Implementing the NICE Guideline for Schizophrenia Recommendations for Psychological Therapies: A Qualitative Analysis of the Attitudes of CMHT Staff

M. Prytys, P. A. Garety, S. Jolley, J. Onwumere and T. Craig*
Institute of Psychiatry, Kings College, London, UK

Objectives. Despite national guidelines recommending cognitive–behavioural therapy (CBT) and family intervention (FI) in the treatment of schizophrenia, levels of implementation in routine care remain low. The present study investigates attitudinal factors amongst community mental health team (CMHT) staff affecting guideline implementation.

Design. CMHTs were audited to measure the capacity and delivery of CBT and FI, and semi-structured interviews were conducted with staff from the teams.

Methods. Four CMHTs were audited, and five care coordinators from each team were interviewed. A purposive approach to sampling was used to represent the range of professional training of care coordinating staff. Data were analysed using thematic content analysis.

Results. Positive views towards guidelines were evident, although tempered by specific implementation issues. Employing simple psychological interventions and approaches as part of the care coordinating role also emerged as highly valued by staff. Severe workload, time pressure and the need for specialist staff were crucial barriers to implementation. Pessimistic views of recovery for clients with psychosis were also apparent and may affect implementation.

Conclusions. Staff attitudes and knowledge are an important area of research when examining guideline implementation and require further study. Key themes that have emerged could inform future training agendas and should be considered when developing guideline implementation strategies for the updated 2009 guidelines. Copyright © 2010 John Wiley & Sons, Ltd.

*Correspondence to: Tom K. J. Craig, Professor Social Psychiatry Box 33, HSPRD, Institute of Psychiatry, De Crespigny Park, London SE5 8AF, UK.
E-mail: t.craig@iop.kcl.ac.uk

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INTRODUCTION

In 2002, the National Institute for Clinical Excellence (NICE) published its first clinical guideline, providing evidence-based recommendations for the care and treatment of adults with schizophrenia. The NICE guideline was produced on the basis of an extensive review of evidence for psychological treatments for schizophrenia (NICE, 2002) and contains 69 recommendations of which 14 are concerned with psychological interventions (Pilling & Price, 2006). Family intervention (FI) and cognitive–behavioural therapy (CBT) for psychosis are recommended as first-line treatments for those with a schizophrenia spectrum diagnosis and persisting positive symptoms or who are at risk of relapse (NICE, 2002). More recently, an updated version of the NICE guideline for schizophrenia (NICE, 2009) has been published which continues to recommend both CBT and FI for schizophrenia.

There is a substantial body of research examining the efficacy of both CBT and FI for psychosis (Pilling et al., 2002; Tarrier, 2005; Wykes, Steel, Everitt, & Tarrier, 2008). Evidence supports the efficacy of CBT in reducing positive symptoms, and there is some evidence for reduction in depression and improvement in functioning, although less for its role in reducing relapse (Garety et al., 2008; Tarrier, 2005). FIs have been found to reduce relapse and hospitalizations and lead to improvement in the social adjustment of the patients and an overall reduction in psychopathology at follow-up (Pfammatter, Junghan, & Brenner, 2006).

Clinical guidelines have the potential to improve care for patients by promoting the routine provision of evidence-based treatments. However, the success of such guidelines depends on the effectiveness of the strategies that are employed in their dissemination and implementation. Furthermore, the costs these strategies incur may outweigh their potential benefits to patients. Evidence-based and cost-effective dissemination and implementation strategies are thus essential for ensuring that clinical guidelines translate into improvements in care.

Extensive research has been conducted examining the efficacy of interventions supporting guideline implementation in health care; however, the evidence base has significant limitations. Grimshaw et al. (2004) conducted a comprehensive systematic review of 235 studies of guideline dissemination and implementation strategies in health care. They found that reminders, the most commonly evaluated single intervention, produced moderate improvements and that educational outreach produced modest improvements. Other interventions, such as the dissemination of educational materials, audit and feedback, produced modest to moderate improvements in care, although on the basis of fewer evaluations and with many studies found to have methodological weaknesses. Multi-faceted interventions have also been found to be effective but potentially more costly (Wensing, Van der Weijden, & Grol, 1998). As there are few replications of specific multifaceted interventions, only tentative conclusions can be drawn regarding their comparative efficacy (Grimshaw et al., 2004).

