Parenting Interventions on a Mother and Baby Unit: An Investigation

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List of Abbreviations

Baby TP	Baby Triple P Positive Parenting Programme
CBT	Cognitive Behavioural Therapy
cCBT	Computerised Cognitive Behavioural Therapy
DoH	Department of Health
MBU	Mother and Baby Unit
NHS	National Health Service
NICE	National Institute for Clinical Excellence
P-Set	Collection of participants who performed the Q-Sort
Q-Set	Set of statements used in the Q-Sort
Q-Sort	The process of arranging statements (Q-set) printed on cards on a Q-Grid
Q-Grid	The ranking continuum where the Q-set are arranged by the participant
SMI	Severe Mental Illness

Thesis Abstract

Parenting Interventions on a Mother and Baby Unit: An Investigation

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Hannah Lisa Butler

In this thesis the intricacies of service user and staff perceptions of psychological interventions for mental health difficulties were explored. Expanding upon this theme, mothers and staff on a Mother and Baby Unit (MBU) were asked about their views regarding the acceptability and feasibility of the implementation of a parenting intervention, Baby Triple P Positive Parenting Programme (Baby TP). This investigation is presented as four papers: a literature review, two empirical papers (a & b) and, a critical review and personal reflection of the research process.

The literature review, a meta-synthesis of qualitative studies, explores service user and staff perceptions of psychological interventions for mental health difficulties. Twenty-eight studies were synthesised to develop comprehensive understanding of subtle, specific and overlapping elements involved in the implementation of psychological intervention. Guided by Noblit and Hare's (1988) approach, 11 over-arching themes and 25 sub-ordinate themes emerged from the synthesis. Findings provide a detailed description of the concepts pertinent to both service users and staff. Implications are identified for service managers and clinicians in obtaining optimum efficiency and outcomes of psychological intervention.

The empirical study is a Q-methodological investigation into service user and staff perceptions of the acceptability and feasibility of a parenting intervention, Baby TP, on a MBU. This study is split into two population-specific papers. Overall five main factors were identified (service users: three; staff: two), which provides new insights into the acceptable and feasible elements of a parenting intervention within this specialist setting. The findings highlight a positive consensus as to the acceptability and feasibility of Baby TP in a MBU setting alongside a number of identified needs pertinent to service users, staff and the setting. Clinical implications and recommendations are provided to address identified areas of need for both populations within this setting.

The third paper is a critical review of the thesis illustrated through personal reflections of the research process.

Declaration

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Paper 1: Literature Review

Professional and Service User Perceptions of Psychological Intervention for Mental Health Difficulties

Prepared according to submission guidelines for the

British Journal of Psychiatry (Appendix 1)

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Abstract

Background: A variety of psychological interventions are endorsed by national guidelines as effective treatments for a wide vast range of mental health difficulties. However, service user and professional experiences of psychological intervention remains relatively under-researched.

Aims: To explore service user and professional experiences of a cross-section of psychological interventions to gain a more comprehensive understanding of fundamental aspects of psychological therapy.

Method: A meta-synthesis of published qualitative research.

Results: Twenty-eight qualitative papers were selected for review and synthesised, resulting in 11 over-arching themes and 25 sub-ordinate themes categorised into interlinked service user, professional and psychological intervention domains.

Conclusions: The current findings inform the refinement, development and evaluation of psychological therapies, whilst offering new insights into the unique and overarching elements pertinent to involvement in 'psychological intervention' as perceived by service users and staff.

Introduction

There appears to be a global increase in the diagnosis of mental health problems, with depression predicted to be the most prevalent mental health difficulty by 2020.[1] The growing need for therapeutic treatment is placing increasing demand upon mental health services and optimal provision of psychological therapies.[2]

Within the United Kingdom, both the National Institute for Clinical Excellence (NICE) and Department of Health (DoH) endorse treatment of various mental health difficulties with low to high intensity psychological interventions.[3,4] The Improving Access to Psychological Therapy [IAPT] programme and stepped care approaches, primarily targeted towards treatment for mild to moderate anxiety and depression, delivers low intensity evidence-based interventions (such as guided self-help programmes and computer-assisted psychotherapy), whilst offering individual therapy within primary care settings.[3-5] Psychological intervention via IAPT and stepped care approaches enables prompt, cost-effective, evidence-based access to therapy, whilst reducing additional or potential burden on those specialist psychological services targeting more severe mental health difficulties.[6-8]

Various outcome measures are currently in use in IAPT and psychological services,[9,10] but this is dominated by service user self-report rating scales, and questionnaires on symptom reduction, that can marginalise clinically relevant data.[11,12] Such measurement also makes assumptions as to 'successful' psychological treatment, with reports being forced into preconceived measures and criteria.[13] Literature reviews have examined perspectives of the effectiveness of specific psychological interventions for varying severities of mental health difficulties, such as CBT and family therapy for psychosis,[14,15] psycho-social

intervention for self harm[16] or mindfulness for people with severe mental illness.[17] These are service user dominated and focus on standardised psychological approaches, whereas in practice clinical applications tend to be an eclectic mix, inclusive of several theoretical frameworks.[3] There is a need for a more holistic and inclusive appraisal of psychological practices. The distinct lack of appreciation of staff attitudes and opinions, cited as crucial in moving psychological intervention from efficacy to effectiveness, is also noteworthy.[8,14,18] Little attention is given to what happens in therapy[19] or the key components to 'successful' psychological treatment.[20]

In the interests of both research and clinical practice, it is important to examine the perceptions of all those involved in psychological therapy. Assessment of the full process of these viewpoints will facilitate in both the development of new approaches, and provision of valuable insight into those essential elements that serve to promote accessible and effective psychological intervention.[6,21]

Methodology

Eight electronic databases (Ovid MEDLINE (R), Embase, PsycINFO, PUBMED, AMED (Allied and Complimentary Medicine), CINAHL+ (Cumulative Index to Nursing and Allied Health Plus), Web of Knowledge and Scopus) and Google Scholar were searched using these following keywords: *staff/professional perceptions, staff beliefs AND attitudes, mental health interventions, staff/professional opinion, service user opinion/perceptions/beliefs AND attitudes, patient AND client perceptions, therapy beliefs, treatment beliefs, treatment perceptions, acceptability*. Manual searches of Qualitative Health Research,

reference lists and Google Scholar were also undertaken (Appendix 2). The search was conducted between November 2012 and February 2013.

Inclusion criteria were primary qualitative research studies, published in the English language in peer-reviewed journals between 1987-2013 and inclusive of participants of reproductive age who have expressed perceptions, opinions and attitudes about psychological intervention for mental health issues. Book chapters, case studies, dissertations, unpublished articles, articles about psychological interventions for physical health issues, and those written in a language other than English, were excluded.

Study titles were screened with duplications and irrelevant topics removed. Abstracts of the remaining studies were read and checked against the inclusion and exclusion criteria. Twenty-eight studies[11,14,21-46] were identified exploring the topic of professional and service user perceptions of psychological interventions for mental health issues (Figure 1).

[Insert Figure 1 here]

Quality Appraisal

The first author (HB) and a peer, independent of the research team and also experienced in the assessment of methodological quality, assessed the quality of the papers using the Critical Appraisal Skills Programme (CASP) checklist[47] and Walsh and Downe's guidelines[48] (Appendix 3) to optimise reliability.

The 10-item CASP is a subjective measure validated for use for critical appraisal, structured around rigour, credibility and relevance. Walsh and Downe's appraisal criteria focus on eight key areas: scope and purpose, design, sampling

strategies, analysis, interpretation, reflexivity, ethical dimensions and, relevance and transferability.[48] An overall quality category was obtained for all the papers ranging from A to C (A = high methodological quality and low bias; B = moderate quality and moderate bias; C = low quality and high bias) (see Appendix 4 for Critical Appraisal Rating Summary and Appendix 5 for Critical Appraisal Category Summary). There were no significant scoring and category differences between the raters. The studies and their key characteristics are presented in Tables 1-3.

[Insert Tables 1-3 here]

Data Extraction and Synthesis

Contextual information including sampling, participant characteristics, form of data collection and type of qualitative analysis were recorded. Noblit and Hare's meta-ethnological guidelines[49] informed the synthesis process (Appendix 6), and key concepts and original thematic data were extracted and tabulated (see Appendix 7 for Concept Findings and Identified Themes and Appendix 8 for Concept Findings and Identified Sub-Ordinate Themes).

Results

Twenty-eight, 'A'-rated studies were included in the meta-synthesis and comprised service users (n = 16), staff (n = 6) and service user-staff combinations (n = 6) from a range of countries (United Kingdom [UK] (n = 15), Southern Ireland (n = 2), United States of America (USA) (n = 6), Austria (n = 1), Australia (n = 1), China (n = 1), Pakistan (n = 1) and The Netherlands (n = 1). [11,14,21-46]

Service user studies represented 166 service users aged between 16 to 64 years old with a range of mental health difficulties (depression, anxiety, psychosis, eating disorders, obsessive compulsive disorder (OCD), self-harm, bipolar disorder, schizophrenia, schizo-affective disorder, post-natal depression, social phobia) and experience of psychological interventions (including Cognitive Behavioural Therapy (CBT), Cognitive Therapy (CT), Psychotherapy, Individual Psychoanalytic Psychotherapy, Brief Psychological Therapy, Psycho-Educational groups, Cognitive Remediation Therapy and Mindfulness).

Staff studies included 81 individuals with various professional backgrounds (including Nurses, Social Workers, Occupational Therapists, Clinical and Counselling Psychologists, Psychodynamic and CBT therapists) working with Psychodynamic Therapy, Rational Emotive Behaviour Therapy and CBT.

The studies employed various analytic approaches including Naturalistic Inquiry, Constructivist Grounded Theory, Discourse Analysis, Phenomenological Approaches, Biographical-Interpretative Approach, Thematic Content Analysis, Systematic Content and Question Analysis, Essentialist/Realist Theoretical Approach, Analytic Comparative Approach, Constant Comparison and Idiographic Approach.

Main Findings

The synthesis identified three main domains (service user, therapy and staff) with 11 over-arching themes with 25 sub-ordinate themes (Table 4 and Figure 2). Results indicated strong thematic commonalities within and between study

narratives. Quotes taken from raw data illustrating the identified themes can be found in Appendix 9.

[Insert Table 4 and Figure 2 here]

Service User Factors Theme 1: Predisposing Cultural Beliefs and Attitudes

All studies highlighted specific service user *expectancy*, *experience* and *motivation* as strong inter-related sub-ordinate elements within a main overarching theme of '***predisposing cultural beliefs and attitudes***'.

Cultural and personal *expectancies* of psychological intervention related to service user *experience* of the intervention as well as initial and sustained *motivation* to attend therapy sessions. *Expectations* of therapy and therapeutic staff related to past experience, media exposure and/or particular cultural perspectives of 'what therapy looks like' (Q1). Positive *expectations* of psychological interventions were coupled with both internal (Q2) and external *motivators* (Q3). Similarly a number of (internal and external) *de-motivators* to psychological intervention were identified including shame, embarrassment, practical difficulties and a preference for medical treatment (Q4).

Studies with staff highlighted the importance of understanding service user beliefs about mental health difficulties and therapy and considering the impact of these on service user *expectancy* and *motivation*.

Service User Factors Theme 2: Therapeutic Experience

Normalising and validating, *learning and sharing*, *support*, *acceptance and change* were all interconnected sub-ordinate themes of the '***therapeutic experience***'. Psychological therapy (across all formats and disciplines) provided a

normalising and validating environment with group-format studies identifying reoccurring themes of opportunities to relate to peers with similar mental health issues (Q5). Normalisation related to providing alternative (non-blaming) explanations and re-evaluations of mental health difficulties with direct effects on decreasing feelings of shame and embarrassment (Q6). Humour was recognised as a reoccurring normalisation technique, particularly in individual therapy (Q7). However, the one-sided sharing of personal information was identified as being, at times, invalidating and impersonal (Q8), with the therapist not necessarily demonstrating genuine involvement in the relationship. Equally, if the therapeutic group environment was too diverse, this was perceived as negative and unsupportive (Q11).

Learning and sharing were identified as fundamental in promoting the functions of *normalising and validating* and *supporting* within the ***therapeutic experience*** (Q9). More specifically, learning included acquiring specific skills and factual information, as well as more contextual understanding of mental health difficulties (Q10). The sharing of specific techniques between individuals (through group or individual therapy) was identified as part of the ***therapeutic experience***.

Reoccurring themes of the therapeutic 'journey' and the transition from old to new perspectives of mental health difficulties were identified as a defining feature of *acceptance and change* (Q12).

Service User Factors Theme 3: Personal and Therapeutic Change

Benefits and *barriers and challenges* were interconnected sub-ordinate themes of the main overarching theme '***personal and therapeutic change***'. *Beneficial*

elements of psychological intervention were identified as increased knowledge and understanding of mental health difficulties, acquisition of techniques in providing a "sense of mastery" (Study No. 6), and also the identification with others promoted feelings of hope and recovery (Q13). All themes and sub-themes within the service user, therapy and staff domains were *challenging* for service users (Q14) and, at times, caused *barriers* to engagement. Power dynamics and the understanding of social rules within the therapeutic relationship posed some *challenges and barriers* (Q15).

Service User Factors Theme 4: Reflection and Evaluation

'***Reflection and evaluation***' comprises two independent sub-themes: *illness perceptions* and *facilitator and operational aspects*.

Service users identified that new *illness perceptions* developed from understanding gained through their therapeutic experience, which can also be shaped by '***predisposing cultural beliefs***' (Q16). Service users reflected on the new *illness perceptions* and together with evaluations of their therapeutic experience identified a renewed hope in recovery (Q17).

Facilitator aspects were dominated by descriptions of desirable personal characteristics relating to safety and security (Q18) with reflection on expectations of what therapists should do and say (Q19). *Operational aspects* were identified and referred to practical elements including (lack of) resources or equipment and venue (Q20). There were mixed reports regarding the number, optimum length and frequency of therapy sessions.

Therapy Factors Theme 5: Illness Perceptions

The synthesis identified four main overarching interconnected 'Therapy Factor' themes and 10 inter-related sub-themes. The theme of '***illness perceptions***' contains two individual inter-related sub-themes of *stigma* and *stage of illness*. *Stigma* associated with psychological intervention was identified with both service user and staff beliefs. Service user shame of mental health difficulties together with a perceived negative association in seeking psychological intervention, compromised accessing therapy (Q21). Staff beliefs about the 'benefits' of psychological intervention for some specific mental health difficulties resulted in hesitation to refer and increased consultation with medical colleagues (Q22).

Stage of illness directly impacted upon service user engagement in the psychological intervention (Q23); service users reflected upon the timing of therapy and their 'readiness' (Q24) to engage.

Therapy Factors Theme 6: Therapy Stages

The main themes of '***therapy stages***' comprised four sub-themes, namely *suitability and accessibility, process, flexibility, continuity and consistency* and *endings and outcomes*, relevant pre-, mid- and post-therapy.

Suitability and accessibility of therapy were identified in numerous ways by both service users and staff. Service user attitudes towards the therapy experience (at all points of therapy) alongside practical and operational aspects of attending sessions were important elements in terms of *suitability and accessibility* (Q25). Staff pertinent factors, however, were personal beliefs about the benefits of therapy alongside practical challenges and barriers relating to access to

appropriate therapeutic space, time and resources. Both service users and staff identified psychological intervention as being a fluid process with different demands and requirements for both service users and staff at the various stages (pre-, mid- and post-therapy) (Q26).

Studies highlighted psychological therapy having to be *flexible* to both practical elements of therapy, including modification of techniques, location, timing of appointments (i.e., therapeutic materials), and mental health factors (i.e., stages of illness changes) (Q27). Equally, *continuity and consistency* were identified as being important safety and security factors within the therapeutic experience (Q28). Service users and staff identified *therapy endings* as being a significant element to the therapy stages impacting on '***illness perceptions***', '***therapeutic relationship(s)***', overall '***recovery and hope***' as well as individualised factors identified for both service users and staff (Q29).

Therapy Factors Theme 7: Therapeutic Relationship(s)

The main theme of '***therapeutic relationship(s)***' referred to relationships with individual therapists, group facilitators or peers and contains two subordinate themes of *partnership and collaboration* and *shared control and focus*.

Partnership and collaboration referred to the development of trusting, respectful and equal relationships, essential in the optimum therapeutic relationship (Q30). Within a group format, partnerships with peers were highlighted as a particularly valued part of the therapeutic experience (Q31). Staff commented upon the personal satisfaction in developing partnerships and promoting genuine collaboration with service users in the aim of helping them to recover and regain hope (Q32).

Shared control in therapy was identified as an important aspect in building respectful '***therapeutic relationship(s)***' within all formats of therapy. '***Therapeutic relationship(s)***' obtained with peers who had a *shared focus* proved to be particularly helpful for '***recovery and hope***' (Q33).

Therapy Factors Theme 8: Recovery and Hope

'***Recovery and hope***' comprised the subordinate theme of *real life implementation and outlook*. '***Recovery and hope***' was important to the service user's ability to successfully put the learning and understanding gained in the therapeutic experience into real life situations, effectively changing their outlook on their own mental health as well as the psychological intervention (Q34).

Staff Factors Theme 9: Professional Background and Psychological Perspective

This main theme comprised the two inter-related subordinates: *beliefs, attitudes and views of recovery* and *expertise*.

Staff *beliefs, attitudes and views of recovery* were influenced by their perceptions of service user characteristics and understanding about psychological intervention and mental health difficulties (Q35). *Expertise*, and perceived expertise, of staff related to service user expectations of 'what therapy should look like' (Q36) and tended to be measured by preconceived ideas as to 'how therapists should present themselves' and what favourable personal characteristics 'therapists should display' such as 'honesty and warmth' (Q37).

Staff Factors Theme 10: Staff Role

The main theme of '***staff role***' comprised the two sub-ordinate themes of *therapeutic approach and response* and *working relationships*.

Studies identified the importance of the therapeutic approach for both continuous engagement of service users and to develop trusting relationships (Q38). Service uses identified staff responses to be of crucial importance in providing a safe environment to discuss difficult issues (Q39). A clear pragmatic approach was identified as the optimum approach regardless of therapeutic stance (Q40 & Q41).

Liaison and close *working relationships* between professionals was reported as providing the ideal environment for the success of psychological intervention (Q42) with identified benefits to staff-service user relationships, albeit therapeutic or to address other healthcare needs.

Staff Factors Theme 11: Evaluation

The main theme of '***evaluation***' contained the sub-ordinate theme of *challenges and barriers*.

Lack of resources (e.g. funding, available time) together with work pressure and waiting lists was reported as a constant challenge with frustration at NHS systems taking precedence over service user needs (Q43). Staff discussed their hesitation to refer to specialist psychological intervention due to their knowledge about these resource issues (Q44).

Discussion

A comprehensive understanding of service user and staff perspectives regarding acceptable and feasible psychological interventions is important for successful clinical outcome. This meta-synthesis identified a multifaceted model involving three main inter-related domains: service user, therapy and staff. Within these domains 11 overarching themes and 25 subordinate themes were identified.

Of the three domains, the service user specific domain comprised most inter-related and overarching themes. This is indicative of their substantial personal investment and expectation within the therapeutic experience. Their predisposition of cultural beliefs and attitudes was identified as being of significant importance in shaping expectation, motivation and experience. This supports earlier research, which highlights the influence of culture and service user expectations on recovery.[50] More thorough and informed education about psychological interventions and mental health difficulties at pre-referral to psychological therapy would enable service users to make more informed treatment choices and allay any unhelpful cultural beliefs.

Service users value the opportunity to 'normalise and validate' their mental health difficulties, 'learn and share' techniques and gain 'support' from peers and the therapist. Earlier research suggests that approach-specific techniques are not of primary importance, emphasis being more on the combination of those experiences that promote knowledge, acceptance and change.[19,51] Peer relationships and therapist humour are identified as being significantly valuable in therapy. However, the one-sided nature of the therapeutic relationship within individual therapy can result in a negative, invalidating experience for the service user. Addressing this scenario can challenge therapy boundaries and

confidentiality. However, Hodgetts and Wright suggest a ‘less rather than more approach’ (tempered with supportive and reassuring comment and suggestion) as being useful in enhancing the therapeutic relationship.[19] Similarly, perceived authority differentials within the therapeutic relationship are a potential barrier to accessing successful psychological intervention and therapy. This supports previous research in highlighting therapist “superiority” as being an unhelpful relationship dynamic,[19] whereas favourable therapist characteristics (i.e. kindness and warmth) promote a safe therapeutic environment. The development of a “sense of mastery” and increased awareness and knowledge of the specific mental health difficulty are a benefit of psychological intervention. In their evaluation of therapeutic experiences, service users frequently refer to the benefit of a greater awareness and perception of their mental health difficulty. Duration of therapy, session length and frequency, receive mixed satisfaction from service users. This supports the findings of other studies and aligns with that of Cuijpers et al, [52] who emphasise the importance of tailoring therapy to the individual and a thorough consideration of approach to therapy endings. A formulation driven patient-centred therapy would aid in ensuring optimum tailored session lengths and frequencies.[53]

Service users and staff both agreed that ‘therapy’ involved fundamental conceptual elements (regardless of approach or discipline). As supported by previous research, perceptions of illness (‘***illness perception***’) involving *stigma* and *stage of illness* were perceived by both service users and staff as influential to engagement in therapy.[54] Service user feelings of shame and ambivalence alongside staff perceptions, beliefs (and scepticism) of the values and benefits of psychological intervention for particular mental health difficulties (such as

schizophrenia) are influential to therapy engagement. Timing of therapy needs to balance service user 'readiness' to engage and the stage of illness. Specific stages of therapy are identified as 'suitability and accessibility', 'process', 'flexibility, continuity and consistency', and 'endings and outcome'. All are recognised to be important considerations at pre-, mid- and post-therapy time points. The successful therapeutic relationship is described as involving a shared trusting, respectful and equal partnership(s) with active collaboration, which emphasises the importance of social contact.[55] Service users' ability to apply new knowledge gained from their 'therapeutic experience' to a real life context was related to both staff and service user perceptions of recovery and hope.

The staff domain reflected the fewest overarching themes, emphasising the "unequal relationship" dynamic in the service user domain and as identified in previous research.[19] Staff views about psychological intervention and recovery are influenced by pre-existing perceptions and opinions about mental health difficulties and service user characteristics and behaviours. Their beliefs are acknowledged as being important in the provision of good quality care[12] and recent agendas do focus on promoting awareness of staff values and behaviours (Compassion in Practice Documentation[56]). Nevertheless, there is still a lack of examination of the influence of staff beliefs, attitudes, and their views of recovery in shaping the therapeutic environment and experience.[57] Service user perceptions of expertise are linked to preconceived ideas of 'what therapy should look like' and 'how professionals should (physically) present themselves'. One study for example, recorded how service users voiced surprise and uncertainty at the therapist being younger than expected.[24] The overarching theme 'therapeutic approach and response' identifies how a more flexible and pragmatic approach is

most favoured in ensuring optimum accessibility to therapy. Staff identified the benefits of liaison between (multidisciplinary) professionals and close collaborative working relationships as important and key to providing a model environment for psychological intervention. Their evaluation of therapy highlights the lack of available resources as a problem and an acknowledgment and resignation that all too frequently operational systems take precedence over service user need. As a consequence, there is a certain level of hesitation and reluctance to refer service users to higher intensity interventions. Staff are aware of additional work pressures and waiting list problems and, as also noted by Bower and Gilbody, find it difficult to effectively balance the (limited) resources with the perceived need (and urgency) for intervention.[2]

Limitations

This comprehensive search resulted in a large number of studies heterogeneous in context, methodology and sample, with a proportional discrepancy towards service user populations.

The research aim of the meta-synthesis necessitated a restriction of criteria to ensure synthesis of a manageable volume of studies. The resultant limitation determined that studies outside these criteria, such as those inclusive of child and older adult populations, and physical health settings, could not contribute to the synthesis and potentially specific data and theme interpretation may be missed.

Within the field of meta-synthesis research, there is lack of general agreement as to both the appropriateness of synthesising qualitative research and also with the methods employed to analyse quality of the original studies. This provides a significant challenge to ensuring a scientifically rigorous review. The

quality of a meta-synthesis analysis relies on the quality of the studies referenced.[48] To address this issue, thorough methods to assess study quality have been employed. However, it is acknowledged that whilst all studies met designated criteria they often lacked in the reporting of raw data, or in providing any indication of the authors' influence on the interpretation of the original data. Thus, re-interpretation of data could only be conducted on the quality of the original interpretation.

The majority of studies provided retrospective experiences of psychological interventions, which may have been influenced by a number of factors (such as treatment outcome).[24] With few studies examining individual perspectives during therapy, further research could be more inclusive of mid-therapy processes which may disclose other significant data.

Despite these considered limitations, this meta-synthesis provides a comprehensive perspective of important factors of psychological intervention. The results imply that there are specific and consistently identified elements of therapy, which both service users and staff consider essential to the success of psychological therapy.

Implications for Practice

This is the first systematic review to provide an overview of the qualitative literature on both service user and staff perceptions of psychological intervention. The varied nature of the 28 studies reviewed provides a basis for some clear clinical implications for practice. The meta-synthesis acknowledges the advantage of a thorough assessment which focuses on service users' cultural beliefs, illness perceptions (pre-therapy) and 'what they expect from therapy', together with an approach which offers more information about the whole therapy process,

therapist and therapeutic strategy. Equally, staff training should focus on exploring staff perceptions and beliefs towards specific mental health difficulties, the benefits of psychological intervention, and the enhancement of cultural awareness as a means to address pre-conceived opinions about service user characteristics. Clinical supervision, case formulation and discussion should be readily accessible for staff in consideration of their personal attributes, opinions, difficult relationship dynamics, therapeutic self-disclosure boundaries and techniques necessary to develop a safe therapeutic environment.

Group interventions and/or close liaison with third sector organisations would promote the identified benefits of peer relationships and social contact,[55] and be of particular benefit to service users accessing low intensity psychological interventions not requiring therapist input.

A number of organisational demands are also identified, which are particularly difficult to resolve and manage efficiently within the current economic climate. Strains on provision of resources, work pressure and long waiting lists present constant challenges. Furthermore, service managers should consider the wider implications of organisational restraints, an example being the process of service user discharge following a number of non-attended appointments. Equally, there is an identified need for flexibility in approach to therapy. Staff resistance in referring to appropriate psychological services should also be addressed with service managers and clinical leads.

Implications for Research

The findings of this meta-synthesis are supported by previous research and reaffirms the need for more qualitative research into the experience of

psychological intervention and recognition of acceptable and feasible therapy components.[52] Significant gaps in the literature search are defined and further consideration needed in regard to the views of service users who have ‘opted out’, discontinued or experienced more than one form of therapy, together with staff opinion of psychological or psychiatric intervention. Further exploration within these areas would provide a broader insight into those elements that promote or inhibit access to treatment.

Declaration of Interest

None of the authors of the above manuscript have declared any conflict of interest, which may arise from being named as an author on this manuscript. There were no funding sources for this study.

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Table 1. Study Characteristics for Service User Studies

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
1.	Messari, S. & Hallam, R. (2003) CBT for psychosis: a qualitative analysis of clients' experiences United Kingdom	*Sampling Method*: Clinical Psychologist supervising the CBT work identified the participant sample *Sample Origin and Total:* UK sample of 5 participants *Participant Characteristics:* - 4 inpatients and 1 outpatient who received CBT for psychosis - 4 males and 1 female - Age range from 28 to 49 - 2 white British, 1 white Irish, 1 black African and 1 Afro-Caribbean - Range of history of psychosis (10 to 28 years) with a variety and combination of problems (delusions, medication compliance, hearing voices, alcohol abuse and social anxiety) addressed in therapy	Semi-structured audio-taped individual interviews (lasting between 40-60 minutes).	Guidelines suggested by Parker (1994) and Potter & Wetherell (1995).	Discourse Analysis	A(9)	A(7)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
2.	Gallegos, N. (2005) Client perspectives on what contributes to symptom relief in psychotherapy: a qualitative outcome study America	*Sampling Method:* Recruitment through flyers, newspaper adverts and provider solicitation. *Sample Origin and Total:* American sample utilising 3 participants data out of a potential sample of 9 *Participant Characteristics:* - 8 female (6 approx. 50 years old and 2 approx. 30 years old) and 1 male aged approx. 50 years (potential sample) - No specific details stated for the 3 participants whose data was used in the study - All participants had experiences symptom relief as a response to psychotherapy - Symptoms of depression and anxiety were deemed to have lead to participants seeking psychotherapy - 8 participants were in therapy at the time of the study	Individual interview (max. time 90 minutes) The only data used was from the first three participants to be interviewed	Descriptive Phenomenology Approach	Not explicitly stated	A(10)	A(8)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
		- 8 participants had multiple therapeutic experiences						
3.	Bury, C., Raval, H. & Lyon, L. (2007) Young people's experiences of individual psychoanalytic psychotherapy United Kingdom	*Sampling Method:* Opportunistic sampling recruited by invite letter within a community-based mental health clinic *Sample Origin and Total:* UK sample of 6 participants out of a potential of 36 *Participant Characteristics:* - 4 females and 2 males - Age range 17-21 years old - Engaged in regular (min. 1 per week) sessions of individual psychoanalytic psychotherapy - Length of time in treatment ranged from 9 to 26 months (mean 16 months) - Clinical problems included depression, eating disorders, self-harm, behavioural difficulties, relationship and	Semi-structured interviews	Biographical-interpretive Approach (Hollway & Jefferson, 2000) Phenomenological Approach	Interpretative Phenomenological Analysis (IPA) (Osborn & Smith, 1998; Smith, 1996)	A(10)	A(8)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
		emotional problems - All participants ceased had therapy for at least 3 months and no longer than 18 months						
4.	Macdonald, W., Mead, N., Bower, P., Richards & Lovell, K. (2007) A qualitative study of patients' perceptions of a 'minimal' psychological therapy United Kingdom	*Sampling Method:* Recruitment as a part of a RCT, not explicitly stated *Sample Origin and Total:* UK Sample of 24 participants *Participant Characteristics:* - 20 females and 4 males - Classed as white - Age range 21-56 years (mean 39) - Individuals with depression (>14 BDI) or anxiety (>11 HADS) - On a psychological therapy services waiting list (> 3 months) - Randomised to 'brief' psychological therapy comprising of guided self help	Semi-structured home-based audio-taped interviews (lasting between 30-65 minutes) Interviewed 3-4 months after entry onto the randomised control trial	Constant Comparison Method (Strauss & Corbin, 1990)	An initial coding framework was devised. Analysis of transcripts was conducted, line by line, with chunks of text reflecting themes (Ryan & Bernard, 2003).	A (9)	A (7)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
5.	Newton, E., Larkin, M., Melhuish, R. & Wykes, T. (2007) More than just a place to talk: young people's experiences of group psychological therapy as an early intervention for auditory hallucinations United Kingdom	*Sampling Method:* Not explicitly stated *Sample Origin and Total:* UK Sample of 8 participants *Participant Characteristics:* - 5 females and 3 males - Age 17 or 18 years old - Variety of ethical, cultural and geographical origins - Mixture of inpatients and outpatients - Experiencing auditory hallucinations who had completed one of 4 cognitive behavioural group interventions	Semi-structured audio-taped interviews following the final group session.	Phenomenological Approach	Interpretative Phenomenological Analysis (Smith, Osborn & Jarman, 1999)	A (9)	A (7)	A
6.	Sibitz, I., Amering, M., Gössler, R., Unger, A. & Katschnig, H. (2007) Patients' perspectives on	*Sampling Methods:* Focus group samples selected by moderators of the groups *Sample Origin and Total:* Austrian sample comprising of 2 focus groups with a total of 14 participants	2 audio-taped focus group sessions (lasting 120 minutes).	Not explicitly stated	Thematic Content Analysis	A(8)	A(6)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	what works in psychoeducational groups for schizophrenia: a qualitative study Austria	*Participant Characteristics:* - 11 females and 3 males - Age range between 20-50 years - Mean age of schizophrenia onset was 25 years old - Focus group characteristics were 1 group comprising of the "enthusiastic" participants (n=7) and the other group the "critical" participants (n=7)						
7.	Ma.J.L.C. (2008) Patients' perspective on family therapy for anorexia nervosa: a qualitative inquiry in a Chinese context China	*Sampling Methods:* Not explicitly stated *Sample Origin and Total:* Chinese sample of 24 patients *Participant Characteristics:* - In total 24 female participants who had completed family therapy - 18 adolescents and 6 young adult women - Mean age for adolescents was 13 years (SD 1.78) - All diagnosed with anorexia	Semi-structured audio-taped interviews	Not explicitly stated	Content Analysis	A(8)	A(6)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
		nervosa (restrictive type) and one with an additional diagnosis of bulimic symptoms - Mean age for adults was 18.5 years (SD 2.1)						
8.	O'Connor, C., Gordon, O., Graham, M., Kelly, F. & O'Grady-Walshe, A. (2008) Service user perspectives of a psychoeducation group for individuals with a diagnosis of bipolar disorder: a qualitative study Ireland	*Sampling Methods:* Not explicitly stated *Sample Origin and Total:* Irish sample of 11 participants *Participant Characteristics:* - 7 females and 4 males - Age range 34-54 years (mean 41) - Contact with mental health services ranged from 2-33 years (mean 10) - No. of hospital admissions ranged from 1-11 (m= 4) - All met DSM-IV (APA, 1994) criteria for bipolar disorder diagnosis - Completed psychoeducation group	Post-group completion semi-structured interviews (lasting approximately 1 hour).	Not explicitly stated	Interpretative Phenomenological Analysis (Smith, 1996)	A(8)	A(6)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
9.	Whitney, J., Easter, A. & Tchanturia, K. (2008) Service users' feedback on cognitive training in the treatment of anorexia nervosa: a qualitative study United Kingdom	*Sampling Methods:* Treatment attenders of Cognitive Remediation Therapy (CRT) asked to write a feedback letter *Sample Origin and Total:* UK sample comprising of 10 participant feedback letters out of a potential 19 *Participant Characteristics:* - Female inpatients with Anorexia Nervosa - Age range 17-54 years (mean 30.3; SD 10.1) - Illness duration ranged from 1-40 years (mean 14.3; SD 10.5) - All received 10 manualised sessions of individual CRT	At the penultimate CRT session individuals asked to write a feedback letter outlining their experience of CRT. One patient gave feedback via video-taped interview.	Grounded Theory Approach	Not explicitly stated	A(9)	A(7)	A
10.	O'Donovan, A. & O'Mahony, J. (2009) Service users' experiences of a	*Sampling Methods:* Purposeful sampling *Sample Origin and Total:* Irish sample of 8 participants	In-depth audio-taped semi-structured interviews lasting between 20 and 45	Not explicitly stated	Thematic Content Analysis (Burnard, 1991)	A(10)	A(8)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	therapeutic group programme in an acute psychiatric inpatient unit Ireland	*Participant Characteristics:* - 5 females and 3 males - Age range from 18 to 65 years old - All were classed as Caucasians and of Irish nationality - 2 participants were first time admissions to the unit with 6 participants being re-admissions - Difficulties included schizophrenia, eating disorders, bipolar disorder, post-natal depression, depression and a combination of alcohol dependence and depression - All participants had attended a minimum of 4 groups per week	minutes.					
11.	Bevan, A., Oldfield, V.B. & Salkovskis, P.M. (2010)	*Sampling Methods:* Participants were drawn from a larger study. Methods were not explicitly stated.	Semi-structured audio-taped interview (lasting 20 – 40 minutes).	Essentialist/Realist Theoretical Approach	Thematic Analysis (Braun & Clarke, 2006)	A(8)	A(7)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	A qualitative study of the acceptability of an intensive format for the delivery of cognitive-behavioural therapy for obsessive-compulsive disorder United Kingdom	*Sample Origin and Total:* UK sample of 12 participants (6 treatment completed in each format, intensive or weekly CBT) *Participant Characteristics:* - Each group (intensive or weekly) consisted of 4 females and 2 males - Allocation to treatment format not randomised - Intensive group participants age range 19-40 years (mean 30) with an Obsessive Compulsive Inventory (OCI) mean score of 86.33 (range 42-125) - Weekly group participants age range 19-37 years (mean 29 years) with an OCI mean score of 83.83 (range 69-100)						
12.	Brown, L.F., Davis, L.W., LaRocco, V.A. & Strasburger, A.	*Sampling Method:* Not explicitly stated *Sample Origin and Total:*	Individual program-end interviews	Not explicitly stated	Content Analysis	A(8)	A(7)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	(2010) Participant perspectives on mindfulness mediation training for anxiety in schizophrenia America	American sample of 15 participants *Participant Characteristics:* - 15 males - Age range between 45-58 (mean 51; SD 4.78) - 60% Caucasian and 40% African American - All participants either had a diagnosis of schizophrenia (N=5) or schizoaffective disorder (N=10) - Post-acute phase of illness - Reporting significant levels of anxiety symptoms as indicated by the State-Trait Anxiety Inventory (Spielberger, 1983) or the Multidimensional Anxiety Questionnaire (Reynolds, 1999)						
13.	McManus, F., Peerbhoy, D., Larkin, M. & Clark, D.M. (2010)	*Sampling Method:* Clinicians identified potential participants for inclusion.	Semi-structured audio-taped interview (lasting between	Not explicitly stated	Interpretative Phenomenological Analysis (Smith, Flowers & Larkin,	A(9)	A(7)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	Learning to change a way of being: an interpretative phenomenological perspective on cognitive therapy for social phobia United Kingdom	*Sample Origin and Total:* UK sample of 8 participants *Participant Characteristics:* - 5 females and 3 males - Mean age 31.26 years (SD 6.54) - 5 participants were deemed employed, 2 students and 1 unemployed - 6 classed as White European and 2 as other - Completed a standardised cognitive therapy (CT) for social phobia treatment protocol during the previous 2 years - Received an average of 13 sessions (SD 3.63)	45 to 60 minutes).		2009)			
14.	Gerhards, S.A.H., Abma, T.A., Arntz, A., de Graff, L.E., Evers, S.M.A.A., Huibers, M.J.H. & Widdershoven, G.A.M. (2011)	*Sampling Method:* Participants were recruited from a larger trail population *Sample Origin and Total:* Dutch sample of 18 participants	Semi-structured audio-recorded interviews (lasting approximately 55 minutes).	Grounded Theory Approach (Chamaz, 2000)	Inductive content analysis	A(8)	A(6)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	Improving adherence and effectiveness of computerised cognitive behavioural therapy without support for depression: a qualitative study on patient experiences The Netherlands	*Participant Characteristics:* - 9 females and 9 males - Mean age 43.6 years (SD 14.5) - Recruited from the computerised cognitive behavioural therapy (CCBT) trial and COMBI (combination of CCBT and treatment as usual) groups - 8 participants had fully completed the CCBT sessions, 3 had never started CCBT nor changed to another form of help, whilst 7 had started CCBT						
15.	Williams, M.J., McManus, F., Muse, K. & Williams, J.M.G. (2011) Mindfulness-based cognitive therapy for severe health	*Sampling Method:* Participants recruited from a RCT *Sampling Origin and Total:* UK sample of 9 participants *Participant Characteristics:* - All participants were of Caucasian background	Individual semi-structured interviews carried out 3 months post-completion of Mindfulness-Based Cognitive Therapy	Phenomenological Approach	Interpretative Phenomenological Analysis (Smith, 1996)	A(10)	A(8)	A

