventing them from achieving their goals. All other analyses were non-significant (p > .05).

5.3.2.2 Experience of working with voice hearers:

Currently asking patients whether voices generally (B15; t = 2.37, p = .02) or command hallucinations specifically (B16; t = 3.98, p < .001) contained any harm-related content was significantly associated with greater experience working with voice-hearers. Moreover, clinicians who had greater experience working with voice-hearers were less sure about the value of asking patients about the factors driving the valence of voice content (B3; r = -.30, p = .04).Those with a greater level of experience were also more likely to generally feel they knew what questions to ask patients who hear voices (A3i; r = -.32, p = .02). All other analyses were non-significant (p > .05).

5.4   What are the barriers and benefits to asking patients about their voices?

5.4.1   Barriers:

Generally, few barriers were endorsed by clinicians. The most frequently endorsed barrier with the greatest level of agreement was that patients will not disclose whether they hear voices or not (36%; M= 1.44; SD = 1.18); followed by staff not knowing what questions to ask (26%; M = 1.02; SD = 1.33). Only a few members of staff believed that talking about voices was not a part of their job (4%; M = 0.16; SD = 0.55), didn't know where to document this information (6%; M = 0.18; SD = 0.66), or thought talking about voices was a waste of time (6%; M = 0.26; SD = 0.69). On average, each clinician endorsed one barrier. See Table 2.

5.4.2   Benefits:

The number of benefits endorsed by each clinician was greater than the number of barriers, with 6 benefits (compared to 1) endorsed on average by each staff member. The most frequently endorsed benefits, with the strongest level of agreement, were that talking about voices with patients shows

them that staff care (98%; $M = 3.78$; $SD = 0.55$), can aid the development of effective care plans(98%; $M = 3.92$; $SD = 3.40$), and improve risk management(98%; $M = 3.88$; $SD = 0.52$). The benefit with the least agreement was that talking about voices can reduce distress. See Table 2.

5.5 *How do clinicians intend to change their practice moving forward?*

When asked if clinicians will be changing their behaviour in anyway after completing the SVAVQ, 42 (84%) said yes, they would, with 7 (14%) saying no and 1 (2%) not sure. For those staff who said they did plan to make a change: (i) 11 (22%) would ask more questions about what influences a voice ('influences'); (ii) 24 (48%) would ask more about voice topography ('topography'); (iii) 14 (28%) would ask more about the content of voices ('content'); (iv) 13 (26%) would ask more about the beliefs patients have about their voices ('beliefs'); and (v) 13 (26%) would ask more questions about how the patients reacts to the voice ('reactions').

When asked what tools would help them to have talk about voices with patients, clinicians largely supported the implementation of a checklist of voice-related topics in case notes ($n = 48$; 96%), a training module on voice assessment ($n = 48$; 96%), and a training module on voice intervention ($n = 47$; 94%). Most staff also liked the idea of a voice assessment form (36; 72%).

6 Discussion:

The objective of the present project was to identify what cognitive aspects of voice-hearing clinicians are currently discussing with their patients, the aspects that they believe they should be discussing, and whether these responses vary according to profession or experience. We also aimed to identify what barriers and benefits clinicians associate with talking about voices. Finally, we asked clinicians whether they planned to change their practice and what tools would help them to have more frequent and comprehensive cognitive conversations about voices with their patients. The Clinical Audit data was collected using the SVAVQ developed by the service Clinical Psychologist (DR).

The results of the SVAVQ revealed that most clinicians asked their patients about command hallucinations, coping strategies, and the role of voices in relation to risk. Command hallucinations and risk management were also the aspects of voice hearing that clinicians most often believed they

should ask. Clinicians were least likely to currently ask and also believe they should ask about factors maintaining voices. This is ironic given that the patients in Psychiatric Rehabilitation are by definition chronic in their presentation and therein likely to have entrenched maintenance cycles that require targeting. There was also less staff support for asking patients about their optimism and hope for the future. This is concerning given the high risk for suicide amongst those with psychosis (NICE, 2014; Pompili et al., 2011). The very many cognitive aspects that were not asked about by large percentages of staff represent lost opportunities to promote therapeutic relationships, improve patient self-esteem and increase staff empathy (McLeod, Deane, & Hogbin, 2002), as well as miss important sources of distress, for example, male gender of the voice (Badcock & Chhabra, 2013).