Guideline implementation and care improvement strategies in the treatment of depression have been examined in some detail. Katon et al. (1995, 1999) found that collaborative care, incorporating

Key Practitioner Message:

- There continues to be limited access to psychological therapies for those with a diagnosis of schizophrenia—barriers relate to staff attitudes and knowledge as well as training, resources and organization of services.
- A rolling programme of training is required to ensure all clinical staff have a broad understanding of recommended psychological therapies and are competent to discuss these interventions with patients and carers.
- Services require access to staff with both the appropriate competencies and dedicated time to deliver CBT for psychosis and FI and ongoing supervision of this work.
- Services should regularly and objectively audit eligibility for interventions and offers, uptake and outcome of therapy.

Keywords: Schizophrenia, Guideline, Implementation, Attitudes, CBT, FI
patient education and intensified care programmes, was effective in improving patient outcomes and reducing costs. The involvement of nurses in case management, including brief medication counselling (Peveler, George, Kinmonth, & Thompson, 1999) or psychosocial support over the telephone (Hunkeler et al., 2000) is also effective, as is incorporating more intensive case management as the central intervention (Rost, Nutting, Smith, Werner, & Duan, 2001). However, a systematic review of educational and organizational interventions to improve management of depression in primary care (Gilbody, Whitty, Grimshaw, & Thomas, 2003) found that simple educational strategies or the passive dissemination of guidelines had little effect on care. In order to be successful, guideline implementation and educational interventions, such as clinician and patient education and nurse case management, needed to be accompanied by strategies for effecting complex organizational change.

The implementation of the NICE recommendations regarding psychological therapies in schizophrenia is challenging; demand for psychological therapies far outstrips supply, there is a shortage in trained therapists and the systems for training and ensuring therapist competence are underdeveloped (Pilling & Price, 2006). Furthermore, neither the funding nor systems are in place for the delivery of psychological interventions.

Currently, provision of FIs for psychosis in the National Health Service (NHS) is limited, despite the evidence base stretching back over two decades. Despite some success with team-based training approaches and flagship training programmes, there remain organizational factors impeding the dissemination and implementation of FIs, such as lack of support for training, clinical services being overwhelmed with change and the absence of systematic data collection (Fadden, 2006, 2007, 2009; Leggatt, 2007; Smith and Velleman, 2002). CBT has been found to have a low priority in mental health services, with little time allocated to CBT interventions in a case management approach where the emphasis tends to be placed on generic tasks at the expense of ‘extra’ psychosocial interventions (Farhall & Cotton, 2002). Additionally, biological models of psychosis still influence staff members’ attitudes against incorporating psychological intervention in routine practice (Fowler, Garety, & Kuipers, 1998).

The knowledge and attitudes of mental health staff are argued to be crucial to the move from efficacy to effectiveness of evidence-based psychological interventions (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Fowler et al., 1998; Jones, 2002; Spidel, Lecomte, & Leclerc, 2006).

In a review of the evidence regarding the implementation of the NICE guideline for psychological therapies for schizophrenia, Berry and Haddock (2008) highlight the lack of research into the barriers to implementation. They report finding very few such studies pertaining to FI since 2002, and none for CBT. This indicates a strong need for clarification of the barriers to implementation post-NICE in order to guide future decisions about how to support and encourage implementation of the 2009 guideline update.

In the current paper, we report an audit of the provision and delivery of CBT and FI in community mental health teams (CMHTs). We also present findings from semi-structured qualitative interviews conducted with care coordinators in these teams during the follow-up phase of a guideline implementation project carried out in a large mental health Trust in London. The NICE Guideline for Schizophrenia Implementation and Evaluation Project was started in 2003 and involved developing audit criteria and conducting the audit, examining capacity and need for psychological therapies in community teams across the Trust. Ongoing analysis of the audit information as it was gathered and the identification of likely obstacles to implementation from the literature led to an implementation plan being drawn up, based around a ‘10-point charter’ for team leaders (Figure 1), which sets out the elements considered necessary to improve access to evidence-based psychological interventions in psychosis.