No.	Authors, Date, Title and Country of Origin	Study Sampling and Participant Characteristics	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	anxiety (hypochrondriasis): an interpretative phenomenological analysis of patients' experiences United Kingdom	- Age range from 36-64 years (mean 49.2) - Met DSM-IV-TR (APA, 2000) criteria for the diagnosis of hypochrondrasis - All participants had received Mindfulness Based Cognitive Therapy as part of the same group within a RCT						
16.	Kilbride, M., Byrne, R., Price, J., Wood, L., Barratt, S., Welford, M. & Morrison, A.P. (2012) Exploring service users' perceptions of cognitive behavioural therapy for psychosis: a user led study United Kingdom	*Sampling Method:* Not explicitly stated *Sampling Origin and Total:* UK sample of 9 participants *Participant Characteristics:* - 5 females and 4 males - Age 18-65 years (M= 26) - 8 participants were white British and 1 was black British - All experienced CBT for psychosis last 12 months - 8 participants from Early Intervention Services and 1 from a Community Mental Health Team.	User-led semi-structured interviews	Not explicitly stated	Interpretive Phenomenological Analysis	A(8)	A(6)	A

Table 2. Study Characteristics Table for Staff Participant Studies

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
17.	Frueh, C., Cusack, K.J., Grubaugh, A.L., Sauvageot, J.A. & Wells, C. (2006) Clinicians' perspectives on cognitive-behavioral treatment for PTSD among persons with severe illness America	*Sampling Method:* Not explicitly stated *Sample Origin and Total:* American sample of 33 participants *Participant Characteristics:* - 26 female, 7 male - 23 being Caucasian, 10 African American - 27 primarily clinicians and 6 clinical supervisors or program administrators	Focus groups containing 5-9 participants (lasting 60-90 minutes)	Narrative Analysis	Content Analysis	A(8)	A(6)	A
18.	Awty, P., Welch, A. & Kuhn, L. (2010) A naturalistic inquiry of registered nurse's perspectives and expectation of psychodynamic therapeutic care in	*Sampling Method:* Purposeful sampling *Sample Origin and Total:* Australian sample *Participant Characteristics:* - Division 1 Registered	Semi-structured audio-taped interviews (lasting between 30-60 minutes).	Naturalistic Inquiry (Lincoln & Guba, 1985; 2004)	Not explicitly stated	A(9)	A(7)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	acute psychiatric inpatient facilities Australia	General Nurses and/or Division 3 Registered Mental Health Nurses with the Nurses Board of Victoria (Australia) - 5 or more years experience working in the area of acute inpatient psychiatric/mental health facilities - 10 participants from multiple mental health facilities including city, suburban, country, private, and public sectors - Variety of nursing experience, age range and cultural/educational backgrounds - All participants had perspectives on providing psychodynamic therapeutic care						
19.	Naeem, F., Gobbi, M., Ayub, M & Kingdon, D. (2010)	*Sampling Method:* Not explicitly stated	In-depth individual audio-taped semi-structured interviews	Not explicitly stated	Thematic Content Analysis	A(8)	A(6)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	Psychologists experience of cognitive behaviour therapy in a developing country: a qualitative study from Pakistan Pakistan	*Sample Origin and Total:* Lahore, Pakistan sample comprising of 5 participants *Participant Characteristics:* - 5 psychologists working in psychiatry departments in Lahore, Pakistan - All female participants trained in Rational Emotive Behaviour Therapy (REBT) and aware of CBT techniques - Experience range 3-15yrs	(lasting between 30-60 minutes). Interviews were conducted in English					
20.	Prytys, M., Garety, P.A., Jolley, S., Onwumere, J. & Craig, T. (2010) Implementing the NICE guideline for schizophrenia recommendations for psychological	*Sampling Method:* Purposive sampling *Sample Origin and Total:* UK sample of 20 participants *Participant Characteristics:* - 20 care co-ordinators	Individual audio-taped interviews (lasting between 25-60 minutes in length) 2 participants refused to be taped and therefore notes were taken	Not explicitly stated	Thematic Content Analysis (Bauer, 2000)	A(8)	A(6)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	therapies: a qualitative analysis of the attitudes of CMHT staff United Kingdom	from four CMHT's (5 care co-ordinators were interviewed from each team) - The sample included nurses (n=11), social workers (n=6), and occupational therapists (n=3) - The mean length of time working in the team was 6.3 years with a case load size of 24 clients.						
21.	Gearing, R.E., Schwalbe, C.S. & Short, K.D. (2012) Adolescent adherence to psychosocial treatment: mental health clinicians' perspectives on barriers and promoters America	*Sampling Method:* Not explicitly stated *Sample Origin and Total:* American sample consisting of 34 participants *Participant Characteristics:* - 31 females and 3 males - Overall average age of 42.5 years (SD 10.8)	In-depth, semi-structured audio-taped focus group interviews (lasting approximately 1.5-2 hours).	Grounded Theory Approach (Charmaz, 2006; Strauss & Corbin, 1998)	Open and Axial Coding (Strauss & Corbin, 1998) NVivo 8 (computer-assisted qualitative data analysis software) was used to manage and explore the data.	A(9)	A(7)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
		- 29 clinical social workers, 1 doctoral level psychologist and 4 clinical social worker interns - Average years of experience within the mental health field was 11.4 (SD 9.4) - 3 focus groups with 34 mental health professionals employed by the host agency who provided clinical service to children and adolescents - Each focus group had between 10 -14 clinicians						
22.	Luca, M. (2012) Therapeutic activities and psychological interventions by cognitive behavioural and psychodynamic therapists working with medically unexplained	*Sampling Method:* Not explicitly stated *Sample Origin and Total:* UK sample of 12 participants *Participant Characteristics:* - 6 female and 6 male	Semi-structured interviews	Constructivist Grounded Theory Approach (Charmaz, 2006)	Axial coding (Strauss & Corbin, 1998)	A(9)	A(8)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	symptoms: a qualitative study United Kingdom	individuals - Participant therapeutic modality was psychodynamic (n=6) and CBT (n=6) - Background disciplines included clinical psychology (n=5), psychiatry (n=1), social work (n=3), occupational therapy (n=2) and counselling psychology (n=1) - All participants were being trained in psychotherapy - Mean post-qualification experience was 14.5 and 13.8 in each (of the two) localities.						

Table 3. Study Characteristics Table for Combination Study Samples of Service User and Staff Participants

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
23.	Metcalf, L. & Thomas, F. (1995) Client and therapist perceptions of solution forucsed brief therapy: a qualitative analysis America	*Sampling Method:* Purposive sampling Sample Origin and Total: American sample comprising of 6 couples and their therapists. Total sample not explicitly stated *Participant Characteristics:* - 6 cohabiting couples aged between 25-65 years old and their (family) therapists. - Participants were chosen to take part in the study based on their therapists opinion that they had completed and terminated family therapy successfully - The therapist participants had conducted solution focused brief therapy for at least two years	Individual semi-structured interviews with couples and therapists	Analytical comparative approach (Turner, 1981)	Constant Comparison (Glasser & Strauss, 1967)	A(8)	A(6)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
24.	Raingruber, B.J. (2001) Three perspectives regarding what works and does not work in therapy: a comparison of judgements of clients, nurse-therapists, and uninvolved evaluators America	*Sampling Method:* Not explicitly stated *Sample Origin and Total:* American sample comprising of 8 matched-pairs of clients and nurse-therapists as well as 8 family therapists *Participant Characteristics:* - 8 service users - 6 nurse-therapists - 8 family therapists - Nurse-therapists and family therapists to have been in private practice for >5 years and were working >17 hours per week as a therapist - Nurse-therapists and their clients were white females aged between 28-66 years - Family therapists were female, aged between 25-54 years	Separate individual audio-taped interviews with clients and nurse-therapists whilst reviewing video-taped recordings of their session. Completed within 48 hours of the therapy session. 8 family therapists, independent to the therapy sessions, were interviewed whilst reviewing the video-taped sessions. All individuals interviewed and reviewing tapes were told to stop the video at significant points	Phenomenological Approach	Unspecified analysis method	A(8)	A(6)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
			and comment on these.					
25.	McGowan, J.F., Lavender, T. & Garety, P.A. (2005) Factors in outcome of cognitive-behavioural therapy for psychosis: users' and clinicians' views United Kingdom	*Sampling Method:* Purposive systematic, non-probabilistic sampling (Mayes & Pope, 1995) *Sample Origin and Total:* UK sample comprising of 12 participants (8 therapeutic dyads) *Participant Characteristics:* - 8 service users and 4 clinical psychologists - 4 male and 4 female clients with an age range of 26 to 42 - Service users had at least one positive symptom of schizophrenia according to DSM-IV - Service users had received treatment for psychotic symptoms using CBT methods with the outcome	Individual audio-taped interviews with therapists (lasting between 60 to 75 minutes) and two of each therapists clients (lasting between 40 to 50 minutes), whom were categorised as 'progressor' and 'non-progressor'	Grounded Theory Approach To control subjectivity and enhance transparency the following measures were put in place; using several data sources, the 'grounding' of ideas in a fine-grained analysis of the data, inter-rater reliability and respondent validity studies of the final analysis, and regular peer review	Not explicitly stated	A (8)	A (6)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
		of therapy either ‘progressed’ or ‘failed to progress’ - Service users had completed therapy within 3 months of the interview or had completed ‘substantive work’ - Clinical psychologists had completed formal CBT training and received further training and/or supervision in using CBT - Clinical psychologists were able to suggest two clients they had seen in therapy who met the inclusion criteria						
26.	Pontin, E., Peters, S., Lobban, F., Rogers, A. & Morriss, R.K. (2009) Enhanced relapse prevention for	*Sampling Method:* Purposive sub-sample from a cluster Randomised Control Trial *Sample Origin and Total:* UK sample consisting of 42 participants (21 service	Semi-structured interviews lasting on average 60 minutes (range 15 to 120 minutes) with service users and 45 minutes (range 25 to 96	Grounded Theorising Approach	Thematic Analysis	A(10)	A(7)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	bipolar disorder: a qualitative investigation of value perceived for service users and care coordinators United Kingdom	users with bipolar disorder and 21 Care co-ordinators) *Participant Characteristics:* - Service users; 13 females and 8 males with a mean age of 47 (range 24-63 years). Employment status ranged from unemployed (n=10), part or full-time employment (n=7), retired (n=2) and student (n=2) - Sample of care coordinator's (n=21) included 14 females and 7 males with a mean age of 45 (range 29-57) - Care coordinators professional background ranged from community psychiatric nurse (n=18), occupational therapist (n=2) and social worker (1) with a mean of 7.2 years working in the community mental health team and on average 20% of their case load	minutes) with care coordinators All interviews were conducted within 12 months of the delivery of the intervention.					

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
		having a bipolar disorder diagnosis (range 3-40%)						
27.	Rathod, S. Kingdon, D., Phiri, P. & Gobbi, M. (2010) Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions United Kingdom	*Sampling Method:* Purposive, targeted sampling *Sample Origin and Total:* UK sample comprising of 114 participants *Participant Characteristics:* - Patients with schizophrenia (n=15), focus groups with lay members from selected ethic communities (n=52) , focus groups or semi-structured interviews with CBT therapists (n=22), and mental health practitioners who work with patients from ethnic communities (n=25) - The research team actively recruited those who were defined as Black Caribbean,	Individual semi-structured audio-recorded interviews and focus groups with participants.	Not explicitly stated	Systematic Content and Question Analysis (Morse and Field, 1996) NVivo 8 (computer-assisted qualitative data analysis software) was used to manage and explore the data.	A(10)	A(8)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
		Black British, Black African and Pakistani or Bangladeshi - 20 face-to-face interviews (patients = 15; lay participants = 3; mental health practitioner = 1 and CBT therapist = 1). - 18 focus groups comprising 99 participants. Five focus groups with therapists (n=21); four focus groups with mental health practitioners (n = 24); none focus groups with lay members (n = 49)						
28.	Chouliara, Z., Karatzias, T., Scott-Brien, G., Macdonald, A., MacArthur, J. & Frazer, N. (2011) Talking therapy services for adult survivors of	*Sampling Method:* Professionals recruited by leaflets. The recruited professionals identified service user participants *Sample Origin and Total:* Scottish sample comprising of 44 participants	Individual interviews lasting between 40-60 minutes.	Idiographic approach NVivo 8 (computer-assisted qualitative data analysis software) was used to manage and explore the data.	Interpretative Phenomenologica l Analysis (IPA) (Smith, 1996; Smith and Osborn, 2003)	A(9)	A(7)	A

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
	childhood sexual abuse (CSA) in Scotland: perspectives of service users and professionals Scotland	*Participant Characteristics:* - 13 survivors of child sexual abuse and 31 professionals working in the field over 9 National Health Service (NHS) settings and mainstream services and 11 voluntary sector settings - Service user participants were >18 years old, a client of the mental health services in the area with a history of child sexual abuse - 7 'survivor' participants were accessing NHS services and 6 were utilising services in the voluntary sectors - All service user participants were female - 16 professional participants worked in the statutory and 15 in the voluntary sector. - Professionals therapeutic approaches ranged from CBT (n=12), person-centred						

No.	Authors, Date and Country of Study Origin	Participant Characteristics & Sampling Method	Data Collection	Method/Approach	Analysis	Category (Score) CASP	Walsh & Downes	Overall Quality
		therapy (n=14), art therapy (n=1), cognitive analytical therapy (n=2), compassionate mind therapy (n=1), dialectic-behavioural therapy (n=3), interface intervention model (n=1) and solution focused therapy (n=1) with most professionals stating that they utilised an "eclectic" approach.						

Table 4. Overview of Study Concepts as Related to Overarching Themes and Sub-Themes

Study		Service User Factors										
		Predisposing Cultural Beliefs & Attitudes			Therapeutic Experience				Personal & Therapeutic Change		Reflection & Evaluation	
		Expectancy	Experience	Motivation	Normalising & Validating	Learning & Sharing	Support	Acceptance & Change	Benefits	Barriers & Challenges	Illness Perceptions	Facilitator & Operational Aspects
Service User	1							x		x		
	2	x		x		x	x		x		x	x
	3	x	x	x				x				x
	4	x	x								x	x
	5		x		x	x	x				x	x
	6	x		x	x	x	x		x	x	x	
	7				x	x	x		x		x	x
	8					x					x	
	9	x	x					x		x		x
	10				x	x			x	x		x
	11	x	x	x			x		x	x		x
	12	x			x	x		x		x		x
	13	x			x	x	x	x	x	x	x	
	14			x			x		x	x		x
	15			x	x			x		x		
	16			x	x	x	x	x	x	x	x	x
Staff	17											
	18	x	x			x					x	x
	19	x			x					x		x
	20			x								
	21	x		x						x		
	22				x		x					
SU-Staff	23		x	x	x	x	x	x	x			x
	24											
	25			x		x		x			x	x
	26				x	x	x	x	x	x	x	x
	27	x	x	x	x					x		x
	28				x	x	x	x	x	x		x

Study		Therapy Factors								
		Illness Perceptions		Therapy Stages				Therapeutic Relationship(s)		Recovery & Hope
		Stigma	Stage of Illness	Suitability & Accessibility	Process	Flexibility, Continuity & Consistency	Endings & Outcome	Partnership & Collaboration	Shared Control & Focus	Real Life Implementation & Outlook
Service User	1		x		x			x	x	
	2		x	x		x	x	x		x
	3	x		x	x		x			x
	4		x	x	x		x			x
	5	x								
	6		x	x	x			x		x
	7				x		x	x	x	x
	8			x				x		x
	9		x	x	x	x	x	x	x	x
	10		x	x	x			x		
	11		x	x	x	x	x	x		
	12			x	x	x	x	x	x	
	13	x	x	x			x	x		x
	14			x	x		x	x		
	15		x	x		x	x			x
	16		x	x	x	x	x	x	x	x
Staff	17									
	18	x	x	x	x			x		x
	19	x		x	x	x		x		
	20	x		x		x				
	21	x		x						
	22	x			x	x		x	x	
SU-Staff	23		x		x	x	x	x	x	x
	24				x	x				
	25		x			x		x	x	
	26						x	x		x
	27	x	x	x						
	28	x	x	x	x	x	x	x		x

Study		Staff Factors				
		Professional Background & Psychological Perspective		Staff Role		Evaluation
		Beliefs, Attitudes & Views of Recovery	Expertise	Therapeutic Approach & Response	Working Relationship(s)	Challenges & Barriers
Service User	1					
	2		x	x	x	
	3			x		
	4		x			
	5					
	6			x		x
	7	x		x		
	8			x		
	9			x	x	
	10			x		
	11					
	12					
	13					
	14					
	15					
	16					
Staff	17	x		x		x
	18	x	x	x		x
	19			x		x
	20	x	x			x
	21			x		x
	22	x		x	x	
SU-Staff	23	x	x	x	x	
	24			x	x	
	25			x		
	26	x		x	x	x
	27	x		x		x
	28			x		x

Figure 1. Overview of Literature Search

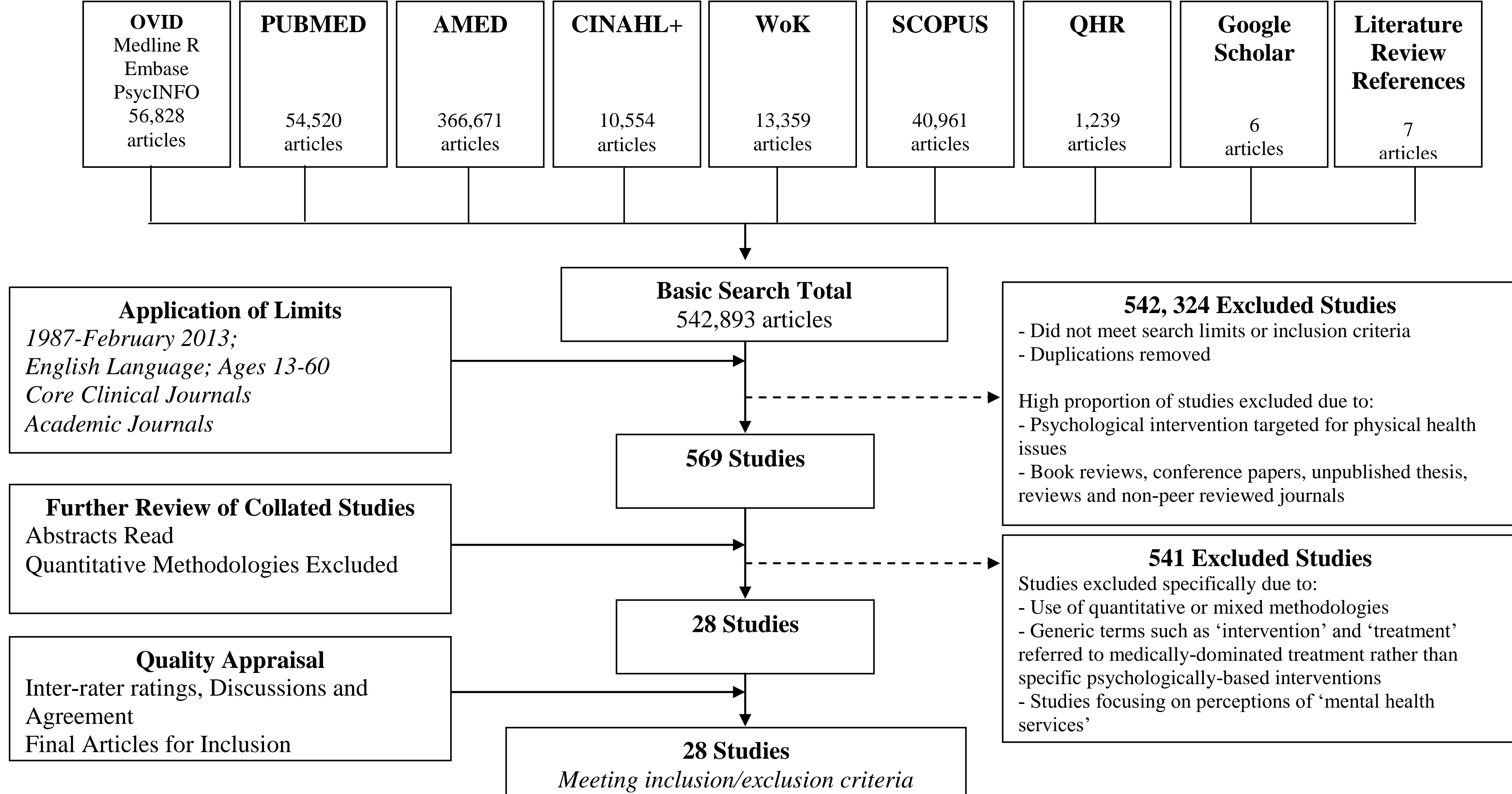

Figure 2. Diagrammatic Illustration of the Overarching Themes

Service User Factors
Therapy Factors
Staff Factors

Predisposing Cultural Beliefs & Attitudes
Expectancy
Experience
Motivation

Therapeutic Experience
Normalising & Validating
Learning & Sharing
Support
Acceptance & Change

Personal & Therapeutic Change
Benefits
Barriers & Challenges

Reflection & Evaluation
Illness Perceptions
Facilitator & Operational Aspects

Illness Perceptions
Stigma
Stage of Illness

Therapy Stages
Suitability & Accessibility
Process
Flexibility, Continuity & Consistency
Endings & Outcome
Pre - Mid- Post Therapy

Therapeutic Relationship(s)
Partnership & Collaboration
Shared Control & Focus

Recovery & Hope
Real Life Implementation & Outlook

Professional Background & Psychological Perspective
Beliefs, Attitudes & Views of Recovery
Expertise

Staff Role
Therapeutic Approach & Response
Working Relationship(s)

Evaluation
Challenges & Barriers

Paper 2.a

The Acceptability and Feasibility of the Baby Triple P Positive Parenting Programme on a Mother and Baby Unit: Q-Methodology with Mothers with Severe Mental Illness

Prepared according to submission guidelines for the
Journal of Child Psychology and Psychiatry (see Appendix 10)

Abbreviated Title: Baby Triple P on a Mother and Baby Unit: Q-Methodology with Mothers with SMI

Word Count: 4820*

*Excluding: Tables, Figures and References

Word Count for Tables and Figures: 1642

Abstract

Background: There is no national clinical guidance for the provision of parenting interventions for mothers with severe mental illness (SMI) in Mother and Baby Units (MBU's). The recent introduction of Baby Triple P Positive Parenting Programme, a new 'level 4' addition to the extensively researched and evidence-based Triple P Parenting Programmes, on a MBU permits an exploration of service user views about its acceptability and feasibility.

Method: A Q-methodology approach using an 88-item Q-sort, was conducted with a purposive sample of 15 service users with SMI.

Results: Three main factors were identified: 'w*hat we need*', '*what we want*' and '*we can do it*'. A consensus of opinion was noted with general agreement as to the benefits of Baby TP and the suitability of the MBU environment to accommodate Baby TP.

Conclusions: Service users with SMI regarded Baby TP to be an acceptable and feasible parenting intervention for them, viewing it as positive and non-stigmatising. They wanted more staff to have an awareness and knowledge about the programme to support them in generalising skills learnt in the MBU in preparation for use in their home environment.

Keywords: Baby Triple P, Mother and Baby Unit, Mothers with Severe Mental Illness, Q-methodology, Q-sorts

New parents receive little preparation for their role (de Graaf et al, 2008) and mothers presenting with severe mental illness (SMI) have the additional challenge of not only attending to the ongoing needs of their baby, but also managing their own mental health difficulties (National Institute for Clinical Excellence [NICE], 2007). How this is managed has short and long-term consequences for the health and well-being of both mother and baby (NICE, 2008), because parental mental health difficulties affect social and emotional development of the child (Sanders, 2012; Fraser et al, 2006; White et al, 1995). Mothers with SMI consistently report of feeling guilt for the impact their mental health problems have on their child (Davies & Allen, 2007) and can perceive themselves as having divided identity of being a 'mother' but also a 'woman with mental illness' (Dolman, Jones & Howard, 2013). Various studies document the importance of motherhood to women with SMI (Chernomas et al, 2000), but there remains a general trend of poor parenting outcomes within this population (David, Styron & Davidson, 2011).

Mothers presenting with more chronic and persistent mental health difficulties, such as schizophrenia or major affective disorders, are often admitted to specialist psychiatric services including Mother and Baby Units (MBUs), which address assessment, treatment and practical issues and provide a range of therapeutic interventions (NICE, 2008). Although the importance of parenting in the early years is widely recognised (Allen, 2011), national guidance (NICE, 2007) with regard to the role of parenting interventions in such settings is limited, with no consensus or clear recommendations (Royal College of Psychiatrists, 2008). This indicated that research into the feasibility, acceptability and

effectiveness of parenting interventions in this area would be both timely and warranted (Dolman, Jones & Howard, 2013; Howard & Hunt, 2008).

The Triple P Positive Parenting Programme (Triple P) is a well established multi-layer preventively orientated family intervention programme, which promotes positive parenting relationships between parents and their children, regardless of socio-cultural boundaries, age or gender (Thomas & Zimmer-Gembeck, 2007; Turner & Sanders, 2006). Based on social learning, cognitive behavioural and developmental theory, the five levels of intervention range in intensity from Level 1 (lowest intensity), a universal parenting programme for improving general knowledge and awareness of parenting information, to Level 5, an enhanced and specialised programme targeted at families whose parenting is compromised due to significant stressors (e.g. marital conflict) (Sanders, Markie-Dadds & Turner, 2003). All Triple P programmes are based on five core principles (i.e. safe and engaging environment, positive learning environment, assertive discipline, realistic expectations and parental self-care). These act to both normalise and validate the difficulties experienced by parents, and promote the development of key parenting skills to increase confidence and self-sufficiency in being able to manage parenting and family challenges independently and without need for professional support ("Triple P", 2013; Sanders, 2012). Triple P is accessible and effective within various settings, such as schools and day centres (Mazzucchelli & Sanders, 2010), and populations including children with anti-social behaviour and ADHD (Bor, Sanders & Markie-Dadds, 2002; Serketich & Dumas, 1996). Research is being conducted into the applicability of Triple P for parent populations with mental health difficulties (Jones et al, 2013).

The Baby Triple P Positive Parenting Programme (Baby TP), at Level 4 of the Triple P series is one of the newest additions to the programmes and is specifically designed to enhance the knowledge, skills and confidence of new parents, reduce parental psychopathology and family risk factors. One MBU in the North West of England is currently evaluating the benefits of this specific parenting intervention to mothers of babies within this setting.

Baby TP incorporates many of the techniques and practices developed to encourage positive mother-baby relationships within the MBU setting; and it meets clinical guidance for postnatal care in empowering women and families in long term independent care for their baby (Demott et al, 2006). Four sessions covering positive parenting, responding to the baby, psychological coping skills and family support are offered whilst the mother is still on the MBU. After discharge four sessions are offered as telephone support to increase confidence and efficiency in applying the Baby TP skills within the family system.

For the service user population, intervention acceptability and feasibility can be operationalised as accessibility, applicability, sustainability and achievability (Breitenstein, 2013; Dahlgren, Lask, Landrø & Rø, 2013; Stallard & Buck, 2013). The service user views on feasibility and acceptability of any type of psychological or psychiatric intervention is a most valuable source of information and can provide the opportunity for collaborative contribution to clinical practice, decision making and refining of any future programme (Mazzucchelli & Sanders, 2010; NICE, 2008, 2007). An appropriate method to examine a potentially diverse range of service user opinions is Q-methodology, which combines both qualitative and quantitative techniques (Cross, 2005) with minimal constraints and researcher bias (Watts & Stenner, 2012).

There are ongoing evaluations into the efficacy of Baby TP. Currently, however, there is no published research on the applicability of Baby TP for mothers presenting with mental health difficulties. This study examines how service users consider the effectiveness of the Baby TP programme in terms of feasibility and acceptability.

Method

The study was approved by a local National Health Service Research Committee (REC Reference 11/NW/0716; Appendix 11) and National Health Service Research and Development department (R&D Reference 1091; Appendix 12).

Recruitment

The sample comprised mothers with SMI from one MBU in the North West of England who had either completed Baby TP ('experienced Baby TP') or had no experience because they could not complete it prior to their discharge from the unit ('no experience of Baby TP'). It was considered important to obtain opinion from both groups of mothers to determine a broad perspective. Participants were included in the study if they were over 18 years old, able to comprehend written or spoken English, residing on the MBU at the time of interview, and deemed "well" by MBU staff members on the day of the Q-sort. Participants who had participated in Baby TP and had subsequently been discharged were also approached.

Initially participants were informed about the study by the Baby TP facilitator (AW) or by MBU staff. Consenting participants were provided with participant information sheets and consent forms (Appendix 13-16).

Participants

The final participant sample included 15 mothers of whom seven had Baby TP experience and eight had no experience of taking part in Baby TP. The sample ranged in age (mean = 31.9 years; SD = 5.5), nationality, number of children in the household and diagnosis (Table 1).

[Insert Table 1 here]

Procedure

Phase 1 – Concourse and Q-Set Development

The initial 'concourse' was developed through a range of strategies (Watts & Stenner, 2012) (Appendix 17), including a literature search into perceptions of acceptability and feasibility of parenting programmes, parenting satisfaction questionnaires and evaluation forms, existing relevant Q-sets, e-mail correspondence with the Quality Network for Perinatal Mental Health and the Division of Clinical Psychology Faculty of Perinatal Psychology together with semi-structured interviews exploring concepts of acceptability and feasibility of parenting interventions with one MBU service user and two members of staff.

The principle researcher (HB) and a clinical psychologist (SW) experienced in Q-methodology identified discreet statements from the Q-concourse, which were initially categorised into 68 themes. Representative statements from each

theme were identified to give a final total of 88 statements (Q-set). This Q-set covered a range of opinions and attitudes regarding parenting interventions (Appendix 18). Statements were printed on yellow card, allocated random numbers and laminated for use with participants.

Phase 2 – Q-Sort

Two clinical psychologists independent of the study and a Baby TP experienced service user who had been discharged from the MBU completed a pilot Q-sort. No changes to the statements or method were required.

Participants read through the Q-statements and sorted them into three sets: disagree, neutral and agree. They were then asked to complete a forced choice Q-grid (Appendix 19) by systematically ranking statements from "most agree" (+6) to "most disagree" (-6). Finally, participants re-examined their sort and made any required changes. Post-sort interviews were carried out to obtain feedback about the Q-statements ranked at the extreme ends of the Q-grid and salient elements of the topic or process. The Q-sort task took approximately 60 minutes to complete.

Data Analysis

The PQMethod (Schomolck & Atkinson, 2002), a statistical package specifically designed for the analysis of Q-sort data, was used for the Q-analysis. It allows for principal component analysis (PCA) for factor extraction with a varimax rotation to maximise the amount of variance within the factors. This process utilises the participant as the factor rather than the variables or statements, therefore the participants who ranked the Q-statements in a similar manner were clustered (Brown, 1996).

Initially, PQMethod presented the relationships between all of the individual Q-sorts through a correlation matrix (Appendix 20). Using PCA, eight (unrotated) factors were extracted of which the three factors accounting for the largest amount of variance (57%) were then rotated with varimax rotation. The overall analysis highlighted factor defining Q-sorts, factor scores, factor arrays ('ideal' sorts) and consensus statements (Watts & Stenner, 2012).

Q-methodology focuses on the quality of opinions and applicability of the participants employed to voice relevant viewpoints about a topic, rather than sample size (Brown, 1996). A general rule in Q-methodology is for participant samples to be 'less than the number of items in the Q-set' (p.73, Watts & Stenner, 2013).

Results

The varimax rotation produced a solution in which 14 of the sorts loaded onto three factors accounting for 57% of the variance. Five Q-sorts loaded onto Factor 1 (23% variance), six loaded onto Factor 2 (19% variance) and three loaded onto Factor 3 (15% variance) (Table 2). One Q-sort (P9) did not significantly load onto any of the factors and hence did not typify any of the study factors. However, this does not mean that these opinions regarding the acceptability and feasibility of Baby TP are disregarded or unhelpful. The opinions and attitudes from this Q-sort were considered alongside defining sorts as part of the interpretative process (Brown, 1996).

[Insert Table 2 here]

Factor 1 was the "strongest" factor because it accounted for the largest amount of the variance. The Factor Arrays, exemplar or "ideal" Q-sorts, for each of the three factors (see Table 3) (Appendix 21) as well as the post Q-sort interviews were used to further delineate the three factors.

[Insert Table 3 here]

Interpretation of the Q-sorts

Factor 1: *'What We Need'*

This factor accounted for 23% of the variance and represented the Q-sorts of five participants (33%), with the majority (n = 4) having completed the Baby TP programme. This principle factor was labelled *'What We Need'* to reflect participants' strong agreement with a number of needs that Baby TP should aim to fulfil.

Responses loading onto this factor suggested that Baby TP was accessible for mothers within the MBU. They strongly disagreed (-6) with the programme being too labour-intensive (44: "Baby TP will use all the mothers energy and focus") or having a negative focus (53: "Baby TP will be about what has gone wrong for mother and baby"). Participants also strongly disagreed (-5) that being involved in Baby TP would negatively impact on their perception of being a parent (28: "Doing Baby TP will make mothers feel like 'bad parents' "; 75: "Doing Baby TP will make mothers feel exposed or a bad mother") and they also disagreed (-4) that others would be negatively viewed (29: "Baby TP might make people feel that they are being unfairly judged or blamed"). Participants agreed

(+4) that this parenting programme would be beneficial (36: "Baby TP will help develop skills that can help deal with family problems").

With regard to their own mental health, participants strongly endorsed (+6) that mothers need a positive approach (54: "Baby TP needs to emphasise the positive so as not to make the mother's mental health worse"), that focuses on and is flexible to the mother's practical and mental health needs (73: "It is important for that Baby TP highlights the importance of the mother's self-care" (+6); 6: "Baby TP needs to fit with the mother's mental health needs"(+5); and 7: "Baby TP should be flexible to the mothers mental health status' (+5)). The therapeutic relationship was highlighted as a significant element of Baby TP with strong agreement (+6) that "A trusting relationship with the Baby TP therapist is important" (24).

Service users highlighted a staff need by strongly agreeing (+5) that "Staff need support and training to feel confident in delivering the Baby TP skills" (62). Participants commented further on their support for Baby TP, reflecting particularly on the points pertinent to them (Appendix 22):

"I think the delivery of the programme needs to be very responsive and adaptive to what's going on with the mum." (Participant 2, Baby TP experienced)

"I think it is really important that you trust whoever you are working with because, especially as this is for people with mental health problems, you feel very exposed and vulnerable, which I think you do as a first time mother anyway." (Participant 4, Baby TP experienced)

Factor 2: *'What We Want'*

This factor accounted for 19% of the variance and represented views endorsed by six participants (40%), with four having no experience of Baby TP. The factor label captures a number of issues pertaining to what these participants wanted from Baby TP. Similar to Factor 1, participants positively endorsed Baby TP by strongly refuting (-6) any associated stigma with the programme (28: "Doing Baby TP will make mothers feel like 'bad parents'"; 75: "Doing Baby TP would make mother's feel exposed or bad mother"). They also strongly perceived Baby TP as beneficial in developing parenting skills and techniques, applicable to the family system (+6, 40: "Baby TP will be helpful for mothers in meeting their parenting needs" and; +5, 36: "Baby TP will develop skills that can help with family problems"). The therapeutic relationship was again strongly endorsed (+6) as being important (24: "A trusting relationship with the Baby TP therapist is important"). Despite their inpatient admission, mothers believed the intervention to be offered at the right time and strongly disagreed (-6) that this was not appropriate (79: "Baby TP comes at the wrong time").

Participants endorsed a number of items relating to what they would 'want' from Baby TP. Whilst there was strong agreement that "Mothers want factual information about parenting" (+5; 77), they also emphasised that "It is important that Baby TP will highlight the importance of mothers looking after themselves" (+5; 73). In addition, participants also endorsed (+4) that they wanted to gain a sense of achievement when taking part in Baby TP (57: "It is important for the mother to recognise what she has done well"; 30:"It is important for mothers doing Baby TP can gauge their progress").

Participants believed that MBU staff should be knowledgeable about Baby TP (+6; 84: "It is important that staff understand why Baby TP works") and should be able to accommodate the Baby TP approach into their work by strongly disagreeing with the statement that "staff have too much work to do to support Baby TP skills adequately" (-6; 65). The views that Baby TP should complement usual MBU staff activities were also endorsed (-4, 70: "Baby TP should not get in the way of other MBU work", -5, 68: "It is important that Baby TP takes small amount of staff time"). Finally, participants emphasised the benefits of the specific parenting skills learnt and the need for all MBU staff to be knowledgeable about Baby TP:

"I mean some (mothers) will be first time mums and some will have a couple of children, it doesn't matter, they all want new skills because they care about their children." (Participant 8, no Baby TP experience)

"It (Baby TP) is not going to expose you as a bad parent or that you are doing bad parenting. You want the help and there you have it." (Participant 3, Baby TP experienced)

"The Baby TP should be incorporated into their (staff) work, so that if they are working together with the therapy or the therapist, it would be very helpful for us, if both of them know what is what. We may not have the therapist with us so then the staff may be able to do something about it" (Participant 10, no Baby TP experience)

Factor 3: *'We Can Do It'*

Factor 3 accounted for 15% variance and represented the views of three participants (20%), with the majority (n= 2) having no Baby TP experience. The

participants had strong opinions about the ability to engage with Baby TP and the importance of mothers feeling a sense of achievement in doing the programme.

As with Factor 1 and 2, participants did not view Baby TP as stigmatising (-6, 28: "Doing Baby TP will make mothers feel like 'bad parents'). The participants, two of whom had not experienced this intervention, strongly endorsed that "Baby TP should be based on common-sense" (+6; 88) and they rejected the statements that implied that engaging in this intervention would overburden mothers admitted to a psychiatric unit (-6, 32: "Baby TP is an extra thing to engage in and will make mothers feel overwhelmed"; 44:"Baby TP will use all of the mothers energy and focus"). Their views on mothers' ability to engage with this intervention at this time were further supported by their agreement to the statement that "It is important that mothers have a positive attitude towards recovery from illness" (+5; 48). They also believed that involvement in Baby TP increased their sense of achievement (+6, 31: "It is important that mothers feel that they have achieved something"; +5, 57: "It is important that mothers recognise what they have done well"). Their reflective comments also highlight the themes captured by this factor:

"I think it is important to be positive (towards recovery). I think it possibly does make a difference as to whether people can understand Baby TP." (Participant 6, Baby TP experienced)

"Recognising what I have done well, you know, you would be thinking "well I have done it well this week so I will do it well next week." (Participant 12, no Baby TP experience)

Consensus Statements

The Q-analysis identified three statements having the same ranking across the factor arrays (20; 42; 51), which is indicative of universally shared opinions (Watts & Stenner, 2012). All participants believed that the MBU was a suitable environment for Baby TP by strongly disagreeing with the statement that "There is no opportunity to practice the Baby TP skills on the MBU" (-5; 51). They also believed Baby TP to be beneficial regardless of personal circumstances (-4, 20: "If the mother has unchangeable situations at home Baby TP is not going to be helpful"). Most participants believed that residing on a MBU did not necessarily facilitate their engagement with this intervention (-1; 42 "Whilst staying on the MBU it is easy for mothers to commit to Baby TP").

