Exploring the barriers to the implementation of cognitive behavioural therapy for psychosis (CBTp)

Fiona Switzer, Sean Harper and David Peck

Abstract

Purpose – The purpose of this paper is to identify barriers for people with psychotic spectrum disorders accessing CBTp in NHS Lothian. Despite national guidelines recommending CBT for the treatment of schizophrenia (National Institute for Health and Care Excellence Guidelines 2014) and (Scottish Intercollegiate Guidelines Network Guidelines 2013), levels of access to CBTp remain low. The overall goal of the study is to uncover emergent themes regarding barriers to access to CBT for patients with psychosis. In addition, the influence of psychosocial skills intervention (PSI) training for psychosis (Brooker and Brabban, 2006) will be explored and if completion of this training effects referral behaviours and attitudes to CBTp.

Design/methodology/approach – This study is a quantitative service evaluation project which uses a questionnaire design to explore the factors that influence a clinician’s decision to refer a patient for CBTp. Three qualitative questions are included for thematic analysis to allow the respondents to elaborate on their views on potential barriers. All appropriate Community Mental Health Team (CMHT) staff in adult mental health in NHS Lothian were invited to participate in the study.

Findings – CMHT staff in NHS Lothian hold favourable views of CBTp and would support an increase in access for patients with psychosis. Key barriers to access for CBTp identified in this study comprise of, little or no access to CBTp, lack of integration of services and unclear referral pathways. Further themes emerging from the study also included, improving multi-disciplinary communication and increasing CMHT staff knowledge and confidence in CBTp. PSI training was shown to have a significant effect on referral rates. Further research would be warranted to explore the influence of PSI training on CMHT staff confidence and knowledge in CBTp.

Originality/value – This is the first paper of its kind to investigate the potential barriers to access to CBTp in Scotland. The paper has highlighted some key barriers and potential strategies to overcome the barriers identified will be discussed.

Keywords Access, Psychosis, Cognitive behavioural therapy, CBTp, Psychosocial intervention training

Paper type Research paper

Introduction

This study is a quantitative service evaluation project exploring factors that influence a clinician’s decision to refer a patient for CBTp with three qualitative questions included for thematic analysis. Richardson and Oldershaw (2011) carried out a similar study in a London Community Mental Health Team (CMHT) for adults with mental health issues. The questionnaire they developed explored factors that might influence the implementation of the NICE (2014) guideline regarding access to psychological therapies for patients with schizophrenia. Permission was given from the authors to adapt this questionnaire in NHS Lothian to compare population and emergent themes. The questionnaire was refined with regard to the latest literature on access to psychological therapies for people with a diagnosis of schizophrenia or psychosis. It was then piloted to a group of mental health team staff, in NHS Lothian, to identify any ambiguous or misleading questions and participants were asked to help identify any local issues the questionnaire should explore. The questionnaire was then distributed to all members of the

Fiona Switzer is based at Psychological Therapies Department, NHS Lothian, Haddington, UK and Queen Margaret University Edinburgh, Musselburgh, UK.

Sean Harper is based at the South of Scotland CBT Course, NHS Lothian, Haddington, UK and Queen Margaret University Edinburgh, Musselburgh, UK.

David Peck is Professor at the Faculty of Medicine and Health Sciences, University of East Anglia, Norwich, UK.
CMHT in NHS Lothian (around 100 invited participants.) The results were analysed to establish emergent themes and barriers to access to CBTp within NHS Lothian. Results were then compared with the wider UK literature on access to CBTp.

The authors work in a Psychological Therapies Team in NHS Lothian which provides psychological therapies to the CMHT’s patients, including offering CBT for patients with a diagnosis of psychosis or schizophrenia. As the authors are known to some of the participants the possibility of acquiescence bias was considered. The authors sought to ameliorate this risk by ensuring the anonymity of the questionnaire.

Literature review

Cognitive behavioural therapy for psychosis is recommended in the NICE (2014) guidelines for patients who are at risk of developing psychosis, during first or subsequent episodes of psychosis or during the recovery period for those with persistent symptoms. SIGN (2013) guidelines recommend CBTp for those who have not responded to an anti-psychotic medication and have residual symptoms. The NICE (2017) surveillance report on the Psychosis and Schizophrenia guideline (NICE, 2014) supported the initial findings from the 2014 guideline with the addition that there seemed to be limited evidence for the efficacy of CBT on negative symptoms and that individual CBTp seemed to be significantly more effective than CBT delivered in a group.