Later implementation work aimed to help teams meet the requirements set out in the 10-point charter and included developing reliable information systems, developing teams’ awareness and understanding psychological interventions for psychosis and promoting the delivery of high-standard CBT and FI and evaluating this. An initial target for delivery of 10% of the eligible caseload for CBT and 5% of the eligible caseload for FI per year was set.

The interviews reported in this paper aimed to investigate the factors affecting the implementation of the NICE guideline for CBT and FI for schizophrenia. They were intended to elicit themes and patterns in staff attitudes and knowledge expressed in a confidential setting where participants were able to discuss sensitive matters openly. Furthermore, it was hoped that the findings would help generate hypotheses for future research in this area.
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IMPLEMENTING THE NICE SCHIZOPHRENIA GUIDELINES
A TEN POINT CHARTER FOR TEAM LEADERS

1. Keep a case register of clients by diagnosis
2. Ensure case register is updated regularly with information on persistent symptoms and relapse and that it holds information on carers
3. Ensure information for service users and carers on psychological interventions and choice of medication is readily available in the team
4. Identify team lead for Psychological Interventions
5. Ensure team has a system to review, at least 6 monthly, all clients and to offer Psychological Interventions by agreed criteria
6. Ensure all team members are knowledgeable about a psychosocial understanding of psychosis; know the criteria for CBT and FI; are competent to discuss these psychological interventions with clients and carers; are competent to discuss choice of medication; and facilitate this occurring through supervision
7. Ensure the team has at least one WTE staff member competent to offer CBT; aim to ensure capacity at minimum 10% of team caseload - a full-time CBT practitioner has capacity for 15 clients (and may be able to support others in providing therapy)
8. Ensure there is also capacity in the team for FI on a sessional basis (5 active FIs will be 10% of most CMHTs caseloads)
9. Monitor outcomes (at a minimum relapse and psychotic and affective symptoms) at least six monthly
10. Ensure clinical supervision is in place from within the team, the directorate or from SL&M NICE implementation support

Figure 1. Ten-point charter

METHOD

Design

Four CMHTs were audited regarding need and capacity to deliver CBT and FI for psychosis as part of a large-scale guideline implementation and evaluation project. Qualitative interviews were conducted with five care coordinators from each team and analysed using thematic content analysis methodology. Thematic content analysis (Bauer, 2000) of the respondents’ comments was used to identify common themes, and quotations illustrating these themes are presented in this paper.

Participants

Twenty care coordinators from four CMHTs involved in the implementation study were the participants. A minimum sample size of 12 is suggested as sufficient for achieving theoretical saturation when looking at shared beliefs, perceptions and behaviours amongst a relatively homogenous group (Guest, Bunce, & Johnson, 2006). In this case, the group consisted of mental health professionals working as care coordinators in one NHS mental health Trust in London. Eligible participants were permanent members of the teams (i.e., not locum or temporary posts) and who had been working as care coordinators in their team during the implementation intervention. From this pool, purposive sampling was used to select care coordinators from nursing, social work and occupational therapy professions. Having explained the study at a team meeting, the researcher approached five care coordinators in each team based on availability for interview and eligibility according to the criteria outlined above. There were no other exclusion criteria and no refusals for taking part. Of the 20 participants, 11 were nurses, 6 social workers, and 3 occupational therapists, reflecting the relative balance of these professional groupings. The mean length of time working in the team was 6.3 years, and the mean caseload size was 24 clients (for 1.0 whole time equivalent).

Procedure

A researcher (M.P.) attended one of the regular team meetings and explained the study to the team...
before selecting and approaching participants who were eligible. Each participant was informed of the study’s purpose—to investigate their experiences of the implementation of the NICE schizophrenia guideline in their team, their knowledge of the guideline with particular relation to psychological interventions and their views on the schizophrenia guideline in particular and clinical practice guidelines in general. Written information sheets were provided, and participants gave informed consent, including consent for any quotations from interviews to be used as long as data were made anonymous. Interviews lasted between 25 and 60 minutes and were taped (two refused to be taped—notes were used), and literal transcription was undertaken by the interviewer. A paid full time researcher, not employed by the Trust (MP—psychology graduate) conducted all the research described in this study, with the support of the implementation evaluation research team. The study had ethical approval from the local ethics department (South London and Maudsley and Institute of Psychiatry Joint Ethics committee 063/04).