Factor Comparisons

All factor arrays revealed that Baby TP was regarded as a positive and worthwhile parenting intervention. The relationship between the factors was moderately correlated (Table 4), which indicates similarities in factor findings. Analysis of Z-score differences between the factors (Appendix 23) and an examination of the participants' reflective comments confirmed themes and topics identified within specific factors.

[Insert Table 4 here]

Discussion

The views and perceptions of 15 mothers, admitted to a MBU because of mental health difficulties, were examined regarding the acceptability and feasibility of the Baby TP parenting intervention. Using Q-methodology and analysis, three factors

were identified: '*What We Need*', '*What We Want*' and '*We Can Do It*'. There was also a strong consensus in perception that the MBU setting was both a suitable environment to engage in a parenting intervention, and that the environment provided the opportunity and the time to accommodate the practice of Baby TP skills. However, the findings also indicate that service user ability to commit to Baby TP may be difficult at times which possibly reflects the multiple challenges of recovering from mental health difficulties whilst caring for a baby.

All participants regarded Baby TP as a non-stigmatising, positive approach, which facilitated learning parenting skills and coping with family problems, irrespective of their home situations. The perceived value of Baby TP in this respect is in line with previous findings which emphasise the importance of family support to mothers with SMI (Borba et al, 2012). Establishing a therapeutic and trusting relationship was consistently recognised as being important in Baby TP, in line with previous research (David, Styron & Davidson, 2011). This underscores that mothers value the time and opportunity to discuss issues of parenting concerns on an individual and regular basis (Dolman, Jones & Howard, 2013; NICE, 2007).

The principle factor '*What We Need*' reflected the views of individuals who had completed the intervention. As previously noted (David, Styron & Davidson, 2011), service users emphasise the need for the intervention to provide a flexible approach, which can accommodate the variability of a mother's mental health and circumstantial requirements. Service users stressed that staff working on the MBU need to be familiar with Baby TP to be able to support practice and the implementation of learnt skills.

Participants loading on the second factor '*What We Want*' detailed the elements service users wished to see in a parenting programme. As the majority of mothers loading onto this factor did not have Baby TP experience, they emphasised the provision of factual information and a focus on self-care as being the most valued programme elements. They also wanted to be able to evaluate their own progress and viewed the parenting programme as a way of developing a positive sense of achievement.

The difference in emphasis between Factor 1 and Factor 2 (i.e. the "Need" and the "Want") is subtle, with participant comments being important in making this delineation, as well as the different demographic profile of the two groups of participants, i.e. with and without Baby TP. Mothers with Baby TP experience were able to provide a considered and retrospective view of their perceived absolute essential elements (i.e. the "Needs" of Baby TP), whereas those without Baby TP experience and awareness of the exact intervention aims endorsed elements that reflected their own priorities or "Wants" (what they would wish to have).

Factor 3 ('*We Can Do It*') reflects the strongly endorsed opinion of these service users that they would be able to engage in Baby TP, whilst (and despite) residing on the MBU. They regarded Baby TP as an achievable and desirable parenting intervention, not too overwhelming, taxing or intensive. However, they also recognised that in order to fully benefit from Baby TP, it would be important for mothers to have a positive attitude towards their own recovery.

Limitations

A limitation of the present study is the difficulty, inherent in Q-methodological research, in generalising the findings. Whilst large sample sizes are not required for Q-methodology research, the small purposive sample of opinions obtained from 15 services users who were admitted to the same MBU, albeit at different times, creates contextually bound findings and is therefore not necessarily representative of the opinions of all mothers with SMI or on a MBU. Additionally, Q-methodology focuses on subjective opinion and perception, which in itself can cause difficulties in generalising findings.

Although the collation process of the range of Q-statements used in the Q-sort was comprehensive and inclusive, it is important to ensure that all opinions and attitudes were captured as far as is reasonably practical to avoid any limitations this might impose on the Q-statements and sort. No additional topics are identified in the post-sort interviews, which suggests that the collation process for this study was indeed comprehensive.

The influence of any participant and researcher bias must be considered in the interpretation of the Q-analysis. Stressing the anonymity of response, providing ample opportunity to clarify any immediate issues, and conducting a post-sort interview help to address the potential for participants to interpret and sort Q-statements in a socially desirable manner. The risk of researcher bias was minimised through discussion and consultation with peers and researchers, independent of the research team.

Clinical implications

In line with other findings, service users within this study identified specific 'needs' and 'wants' that are worthy of consideration (Dolman, Jones & Howard, 2013). Three main clinical implications emerge. Firstly, Baby TP was perceived to be a non-stigmatising, acceptable and feasible parenting intervention for them despite their admission to a MBU setting. The programme would therefore be a beneficial addition to the psychiatric and nursing care offered within a MBU setting (NICE, 2007). More generally, Baby TP can provide the clarity and consistency to parenting skills and approaches within this setting, lacking in current national guidance and policy. Secondly, service users identified the need for all MBU staff to be familiar with the basic skills and techniques of the Baby TP programme. They emphasised that they wanted to be supported in their implementation of the skills learnt. Training all staff (at least within one unit) in this approach should be considered by service providers to ensure consistency of this approach for service users. Thirdly, to expand awareness, promotion and adoption of the use of Baby TP on the MBU, topic-specific parenting discussion groups (Sanders, 2012), peer support groups and access to multi-media forms of Triple P information (i.e. web-based Triple P; Jones et al, 2013) could be implemented.

Future directions

Replications of this study in other MBU settings with a larger and more diverse sample are needed to expand upon and validate study findings to provide wider confirmation of the efficacy of the Baby TP programme, as perceived by mothers presenting with SMI. Staff opinion about the feasibility and acceptability of the

Baby TP programme on the MBU is currently being investigated (Butler et al, 2013; Paper 2.b.). Combining findings from both studies will provide a more comprehensive assessment of the views of all those involved with this intervention.

In terms of overall and ongoing efficacy, it would be useful to investigate the impact of the Baby TP intervention on the mother-infant relationship, maternal mental health (symptoms and severity), and family functionality. Further exploration into how skills and techniques gained from Baby TP within the MBU setting are incorporated into the family system and the benefits this provides to the functionality of the family unit would direct future policy and research.

Service users appear to enjoy and engage in the novel experience of the Q-method. It should be possible to adapt and develop this approach to use as a 'user-friendly' therapeutic tool or evaluation measure to help service users within the MBU express and rationalise their parenting needs and experiences.

Conclusions

This is the first study to investigate service user opinion regarding the acceptability and feasibility of the Baby TP programme in a MBU setting using Q-methodology. On the basis of the current data, Baby TP appears to be a feasible and acceptable intervention within a mental health context.

Key Points

- There is a gap in national guidelines, policy and research as to the role of parenting interventions for mothers with severe mental illness (SMI) and within a Mother and Baby Unit (MBU) setting.
- New research is being conducted into the applicability of Triple P Positive Parenting Programmes, a well-established, evidenced-based parenting series, for parents with mental health difficulties.
- The benefits of Baby Triple P, a relatively new addition to level 4 of the Triple P series, are currently being examined on a MBU.
- Using a Q-methodology design, the current study showed that Baby TP was perceived as an acceptable, feasible, non-stigmatising parenting programme for the MBU setting by two groups of service users (Baby TP experienced and inexperienced).

Declaration of Interest

None of the authors of the above manuscript have declared any conflict of interest, which may arise from being named as an author on this manuscript. There were no funding sources for this study.

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Table 1. Service User Demographics

No	Diagnosis	Age (Years)	No of Children	Nationality
1	Depression and Anxiety*	28	1	British
2	Bipolar Disorder*	36	1	British
3	Paranoid Schizophrenia*	40	1	British
4	Depression with Anxiety*	34	1	British
5	Depression with Anxiety*	29	1	British
6	Paranoid Schizophrenia*	31	1	British
7	Depression with Anxiety*	37	1	British
8	Psychotic Depression	31	Pregnant	British
9	Schizophrenia	31	1	British
10	Depression and Psychotic Symptoms	37	1	French
11	Postnatal Depression	20	1	British
12	Grief Reaction	40	3	British
13	Psychotic Depression	32	1	French
14	Depression with Anxiety	27	1	British
15	Psychotic Depression	26	1	British

*Baby TP experienced participants

Table 2. Factor Loadings and Factor Dependent Demographics

Factor Loading	BTP/nBTP*	Age	Diagnosis	Nationality	Children
1	BTP	36	Bipolar Disorder	British	1
1	BTP	34	Depression with Anxiety	British	1
1	BTP	29	Depression with Anxiety	British	1
1	BTP	37	Depression with Anxiety	British	1
1	nBTP	20	Postnatal Depression	British	1
2	BTP	28	Depression with Anxiety	British	1
2	nBTP	31	Psychotic Depression	British	Pregnant
2	nBTP	37	Depression and Psychosis	French	1
2	nBTP	32	Psychotic Depression	French	1
2	nBTP	27	Depression with Anxiety	British	1
2	BTP	40	Schizophrenia	British	1
3	BTP	31	Schizophrenia	British	1
3	nBTP	40	Grief Reaction	British	3
3	nBTP	26	Psychotic Depression	British	1
-	nBTP	31	Schizophrenia	British	1

*BTP – Baby TP Experience   nBTP – no Baby TP experience

Table 3. Factor Arrays for all Three Factors

No	Statement	Factor		
		1	2	3
1	The MBU provides time to take part in Baby TP	2	3	1
2	It is important that Baby TP fits nicely with the ethos of the unit	2	0	0
3	The skills taught in Baby TP need to generalise to environments other than the MBU	3	0	3
4	When mothers are unwell, Baby TP will be intolerable	-4	-3	-3
5	Mental health issues prevent mothers from accessing Baby TP	-4	-3	-3
6	Baby TP needs to fit with the mothers' mental health	5	5	1
7	Baby TP should be flexible to the mothers mental health status	5	-1	6
8	Baby TP will be fluid and flexible	1	-2	-2
9	Baby TP will be flexible to cope with unplanned events	0	-1	3
10	The facilitator needs to be skilled in their explanation of Baby TP	3	-1	1
11	Staff rolling out Baby TP need to have a thorough knowledge about mother and baby	1	2	-1

No	Statement	Factor		
		1	2	3
12	Baby TP will make women's anxieties about their ability to parent worse	-4	-3	-4
13	It is important for staff to be able to answer questions about Baby TP	0	-2	2
14	Baby TP is a reactive response from "anxious" professionals	-5	-3	-2
15	Staff need to believe that Baby TP benefits the mother	1	0	2
16	The techniques of Baby TP flow through to the staff on the MBU	-3	-3	-2
17	It is important that all staff know which mothers are using the Baby TP techniques	-1	-1	-3
18	It is important that the mother thinks Baby TP is worthwhile	5	0	4
19	It is important that mothers are open to change	-1	1	2
20*	If the mother has unchangeable situations at home, Baby TP is not going to be helpful	-4	-4	-4
21	Mothers want to be recognised for the work they are doing in Baby TP	-1	3	-1
22	Baby TP is "preachy"	-6	-4	-3
23	People providing Baby TP should only suggest techniques	1	-2	-1

No	Statement	Factor		
		1	2	3
24	A trusting relationship with the Baby TP therapist is important	6	6	1
25	One-to-one work will make it easier for mothers to say when they find Baby TP difficult	3	2	5
26	If the relationship between the Baby TP facilitator and mother is not working, neither will Baby TP	4	0	-4
27	It is important that Baby TP complements what staff already know	0	-2	1
28	Doing Baby TP will make mothers feel like “bad parents”	-5	-6	-6
29	Baby TP might make people feel like they are being unfairly judged or blamed	-4	-4	-3
30	It is important that mothers doing Baby TP can gauge their progress	0	4	2
31	It is important for mothers to feel they have achieved something	2	2	6
32	Baby TP is an extra thing to engage in and will make mothers feel overwhelmed	-3	-5	-6
33	It is OK for Baby TP to be challenging for mothers	-3	4	0
34	Mothers should have ongoing support in doing Baby TP	1	4	-1
35	It is important that the mother’s family are open to change	-2	0	-2

No	Statement	Factor		
		1	2	3
36	Baby TP will help develop skills that can help deal with family problems	4	5	2
37	It is important that Baby TP sessions do not interfere with family visits on the MBU	0	-2	-3
38	It is important that mothers feel in control and responsible for Baby TP	-2	4	1
39	Well delivered Baby TP will maintain overall confidence in the MBU	1	0	2
40	Baby TP will be helpful for mothers to meet their parenting needs	2	6	4
41	If a mother is severely depressed, they will not have the motivation to do Baby TP	0	-4	1
42*	Whilst staying on the MBU it is easy for mothers to commit to Baby TP	-1	-1	-1
43	In order to engage in Baby TP, staff expect mothers to be open to learning	1	1	0
44	Baby TP will use all the mothers energy and focus	-6	-1	-6
45	It is important that the Baby TP therapist works with both mother and baby	0	3	1
46	Baby TP will address mothers feelings of uncertainty	3	-1	4
47	It is important that Baby TP engages with the current situation and needs of the mother	3	1	5

No	Statement	Factor		
		1	2	3
48	It is important that mothers have a positive attitude towards recovery from illness	-2	1	5
49	Taking part in Baby TP will be a positive experience	3	3	0
50	It is important that mothers discuss Baby TP with other like-minded people	-3	1	-2
51*	There is no opportunity to practice the Baby TP skills on the MBU	-5	-5	-5
52	It is important that Baby TP is easy for mothers to do	0	-1	2
53	Baby TP will be about what has gone wrong for mother and baby	-6	0	0
54	Baby TP needs to emphasise the positive so as not to make the mother's mental illness worse	6	1	-1
55	The way Baby TP is presented to mothers will be important	4	3	4
56	It is important that Baby TP does not go against what mothers already know	0	-2	-2
57	It is important for the mother to recognise what she has done well	4	4	5
58	It is important for the mother to recognise what she could have done differently	-1	0	-1
59	It is important for the mother to recognise what she has done wrong	-3	0	0

No	Statement	Factor		
		1	2	3
60	Staff need to think about what parts of the Baby TP would be helpful for mothers	1	-1	3
61	It is important to encourage staff to reflect	-1	-2	0
62	Staff need support and training to feel confident in delivering the Baby TP skills	5	2	-1
63	All staff should have the same training in Baby TP	0	2	-3
64	It is important that both staff and mothers will find Baby TP enjoyable	-1	1	3
65	Staff have too much work to do to support Baby TP skills adequately	2	-6	-4
66	Baby TP will be easily incorporated into the workload of staff	-2	1	-2
67	Baby TP should not have too much paperwork for staff to do	2	-2	3
68	It is important that Baby TP only takes a small amount of staff time	-2	-5	0
69	Baby TP should be a priority for the MBU	-2	2	-5
70	Baby TP should not get in the way of other MBU work	0	-4	2

No	Statement	Factor		
		1	2	3
71	Baby TP is about learning new skills	-1	3	3
72	Baby TP provides a safe place for mothers who have mental health issues	2	1	3
73	It is important Baby TP will highlight the importance of mothers looking after themselves	6	5	-1
74	Engagement with mothers must be the priority in Baby TP	-1	1	1
75	Doing Baby TP would make mother’s feel exposed or a bad mother	-5	-6	-5
76	Staff attitude affects engagement on Baby TP	2	0	-2
77	Mothers want factual information about parenting	1	5	0
78	Practical materials are essential	0	2	-2
79	Baby TP comes at the wrong time	-3	-5	-5
80	The Baby TP therapist needs to really sell the programme to mothers	-3	-3	-4
81	It is important for all staff on the MBU to have a clear role within Baby TP	-2	-1	-1
82	All staff should support what is done in Baby TP	2	0	-1

No	Statement	Factor		
		1	2	3
83	It is important that mothers and Baby TP therapists work together to solve the mother's problems	4	2	2
84	It is important that staff understand why Baby TP works	1	6	0
85	Mothers being able to make choices in Baby TP is important	3	2	4
86	Mothers should decide when they want to do Baby TP sessions	-1	-3	0
87	Mothers need to know what they can do and cannot do for Baby TP to work	-2	3	0
88	Baby TP needs to be based on common-sense	-2	-2	6

* Consensus statements [statements 20; 42; 51]

Table 4. Factor Correlations

	Factor		
	1	2	3
1	-	0.5491	0.5361
2		-	0.5217
3			-

Paper 2.b

The Acceptability and Feasibility of Baby Triple P Positive Parenting Programme on a Mother and Baby Unit: Q-Methodology with Staff

Prepared according to submission guidelines for the

British Journal of Psychiatry (Appendix 1)

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Abstract

Background: The Baby Triple P Positive Parenting Programme, a new addition to the established Triple P programmes, is currently being trialled on a Mother and Baby Unit (MBU) with the aim of exploring its benefits to mothers presenting with severe mental illness.

Aims: To investigate staff views of the acceptability and feasibility of Baby TP on a MBU.

Method: Q-methodology study, using an 88-item Q-sort, was employed to explore the opinions of 16 staff working in a MBU in the North West of England

Results: The Q-sort analysis identified two distinct factors: 1) *staff qualified acceptance* and 2) *systemic approach/systemic results*.

Conclusions: Preliminary findings indicate that staff perceived Baby TP to be an acceptable and feasible intervention for the MBU setting and that mothers on the unit would be open and receptive to the programme.

As some mothers with severe mental illness (SMI), including schizophrenia and severe depression, require specialist psychiatric services,[1] admission to Mother and Baby Units (MBU's) may be recommended. These units, specifically designed to meet the treatment needs of both mother and baby, provide specialist therapeutic services and access to multi-disciplinary healthcare staff including psychiatrists, psychologists and (nursery) nurses.[2] These clinicians are often asked to make recommendations about specific parenting competences, including the consistency and adequacy of parenting skills.[3] However, there is no clear clinical guidance regarding parenting interventions within this setting,[4] but the Royal College of Psychiatrists [RCP] regards parenting skills training as "desirable".[5]

The Triple P Positive Parenting Programmes, based on social and developmental theories, have been developed to address the need for evidence-based preventively oriented parenting and family support strategies.[6] The multi-level intervention ranges from low intensity (Level one), a universal parenting programme directed towards increasing general knowledge of parenting information, to the high intensity (Level five), an enhanced and specialised programme for parents experiencing significant stressors (marital conflict, parental mental health and high levels of stress).[6] It is based on five core principles (safe and engaging environment, positive learning environment, assertive discipline, realistic expectations and parent self-care) and all levels can be accessed flexibly depending on individual needs and circumstances of individuals.[7,8] There is evidence that the different formats of Triple P are effective in specific populations, such as web-based applications for parents with bipolar disorder.[9] One of the new additions to Triple P is the Baby Triple P Positive Parenting Programme (Baby TP) (Level 4), which aims at developing knowledge,

skills and confidence of parents with their babies. The need for parenting skills training for service users within the MBU has led to one MBU in the North West of England implementing Baby TP on a trial basis.

There is little research into staff views about working with mothers presenting with SMI and, more specifically, the effectiveness and accessibility of parenting interventions in these settings.[10,11] Evaluations of the effectiveness of Baby TP are ongoing, but to date there are no published studies regarding the acceptability and feasibility of Baby TP in mental health services.

Acceptable and feasible interventions involve accessibility, applicability, sustainability and achievability.[12-14] These can aid in the evaluation of Baby TP within a mental health setting. Examination of the views of staff working on an inpatient unit for mothers and their babies will be useful in determining the acceptability and feasibility of Baby TP in such settings. The aim of the current study was to explore these views using Q methodology.

Method

The study received approval from the National Health Service Research Committee (REC Reference 11/NW/0716; Appendix 11) and the National Health Service Research and Development department (R&D Reference 1091; Appendix 12).

Participants

A convenience participant sample (P-Set) comprised of 16 female MBU staff members: 5 nursery nurses (31%), 4 staff nurses (25%), 1 senior staff nurse (6%), 1 support worker (6%), 1 ward manager (6%), 1 assistant ward manager

(6%), 2 specialist trainee psychiatrists (13%) and 1 consultant psychiatrist (6%). The length of experience ranged from 2 months to 34 years (M=14.8 years; SD= 10.9). All staff approached agreed to take part. Most staff (n=13) stated that their knowledge regarding parenting for this specific population came from 'general knowledge and ward experience'; three participants reported their knowledge was informed by undertaking a psychology degree, knowledge of Webster-Stratton techniques and the Parent-child Game and attending an in-house Baby TP presentation. The breadth, depth and quality of participant opinion is taken as being more relevant than sample size in Q-methodology,[15] and the general rule of having fewer participants than the number of Q-set items was followed.[16]

Procedure

Q Methodology Phase 1 - Concourse and Q-Set Development

As per standard Q-Set development, a literature search was undertaken looking at views, attitudes and opinions on acceptability and feasibility of parenting programmes, together with reference to extant satisfaction questionnaires, evaluation proformas and Q-sets on existing research on these concepts. Additionally, semi-structured interviews were conducted with one MBU service user and two members of staff. Members of the Quality Network for Perinatal Mental Health and the Division of Clinical Psychology Faculty of Perinatal Psychology were contacted via e-mail to also determine their views of acceptability and feasibility of parenting interventions. These all contributed to the development of a Q-concourse reflecting a full and balanced range of views and opinions within this area.[16]

The first author (HB) and a clinical psychologist (SW) identified 636 independent items which were grouped into similar themes (68 in total), resulting in an 88-item Q-set (Appendix 18). The statements were allocated a random number, printed onto cards and laminated for use with the participants. To check comprehension of the statements and process, pilot Q-sorts were conducted with two clinical psychologists independent to the study and a former MBU service user. All statements and the method were deemed suitable with no further changes required.

Q Methodology Phase 2 – Administering Q-Sets and Obtaining the Q-Sorts

Sixteen MBU staff members completed the 88-item Q-set by reading through the Q-statements and initially sorting them into piles: disagree, neutral and agree. Then they systematically ranked statements, according to a forced choice distribution, by how strongly they rated the statement on an opinion continuum (Q-grid) (+6 strongly agree to -6 strongly disagree). Post-sort interview questions were conducted about the Q-statements rated at the extreme ends of the Q-grid, as well as about the Q-process. Overall the Q-Sort task took between 45 – 60 minutes to complete.

Data Analysis

The Q-sort analysis was conducted using PQMethod (2.11).[17] Factor extraction was conducted using principle component analysis (PCA) with a varimax rotation to maximise variance within the factors. Q-sort relationships were initially presented in a correlation matrix (Appendix 24). Seven (unrotated) factors were

extracted using PCA, with two factors (accounting for the largest amount of variance) subjected to varimax rotation. The resultant analysis identified defining Q-sorts, factor scores, factor arrays (exemplar sorts) and consensus statements.[16]

Results

Statistical Analysis

Ten Q-sorts loaded onto Factor 1 (26% variance) and six loaded onto Factor 2 (20% variance) (Table 1). Factor 1 was the "strongest" factor because it accounted for the largest rotated variance.

[Insert Table 1 here]

An exemplar or idealised Q-sort for each of the two factors was developed using a factor array (Table 2; Appendix 25-26),[16] which provided more detailed information regarding factor descriptions. The participants' responses post Q-sort interview also aided the labelling of the perspectives represented by each factor.

[Insert Table 2 here]

Interpretation of the Q-Sorts

Factor 1: Staff Qualified Acceptance

This factor accounted for 26% of the variance and represented the majority of the P-set (n=10, 63%), encompassing a diverse range of experience (from 2 months to 34 years), profession and general parenting experience (Table 1). This principle factor was labelled *'Staff Qualified Acceptance'* to reflect staff positive beliefs

about the implementation of Baby TP on the MBU and also highlighted clear training needs. Staff who loaded onto this factor believed Baby TP to be an accessible parenting approach for mothers with SMI. They strongly and consistently disagreed with potential detrimental effects of the intervention by endorsing the following statements: “Baby TP will use all the mother's energy and focus” (-6; 44), “Baby TP will make women’s anxieties about their ability to parent worse” (-3; 12) and “Baby TP is an extra thing to engage in and will make mothers feel overwhelmed” (-4; 32). However, staff indicated that Baby TP should focus on, and be flexible to, the circumstances of the mother and her current mental health within its delivery: “It is important that Baby TP engages with the current situation” (+6; 47). Staff agreed strongly that “one-to-one work will make it easier for mothers to say when they find Baby TP difficult” (+5; 25), whilst emphasising that “a trusting relationship with the Baby TP therapist is important” (+5; 24).

Staff loading onto this factor reported a general lack of knowledge as to the content and concepts taught through the Baby TP programme with strong agreement that “it is important that staff understand why Baby TP works” (+6; 84) and that “staff need support and training to feel confident in delivering the Baby TP skills” (+6; 62). (NB only the MBU clinical psychologist [AW] was trained in Baby TP and other staff were not expected to have been trained at this stage of the study). This was also reflected in the neutral response to statements requiring opinions on the content of Baby TP, such as “Baby TP is about learning new skills” (71). Staff marginally disagreed with “the techniques of Baby TP flow through to the staff on the MBU” (-2; 16), but they agreed with “it is important that all staff know which mothers are using the Baby TP skills” (+2; 17). Staff

commented further about their support for Baby TP and expressed their wish to become more aware of the programme (Appendix 27):

"I don't know as much as I would like to know about Baby TP but my understanding is that it is driven from a needs-led perspective, from mums' perspective and it is not about us, it is about helping people to be successful parents." (Participant 3)

"…We all need to be singing from the same song sheet although I think it should be done by one main person really, who is trained." (Participant 11)

Factor 2: Systemic Approach/Systemic Results

This factor accounted for 20% of the variance and represented six participants (37%) of the total sample ranging in experience (5.5 to 22 years), profession and parenting knowledge (Table 2). All staff with psychiatric training (n=3) loaded onto this factor. The label of '*Systematic Approach/Systematic Results*' reflects staff beliefs that what the service users learned from Baby TP should address and enhance all elements of a mother's life and not just parenting skills per se.

Staff loading onto this factor supported the implementation of Baby TP reporting strong beliefs as to the benefits and positive outcomes for the mother with strong agreement for "Baby TP will be helpful for mothers to meet their parenting needs" (+6; 40). Staff also strongly agreed with the statement that "it is important Baby TP will highlight the importance of the mother looking after herself" (+5; 73). They also strongly agreed that "the skills taught in Baby TP need to generalise to environments other than the MBU" (+6; 3) and "Baby TP will help develop skills that can help deal with family problems" (+6; 36). Equally, staff strongly believed that the mother's circumstance did not negatively

affect the benefits of Baby TP: “if the mother has unchangeable situations at home, Baby TP is not going to be helpful” (-6; 20). They also disagreed that “mental health issues prevent mothers from accessing Baby TP” (-4; 5).

Comments made by staff offer additional support for the implementation of Baby TP and further re-iterate the systemic effects of such an intervention (Appendix 28):

“I think it is like with any talking or psychological therapy, if you can only do it in the session or in a particular situation and you can not translate it into your everyday life, it would not be very useful.” (Participant 16)

“I think that you would be hoping that they would be able to take these skills and use them in the community so it is not just about coping whilst they are in hospital but also with life in general.” (Participant 15)

Consensus Statements

In addition to the two factors, the Q-analysis identified 17 consensus statements, where opinions share equal ratings of agreement or disagreement across the factors.[15] All staff believed that Baby TP as an intervention would be a positive intervention for mothers with SMI with strong disagreement that “doing Baby TP will make mothers feel like 'bad parents'" (-6; 28) and “Baby TP will be about what has gone wrong for mother and baby” (-5; 53). Staff strongly endorsed the statements that “it is important for mothers to feel they have achieved something” (+5; 31) and “it is important for the mother to recognise what she has done well” (+5; 57). They also suggested that the focus of Baby TP should be on the positive aspects of the mother's parenting and therefore mildly disagreed with “it is important for the mother to recognise what she has done wrong” (-2; 59), whilst

equally agreeing with "it is important for the mother to recognise what she could have done differently" (+2; 58). Staff believed that the MBU setting was ideal in accommodating the Baby TP intervention by rejecting the assumption that "there is no opportunity to practice the Baby TP skills on the MBU" (-6; 51). They mildly disagreed with the statement that "it is important that Baby TP complements what staff already know" (-1; 27). Staff acknowledged the importance of Baby TP on the MBU and disagreed that "it is important that Baby TP only takes a small amount of staff time" (-3; 68).

Comparison between Factors 1 and 2

The two factors were significantly correlated (r = 0.67), indicating a strong positive relationship and agreement regarding the acceptability and feasibility of Baby TP. However, similarities and differences were explored through Z-scores between the factors (Appendix 29) and these further confirmed distinct differences in statement agreement between the factors.

Discussion

Main Findings

Q-sorts with 16 MBU staff members indicated that they regarded Baby TP to be a feasible and acceptable intervention that would be favourably perceived by service users who had taken part in the programme and by others admitted to the unit. They indicated that Baby TP did not reflect negative characterisation as a response to the "bad parent" stigma often identified in the population of mothers presenting with SMI.[10] According to staff responses, achievements gained through involvement in Baby TP enhanced mothers' self-esteem, which was viewed

positively because maternal self-esteem is often low due to maternal feelings of failure and inadequacy associated with their situation.[2,11] In terms of feasibility of implementation, staff viewed the MBU ward environment as being conducive and able to accommodate Baby TP.

The main factor emerging from the Q-sort data has been termed '*Staff Qualified Acceptance*' due to their positive attitudes towards the benefits of Baby TP. Staff believed that one important aspect of the intervention was that the Baby TP facilitator spent individual time with mothers working on parenting skills. The need for a flexible delivery was also recognised as being important to accommodate for changing (mental health and situational) circumstances. This does align with Triple P principles and the aim to provide a flexible and individually tailored intervention. The importance in establishing a therapeutic relationship as a means to empower families and build upon resiliencies is recognised as essential in Triple P programmes.[6]

Staff acknowledged that they did not fully understand the content and concepts of the Baby TP programme due to them not having been trained in the approach. Despite their enthusiasm for implementation, it is likely that this lack of training reflected in their general lack of opinion regarding the technical aspects of the intervention. If staff on the unit are to offer this approach more widely, they must feel confident in Baby TP skills and techniques to ensure that the programme is able to be supported beyond the therapy room.[18] Given that disconnected service provision within this population is not uncommon, and that successful intervention implementation is closely linked to communication and collaboration between staff and agencies,[10] it is important that this is addressed for the Baby TP.

The second factor, labelled '*Systemic Approach/Systemic Results*', reflected the view of the staff that any parenting intervention, including Baby TP, should address all areas of a mother's life with the skills being transferable to different life situations. This also aligns with the ethos of Triple P programmes that focus on promoting the wellbeing of the family, enhancing the competence, resourcefulness and self-sufficiency of parents and reducing the incidence in maternal psychopathology.[19] Equally, previous Triple P research demonstrates the potential for improvement in both clinical and parenting outcome in consideration of both family systemic dynamics.[7] Views of staff with psychiatric training backgrounds were particularly prominent within this factor, which reflects the holistic approach of their clinical training.

Methodological Limitations

Whilst the current findings are encouraging, there are some methodological issues in the use of Q to be considered. Although large sample sizes are not necessary in conducting a Q-analysis, with emphasis being on subjective opinion and their similarities and differences,[20] the contextually bound, relatively small sample size of 16 MBU staff members limits the ability to generalise the findings. Consequently, further research is recommended to extend and broaden the sample base. Participant biases, as a result of a perceived need to provide socially desirable responses, can influence outcome. Measures taken to reduce the likelihood of this included anonymity of responses, multiple opportunities throughout the Q-process for participants to clarify any issues or ask questions, and post-sort interview to discuss the Q-statements to address concerns.

Clinical Implications

National guidance for parenting interventions within MBUs[4,5] is limited because it does not endorse any particular parenting approaches for mothers with SMI. In the current study, three main clinical implications were identified. Firstly, Baby TP was viewed positively by staff on this MBU who believed it to be an accessible parenting approach for mothers with SMI. Therefore, from a staff perspective, the programme would be feasible and acceptable within this setting. Secondly, although Baby TP was provided as a therapist-facilitated individual intervention, staff recognised their own lack of knowledge about the programme. It would be advantageous for service users if staff were more knowledgeable about the guiding principles behind Triple P in general and some of the aspects of Baby TP so that staff could support service users by translating and generalising the skills and techniques used within the Baby TP sessions across the MBU. The form and extent of staff training nevertheless requires careful consideration, particularly in an environment where the demands on resources and staff time are at a premium. Staff case discussion groups and designated time slots within clinical meetings to focus on information on Baby TP may be a way of cascading the principles into the MBU environment, together with efforts to promote measures to review the compliance and success of adoption by staff.[21]

Thirdly, the current findings support previous recommendations for more specialist education and training of staff working in MBUs,[10] in particular for working with mental health difficulties and stigma, for which staff have received minimal guidance.[22]

Future Research

This study is limited to the viewpoints of staff members from one MBU within which Baby TP has been offered for a number of months. Obtaining the views from a range of staff, both trained and unfamiliar in the Baby TP programme, and across multiple MBU sites can provide a broader insight into the challenges and success in the implementation of such an intervention.

The longer term assessment of degree of success of outcome, time and cost-effectiveness of implementation of Baby TP intervention, as perceived by both staff and service users in general across the MBU, would provide alternative perspective in terms of ongoing feasibility and acceptability. In expansion of research, this could provide additional validation to inform and guide clinical practice. The acceptability and feasibility of Baby TP on a MBU from the service user perspective has already been examined and offers insight into the service user-specific opinions within this same setting (Paper 2.a.).[23]

In conclusion, Baby TP appears to be an acceptable, feasible and valued intervention for use within a specialist mental health context.

Declaration of Interest

None of the authors of the above manuscript have declared any conflict of interest, which may arise from being named as an author on this manuscript. There were no funding sources for this study.

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Table 1. Participant Demographics and Factor Loading

Factor Loading	No.	Professional Title	Experience (Years)	Previous Knowledge of Parenting Interventions
1	2	Nursery Nurse	17	General Knowledge and Ward Experience
1	3	Staff Nurse	14	Degree in Psychology
1	4	Nursery Nurse	31	General Knowledge and Ward Experience
1	5	Assistant Ward Manager	2.5	General Knowledge and Ward Experience
1	6	Staff Nurse	3	General Knowledge and Ward Experience
1	9	Nursery Nurse	23	General Knowledge and Ward Experience
1	10	Senior Staff Nurse	32	General Knowledge and Ward Experience
1	11	Nursery Nurse	9	General Knowledge and Ward Experience
1	12	Nursery Nurse	34	Baby TP presentation and General Knowledge
1	14	Staff Nurse	0.16	General Knowledge and Ward Experience
2	1	Psychiatry - Specialist Trainee	7	General Knowledge and Ward Experience
2	7	Ward Manager	7	General Knowledge and Ward Experience
2	8	Support Worker	10	General Knowledge and Ward Experience
2	13	Staff Nurse	5.5	General Knowledge and Ward Experience
2	15	Psychiatry - Specialist Trainee	6	General Knowledge and Ward Experience
2	16	Consultant Psychiatrist	22	Webster Stratton, Parent-Child Game

Table 2. Factor Arrays for the Two Factors

No	Statement	Factor 1	Factor 2
1	The MBU provides time to take part in Baby TP	1	2
2	It is important that Baby TP fits nicely with the ethos of the unit	0	-1
3	The skills taught in Baby TP need to generalise to environments other than the MBU	3	6
4	When mothers are unwell, Baby TP will be intolerable	-1	-3
5	Mental health issues prevent mothers from accessing Baby TP	-3	-4
6	Baby TP needs to fit with the mothers' mental health	4	-1
7	Baby TP should be flexible to the mothers mental health status	2	3
8	Baby TP will be fluid and flexible	-1	0
9	Baby TP will be flexible to cope with unplanned events	0	4
10*	The facilitator needs to be skilled in their explanation of Baby TP	1	1
11	Staff rolling out Baby TP need to have a thorough knowledge about mother and baby	1	-2

No	Statement	Factor 1	Factor 2
12	Baby TP will make women’s anxieties about their ability to parent worse	-3	-4
13	It is important for staff to be able to answer questions about Baby TP	4	2
14	Baby TP is a reactive response from “anxious” professionals	-5	-4
15	Staff need to believe that Baby TP benefits the mother	1	0
16	The techniques of Baby TP flow through to the staff on the MBU	-2	1
17	It is important that all staff know which mothers are using the Baby TP techniques	2	-1
18	It is important that the mother thinks Baby TP is worthwhile	4	1
19	It is important that mothers are open to change	2	4
20	If the mother has unchangeable situations at home, Baby TP is not going to be helpful	-4	-6
21	Mothers want to be recognised for the work they are doing in Baby TP	0	2
22	Baby TP is “preachy”	-5	-3
23	People providing Baby TP should only suggest techniques	-1	-3

No	Statement	Factor 1	Factor 2
24	A trusting relationship with the Baby TP therapist is important	5	3
25	One-to-one work will make it easier for mothers to say when they find Baby TP difficult	5	1
26	If the relationship between the Baby TP facilitator and mother is not working, neither will Baby TP	-1	0
27*	It is important that Baby TP complements what staff already know	-1	-1
28*	Doing Baby TP will make mothers feel like “bad parents”	-6	-6
29	Baby TP might make people feel like they are being unfairly judged or blamed	-4	-3
30	It is important that mothers doing Baby TP can gauge their progress	4	2
31*	It is important for mothers to feel they have achieved something	5	5
32	Baby TP is an extra thing to engage in and will make mothers feel overwhelmed	-4	-5
33	It is OK for Baby TP to be challenging for mothers	0	3
34	Mothers should have ongoing support in doing Baby TP	3	2
35	It is important that the mother’s family are open to change	-1	0

No	Statement	Factor 1	Factor 2
36	Baby TP will help develop skills that can help deal with family problems	-1	6
37*	It is important that Baby TP sessions do not interfere with family visits on the MBU	-2	-2
38	It is important that mothers feel in control and responsible for Baby TP	2	0
39	Well delivered Baby TP will maintain overall confidence in the MBU	1	0
40	Baby TP will be helpful for mothers to meet their parenting needs	2	6
41	If a mother is severely depressed, they will not have the motivation to do Baby TP	1	-2
42	Whilst staying on the MBU it is easy for mothers to commit to Baby TP	-2	2
43*	In order to engage in Baby TP, staff expect mothers to be open to learning	0	0
44	Baby TP will use all the mothers energy and focus	-6	-4
45	It is important that the Baby TP therapist works with both mother and baby	4	-3
46	Baby TP will address mothers feelings of uncertainty	0	1
47	It is important that Baby TP engages with the current situation and needs of the mother	6	4

No	Statement	Factor 1	Factor 2
48	It is important that mothers have a positive attitude towards recovery from illness	2	1
49*	Taking part in Baby TP will be a positive experience	1	1
50*	It is important that mothers discuss Baby TP with other like-minded people	-3	-3
51*	There is no opportunity to practice the Baby TP skills on the MBU	-6	-6
52*	It is important that Baby TP is easy for mothers to do	-1	-1
53*	Baby TP will be about what has gone wrong for mother and baby	-5	-5
54	Baby TP needs to emphasise the positive so as not to make the mother's mental illness worse	2	3
55	The way Baby TP is presented to mothers will be important	3	0
56	It is important that Baby TP does not go against what mothers already know	-1	-4
57*	It is important for the mother to recognise what she has done well	5	5
58*	It is important for the mother to recognise what she could have done differently	2	2
59*	It is important for the mother to recognise what she has done wrong	-2	-2

No	Statement	Factor 1	Factor 2
60	Staff need to think about what parts of the Baby TP would be helpful for mothers	3	0
61	It is important to encourage staff to reflect	0	3
62	Staff need support and training to feel confident in delivering the Baby TP skills	6	3
63	All staff should have the same training in Baby TP	1	0
64*	It is important that both staff and mothers will find Baby TP enjoyable	1	1
65	Staff have too much work to do to support Baby TP skills adequately	-4	-5
66	Baby TP will be easily incorporated into the workload of staff	-2	-1
67	Baby TP should not have too much paperwork for staff to do	-3	2
68*	It is important that Baby TP only takes a small amount of staff time	-3	-3
69	Baby TP should be a priority for the MBU	-2	2
70	Baby TP should not get in the way of other MBU work	-3	-2
71	Baby TP is about learning new skills	0	1

No	Statement	Factor 1	Factor 2
72	Baby TP provides a safe place for mothers who have mental health issues	-2	-1
73	It is important Baby TP will highlight the importance of mothers looking after themselves	0	5
74	Engagement with mothers must be the priority in Baby TP	3	5
75	Doing Baby TP would make mother's feel exposed or a bad mother	-4	-5
76	Staff attitude affects engagement on Baby TP	1	4
77	Mothers want factual information about parenting	0	4
78	Practical materials are essential	-2	3
79	Baby TP comes at the wrong time	-5	0
80	The Baby TP therapist needs to really sell the programme to mothers	-3	-1
81	It is important for all staff on the MBU to have a clear role within Baby TP	3	-2
82*	All staff should support what is done in Baby TP	-1	-1
83	It is important that mothers and Baby TP therapists work together to solve the mother's problems	2	1

No	Statement	Factor 1	Factor 2
84	It is important that staff understand why Baby TP works	6	0
85	Mothers being able to make choices in Baby TP is important	3	-1
86	Mothers should decide when they want to do Baby TP sessions	0	-2
87	Mothers need to know what they can do and cannot do for Baby TP to work	0	-2
88*	Baby TP needs to be based on common-sense	-2	-2

* Consensus statement [statements 10; 27; 28; 31; 37; 43; 49; 50; 51; 52; 53; 57; 58; 59; 64; 68; 82; 88]

Paper 3

Appraisal and Reflection

Word Count: 5243

Introduction to Paper 3

This paper offers the author's review and reflective account in undertaking the multiple elements of this research project. The review considers the complexities underlining the fundamental issues in performing the meta-synthesis, the rationale behind the choice of methodology, data analysis and the considerations and limitations of the Q-method approach used in this research study. The author considers those issues which have been of most significance in broadening experience and learning of the research process and equally which have presented the most challenges.