The topic areas prioritised by clinicians were largely related to risk management. Reducing risk is considered a fundamental component of clinical recovery (Le Boutillier, Chevalier, et al., 2015); but clinicians reported that managing risk is not conducive with recovery-orientated care, with risk always taking priority (Le Boutillier, Slade, et al., 2015). This conflict appears to be at play in our findings. While risk was most frequently endorsed, factors that may maintain or influence voices as well as the patients' hopes for the future were the least endorsed. Although this pattern matches those found in other studies, this does contradict the aims of Psychiatric Rehabilitation services – which are to improve quality of life, increase hope, and increase independence of their patients (Killaspy, Harden, Holloway, & King, 2005). The mismatch between service aims and current practice requires addressing.

There was some suggestion that the frequency with which clinicians asked questions and believed they should ask questions varied according to profession and experience. Nurses compared to other professions were more likely to ask several voice-related questions. Experience of working with voice-hearers and in rehabilitation services was associated with only a few differences in the number of questions asked. More experienced staff were more likely to ask about voice-related harm but ironically were less likely to ask about what life goals the voices might block for the patient, suggesting a possible element of staff therapeutic pessimism and burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). On the other hand, the benefits of hearing voices reported

outnumbered the number of barriers; with the most frequently endorsed barrier being patients' unwillingness to disclose about voices. This suggests a potential willingness to improve their practice if guided in the correct way. Indeed, most staff (84%) demonstrated a willingness to change their practice based on the content of the SVAVQ.

Clinicians are not consistently exploring the factors that may influence and/or maintain voices which opposes the core tenants of the cognitive-behavioural approach to distressing voices (Hayward, Strauss, & Kingdon, 2012). That is, within cognitive behaviour therapy for voices (CBTv) the goal is to use cognitive-behavioural techniques to target the mechanisms known to maintain and cause distress. The rationale being that addressing the mechanism should reduce the distress associated with voices. Key mechanisms within the CBTv model include: beliefs about voices (P. Chadwick & Birchwood, 1994), beliefs about the self (Fielding-Smith et al., 2015), patterns of relating (Hayward, 2003), safety behaviours (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001), and beliefs regarding compliance (Byrne, Birchwood, Trower, & Meaden, 2006). Reviews have found CBTv to be an effective intervention for patients (Lincoln & Peters, 2018; Van der Gaag, Valmaggia, & Smit, 2014). By overlooking maintenance factors in their assessment of voices, clinicians are missing out on having interactions with their patients that could have high therapeutic value.

The most strongly endorsed barrier to assessing voices was patients' reluctance to disclose information about the voices they hear. Difficulties disclosing voices is common (Romme, Escher, Dillon, Corstens, & Morris, 2009). There are several reasons why people do not disclose or delay disclosing voices. For example, difficulties recognising and acknowledging the experience, shame, stigma and feeling uncertain about how others would react (Bogen-Johnston et al., 2019). Addressing some of these barriers (e.g. stigma) requires addressing at a societal level (Hazell et al., 2018). However, the last of these (others' reactions) can be addressed more immediately within the rehabilitation service. Disclosure of voices can feel more comfortable if the hearer feels like the person they are disclosing too is likely to be understanding and non-judgemental (Bogen-Johnston et al., 2019). Normalising the experience of hearing voices (Kay, Kendall, & Dark, 2017) and having a trusting relationship with a clinician (Hewitt & Coffey, 2005) can help create an environment where

patients feel safe to discuss their voice-hearing experiences. Where clinicians perceive patients are withholding information, this may indicate a need to invest more time in developing the therapeutic alliance.

