Service users views of the barriers to ‘recovery’ from psychosis: A Q-Methodological Study.

Philippa Lawton

Thesis submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Doctorate in Clinical Psychology

April 2021

Total word count: 19,238 (excluding references and appendices)

Acknowledgements

Firstly, I would like to say thank you to my Academic Supervisor, Dr Helen Combes, who despite all the twists and turns of negotiating life and work in a global pandemic offered on-going support, encouragement and reassurance that all would be okay. I would also like to thank Dr Chris John, my Clinical Supervisor, although our initial plans for your input into my project never really came to fruition your advice and thoughts on the project have very much been appreciated.

I would also like to give a big thanks to my ‘QCrew’, without our WhatsApp chat I don’t think I would have made it through, your support and friendship has been invaluable! Similarly to the cohort of 2018, you have been wonderful and a great support.

To Peter Bullimore and his co-workers at the The National Paranoia Network, I can’t thank you enough for your input into the design and advertisement of the project given the changes that had to be made to my initial plans as a result of COVID-19. You’ve been such a great help.

To Phil, Dave and Mark, thank you for your advice and thoughts on how to ensure the project was relevant and useful to service users. Your ongoing support and feedback on the project has been irreplaceable. I am hugely appreciative and am so glad you were able to be involved. Finally, to the participants that took the time to complete the research, thank you! Without you this would not have been possible and I am sincerely grateful.

Table of Contents

[Thesis Abstract 1](#_Toc78360963)

[Paper 1: Literature Review. 2](#_Toc78360964)

[Barriers to recovery for people with serious mental health difficulties in the UK: A Literature Review 2](#_Toc78360965)

[Abstract 3](#_Toc78360966)

[Introduction 4](#_Toc78360967)

[The concept of Recovery 4](#_Toc78360968)

[Mental Health in the UK 4](#_Toc78360969)

[Aims/ Research Question 5](#_Toc78360970)

[Method 5](#_Toc78360971)

[Search terms & databases 5](#_Toc78360972)

[Inclusion and Exclusion Criteria 6](#_Toc78360973)

[Search Strategy 7](#_Toc78360974)

[Quality assessment 9](#_Toc78360975)

[Results 9](#_Toc78360976)

[General critique of key papers 15](#_Toc78360977)

[Synthesis of findings 19](#_Toc78360978)

[Discussion 23](#_Toc78360979)

[Limitations of the review 24](#_Toc78360980)

[Clinical implications 25](#_Toc78360981)

[Future research 26](#_Toc78360982)

[Conclusions 26](#_Toc78360983)

[References 27](#_Toc78360984)

[Appendices 32](#_Toc78360985)

[Appendix 1: British Journal of Clinical Psychology Author Guidelines 32](#_Toc78360986)

[Appendix 2: Critical Appraisal Skills Programme Qualitative Checklist 41](#_Toc78360987)

[Appendix 3: Critical Appraisal Skills Programme Randomised Controlled Trial Checklist 41](#_Toc78360988)

[Appendix 4: Quality Scores for articles reviewed 42](#_Toc78360989)

[Paper 2: Empirical Paper. 44](#_Toc78360990)

[Exploring the barriers to ‘recovery’ from psychosis as told by clients who experience psychosis using Q Methodology. 44](#_Toc78360991)

[Abstract 45](#_Toc78360992)

[Introduction 46](#_Toc78360993)

[Psychosis 46](#_Toc78360994)

[Recovery and Psychosis 46](#_Toc78360995)

[Gaps in Literature and Research Rationale 48](#_Toc78360996)

[Research Aims 48](#_Toc78360997)

[Method 49](#_Toc78360998)

[Ethics 49](#_Toc78360999)

[General overview of Q-Methodology 49](#_Toc78361000)

[Service user involvement 49](#_Toc78361001)

[Q-set design and content 50](#_Toc78361002)

[Participants 50](#_Toc78361003)

[Procedure 51](#_Toc78361004)

[Results 53](#_Toc78361005)

[Statistical Analysis 53](#_Toc78361006)

[Initial Analysis 53](#_Toc78361007)

[Interpretation 54](#_Toc78361008)

[Consensus Statements 61](#_Toc78361009)

[Discussion 62](#_Toc78361010)

[Summary of Findings 62](#_Toc78361011)

[Implications for Clinical Practice 64](#_Toc78361012)

[Methodological Considerations and Limitations 65](#_Toc78361013)

[Statement about impact of global pandemic 2019-2021 66](#_Toc78361014)

[Recommendations for Future Research 66](#_Toc78361015)

[Conclusion 66](#_Toc78361016)

[References 68](#_Toc78361017)

[Appendices 75](#_Toc78361018)

[Appendix 1 - British Journal of Clinical Psychology Author Guidelines 75](#_Toc78361019)

[Appendix 2 - Ethical Approval 84](#_Toc78361020)

[Appendix 3 - Amendment Approval 85](#_Toc78361021)

[Appendix 4 - Q set (List of Statements) 86](#_Toc78361022)

[Appendix 5 - Study Advert 88](#_Toc78361023)

[Appendix 6 - Participant Information Sheet 89](#_Toc78361024)