NICE (2014) carried out a meta-analysis for CBTp which included 31 RCTs. The meta-analysis demonstrated moderate effect sizes and National Institute for Health and Care Excellence concluded that CBT was better than treatment as usual in decreasing rehospitalisation (Turkington et al., 2006), reducing rates of depression (Penn et al., 2009; Garety et al., 2008) and improving social functioning (Startup et al., 2004). Key RCTs concluded that CBTp should be considered to reduce positive symptoms (Sensky et al., 2000; Wykes et al., 2008; Tarrier et al., 1998) and improve negative symptoms (Rector et al., 2003; Gould et al., 2001). The evidence base does have its detractors who argue that the effect sizes for CBTp tend to be small to moderate and that the lack of homogeneity in approach and target problem brings the quality of the CBTp research into question (Jauhar et al., 2014; Wykes et al., 2008; Zimmermann et al., 2005; Jones et al., 2012; Sivec and Montesano, 2012; Lynch et al., 2010). The NICE (2014) guideline noted within their meta-analysis of 31 RCTs, there was a wide variance in the target phase of the illness across the studies (first episode of psychosis, acute episode or recovery phase); further limitations posited in the guideline was the variance in session number (ranging from 4–156 sessions), the type of control group and the length of treatment. Nevertheless, Tarrier and Wykes (2004) noted that although the effect sizes for CBTp are small, this should be understood in the context of the severity of the disorder and that, in fact, around 30–40 per cent of those diagnosed with schizophrenia will continue to experience distressing symptoms despite taking medication (Cannon and Jones, 1996). It is also important to note that a significant number of patients are non-compliant with medication; in the largest trial of this kind, Lieberman et al. (2005) found that 74 per cent of patients with schizophrenia chose to discontinue their medication.

Despite CBT for schizophrenia being part of UK national guidelines since 2002, many studies across the UK indicate that implementation of this guideline is extremely variable. It should be noted, however, that much of the research in this area has tended to be small-scale audit or service evaluation projects. This literature review identified three national audits exploring the implementation of CBTp (Healthcare Commission, 2007; The Scottish Schizophrenia Survey Larkin and Simpson, 2014 and The National Audit of Schizophrenia carried out by the Royal College of Psychiatrists, 2012), eight local service evaluation audits (Prytys et al., 2011; Richardson and Oldershaw, 2011; Hartigan and Ranger, 2014; Currell et al., 2016; Haddock et al., 2014; Kingdon and Kirshen, 2006; Pawel et al., 2012; Lewis et al., 2012), one paper on the development and implementation of the guideline (Pilling and Price, 2006), one narrative literature review (Corrigan et al., 2001) and one systematic review (Ince et al., 2016.) The National Audit of Schizophrenia carried out by the Royal College of Psychiatrists (2012) demonstrated that only 34 per cent of people being treated for schizophrenia had been offered a psychological therapy. The Healthcare Commission and the Commission for Social Care Inspection Report
(2007) indicated that, across all mental health trusts in England in 2005–2006, an average of 46 per cent of people had received CBTp, although the figures ranged from 20 to 90 per cent. Hartigan and Ranger (2014) demonstrated in their local service audit that only 33.5 per cent of service users in their study were referred for CBTp and only 12 per cent of the sample actually received CBTp. Haddock et al. (2014) in their service evaluation project in the North West of England showed that only 6.9 per cent of the service users with a diagnosis of schizophrenia were offered CBTp and this figure was further reduced when they examined patients who actually received CBTp (5.3 per cent). Kingdon and Kirschen (2006) highlighted, in their Southhampton audit, that even in areas where CBTp is readily available, only half of all patients were deemed appropriate for referral.