Paper 1: Literature Review - Meta-Synthesis Considerations

Rationale for Study Topic

In working within various clinical settings during my training period, I frequently had conversations with both service users and clinical practitioners about their perceptions and experiences of psychological interventions. I believe that there is much to be gained by undertaking a qualitative approach to investigate the rich and sometimes hidden reserve of individual perspectives and accounts, which has been instrumental in providing the direction for my literature review.

Preliminary searches exploring current literature reviews were conducted to gain a feel for the general topic of attitudes towards psychological interventions. These initial searches identified mostly quantitative reviews, which tended to focus on specific psychological intervention (such as CBT), effectiveness and clinical outcome. There were fewer qualitative reviews to be found which referenced opinions and attitudes. Therefore, these searches alerted me to a distinct lack of reviews, which considered systemic elements, determined

from both service users and staff perspectives, of involvement and experience with 'psychological intervention'. I was keen to explore the common factors and relationships within and between interventions and therefore chose not to limit the review in being intervention-specific.

I believe that undertaking this investigation as a meta-synthesis, rather than a quantitative systematic review, provided a greater understanding of subtle therapy dynamics, which may not have been highlighted through statistical analysis alone. I also felt that this review would align with broader NHS, NICE and DoH agendas, and produce clinical implications pertinent to all practitioners and service managers in highlighting perceptions of specific and strategic needs of service users and staff undergoing or implementing a psychological intervention.

Literature Search

The literature search proved to be challenging and demanding, mainly due to the vast number of studies identified when exploring such a broad search area of 'psychological intervention'. It was important to thoroughly consider search terms with the research team in order to be fully inclusive and exhaustive of the literature. This resulted in a significant number of search terms being used, which consequently generated a very large number of studies.

The inclusion criteria (primary qualitative research studies, published in the English language in peer-reviewed journals between 1987-2013, and inclusive of participants of reproductive age who have expressed perceptions, opinions and attitudes about psychological intervention for mental health issues) was extremely important to aid in managing the volume of studies. However, there were several criteria dilemmas experienced worthy of note.

The date range (1987-2013) captures the last 26 years of research and in doing so was thought to gain a diverse range of perspectives from current and past literature findings. This restriction, however, alongside the limit to articles published in the English Language, also created a number of issues, including the potential for excluding relevant studies outside the data range and the use of studies privy to publication bias.

Psychological intervention for physical health difficulties, whilst an exclusion criteria, proved challenging to reconcile. I deliberated over studies which, although seemingly addressed mental health difficulties associated with physical health problems (i.e. depression as a result of diabetes or injuries), could have actually been addressing pre-morbid mental health issues. To retain clarity such studies were excluded on a basis of ambivalence.

An inclusion criterion was for participants to be within a reproductive age, a criterion most appropriate in providing a substantial range of individuals who would have access to psychological intervention. Albeit a seemingly specific guideline, it is particularly difficult to define the reproductive age of male participants with cultural boundaries providing additional confusion. Informed by medical texts, an age range from 15 to 64 years old was deemed as appropriate in meeting the 'reproductive age' criterion (Piñón, 2002; Heffner, 2001).

Although the selection of inclusion and exclusion criteria was an essential element in ensuring a transparent and systematic approach to this literature review, this does nevertheless result in certain populations and literature not being considered. Future reviews inclusive of individuals with physical health conditions and/or populations outside the reproductive age, for example,

(particularly child and older adult) could provide additional support to population-specific themes and issues, which are otherwise overlooked.

Meta-synthesis Debate

The value of synthesising qualitative literature findings has, and continues to be, under debate due to different viewpoints about both the nature and purpose of qualitative research (Campbell et al, 2003). For the meta-synthesis, I felt that it was important to have a thorough understanding of the potential difficulties and more contentious issues to best manage and address any stages of the synthesis prone to compromise.

For some researchers, the concept of providing a collective overall analysis of qualitative studies, which hold different philosophical perspectives and positions, presents the most significant issue. However, others regard the value of meta-synthesis is in being just that point, the ability to gain an accumulate knowledge through reinterpretation of single study findings, whilst maintaining their unique meanings, regardless of philosophical stance (Beck, 2002; Schreiber, Crooks & Stern, 1997).

Discrepancies can also arise when comparing studies using different qualitative methodologies. Again, opposing viewpoints are highlighted in meta-synthesis literature. One stance suggests that different qualitative methods encompass unique limitations and impact on findings differently. Considering these findings together would therefore ignore the potentially confounding issues associated with the individual methodologies (Dixon-Woods et al, 2004). Counter to this, there are views that being inclusive of the different qualitative methodologies counterbalances the methodology-specific limitations and

strengths and hence provides a more scientifically rigorous and robust approach and analysis (Campbell et al, 2003; Beck, 2002; Jensen & Allen, 1996).

Regardless of the ongoing debate, there are numerous heavily cited reviews using the meta-synthesis approach to explore multiple topics pertaining to mental and physical health (Campbell et al, 2003; Beck, 2002; Thorne et al, 2002). The meta-synthesis debate and previous literature are suggestive of two critical factors to consider when using this approach. Firstly, maintenance of the integrity and meaning of the original study findings and secondly, that the researcher considers individual study data with curiosity without becoming overly absorbed to the point that re-interpretation of an original conclusion becomes compromised (Beck, 2002). I found that the Noblit and Hare (1988) guidance to meta-synthesis was a useful tool, particularly in the interpretative phase, in ensuring data maintained its original meaning throughout the synthesis stages in a transparent and systematic method.

Choosing the Critical Appraisal Tool

The reasoned argument with regard to the quality assessment of original qualitative studies for use within the meta-synthesis follows on from the earlier consideration of contentious issues relating to general application of qualitative methodologies.

Formal measures, using set criteria, have been criticised for being a “one size fits all” approach and may be lacking in respect of the study’s unique qualitative methodology and philosophy (Dixon-Woods et al, 2004). However, the use of various approach specific critical appraisal measures causes issues with consistency and reliability (Walsh & Downe, 2006). With no specifically recommended approach, I decided to use two critical appraisal measures, which is

not unusual with meta-synthesis research (Walsh & Downe, 2005), for a multi-dimensional concept of quality with two study raters as a means to ensure rigour. I also felt that this aligned with the ethos of meta-synthesis research in that multiple methods of approaching appraisal would counterbalance the strengths and limitations of a single approach (Campbell et al, 2003; Beck, 2002).

The Critical Appraisal Skills Programme (CASP, 2002) and Walsh and Downe's (2006) checklist were chosen due to their popularity and positive reviews in current literature, as well as their practical appeal in being straight forward to use (Ring et al, 2010; Walsh & Downe, 2005). Both measures cover slightly different elements of appraisal, the CASP including ten questions on rigour, credibility and relevance and Walsh and Downe (2006) considering the eight areas of scope and purpose, design, sampling strategies, analysis, interpretation, reflexivity, ethical dimensions and, relevance and transferability. The CASP (2002) and Walsh and Downe's (2006) criteria were separately used to score and categorise. This resulted in the 28 papers receiving independent score categories for each measure (Appendix 5). The rating and categorisation process of all of the studies was then completed by an independent reviewer, practiced in the methodology, to maintain inter-rater reliability, prevention of researcher bias and generally ensure an overall robust appraisal process. The raters independently scored the papers and met to review their conclusions. There was good agreement between interpretations and any differences were quickly resolved by detailed discussion. There were no issues unresolved, and by agreement an overall quality category for each paper was determined.

Ensuring the Credibility and Relevance of the Meta-Synthesis

The researcher aims at providing a piece of work which is credible and relevant, and I was even more sensitive to this given the number of contentious issues with a meta-synthesis approach. Therefore, three strategies were adopted from the Elliot, Fischer and Rennie (1999) trustworthiness and credibility guidelines. Firstly, as discussed, the use of two critical appraisal tools using independent measures to address rigour, relevance, credibility and transferability (Walsh & Downe, 2006; CASP 2002). Secondly, a validated meta-synthesis technique (Noblit & Hare, 1988) extensively used within nursing (Jensen & Allen, 1996) and educational research (Campbell et al, 2003), provided a transparent, reliable and replicable process. Thirdly, within the analytical process, the research team checked, revised and validated reconceptualised themes, new interpretations analysis and findings. Original participant quotes were included to ensure rigour and credibility to findings and analysis.

Time and resource restrictions prevented further exploration and implementation of measures of credibility and relevance endorsed by other researchers; for example, Thorne et al (2004) suggested meta-synthesis data should be discussed with the original study authors to ensure that data have not been misinterpreted or employed beyond its meaning. Equally, Campbell et al (2003) advise that the findings could be discussed with the targeted population groups to gauge the relevance and credibility at a core level. Each of these measures potentially offer valuable insight as to the reliability and credibility of the meta-synthesis findings and could provide the opportunity to address some of the ethical questions raised in conducting a meta-synthesis study. Example being: should the original authors give permission, in the first instance for their study to

be involved in such a review? Or, again, should raw data from the original sourced data be used without the permission of the participants (Dixon-Woods et al, 2004)?

My own review of meta-synthesis studies has not revealed any due reference given to these measures to reinforce credibility and relevance, though clearly any analysis would be more complete if this was taken into account. However, it is likely that the same issues of time and resource have posed similar limitations to other researchers.

Limitations of the Meta-Synthesis

The contentious issue and ongoing philosophical debate surrounding the varying approaches to validity of qualitative analysis has been, I feel, a particular limitation to the meta-synthesis. I found myself becoming a ‘defensive researcher’ in response to the potential critique in the employed approach, alongside my own concerns to ‘get it right’.

Consultation with research team colleagues and spending considerable time to thoroughly explore the meta-synthesis literature has helped focus understanding towards resolution and management of these issues. However, in reflection, I do wonder whether the challenges surrounding the meta-synthesis approach present too many obstacles and leave the researcher reluctant to pursue this avenue of research. This may go someway to explaining the relatively small number of meta-synthesis reviews in comparison to other methodologies.

Conclusion

This meta-synthesis provides a comprehensive understanding and a new appreciation of the process of 'psychological intervention' through the perspectives of a cross-section of service users and professionals. Given the time and resources, I believe this approach to research could be expanded to explore perspectives throughout child, older adult and physical health settings to determine any setting-specific themes and dynamics.

Paper 2: Empirical Papers 2.a and 2.b

Rationale for the Study Topic

In my roles of trainee and assistant clinical psychologist I have been introduced to different psychological interventions designed to help address situations arising within parenting and family relationships. My own experience of learning and facilitating family therapy, the Webster-Stratton 'Incredible Years' Parenting Programme and Parent-Child Game, sparked an interest in the role of parenting within challenging family dynamics, encompassing situational factors, such as parental mental health difficulties amongst others. I was therefore keen to take up the opportunity to conduct research into the new addition to the Triple P series, Baby TP, in a setting where parenting skills training has no clear national guidance, yet involves arguably one of the most challenging issues.

Two Separate Papers

Since there was to be an analysis of the feasibility and acceptability of a particular intervention programme as viewed from the two very different standpoints of provider and user, it was thought that each analysis would provide a different insight into similar elements of the psychological processes. Supported by the

meta-synthesis (Paper 1.), it was determined that there would be a benefit to producing two distinct research papers to distinguish between service user and staff orientated perceptions. I also considered that presenting the findings of this research as different papers would have the potential to reach a wider audience by publication in diverse journals.

The task of writing two papers to suite different journal guidelines about similar studies at the same time has been a difficult but important learning experience, particularly in needing to adapt and vary writing style for different academic audiences and journal criteria.

Why Q-Methodology?

Initially both qualitative and quantitative methodologies were considered as means to address the research questions. However, after developing an awareness of Q-methodology, I felt the quanti-qualitative approach (Watts & Stenner, 2012) had a number of benefits over use of a singular qualitative or quantitative approach and that this would be particularly advantageous within the MBU setting. Firstly, participants have the opportunity to share and explore opinions using a less invasive method than interview-based approaches. Secondly, large sample sizes are not required for Q-method to obtain meaningful results, which was appealing due to the limited numbers and availability of service users and staff on the MBU.

Being less familiar with Q-methodology, I also felt that this was an ideal opportunity to expand my research knowledge and develop awareness and skill in the use and application of a new method.

Development of the Q-Set

The initial phase of Q-methodology is to devise a concourse through various strategies and approaches (Appendix 17). A balanced set of readable and understandable (as measured by the Flesch Reading Ease Measure) representative theme statements (Q-set) containing an array of beliefs, opinions and descriptions of the subject area are then extrapolated to form the Q-set (Watts & Stenner, 2012). I found this stage of the Q-methodology extremely time-consuming, which also led to a large quantity of material, and hence statements, for consideration in the inclusion within the Q-set. The concourse material is reviewed and grouped into themes and topics. For this Q-study 636 individual items were gathered and grouped into 68 core themes. The core themes were further analysed with the view to extract (a manageable amount of) specific statements which represent the theme meaning for use in the final Q-set. Exclusion or exemption of statements is therefore necessary and was conducted through discussion with the research team. The challenge at this point was to provide balanced Q-statements containing the full breadth of opinion, whilst not being overwhelmed by the volume. Recommendations for the optimum number of Q-statements vary (Stainton-Rodgers, 1995), the general 'rule of thumb' being a 1:3 ratio of participant to statements (Webler, Danielson & Tuler, 2009). Most Q-studies tend to range from 10 to 100 items (Cross, 2005). A 'common sense' approach recently advocated by Watts and Stenner (2012) suggests that the number is arbitrary and focus needs to be the breadth and depth of attitudes. Whilst this process is pivotal to the resultant analysis, I was reassured in that valuable results would still be obtained from a 'less than ideal' Q-set (Watts & Stenner, 2012; Stainton Rodgers, 1995). The final Q-set comprised 88 statements agreed by the research team as capturing the full

range of opinions whilst being numerically robust. Pilot Q-sorts and post-sort interviews further confirmed the suitability of both volume of statements as well as inclusivity of opinion. There were perceived to be no missed topics or opinions relevant to this analysis.

Q-Sort Completion

The Q-sort process was well received by both service user and staff participants. They referred to the technique as “easy to do” and “making them think”. Two service user participants did require support in understanding the words ‘gauge’ and ‘preachy’, although this was quickly resolved in the session. Some service user participants commented that the ranking exercise (sorting the cards onto the Q-grid) required some intense thought, especially when disagreeing with the negative comments.

This study employed a direct, face-to-face approach in collecting data and resulted in placing a large Q-grid (the continuum where participants rank the Q-statements) on the floor as visual aid and reference upon which to place the Q-statements. Whilst an important aspect to the Q-process, this proved at times to be physically awkward and cumbersome, particularly where there was limited space. It is worthwhile considering the setting up of a Q-grid on a laptop programme to accommodate this process.

Free or Forced Choice Distribution

A Q-methodology debate involves the use of “forced choice” as opposed to “free choice” (Watts & Stenner, 2012). The process of forced choice requires participants to make definitive decisions with the Q-statements and distributions where they may not normally have an opinion. Whereas free-choice provides

participants with an opportunity rather than requirement to place any number of Q-statements to the available ranking values (Watts & Stenner, 2012). The majority of published Q-studies use forced choice distribution and state that this is statistically easier to interpret, whilst also being no more restrictive than the free distribution (Watts & Stenner, 2005). Therefore, I elected to employ the forced-choice distribution for this Q-methodological study. However, it was observed particularly within the staff participants, that individuals became frustrated at having to choose one statement over another, with having to more carefully reflect on their choice. Van Exel and de Graaf (2005) state that it is this deliberation, which ensures a more considered and stable decision.

The Recruitment Process

Ethical approval from both a local National Health Service Research Committee (REC ref 11/NW/0716; Appendix 11) and a National Health Service Research and Development department (R&D ref 1091; Appendix 12) was initially gained to recruit participants from service users who had completed, discontinued or opted out of Baby TP and from MBU staff. Service user recruitment proved challenging. A number who had discontinued or opted out of Baby TP declined participation, whilst many who had completed Baby TP and had subsequently been discharged from the MBU proved to be difficult to contact. Owing to poor service user participant recruitment, an amendment was required to the ethics application. This was agreed through REC (Appendix 30) and R&D (Appendix 31). The amendment expanded the inclusion criteria to capture the views of women on the MBU who would not usually be offered Baby TP due to their being close to

discharge from the unit. It was believed that this would also add further dimension to the study by providing a broader opinion base.

Staff on the MBU were clearly very interested in the research and although willing to take part, found it frequently difficult to commit to participation due to the variable nature of work and situational pressures. This experience typified the practicalities of conducting research on a busy ward and underlined an appreciation of the context of these services, the day-to-day difficulties ward staff face, and the specific areas of demand within perinatal services. Throughout the recruitment phase staff were having to work with a 'skeleton' team for various reasons. Bank staff were employed to cover duties which, from my observations, actually demanded extra core staff time to ensure stand-in staff were aware of policy and procedures. I was acutely aware that I was an additional burden because I was taking core staff away from their ward duties. Understandably, I felt that this was met with a degree of reluctance, some resistance, and perhaps a degree of suspicion that my research may cause extra work. I was extremely mindful that my research was by no means a priority for staff on the MBU. Nevertheless, this did cause frustrations with the logistics of staff frequently not being in a position to meet research appointments. Compounding this issue was my own limited flexibility with time because of the demands and commitments of clinical placement responsibilities. However, through this experience I have developed a new appreciation and understanding of the recruitment challenges faced at all levels of research.

Participants (P-Set)

The number of participants within each of the studies was approximately 15, a relatively small sample, yet adequate and acceptable within Q-methodology (Watts & Stenner, 2012). However, low numbers of participants can cause difficulties in determining the reliability of factors, an assumption within Q-methodology being that a loading of four or more participants is a reliable factor (van Exel & de Graaf, 2005). One factor (Paper 2.a; service user Q-analysis Factor 3) went below this threshold with only three participants loading onto it. This may be an indication that more service user participants are needed to strengthen the loading numbers on that factor, given the possibility of a finite number of viewpoints (Brown, 1980).

Due to the small sample size and concerns regarding anonymity, information gathered about service user socio-demographic and clinical details remained basic. Although limited in content, these elements did inform the Q-analysis with no specific effects observed upon the emergent Factors. Further socio-demographic considerations (such as marital and job status), information about parenting experience alongside self-report measures such as the Postpartum Bonding Questionnaire (Brocklington et al, 2001) and The Maternal Efficacy Questionnaire (Teti & Gelfand, 1991) may have generated a richer description and potentially deeper insight into the service users who had Q-sorts loading onto particular Factors.

I think it is also important to consider the effect of variability of staff knowledge-base of the Baby TP on the staff P-set. Some staff had attended presentations on Baby TP, others had only an awareness it was being offered on the MBU. Similarly, service user participants had either full awareness of Baby

TP or none at all. In terms of validity, I feel that Q-methodology was therefore the ideal approach to accommodate this issue with the primary focus being 'what they think' rather than factual knowledge of 'what they know'.

Q- Analysis

The PQMethod (Schmolck & Atkinson, 2002) is a specialist programme specifically designed for Q-methodology analysis. PQMethod extracts (unrotated) factors using principal component analysis (PCA) and then rotates those factors, accounting for the largest amount of variance, using varimax rotation. This part of the analysis determines the clusters of participants who share similar opinions. This statistical process is then followed by an interpretative element, by which the factors are examined alongside the post-sort interviews to identify common themes. This was a novel and interesting approach and I particularly enjoyed the challenge of identifying the subtle theme differences between the factors through this combination of statistical and qualitative analysis. Whilst there is significant potential for researcher bias at the interpretation stage, I was very conscious of this and took measures to minimise this likelihood. Detailed discussion and consultation both with the research team and with colleagues with Q-expertise were conducted throughout all phases of the Q-analysis.

Within Q-analysis literature the resultant factors are referred to as "strong" (more than four participant Q-sort loadings) or "weak" as a guide of reliability (Watts & Stenner, 2012). However, I think this terminology can be misleading. Although a "strong" factor is indicative of more Q-sorts sharing similar views, it does not signify that those views are any more 'important' than factors, which have only one Q-sort participant loading (Brown, 1996). Brown (1980) has also

suggested that participants with unique perspectives may not load onto common factors, i.e. they may not conform to the norm, yet of course, their opinion is extremely valid. Factor three from the service user Q-analysis had a loading of three participants and hence is termed a "weak" factor. However, the interpretation and contribution of the opinions within that factor was no less important than the others termed "strong".

One Q-sort (P9; Paper 2.a) did not load onto any factor. When the statements within this Q-sort and post-sort interview were manually reviewed, expressions, whilst being close to others did not statistically fit with any of the defined factors. The views were, nevertheless considered within the interpretative process (Brown, 1996).

Limitations of Q-Methodology

The quanti-qualitative analysis of Q-methodology was recognised as being an ideal approach to determine meaningful implications from relatively small numbers of participants. The focus of the approach is towards the quality rather than volume of viewpoints. The results determine a number of clinical implications underlining the opinions of participants from differing perspectives. However, in using Q-methodology it was obvious from a practical standpoint that there are, and need to be, limitations worthy of note.

During the initial concourse development, I was aware of the distinct lack of direct service user involvement. Prevented by both service user and principle researcher (HB) availability, only opinions from one service user (experienced in Baby TP) were obtained, limiting service user material at this point in the methodology. The inclusion of other service user input (both experienced and

inexperienced in Baby TP) would have provided additional indication as to important service user beliefs within this subject area. Despite this omission a large concourse was generated with a substantial number of statements excluded in order to provide a balanced and manageable Q-set to be rated by participants. However, there are two specific risks here, firstly that of excluding relevant statements, which could carry subtle viewpoints and opinions not otherwise captured by other statements, and secondly that of researcher bias. Whilst it was considered that missed and lost opinion (whether this be through lack of service user involvement or exclusion of statements) was minimised through the use of the post sort-interview and that opportunity for researcher bias similarly minimised, by peer and independent consultation, it would have been interesting to examine by comparison how this might have been better served by using a 'concourse matrix' (Dryzek & Berejikian, 1993). This provides an independent technique for choosing statements whilst minimising researcher bias (Barry & Proops, 1999). Nevertheless, for this study purpose, the methodology used has been considered to be sufficiently robust.

The Q-set comprised 88 statements which, when compared with other Q-research and in following Q-guidelines (Watts & Stenner, 2012; Webler et al, 2007), is deemed a reasonable number to establish a valid Q-set. However, this presented a large number of cards for participants to review and took both staff and service user populations on average 45-60 minutes to complete. It is possible that this task was a little daunting and perhaps overwhelming for particular participants. This Q-set volume effect possibly reflected in their responses and had the potential for the Q-sorts to be less defined than for a smaller Q-set.

In the same vein, and despite Q-methodology being recognised as an appropriate and reliable research method to use with individuals with mental health difficulties (Absalom-Hornby et al, 2011: Gregg, Haddock & Barrowclough, 2009), the Q-sorting task can be quite challenging to some, relying on a high level of cognitive functioning (Jones, Guy & Ormrod, 2003). Service users have nevertheless provided positive feedback and did comment on how “it really made me think”. This seems to reflect the effort and thought needed by them to complete the task and is quite encouraging in that their responses had been considered in some depth.

Conclusion

Across both papers, I believe the use of Q-methodology has been the right choice to enable a constructive analysis. The end result has been a robust and valid endorsement of a new parenting intervention being trialled within a MBU setting from both staff and service user perspectives. The findings present clinical implications, which would specifically extend the implementation of Baby TP intervention beyond the current setting into the broader MBU. There is an argument to suggest that assessment of the effectiveness of parenting interventions in general would benefit from a review of both service provider and service user perspectives of feasibility and acceptability relative to their setting.

Paper 1. and Paper 2: Implications for Future Research

The meta-synthesis and Q-methodology studies identify potential future research.

Meta-synthesis findings highlight a potential to further explore the views of service users who had ‘opted out’, discontinued, or experienced more than one

therapy, as well as staff opinion regarding psychological or psychiatric intervention. Future studies could be tailored to address these areas.

The search parameters of this meta-synthesis have been necessarily exclusive. There is the opportunity for future literature reviews to be inclusive of child and older adult populations, and physical health settings. This could provide a broader population-specific understanding and help develop and build upon the current research model (Paper 1; Figure 2).

Q-methodology studies identify potential research to aid in addressing distinct policy gaps, in addition to expanding the Baby TP evidence-base:

a). replication of the study in other MBU settings to further expand and validate the findings

b). (as supported by the meta-synthesis, and within the Baby TP Q-methodology studies) the promotion of inclusion of service users who have ‘opted out’, discontinued or experienced more than one psychological intervention

c). investigation of the longer-term effectiveness of Baby TP by assessment of the application and incorporation into the family system of the skills and techniques gained from Baby TP

d). exploration of perceptions (family and staff) of the mother-infant relationship pre and post involvement in Baby TP through techniques such as the Repertory Grid

e). a cost-benefit analysis, as perceived by both staff and service users, to provide their views of the feasibility, acceptability and value from an organisational perspective.

Thesis Overview

Undertaking this study has provided many learning and development opportunities as well as challenges, which will all enhance and inform my work within both the researcher and therapist role. Experience and insight gained from working with staff and mothers from the MBU has broadened my knowledge about the difficulties and rewards of working in such an environment. Developing new skills, learning a new methodology, and writing to satisfy the differing demands and criterion of two journals has been very challenging at times, albeit most educational and enlightening in giving me a much wider perspective of the complementary researcher and therapist roles of the clinical psychologist.

This last paper has provided opportunity to stop and reflect on this whole research process. I believe that I have been privileged to learn and be guided by experts in their field and by those on the receiving end, the service users, who get little opportunity to present their views in such a way. This can only have positive implications for my own clinical practice and professional development.

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Appendix 1. British Journal of Psychiatry Submission Guidelines

The following information has been taken from the BJP guidance documentation accessed from: http://bjp.rcpsych.org/site/misc/ifora.xhtml

Title and Authors

- Brief and relevant
- Subtitles not to be used unless essential
- Authors to sign a copyright transfer and publication agreement

Structure of Manuscript Papers

Abstract

- Not to exceed 150 words
- Incorporated the following headings: background, aims, method, results, conclusions, declaration of interest

General

- General format: Introduction, Method, Results and Discussion
- Introductions - no more than one paragraph
- Discussion to include limitations of the paper
- Subheadings are encouraged particularly in the Discussion sections
- 3000 to 5000 words in length (excl. references, tables and figures)
- No more than 25 references
- Large tables to be in the BJP online version

Structure of Review articles

- Same structure as regular papers

References

- All references should be numbered in the order in which they appear in the text and listed at the end of the article using Vancouver style

Tables and Figures

- Clearly numbered with an appropriate heading
- The position of the table in the manuscript should be indicated

Appendix 2. Search Terms

Medline R, Embase; PsycINFO; AMED ***(Allied and Complementary Medicine Database)*****, search terms:** staff perceptions; staff beliefs; staff attitudes; mental health interventions; psychological interventions; therapeutic interventions; professional perceptions; staff opinion; professional opinion; staff feedback; service user opinion; service user perceptions; service user beliefs; service user attitudes; patient perspectives; client perspectives; therapy beliefs; psychological therapy; treatment beliefs; treatment perceptions; acceptability

CINAHL+ *(Cumulative Index to Nursing and Allied Health Plus)* **search terms:** staff perceptions; staff beliefs; staff attitudes; mental health interventions; psychological interventions; therapeutic interventions; professional perceptions; staff opinions; professional opinion; staff feedback; service user opinion; service user perceptions; service user beliefs; service user attitudes; patient perspectives; client perspectives; therapy beliefs; psychological therapy; treatment beliefs; treatment perceptions; treatment acceptability

PUBMED search terms:
(staff [All Fields] AND ("perception" [MeSH Terms] OR "perceptions" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(staff [All Fields] AND ("belief" [MeSH Terms] OR "beliefs" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(staff [All Fields] AND ("attitude" [MeSH Terms] OR "attitudes" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(mental [All Fields] AND (health [All Fields] AND "intervention" [MeSH Terms] OR "interventions" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(psychological [All Fields] AND ("intervention" [MeSH Terms] OR "interventions" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(therapeutic [All Fields] AND ("intervention" [MeSH Terms] OR "interventions" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(professional [All Fields] AND ("perception" [MeSH Terms] OR "perceptions" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(staff [All Fields] AND ("opinion" [MeSH Terms]) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(professional [All Fields] AND ("opinion" [MeSH Terms]) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(staff [All Fields] AND ("feedback" [MeSH Terms]) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(service [All Fields] AND (user [All Fields] AND "opinion" [MeSH Terms]) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])

(service [All Fields] AND (user [All Fields] AND "perception" [MeSH Terms] OR "perceptions" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
service user beliefs(service [All Fields] AND (user [All Fields] AND "belief" [MeSH Terms] OR "beliefs" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(service [All Fields] AND (user [All Fields] AND "attitude" [MeSH Terms] OR "attitudes" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(patient [All Fields] AND ("perspective" [MeSH Terms] OR "perspectives" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(client [All Fields] AND ("perspective" [MeSH Terms] OR "perspectives" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(therapy [All Fields] AND ("belief" [MeSH Terms] OR "beliefs" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(psychological [All Fields] AND ("therapy" [MeSH Terms]) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(treatment [All Fields] AND ("belief" [MeSH Terms] OR "beliefs" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
(treatment [All Fields] AND ("perception" [MeSH Terms] OR "perceptions" [All Fields])) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])
acceptability(acceptability [All Fields]) AND (Journal Article [ptyp] AND ("1987/02/01" [PDAT]: "2013/02/01" [PDAT]) AND "humans" [MeSH Terms] AND English [Lang] and jsubsetaim [text])

Web of Knowledge ***(Web of Science)*** **search terms:** staff perceptions*mental health; staff perceptions*mental health treatment; staff perceptions*mental health interventions; staff beliefs*mental health; staff attitudes*mental health; staff perceptions*psychological interventions; staff perceptions*therapeutic interventions; staff opinion*mental health interventions; staff feedback*mental health; service user opinion*; service user perceptions*; service user beliefs*; service user attitudes*; patient perspectives*; client perspectives*; therapy beliefs*mental health

Scopus search terms: "staff perceptions" AND mental health; "staff beliefs" AND mental health; "staff attitudes" AND mental health; "mental health interventions"; "psychological interventions"; "therapeutic interventions"; "professional perceptions"; "staff opinion" ; "professional opinion"; "service user opinion"; "service user perceptions"; "service user beliefs"; "service user attitudes"; "patient perspectives"; "client perspectives"; "therapy beliefs"; "psychological therapy"; "treatment beliefs"; "treatment perceptions"

Journal of Qualitative Health Research search terms: Psychological therapy; Mental health interventions

Google Scholar and Literature Review Reference Section search terms:
perceptions of mental health interventions; perceptions of psychological therapy; belief in

mental health interventions; belief in psychological therapy; attitudes towards mental health interventions; attitudes towards psychological therapy; opinion of mental health interventions; opinion of psychological therapy

Example of Search Terms and Number of Articles Retrieved: Medline R:

Search Terms	Number of Articles		
	Basic Search	Application of Limits & Removal of Duplicates	Articles after Titles Screened
staff perceptions	388	237	3
staff beliefs	27	14	4
staff attitudes	455	300	7
mental health interventions	274	131	4
psychological interventions	1073	592	3
therapeutic interventions	428	136	0
professional perceptions	51	29	0
staff opinion	23	0	0
professional opinion	100	4	0
staff feedback	48	3	0
service user opinion	2445	1430	4
service user perceptions	2784	2663	10
service user beliefs	2530	2019	25
service user attitudes	2354	2041	31
patient perspectives	2457	1976	0
client perspectives	36	1	0
therapy beliefs	6	5	0
psychological therapy	296	12	0
treatment beliefs	78	2	0
treatment perceptions	58	2	0
acceptability	1849	1590	19
Total	*17760*	*13187*	*110*

Appendix 3.