The SVAVQ uses a Socratic questioning method. In educational contexts, Socratic questioning encourages critical thinking (Yang, Newby, & Bill, 2005), and in a therapy context, it can encourage cognitive change (Padesky, 1993). This approach was coupled with cognitive dissonance – explicitly highlighting disparities between clinicians' current behaviour and what they believed to the correct practice. This disparity creates a psychological discomfort that can only be relieved through adapting behaviours to match beliefs (Elliot & Devine, 1994). Both psychological strategies appear to have worked within the current project. There was some similarity between the results obtained for current behaviour and beliefs about asking, but there were also some aspects of voice-hearing that clinicians acknowledged they should be asking about but weren't currently (e.g. clarity of the voice). Also, when asked if they planned to change their practice, the majority said they would.

6.1 *Limitations:*

Despite various measures to promote staff honesty (neutrality, anonymity, and asking for patients' names so records could be checked), some staff may have exaggerated how many cognitive features of voices they assessed. If so, this would underline even more that there are major gaps in cognitive assessment. Also, there may be other important cognitive features of voices and benefits/barriers to assessing them that we did not include in the current version of the SVAVQ.

6.2 *Research Implications:*

The results of our clinical audit suggest that the SVAVQ approach is worth testing in the context of a research study to see if other services have gaps in the comprehensiveness of their cognitive assessment of voices and whether a 'Socratic-plus-cognitive-dissonance' approach leads to actual improvement in staff's cognitive assessment of voices.

6.3 *Clinical Applications:*

All staff were able to complete the full SVAVQ, suggesting that the instrument was acceptable across disciplines and cultural backgrounds. Staff cognitive assessment training based on the particular pattern of cognitive assessment deficits is recommended. As staff support is a key facilitator of successful implementation (May & Finch, 2009), our service should consider also implementing a SVAVQ checklist as a staff memory aid. The present Clinical Audit involved an individual interview method, but the SVAVQ could also be used in a *group* format to efficiently create a cross-sectional map of the assessment behaviours and beliefs of much larger workforces. Improved assessment of voices would allow our Psychiatric Rehabilitation setting to longitudinally track the outcomes of the psychiatric rehabilitation service i.e. clinical improvement/deterioration over time. This data can inform both individual patient discharge decisions and be a marker for service evaluation effectiveness. Overall, increased assessment should lead to CBT that is more person-centred, permit a larger number of frontline staff to contribute to the delivery of psychological interventions (Douglas Turkington, Kingdon, & Chadwick, 2003; Waller, Garety, Jolley, Fornells-Ambrojo, Kuipers, Onwumere, Woodall, & Craig, 2013), and permit much easier tracking of cognitive change across time for individual patients and cohorts of patients.

6.4   Conclusion:

The SVAVQ appeared to be an acceptable, valid and reliable clinical tool for understanding clinicians' current behaviour and attitudes towards cognitive assessment of voices, as well as perhaps prompting changes to clinical practice. The staff cognitive assessment gaps identified represent a significant barrier to the expansion of cognitive behavioural interventions through the multidisciplinary workforce. Our findings require replication as part of a large-scale research study with other services.

7   Word count:

4691.

8   References:

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9   Tables:

		Total	Current behaviour		Beliefs				
			Yes	No	Likert ratings			Agree	Disagree
		n	*n(%)*	*n(%)*	*M(SD)*	*Med*	*Mo*	*n(%)*	*n(%)*
Influences:									
B1	Triggers to the voice going on and off	49	31(62)	18(38)	3.58(0.73)	4	4	N/A	4(8)
B2	What make the voice more or less intense	50	29(58)	21(42)	3.76(0.59)	4	4	N/A	1(2)
B3	What makes the voice content positive or negative	49	26(52)	23(48)	3.64(0.60)	4	4	N/A	2(4)
	NO questions in this section	48	9(18)	N/A	N/A	N/A	N/A	0(0)	N/A
	ALL of the questions in this section	48	15(30)	N/A	N/A	N/A	N/A	43(86)	N/A
	At LEAST ONE question in this section	48	39(78)	N/A	N/A	N/A	N/A	N/A	N/A
Topography:									
B4	Number of voices	50	24(48)	26(52)	3.46(0.97)	4	4	N/A	2(4)
B5	Frequency of voices	50	35(70)	15(30)	3.88(0.39)	4	4	N/A	1(2)
B6	Duration of voices	50	28(56)	22(44)	3.62(0.75)	4	4	N/A	2(4)
B7	Volume (how loud) of voices	50	19(38)	31(62)	3.50(0.91)	4	4	N/A	5(10)