Van der Gaag et al. (2014), Pilling and Price (2006) and Corrigan et al. (2001) identified lack of an implementation infrastructure and shortage of appropriately trained staff as key barriers to increasing access to CBT for people with psychosis. Hartigan and Ranger (2014) identified some key barriers in their study regarding CMHT staff attitudes to CBTp: staff pessimism about the efficacy of CBTp; a lack of awareness of the utility of CBTp; and a lack of confidence in discussing CBTp with patients, all seemed to be significant factors when considering a referral for CBTp. In addition, a focus on biological treatments and the belief that certain patients were unsuitable for psychological therapy prevented referral for CBTp (Pryty et al., 2011; Richardson and Oldershaw, 2011; Currell et al., 2016). These smaller scales and service evaluation audits seem to concur with the national survey and more recent systematic reviews that suggest limited access to CBTp across the country. Ince, Haddock and Tai in their 2016, systematic review, found rates of implementation of CBTp across the UK varying from 0 to 100 per cent and suggest it is extremely difficult to estimate an accurate figure. There was a clear lack of distinction across the studies if CBTp had been offered, delivered or received with some studies, suggesting CBTp was “offered” if the patient received a leaflet on CBTp (Pawel et al., 2012) or “received” if the patient attended one session (Healthcare Commission, 2007; Lewis et al., 2012).

The Scottish Schizophrenia Survey (Larkin and Simpson, 2014) indicated that only 23 per cent of people with lived experience of schizophrenia reported access to CBT, although 96 per cent were offered medication and 65 per cent were involved with a CMHT (Larkin and Simpson, 2014). A key target of The Scottish Government (2017) is that there should be no unwarranted variation across the country and no lower levels of access to psychological therapies for people who are already receiving other forms of mental healthcare. A particular focus in this strategy is to ensure early access to treatment for people with a first episode of psychosis in accordance with SIGN (2013) guidelines and that access to recommended psychological therapies for psychosis such as CBT and family intervention should be timely and equitable across Scotland.

Aims and objectives

The aim of the study is to explore potential barriers for people with psychotic spectrum disorders in NHS Lothian accessing CBTp. The study investigated attitudinal factors among staff in the CMHTs in NHS Lothian and audited any links between referral behaviour and questionnaire responses, in order to identify potential barriers. The influence of psychosocial skills intervention (PSI) training for psychosis was explored and if completion of this training effected referral behaviours and attitudes to CBTp. PSI training is a CBT informed training for CMHT staff to improve psychological well-being for patients with psychosis (Brooker and Brabban, 2006) which has been delivered across NHS Lothian to around 80 staff in the CMHTs.

Methodology

Study design

The study design was chosen to allow for both quantitative and qualitative participant responses. The author adapted an existing questionnaire design to maximise participation, to poll the widest range of attitudes and to ensure the sample size was sufficient for statistical power. Moreover, the additional open questions provided the opportunity to give qualitative responses to allow further potential themes to emerge that may have been overlooked by the questionnaire design.
There are a number of strengths and weaknesses when using a questionnaire design: the anonymity it allows may result in more honest answers and can reduce interviewer bias; however, if questions are misunderstood, then there is no opportunity to correct this (Coolican, 2009). The standardisation of the questions can reduce another potential source of bias but if the questionnaire has been poorly developed, misunderstandings can increase. Gillham (2007) argues that many of these weaknesses can be offset by the rigorous design and development of the questionnaire; rigour can be enhanced by utilising current literature and piloting the questionnaire prior to its final distribution. An established questionnaire was chosen and piloted in order to take account of the local context and mitigate for potential weaknesses in the questionnaire design. Open-ended questions were included to allow for more detailed feedback.

Questionnaire design

All CMHT staff in adult mental health services in NHS Lothian, who were in a position to refer to a psychological therapies service (PTS), were invited to take part in the study, even if there was no CBTp available in their area. Approximately, 100 CMHT staff were identified and 59 questionnaires were completed. Respondents were from a variety of professional backgrounds, including psychiatrists, community psychiatric nurses, OTs, physiotherapists, clinical psychologists/psychological therapists and social workers (Figure 1).

The questionnaire was distributed to all appropriate staff members in the seven CMHTs across NHS Lothian (Figure 2) using an anonymously coded, computerised survey via e-mail. Optional paper copies were available and a small number of these were completed.