The Interview Timetable

Interviews questions were devised through discussion within the implementation evaluation research team and based on key themes from existing literature and the experiences of the team. Questions were open ended and designed to elicit reflections from care coordinators on the following areas:

- Attitudes to course of illness, functioning, well-being and recovery from psychosis (example question: What is your understanding of the outcomes of people with a diagnosis of schizophrenia?)
- Perception of the role of care coordinator for clients with psychosis (example question: How do you work with clients with a diagnosis of schizophrenia?)
- The nature and role of psychological interventions for psychosis (example question: How would you prioritize which service users are offered therapy?)
- Knowledge of the recommendations for psychological interventions in the NICE schizophrenia guideline (example question: Have you heard of the schizophrenia guideline produced by NICE? If yes, are you aware of the recommendations regarding psychological therapies? Can you tell me what they are?)
- Implementation barriers and promoters (example question: What are your views about clinical practice guidelines such as the NICE guideline for schizophrenia?)

METHODOLOGICAL QUALITY

The coding frame was developed through an iterative process involving a senior member of the research team (TC) and the researcher (MP) who coded the transcripts using the interview topic guide as a framework. Regular meetings took place throughout this process for discussion and to reach consensus on code definitions and disagreements in coding, as well as to assess inter-coder reliability. Forty-three codes were developed in total. These were grouped in sub-themes under nine broad categories, which largely follow the five expected areas of interest targeted in the topic guide (with the addition of attitudes to guidelines, dissemination, reasons for referral/non-referral and the intervention). Quotations were selected on the basis of providing succinct examples of the central themes.

An independent rater classified randomly selected quotations for each code. Inter-rater reliability was calculated using Cohen’s kappa \((k)\). Landis and Koch’s (1977) system of classification for strength of agreement was used for the interpretation of the current results. The overall \(k\) value was 0.69, equalling substantial strength of agreement.

RESULTS

Teams

The four teams sampled had caseloads of between 18 and 26 per care coordinator on average. All are based in deprived urban areas. The percentages of eligible clients offered CBT varied widely between the teams (7%–20%), and this was similar for FI (4%–28%). Further details of each team are provided in Table 1.

Care Coordinators

Of the 20 CMHT care coordinators interviewed, 11 were nurses, 6 social workers and 3 occupational therapists. All were experienced community mental health professionals with a minimum of 4 years post-qualification experience (and a minimum of 1 year working in the current team). Several had undertaken additional training including one participant who had trained in group work (nurse),
Implementing the NICE Guideline for Schizophrenia

Table 1. Team audit data at follow-up

<table>
<thead>
<tr>
<th>Team</th>
<th>Team 1</th>
<th>Team 2</th>
<th>Team 3</th>
<th>Team 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total team caseload</td>
<td>215</td>
<td>161</td>
<td>241</td>
<td>274</td>
</tr>
<tr>
<td>No. of care coordinators</td>
<td>8</td>
<td>4</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Nurses</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>OT</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Social worker</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Psychology provision in team</td>
<td>0.6 WTE clinical psychologist 98 (46)</td>
<td>0.6 WTE clinical psychologist 61 (38)</td>
<td>0.2 WTE clinical psychologist 168 (70)</td>
<td>0.7 WTE clinical psychologist 161 (59)</td>
</tr>
<tr>
<td>No. of clients with SSD (% of total caseload)</td>
<td>19 (19)</td>
<td>4 (7)</td>
<td>16 (10)</td>
<td>33 (20)</td>
</tr>
<tr>
<td>No. offered CBT for psychosis in the last 2 years (%)</td>
<td>47 (47)</td>
<td>32 (52)</td>
<td>67 (40)</td>
<td>85 (53)</td>
</tr>
<tr>
<td>No. of clients with family contact (% of those with SSD)</td>
<td>2 (4)</td>
<td>9 (28)</td>
<td>5 (7)</td>
<td>5 (6)</td>
</tr>
<tr>
<td>No. offered FI for psychosis in the last 2 years (% of those with family contact)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WTE = whole time equivalent.