Quality Rating Tool

Summary Sheet

Paper Rated:-

Rater Initials…………………. Date Rated…………………

	Total
CASP (2002)	
Walsh and Downe (2006)	

Inter-Rater Discussion

Inter-Rater Agreement:-

	Rater 1.	Rater 2.
CASP (2002)		
Walsh and Downe (2006)		

Inter-Rater Discussion Notes

Critical Appraisal Skills Programme Checklist (CASP, 2002)				
Screening Questions		**Y**	**N**	**Comments**
1	**Was there a clear statement of the aims of the research?** *(Consider: goal, importance, relevance)*	1	0	
2	**Is a qualitative methodology appropriate?** *(Consider: does the research seek to interpret or illuminate the actions and/or subjective experiences of research participants)*	1	0	
Detailed Questions				
3	**Was the research design appropriate to address the aims of the research?***(Consider: has the researcher justified the research design? Have they discussed how they decided which method to use?)*	1	0	
4	**Was the recruitment strategy appropriate to the aims of the research?** *(Consider: explanation of participant selection, why participants are most appropriate, discussion around recruitment)*	1	0	
5	**Were the data collected in a way that addressed the research issue?** *(Consider: justifiication for setting of data collection and methods used, clarify of how data was collected, explicit about methods, any modifications of methods and is so why and how, form of data clear e.g. tapes, videos etc, discussion of saturation of data)*	1	0	
6	**Has the relationship between researcher and participants been adequately considered?** *(Consider: researcher critically examine own role, potential bias and influence during all stages of research, details of how researcher responded to events during the study and whether they considered the implications of any change in research design)*	1	0	
7	**Have ethical issues been taken into consideration?** *(Consider: ethical standards maintained, issues raised by the study such as confidentiality or informed consent and how these were handled, obtained REC approval)*	1	0	
8	**Was the data analysis sufficiently rigorous?** *(Consider: in-depth description of analysis process, thematic analysis – clarity of how categories/themes derived, explanation of data selection from original sample to demonstrate analysis process, sufficient data, extent of contradictory data, critically examines own role and bias)*	1	0	
9	**Is there a clear statement of the findings?** *(Consider: explicit findings, adequate discussion for and against the researchers arguments, discussion of credibility of findings, relation to original question).*	1	0	
10	**How valuable is the research?***(Consider: discussion of contribution to existing knowledge/understanding/policy/practice, identification of new research areas, discussion of transference to other populations, discusses other ways research can be used)*	1	0	

Walsh and Downe Criteria (2006)				
		Y	**N**	**Comments**
1	**Scope and Purpose** *Clear statement of, and rationale for, research question/aims/purposes* • *Link between research and existing knowledge demonstrated* *Study thoroughly contextualised by existing literature*	1	0	
2	**Design** *Method/design apparent, and consistent with research intent* • *Rationale and exploration of qual. approach and method* • *Discussion of why particular method chosen* *Data collection strategy apparent and appropriate* • *Appropriate data collection method* • *Likely to capture complexity/diversity of experience and illuminate context* • *Triangulation of data courses*	1	0	
3	**Sampling Strategy** *Sample and sampling method appropriate* • *Detail of selection criteria and description of sampling undertaken* • *Justification for sampling strategy* • *Disparity between planned and actual sample explained*	1	0	
4	**Analysis** *Analytic approach appropriate* • *Approach made explicit* • *Appropriate for method* • *Data management explained* • *Coding systems/conceptual framework evolution discussed* • *How was context of data retained?* • *Evidence of subjective meanings of participants portrayed* • *More than one researcher if appropriate* • *Participants involved in analysis, evidence of data saturation or discussion if not* • *Evidence that deviant data was sought, or discussion/rationale if it was not*	1	0	
5	**Interpretation** *Context described and taken into account of in interpretation* • *Descrip. of social/physical and interpersonal contexts of data collection* • *Evidence that researcher spent "time" with the data* *Clear audit trail given* • *Discussion of research process – others can follow* *Data used to support interpretation* • *Extensive use of notes/verbatim interview quotes* • *Clear exposition of how interpretation led to conclusions*	1	0	
6	**Reflexivity** *Researcher reflexivity demonstrated* • *Discussion of relationship between researcher and participants during fieldwork*	1	0	

	• *Demonstration of researcher's influence on stages of research process* • *Evidence of self-awareness/insight* • *Documentation of effects of the research on researcher* • *Evidence of how problems/complications met were dealt with*			
7	**Ethical dimensions** *Demonstration of sensitivity to ethical concerns* • *Approval granted* • *Clear commitment to integrity, honesty, transparency, equality and mutual respect in relationships with participants* • *Evidence of fairness, recording of dilemmas met and how resolved in relation to ethical issues* • *Documentation of how autonomy, consent, confidentiality, anonymity were managed*	1	0	
8	**Relevance and transferability** • *Evidence for typicality specificity to be assessed* • *Analysis interwoven with existing theories and other relevant explanatory literature drawn from similar settings and studies* • *Discussion of how explanatory propositions/emergent theory may fit other contexts* • *Limitations/weaknesses detailed* • *Resonates with other knowledge and experience* • *Results/conclusions supported by evidence* • *Interpretation plausible and "makes sense"* • *New insights and increases understanding* • *Sign. to current policy and practice* • *Assessment of value/empowerment for participants* • *Further directions for investigations* • *Aims/purposes of research achieved and discussed*	1	0	

Further Notes

Appendix 4. Critical Appraisal Rating Summary

	Paper No.	1		2		3		4		5		6		7		8		9		10		11	
	Rater	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
CASP																							
Screening Questions																							
1	Clear statement of research aims?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Qualitative method appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Detailed Questions																							
3	Research design appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4	Recruitment strategy appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5	Data collection appropriate	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6	Researcher-participant relationship considered?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y
7	Ethical Issues considered?	Y	Y	Y	Y	N	N	N	N	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y
8	Data analysis rigorous?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9	Clear statement of findings?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Valuable research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Total Score	9	9	9	9	8	8	8	8	9	9	8	8	8	8	10	10	10	10	10	10	10	10
Walsh and Downe Criteria																							
1	Scope and Purpose	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Design	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3	Sampling Strategy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4	Analysis	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5	Interpretation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6	Reflexivity	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
7	Ethical Dimensions	Y	Y	Y	Y	N	N	N	N	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y
8	Relevance and Transferability	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Total Score	7	7	7	7	6	6	6	6	7	7	6	6	7	7	8	8	8	8	8	8	8	8

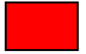
	Paper No.	12		13		14		15		16		17		18		19		20		21		22		23	
	Rater	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
CASP																									
Screening Questions																									
1	Clear statement of research aims?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Qualitative method appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Detailed Questions																									
3	Research design appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4	Recruitment strategy appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5	Data collection appropriate	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6	Researcher-participant relationship considered?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N	N	Y	Y	N	N
7	Ethical Issues considered?	N	N	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8	Data analysis rigorous?	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9	Clear statement of findings?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Valuable research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Total Score	8	8	9	9	8	8	8	8	8	8	8	8	8	8	9	9	10	10	9	9	10	10	9	9
Walsh and Downe Criteria																									
1	Scope and Purpose	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Design	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3	Sampling Strategy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4	Analysis	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5	Interpretation	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6	Reflexivity	N	N	N	N	N	N	Y	Y	N	N	N	N	N	N	Y	Y	N	N	N	N	Y	Y	Y	Y
7	Ethical Dimensions	N	N	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N
8	Relevance and Transferability	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Total Score	6	6	7	7	6	6	6	6	6	6	6	6	6	6	8	8	7	7	7	7	8	8	7	7

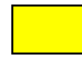
Paper No.	24		25		26		27		28	
Rater	1	2	1	2	1	2	1	2	1	2
CASP										
Screening Questions										
1 Clear statement of research aims?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2 Qualitative method appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Detailed Questions										
3 Research design appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4 Recruitment strategy appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5 Data collection appropriate	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6 Researcher-participant relationship considered?	N	N	N	N	N	N	N	N	Y	Y
7 Ethical Issues considered?	N	N	Y	Y	N	N	N	N	N	N
8 Data analysis rigorous?	N	N	Y	Y	Y	Y	Y	Y	Y	Y
9 Clear statement of findings?	N	N	Y	Y	Y	Y	Y	Y	Y	Y
10 Valuable research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total Score	6	6	9	9	8	8	8	8	9	9
Walsh and Downe Criteria										
1 Scope and Purpose	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2 Design	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3 Sampling Strategy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4 Analysis	N	N	Y	Y	Y	Y	Y	Y	Y	Y
5 Interpretation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6 Reflexivity	N	N	N	N	N	N	N	N	Y	Y
7 Ethical Dimensions	N	N	Y	Y	N	N	N	N	N	N
8 Relevance and Transferability	N	N	Y	Y	Y	Y	Y	Y	Y	Y
Total Score	4	4	7	7	6	6	6	6	7	7

Scoring Key

Y = Fully conclusive and meets criteria
N = Flawed or no mention

Agreement

 **Disagreement**

 **Area of scoring difference**

CASP
8-10 = category 'A' rating (no or minor issues)
5-7 = category 'B' rating (several issues)
1-4 = category 'C' rating (major issues)

Walsh and Downe
6-8 = category 'A' rating (no or minor issues)
3-5 = category 'B' rating (several issues)
0-2 = category 'C' rating (major issues)

Appendix 5. Critical Appraisal Category Summary and Post-Rating Re-Order Numbering (Category highlighted)

Paper No.	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**		**11**		**12**		**13**		**14**		**15**		**16**		**17**	
Rater	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
CASP Score	9	9	9	9	8	8	8	8	9	9	8	8	8	8	10	10	10	10	10	10	10	10	8	8	9	9	8	8	8	8	8	8	8	8
CASP Category	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Walsh & Downe Score	7	7	7	7	6	6	6	6	7	7	6	6	7	7	8	8	8	8	8	8	8	8	6	6	7	7	6	6	6	6	6	6	6	6
Walsh & Downe Category	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Overall Quality Category	A		A		A		A		A		A		A		A		A		A		A		A		A		A		A		A		A	
Post-Rating No.	**4 SU**		**5 SU**		**25 SU-S**		**24 SU-S**		**9 SU**		**12 SU**		**11 SU**		**2 SU**		**3 SU**		**10 SU**		**27 SU-S**		**8 SU**		**28 SU-S**		**20 S**		**19 S**		**16 SU**		**14 SU**	

Paper No.	**18**		**19**		**20**		**21**		**22**		**23**		**24**		**25**		**26**		**27**		**28**	
Rater	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
CASP Score	8	8	9	9	10	10	9	9	10	10	9	9	8	8	9	9	8	8	8	8	9	9
CASP Category	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Walsh & Downe Score	6	6	8	8	7	7	7	7	8	8	7	7	6	6	7	7	6	6	6	6	7	7
Walsh & Downe Category	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Overall Quality Category	A		A		A		A		A		A		A		A		A		A		A	
Post-Rating Re-Order No.	**6 SU**		**22 S**		**26 SU-S**		**21 S**		**15 SU**		**13 SU**		**7 SU**		**18 S**		**23 SU-S**		**17 S**		**1 SU**	

Scoring Key

CASP
8-10 = category 'A' rating (no or minor issues)
5-7 = category 'B' rating (several issues)
1-4 = category 'C' rating (major issues)

Walsh & Downe
6-8 = category 'A' rating (no or minor issues)
3-5 = category 'B' rating (several issues)
0-2 = category 'C' rating (major issues)

Overall Categories
Category 'A' = high quality and low bias
Category 'B' = moderate quality and moderate bias
Category 'C' = low quality and high bias

Post-Rating Re-Order No.
Papers placed chronologically within the categories (Service User (SU); Staff (S); Service User-Staff (SU-S)

Appendix 6. Noblit and Hare (1988) Seven Step Meta-synthesis Approach

1. *Getting Started – researcher identifies area of interest that qualitative studies might inform.*

A research question was formed which required the qualitative approach to fully explore the area: Service user and staff perceptions of psychological interventions for mental health difficulties.

2. *Deciding what is relevant to the initial interest - Researcher must decide which qualitative studies are relevant to meta-synthesis.*

Exclusion and inclusion criteria were used in order to ensure qualitative studies relevant to the research question were included. Further to this critical appraisal criteria (CASP, 2002 and Walsh and Downe, 2006) were used on the resultant studies as a means of accounting for an optimum level of study quality.

3. *Read studies – Researcher reads and rereads the qualitative studies to identify the key metaphors, themes or concepts.*

The studies meeting inclusion criteria were read numerous times. Demographic, methodological and original themes/concepts were extracted and tabulated for all 28 studies.

4. *Determining how studies are related – create list and compare key themes, metaphors or concepts for each qualitative study.*

Studies and raw data (participant quotes) were compared against each other to identify comparable, oppositional or new themes and concepts.

5. *Translate the studies into one another – Metaphors or themes in one study are compared with those of another.*

Themes and concepts were further compared and examined. Whilst maintaining integrity and meaning of the original data themes were translated from one study to another through interpretative processes.

6. *Synthesising Translation – after translating studies into one another the next challenge for the researcher is to make a whole into more individual parts.*

Themes were translated into over-arching themes through clustering together themes in relation to their meaning.

7. *Expressing the synthesis.*

A written explanation and comprehensive diagrammatic illustration was comprised of the relationships between the overarching and subordinate themes.

Appendix 7. Concept Findings and Identified Themes

Concept Findings and Identified Themes for Service User Participants

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
1.	Messari, S. & Hallam, R. (2003)	**CBT as a healing process**		Therapy Stages (TF)
		CBT participation as compliance with the powerful medical establishment		Personal & Therapeutic Change (SUF)
		CBT as an educational process (educational discourse)		Therapy Stages (TF)
		CBT as a respectful relationship between equals (friendship discourse)		Therapeutic Relationship(s) (TF)
		This is truly happening		Therapeutic Experience (SUF)
		I am ill		Therapeutic Experience (SUF) Illness Perceptions (TF)
		Contradiction between 'This is truly happening' and 'I am ill' discourses		Therapeutic Experience (SUF) Illness Perceptions (TF)
2.	Gallegos, N. (2005)	**Reasons for seeking therapy**		Predisposing Cultural Beliefs & Attitudes (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Accommodation	*Did phone counselling* *Did not charge for therapy* *Went over scheduled time*	Illness Perceptions (TF) Therapy Stages (TF)
		Adjunctive therapy	*Psychopharmacology* *Group therapy* *Couples therapy*	Therapeutic Experience (SUF) Therapy Stages (TF)
		Attunement	*Responded to need for interaction* *Connected through diary* *Responded to cerebral personality*	Personal & Therapeutic Change (SUF) Therapy Stages (TF) Staff Role (SF)
		Extratherapeutic events and growth	*Improved marital interaction* *Returned to art and piano lesions* *Husband saw therapist*	Personal & Therapeutic Change (SUF)
		Insight and awareness **Knowledgeable/credible other**	*Psychosocial history* *Gave effective advice* *Noticed and took action on physiological problem* *Taught communication skills*	Reflection & Evaluation (SUF) Professional Background & Characteristics (SF) Therapeutic Experience (SUF) Staff Role (SF) Staff Role (SF)
		Provider attributes	*Immediate personal connection* *Deep expression of care* *Authentic*	Reflection & Evaluation (SUF) Therapeutic Relationship(s) (TF) Personal & Therapeutic Change (SUF)
		Safety and trust **Support**		Therapeutic Relationship(s) (TF) Therapeutic Experience (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
3.	Bury, C., Raval, H. & Lyon, L. (2007)	**Seeking help and engagement**	*Being in difficulty* *Feelings about referral and stigma* *Expectations of therapy*	Predisposing Cultural Beliefs & Attitudes (SUF)
		Beginning therapy	*Mixed feelings* *Therapist's response*	Illness Perceptions (TF) Predisposing Cultural Beliefs & Attitudes (SUF)
		The therapeutic process	*Learning the ropes* *Facilitative aspects* *Power*	Staff Role (SF) Therapy Stages (TF) Staff Role (SF)
		Endings	*Ambivalence* *Feelings of separation and loss* *Moving on*	Reflection & Evaluation (SUF) Therapeutic Experience (SUF) Therapy Stages (TF) Recovery & Hope (TF)
4.	Macdonald, W., Mead, N., Bower, P., Richards & Lovell, K. (2007)	**Patient expectancies**	*Process of guided self-help* *Outcome of guided self-help*	Predisposing Cultural Beliefs & Attitudes (SUF) Therapy Stages (TF)
		Patient experience	*Expertise of the assistant psychologist* *Suitability for guided self-help* *Process of guided self-help* *Outcome of guided self-help*	End & Outcome (TF) Predisposing Cultural Beliefs & Attitudes (SUF) Professional Background & Characteristics (SF) Therapy Stages (TF)
		Other influences on patient decision-making about accessing further therapy		Illness Perceptions (TF) Therapy Stages (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
				Reflection & Evaluation (SUF) Recovery & Hope (TF)
5.	Newton, E., Larkin, M., Melhuish, R. & Wykes, T. (2007)	**A place to explore shared experiences**	*A safe place to talk Normalising & destigmatising* *Learning from and helping others* *The role of the facilitators*	Therapeutic Experience (SUF) Illness Perceptions (TF) Reflection & Evaluation (SUF)
		An inductive account of coping with auditory hallucinations	*Passive explanations* *Agentic explanations* *Socio-cultural explanations*	Predisposing Cultural Beliefs & Attitudes (SUF) Reflection & Evaluation (SUF)
6.	Sibitz, I., Amering, M., Gössler, R., Unger, A. & Katschnig, H. (2007)	**Changes caused by participating in the seminar**	*Increase in knowledge* *Better life management* *More social interaction* *Increased self-esteem* *Sense of mastery*	Therapeutic Experience (SUF) Real Life Implementation (TF) Therapeutic Relationship(s) (TF) Personal & Therapeutic Change (SUF)
		Causal factors judged as responsible for change	*Knowledge gained* *Reflecting about illness and life* *Increased motivation to become active* *Getting emotional support and understanding form other people suffering from a mental illness*	Therapeutic Experience (SUF) Reflection & Evaluation (SUF) Therapy Stages (TF) Personal & Therapeutic Change (SUF) Therapeutic Experience (SUF) Recovery & Hope (TF) Therapeutic Experience (SUF)
		Prerequisites for benefiting from the seminar	*Participant dependent* *Moderator dependant*	Illness Perceptions (TF) Predisposing Cultural Beliefs & Attitudes

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			Interactions between group members	(SUF)
			Illness state	Staff Role (SF)
			Motivation	
			Extent of prior information	
		Problems, difficulties and criticism		
			Participant lack of concentration	Therapy Stages (TF)
			Other participant tediousness	Evaluation (SF)
				Personal & Therapeutic Change (SUF)
7.	Ma, J.L.C. (2008)	**Focus of attention**		Therapeutic Experience (SUF)
				Reflection & Evaluation (SUF)
				Therapy Stages (TF)
		Treatment format		Therapeutic Experience (SUF)
				Reflection & Evaluation (SUF)
				Therapy Stages (TF)
				Personal & Therapeutic Change (SUF)
		Purposes of family therapy		Therapeutic Experience (SUF)
				Therapy Stages (TF)
				Personal & Therapeutic Change (SUF)
				Reflection & Evaluation (SUF)
				Recovery & Hope (TF)
		Therapeutic relationship and its linkage to change and recovery		Therapeutic Experience (SUF)
				Therapy Stages (TF)
				Therapeutic Relationship(s) (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			Assisting in problem solving	Professional Background & Characteristics (SF) Reflection & Evaluation (SUF) Staff Role (SF)
		Perceived intervention and family's contribution	*Allowing for the emergence of multiple voices*	Therapeutic Relationship(s) (TF) Therapeutic Experience (SUF) Reflection & Evaluation (SUF) Staff Role (SF)
			Direct observations	Staff Role (SF) Therapeutic Relationship(s) (TF) Therapeutic Experience (SUF) Personal & Therapeutic Change (SUF) Staff Role (SF) Therapeutic Relationship(s) (TF) Therapeutic Experience (SUF) Personal & Therapeutic Change (SUF)
8.	O'Connor, C., Gordon, O., Graham, M., Kelly, F. & O'Grady-Walshe, A. (2008)	**The treatment of bipolar disorder**		Staff Role (SF) Therapy Stages (TF)
		Perception of others		Illness Perception (SUF)
		Learning from the group		Therapeutic Relationship(s) (TF)
9.	Whitney, J., Easter, A. &	**Expectations and experiences of CRT at the beginning of treatment**	*Uncertainty*	Predisposing Cultural Beliefs & Attitudes (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
	Tchanturia, K. (2008)	**Targeted characteristics of Anorexia Nervosa**	*Perfectionism* *Rigidity/Lack of flexibility* *Attention-to-detail/failure to see the bigger picture* *Lack of confidence* *Low mental capacity* *Other (take things at face value, obsessionality)*	Illness Perceptions (TF) Personal & Therapeutic Change (SUF)
		Stages of therapy	*Get familiar with exercises* *Connections between exercises and thinking style* *Connections between exercises and real life* *Implementation into real life* *Practice and continuity*	Therapy Stages (TF) Recovery & Hope (TF)
		Insight, skills and implementation	*Insight (recognition of unhelpful thinking style and behaviours)* *Change (statements of change, e.g. I am less rigid)* *Specific examples of implementation and change* *As an introduction to other psychological therapies*	Therapeutic Experience (SUF) Recovery & Hope (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Experience with CRT as compared to other therapies	*Good attributes (fun, interesting, refreshing)* *Unrelated to food, eating, weight and shape* *Less intense than other therapies* *Related to rules, rituals, behaviours*	Therapy Stages (TF) Reflection & Evaluation (SUF) Therapy Stages (TF)
		Relationship with therapist	*Good qualities of therapist (warm, empathetic)* *Importance of good therapeutic relationship*	Staff Role (SF) Personal & Therapeutic Change (SUF) Therapeutic Relationship(s) (TF)
		What patients did not like and suggestions for the future	*Too easy/more challenge needed/ need for varying levels of difficulty* *Need for individual tailoring* *Need for more help to translate skills to real life* *Need for patient motivation* *Application to different treatment settings* *Application to different disorders* *More (longer duration of intervention and more tasks)*	Personal & Therapeutic Change (SUF) Reflection & Evaluation (SUF) Recovery & Hope (TF) Therapy Stages (TF)
		Overall satisfaction and importance of CRT	*Helpful* *Unhelpful* *CRT's role in recovery*	Therapy Stages (TF) Reflection & Evaluation (SUF) Recovery & Hope (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
10.	O'Donovan, A. & O'Mahony, J. (2009)	**The value service users placed on the programme**	*Personal gains: I have that too!* *The overall experience* *Interaction: Relating to others*	Therapeutic Experience (SUF) Personal & Therapeutic Change (SUF) Therapy Stages (TF) Therapeutic Relationship(s) (TF)
		The benefits they gained	*Normalisation* *Helpful Content*	Personal & Therapeutic Change (SUF) Therapy Stages (TF)
		The unhelpful aspects they experienced	*Unhelpful/Irrelevant content* *Mental health dependent*	Reflection & Evaluation (SUF) Personal & Therapeutic Change (SUF) Illness Perceptions (TF)
		The factors that influenced their participation	*Sample characteristics of the group* *Facilitator approach*	Therapy Stages (TF) Staff Role (SF) Reflection & Evaluation (SUF)
11.	Bevan, A., Oldfield, V.B. & Salkovskis, P.M. (2010)	**Background**		Predisposing Cultural Beliefs & Attitudes (SUF)
		Perception of outcome	*Views of therapy*	Predisposing Cultural Beliefs & Attitudes (SUF)
		Relevance		Therapy Stages (TF) Predisposing Cultural Beliefs & Attitudes (SUF)
		Perceived quantity of therapy		
		Ongoing support		
		Therapeutic alliance	*Preference for treatment format*	Therapeutic Experience (SUF) Therapy Stages (TF)
		Time between sessions (benefits)	*Time to learn* *Time to reflect and practise*	Therapeutic Relationship(s) (TF) Therapy Stages (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			Time to make sure everything covered	Personal & Therapeutic Change (SUF)
			Five days not long enough	
		Time between sessions (drawbacks)	*Thinking too much* *Daily support* *Concentration* *Efficiency*	Reflection & Evaluation (SUF) Personal & Therapeutic Change (SUF) Endings & Outcomes (TF)
		Longer sessions		Therapy Stages (TF)
		Stress		Personal & Therapeutic Change (SUF) Illness Perceptions (TF)
		Motivation	*Momentum* *Perceived power of treatment*	Predisposing Cultural Beliefs & Attitudes (SUF)
		Accessibility		Illness Perceptions (TF) Therapy Stages (TF)
12.	Brown, L.F., Davis, L.W., LaRocco, V.A. & Strasburger, A. (2010)	**Expectations**	*Coping skills* *Meditation, learning how* *Present focus* *Symptom reduction*	Predisposing Cultural Beliefs & Attitudes (SUF) Therapy Stages (TF) Therapeutic Experience (SUF)
		Positive outcome	*Cognitive changes (e.g. better ways of thinking, new thoughts and ideas)* *Group support)e.g. sharing, offering feedback)*	Therapeutic Experience (SUF) Therapy Stages (TF) Therapeutic Relationship(s) (TF) Shared Focus & Control (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			Present focus *Relaxation* *Self awareness/acceptance* *Symptom reduction*	
		Negative outcomes	*Bad memories (low incidence)* *Sad feelings (low incidence)*	Personal & Therapeutic Change (SUF) Therapy Stages (TF)
		Personal difficulties with program	*Cognitive difficulties (e.g. imagery, concentration, learning, memory)* *Physical limitations (e.g. hearing, pain)* *Social Anxiety (uncomfortable in group setting)* *Time management (finding time for meditations; working classes into schedule)*	Personal & Therapeutic Change (SUF) Facilitator & Operational Factors (SUF) Therapy Stages (TF) Flexibility, Continuity & Consistency (TF)
		Negative Program structure	*Limited space (low incidence)* *Short length*	Therapy Stages (TF) Personal & Therapeutic Change (SUF) Therapy Stages (TF)
		Positive program structure	*Acceptable structure (pace, class length, frequency, time, location, etc)* *CDs, different guided meditations* *Group dynamics (sharing, inclusions)*	Flexibility, Continuity & Consistency (TF) Therapeutic Experience (SUF) Therapy Stages (TF)
		How participants would describe what the program is about	*Cognitive changes, thinking about things differently*	Accessibility & Change (SUF) Therapeutic Experience (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			Coping skills *Meditation* *Present focus* *Relaxation* *Self-awareness/acceptance* *Symptom reduction*	
13.	McManus, F., Peerbhoy, D., Larkin, M. & Clark, D.M. (2010)	**Social phobia as a way of being**		Illness Perceptions (TF) Predisposing Cultural Beliefs & Attitudes
		Learning to challenge social phobia as a way of being: transformative mechanisms of therapy	*Value of the therapeutic relationship* *Value of the diagnosis and formulation* *Learning to interpret experiences differently thought experiential learning in therapy*	Reflection & Evaluation (SUF) SU-Staff Interactions (SUF) Therapeutic Experience (SUF) Personal & Therapeutic Change (SUF) Therapeutic Experience (SUF) Illness Perceptions (TF)
		Challenges faced in the pursuit of change	*Therapy being an emotional roller-coaster* *Transferring theory and skills into practicing in the real world*	Personal & Therapeutic Change (SUF) Recovery & Hope (TF) Therapy Stages (TF)
		A whole new world: new ways of being	*Relief from and reappraisal of anxiety* *Enhanced acceptance of anxiety and of self and others* *Re-engaging with the world*	Therapy Stages (TF) Recovery & Hope (TF) Personal & Therapeutic Change (SUF) Therapeutic Experience (SUF) Illness Perception (SUF)
14.	Gerhards, S.A.H., Abma, T.A., Arntz, A.,	**Computer aspects**	*Computer/internet skills and equipment* *Online vs printed medium* *Location and time of computer/CCBT*	Reflection & Evaluation (SUF) Personal & Therapeutic Change (SUF) Therapy Stages (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
	de Graff, L.E., Evers, S.M.A.A., Huibers, M.J.H. & Widdershoven, G.A.M. (2011)		*access*	Reflection & Evaluation (SUF)
		Social aspects	*Identification with and applicability of CCBT* *Demand for support* *Motivation* *Personal contact* *Feedback*	Personal & Therapeutic Change (SUF) Therapeutic Experience (SUF) Predisposing Cultural Beliefs & Attitudes (SUF) Personal & Therapeutic Change (SUF) Therapeutic Relationship(s) (TF) Therapy Stages (TF)
		Research aspects	*Hawthrone effect* *Research activities impact* *CCBT/depression complaints*	Reflection & Evaluation (SUF)
15.	Williams, M.J., McManus, F., Muse, K. & Williams, J.M.G. (2011)	**My awareness of barriers to experiencing change through MBCT**	*My desire to experience change in the face of initial uncertainties* *The struggle to find the time: Is practising MBCT regularly worthwhile to me?* *My need for variety and flexibility*	Predisposing Cultural Beliefs & Attitudes (SUF) Illness Perceptions (TF) Personal & Therapeutic Change (SUF) Therapy Stages (TF) Flexibility, Continuity & Consistency (TF)
		Cultivation of a new approach to health anxiety and my life in general	*Validation and normalisation of my experiences through MBCT* *An awareness of my anxiety cycle enables me to break it* *Acceptance of my experiences* *A different outlook on my life in general* *Change large enough for significant others to notice*	Therapeutic Experience (SUF) Therapy Stages (TF) Recovery & Hope (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
16.	Kilbride, M., Byrne, R., Price, J., Wood, L., Barratt, S., Welford, M. & Morrison, A.P. (2012)	**CBT as a process of person-centred engagement**	*Personal engagement and trust* *Partnership and collaboration* *Sharing control with clients* *Flexibility enabling continued engagement*	Therapeutic Relationship(s) (TF) Flexibility, Continuity & Consistency (TF) Therapeutic Experience (SUF)
		CBT as an active process of structured learning	*Identifying clients' "psychological map" through formulation* *Re-appraising psychological difficulties through evidence-gathering* *The value of practical [written] tools* *Carrying on CBT work with homework* *Gaining a different perspective*	Therapy Stages (TF) Therapeutic Experience (SUF) Predisposing Cultural Beliefs & Attitudes (SUF)
		CBT helping to improve personal understanding	*Normalisation as a central active process* *The role of improved understanding in long-term coping*	Therapeutic Experience (SUF) Personal & Therapeutic Change (SUF) Recovery & Hope (TF) Therapy Stages (TF)
		CBT is hard work	*"Being ready"* *Finding it difficult to engage with or complete work* *Emotionally difficult*	Illness Perceptions (TF) Therapy Stages (TF) Personal & Therapeutic Change (SUF) Predisposing Cultural Beliefs & Attitudes (SUF)
		CBT and recovery	*Acceptance as a part of recovery* *Practical, social and functional recovery* *Achievement, empowerment and independence in recover* *Gaining or regaining hope*	Reflection & Evaluation (SUF) Therapeutic Experience (SUF) Reflection & Evaluation (SUF) Recovery & Hope (TF)

Concept Findings and Identified Themes for Staff Participants

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
17.	Frueh, C.B., Cusack, K.J., Grubaugh, A.L., Sauvageot, J.A. & Wells, C. (2006)	**Trauma**	*Life of person with severe illness*	Predisposing Cultural Beliefs & Attitudes (SUF) Illness Perceptions (TF)
			Clinician fear	Professional Background & Characteristics (SF) Staff Role (SF) Therapeutic Relationship(s) (TF) Evaluation (SF)
			Cognitive-Behavioral Treatment	Therapy Stages (TF) Professional Background & Characteristics (SF)
			Miscellaneous implementation issues	Evaluation (SF) Recovery & Hope (TF) Reflection & Evaluation (SUF)
18.	Awty, P., Welch, A. & Kuhn, L. (2010)	**Deciphering the wood from the trees: a personal choice of a lifelong career**		Staff Role (SF) Professional Background & Characteristics (SF)
		Adopting a philosophical disposition for practice: a position of difference		Professional Background & Characteristics (SF) Illness Perceptions (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Relating in a psychodynamic therapeutic manner: the key to effective intervention		Staff Role (SF)
		Perceiving barriers to the provision of psychodynamic therapeutic care		Evaluation (SF)
		Hopeful expectancy: nurturing personal hopes for rebirth of a psychodynamic approach to care		Staff Role (SF) Professional Background & Characteristics (SF)
19.	Naeem, F., Gobbi, M., Ayub, M & Kingdon, D. (2010)	**Hurdles in therapy**	*Service issues* *Dealing with somatic complaints* *Pills and psychotherapy* *Homework* *Patient's expectations from mental health system* *Literal translation does not work* *Beliefs about illness*	Evaluation (SF) Predisposing Cultural Beliefs & Attitudes (SUF) Personal & Therapeutic Change (SUF) Illness Perceptions (TF) Therapy Stages (TF)
		Issues related to therapy	*Assessment* *Commonly used techniques* *Structure and content of sessions* *Normalising techniques*	Reflection & Evaluation (SUF) Therapy Stages (TF) Evaluation (SF) Therapeutic Experience (SUF) Personal & Therapeutic Change (SUF) Therapy Stages (TF)
		Techniques which patients find	*Style of therapy*	Therapeutic Relationship(s) (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		helpful	*Involvement of the family*	Staff Role (SF)
		Modifications in therapy		
20.	Prytys, M., Garety, P.A., Jolley, S., Onwumere, J. & Craig, T. (2010)	**Understanding and beliefs about psychosis**	*Beliefs about treatment for psychosis* *Expectations of clients with psychosis* *Views of recovery in psychosis*	Professional Background & Characteristics (SF)
		Beliefs about and attitudes to clinical guidelines and psychological therapies	*Positive attitudes to clinical guidelines* *Doubts about relevance and applicability of clinical guidelines* *Views about psychological therapy for psychosis*	Illness Perceptions (TF) Professional Background & Characteristics (SF) Therapy Stages (TF)
		Views on the role of the care coordinator	*Care coordinators using psychological interventions* *Other aspects of the care coordinator role*	Professional Background & Characteristics (SF)
		Factors affecting implementation	*Lack of time* *Role confusion* *Need for specialist workers in teams* *Service user refusal* *Work pressure* *Long waiting lists*	Therapy Stages (TF) Professional Background & Characteristics (SF) Predisposing Cultural Beliefs & Attitudes (SUF) Evaluation (SF)
21.	Gearing, R.E., Schwalbe, C.S. &	**Psychosocial treatment adherence**	*Attendance to treatment* *Participation in treatment*	Predisposing Cultural Beliefs & Attitudes (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
	Short, K.D. (2012)	**Treatment adherence: adolescent domain**	*Barriers and promoters* - *Motivation to change* - *View of treatment* - *Concrete barriers and promoters*	Predisposing Cultural Beliefs & Attitudes (SUF) Personal & Therapeutic Change (SUF)
		Treatment adherence: family	*Parental agreement with treatment* *Parent health and strain* *Concrete barriers* *Stigma*	Predisposing Cultural Beliefs & Attitudes Personal & Therapeutic Change (SUF)
		Treatment adherence: clinician domain	*Aimed at adolescents* *Aimed at parents* *Used in response to non-adherence*	Illness Perceptions (TF) Evaluation (SF)
		Treatment adherence: agency domain	*Financial* *Procedural* *Technology*	Therapy Stages (TF) Therapeutic Response & Approach (SF) Evaluation (SF)
22.	Luca, M. (2012)	**Shared CBT and psychodynamic therapeutic activities and interventions**	*Working together with client* *Sensitive, empathic responding and building trust* *Being flexible with techniques* *Keeping an open mind* *Multi-disciplinary cooperation*	Staff Role (SF) Professional Background & Characteristics (SF) Therapeutic Relationship(s) (TF) Therapy Stages (TF)
		Cognitive behavioural therapeutic activities and interventions	*Collaboration with client* *Using a pragmatic style*	Therapeutic Relationship(s) (TF) Staff Role (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			Avoiding assumptions on causes of MUS *Categorising issues with client*	Personal & Therapeutic Change (SUF) Illness Perceptions (TF)
		Psychodynamic therapeutic activities and interventions	*Link physiological responses to psychological factors* *Do supportive work* *Tune into a client's emotional distress* *No focus on somatic symptom*	Therapeutic Experience (SUF) Therapeutic Relationship(s) (TF) Therapy Stages (TF) Staff Role (SF)

Concept Findings and Identified Main Theme for Service User and Staff Combined Studies

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
23.	Metcalf, L. & Thomas, F. (1995)	**The role of the therapist in the therapy process**	*Therapist:-* - *consultant* - *ask scaling questions* - *paraphrase* - *look for strengths, resources* - *listen* - *don't participate unless asked* - *give ideas* - *highlight competencies*	Professional Background & Characteristics (SF) Therapy Stages (TF) Staff Role (SF) Therapeutic Experience (SUF)
			Couple:- - *mediator* - *friend* - *outsider* - *sounding board* - *said what would work* - *savior* - *guide* - *made suggestions*	Staff Role (SF) Therapeutic Experience (SUF) Personal & Therapeutic Change (SUF) Therapeutic Relationship(s) (TF)
		Why clients sought therapy	*Therapist:-* - *Divorce* - *Multiple relationships* - *Death* - *Familial worry* - *Physical and depressive*	Predisposing Cultural Beliefs & Attitudes (SUF) Illness Perceptions (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			symptoms - *Panic disorder* - *Agoraphobia* - *Marital discord* - *Childhood experiences with abusive parents* - *Tension* - *Sadness*	
			Couple:- - *Emergency treatment* - *Concerns about family* - *Panic disease* - *Family stressors* - *To try to stay together* - *Life events* - *To figure out the problem* - *Doctors suggestion*	Illness Perceptions (TF) Professional Background & Characteristics (SF) Predisposing Cultural Beliefs & Attitudes (SUF)
		The process of termination	*Therapist:-* - *Suggestion of a break in therapy* - *Significant process and appropriate time to terminate* - *Couples decision* - *Spacing out sessions* - *Leave next appointment open* - *Their choice* - *Couple felt things had resolved* - *They decided to stop*	Therapeutic Experience (SUF) Personal & Therapeutic Change (SUF) Therapy Stages (TF) Recovery & Hope (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			Couple:- - *Therapists decision* - *'You must go'* - *Limited visits* - *Left it open* - *Changed jobs so couldn't carry on* - *Completed agreed sessions*	Professional Background & Characteristics (SF) Reflection & Evaluation (SUF) Therapy Stages (TF)
		The process of therapy	*Therapist:-* - *We consult together* - *Work together to achieve objectives* - *Talk about the mirror…team…find a way to dialogue* - *Take a break* - *Ask what is better, what is improved and spend majority of the session trying to identify what caused it and reinforcing it*	Therapy Stages (TF) Therapeutic Relationship(s) (TF) Staff Role (SF)
			- *Don't give suggestions* *Couple:-* - *Talked and focused on me* - *Sat and babbled about my fears* - *He/she said "Im impressed"* - *Pointed out false attitudes*	Shared Focus & Control (TF) Therapy Stages (TF) Learning & Sharing (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			- *He/she made a difference* - *He/she set me up for success* - *He/she taught me a scheme* - *He/she jumbled it all up so I could get it straight* - *Team made suggestions* - *He/she made suggestions*	
		The pragmatics of change	*Therapist:-* - *Validated and helped think about what they wanted* - *Empowered them* - *Believed in them* - *Found strengths and resources they had through questions* - *Reinforced* - *Positive blame* - *I showed up* - *I punctuated*	Therapeutic Experience (SUF) Therapy Stages (TF) Therapeutic Relationship(s) (TF) Professional Background & Characteristics (SF) Staff Role (SF)
			Couple:- - *He/she and the team told us some very positive things we were doing* - *He/she was positive* - *Reminded us of things we had forgotten about ourselves* - *He/she mixed things up and asked*	Staff Role (SF) Therapeutic Relationship(s) (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			"why?" - *He/she told us about themselves* - *He/she made us think a little more before we did stuff* - *Pointed things out in a different way* - *Praised us* - *He/she gave us a neutral place to come*	
24.	Raingruber, B.J. (2001)	**Importance of "reading" each other**		Personal & Therapeutic Change (SUF) Staff- SU Interaction (SF)
		Importance of focusing on feelings during therapy		Therapy Stages (TF)
		Importance of letting sessions "flow"		Therapy Stages (TF) Staff Role (SF)
		Nurse-therapist and client familiarity		Staff Role (SF)
		Metaphors help to discuss difficult issues		Therapy Stages (TF) Staff Role (SF)
		Therapist differences between approach	*Visual thinkers*	Staff Role (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Client preferences to therapist approach	*Family therapist – more directive*	Staff Role (SF)
25.	McGowan, J.F., Lavender, T. & Garety, P.A. (2005)	**Definitions of progress**	*Changed interpretation of symptom* *Reduced distress relative to symptom* *No changed interpretation of symptoms*	Reflection & Evaluation (SUF) Therapeutic Experience (SUF)
		Moving to new and disregarding old understanding	*One explanation superseding another* *Eliminating other explanations* *Holding two explanations simultaneously* *Sliding into other multiple explanations*	Illness Perception (SUF) Therapeutic Experience (SUF)
		Ability to engage in clear, logical thinking	*Using therapist to aid clarity of thought* *Clear thinking aiding understanding* *Inability to think logically enough*	Personal & Therapeutic Change (SUF) Therapeutic Relationship(s) (TF)
		Continuity in therapy	*Continuity in therapy* *Absence of continuity* *Discontinuity in client's experiential world*	Therapy Stages (TF)
		Remembering and understanding therapy	*Operationalising a change* *Failing to operationalise the idea of helpful*	Therapeutic Experience (SUF)
		Therapeutic alliance-shared goal	*Clear description of shared task* *No sense of shared task*	Therapeutic Experience (SUF) Staff Role (SF) Predisposing Cultural Beliefs & Attitudes

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			Difficulty of sharing task with client *Client has different agenda* *Therapist becoming incorporated into the delusional system of the client*	(SUF) Reflection & Evaluation (SUF) Illness Perceptions (TF) Therapeutic Relationship(s) (TF)
		Central Theme: understanding, holding and engaging with the therapist's model of reality		
26.	Pontin, E., Peters, S., Lobban, F., Rogers, A. & Morriss, R.K. (2009)	**Elaborated understanding of Bipolar Disorder (BD)**	*Implications for Care Coordinators (CC)* - *Learns about BD* - *Learns about early warning signs, triggers and coping strategies* - *Acquires new skills for working with individuals with BD – increases competence and confidence of working with individuals with BD* - *Acquires new skills and strategies that generalise to working with individuals with other disorders* - *Gains further understanding of SU perspective and experience of BD* - *Need to manage SUs distress and anxiety talking about past illness episodes*	Professional Background & Characteristics (SF) Staff Role (SF) Evaluation (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			Implications for service users (SU) - *Learns about BD* - *Learns about early warning signs, triggers and coping strategies* - *Increases acceptance of diagnosis and rationale for medication concordance* - *Reduces feeling of isolation and fear of BD* - *Allows opportunity to reflect and make sense of lives* - *Distress and anxiety talking about past illness episodes*	Therapeutic Experience (SUF) Reflection & Evaluation (SUF) Personal & Therapeutic Change (SUF) Therapeutic Relationship(s) (TF) Therapy Stages (TF)
		Developed ways of working with and managing BD	*Implications for CC's* - *More contact with SU* - *Opportunity to work with SU when well* - *Added burden to workload and time* - *Increases complexity of role* - *Sessions are more structured and focused* - *Provides added sense of purpose* - *Documentation to support*	Staff- SU Interaction (SF) Evaluation (SF) Personal & Therapeutic Change (SUF) Shared Focus & Control (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	**Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors**
			working - *Creation of concise, individualised action plan* - *Concerns that action plan not used in crisis by SU and wider team* - *Identifying and reinforcing personalised coping strategies*	
			Implications for SU - *More contact with CC* - *Improves recognition of triggers, early warning signs and coping strategies* - *Increases monitoring of mood and behaviour* - *Empowerment and control over BD* - *Identifying and using coping strategies to prevent relapse* - *Creation of concise, individualised action plan* - *Relapses can occur too quickly to use action plan* - *SU not motivated to prevent mania relapse*	Personal & Therapeutic Change (SUF) Therapeutic Experience (SUF) Personal & Therapeutic Change (SUF) Reflection & Evaluation (SUF) Therapy Stages (TF) Recovery & Hope (TF) Staff Role (SF)
		Enhanced working relationships	*Implications for CC*	Staff Role (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			- *Discovers new relevant information* - *Collaborative working* - *Is considered as more trustworthy* - *Improves contact by SU when needed* - *Increased dependency n CC rather than service as a whole* - *Changes relationship dynamic*	Personal & Therapeutic Change (SUF) Therapeutic Relationship(s) (TF)
			Implications for SU - *Shares new relevant information* - *Collaborative working* - *Increases trust in CC* - *Improves contact with services when needed* - *Increased dependency on CC rather than service as a whole* - *Changes relationship dynamic*	Therapeutic Relationship(s) (TF) Staff Role (SF) Personal & Therapeutic Change (SUF)
27.	Rathod, S. Kingdon, D., Phiri, P. & Gobbi, M. (2010)	**Health beliefs and attributions to psychosis**	*Previous wrong-doing* *Supernatural beliefs* *Specific African Caribbean attributions*	Predisposing Cultural Beliefs & Attitudes (SUF) Illness Perceptions (TF)
		Being arrested by the police		
		Help seeking behaviours and	*South Asian Muslims:-*	