The questionnaire was adapted from the Richardson and Oldershaw (2011) questionnaire and was piloted to a small group of mental health staff to identify any ambiguous or misleading questions and to help identify any local issues the study should explore. Three questions were removed from the original questionnaire which was specific to the South London and Maudsley NHS Foundation Trust, 10 Point Charter (Prytys et al., 2011). An additional question was added regarding PSI for psychosis which has been delivered across NHS Lothian. The questionnaire asked if the respondent had completed PSI training and asked about the number of referrals they had made in the previous two years for CBTp.

Two additional questions were added in line with key themes emerging from recent literature on access to CBTp and asked participants to state how strongly they agreed or disagreed with the following statements: Q3: “Psychosis is primarily a biological disorder” (Prytys et al., 2011; Richardson and Oldershaw, 2011; Lewis et al., 2012; Braehler and Harper, 2008)) and Q17: “There are staff in my area trained in CBTp that are unable to practice this approach” (Van der Gaag et al., 2014; Pilling and Price, 2006; Corrigan et al., 2001). Q17 allowed participants to give further comments on this question should they wish to do so with a free text box. The remaining questions from the Richardson and Oldershaw (2011) study were retained after the questionnaire pilot and covered four key themes which included: general view on value of CBTp, confidence in knowledge
and ability to discuss CBTp with clients, communication and referral pathways and general service provision. The questions were scored on a five-point Likert scale and two open-ended (free text) questions were retained from the original study to allow for more detailed feedback.

**Ethical considerations**

Participants were informed that completing the questionnaire was entirely voluntary and that they could freely refuse to take part, refuse to answer particular questions or withdraw at any time. Respondents were informed that the questionnaire was fully anonymised and any information collected would be held in an NHS Lothian secure drive and would be destroyed when the project was complete.

**Inclusion criteria**

To be included in the study, participants were to be employed in a CMHT in NHS Lothian and were to be in a position to refer clients with a diagnosis of schizophrenia or a psychotic spectrum disorder for CBTp, even if there was no CBTp service in their area. All appropriate CMHT staff were invited to take part in the study and this included occupational therapists, psychiatrists, community psychiatric nurses, social workers, psychological therapists and psychologists.

**Exclusion criteria**

- not employed in an adult CMHT;
- unable to refer to a PTS; and
- no professional qualification.

**Statistical analysis**

**Quantitative methods**

Chi square and Fisher’s exact test (two-tailed) Exact p-values were sought to examine associations between responses, PSI training and referral rate (Table I). In order to counteract for multiple analyses, Holm’s method was applied to the Fisher p-values to control for Type 1 errors (Wright, 1992).

**Qualitative methods**

The open-ended responses were analysed using thematic analysis and a second independent rater applied the coding framework to analyse the data and draw independent conclusions (Dempster and Hanna, 2012).
Results

Quantitative findings

Respondents to the questionnaire were positive in their general view on the benefits of CBTp with 81 per cent responding that CBTp was a useful addition to their service (Figure 3) and 88 per cent believing that people with psychosis benefit from CBT (Figure 4), only 10 per cent of respondents felt that CBT was not beneficial to the clients they had referred and 55 per cent agreed that CBTp supported them in their work with psychotic patients in the CMHT. In total, 23 per cent of the sample believed that psychosis was primarily a biological disorder.

Figure 3  CBT for psychosis is a useful addition to our service
In the domain of confidence: 51 per cent of respondents felt that they had enough information on CBTp and 46 per cent felt clear about who to refer for CBTp, 56 per cent felt confident discussing CBTp with clients and only 15 per cent found that it was difficult to encourage clients to see the benefit of CBTp. Regarding communication and referral pathways: 54 per cent of respondents stated that they knew who to contact to discuss a referral, 60 per cent felt that it was helpful to discuss a referral with a clinical psychologist or psychological therapist; however, 47 per cent agreed that they would like more communication with the PTS while their clients are in therapy. The final domain area explored views on service provision: 64 per cent supported the view that psychological therapies needed to improve its provision of CBTp and 72 per cent felt that PTS could be of more help with CMHT clients with psychosis. Only 4 per cent of respondents believed that there to be staff trained in CBTp who were unable to practice.