Table 2. Care coordinators participating in interviews by profession

<table>
<thead>
<tr>
<th>Profession</th>
<th>Gender</th>
<th>Mean length of time in team (range)</th>
<th>Mean caseload (for 1.0 WTE)</th>
<th>CBT trained for any disorder</th>
<th>FI training (including Thorn)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse (n = 11)</td>
<td>9 female, 2 male</td>
<td>6.9 (range 1–15)</td>
<td>26 (range 22–30)</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Social worker (n = 6)</td>
<td>4 female, 2 male</td>
<td>6.4 (range 2–13)</td>
<td>23 (range 17–25)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>OT (n = 3)</td>
<td>3 female, 0 male</td>
<td>3.5 (range 3–4.5)</td>
<td>22 (range 17–25)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total (n = 20)</td>
<td>16 female, 4 male</td>
<td>6.3 (range: 1–15)</td>
<td>24 (range 17–30)</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

another who had a diploma in psychodynamic counselling (nurse), one who had a post-graduate diploma in CBT for depression (social worker) and one who had attended a systematic family therapy course (Occupational Therapy (OT)). We were particularly interested in whether participants had received any training in CBT or FI. For the purposes of the study, CBT or FI training was defined as a course of study of at least 3 months’ duration designed to equip the person with some skills in therapy delivery, even if these were limited to technique-based interventions. Training ranged from Thorn type to more extensive courses, designed to equip the person to practice formal CBT interventions. We relied on the self-report of the individual care coordinator to assess training. Very few participants had completed even this modest exposure to relevant training. Two nurses had started but not completed a Thorn course in psychosocial interventions for severe mental illness, two (10%) participants (one social worker and one OT) met our criteria for having trained in CBT for psychosis and only four (20%—two nurses and two social workers) had completed training relevant to FI (including Thorn). Further details are reported in Table 2.

Knowledge of Recommendations for and Referral Criteria in NICE Guideline

Of the 20 care coordinators who participated in this study, 12 knew that both CBT and FI are psychological interventions recommended by the NICE guideline, 6 knew only that CBT is recommended and 2 did not know which interventions are recommended. Fourteen were not able to articulate the Trust agreed referral criteria for CBT or FI. Three knew the referral criteria for both FI and CBT. Two knew the referral criteria for CBT only, and one knew the referral criteria for FI only.

KEY THEMES

1. Understanding and beliefs about psychosis
   a. Beliefs about treatment for psychosis
      I mean, they have to be on their medication obviously. Most of mine are taking medication, and if they don’t take their medication it

(therapy) is not going to work. All of them are taking medication.

A central theme that emerged from the data was the combined role of medication and talking therapy in treating service users with psychosis, which was raised by 10 participants. Medication was described as an essential aspect of treatment, stabilizing symptoms before talking therapies could be considered. Of the 10 participants, 2 felt that medication did not address the root cause of service users’ problems and that these could be targeted through talking therapies. One participant expressed the view that medication does not work for all service users, so talking therapies would provide an alternative option for treatment. Eight participants viewed medication alone as the essential prerequisite to achieving a positive outcome.

b. Expectations of clients with psychosis

What I have seen is that people find it quite hard to sustain. So there is pattern of them achieving some difference and making relationships, but then also that not being sustained in the long term and leading to them needing to have support again a few months or a year down the line.

A pessimistic view of individuals with a diagnosis of schizophrenia as being chronically ill and requiring ongoing long-term support emerged from the data. Eight care coordinators referred to clients as revolving door patients, making small improvements but then deteriorating again and having repeated admissions to the hospital. This was often seen as being related to service users’ lack of motivation. In particular, negative expectations of service users’ ability to achieve social and occupational goals were expressed by eight participants. Service users were described as predominantly single, isolated and unable to gain employment. Four care coordinators demonstrated positive attitudes to social and occupational outcomes. These referred to the possibility of developing meaningful relationships, working towards training and employment and being employed.

c. Views of recovery in psychosis

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 can be chronic and disabling and could stand in the way of 100% recovery.