B8	Clarity (how clear the sound of the voice is)	50	14(28)	36(72)	3.58(0.79)	4	4	N/A	3(6)
B9	Location of voices (inside head or outside head)	50	24(48)	26(52)	3.62(0.78)	4	4	N/A	3(6)
B10	If more than one voice, whether more than one voice is heard at once	50	24(48)	26(52)	3.68(0.65)	4	4	N/A	2(4)
	NO questions in this section	50	8(16)	N/A	N/A	N/A	N/A	0(0)	N/A
	ALL of the questions in this section	50	10(20)	N/A	N/A	N/A	N/A	42(78)	N/A
	At LEAST ONE question in this section	50	42(84)	N/A	N/A	N/A	N/A	N/A	N/A

Content:

B11	Whether the voice is male or female	50	34(68)	16(32)	3.68(0.71)	4	4	N/A	2(4)
B12	Whether the voice content is negative or positive	50	40(80)	10(20)	3.70(0.76)	4	4	N/A	3(6)
B13	Whether the voice content talks about the patient or other people	50	38(76)	12(24)	3.78(0.76)	4	4	N/A	2(4)
B14	Whether or not the voice content commands the patient to act	50	41(82)	9(18)	3.92(0.34)	4	4	N/A	1(2)
B15	Whether the command content involves harm to self or others	50	41(82)	9(18)	3.98(0.14)	4	4	N/A	0(0)
B16	If the voice content involves harm, what type of harm (e.g. physical, social etc.)	50	39(78)	11(22)	3.98(0.14)	4	4	N/A	0(0)
	NO questions in this section	50	3(6)	N/A	N/A	N/A	N/A	0(0)	N/A
	ALL of the questions in this section	50	25(50)	N/A	N/A	N/A	N/A	46(84)	N/A
	At LEAST ONE question in this section	50	47(94)	N/A	N/A	N/A	N/A	N/A	N/A

Beliefs:

B17	Meaning of the voice for the person e.g. "the voice means I am…"	50	23(46)	27(54)	3.68(0.65)	4	4	N/A	2(4)
B18	What caused the voice to originally start	50	26(52)	24(48)	3.66(0.69)	4	4	N/A	3(6)
B19	What keeps the voice saying things	50	14(28)	36(72)	3.42(0.84)	4	4	N/A	5(10)
B20	Purpose of the voice i.e. benevolent or malevolent	50	29(58)	21(42)	3.52(0.86)	4	4	N/A	3(6)
B21	Power of the voice	50	23(46)	27(54)	3.50(0.84)	4	4	N/A	2(4)
B22	Controllability of the voice by the patient	50	35(70)	15(30)	3.74(0.63)	4	4	N/A	2(4)
B23	Whether or not the patient recognises the identity of the voice	50	33(66)	17(34)	3.72(0.61)	4	4	N/A	1(2)
B24	Whether the patient has a delusion that supports the voice content	50	24(48)	26(52)	3.52(0.71)	4	4	N/A	3(6)
B25	Benefits the voice brings to the patients' life	50	20(40)	30(60)	3.28(1.07)	4	4	N/A	5(10)
B26	Disadvantages the voice brings to the patients' life	50	32(64)	18(36)	3.64(0.63)	4	4	N/A	2(4)
B27	Why the patient should or should not obey any voice commands	50	36(72)	14(28)	3.57(0.98)	4	4	N/A	2(4)
B28	Optimism/pessimism the voice will improve over time	50	17(34)	33(66)	3.12(1.22)	4	4	N/A	4(8)
	NO questions in this section	50	6(12)	N/A	N/A	N/A	N/A	0(0)	N/A
	ALL of the questions in this section	50	1(2)	N/A	N/A	N/A	N/A	38(58)	N/A
	At LEAST ONE question in this section	50	44(88)	N/A	N/A	N/A	N/A	N/A	N/A