Initial analyses indicated that the data in relation to the ratings and to referral rate were highly skewed. This prohibited the use of $\chi^2$ as expected frequencies were too low. Accordingly, the data were dichotomised into “Strongly agree” and “Agree” vs “Neutral”, “Disagree” and “Strongly disagree”, and Fisher’s exact test was used instead (see e.g. Figure 3). The Holm method to correct for type 1 errors arising from multiple analyses was carried out on all the Fisher’s $p$-values. The question “On average I feel psychological interventions for psychosis have benefitted the clients I have referred” produced a significant $p$-value of 0.005. This finding seems unsurprising; if a CMHT staff member has found CBTp to be beneficial for a patient, then it would seem logical that they might generate a higher referral rate. Thus, the completion of PSI training could have a positive influence on staff referral rates for CBTp. After correcting using the Holm method, no further questions achieved a significant association. However, two questions were close to significance and would warrant further examination with a larger sample size. In the Richardson and Oldershaw (2011) study (which did not incorporate adjustments for multiple testing), the question “I know whom to contact to discuss a referral for CBTp” was significantly associated with referral rate ($p < 0.05$); in this study, the association was also significant at 0.015 but lost significance after the Holm correction (Table II). One further association with referral rate was almost significant ($p = 0.053$) and would warrant further exploration: “I feel confident about discussing CBTp with my clients”.

**Qualitative finding/thematic analysis**

In total, 30 out of the 59 respondents answered the open-ended questions but provided 79 comments in total to the three open-ended questions. Content analysis by the researcher and an independent rater resulted in a coding framework of four key themes with nine sub-themes. The four key themes were: limits to provision, increase awareness, training issues and integration of services.
Limits to provision. A key theme emerging from the analysis was limits to service provision for CBT for this patient group, resulting in three sub-themes: low or no access in some areas, long waiting times and widening access. A number of respondents commented that they had no service provision for CBTp in their area with 20 per cent of respondents stating that they had no service in their area (Figure 5) or have very limited service provision: “Extend provision of service as currently none in my area”. “To my knowledge, there are no specific psychological treatments offered to people with psychosis in my area”. “I have difficulty accessing any psychology for those with severe and enduring illness […] and have been told on many occasions a service does not exist”. “As I am aware, at this present time there is no provision for this in […] So it would be helpful to have session in this locality”.

Other respondents complained of long wait times “A reduction in waiting times would be helpful but this would entail increasing the number of therapists available” and “long waiting times currently”.

The third sub-theme emerging from “limits to provision” was the desire of some respondents to widen access to CBTp to particular groups of patients. Some respondents were keen to see CBTp expand into some specialist areas such as inpatient care, older adults or early intervention services: “taking into account the importance of early intervention with recent onset” “would benefit inpatients to start work prior to discharge. Come and visit patients on the ward to explain CBTp when alerted that the patient is well enough to do so” and “There is no service for folk who are over 65. The psychology service needs to expand its training of nurses in CBTp and end use of age as an access criterion”.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits to provision</td>
<td>Low or no access</td>
</tr>
<tr>
<td></td>
<td>Long waiting times</td>
</tr>
<tr>
<td></td>
<td>Widening access to a range of specialist areas</td>
</tr>
<tr>
<td>Increasing awareness</td>
<td>Advertising</td>
</tr>
<tr>
<td></td>
<td>Clearer referral pathways</td>
</tr>
<tr>
<td>Training issues</td>
<td>Limited staff with appropriate training</td>
</tr>
<tr>
<td></td>
<td>Barriers to use of skills</td>
</tr>
<tr>
<td>Integration of services</td>
<td>Potential benefits of closer working/integration</td>
</tr>
<tr>
<td></td>
<td>Communication between staff</td>
</tr>
</tbody>
</table>

Limits to provision.
Increase awareness. Where there was a service available, respondents noted the need to increase awareness of the availability of CBTp and this emerged as a second important theme, with two sub-themes identified as advertising and clearer referral pathways. Greater awareness through advertising was frequently noted in the comments: “Advertise the service for psychosis more”, “More awareness of existing services given to staff” and “Could improve access to therapy by promoting awareness of CBTp”.

The need to provide clearer referral pathways to improve access for patients was an additional theme: “To communicate this availability more widely with contacts to facilitate communication and joined up services for clients wherever they may stay in Lothian”, “Having specific pathways for psychosis referral” and “more info on how to access this with appropriate referral criteria”.