Individual variation in outcome was emphasized by eight care coordinators. Amongst these, a number mentioned service users who were doing well and had made significant progress, referring to protective factors assisting their recovery. One care coordinator was ambivalent about service users’ capacity for recovery.

2. Beliefs about and attitudes to clinical guidelines and psychological therapies

a. Positive attitudes to clinical guidelines

Positive attitudes to clinical guidelines emerged as a key theme from the data with 17 care coordinators expressing this. Sub-themes that emerged include the perception of guidelines as providing direction to staff, helping to prioritize interventions, increasing professionalism and improving quality of care. Four expressed positive perceptions of clinical guidelines in the context of their basis in research.

b. Doubts about relevance and applicability of clinical guidelines

Well you know, the bodies that produce these guidelines and it can feel like, you know, something we need to know about but do they really know what it is like down on the ground level where we are struggling to just manage the vast number of people on the caseload and get them monitored and everything.

Another central theme, expressed by six care coordinators, was doubts over the relevance and realism of clinical guidelines. This included concerns regarding implementing recommendations in routine practice with time constraints and competing demands cited as persistent challenges. The need to think about individual service user needs was also raised. One care coordinator questioned the experience and understanding of routine practice of those writing the guidelines, and another questioned the research evidence on which guidelines are based.

c. Views about psychological therapy for psychosis

I have had a couple of people who have seen the psychologists and done some specific work and I think it has helped them maybe move on a little bit.
one of my clients received some CBT . . . and he, I think that whilst it was going on he seemed to be benefiting from it, but now I am not sure anymore.

There was a mixture of views about the NICE schizophrenia guideline recommendations regarding psychological therapies for psychosis. Seven care coordinators had positive views about CBT and FI for psychosis, identifying examples of service users who had benefited. Conversely, a theme that emerged and was referred to by six care coordinators was a tentative belief that CBT and FI are not effective for people with schizophrenia. This was related to participants’ experiences of working with service users who had received therapy and either had not benefited or improvements had not been sustained in the long term. Four demonstrated ambivalent views towards the recommendations, highlighting both pros and cons of psychological interventions. This included a concern that CBT might be seen a panacea rather than part of a holistic package of treatment and additionally that those who benefit from talking therapies would tend to be from the higher functioning, less symptomatic end of the psychosis spectrum.

3. Views on the role of the care coordinator
   a. Care coordinators using psychological interventions

   I mean we are all aware of CBT techniques I think, and a lot of us try and use them anyway in the work we do with clients.

   Using simple psychological interventions and approaches emerged as an important theme in care coordinators’ perception of their role, referred to by 13 of the 20 participants. Psycho-education, relapse prevention and anxiety and stress management were posited as interventions that were valued, could be usefully offered and were routinely implemented by care coordinators.

   b. Other aspects of the care coordinator role.

   Providing practical support in areas such as housing, benefits and referrals to other services emerged as an integral aspect of the role and was commented on by eight participants. Also emerging as a central theme was the importance of a supportive, collaborative relationship with service users. Seven participants referred to this aspect of their role, highlighting engagement and gaining trust, listening to service users’ needs and providing consistent contact and support. Five participants emphasized the key role of monitoring medication adherence and education about compliance, whilst four highlighted their role in monitoring service users’ mental state in relation to risk.

4. Factors affecting implementation
   a. Lack of time

   . . . we had this influx of, you know, a heavy caseload and the focus became more on keeping them stable, sort of, we are saying by, just compliance with medication and very little support.

   A key theme that emerged from the data was that severe workload pressure leading to lack of time was a barrier to care coordinator training in and then offering psychological interventions. This was raised by 16 of the 20 participants. Four of these referred to the time pressures, meaning that they did not have time to become familiar with the guidelines.

   b. Role confusion

   I think it just isn’t possible, I think you can’t underestimate the immense work, as care coordinator the level of responsibility and workload is very high. I think there also would be role confusion; you know, it would be very difficult slipping in and out of roles.