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		pathways	- *Person's mental illness, dealt in the family/extended family* - *Denial* - *General practitioner (seek medical treatment usually medication-pill/injection)* - *Symptom severity/extent of illness* - *Stigma/shame* - *Community pressure/denial* - *Community grapevine* - *Faith healers/Imams* - *Return to country of origin for healing or arranged marriage* - *Religiosity* - *Use of talisman or arm lockets with Qur'an verses inscribed* - *Level of education and awareness* - *1st or 2nd generation* - *Language/terminology* - *Fear of being detained*	Predisposing Cultural Beliefs & Attitudes (SUF) Illness Perceptions (TF)
			African-Caribbean:- - *Denial/resilience* - *Stigma/shame* - *Isolation* - *Mistrust of mental health services* - *Fear of mental health services*	Illness Perceptions (TF) Predisposing Cultural Beliefs & Attitudes (SUF) Illness Perceptions (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			- *(incarcerated/medicated)* - *Fragmented family support (in some cases)* - *Racism* - *Drug misuse* - *Religiosity/spirituality* - *Previous experience of mental health services* - *Faith healers* - *Traditional remedies*	Illness Perceptions (TF)
		Shame and stigma		Predisposing Cultural Beliefs & Attitudes (SUF)
		Opinions regarding treatment and CBT		Professional Background & Characteristics (SF) Evaluation (SF)
		Barriers to accessing CBT		Personal & Therapeutic Change (SUF) Reflection & Evaluation (SUF) Therapy Stages (TF) Therapeutic Approach & Response (TF) Therapeutic Experience (SUF)
		Validation		Predisposing Cultural Beliefs & Attitudes (SUF)
		Racism and its effects		Personal & Therapeutic Change (SUF) Evaluation (SF)
		Role of religion		Predisposing Cultural Beliefs & Attitudes (SUF) Personal & Therapeutic Change (SUF) Evaluation (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
28.	Chouliara, Z., Karatzias, T., Scott-Brien, G., Macdonald, A., MacArthur, J. & Frazer, N. (2011)	**Benefits from talking therapies**	*Confidential* *Transparent* *Non-judgemental* *Safe*	Personal & Therapeutic Change (SUF) Therapy Stages (TF) Staff Role (SF)
		Safety to Disclose	*To be listened to* *To be heard* *To be believed* *Not to be judged*	Staff Role (SF) Personal & Therapeutic Change (SUF)
		Break isolation	*Someone to talk to* *Fellow survivors* *Safety and support*	Personal & Therapeutic Change (SUF) Therapeutic Experience (SUF) Therapeutic Relationship(s) (TF)
		Enhancing self-worth and sense of self	*Improving self-esteem* *Learning better self-care*	Personal & Therapeutic Change (SUF) Recovery & Hope (TF) Therapy Stages (TF)
		Contextualising the abuse	*Accept the reality of abuse* *Connect past, present, future* *Make connections between feelings, thoughts, behaviours* *Minimising stigma*	Personal & Therapeutic Change (SUF) Therapeutic Experience (SUF) Illness Perceptions (TF)
		"Movement" toward recovery	*Healing* *Affirming and rewarding experience* *Contribution to recovery*	Therapy Stages (TF) Recovery & Hope (TF) Reflection & Evaluation (SUF)
		Challenges of using/providing services		Therapy Stages (TF) Evaluation (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Overarching Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Difficulties of trauma-focused work	*Appropriate time*	Reflection & Evaluation (SUF)
			Appropriate depth	Illness Perceptions (TF)
			Preparation	Therapy Stages (TF)
				Personal & Therapeutic Change (SUF)
			Worsening of symptoms	
				Evaluation (SF)
		Contact between appointments	*Emotional regulation*	
			Out-of-hours support	Therapy Stages (TF)
		Continuity and consistency	*Same therapist*	
			Time restrictions	Personal & Therapeutic Change (SUF)
			Flexibility	Therapy Stages (TF)
			Feeling valued	Evaluation (SF)
				Reflection & Evaluation (SUF)
		Accessibility in acute episodes	*Not available when much needed*	
				Personal & Therapeutic Change (SUF)
		Hearing and managing disclosures	*Challenging and difficult*	
			To be listened to	Evaluation (SF)
			To be treated with care and tenderness	Therapeutic Relationship(s) (TF)
				Staff Role (SF)
		Dealing with child protection issues	*Delicate balances to be kept*	
			Impact on trust in the therapeutic relationship	Evaluation (SF)
		Resource availability and service accessibility	*More resources needed*	
			Focus on specific groups	Reflection & Evaluation (SUF)
				Personal & Therapeutic Change (SUF)
				Evaluation (SF)

Appendix 8. Concept Findings and Sub-Ordinate Themes Concept Findings

Concept Findings and Sub-Ordinate Themes Concept Findings for Service User Participants

No.	**Author(s)**	**Core Concepts/Themes/ Categories**	***Subthemes/ subcategories***	**Identified Sub-Ordinate Themes** **SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors**
1.	Messari, S. & Hallam, R. (2003)	**CBT as a healing process**		Process (TF)
		CBT participation as compliance with the powerful medical establishment		Barriers & Challenges (SUF)
		CBT as an educational process (educational discourse)		Process (TF)
		CBT as a respectful relationship between equals (friendship discourse)		Shared Control & Focus (TF) Partnership & Collaboration (TF)
		This is truly happening		Acceptance (SUF)
		I am ill		Acceptance (SUF) Stage of Illness (TF)
		Contradiction between 'This is truly happening' and 'I am ill' discourses		Acceptance (SUF) Stage of Illness (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
2.	Gallegos, N. (2005)	**Reasons for seeking therapy**		Expectancy (SUF) Motivation (SUF) Stage of Illness (TF)
		Accommodation	*Did phone counselling* *Did not charge for therapy* *Went over scheduled time*	Suitability & Accessibility (TF) Flexibility, Continuity & Consistency (TF)
		Adjunctive therapy	*Psychopharmacology* *Group therapy* *Couples therapy*	Support (SUF) Endings & Outcome (TF)
		Attunement	*Responded to need for interaction* *Connected through diary* *Responded to cerebral personality*	Flexibility, Continuity & Consistency (TF) Therapeutic Approach & Response (SF)
		Extratherapeutic events and growth	*Improved marital interaction* *Returned to art and piano lesions* *Husband saw therapist*	Benefits (SUF)
		Insight and awareness	*Psychosocial history*	Illness Perceptions (SUF)
		Knowledgeable/credible other	*Gave effective advice* *Noticed and took action on physiological problem* *Taught communication skills*	Expertise (SF) Learning & Sharing (SUF) Working Relationship (SF) Therapeutic Approach & Response (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Provider attributes	*Immediate personal connection* *Deep expression of care* *Authentic*	Working Relationship (SF) Facilitator & Operational Aspects (SUF) Partnership & Collaboration (TF)
		Safety and trust **Support**		Partnership & Collaboration (TF) Support (SUF)
3.	Bury, C., Raval, H. & Lyon, L. (2007)	**Seeking help and engagement**	*Being in difficulty* *Feelings about referral and stigma* *Expectations of therapy*	Motivation (SUF) Experience (SUF) Expectancy (SUF) Stigma (TF)
		Beginning therapy	*Mixed feelings* *Therapist's response*	Experience (SUF) Expectancy (SUF) Therapeutic Approach & Response (SF)
		The therapeutic process	*Learning the ropes* *Facilitative aspects* *Power*	Suitability & Accessibility (TF) Process (TF) Therapeutic Approach & Response (SF) Facilitator & Operational Aspects (SUF)
		Endings	*Ambivalence* *Feelings of separation and loss* *Moving on*	Acceptance (SUF) Endings & Outcome (TF) Future Outlook (TF)
4.	Macdonald, W., Mead, N., Bower, P., Richards	**Patient expectancies**	*Process of guided self-help* *Outcome of guided self-help*	Expectancy (SUF) Process (TF) End & Outcome (TF)
		Patient experience	*Expertise of the assistant psychologist*	Experience (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
	& Lovell, K. (2007)		*Suitability for guided self-help* *Process of guided self-help* *Outcome of guided self-help*	Expertise (SF) Suitability & Accessibility (TF) Process (TF) Endings & Outcome (TF) Stage of Illness (TF)
		Other influences on patient decision-making about accessing further therapy		Endings & Outcome (TF) Facilitator & Operational Aspects (SUF) Illness Perceptions (SUF) Future Outlook (TF)
5.	Newton, E., Larkin, M., Melhuish, R. & Wykes, T. (2007)	**A place to explore shared experiences**	*A safe place to talk Normalising & destigmatising* *Learning from and helping others* *The role of the facilitators*	Normalising & Validating (SUF) Learning & Sharing (SUF) Support (SUF) Stigma (TF) Facilitator & Operational Aspects (SUF)
		An inductive account of coping with auditory hallucinations	*Passive explanations* *Agentic explanations* *Socio-cultural explanations*	Experience (SUF) Illness Perceptions (SUF)
6.	Sibitz, I., Amering, M., Gössler, R., Unger, A. & Katschnig, H. (2007)	**Changes caused by participating in the seminar**	*Increase in knowledge* *Better life management* *More social interaction* *Increased self-esteem* *Sense of mastery*	Learning & Sharing (SUF) Real Life Implementation (TF) Partnership & Collaboration (TF) Benefits (SUF)
		Causal factors judged as	*Knowledge gained*	Learning & Sharing (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		responsible for change	*Reflecting about illness and life* *Increased motivation to become active* *Getting emotional support and understanding form other people suffering from a mental illness*	Illness Perceptions (SUF) Process (TF) Benefits (SUF) Support (SUF) Future Outlook (TF) Real Life Implementation (TF) Normalising & Validating (SUF)
		Prerequisites for benefiting from the seminar	*Participant dependent* *Moderator dependant* *Interactions between group members* *Illness state* *Motivation* *Extent of prior information*	Stage of Illness (TF) Motivation (SUF) Therapeutic Approach & Response (SF) Expectancy (SUF)
		Problems, difficulties and criticism	*Participant lack of concentration* *Other participant tediousness*	Suitability & Accessibility (TF) Challenges & Barriers (SF) Barriers & Challenges (SUF)
7.	Ma, J.L.C. (2008)	**Focus of attention**		Normalising & Validating (SUF) Learning & Sharing (SUF) Facilitator & Operational Aspects (SUF)
		Treatment format		Process (TF) Facilitator & Operational Aspects (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Purposes of family therapy		Suitability & Accessibility (TF) Process (TF) Endings & Outcome (TF) Benefits (SUF)
		Therapeutic relationship and its linkage to change and recovery		Learning & Sharing (SUF) Support (SUF) Process (TF) Benefits (SUF) Illness Perceptions (SUF) Facilitator & Operational Aspects (SUF) Real Life Implementation & Outlook (TF) Partnership & Collaboration (TF) Shared Control & Focus (TF) Therapeutic Approach & Response (SF)
		Perceived intervention and family's contribution	*Assisting in problem solving*	Learning & Sharing (SUF) Process (TF) Endings & Outcome (TF) Partnership & Collaboration (TF) Shared Control & Focus (TF) Beliefs, Attitudes & Views of Recovery (SF) Illness Perceptions (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			Allowing for the emergence of multiple voices	Partnership & Collaboration (TF) Shared Control & Focus (TF) Learning & Sharing (SUF) Illness Perceptions (SUF) Therapeutic Approach & Response (SF)
			Direct observations	Partnership & Collaboration (TF) Shared Control & Focus (TF) Learning & Sharing (SUF) Illness Perceptions (SUF) Therapeutic Approach & Response (SF) Benefits (SUF)
8.	O'Connor, C., Gordon, O., Graham, M., Kelly, F. & O'Grady-Walshe, A. (2008)	**The treatment of bipolar disorder** **Perception of others** **Learning from the group**		Therapeutic Approach & Response (SF) Suitability & Accessibility (TF) Illness Perception (SUF) Learning & Sharing (SUF) Partnership & Collaboration (TF)
9.	Whitney, J., Easter, A. & Tchanturia, K. (2008)	**Expectations and experiences of CRT at the beginning of treatment**	*Uncertainty*	Experience (SUF) Expectancy (SUF)
		Targeted characteristics of	*Perfectionism*	Stage of Illness (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Anorexia Nervosa	*Rigidity/Lack of flexibility* *Attention-to-detail/failure to see the bigger picture* *Lack of confidence* *Low mental capacity* *Other (take things at face value, obsessionality)*	Barriers & Challenges (SUF)
		Stages of therapy	*Get familiar with exercises* *Connections between exercises and thinking style* *Connections between exercises and real life* *Implementation into real life* *Practice and continuity*	Suitability & Accessibility (TF) Process (TF) Flexibility, Continuity & Consistency (TF) Real Life Implementation (TF)
		Insight, skills and implementation	*Insight (recognition of unhelpful thinking style and behaviours)* *Change (statements of change, e.g. I am less rigid)* *Specific examples of implementation and change* *As an introduction to other psychological therapies*	Acceptance & Change (SUF) Real Life Implementation (TF) Future Outlook (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Experience with CRT as compared to other therapies	*Good attributes (fun, interesting, refreshing)* *Unrelated to food, eating, weight and shape* *Less intense than other therapies* *Related to rules, rituals, behaviours*	Process (TF) Facilitator & Operational Aspects (SUF) Endings & Outcome (TF) Suitability & Accessibility (TF)
		Relationship with therapist	*Good qualities of therapist (warm, empathetic)* *Importance of good therapeutic relationship*	Therapeutic Approach & Response (SF) Working Relationship (SF)
		What patients did not like and suggestions for the future	*Too easy/more challenge needed/ need for varying levels of difficulty* *Need for individual tailoring* *Need for more help to translate skills to real life* *Need for patient motivation* *Application to different treatment settings* *Application to different disorders* *More (longer duration of intervention and more tasks)*	Partnership & Collaboration (TF) Shared Control & Focus (TF) Barriers & Challenges (SUF) Facilitator & Operational Aspects (SUF) Real Life Implementation (TF) Endings & Outcome (TF)
		Overall satisfaction and importance of CRT	*Helpful* *Unhelpful* *CRT's role in recovery*	Endings & Outcome (TF) Facilitator & Operational Aspects (SUF) Future Outlook (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
10.	O'Donovan, A. & O'Mahony, J. (2009)	**The value service users placed on the programme**	*Personal gains: I have that too!* *The overall experience* *Interaction: Relating to others* *Normalisation*	Normalising & Validating (SUF) Learning & Sharing (SUF) Benefits (SUF) Process (TF) Partnership & Collaboration (TF)
		The benefits they gained	*Helpful Content*	Benefits (SUF) Suitability & Accessibility (TF)
		The unhelpful aspects they experienced	*Unhelpful/Irrelevant content*	Facilitator & Operational Aspects (SUF) Barriers & Challenges (SUF)
		The factors that influenced their participation	*Mental health dependent* *Sample characteristics of the group* *Facilitator approach*	Stage of Illness (TF) Suitability & Accessibility (TF) Therapeutic Approach & Response (SF) Facilitator & Operational Aspects (SUF)
11.	Bevan, A., Oldfield, V.B. & Salkovskis, P.M. (2010)	**Background**		Experience (SUF)
		Perception of outcome	*Views of therapy*	Expectancy (SUF)
		Relevance		Suitability & Accessibility (TF)
		Perceived quantity of therapy		Expectancy (SUF)
		Ongoing support		Support (SUF) Endings & Outcome (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Therapeutic alliance	*Preference for treatment format*	Partnership & Collaboration (TF)
				Suitability & Accessibility (TF)
		Time between sessions (benefits)	*Time to learn*	Benefits (SUF)
			Time to reflect and practise	Process (TF)
			Time to make sure everything covered	Flexibility, Continuity & Consistency
			Five days not long enough	(TF)
				Endings & Outcome (TF)
		Time between sessions (drawbacks)	*Thinking too much*	Facilitator & Operational Aspects (SUF)
			Daily support	Barriers & Challenges (SUF)
			Concentration	Endings & Outcome (TF)
			Efficiency	Facilitator & Operational Aspects (SUF)
		Longer sessions		
		Stress		Endings & Outcome (TF)
				Barriers & Challenges (SUF)
		Motivation	*Momentum*	Stage of Illness (TF)
			Perceived power of treatment	
		Accessibility		Motivation (SUF)
				Stage of Illness (TF)
				Expectancy (SUF)
				Suitability & Accessibility (TF)
12.	Brown, L.F.,	**Expectations**	*Coping skills*	Expectancy (SUF)
	Davis, L.W.,		*Meditation, learning how*	Suitability & Accessibility (TF)
	LaRocco,		*Present focus*	Learning & Sharing (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
	V.A. & Strasburger, A. (2010)		*Symptom reduction*	
		Positive outcome	*Cognitive changes (e.g. better ways of thinking, new thoughts and ideas)* *Group support)e.g. sharing, offering feedback)*	Normalising & Validating (SUF) Learning & Sharing (SUF) Acceptance & Change (SUF) Process (TF)
			Present focus *Relaxation* *Self awareness/acceptance* *Symptom reduction*	Endings & Outcome (TF) Partnership & Collaboration (TF) Shared Focus & Control (TF)
		Negative outcomes	*Bad memories (low incidence)* *Sad feelings (low incidence)*	Barriers & Challenges (SUF) Endings & Outcome (TF)
		Personal difficulties with program	*Cognitive difficulties (e.g. imagery, concentration, learning, memory)* *Physical limitations (e.g. hearing, pain)* *Social Anxiety (uncomfortable in group setting)* *Time management (finding time for meditations; working classes into schedule)*	Barriers & Challenges (SUF) Facilitator & Operational Factors (SUF) Suitability & Accessibility (TF) Flexibility, Continuity & Consistency (TF)
		Negative Program structure	*Limited space (low incidence)* *Short length*	Endings & Outcome (TF) Barriers & Challenges (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		Positive program structure	*Acceptable structure (pace, class length, frequency, time, location, etc)* *CDs, different guided meditations* *Group dynamics (sharing, inclusions)*	Suitability & Accessibility (TF) Flexibility, Continuity & Consistency (TF) Learning & Sharing (SUF) Normalising & Validating (SUF)
		How participants would describe what the program is about	*Cognitive changes, thinking about things differently* *Coping skills* *Meditation* *Present focus* *Relaxation* *Self-awareness/acceptance* *Symptom reduction*	Process (TF) Endings & Outcome (TF) Accessibility & Change (SUF) Learning & Sharing (SUF)
13.	McManus, F., Peerbhoy, D., Larkin, M. & Clark, D.M. (2010)	**Social phobia as a way of being** **Learning to challenge social phobia as a way of being: transformative mechanisms of therapy** **Challenges faced in the pursuit of change**	*Value of the therapeutic relationship* *Value of the diagnosis and formulation* *Learning to interpret experiences differently thought experiential learning in therapy* *Therapy being an emotional roller-coaster*	Stigma (TF) Expectancy (SUF) Illness Perceptions (SUF) SU-Staff Interactions (SUF) Support (SUF) Benefits (SUF) Learning & Sharing (SUF) Stage of Illness (TF) Normalising & Validating (SUF) Barriers & Challenges (SUF) Real Life Implementation (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
		A whole new world: new ways of being	*Transferring theory and skills into practicing in the real world* *Relief from and reappraisal of anxiety* *Enhanced acceptance of anxiety and of self and others* *Re-engaging with the world*	Suitability & Accessibility (TF) Endings & Outcome (TF) Future Outlook (TF) Benefits (SUF) Acceptance & Change (SUF) Illness Perception (SUF)
14.	Gerhards, S.A.H., Abma, T.A., Arntz, A., de Graff, L.E., Evers, S.M.A.A., Huibers, M.J.H. & Widdershoven, G.A.M. (2011)	**Computer aspects**	*Computer/internet skills and equipment* *Online vs printed medium* *Location and time of computer/CCBT access*	Facilitator & Operational Aspects (SUF) Benefits (SUF) Barriers & Challenges (SUF) Suitability & Accessibility (TF) Process (TF)
		Social aspects	*Identification with and applicability of CCBT* *Demand for support* *Motivation* *Personal contact* *Feedback*	Facilitator & Operational Aspects (SUF) Benefits (SUF) Support (SUF) Motivation (SUF) Barriers & Challenges (SUF) Suitability & Accessibility (TF) Partnership & Collaboration (TF) Endings & Outcome (TF)
		Research aspects	*Hawthrone effect* *Research activities impact* *CCBT/depression complaints*	Facilitator & Operational Aspects (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
15.	Williams, M.J., McManus, F., Muse, K. & Williams, J.M.G. (2011)	**My awareness of barriers to experiencing change through MBCT** **Cultivation of a new approach to health anxiety and my life in general**	*My desire to experience change in the face of initial uncertainties* *The struggle to find the time: Is practising MBCT regularly worthwhile to me?* *My need for variety and flexibility* *Validation and normalisation of my experiences through MBCT* *An awareness of my anxiety cycle enables me to break it* *Acceptance of my experiences* *A different outlook on my life in general* *Change large enough for significant others to notice*	Motivation (SUF) Stage of Illness (TF) Barriers & Challenges (SUF) Suitability & Accessibility (TF) Flexibility, Continuity & Consistency (TF) Normalising & Validating (SUF) Acceptance & Change (SUF) Endings & Outcome (TF) Future Outlook (TF)
16.	Kilbride, M., Byrne, R., Price, J., Wood, L., Barratt, S., Welford, M. & Morrison, A.P. (2012).	**CBT as a process of person-centred engagement** **CBT as an active process of structured learning**	*Personal engagement and trust* *Partnership and collaboration* *Sharing control with clients* *Flexibility enabling continued engagement* *Identifying clients' "psychological map" through formulation* *Re-appraising psychological difficulties through evidence-gathering*	Partnership & Collaboration (TF) Flexibility, Continuity & Consistency (TF) Shared Control & Focus (TF) Learning & Sharing (SUF) Process (TF) Suitability & Accessibility (TF) Acceptance & Change (SUF) Support (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF - Therapy Factors; SF – Staff Factors
			The value of practical [written] tools *Carrying on CBT work with homework*	Motivation (SUF)
		CBT helping to improve personal understanding	*Gaining a different perspective* *Normalisation as a central active process* *The role of improved understanding in long-term coping*	Normalising & Validating (SUF) Benefits (SUF) Acceptance & Change (SUF) Future Outlook (TF) Endings & Outcome (TF)
		CBT is hard work	*"Being ready"* *Finding it difficult to engage with or complete work* *Emotionally difficult*	Stage of Illness (TF) Suitability & Accessibility (TF) Barriers & Challenges (SUF) Motivation (SUF) Facilitator & Operational Aspects (SUF)
		CBT and recovery	*Acceptance as a part of recovery* *Practical, social and functional recovery* *Achievement, empowerment and independence in recover* *Gaining or regaining hope*	Acceptance & Change (SUF) Illness Perceptions (SUF) Real Life Implementation (TF) Future Outlook (TF)

Concept Findings and Sub-Ordinate Themes Concept Findings for Staff Participants

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
17.	Frueh, C.B., Cusack, K.J., Grubaugh, A.L., Sauvageot, J.A. & Wells, C. (2006)	**Trauma**	*Life of person with severe illness*	Expectancy (SUF) Experience (SUF) Stigma (TF) Stage of Illness (TF)
			Clinician fear	Beliefs, Attitudes & Views of Recovery (SF) Therapeutic Approach & Response (SF) Partnership & Collaboration (TF) Challenges & Barriers (SF)
			Cognitive-Behavioral Treatment	Suitability & Accessibility (TF) Process (TF) Beliefs, Attitudes & Views of Recovery (SF) Expertise (SF)
			Miscellaneous implementation issues	Challenges & Barriers (SF) Real Life Implementation & Outlook (TF) Illness Perceptions (SUF) Facilitator & Operational Aspects (SUF)
18.	Awty, P., Welch, A. &	**Deciphering the wood from the trees: a personal choice of a lifelong**		Therapeutic Approach & Response (SF) Beliefs, Attitudes & Views of Recovery

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
	Kuhn, L. (2010)	**career**		(SF)
		Adopting a philosophical disposition for practice: a position of difference		Beliefs, Attitudes & Views of Recovery (SF) Stigma (TF)
		Relating in a psychodynamic therapeutic manner: the key to effective intervention		Therapeutic Approach & Response (SF)
		Perceiving barriers to the provision of psychodynamic therapeutic care		Challenges & Barriers (SF)
		Hopeful expectancy: nurturing personal hopes for rebirth of a psychodynamic approach to care		Therapeutic Approach & Response (SF) Beliefs, Attitudes & Views of Recovery (SF)
19.	Naeem, F., Gobbi, M., Ayub, M & Kingdon, D. (2010)	**Hurdles in therapy**	*Service issues* *Dealing with somatic complaints* *Pills and psychotherapy* *Homework* *Patient's expectations from mental health system* *Literal translation does not work* *Beliefs about illness*	Challenges & Barriers (SF) Expectancy (SUF) Barriers & Challenges (SUF) Stigma (TF) Suitability & Accessibility (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
		Issues related to therapy	*Assessment* *Commonly used techniques* *Structure and content of sessions* *Normalising techniques*	Facilitator & Operational Aspects (SUF) Suitability & Accessibility (TF) Process (TF) Challenges & Barriers (SF) Normalising & Validating (SUF) Barriers & Challenges (SUF)
		Techniques which patients find helpful	*Style of therapy* *Involvement of the family*	Process (TF) Partnership & Collaboration (TF) Therapeutic Approach & Response (SF)
		Modifications in therapy		Flexibility, Continuity & Consistency (TF)
20.	Prytys, M., Garety, P.A., Jolley, S., Onwumere, J. & Craig, T. (2010)	**Understanding and beliefs about psychosis**	*Beliefs about treatment for psychosis* *Expectations of clients with psychosis* *Views of recovery in psychosis*	Beliefs, Attitudes & Views of Recovery (SF)
		Beliefs about and attitudes to clinical guidelines and psychological therapies	*Positive attitudes to clinical guidelines* *Doubts about relevance and applicability of clinical guidelines* *Views about psychological therapy for psychosis*	Stigma (TF) Beliefs, Attitudes & Views of Recovery (SF) Views of Recovery (SF) Suitability & Accessibility (TF)
		Views on the role of the care coordinator	*Care coordinators using psychological interventions* *Other aspects of the care coordinator role*	Beliefs, Attitudes & Views of Recovery (SF) Expertise (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
		Factors affecting implementation	*Lack of time* *Role confusion* *Need for specialist workers in teams* *Service user refusal* *Work pressure* *Long waiting lists*	Suitability & Accessibility (TF) Flexibility, Continuity & Consistency (TF) Expertise (SF) Motivation (SUF) Challenges & Barriers (SF)
21.	Gearing, R.E., Schwalbe, C.S. & Short, K.D. (2012)	**Psychosocial treatment adherence**	*Attendance to treatment* *Participation in treatment*	Motivation (SUF)
		Treatment adherence: adolescent domain	*Barriers and promoters* - *Motivation to change* - *View of treatment* - *Concrete barriers and promoters*	Motivation (SUF) Barriers & Challenges (SUF) Expectancy (SUF)
		Treatment adherence: family	*Parental agreement with treatment* *Parent health and strain* *Concrete barriers* *Stigma*	Barriers & Challenges (SUF) Stigma (TF) Challenges & Barriers (SF)
		Treatment adherence: clinician domain	*Aimed at adolescents* *Aimed at parents* *Used in response to non-adherence*	Suitability & Accessibility (TF) Therapeutic Response & Approach (SF)
		Treatment adherence: agency	*Financial*	Challenges & Barriers (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
		domain	*Procedural* *Technology*	
22.	Luca, M. (2012)	**Shared CBT and psychodynamic therapeutic activities and interventions** **Cognitive behavioural therapeutic activities and interventions** **Psychodynamic therapeutic activities and interventions**	*Working together with client* *Sensitive, empathic responding and building trust* *Being flexible with techniques* *Keeping an open mind* *Multi-disciplinary cooperation* *Collaboration with client* *Using a pragmatic style* *Avoiding assumptions on causes of MUS* *Categorising issues with client* *Link physiological responses to psychological factors* *Do supportive work* *Tune into a client's emotional distress* *No focus on somatic symptom*	Therapeutic Approach & Response (SF) Working Relationship (SF) Beliefs, Attitudes & Views of Recovery (SF) Views of Recovery (SF) Partnership & Collaboration (TF) Shared Control & Focus (TF) Flexibility, Continuity & Consistency (TF) Partnership & Collaboration (TF) Therapeutic Approach & Response (SF) Working Relationship (SF) Stigma (TF) Support (SUF) Normalising & Validating (SUF) Partnership & Collaboration (TF) Process (TF) Flexibility, Continuity & Consistency (TF) Therapeutic Approach & Response (SF) Working Relationship (SF)

Concept Findings and Sub-Ordinate Themes Concept Findings for Service User and Staff Combined Studies

No.	Author(s)	Core Concepts/Themes/ Categories	***Subthemes/ subcategories***	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
23.	Metcalf, L. & Thomas, F. (1995)	**The role of the therapist in the therapy process**	*Therapist:-*	
			- *consultant*	Expertise (SF)
			- *ask scaling questions*	Therapeutic Approach & Response (SF)
			- *paraphrase*	Process (TF)
			- *look for strengths, resources*	Working Relationship (SF)
			- *listen*	Learning & Sharing (SUF)
			- *don't participate unless asked*	
			- *give ideas*	
			- *highlight competencies*	
			Couple:-	
			- *mediator*	Working Relationship (SF)
			- *friend*	Therapeutic Approach & Response (SF)
			- *outsider*	Support (SUF)
			- *sounding board*	
			- *said what would work*	Partnership & Collaboration (TF)
			- *saviour*	Shared Control & Focus (TF)
			- *guide*	
			- *made suggestions*	
		Why clients sought therapy	*Therapist:-*	
			- *Divorce*	Motivation (SUF)
			- *Multiple relationships*	Experience (SUF)
			- *Death*	Stage of Illness (TF)
			- *Familial worry*	

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
			- *Physical and depressive symptoms* - *Panic disorder* - *Agoraphobia* - *Marital discord* - *Childhood experiences with abusive parents* - *Tension* - *Sadness*	
			Couple:- - *Emergency treatment* - *Concerns about family* - *Panic disease* - *Family stressors* - *To try to stay together* - *Life events* - *To figure out the problem* - *Doctors suggestion*	Stage of Illness (TF) Expertise (SF) Motivation (SUF) Experience (SUF)
		The process of termination	*Therapist:-* - *Suggestion of a break in therapy* - *Significant process and appropriate time to terminate* - *Couples decision* - *Spacing out sessions* - *Leave next appointment open*	Acceptance & Change (SUF) Benefits (SUF) Endings & Outcome (TF) Future Outlook (TF) Flexibility, Continuity & Consistency (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
			- *Their choice* - *Couple felt things had resolved* - *They decided to stop* *Couple:-* - *Therapists decision* - *'You must go'* - *Limited visits* - *Left it open* - *Changed jobs so couldn't carry on* - *Completed agreed sessions*	Expertise (SF) Facilitator & Operational Aspects (SUF) Endings & Outcome (TF) Flexibility, Continuity & Consistency (TF)
		The process of therapy	*Therapist:-* - *We consult together* - *Work together to achieve objectives* - *Talk about the mirror…team…find a way to dialogue* - *Take a break* - *Ask what is better, what is improved and spend majority of the session trying to identify what caused it and reinforcing it* - *Don't give suggestions* *Couple:-*	Process (TF) Partnership & Collaboration (TF) Flexibility, Continuity & Consistency (TF) Therapeutic Approach & Response (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
			- *Talked and focused on me* - *Sat and babbled about my fears* - *He/she said "Im impressed"* - *Pointed out false attitudes* - *He/she made a difference* - *He/she set me up for success* - *He/she taught me a scheme* - *He/she jumbled it all up so I could get it straight* - *Team made suggestions* - *He/she made suggestions*	Shared Focus & Control (TF) Process (TF) Learning & Sharing (TF)
		The pragmatics of change	*Therapist:-* - *Validated and helped think about what they wanted* - *Empowered them* - *Believed in them* - *Found strengths and resources they had through questions* - *Reinforced* - *Positive blame* - *I showed up* - *I punctuated* *Couple:-* - *He/she and the team told us some very positive things we were*	Normalising & Validating (SUF) Support (SUF) Process (TF) Flexibility, Continuity & Consistency (TF) Partnership & Collaboration (TF) Shared Control & Focus (TF) Beliefs, Attitudes & Views of Recovery (SF) Views of Recovery (SF) Therapeutic Approach & Response (SF) Therapeutic Approach & Response (SF) Shared Control & Focus (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
			doing - *He/she was positive* - *Reminded us of things we had forgotten about ourselves* - *He/she mixed things up and asked "why?"* - *He/she told us about themselves* - *He/she made us think a little more before we did stuff* - *Pointed things out in a different way* - *Praised us* - *He/she gave us a neutral place to come*	
24.	Raingruber, B.J. (2001)	**Importance of "reading" each other** **Importance of focusing on feelings during therapy** **Importance of letting sessions "flow"** **Nurse-therapist and client familiarity**		Staff- SU Interaction (SF) Process (TF) Process (TF) Flexibility, Continuity & Consistency (TF) Therapeutic Approach & Response (SF) Working Relationship (SF) Process (TF) Flexibility, Continuity & Consistency

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
		Metaphors help to discuss difficult issues		(TF) Therapeutic Approach & Response (SF)
		Therapist differences between approach	*Visual thinkers*	Therapeutic Approach & Response (SF)
		Client preferences to therapist approach	*Family therapist – more directive*	Therapeutic Approach & Response (SF)
25.	McGowan, J.F., Lavender, T. & Garety, P.A. (2005)	**Definitions of progress**	*Changed interpretation of symptom* *Reduced distress relative to symptom* *No changed interpretation of symptoms*	Illness Perceptions (SUF) Acceptance & Change (SUF)
		Moving to new and disregarding old understanding	*One explanation superseding another* *Eliminating other explanations* *Holding two explanations simultaneously* *Sliding into other multiple explanations*	Illness Perception (SUF) Acceptance & Change (SUF)
		Ability to engage in clear, logical thinking	*Using therapist to aid clarity of thought* *Clear thinking aiding understanding* *Inability to think logically enough*	Partnership & Collaboration (TF)
		Continuity in therapy	*Continuity in therapy* *Absence of continuity* *Discontinuity in client's experiential world*	Flexibility, Continuity & Consistency (TF)
		Remembering and understanding	*Operationalising a change*	Acceptance & Change (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
		therapy	*Failing to operationalise the idea of helpful*	
		Therapeutic alliance-shared goal	*Clear description of shared task* *No sense of shared task* *Difficulty of sharing task with client* *Client has different agenda* *Therapist becoming incorporated into the delusional system of the client*	Learning & Sharing (SUF) Therapeutic Approach & Response (SF) Motivation (SUF) Facilitator & Operational Aspects (SUF) Stage of Illness (TF) Partnership & Collaboration (TF) Shared Control & Focus (TF)
		Central Theme: understanding, holding and engaging with the therapist's model of reality		
26.	Pontin, E., Peters, S., Lobban, F., Rogers, A. & Morriss, R.K. (2009)	**Elaborated understanding of Bipolar Disorder (BD)**	*Implications for Care Coordinators (CC)* - *Learns about BD* - *Learns about early warning signs, triggers and coping strategies* - *Acquires new skills for working with individuals with BD – increases competence and confidence of working with individuals with BD* - *Acquires new skills and strategies that generalise to*	Beliefs, Attitudes & Views of Recovery (SF) Professional Development (SF) Therapeutic Approach & Response (SF) Challenges & Barriers (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	**Identified Sub-Ordinate Themes** **SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors**
			working with individuals with other disorders - *Gains further understanding of SU perspective and experience of BD* - *Need to manage SUs distress and anxiety talking about past illness episodes*	
			Implications for service users (SU) - *Learns about BD* - *Learns about early warning signs, triggers and coping strategies* - *Increases acceptance of diagnosis and rationale for medication concordance* - *Reduces feeling of isolation and fear of BD* - *Allows opportunity to reflect and make sense of lives* - *Distress and anxiety talking about past illness episodes*	Learning & Sharing (SUF) Acceptance & Change (SUF) Support (SUF) Normalising & Validating (SUF) Illness Perceptions (SUF) Barriers & Challenges (SUF) Partnership & Collaboration (TF) Endings & Outcome (TF)
		Developed ways of working with and managing BD	*Implications for CC's* - *More contact with SU* - *Opportunity to work with SU*	Staff- SU Interaction (SF) Challenges & Barriers (SF) Shared Focus & Control (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
			when well - *Added burden to workload and time* - *Increases complexity of role* - *Sessions are more structured and focused* - *Provides added sense of purpose* - *Documentation to support working* - *Creation of concise, individualised action plan* - *Concerns that action plan not used in crisis by SU and wider team* - *Identifying and reinforcing personalised coping strategies*	
			Implications for SU - *More contact with CC* - *Improves recognition of triggers, early warning signs and coping strategies* - *Increases monitoring of mood and behaviour* - *Empowerment and control over BD*	Learning & Sharing (SUF) Acceptance & Change (SUF) Benefits (SUF) Illness Perceptions (SUF) Endings & Outcome (TF) Real Life Implementation (TF) Working Relationship (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
			- *Identifying and using coping strategies to prevent relapse* - *Creation of concise, individualised action plan* - *Relapses can occur too quickly to use action plan* - *SU not motivated to prevent mania relapse*	
		Enhanced working relationships	*Implications for CC* - *Discovers new relevant information* - *Collaborative working* - *Is considered as more trustworthy* - *Improves contact by SU when needed* - *Increased dependency n CC rather than service as a whole* - *Changes relationship dynamic*	Working Relationship (SF) Partnership & Collaboration (TF)
			Implications for SU - *Shares new relevant information* - *Collaborative working* - *Increases trust in CC* - *Improves contact with services when needed* - *Increased dependency on CC*	Partnership & Collaboration (TF) Working Relationship (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
			rather than service as a whole *Changes relationship dynamic*	
27.	Rathod, S. Kingdon, D., Phiri, P. & Gobbi, M. (2010)	**Health beliefs and attributions to psychosis**	*Previous wrong-doing* *Supernatural beliefs* *Specific African Caribbean attributions*	Experience (SUF) Stigma (TF)
		Being arrested by the police		
		Help seeking behaviours and pathways	*South Asian Muslims:-* - *Person's mental illness, dealt in the family/extended family* - *Denial* - *General practitioner (seek medical treatment usually medication-pill/injection)* - *Symptom severity/extent of illness* - *Stigma/shame* - *Community pressure/denial* - *Community grapevine* - *Faith healers/Imams* - *Return to country of origin for healing or arranged marriage* - *Religiosity* - *Use of talisman or arm lockets with Qur'an verses inscribed* - *Level of education and*	Experience (SUF) Motivation (SUF) Stigma (TF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
			awareness - *1st or 2nd generation* - *Language/terminology* - *Fear of being detained* *African-Caribbean:-* - *Denial/resilience* - *Stigma/shame* - *Isolation* - *Mistrust of mental health services* - *Fear of mental health services (incarcerated/medicated)* - *Fragmented family support (in some cases)* - *Racism* - *Drug misuse* - *Religiosity/spirituality* - *Previous experience of mental health services* - *Faith healers* - *Bush doctors* - *Traditional remedies*	Stigma (TF) Experience (SUF) Motivation (SUF) Stage of Illness (TF)
		Shame and stigma		Stigma (TF) Experience (SUF)
		Opinions regarding treatment and CBT		Experience (SUF) Expectancy (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
		Barriers to accessing CBT		Beliefs, Attitudes & Views of Recovery (SF) Challenges & Barriers (SF) Barriers & Challenges (SUF) Facilitator & Operational Aspects (SUF)
		Validation		Suitability & Accessibility (TF) Therapeutic Approach & Response (TF)
		Racism and its effects		Normalising & Validating (SUF) Experience (SUF)
		Role of religion		Barriers & Challenges (SUF) Challenges & Barriers (SF) Experience (SUF) Barriers & Challenges (SUF) Challenges & Barriers (SF)
28.	Chouliara, Z., Karatzias, T., Scott-Brien, G., Macdonald, A., MacArthur, J. & Frazer, N. (2011)	**Benefits from talking therapies**	*Confidential* *Transparent* *Non-judgemental* *Safe*	Benefits (SUF) Process (TF) Therapeutic Approach & Response (SF)
		Safety to Disclose	*To be listened to* *To be heard* *To be believed* *Not to be judged*	Therapeutic Approach & Response (SF) Benefits (SUF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
		Break isolation	*Someone to talk to* *Fellow survivors* *Safety and support*	Benefits (SUF) Learning & Sharing (SUF) Normalising & Validating (SUF) Partnership & Collaboration (TF) Support (SUF)
		Enhancing self-worth and sense of self	*Improving self-esteem* *Learning better self-care*	Benefits (SUF) Future Outlook (TF) Endings & Outcome (TF)
		Contextualising the abuse	*Accept the reality of abuse* *Connect past, present, future* *Make connections between feelings, thoughts, behaviours* *Minimising stigma*	Benefits (SUF) Acceptance & Change (SUF) Learning & Sharing (SUF) Stigma (TF)
		“Movement” toward recovery	*Healing* *Affirming and rewarding experience* *Contribution to recovery*	Endings & Outcome (TF) Future Outlook (TF) Facilitator & Operational Aspects (SUF)
		Challenges of using/providing services		Endings & Outcome (TF) Challenges & Barriers (SF)
		Difficulties of trauma-focused work	*Appropriate time* *Appropriate depth* *Preparation* *Worsening of symptoms*	Facilitator & Operational Aspects (SUF) Stage of Illness (TF) Endings & Outcome (TF) Suitability & Accessibility (TF) Barriers & Challenges (SUF) Challenges & Barriers (SF)