Training issues. The third key theme was identified as particular to training issues with two sub-themes “limited staff with appropriate training” and “barriers to use of skills”. The respondents described the limited number of staff who could provide this therapy to this patient group with frequent calls for more staff to be trained: “Need to train more therapists in CBTp”, “To provide psychological therapists or psychologists or CPN’s who are able to provide this locally” and “By increasing the number of therapists providing CBT for psychosis”.

In those areas where staff were trained, respondents noted that certain barriers such as waiting time targets (Psychological Therapies HEAT Target, 2014) or the extra MDT time involved with psychosis cases as a barrier to making use of CBTp skills: “I think that perhaps some people who are trained or interested may be under pressure to achieve numbers for A12 (Psychological Therapies HEAT Target, 2014) and therefore have to prioritise time for attending other supervision”. “My manager could recognise that psychosis cases can take more of my time than most other cases (e.g. more prep, more supervision, more MDT (multi-disciplinary team) communication and allow me to adjust my time allocation accordingly”.

Integration of services. Greater integration of services seemed to be a fourth theme with two further sub-themes. The importance of closer working relationships and improved communication between psychological therapy services and CMHTs was mentioned by a number of respondents. Many respondents highlighted the potential benefits of closer working or integration of services: “By embedding practitioners in current MDTs, not as a floating, rather separate service”, “Inreach to CMHT teams” and “More Psychology time allocated to CMHT please”.

More frequent and better quality communication between staff was mentioned by a number of respondents as a way to improve access: “Close working between professionals and recognition of overlap in CBT work between keyworker and psychologist/nurse therapist helps engagement of the client into therapy” and “MDT discussions. Participation in team formulations”.

Discussion

This service evaluation project set out to explore some of the potential barriers for people with a psychotic spectrum disorder accessing CBT in NHS Lothian. It was encouraging to discover that overall CBTp has a high level of regard amongst the staff who responded to the questionnaire with 81 per cent agreeing that CBTp is a useful addition to their service and 88 per cent believing that CBT is beneficial to patients with psychotic symptoms. This is in contrast to some previous studies that highlighted much a more pessimistic view of psychological therapies for this patient group amongst CMHT staff (Hartigan and Ranger, 2014; Prytys et al., 2011). This positive view of CBTp is reflected in the thematic analysis with frequent calls for increased provision of CBTp and increased number of staff to be trained in CBTp. This is further supported by the statistical analysis which provided a significant correlation between the statement “On average I feel psychological interventions for psychosis have benefitted the clients I have referred” and a higher rate of referral. Unsurprisingly, if CMHT staff feel that the clients they have referred have benefitted from CBTp, they are more likely to refer and more likely to have a positive view of the intervention.

Another interesting finding of this study was that only 4 per cent of respondents believed that there to be staff trained in CBTp in their area that were unable to practise. This is contradictory to
recent literature which identified some staff trained in CBTp were not being supported to practise and that a lack of protected time for CBTp was a key barrier to access (Jolley et al., 2012, 2015; The Schizophrenia Commission, 2012; Poole and Grant, 2005). Nevertheless, this is somewhat inconsistent with some of the qualitative feedback, where respondents highlighted a lack of support from managers or the focus on waiting time targets as a potential barrier to access for CBTp in NHS Lothian (Psychological Therapies HEAT Target, 2014.)

This view is supported in the wider literature on access to psychological therapies for patients with severe and enduring mental health issues. The We Need to Talk Coalition (2013) argues that ensuring greater access to psychological therapies for those with more severe mental health conditions will be problematic unless, there is targeted governmental backing and funding to support a national roll out, as was the case for the increasing access to psychological therapies programme for mild to moderate mental health problems (Layard et al., 2006).

Moreover, some authors have argued that given the complex and stigmatising nature of psychotic disorders, this is a patient group who face additional barriers in accessing services and may need further support to get the recommended treatment they require (Byrne and Morrison, 2010; Rathod et al., 2010). Whilst timely provision of psychological therapies, to those with mild to moderate mental health issues, is an important target for the NHS to pursue, it would seem essential that those with more complex problems are not overlooked. It would also seem important that those managing services for those with more complex mental health issues are aware that staff working psychologically with this patient group may require more time to allow for longer term work, supervision and MDT working.