   The theme of role confusion emerged as a barrier to implementing training in psychological interventions for psychosis within the context of generic team roles and was mentioned by 10 participants. The difficulties experienced by care coordinators trained in CBT or FI to allocate time for implementing their skills acquired in training and to manage both the role of care coordinator and therapist was highlighted. This was referred to both by individuals who had relevant training and by those who were thinking about training or had noted problems with other staff implementing training.

   c. Need for specialist workers in teams

   Another important theme that emerged was the importance of having specialist workers in the team to offer a psychological intervention, which was commented on by 13 participants. Five referred to the beneficial effects of having specialist workers present in the team for easing referral for psychological therapies and communication regarding clients, whilst six referred to the lack of psychological therapists and communication regarding clients, whilst six referred to the lack of specialist workers in the team as a barrier to implementing the NICE guideline.
d. Service user refusal
If we feel that it will be helpful we discuss it with them, usually they say they will do it and then change their minds. It’s not something that clients, I don’t think they would ask for it, a lot of them have had it in the past and don’t want it again.

Service user refusal to consider CBT or FI for psychosis emerged from the data as a barrier to implementation and was cited by 10 participants. Within this, care coordinators described clients reporting they had tried talking therapy before and did not want it again, those who were unwilling to talk about the past and those who preferred to have minimum input from services.

e. Work pressure
I think that is the nature of mental health work and working within the NHS at the moment. It is pressured, it is difficult and I think whilst those targets are important it is important not to get away from the importance of our day to day clinical work.

The pressure of taking on many roles and high caseloads, together with the challenges of working with a difficult and chronic caseload, emerged as a central issue and was referred to by nine participants in the present study. This was linked to perceptions of the guidelines as adding to existing targets to be met by care coordinators.

f. Long waiting lists.
I am too frightened to tell them 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?

A further barrier to the implementation of the NICE guideline for schizophrenia that emerged from the data was the long waiting lists for psychological therapy, which was mentioned by nine participants. Three care coordinators described frustrations at the long wait between referral and the problem of clients’ situations changing.

DISCUSSION

Both the original 2002 NICE guideline (NICE, 2002) and the recently updated guideline (NICE, 2009) recommend the provision of FI and CBT for individuals with schizophrenia. As the results of the audit indicate, there continue to be large numbers of individuals who are not being offered psychological interventions. Although most care coordinators participating in this study were aware of NICE recommendations for psychological treatments, the majority did not know the Trust’s agreed referral criteria. It appears that staff knowledge and attitudes regarding evidence-based psychological therapies for psychosis present systemic barriers to the implementation of psychological therapies guidelines, impacting on the delivery of nationally recommended evidence-based treatments.

Two factors emerged as important when considering care coordinator attitudes towards clients with psychosis. First, pessimistic views of outcomes were common, with a focus on chronicity and poor functioning. Alongside this, an ambivalent attitude towards recovery was evident, with recovery-oriented attitudes countered by negative attitudes based on clinical experience. ‘Offering help, treatment and care in an atmosphere of hope and optimism’ is a crucial tenet of the NICE clinical guideline (Roberts & Wolfson, 2004). Negative attitudes towards service users’ potential for recovery may constitute a barrier to engagement and to the development of collaborative working relationships. Furthermore, care coordinators’ beliefs about whether clients were appropriate for referral for psychological therapy were often not based on research evidence. This has been suggested as disadvantaging certain groups for referral (Kingdon & Kirschen, 2006; Spidel et al., 2006).

The belief in the role of medication for treating psychotic symptoms is strongly emphasized in the present data, with psychological therapies seen as an adjunctive treatment. More biologically based models of psychosis present a barrier to the integration of psychological interventions for psychosis in routine practice (Fowler et al., 1998) and to the establishment of hope inspiring relationships (Roberts & Wolfson, 2004). The present data suggest psychological needs are seen as secondary and lend support to Braehler and Harper (2008), who found that the highly prevalent psychological needs of people with psychosis often remain unidentified or are viewed as lower priority than non-psychological needs. There is a clear need for the care of people with psychosis to move from an ethos of maintenance to prevention (Corrigan et al., 2001; Jones, 2002) with psychological approaches lying at the core of this.