No.	Author(s)	Core Concepts/Themes/ Categories	*Subthemes/ subcategories*	Identified Sub-Ordinate Themes SUF – Service User Factors; TF – Therapy Factors; SF – Staff Factors
		Contact between appointments	*Emotional regulation* *Out-of-hours support*	Flexibility, Continuity & Consistency (TF)
		Continuity and consistency	*Same therapist* *Time restrictions* *Flexibility* *Feeling valued*	Benefits (SUF) Flexibility, Continuity & Consistency (TF) Barriers & Challenges (SUF) Challenges & Barriers (SF)
		Accessibility in acute episodes	*Not available when much needed*	Facilitator & Operational Aspects (SUF) Barriers & Challenges (SUF)
		Hearing and managing disclosures	*Challenging and difficult* *To be listened to* *To be treated with care and tenderness*	Challenges & Barriers (SF) Partnership & Collaboration (TF) Therapeutic Approach & Response (SF)
		Dealing with child protection issues	*Delicate balances to be kept* *Impact on trust in the therapeutic relationship*	Challenges & Barriers (SF)
		Resource availability and service accessibility	*More resources needed* *Focus on specific groups*	Facilitator & Operational Aspects (SUF) Barriers & Challenges (SUF) Challenges & Barriers (SF)

Appendix 9. Theme Quotes

Theme	Study	Quote and Reference
Service User Factors Theme 1: Predisposing Cultural Beliefs and Attitudes	3	"lying down on the chair" Q1
	21	"I wanted to figure out what the problem was" Q2
	3	"it was purely to pacify her (the therapist)" Q3
	25	"would take pill rather than talk" Q4
Service User Factors Theme 2: Therapeutic Experience	23	"I think it's really like opened my mind and it was really, really useful because first of all I realized that I wasn't the only one...I didn't feel like I was not normal, this can happen to anyone. So from there on I felt I was a bit more confident…and positive" Q5
	15	"…all these thoughts, I was thinking when I felt fine, oh my god they're crazy but [therapist]helped me to see that the thoughts weren't crazy, after looking at what happened." Q6
	17	"Sometimes we use humour with them. Let me give one example, one of my patients said that she had been scolded by mother-in-law and I said every mother-in-law is like that, you are not on your own" Q7
	25	If I'm going to tell you about myself, I want to know something about you" Q8
	10	"CBT gave me an opportunity to see- well, you know, these are the kind of symptoms, but actually there's huge thought processes that is going on, and in that context that makes sense" Q10
	5	"It was good because you got to meet people like yourself…and that's it, and you went over your strategies and stuff like that and you could help each other and stuff like that." Q9
	14	"In nearly all of the sessions I was the only man there, and it often seemed like I was in a girls' club…And they were

Theme	Study	Quote and Reference
		much more articulate about their problems…and I felt more and more kind of fenced in a bit …[MBCT] probably didn't work as well because of that" Q11
	26	"Accepting things as they are umm permission, give permission to myself or the capacity to give myself permission to myself that it is ok to be me, meaning think and feel the way I do and the ability to cope with what happened and…and cope with the past and move on…" Q12
Service User Factors Theme 3: Personal and Therapeutic Change	2	"…so part of the positive experience was I got new ideas. I had someone who was a professional who could help me figure out how to deal with the situation and ultimately eliminate or reduce the anxiety" Q13
	3	"I know that your sores open up always talking about what your feeling and thinking, but it's just to say that I don't really like opening up. Every time I think about it I just feel like sleeping. Get very tired" Q14
	3	"Sometimes I felt I wanted to ask some questions about my therapist but I thought it might scare the person but it wasn't kind of the right thing to do even though I wanted to do it. Also the person would see me as intruding. I didn't want to be rude. I wanted to be friendly in some respects" Q15
Service User Factors Theme 4: Reflection and Evaluation	3	"And the kind of realisation of why things happen, kind of makes you feel better, cos the one thing you are wondering is, especially when nothing that you can think of has happened, is why you're ill…but then when you start to realise that maybe there are reasons I think you feel better because you don't feel like you're just being silly of making it up" Q16
	12	"Whereas in the past I would have felt like um there's something to discover about me which is you know undesirable sort of thing, um, that isn't there anymore, so even if I am self-conscious, its just like I'm a normal bloke so it's not a big deal really" Q17

Theme	Study	Quote and Reference
	8	“I found (the therapist) very warm and caring” Q18
	4	“I suppose I expected someone to say to me: ‘what’s wrong?’ and you could sort of pour your heart out. But it wasn’t … I don’t think I was ever asked: ‘Don’t you think you know what’s wrong?’, you know, or ‘How do you feel in yourself?’ or anything like that” Q19
	13	“The problem was the whole computer course didn’t fit in with my problems and my feelings. There were often things that I never had any problem with, then I thought this has nothing to do with me and I don’t think that I followed the last lessons if I’m honest. Because I just had the feeling that it didn’t help me” Q20
Therapy Factors Theme 5: Illness Perceptions	3	“Yeah, I don’t know really, I just remember being so worried about what they were gonna think of me” Q21
	22	“Psychiatrists I would refer to anyway. I talk and get the view of CBT colleagues, or psychologist and occupational therapists; theres no harm in getting other people’s view on what works best for certain clients.” Q22
	9	“When I came in I was elated so the groups were excellent but then as time went on I got more depressed so I found the groups harder to attend” Q23
	15	“I don’t know if I had cognitive therapy many years ago if it would have helped, as I don’t know if I’d be ready you know, but since having CBT I’ve never looked back” Q24
Therapy Factors Theme 6: Therapy Stages	10	“I think in terms of fitting it in with my work, once a week was good” Q25
	3	“It was kind of a roller coaster I suppose. In the beginning it was just scratching the surface and then there’s a period where you’re feeling really awful which is kind of when you’ve hit the spot of whatever it was that’s causing it” Q26
	15	“…if something wasn’t so much of a problem later on we could reduce that, if something else came up we could add that in to the plan” Q27

Theme	Study	Quote and Reference
	23	"It's only relatively recently after a year and a half of working with him that he thinks I might come back. Previously he thought that a missed session was me gone. And he would be really quite shocked when I returned" Q28
Therapy Factors Theme 7: Therapeutic Relationship(s)	3	"Yeah, that was really difficult and then my therapist left and that was just oh my god my therapist is the one person I had actually sustained a relationship in therapy with and I remember coming back and I was upset, I was really upset" Q29
	15	"I'm not just a service user, I'm someone on her level you know, really as a service user you get looked down on and you don't get considered at all, your feelings don't get considered at all when you're ill, you know people tend to talk over you or at you, or at someone else for you, but people in [therapist's] position, and people on her level and people such as you don't do that you know" Q30
	7	"I really liked and respected the people that were there, and they respected me, to give a little respect and to get some back, it's as simple as that" Q31
	16	"engaging with patients and developing meaningful patient-centred relationships…being there in moments of personal crisis…and witnessing the struggle, the confusion and the all important beginnings of recovery and taking back a personal sense of control of life" Q32
Therapy Factors Theme 8: Recovery and Hope	5	"…you got to know people who was/who had the same problems as you and you can just/like Jocasta – I have made a friend like/who's been through the same thing as me and she's just cool with it" Q33
	15	"The first time I came into contact with the mental health services I couldn't see anywhere forward, didn't want to be here, couldn't see the point in being here, now I've got things to aim for, it's like, okay, I've got things to aim for" Q34

Theme	Study	Quote and Reference
Staff Factors Theme 9: Professional Background and Psychological Perspective	18	"Partly I believe that there is scope for recovery, improvements in wellbeing, higher functioning and a better mental state. But the other part of me is more realistic, seeing that the diagnosis (schizophrenia) can be chronic and disabling and could stand in the way of 100% recovery" Q35
	4	"When I first walked in, I was really shocked at how young she was. It just really took me by surprise 'cos I then started feeling…because I felt that I was older than her, I felt like I needed to, not 'mother' her, but in some way…it was really quite strange. It felt weird to put myself in a position where I was sort of under her" Q36
	26	"She is just very very experienced and very…I don't know I feel like she is honest, genuine that she is very caring, she is kind, she is warm, she gives me space, she doesn't push things, she doesn't judge me, she doesn't get angry, she doesn't get frustrated she is just like wow but also really like down to earth and grounded" Q37
Staff Factors Theme 10: Staff Role	20	"A lot of the work initially was engagement and exploring. I tried to engage in a non-threatening way. I'd be gentle, very gentle. I feel I'd need just to understand the whole of what's going on; and working on what she feels most relevant" Q38
	3	"Yeah, she'd ask me questions like how have you been feeling this week and everything and stuff like that. it's hard when you're talking to a stranger and everything, it's hard to say what you actually feel as well" Q39
	20	"…Not getting too analytical about things, just nice, straightforward language, making the complex simple. Not that by making it simple, it's simple, it's just that it becomes more understandable; more accessible" Q40
	19	"The question that comes up for me is to what degree we modify our interventions, or approach, or refer on where we feel we cant provide what this patient needs. It's time to think again where we can offer a type of integrative treatment, or treatment alongside different professionals" Q41

Theme	Study	Quote and Reference
	20	“My ideal plan would be teamwork between medical people and the psychological or psychiatric people; at the moment we don’t have that in the health service” Q42
Staff Factors Theme 11: Evaluation	16	“It’s all about…money…and management…the system frustrates the hell out of me…the power imbalance and putting the needs of the system before those of the patients…not to mention having to deal with continuing social intolerance and stigma” Q43
	18	“I am too frightened to tell them (patients) because they will want it then and there, so I will only tell people who are very suitable. I’m not doing anything to increase awareness, what’s the point? When they will be on the waiting list for over a year?” Q44

Appendix 10. Journal of Child Psychology and Psychiatry Guidelines

Guidance accessed: http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1469-7610/homepage/ForAuthors.html

General:

- 6000 word limit (including title page, abstract, references, tables, and figures). Word count to be given on the title page.
- Double spaced throughout, including references and tables.

Manuscript preparation and submission:

Title: The first page of the manuscript should give the title, name(s) and short address(es) of author(s), and an abbreviated title (for use as a running head) of up to 80 characters.

Abstract: The abstract should not exceed 300 words and should be structured in the following way with bold marked headings: Background; Methods; Results; Conclusions; Keywords; Abbreviations. The abbreviations will apply where authors are using acronyms for tests or abbreviations not in common usage.

Method Section: Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval.

Key points: A text box at the end of the manuscript outlining the four to five Key (bullet) points of the paper (80-120 words in length). Outline what's known, what's new, and what's clinically relevant.

Headings: Articles and research reports should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

Acknowledgements: These should appear at the end of the main text, before the References.

Correspondence to. Full name, address, phone, fax and email details of the corresponding author should appear at the end of the main text, before the References.

References, Tables and Figures
The *JCPP* follows the text referencing style and reference list style detailed in the *Publication manual of the American Psychological Association* (5th edn., 2001). All Tables and Figures should appear at the end of main text and references, but have their intended position clearly indicated in the manuscript.

Appendix 11. Research Ethics Committee Approval

National Research Ethics Service

NRES Committee North West - Greater Manchester North
3rd Floor, Barlow House
4 Minshull Street
Manchester
M1 3DZ
Tel: 0161 625 7817
Email: cynthia.carter@northwest.nhs.uk

Miss Hannah Lisa Butler
Trainee Clinical Psychologist
University of Manchester
Division of Clinical Psychology
2nd Floor, Zochonis Building
M13 9PL

03 November 2011

Dear Miss Butler

Study title: **The Acceptability and Feasibility of Baby Triple P Positive Parenting Programme on a Mother and Baby Unit: Q Methodology with Mothers with Severe Mental Illness and Staff**
REC reference: **11/NW/0716**

Thank you for your email dated 26 October 2011, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the Chair of the Sub-Committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

This Research Ethics Committee is an advisory committee to the North West Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved by the Committee are:

Document	*Version*	*Date*
Advertisement	2 - Service User	17 October 2011
Covering Letter	1	26 October 2011
Evidence of insurance or indemnity	1	09 September 2011
Investigator CV	Butler	06 September 2011
Letter from Sponsor	1	09 September 2011
Other: CV Wittkowski		09 September 2011
Other: CV Hare		18 August 2011
Other: CV Walker		30 August 2011
Other: Q-Sort Step-by-Step	1	07 September 2011
Other: Post-Sort Follow-up Questions	1	07 September 2011
Participant Consent Form: Service Users	2	17 October 2011
Participant Consent Form: Service Users interviews	2	17 October 2011
Participant Consent Form: Staff	2	17 October 2011
Participant Consent Form: Staff interviews	2	17 October 2011
Participant Information Sheet: Service Users	2	17 October 2011
Participant Information Sheet: Service Users interviews	2	17 October 2011
Participant Information Sheet: Staff	2	17 October 2011
Participant Information Sheet: Staff interviews	2	17 October 2011
Protocol	1	06 September 2011
REC application	3.3	09 September 2011
REC application	3.3	26 October 2011
Response to Request for Further Information	1	26 October 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/NW/0716	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

pp C. Carter

Dr Peter Klimiuk
Chair

Enclosures: "After ethical review – guidance for researchers" SL-AR2

Copy to: Ms Lynne MacRae, University of Manchester

Dr Andy Mee, Manchester Mental Health & Social Care NHS Trust

Appendix 12. Research and Development Department Approval

Standardised Process for Electronic Approval of Research

Research & Development Office
Manchester Mental Health & Social Care Trust
Room N.3.FC027
3rd Floor
Rawnsley Building
Manchester Royal Infirmary
Hathersage Road
Manchester
M13 9WL
t 0161 276 3311

6th December 2011

Miss Hannah Butler
University of Manchester
School of Psychological Sciences
2nd Floor Zochonis Building
Brunswick Street
M13 9PL

Information for ID Badge if required:

Research Project Ref No: 1091
Expiry Date: 30/09/2013

You must take this letter with you.

Dear *Hannah,*

Re: Research Governance Decision Letter

Project Reference: 1091
Project Title : *The Acceptability and Feasibility of Baby Triple P Positive Parenting Programme on a Mother and Baby Unit: Q Methodology with Mothers with Severe Mental Illness and Staff*
REC Ref Number: 11/NW/0716

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study. This also includes all amendments made up to the date of this letter. Please note when contacting the R&D office about your study you must always provide the project reference numbers provided above.

Trust R&D approval covers all locations within the Trust, however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research.

Please take the time to read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the R&D Office should you require any further information. You may need this letter as proof of your approval.

You will need to contact us before any new researchers join your team as they will need Trust permission before they start work on the project.

It is your responsibility to contact us **a week prior** to the expiry date we have recorded for this project to let us know if you wish to extend it, as we will need to send a new approval letter. You will also need to let us know immediately if for any reason the project finishes earlier.

We would like to point out that hosting research studies incurs costs for the Trust such as: staff time, usage of rooms, arrangements for governance of research. We can confirm that in this instance we will not charge for these. However we would like to remind you that Trust costs should be considered and costed at the earliest stage in the development of any future proposals.

It is a condition of our Trust approval that on completion of this study we are in receipt of an end of study report summary and a copy of the Ethics letter confirming that they have closed the study, we will remind you of this nearer the time. You will also be asked to complete an audit form for each year your study is supported by this Trust (including the year of its completion) this approval requirement and failure or refusal to complete it may result in Trust approval being withdrawn.

By beginning your research you are agreeing to all the terms and conditions as stated within this letter.

May I wish you every success with your research and if you have any queries do not hesitate to contact the R&D Team.

Yours sincerely

Dr. Andy Mee
Research & Development Manager

cc : Research Governance Sponsor – University of Manchester
Supervisor: Dr. Anja Wittkowski

Enc: Information for Researchers: Conditions of Research Governance Approval, Induction & ID Badge Information and TrustTECH Leaflet

Appendix 13.
Service user PI Semi-Structured Interview for Q-Concourse Development

Participant Information Sheet
Service Users

Title of Project: The Acceptability and Feasibility of Baby Triple P Positive Parenting Programme on a Mother and Baby Unit: Q Methodology with Mothers with Severe Mental Illness and Staff

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. A member of the research team will go through this information sheet with you.

What is the study about?
Research studies have shown that mothers with mental health difficulties may sometimes find it harder to strengthen their bond with their baby. This is a study investigating if mothers who experience mental health difficulties during pregnancy or after childbirth benefit from taking part in a Baby Parenting Programme (called Baby TP) being offered on the Manchester Mother and Baby Unit (MBU). We would like to investigate if Baby TP is both suitable and adequate in meeting the needs of mothers on the MBU.

Why have I been asked to take part?
You have been asked to take part because you have had a baby in the past 12 months or are currently pregnant, you have been experiencing some mental health difficulties and recently taken part in Baby TP.

What will happen if I do not take part?
Participation in this research is completely voluntary. You do not have to take part and not participating in the study will not alter your treatment in any way. If you wish to withdraw from the study at any point just tell the researcher that you do not wish to continue. We will destroy identifiable information but we will continue to use the data collected up to your withdrawal. Your decision to withdraw from the study will not affect the care that you or your baby receives.

If I decide to take part, what will I have to do?
If you choose to take part in this study, we will ask you to complete a consent form. The interview will take about 20 minutes to complete. It will involve answering questions about you thoughts and views of Baby TP. This interview will be audio-taped so that the researcher can listen back and make notes about

your comments and views. All written information taken from your interview will be completely anonymous and unidentifiable.

You and your baby will continue to receive your usual care from the MBU treatment team.

How will the results be used?
We hope to find out how successful Baby TP is for mothers. The information you provide in the interview will be used to help inform a further study based at the Manchester Mother and Baby Unit. It is anticipated that your input will help contribute to better specialised inpatient care for women and their babies on the Manchester Mother and Baby Unit.

What will happen to the information I supply?
The answers you give will be anonymous. However, in the event of risk of harm to yourself or your baby it will be necessary to breach confidentiality and inform the health care professionals caring for you on the MBU. All data will be stored in a locked filing cabinet accessed only by the researcher and authorised persons to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a participant. Your personal contact details will be stored separately from your other answers, also in locked storage.

What will happen when the interview is complete?
You will be involved in the study for about 20 minutes. Once all the data has been collected and analysed, the findings will be used to inform a further study being held at the Manchester Mother and Baby Unit.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Coordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.

In the unlikely event that something does go wrong and you are harmed during the research you may have grounds for a legal action for compensation against The University of Manchester but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you. You can contact Amanda Owens who works in PALS (amanda.owens@mhsc.nhs.uk or 0161 918 4047).

Who is involved in the research?
This research is being conducted by Hannah Butler in collaboration with Anja Wittkowski, Angelika Wieck, Dougal Hare and Sam Walker.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been

reviewed and approved by the NHS Research Ethics Committee on 3rd November 2011. The REC reference number is 11/NW/0716.

What do I do now?

If you have decided that you would like to take part, you will be asked to sign a consent form. An appointment would be organised for you and the researcher to complete the research task. You will also have the opportunity to be entered into a Raffle Prize Draw where you could win high street vouchers worth up to the value of £30.

Thank you for considering taking part in this study.

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Appendix 14. Service user Q-Sort PI ('Baby TP Experienced')

The University of Manchester

Participant Information Sheet
Service Users

Title of Project: The Acceptability and Feasibility of Baby Triple P Positive Parenting Programme on a Mother and Baby Unit: Q Methodology with Mothers with Severe Mental Illness and Staff

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. A member of the research team will go through this information sheet with you.

What is the study about?

Research studies have shown that mothers with mental health difficulties may sometimes find it harder to strengthen their bond with their baby. This is a study investigating if mothers who experience mental health difficulties during pregnancy or after childbirth benefit from taking part in a Baby Parenting Programme (called Baby TP) being offered on the Manchester Mother and Baby Unit (MBU). We would like to investigate if Baby TP is both suitable and adequate in meeting the needs of mothers on the MBU.

Why have I been asked to take part?

You have been asked to take part because you have had a baby in the past 12 months or are currently pregnant, you have been experiencing some mental health difficulties and recently taken part in Baby TP.

What will happen if I do not take part?

Participation in this research is completely voluntary. You do not have to take part and not participating in the study will not alter your treatment in any way. If you wish to withdraw from the study at any point just tell the researcher that you do not wish to continue. We will destroy identifiable information but we will continue to use the data collected up to your withdrawal. Your decision to withdraw from the study will not affect the care that you or your baby receives.

If I decide to take part, what will I have to do?

If you choose to take part in this study, we will ask you to complete a consent form. The study will take an hour to complete. It will involve you making yourself familiar with around 100 statements on cards that may correspond to your view of Baby TP. You will be asked to divide this large pile into three separate piles as to whether you agree, disagree or are neutral to the statement. You will be asked to further divide each of these into more piles, until you have around 9 piles that range from "does not fit well at all with my thoughts about

Baby TP" to "fits very well with my thoughts about Baby TP". Some of these sessions may be audio-taped to make sure the researcher understands the reasoning for statement positioning.
You and your baby will continue to receive your usual care from the MBU treatment team.

How will the results be used?
We hope to find out how successful Baby TP is for mothers and anticipate that the results from this study will lead to better specialised inpatient care for women and their babies on the Manchester Mother and Baby Unit.

What will happen to the information I supply?
The answers you give will be anonymous. However, in the event of risk of harm to yourself or your baby it will be necessary to breach confidentiality and inform the health care professionals caring for you on the MBU. All data will be stored in a locked filing cabinet accessed only by the researcher and authorised persons to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a participant. Your personal contact details will be stored separately from your other answers, also in locked storage.

What will happen when the study is complete?
You will be involved in the study for about 30 minutes. Once all the data has been collected and analysed, the findings will be summarised in a report which will be sent to academic journals to be published and the findings will be presented at conferences. A summary report of the findings will also be written for participants which would be given to those who would like a copy when the study has been completed.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Coordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.

In the unlikely event that something does go wrong and you are harmed during the research you may have grounds for a legal action for compensation against The University of Manchester but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you. You can contact Amanda Owens who works in PALS (amanda.owens@mhsc.nhs.uk or 0161 918 4047).

Who is involved in the research?
This research is being conducted by Hannah Butler in collaboration with Anja Wittkowski, Angelika Wieck, Dougal Hare and Sam Walker.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been

reviewed and approved by the NHS Research Ethics Committee on 3rd November 2011. The REC reference number is 11/NW/0716.

What do I do now?

If you have decided that you would like to take part, you will be asked to sign a consent form. An appointment would be organised for you and the researcher to complete the research task. You will also have the opportunity to be entered into a Raffle Prize Draw where you could win high street vouchers worth up to the value of £30.

Thank you for considering taking part in this study.

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Appendix 15. Service User Q-Sort PI ('no-experience Baby TP')

Participant Information Sheet
Service Users

Title of Project: The Acceptability and Feasibility of Baby Triple P Positive Parenting Programme on a Mother and Baby Unit: Q Methodology with Mothers with Severe Mental Illness and Staff

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. A member of the research team will go through this information sheet with you.

<u>What is the study about?</u>
Research studies have shown that mothers with mental health difficulties may sometimes find it harder to strengthen their bond with their baby. This is a study investigating if mothers who experience mental health difficulties during pregnancy or after childbirth would benefit from taking part in a Baby Parenting Programme (called Baby TP) being offered on the Manchester Mother and Baby Unit (MBU). We would like to investigate if Baby TP would be something you think would be beneficial for meeting the needs of mothers on the MBU.

<u>Why have I been asked to take part?</u>
You have been asked to take part because you have had a baby in the past 12 months or are currently pregnant and have been experiencing some mental health difficulties.

<u>What will happen if I do not take part?</u>
Participation in this research is completely voluntary. You do not have to take part and not participating in the study will not alter your treatment in any way. If you wish to withdraw from the study at any point just tell the researcher that you do not wish to continue. We will destroy identifiable information but we will continue to use the data collected up to your withdrawal. Your decision to withdraw from the study will not affect the care that you or your baby receives.

<u>If I decide to take part, what will I have to do?</u>
If you choose to take part in this study, we will ask you to complete a consent form.

<u>The study will take around 30 minutes to an hour to complete.</u>
It will involve you making yourself familiar with around 100 statements on cards that may correspond to your thoughts and views about Baby TP. You will be asked to divide this large pile into three separate piles as to whether you agree, disagree or are neutral to the statement. You will be asked to further divide each

of these into more piles, until you have around 9 piles that range from “does not fit well at all with my thoughts about Baby TP” to “fits very well with my thoughts about Baby TP”. Some of these sessions may be audio-taped to make sure the researcher understands the reasoning for statement positioning. **With your consent, anonymous direct quotations, which have had all potentially identifiable information removed, may be used in the reporting of the research.** You and your baby will continue to receive your usual care from the MBU treatment team.

How will the results be used?

We hope to find out about mothers views and opinions about Baby TP and anticipate that the results from this study will be used to inform specialist inpatient care for women and their babies.

What will happen to the information I supply?

The answers you give will be anonymous. However, in the event of risk of harm to yourself or your baby it will be necessary to breach confidentiality and inform the health care professionals caring for you on the MBU. All data will be stored in a locked filing cabinet accessed only by the researcher and authorised persons to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a participant. Your personal contact details will be stored separately from your other answers, also in locked storage.

What will happen when the study is complete?

Once all the data has been collected and analysed, the findings will be summarised in a report which will be sent to academic journals to be published and the findings will be presented at conferences. A summary report of the findings will also be written for participants which would be given to those who would like a copy when the study has been completed.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Coordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.

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Who is involved in the research?

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Who has reviewed the study?

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What do I do now?

If you have decided that you would like to take part, you will be asked to sign a consent form. An appointment would be organised for you and the researcher to complete the research task. You will also have the opportunity to be entered into a Raffle Prize Draw where you could win high street vouchers worth up to the value of £30.

Thank you for considering taking part in this study.

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Appendix 16. Q-Sort Consent Form

The University of Manchester

School of Psychological Sciences
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Consent Form: Service Users

Title of Project: The Acceptability and Feasibility of Baby Triple P Positive Parenting Programme on a Mother and Baby Unit: Q Methodology with Mothers with Severe Mental Illness and Staff

Name of Investigator: Miss Hannah Butler

Please Initial Box

1. I confirm that I have read and understood the information sheet dated 06/09/2011 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

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

3. I give my permission for my data to be retained by the researcher and used confidentially in connection with the study if I withdraw. ☐

4. I understand that audio-taping is anonymous, confidential and will be destroyed after use. I give my permission for the researcher to audio-record the task. ☐

5. I agree that direct quotes from the task can be used in reporting of the research. I understand that my personal details will not be identified. ☐

6. I give permission to be contacted about future studies. ☐

7. I understand that data collected during the study may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

8. I would like to receive a summary of the findings. ☐

9. I would like to be entered into the Raffle Prize Draw. ☐

10. I agree to take part in the above study. ☐

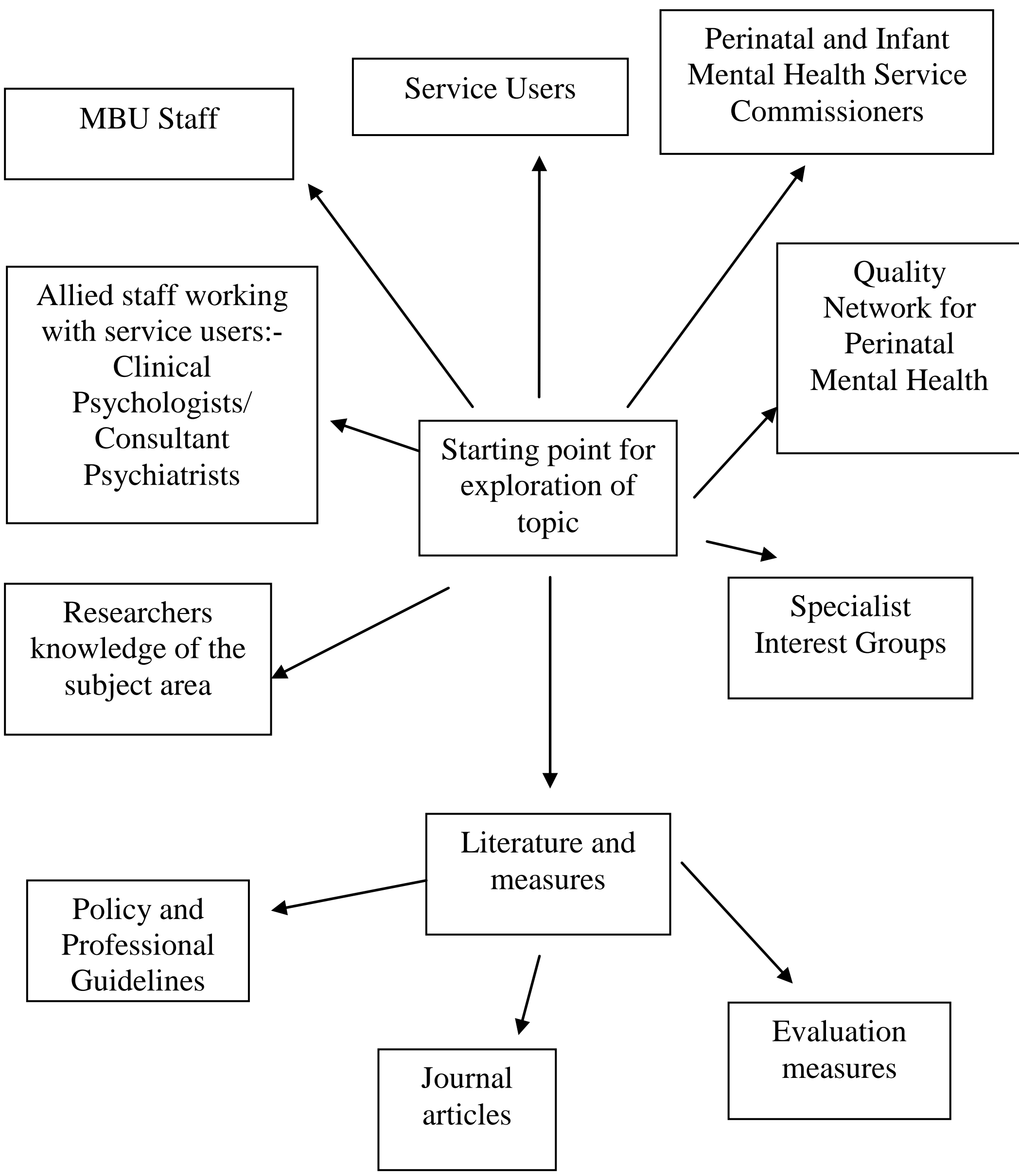
Name of participant:…………………Signature:……………Date:…….

Name of person taking consent:… Signature:………………Date:…….

Participant No:

Appendix 17. Strategies for Concourse Development

Adapted from: Barrett, A. J. (2007). Sorting out differences between staff and patients: using Q methodology to examine the understanding, experience, and treatment of symptoms within inpatient mental health units. University of Manchester, Manchester.