Prytys et al. (2011), Braehler and Harper (2008) and Lewis et al. (2012) observed in their studies that a model of care that is overly focussed on the biological model of psychosis can adversely impact on access to CBTp for patients in a CMHT. However, the overwhelmingly positive response of the role of CBTp in CMHTs in NHS Lothian and the low number of respondents reporting a view that psychosis is primarily a biological disorder (23 per cent) would suggest that this study does not support this finding from previous studies.

Lack of service provision seems to be a key barrier to access in this study and is reflected across many UK studies (We Need to Talk Coalition, 2013; Williams, 2008; Schizophrenia Commission, 2012). In this study, 64 per cent of respondents felt that PTS should improve their provision to this patient group. Many respondents highlighted a total absence of any psychological provision for psychotic patients in their area (20 per cent) and many others cited very limited provision. Respondent’s qualitative responses reflect the view of some national surveys (We Need to Talk Coalition, 2013; Schizophrenia Commission, 2012), which highlight the concern that the current focus on NHS targets for psychological therapy for mild to moderate mental health issues (Psychological Therapies HEAT Target, 2014) could have a detrimental impact on services for those patients with more complex mental health problems.

Limitations in communication and referral pathways were recognised with only 54 per cent of the sample, stating that they knew who to contact to make a referral for CBTp. Richardson and Oldershaw (2011) were able to demonstrate a significant effect on referral rate when referrers were clear about who to refer to ($p < 0.05$) and in this study the question comes close to significance at 0.0149 but lost significance when correcting for type 1 errors. Clear referral pathways seem to be a key strategy in trying to improve access for patients. It is clear from the thematic analysis, respondents would like to have an increased awareness of CBTp with only 51 per cent of respondents feeling that they had enough information on CBTp and only 46 per cent felt clear about who to refer for CBTp. Strategies to raise awareness and increase knowledge of CMHT staff should be further explored. Nevertheless, some studies have highlighted concerns that when psychologists/psychological therapists are involved in awareness raising this can reduce the time available for direct patient work (Richardson and Oldershaw, 2011).

The fourth key theme to emerge from the thematic analysis was the potential benefits of closer working between PTS and CMHTs with one respondent suggesting, “[…] embedding
practitioners in current MDTs (multi-disciplinary team), not as a floating, rather separate service”. This is supported by recent literature that suggests that CMHT and PTS services often do not work in a well-integrated way (Lewis et al., 2012; Braehler and Harper, 2008). It may be that as psychological therapy services have been separated from CMHTs, the close working MDT relationships may have been compromised. Good quality MDT working can provide informal opportunities for awareness raising, sharing psychologically informed approaches, team formulation and need not necessarily impact on the level of direct patient contact. The separation of services may have contributed to CMHT staff feeling less aware of what is available and who CBTp may be best suited for.

Richardson and Oldershaw (2011) were able to show a significant effect, \( p < 0.05 \), that an increase in staff confidence and knowledge of CBTp reflected in a higher referral rate. Unfortunately, this study was unable to demonstrate a significant effect here; however, “I feel confident about discussing CBTp with my clients” in relation to higher referral rate produced a close to a significant \( p \)-value of 0.0531. This is supported by many other studies that suggest when staff have a good understanding of CBTp and feel confident in discussing CBTp with their patients, they are much more likely to refer and support their patients in accessing CBTp (Williams, 2008; Lewis et al., 2012; Braehler and Harper, 2008).

PSI training’s association to a higher referral rate produced a significant \( p \)-value of 0.005. In this study, only 17 out of the 59 respondents had completed PSI training (Brooker and Brabban, 2006). As a CBT informed approach, it has the potential to increase the awareness and knowledge base of CBT approaches with psychotic patients and its impact on confidence and referral rate warrants further research with a larger sample size of CMHT staff who have complete this training.