Encouragingly, staff in the present study reported utilizing a variety of psychological techniques
when working with clients. Unlike previous findings (Braehler & Harper, 2008; Spidel et al., 2006), staff demonstrated a realistic view of the interventions they could offer within the boundaries of their own competencies. We attribute this in some part to the educational work conducted within the guideline implementation project, which highlighted definitions of therapy and clarified the staff competencies required to ensure psychological treatments are adequately delivered.

The routine implementation of formal psychological therapy for psychosis requires highly trained, specialist staff, and lack of skill within teams has been found to be a crucial barrier (Berry & Haddock, 2008). CMHT workers in this study frequently highlighted the lack of such provision, whilst accessibility of specialist staff, where it existed, was valued both for easing the referral process and for facilitating a psychological approach to psychosis within the team.

For those care coordinators with appropriate training, offering formal psychological interventions within care coordinating roles was extremely difficult, and all staff who had completed the appropriate training were no longer conducting therapy. This is in line with the literature on low rates of implementation of FI following training (Mairs & Bradshaw, 2005). Lack of protected time, heavy caseloads and role confusion were key factors preventing implementation of psychological interventions by those with relevant training. As in previous research (Farhall & Cotton, 2002), we found that psychosocial approaches tend to be sidelined when services are under pressure, in favour of other ‘essential tasks’. Stress, burnout and lack of time were raised as key issues preventing implementation of evidence-based interventions. These factors have been found to strongly affect the likelihood of staff implementing innovative interventions (Corrigan et al., 2001).

Various suggestions have been presented as to how the challenge of implementing psychosocial approaches in routine community settings should be met. Fowler et al. (1998) support the formation of specialist teams for such provision, whilst Thornicroft et al. (1999) advocate for the development of capacity within existing generic teams. It has been suggested that the positive consequences of developing such a specialist capacity within generic teams, in terms of improving work-related practices, attitudes towards clients and overall organizational factors, are great (Jones, 2002). Our data suggest that these issues have yet to be resolved (i.e., whether to develop specialist teams or to provide specialists within generic teams), and this uncertainty constitutes a substantial barrier to providing such interventions to individuals with psychosis being cared for in the community.

Positive views about clinical practice guidelines were widely expressed. However, doubts over the relevance and practicability of specific aspects of the NICE guideline recommendations were also frequent, and individuals who described guidelines as useful often reported that they did not implement recommendations in practice. These findings may be helpfully understood in the context of psychological theories of behaviour and behaviour change, which have been previously applied to the implementation intentions of health care professionals and mental health service users (Michie & Lester, 2005; Michie et al., 2007).

There are some limitations to the present study. The sample was drawn from one London-based NHS Trust, which may affect the generalizability of the themes and issues arising from the data. For example, Trusts based in urban areas tend to experience higher staff turnover and deal with increased rates of psychosis in comparison to suburban or rural areas. Additionally, the purposive sampling procedure employed in this study in order to gain views from different professionals who had been working in the team during the implementation project may have biased the data collected. Participants in this study may have had particularly cynical or enthusiastic viewpoints that may not be representative of other workers in the team. Finally, although every attempt was made to ensure the study was methodologically rigorous, the guideline implementation team and the evaluation team were closely linked, and this may have introduced some bias.

A stated reason for employing a qualitative approach in this study was to generate ideas for further research. A number of ideas have emerged from our findings. First, it would be desirable to replicate the emerging themes from this study in more extensive research, taking participants from a variety of locations, and therefore examining different approaches to implementation. Second, it may be of interest for future research to look at differences in views according to professional training background, particularly when considering differential training needs. Finally, an area of interest for future research would be a systematic investigation of the impact of implementation programmes on staff behaviour and to examine this in the context of the theory of planned behaviour.
To conclude, the present study illustrates that there continues to be limited access to psychological therapies for those with a diagnosis of schizophrenia. Barriers to implementing the NICE guideline regarding psychological interventions relate to staff attitudes and knowledge as well as training, resources and organization of services. To promote the implementation of the 2009 guideline update, further research, as well as training and implementation programmes systematically addressing these barriers, is required.

REFERENCES


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