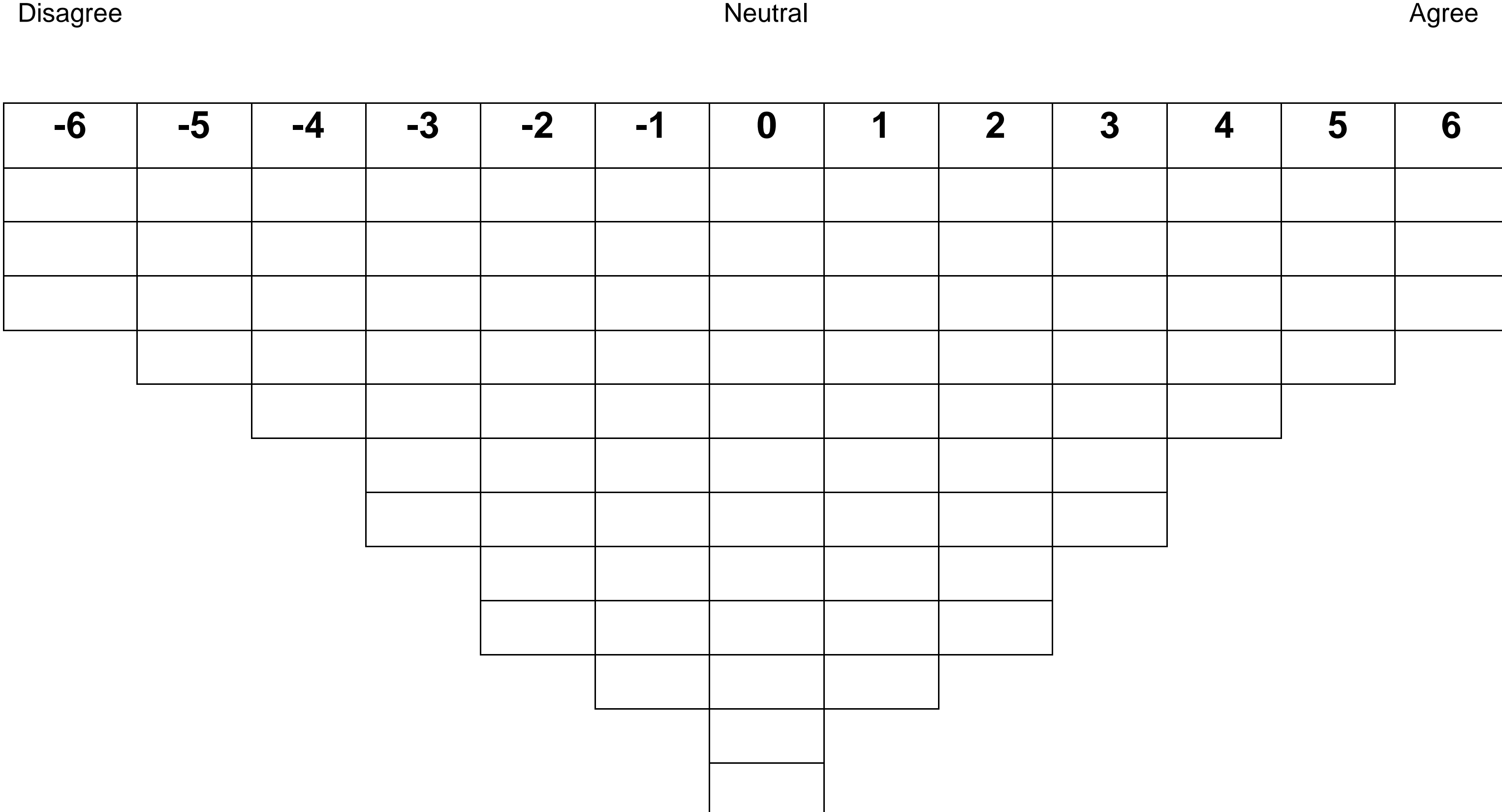
Appendix 18. Original Q-Sort Themes and Q-Statements

Themes	Resultant Q-Statements
Environment	1. The MBU provides time to take part in Baby TP
	2. It is important that Baby TP fits nicely with the ethos of the unit
Environment - Setting Generalisation	3. The skills taught in Baby TP need to generalise to environments other than the MBU
Service User Mental Health	4. When mothers are unwell, Baby TP will be intolerable
	5. Mental health issues prevent mothers from accessing Baby TP
	6. Baby TP needs to fit with the mothers' mental health
	7. Baby TP should be flexible to the mothers mental health status
Intervention Flexibility – Individual Needs	8. Baby TP will be fluid and flexible
Intervention Flexibility - Unplanned Events	9. Baby TP will be flexible to cope with unplanned events
Facilitator Skill	10. The facilitator needs to be skilled in their explanation of Baby TP
Staff Flexibility/Sensitivity	11. Staff rolling out Baby TP need to have a thorough knowledge about mother and baby
Hope and Expectations	12. Baby TP will make women's anxieties about their ability to parent worse
Intervention Rationale	13. It is important for staff to be able to answer questions about Baby TP
Anxious Professionals	14. Baby TP is a reactive response from "anxious" professionals
Staff Belief in Intervention Benefits	15. Staff need to believe that Baby TP benefits the mother
Intervention Transference onto the MBU	16. The techniques of Baby TP flow through to the staff on the MBU
Staff Team Approach	17. It is important that all staff know which mothers are using the Baby TP techniques
Service Users Feelings – Competence/Confidence in Intervention	18. It is important that the mother thinks Baby TP is worthwhile
Change Issues	19. It is important that mothers are open to change
	20. If the mother has unchangeable situations at home, Baby TP is not going to be helpful
Service User Validation	21. Mothers want to be recognised for the work they are doing in Baby TP
Empowering Service Users	22. Baby TP is "preachy"
	23. People providing Baby TP should only suggest techniques
Staff- Service User Relationship – Trust and Respect	24. A trusting relationship with the Baby TP therapist is important
	25. One-to-one work will make it easier for mothers to say when they find Baby TP difficult
Importance of the Staff-Service User Relationship	26. If the relationship between the Baby TP facilitator and mother is not working, neither will Baby TP
Transferable Skills - Staff	27. It is important that Baby TP complements what staff already know
Stigma	28. Doing Baby TP will make mothers feel like "bad parents"
	29. Baby TP might make people feel like they are being unfairly

	judged or blamed
Service User Intervention Achievement	30. It is important that mothers doing Baby TP can gauge their progress
	31. It is important for mothers to feel they have achieved something
Service User Emotion	32. Baby TP is an extra thing to engage in and will make mothers feel overwhelmed
Challenges	33. It is OK for Baby TP to be challenging for mothers
Service User Support	34. Mothers should have ongoing support in doing Baby TP
Family Life – Open to Change	35. It is important that the mother's family are open to change
Family Life – Programme Benefits	36. Baby TP will help develop skills that can help deal with family problems
Importance of Family	37. It is important that Baby TP sessions do not interfere with family visits on the MBU
Control	38. It is important that mothers feel in control and responsible for Baby TP
Service User Confidence in Staff	39. Well delivered Baby TP will maintain overall confidence in the MBU
Helpful	40. Baby TP will be helpful for mothers to meet their parenting needs
Motivation and Mental Health	41. If a mother is severely depressed, they will not have the motivation to do Baby TP
	42. Whilst staying on the MBU it is easy for mothers to commit to Baby TP
Staff Expectations	43. In order to engage in Baby TP, staff expect mothers to be open to learning
Commitment, Focus and Drive	44. Baby TP will use all the mothers energy and focus
Working with Mother and Baby	45. It is important that the Baby TP therapist works with both mother and baby
Uncertainty	46. Baby TP will address mothers feelings of uncertainty
Client-led Intervention	47. It is important that Baby TP engages with the current situation and needs of the mother
Service User Attitude to Illness	48. It is important that mothers have a positive attitude towards recovery from illness
	49. Taking part in Baby TP will be a positive experience
Peer Support	50. It is important that mothers discuss Baby TP with other like-minded people
Service Users – Time Resources	51. There is no opportunity to practice the Baby TP skills on the MBU
Service Users - Easy to Implement	52. It is important that Baby TP is easy for mothers to do
Positive/Reassuring Focus	53. Baby TP will be about what has gone wrong for mother and baby
	54. Baby TP needs to emphasise the positive so as not to make the mother's mental illness worse
Acceptance	55. The way Baby TP is presented to mothers will be important
Service User Prior Knowledge	56. It is important that Baby TP does not go against what mothers already know
Service User Reflective Ability	57. It is important for the mother to recognise what she has done well
	58. It is important for the mother to recognise what she could

	have done differently
	59. It is important for the mother to recognise what she has done wrong
Staff Reflective Ability	60. Staff need to think about what parts of the Baby TP would be helpful for mothers
	61. It is important to encourage staff to reflect
Staff Supervision, Support and Training	62. Staff need support and training to feel confident in delivering the Baby TP skills
	63. All staff should have the same training in Baby TP
Staff and Service User Enjoyment	64. It is important that both staff and mothers will find Baby TP enjoyable
Clinical Workload	65. Staff have too much work to do to support Baby TP skills adequately
	66. Baby TP will be easily incorporated into the workload of staff
Work Load – Administration Demands	67. Baby TP should not have too much paperwork for staff to do
Work Load –Time	68. It is important that Baby TP only takes a small amount of staff time
Work Load – Priorities	69. Baby TP should be a priority for the MBU
	70. Baby TP should not get in the way of other MBU work
Intervention – Content, Learnt Knowledge and Skills	71. Baby TP is about learning new skills
Containment	72. Baby TP provides a safe place for mothers who have mental health issues
Service Users Self Care	73. It is important Baby TP will highlight the importance of mothers looking after themselves
Engagement	74. Engagement with mothers must be the priority in Baby TP
	75. Doing Baby TP would make mother's feel exposed or a bad mother
Staff Qualities	76. Staff attitude affects engagement on Baby TP
Service User Requests	77. Mothers want factual information about parenting
Materials/ Practical Activities	78. Practical materials are essential
Commencement of Intervention	79. Baby TP comes at the wrong time
Intervention Introduction	80. The Baby TP therapist needs to really sell the programme to mothers
Staff Role	81. It is important for all staff on the MBU to have a clear role within Baby TP
Structure	82. All staff should support what is done in Baby TP
Experience of other Techniques	83. It is important that mothers and Baby TP therapists work together to solve the mother's problems
Evidence Base	84. It is important that staff understand why Baby TP works
Service User Choice	85. Mothers being able to make choices in Baby TP is important
	86. Mothers should decide when they want to do Baby TP sessions
Ability Insight	87. Mothers need to know what they can do and cannot do for Baby TP to work
Common Sense	88. Baby TP needs to be based on common-sense

Appendix 19. Q-Grid



Q-Sort grid for 88 statements

Appendix 20. Service User Correlation Matrix

Sorts	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	-	42	39	40	47	20	63	38	34	34	26	36	37	56	17
2		-	22	47	49	30	55	33	52	29	30	53	28	42	26
3			-	36	26	31	38	32	33	31	6	42	43	43	24
4				-	62	21	51	26	48	21	35	50	19	32	37
5					-	27	59	28	51	14	32	36	14	39	42
6						-	29	28	39	35	7	46	22	20	27
7							-	38	48	35	30	54	31	54	39
8								-	38	33	15	40	28	41	35
9									-	22	40	59	18	42	42
10										-	20	40	32	28	4
11											-	30	13	23	15
12												-	30	42	39
13													-	32	22
14														-	33
15															-

Appendix 21. 'Ideal' Factor Sorts for Factor 1-3

Factor 1.

Disagree Neutral Agree

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
22	14	4	16	35	17	9	8	1	3	26	6	24
44	28	5	32	38	19	13	11	2	10	36	7	54
53	51	12	33	48	21	27	15	31	25	55	18	73
	75	20	50	66	42	30	23	40	46	57	62	
		29	59	68	58	37	34	65	47	83		
			79	69	61	41	39	67	49			
			80	81	64	45	43	72	85			
				87	71	52	60	76				
				88	74	56	77	82				
					86	63	84					
						70						
						78						

Factor 2

Disagree | Neutral | Agree

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
28	32	20	4	8	7	2	19	11	1	30	6	24
65	51	22	5	13	9	3	43	25	21	33	36	40
75	68	29	12	23	10	15	47	31	45	34	73	84
	79	41	14	27	17	18	48	62	49	38	77	
		70	16	37	42	26	50	63	55	57		
			80	56	44	35	54	69	71			
			86	61	46	39	64	78	87			
				67	52	53	66	83				
				88	60	58	72	85				
					81	59	74					
						76						
						82						

Factor 3

Disagree | Neutral | Agree

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
28	51	12	4	8	11	2	1	13	3	18	25	7
32	69	20	5	14	21	33	6	15	9	40	47	31
44	75	26	17	16	23	43	10	19	60	46	48	88
	79	65	22	35	34	49	24	30	64	55	57	
		80	29	50	42	53	27	36	67	85		
			37	56	54	59	39	39	71			
			63	66	58	61	41	52	72			
				76	62	68	45	70				
				78	73	77	74	83				
					82	84	81					
						86						
						87						

Appendix 22. Service User Reflective Comments for Factors 1-3

Statement	Reflective Comments for Factor 1 "What We Need"
24. (+6) A trusting relationship with the Baby TP therapist is important	"A lot of what is in the Triple P is quite personal to the Mum and the Dad and the baby so you need to be able to be open with whoever you are discussing it with and you need to be confident that it is just going to stay between you and is not going to be spread out. You need to be as well totally open with the person so you need to get on with them well as well" "If you don't trust them you are not going to be truthful are you."
54. (+6) Baby TP needs to emphasise the positive so as not to make the mother's mental illness worse	"I think that the way that X did the Baby TP with me was really good, erm, and it was a focus on the positive. Because it is very hard to do the positive things when you are mentally ill so, erm, it needs to be an encouragement to do the positive things rather than a focus on the things you have not been able to do and the things that you have been struggling with and therefore try to encourage you to do the good things rather than focus on the things that you are doing that are bad". "With my illness, when I am ill, I will pick up everything that I can to beat myself up about so it was important for me that everything that I was using was not supporting that in myself in any way and actually emphasising positive things did actually help. For example when I was reading through the Triple P stuff the first few chapters I was reading through it thinking "oh actually I did an ok job there" and it accepts that babies can be difficult and that was actually really quite reassuring for me I think. The things that I had come up against were actually normal. For example, I do relate this to a specific time, so I had health visitors for XX when he was quite small and I said to her "he seems to be crying a lot" and she said to me, because I had had some problems in the past "oh well you know if you are anxious your baby can pick up on it". I was really upset when she left because it made me feel even worse when I was already feeling quite anxious. At the time I think what would have been more useful for me would have been for her to have gone "are you making sure that he is sleeping often enough" and you know looking back now I think he was getting over tired and that might have been why he was getting grumpy but she didn't go through all of that stuff with me but it was just making me feel rubbish about myself when I was feeling pretty crap about myself anyway. I didn't get that feeling with this at all because it did support me as it did recognise that things can be really difficult. I can remember the bit about the parent traps, there was about 5 or 6 things that parents get into and being about self, like thinking that everything is your responsibility. Like, I have not read that book since I left hospital but it really stuck with me that XX behaviour isn't always 100% my responsibility. So I think that all of those things, if I hadn't had those then I don't think I wouldn't have gotten on with the programme."
73. (+6) It is important Baby TP will highlight the importance of	"I think during the Triple P programme one of the chapters did focus a lot on taking time out for yourself, getting a bath and getting exercise, and it highlighted very positive things to do for yourself to take time out away from the baby, and those sort of responsibilities and I feel allowing myself to do that, to have a long bath and get out and getting my husband to look after the

Statement	Reflective Comments for Factor 1 “What We Need”
mothers looking after themselves	baby. That has worked wonders to get me out of my depression and has helped with my anxiety and I think that chapter is really good in the Baby Triple P and I think there is a checklist of things you can do, so a list of ideas you can do. I do think that is the key to recovery in a sort of a way, or a least one of the keys to recovery.”
53. (-6) Baby TP will be about what has gone wrong for mother and baby	“I think if you have “whats gone wrong” as the focus then its not going to be as effective as if you look at alternative ways of doing things and looking at things that are good. In its title it is positive parenting so if you are focusing on the negative then that defeats the object of the programme.” “Well I think like I have said, for me, it did not feel like it was like that at all and like I have said with my health visitor example I did look back and could have got him to sleep better. I think that the way that the program you can focus on where you are at, at that time and then move forward with that so that you have practical techniques to focus on for moving forward from where you are at which is really important if you are suffering from mental health problems and you are trying to get better. I never felt I was being told off or there was not anything for me to pick up on and beat myself up about really, it was just really supportive.” “I don’t believe it is about what has gone wrong for mother and baby. It’s a positive thing and you see what is going right as a mother. Definitely myself as I read it I thought “oh I am doing good things” and it doesn’t criticise you or says “if you are doing this you are doing it wrong”, it gives suggestions and pinpoints what you are doing right. For me it was, like I would read a list of say what behaviours there should be at 0-6months or something like that and ticking them and I remember thinking, “oh yeah I am doing that” and it reinforced that I was doing the right things not what I was doing wrong, because I think that would have made me feel like down if I thought, it was pointing out what I was doing wrong. So yeah I think that it was all about the positive not the negative.” “It will be about what has gone wrong but also it needs to look at what’s going right for them and highlight that as well so it doesn’t feel as bad.”
44. (-6) Baby TP will use all the mothers energy and focus	“Yeah I don’t believe that Baby TP used all my energy and focus. I feel like me looking after X on the MBU used a lot more energy and focus than the Baby TP. It only took like an hour out of my week or a couple of hours out of my week, so it didn’t use up a lot of my time. Obviously you did need to focus on it and use some energy to get the most out of it but it only used sot of a small percentage of my energy and I had a lot of energy to do other things.” “It wont, it is not something that, I don’t understand how talking can use all of your energy and focus, its not as if it is going to be a long session or happening all the time. It is going to help them relax if anything because you are going to be talking about your problems.”
22. (-6) Baby TP is “preachy”	“I don’t think it is preachy it makes suggestions rather than being really prescriptive and saying what you should do its about thinking about what you are doing and how you might improve on it. Rather than saying as a mother you should be doing this or that. So that is why I put that as disagree.” “Because it is not really, it is trying to help you I suppose.”

Statement	Reflective Comment for Factor 2 'What We Want'
24. (+6) A trusting relationship with the Baby TP therapist is important	"I think that any programme where you would be talking, like doing talking therapy, about your life would need a non-judging therapist but you would need to be honest too. I was honest about my life with X and I think it helped us to target the things which were important to me. If I hadn't trusted X then I wouldn't have been able to be so open".
40. (+6) Baby TP will be helpful for mother's to meet their parenting needs	"Some of us don't know anything about taking care of baby, it is our first time and all the stress has brought us here. So coming here and doing Baby TP will be able to take care of the baby not doing what we were doing before. If we are here, it means we are not doing well with the baby and therefore to help us to be very organised in how we approach parenting".
84. (+6) It is important that staff understand why Baby TP works	"It is a bit like, to have common sense. I mean if the staff know it will work the mother will probably be more confident and it would be a good thing".
28. (-6) Doing Baby TP will make mothers feel like "bad parents"	"This is not what I felt it was doing at all. I felt that it was making the parenting experience that I was having normal, like, I didn't feel the only person who was experiencing this and that there were others who were. It also made me see that it was OK to think about myself rather than worry that doing that was the wrong thing to do". "No I disagree with that because they are on the unit, I mean some will be first time mums and some will have a couple of children but any new skills they will welcome because they care about their children. They will think "that's a good skill, I could use that skill" so it should be encouraged". "If they accept to do it, it is because they need it".
65. (-6) Staff have too much work to support Baby TP skills adequately	"I think a parenting course should be the mums number one priority really because a lot of mums can lose their relationship with their baby so I think it should be number one priority that we get that relationship back. It should be incorporated into the workload".
75. (-6) Doing Baby TP would make mother's feel exposed or a bad mother	"I disagree because, just because you are doing Baby TP it is for your own health, it is for your own good. So it is not going to expose you as a bad parent or that you are doing bad parenting. You want the help and there you have it, take it". "The Baby TP is just to help us to be a good mother and to let us know where we have gone wrong when we were at home with the baby". "It is just that the mother needs some more than other mothers and that is nothing to do with her being a bad mother. They just need more help". "I don't think it would make me feel like a bad mum it would just help me. I just think sometimes that I have always wanted to be a mum and sometimes I just struggle you know, if I am depressed, you know like making his food and stuff. I just feel that having some tips about how to overcome that would be good and it would just help".

Statement	Reflective Comment for Factor 3 'We Can Do It'
7. (+6) Baby TP should be flexible to the mothers mental health status	
31. (+6) It is important for mothers to feel they have achieved something	
88. (+6) Baby TP needs to be based on common-sense	"Yeah, well it is common-sense. So it has to relate to both those that are teaching it and those that are learning it. So if those that are learning it don't understand and relate to it they wont trust the facts".
44. (-6) Baby TP will use all the mother's energy and focus	"It shouldn't"
32. (-6) Baby TP is an extra thing to engage in and will make mother's feel overwhelmed	"I don't think it would make people feel overwhelmed because if it is done in the right way. There is quite a lot of time on here where there is nothing to do so an extra programme or an extra session would be really good. I think that people would look forward to it. I mean I am not into doing arty things or anything creative but sometimes we made smoothies and that was an activity I wouldn't usually do but it was just something different to do and at the end some of the babies had it and you felt like you had achieved something. So doing something like Baby TP wouldn't overwhelm people. Obviously if people were really really poorly then that's a different ball game but because people are generally in here for quite a long time then I just don't think that would overwhelm people I think that people would want to practise it and even if they were doing the basic things then I would still want to sit and listen because it is something different. I would say that three quarters of the women in here at the minutes would not feel overwhelmed".
28. (-6) Doing Baby TP will make mothers feel like "bad parents"	

Appendix 23. Z-Score Comparison with Distinguishing Statements

Factor 1

Statement	Factor 1		Factor 2		Factor 3	
	Rank	Z Score	Rank	Z Score	Rank	Z Score
24. A trusting relationship with the Baby TP therapist is important	6	2.29	6	1.54	1	0.29
54. Baby TP needs to emphasise the positive so as not to make the mothers mental health worse	6	**1.84***	1	0.40	-1	-0.14
62. Staff need support and training to feel confident in Baby TP skills	5	**1.49***	2	0.60	-1	-0.26
26. If the relationship between the Baby TP facilitator and mother is not working neither will Baby TP	4	**1.33***	0	0.14	-4	-1.46
65. Staff have too much work to support Baby TP adequately	2	**0.59***	-6	-2.09	-4	-1.66
8. It is important that Baby TP will be fluid and flexible	1	**0.35***	-2	-0.46	-2	-0.46
23. It is important that people providing Baby TP should only suggest techniques	1	0.33	-2	-0.86	-1	-0.40
78. Practical materials are essential	0	0.13	2	0.79	-2	-0.57
37. It is important that Baby TP sessions don't interfere with the family visits	0	**0.09***	-2	-0.85	-3	-0.89
30. It is important that mothers doing Baby TP can gauge their progress	0	-0.01	4	1.15	2	0.71
71. Baby TP is about learning new skills	-1	**-0.25***	3	1.02	3	0.86
69. Baby TP should be a priority for the MBU	-2	**-0.43***	2	0.65	-5	-1.72
48. It is important that mothers have a positive attitude towards recovery	-2	**-0.57***	1	0.38	5	1.77
32. Baby TP is an extra thing to engage in and will make mothers feel overwhelmed	-3	**-0.80***	-5	-1.62	-6	-2.23
79. Baby TP comes at the wrong time	-3	-0.98	-5	-1.62	-5	-1.69
59. It is important for the mother to recognise what she has done wrong	-3	**-1.19***	0	0.17	0	0.09
33. It is OK for Baby TP to be challenging for mothers	-3	**-1.21***	4	1.14	0	0.20

Statement	Factor 1		Factor 2		Factor 3	
	Rank	Z Score	Rank	Z Score	Rank	Z Score
14. Baby TP is a reactive response from “anxious” professionals	-5	**-1.73***	-3	-0.94	-2	-0.69
22. Baby TP is “preachy”	-6	-2.12	-4	-1.42	-3	-0.74
53. Baby TP will be about what has gone wrong for mother and baby	-6	**-2.51***	0	0.15	0	0.17

(P<0.05; Asterisk (*) indicates significance at P<0.01)

Factor 2

Statement	Factor 1		Factor 2		Factor 3	
	Rank	Z Score	Rank	Z Score	Rank	Z Score
24. A trusting relationship with the Baby TP therapist is important	6	2.29	6	1.54	1	0.29
84. It is important that staff understand why Baby TP works	1	0.27	6	**1.50***	0	0.11
77. Mothers want factual information about parenting	1	0.28	5	**1.31***	0	0.06
38. It is important that mothers feel in control and responsible for Baby TP	-2	-0.37	4	**1.22***	1	0.23
33. It is OK for Baby TP to be challenging for mothers	-3	-1.21	4	**1.14***	0	0.20
34. Mothers should have ongoing support in doing Baby TP	1	0.37	4	1.12	-1	-0.11
21. Mothers want to recognised for their Baby TP work	-1	-0.12	3	**1.04***	-1	-0.23
87. Mothers need to know what they can and cannot do for Baby TP to work	-2	-0.58	3	**1.03***	0	0.00
78. Practical materials are essential	0	0.13	2	0.79	-2	-0.57
69. Baby TP should be a priority on the MBU	-2	-0.43	2	**0.65***	-5	-1.72
62. Staff need support and training to feel confident in Baby TP skills	5	1.49	2	0.60	-1	-0.26
50. It is important for mothers to discuss Baby TP with other like-minded people	-3	-0.95	1	**0.52***	-2	-0.60
66. Baby TP will be easily incorporated into the staff workload	-2	-0.63	1	**0.46***	-2	-0.43
48. It is important that mothers have a positive	-2	-0.57	1	**0.38***	5	1.77

Statement	Factor 1		Factor 2		Factor 3	
	Rank	Z Score	Rank	Z Score	Rank	Z Score
attitude towards recovery						
35. It is important that the mothers family are open to change	-2	-0.45	0	0.18	-2	-0.63
26. If the relationship between the Baby TP facilitator and mother is not working neither will Baby TP	4	1.33	0	**0.14***	-4	-1.46
18. It is important that the mother thinks Baby TP is worthwhile	5	1.62	0	**0.12***	4	1.34
7. Baby TP should be flexible to the mothers mental health status	5	1.58	-1	**0.00***	6	2.00
46. Baby TP will address the mothers feelings of uncertainty	3	1.03	-1	**-0.18***	4	1.06
44. Baby TP will use all of the mothers energy and focus	-6	-1.90	-1	**-0.22***	-6	-2.34
67. Baby TP shouldn't have too much paperwork for staff to do	2	0.57	-2	**-0.59***	3	0.77
27. It is important that Baby TP complements what staff already know	0	-0.02	-2	-0.65	1	0.29
86. Mothers should decide when they want to do Baby TP sessions	-1	-0.10	-3	**-1.17***	0	0.14
41. Severely depressed mothers will not have the motivation for Baby TP	0	0.12	-4	**-1.39***	1	0.26
22. Baby TP is "preachy"	-6	-2.12	-4	-1.42	-3	-0.74
70. Baby TP shouldn't get in the way of other MBU work	0	0.13	-4	**-1.60***	2	0.46
68. It is important that Baby TP only takes a small amount of staff time	-2	-0.55	-5	**-1.79***	0	-0.09

(P<0.05; Asterisk (*) indicates significance at P<0.01)

Factor 3

Statement	Factor 1		Factor 2		Factor 3	
	Rank	Z Score	Rank	Z Score	Rank	Z Score
31. It is important for mothers to feel that they have achieved something	2	0.58	2	0.55	6	**2.23***
47. It is important that Baby TP engages with the current situation	3	0.83	1	0.48	5	**1.80***

Statement	Factor 1		Factor 2		Factor 3	
	Rank	Z Score	Rank	Z Score	Rank	Z Score
48. It is important that mothers have a positive attitude towards recovery	-2	-0.57	1	0.38	5	**1.77***
88. Baby TP needs to be based on common-sense	-2	-0.40	-2	-0.60	4	**1.26***
9. It is important that Baby TP will be flexible to cope with unplanned events	0	0.10	-1	-0.35	3	0.94
52. It is important that Baby TP is easy for mothers to do	0	-0.08	-1	-0.06	2	0.72
13. It is important for staff to be able to answer questions about Baby TP	0	-0.07	-2	-0.49	2	0.66
24. A trusting relationship with the Baby TP therapist is important	6	2.29	6	1.54	1	**0.29***
6. Baby TP needs to fit with the mothers mental health	5	1.41	5	1.41	1	**0.20***
33. It is OK for Baby TP to be challenging for mothers	-3	-1.21	4	1.14	0	**0.20***
49. Taking part in Baby TP will be a positive experience	3	1.08	3	1.01	0	0.20
73. It is important that Baby TP highlights the importance of the mother's self-care	6	1.76	5	1.38	-1	-0.14*
62. Staff need support and training to feel confident in Baby TP skills	5	1.49	2	0.60	-1	-0.26
82. All staff should support what is done in Baby TP	2	0.56	0	0.31	-1	-0.37
78. Practical materials are essential	0	0.13	2	0.79	-2	-0.57
22. Baby TP is "preachy"	-6	-2.12	-4	-1.42	-3	-0.74
63. All staff should have the same training in Baby TP skills	0	0.16	2	0.63	-3	**-0.92***
17. It is important that all staff know which mothers are using Baby TP	-1	-0.17	-1	-0.10	-3	-0.97
26. If the relationship between the Baby TP facilitator and mother is not working neither will Baby TP	4	1.33	0	0.14	-4	**-1.46***
69. Baby TP should be a priority on the MBU	-2	-0.43	2	0.65	-5	**-1.72**

(P<0.05; Asterisk (*) indicates significance at P<0.01)

Appendix 24. Staff Participant Correlation Matrix

Sorts	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	-	32	55	40	37	42	39	27	54	45	39	52	42	34	59	57
2		-	43	28	40	54	16	5	42	39	44	37	33	38	27	22
3			-	43	37	53	31	34	48	48	60	58	55	55	59	54
4				-	38	32	22	16	54	31	46	43	40	33	55	33
5					-	48	31	16	41	35	34	55	37	28	33	39
6						-	21	10	41	48	37	45	43	42	36	34
7							-	28	27	16	17	16	27	29	39	30
8								-	25	31	24	27	34	29	39	39
9									-	61	54	60	31	34	53	38
10										-	42	44	30	42	37	35
11											-	49	32	42	51	22
12												-	45	43	54	49
13													-	35	53	55
14														-	44	25
15															-	61
16																-

Appendix 25. Staff Factor Loadings

Participant	Factor 1	Factor 2
1	0.4352	0.5646X
2	0.6483X	0.0925
3	0.5791X	0.5320
4	0.4787X	0.3393
5	0.5471X	0.2602
6	0.6248X	0.2386
7	0.1617	0.4382X
8	0.1172	0.4934X
9	0.7014X	0.2856
10	0.6046X	0.2534
11	0.6182X	0.2565
12	0.6290X	0.3818
13	0.3453	0.5650X
14	0.4662X	0.3495
15	0.4097	0.6864X
16	0.2140	0.7745X

Appendix 26. Staff Factor 1 Array

Disagree | Neutral | Agree

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
28	22	20	5	16	4	2	1	7	3	6	24	47
44	53	29	12	37	8	9	10	17	34	13	25	62
51	79	32	50	42	23	21	11	19	55	18	31	84
	14	65	67	59	26	33	15	38	60	30	57	
		75	68	66	27	43	39	40	74	45		
			70	69	35	46	41	48	81			
			80	72	36	61	49	54	85			
				78	52	71	63	58				
				88	56	73	64	83				
					82	77	76					
						86						
						87						

Staff Factor 2 Array

Disagree Neutral Agree

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
20	32	5	4	11	2	8	10	1	7	9	31	3
28	53	12	22	37	6	15	16	13	24	19	57	36
51	65	14	23	41	17	26	18	21	33	47	73	40
	75	44	29	59	27	35	25	30	54	76	74	
		56	45	70	52	38	46	34	61	77		
			50	81	66	39	48	42	62			
			68	86	72	43	49	58	78			
				87	80	55	64	67				
				88	82	60	71	69				
					85	63	83					
						79						
						84						

Appendix 27. Reflective Comments Factor 1

Statement	Reflective Comment
47(+6) It is important that Baby TP engages with the current situation	"I think basically it depends on how the mum is and her mental state because I think that has a big impact on how the mum interacts with her baby" "Again, I think that Baby Triple P needs to be individualised and it needs to take into consideration the background of the mother and her problems at present and how we can individualise this with the mum. I think it needs to be individual to that mum and that current situation rather than being generic and being rolled out to everyone" "If it doesn't engage with the current situation and it doesn't engage the mother, the mother has to be in agreement that it is going to work. It has to fit in with the mothers terms, her illness and the environment that she is from" "Because every mother is different and there are different situations so I think it is good to address what is going on with the illness so it can be more specialised care around the mother"
62 (+6) Staff need support and training to feel confident in delivering the Baby TP skills	"Yes, because not everyone feels confident in doing certain tasks or certain skills. Even I, being a nursery nurse, still get anxious and under confident sometimes, especially depending on certain mums and their illnesses. It can be quite challenging" "Mainly for the mothers so that there is continuity and we are not giving anything conflicting which is what happens generally. So if you are following a specific program then we all need to be confident that we are all saying the same thing"
84 (+6) It is important that staff understand why Baby TP works	"I think as we are responsible for patients we need to know what they are engaging in and what the successful attributes of that are so that we can support the study that is being done" "Well the thing is if you are encouraging something then you need to know that it is actually going to work. There is no point in saying "well you need to do this" but not knowing that it is going to be something that is of help to them really"
28 (-6) Doing Baby TP will make mothers feel like "bad parents"	"Because Baby TP is suppose to be a positive thing" "Baby TP wouldn't be here if that was the result of the study so no, that is contrary to what Baby TP is about" "It is about how it is explained, so that they are doing it because they are not bad parents x, y, and whatever. For a certain percentage of parents with mental health problems they could feel like they were being offered the Baby TP because they see themselves as a bad parent. So it is also about the choice of patient and their illness really"
44 (-6) Baby TP will use	"I think a lot of their energy will be guided towards their baby anyway. So if it could be done in a more relaxed situation

Statement	Reflective Comment
all the mothers energy and focus	but wouldn't feel that there was so much pressure being put on them. You know with things like "you need to do it this way, this way and this way". So I think it would be something that would start naturally and be apart of their everyday working" "I disagree with the "all" part of this statement. I don't think it would use all of the mothers energy and focus, again, if the mother understandably, depending on what illness she has got, it shouldn't use all of the energy and focus. I think that it should be Baby Triple P should be, at a time when mum is to a certain point in her illness when she can engage and concentrate for long periods. So again, I really disagreed with it using "all" of the energy, of course it will use some energy and obviously with focus and concentration"
51 (-6) There is no opportunity to practice Baby TP skills on the mother and baby unit	"There is always opportunity" "Parenting skills are ongoing on the MBU so there is plenty of opportunity to practice on a day-to-day, hour-by-hour basis" "I think there is always a chance to practice any skills whilst they are here because ultimately we want them to be as independent as possible with their baby. So we would be, whether it was our advise or somebody else advise, if we all worked from the same thing then there would be able to practice those skills" "I think I disagreed with this one because on a personal level I have not had any opportunity to find out what Baby Triple P is and I have not had any training in it so I am unable to practice the skills" "We practice positive parenting all the time on the unit and this just reinforces what we do"

Appendix 28. Factor 2 Reflective Comments

Statement	Reflective Comment
3 (+6) The skills taught in Baby TP need to generalise	"The mothers are not just going to be parenting within a MBU environment and therefore they need to be able to use those skills to areas and other situations outside of the unit" "I don't know much about it but that was what I do understand about it in that it supports parenting skills and how to cope with being a new parent. So you would that is exactly what this system is" "I think it is like with many talking or psychological therapies, if you can only do it in the session or in a particular situation and you cannot translate it into your everyday life it would not be very useful"
36 (+6) Baby TP will help develop skills that can deal with family problems	
40 (+6) Baby TP will be helpful for mothers to meet their parenting needs	"I think that you would be hoping that they would be able to take these skills and use them in the community so it is not just about coping whilst they are in hospital but also with life in general" "I understand this is about meeting their needs to parent. Erm, I think that is the whole aim of the intervention that you improve their parenting, what they need to improve their parenting"
20(-6) If the mother has unchangeable situations at home Baby TP is not going to be helpful	"I suppose some of that goes back into reflection because I think if you are with the mum and you are doing things with the mum you are reflecting on what you are doing and how situations happen and how you can do things. I think if you know your patient any problems they have got at home you will be bringing them is not any conversation. You know if they have got a problem at home I would hope that anything that we would be doing would be able to use it at home. So they should be able to take something that they have done here and without knowing they will be using at home" "On the contrary, it is probably going to be very helpful if they have got difficulties at home there are certainly changes that she could make herself with her interaction with her child regardless of what is happening at home"
28 (-6) Doing Baby TP will make mothers feel like "bad parents"	"It is not aimed to make people feel like they have done anything wrong in any way. I completely disagree" "Its opening their eyes that could happen and maybe they may be doing something that could lead to, could be seen as being bad, but if it is explained to mum the right way, you sort of give her time to see for herself. I believe that she will come around to your way of thinking and how you speak to her and how you explain. If it is explained right it can be rectified" "I think it is the way that it is taught and my experience with people who have done the Baby TP program is that they are not made to feel like bad parents if anything they kind of pick out what they are doing well and say that they are going to build on that and that the skills create more opportunities to parent well"
51 (-6) There is no opportunity to practice Baby TP skills on the mother and baby unit	"I think that probably a lot of our practice, we do practice skills from Baby TP not realising that they are skills used in the Baby TP program. So I think we probably do it already but not knowing to a certain degree"

Appendix 29. Distinguishing Statements, Rank and Z-Scores

Statement	Factor 1		Factor 2	
	Rank	Z Score	Rank	Z Score
84 It is important that staff understand why Baby TP works	6	1.91*	0	0.03
62 Staff need support and training to feel confident in delivering the Baby TP skills	6	1.74*	3	0.78
25 One-to-one work will make it easier for mothers to say when they find Baby TP difficult	5	1.33*	1	0.46
18 It is important that the mother thinks Baby TP is worthwhile	4	1.28*	1	0.41
6 Baby TP needs to fit with the mothers' mental health	4	1.17*	-1	-0.13
45 It is important that the Baby TP therapist works with both mother and baby	4	1.14*	-3	-0.88
81 It is important for all staff on the MBU to have a clear role within Baby TP	3	1.07*	-2	-0.57
85 Mothers being able to make choices in Baby TP is important	3	1.04*	-1	-0.02
60 Staff need to think about what parts of the Baby TP would be helpful for mothers	3	1.01*	0	0.04
3 The skills taught in Baby TP need to generalise to environments other than the MBU	3	0.93*	6	2.02
40 Baby TP will be helpful for mothers to meet their parenting needs	2	0.80*	6	1.93
17 It is important that all staff know which mothers are using the Baby TP techniques	2	0.78*	-1	-0.30
38 It is important that mothers feel in control and responsible for Baby TP	2	0.72*	0	0.05
41 If a mother is severely depressed, they will not have the motivation to do Baby TP	1	0.50*	-2	-0.34
11 Staff rolling out Baby TP need to have a thorough knowledge about mother and baby	1	0.47*	-2	-0.62
61 It is important to encourage staff to reflect	0	0.12*	3	0.80

Statement	Factor 1		Factor 2	
	Rank	Z Score	Rank	Z Score
77 Mothers want factual information about parenting	0	0.08*	4	1.19
33 It is OK for Baby TP to be challenging for mothers	0	0.03*	3	0.82
9 Baby TP will be flexible to cope with unplanned events	0	0.02*	4	1.04
73 It is important Baby TP will highlight the importance of mothers looking after themselves	0	-0.06*	5	1.63
56 It is important that Baby TP does not go against what mothers already know	-1	-0.29*	-4	-1.63
4 When mothers are unwell, Baby TP will be intolerable	-1	-0.38*	-3	-1.15
36 Baby TP will help develop skills that can help deal with family problems	-1	-0.44*	6	1.78
16 The techniques of Baby TP flow through to the staff on the MBU	-2	-0.54*	1	0.41
69 Baby TP should be a priority for the MBU	-2	-0.59*	2	0.68
42 Whilst staying on the MBU it is easy for mothers to commit to Baby TP	-2	-0.62*	2	0.56
78 Practical materials are essential	-2	-0.72*	3	0.80
12 Baby TP will make women's anxieties about their ability to parent worse	-3	-0.88*	-4	-1.55
67 Baby TP should not have too much paperwork for staff to do	-3	-1.03*	2	0.72
80 The Baby TP therapist needs to really sell the programme to mothers	-3	-1.23*	-1	-0.29
79 Baby TP comes at the wrong time	-5	-1.63*	0	0.08
44 Baby TP will use all the mothers energy and focus	-6	-2.28*	-4	-1.41

***Indicates significance at $p<0.01$**

Appendix 30. Research Ethics Committee Amendment Approval

National Research Ethics Service

NRES Committee North West - Greater Manchester North
3rd Floor, Barlow House
4 Minshull Street
Manchester
M1 3DZ
Tel: 0161 625 7817
Fax: 0161 625 7299
Email: nrescommittee.northwest-gmnorth@nhs.net

Miss Hannah Lisa Butler
Trainee Clinical Psychologist
University of Manchester
Division of Clinical Psychology
2nd Floor, Zochonis Building
Brunswick Street
M13 9PL

31 January 2013

Dear Miss Butler

Study title:	**The Acceptability and Feasibility of Baby Triple P Positive Parenting Programme on a Mother and Baby Unit: Q Methodology with Mothers with Severe Mental Illness and Staff**
REC reference:	**11/NW/0716**
Amendment number:	**1**
Amendment date:	**23 January 2013**
IRAS project ID:	**89005**

The above amendment was reviewed by the Sub-Committee in correspondence.

- Changes to the Protocol and Participant Information sheet

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter	1	19 January 2013
Protocol	2	21 December 2012
Participant Information Sheet	2	18 December 2012
Sponsor authorisation	Email	23 January 2013
Notice of Substantial Amendment (non-CTIMPs)	1	23 January 2013

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

11/NW/0716:	**Please quote this number on all correspondence**

Yours sincerely

PP **Dr Peter Klimiuk**
Chair

This letter has been signed electronically. If you require a wet ink version please request one from the Committee Co-ordinator by email and it will be sent in the post.

Enclosures: List of names and professions of members who took part in the review

Copy to: Catherine Barrow, Research Office, University of Manchester
catherine.barrow@manchester.ac.uk

Andy Mee, Manchester Mental Health and Social Care Trust
Andy.Mee@mhsc.nhs.uk

NRES Committee North West - Greater Manchester North

Attendance at Sub-Committee of the REC meeting on 31 January 2013

Name	*Profession*	*Capacity*
Mr Ken Cook (Vice Chair)	Acute Care Manager (Retired)	Expert
Dr Peter Klimiuk (Chair)	Consultant Rheumatologist	Expert

Appendix 31. Research and Development Amendment Approval

MANCHESTER CITY COUNCIL

Manchester Mental Health NHS and Social Care Trust

Submission Point for Electronic Approval of Research

Research & Innovation Office
Manchester Mental Health & Social Care Trust
3rd Floor
Rawnsley Building
Manchester Royal Infirmary
Hathersage Road
Manchester
M13 9WL
t 0161 276 3311

11th February 2013

Miss Hannah Butler
University of Manchester
School of Psychological Sciences
2nd Floor Zochonis Building
Brunswick Street
M13 9PL

Dear *Hannah,*

Re: (Substantial) Amendment 1

Project Reference: 1091
Project Title : *The Acceptability and Feasibility of Baby Triple P Positive Parenting Programme on a Mother and Baby Unit: Q Methodology with Mothers with Severe Mental Illness and Staff*
REC Ref Number: 11/NW/0716

We have noted (**SUBSTANTIAL**) Amendment **NO.1** (as detailed in REC approval letter dated 31/01/2013) and have no objections to this.

This letter is simply to confirm our ongoing R&I approval for the study.

Please note when contacting the R&I office about your study you must always provide the project reference numbers provided above.

All conditions from your original approval letter still apply.

May I wish you continued success with your research.

Yours sincerely

Dr. Andy Mee
MMHSCT Research & Innovation Manager

cc : Research Governance Sponsor – University of Manchester
Supervisor: Dr. Anja Wittkowski

Together we are better

A partnership between the NHS and Manchester City Council