**Limitations**

This study is somewhat limited by the relatively small sample size and the proportion of staff declining to complete the questionnaire (41 per cent). Of those who responded there is a risk of self-selection bias as those less supportive of CBTp may have chosen not to complete the questionnaire. Indeed, a further limitation of this study is the high level of positive regard for CBTp within the sample, with only 10 per cent of respondents suggesting that CBTp did not benefit their clients; therefore, any conclusions should be treated with caution. As the author is known to some of the respondents, there was the possibility of acquiescence bias; however, the authors sought to ameliorate this risk by ensuring the anonymity of the questionnaire.

**Future research**

The value of PSI training, as a potential means of increasing psychological awareness and increasing confidence in CMHT staff, could warrant further research in Lothian. The impact of waiting time targets on services for those with more complex or severe mental health issues would be a further area for future research.

**Conclusions and recommendations**

The results of this study highlight the difficulties that services face in trying to provide good quality and equitable access to CBT for people with psychotic spectrum disorders, when services are struggling with limited resources and limited staff with appropriate training. This study indicates that CMHT staff, in NHS Lothian, are supportive of an increase in access to CBTp; however, a lack of services or very low provision of services makes it very difficult for the SIGN (2013) guideline to be fully implemented. In addition to this, the separation of services may have impacted on the ability of teams to facilitate close MDT working, which may, in turn, impact on awareness and confidence levels amongst staff. Closer MDT working or a closer integration of services may have a beneficial effect on these areas (Table III).


Table III  Responses to questions

<table>
<thead>
<tr>
<th>Question (abbreviated)</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CBTp useful addition to our service</td>
<td>28</td>
<td>20</td>
<td>10</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2. People with psychosis benefit from CBT</td>
<td>19</td>
<td>31</td>
<td>8</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. Psychosis is primarily a biological disorder</td>
<td>5</td>
<td>8</td>
<td>25</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>4. I have enough info on CBTp</td>
<td>9</td>
<td>20</td>
<td>10</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>5. I know who to contact to refer for CBTp</td>
<td>9</td>
<td>21</td>
<td>5</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>6. I feel clear about who to refer for CBTp</td>
<td>5</td>
<td>21</td>
<td>14</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>7. I have found it helpful to discuss psychosis cases with PTS</td>
<td>17</td>
<td>16</td>
<td>18</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>8. I would like more communication with PTS</td>
<td>8</td>
<td>18</td>
<td>31</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>9. On average CBTp has helped those I have referred</td>
<td>4</td>
<td>18</td>
<td>31</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>10. I feel confident discussing CBTp with my clients</td>
<td>8</td>
<td>24</td>
<td>18</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>11. My clients may have doubts about being referred for CBTp</td>
<td>1</td>
<td>18</td>
<td>32</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>12. I feel it difficult to encourage clients to CBTp</td>
<td>2</td>
<td>7</td>
<td>29</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>13. Being able to offer CBTp supports me in the CMHT</td>
<td>11</td>
<td>21</td>
<td>24</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>14. CMHT practice should be developed in line with SIGN guidelines</td>
<td>23</td>
<td>31</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15. Offering CBTp in the CMHT makes my job more complicated</td>
<td>0</td>
<td>2</td>
<td>15</td>
<td>31</td>
<td>11</td>
</tr>
<tr>
<td>16. PTS needs to improve its provision of CBTp</td>
<td>16</td>
<td>21</td>
<td>19</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>17. There are staff in my area unable to practice CBTp</td>
<td>0</td>
<td>2</td>
<td>46</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>21. Have you completed PSI</td>
<td>Yes = 17</td>
<td>No = 42</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you referred a client in the past 2 years?</td>
<td>Yes = 20</td>
<td>No = 27</td>
<td>No service = 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of referrals</td>
<td>0 = 39</td>
<td>1–4 = 17</td>
<td>5–10 = 2</td>
<td>10+ = 1</td>
<td></td>
</tr>
</tbody>
</table>

References


Psychological Therapies HEAT Target (2014), Information Services Division Scotland (ISD), NHS.


We Need to Talk Coalition (2013), “We still need to talk report: a report on access to talking therapies”, We Need to Talk Coalition.


Corresponding author
Fiona Switzer can be contacted at: Fswitzer@nhs.net

For instructions on how to order reprints of this article, please visit our website: www.emeraldgrouppublishing.com/licensing/reprints.htm
Or contact us for further details: permissions@emeraldinsight.com