Reactions:

B29	Visual images triggered by the voice	50	23(46)	27(54)	3.58(0.76)	4	4	N/A	2(4)
B30	How the patient copes with the voice	50	41(82)	9(18)	3.92(0.27)	4	4	N/A	0(0)
B31	If command voice content, whether or not the patient has obeyed	50	37(74)	1326)	3.78(0.68)	4	4	N/A	1(2)
B32	Which emotions are activated by the voice	50	29(58)	21(42)	3.58(0.86)	4	4	N/A	3(6)
B33	Emotion frequency triggered by the voice	50	21(42)	29(58)	3.46(0.95)	4	4	N/A	4(8)
B34	Emotion intensity triggered by the voice	50	23(46)	27(54)	3.54(1.05)	4	4	N/A	3(6)
B35	Severity of life disruption caused by the voice	50	32(64)	18(36)	3.54(1.05)	4	4	N/A	3(6)
B36	Which goals are blocked by voice-related problems	50	29(58)	21(42)	3.62(0.95)	4	4	N/A	1(2)
	NO questions in this section	50	6(12)	N/A	N/A	N/A	N/A	0(0)	N/A
	ALL of the questions in this section	50	12(24)	N/A	N/A	N/A	N/A	43(76)	N/A
	At LEAST ONE question in this section	50	44(88)	N/A	N/A	N/A	N/A	N/A	N/A

Table 1. The frequency and percentage of staff that currently ask patients about each aspect of hearing voices, the number of questions asked within each topic area, and descriptive statistics regarding how strongly clinicians believe they should ask each question. *Note:* actual behaviour = whether clinicians are currently asking these questions; beliefs = how strongly clinicians agree that they should ask each question (0 = strongly disagree; 4 = strongly agree) and the frequency of clinicians who agreed/disagreed that the question should be asked; M = mean; Med = median; Mo = mode; SD = standard deviation; N/A = not applicable.

		Total n	n(%)	M(SD)	Med	Mo
Barriers						
A3a	Waste of time	50	3(6)	0.26(0.69)	0	0
A3b	Don't know how to use the information	50	11(22)	0.90(1.28)	0	0
A3c	Dangerous to ask	50	10(20)	0.70(1.07)	0	0
A3d	Patients can't disclose	50	9(18)	0.82(1.16)	0	0
A3e	Patients won't disclose	50	18(36)	1.44(1.18)	1	1
A3f	Not enough time	50	11(22)	0.96(1.29)	0	0
A3g	Not part of my role	50	2(4)	0.16(0.55)	0	0
A3h	Don't know where to document	50	3(6)	0.18(0.66)	0	0
A3i	Don't know what questions to ask	50	13(26)	1.02(1.33)	0	0
	Number of barriers endorsed	50	N/A	1.20(1.55)	N/A	N/A
Benefits						
C1	Asking shows patients that staff care about their problems	50	49(98)	3.78(0.55)	4	4
C2	Asking allows staff to have more accurate empathy and so provide more sensitive care	50	48(96)	3.78(0.51)	4	4
C3	Asking gets the patient thinking about the voice and so may reduce their distress	50	39(78)	3.10(1.25)	4	4
C4	Asking indicates to staff how they can develop more effective voice care plans	50	49(98)	3.92(3.40)	4	4
C5	Asking identifies barriers to patients' rehabilitation	50	42(84)	3.38(1.19)	4	4
C6	Asking improves risk identification and management	50	49(98)	3.88(0.52)	4	4
C7	Asking helps staff with evaluating improvement	50	46(92)	3.78(0.58)	4	4

or deterioration across time					
Number of benefits endorsed	50	N/A	6.44(0.84)	N/A	N/A

Table 2. The descriptive statistics of the extent to which clinicians endorsed barriers and/or benefits to talking about voices with their patients, as well as the frequency and percentage of clinicians whom did not disagree with the barrier/benefit (i.e. agreed or were unsure). *Note:* M = mean; Med = median; Mo = mode; SD = standard deviation; N/A = not applicable.