[Appendix 7 - Consent Form 92](#_Toc78361025)

[Appendix 8 - Demographic questions 93](#_Toc78361026)

[Appendix 9 - Post-Sort Questionnaire 95](#_Toc78361027)

[Appendix 10 - Debrief Sheet 96](#_Toc78361028)

[Appendix 11 - Correlations between Q sorts 97](#_Toc78361029)

[Appendix 12 - Varimax Rotation Factor Loadings 98](#_Toc78361030)

[Appendix 13 - Consensus statements 99](#_Toc78361031)

[Appendix 14 - Factor Arrays for Factor 1, 2, 3a & 3b 100](#_Toc78361032)

[Appendix 15 - Factor Array Grids 103](#_Toc78361033)

[Paper 3: Executive Summary 108](#_Toc78361034)

[Exploring the barriers to ‘recovery’ from psychosis as told by clients who experience psychosis using Q Methodology: Executive Summary. 108](#_Toc78361035)

[Introduction & Background 109](#_Toc78361036)

[Method 110](#_Toc78361037)

[Key findings 113](#_Toc78361038)

[Factor 1. Hopelessness for recovery. 113](#_Toc78361039)

[Factor 2. Interpersonal elements of care and feeling powerless. 113](#_Toc78361040)

[Factor 3. 114](#_Toc78361041)

[Conclusion 115](#_Toc78361042)

[Recommendations 116](#_Toc78361043)

[Limitations 116](#_Toc78361044)

[Statement about impact of global pandemic 2019-2021 116](#_Toc78361045)

[Dissemination 117](#_Toc78361046)

[References 118](#_Toc78361047)

List of Tables and Figures

[Table 1.1. Details of combined search terms used to search relevant databases. 6](#_Toc77543465)

[Table 1.2. Data extraction Table: Characteristics of Reviewed Articles 11](#_Toc77543466)

[Table 1.3. Qualitative CASP Scoring Sheet 42](#_Toc77543467)

[Table 1.4. Quantitative CASP Scoring Sheet 43](#_Toc77543468)

[Table 2.1 Participant demographic details 51](#_Toc77543469)

[Table 2.2. Initial PCA Factor Analysis 53](#_Toc77543470)

[Table 2.3. Correlations between factors 54](#_Toc77543471)

[Table 2.4 Correlations between Q sorts. 97](#_Toc77543472)

[Table 2.5. Varimax Rotation Factor Loadings 98](#_Toc77543473)

[Table 2.6. Consensus Statements 99](#_Toc77543474)

[Table 2.7 Factor arrays for all factors 100](#_Toc77543475)

[Table 1 Participant demographic details 112](#_Toc77543476)

[Figure 1.1. Flow chart diagram of search strategy including reasons for exclusion. 8](#_Toc77543459)

[Figure 2.1 Q sort response matrix. 52](#_Toc77543460)

[Figure 2.2 Factor array for factor 1. 103](#_Toc77543461)

[Figure 2.3 Factor array for factor 2. 104](#_Toc77543462)

[Figure 2.4 Factor array for factor 3a. 105](#_Toc77543463)

[Figure 2.5 Factor array for factor 3b. 106](#_Toc77543464)

## Thesis Abstract

This thesis provides a synthesis of existing literature on research that makes reference to the potential barriers to recovery for people with serious mental health difficulties that require secondary care support in the UK. It further explores the views of people who experience psychosis and the barriers to their recovery using q-methodology.

Paper 1 is a literature review that provides an up-to-date synthesis of existing literature to answer the question: What are the barriers to recovery for people with serious mental health difficulties that require secondary care support in the UK? Ten articles were included in the review and were appraised using Critical Appraisal Skills Program (CASP) tools. Findings suggest that barriers related to both accessing and engaging with services. Clinical implications were that access to care and gaps in services need to be addressed and meaningful service user involvement is key for positive engagement with services and for individuals’ recovery journeys.

Paper 2 is an empirical paper that investigates the views of people who experience psychosis and the barriers to their recovery. Q-methodology, using an online Q-study, was used to gather participants subjective view points on the subject matter. The following factors were identified, ‘Hopelessness for recovery’; ‘Interpersonal elements of care and feeling powerless’; ‘‘Shameful feelings’ and the views of others’ and ‘Negative experiences of care’. These factors showed there is no one universally agreed set of barriers to recovery but that the impact of stigma and hope for recovery can be affected both positively and negatively by interactions with service.

Paper 3 is an executive summary of the full thesis document.

# Paper 1: Literature Review.

## Barriers to recovery for people with serious mental health difficulties in the UK: A Literature Review

The following paper has been broadly prepared in accordance with the requirements of *The British Journal of Clinical Psychology* (see Appendix 1 for journal guidelines). Supplementary material is included for thesis purposes and will be removed for publication.

Word count: 7,924 (Exclusive of references and appendices)

#

## Abstract

The concept of recovery in mental health settings has been gathering momentum since the early 2000’s. Positive steps have been taken by governments to improve mental healthcare in the UK and publications such as ‘No Health without Mental Health’ (2011) have stressed the importance of recovery and for people to be able to access mental health care in a timely manner. This literature review provides an up-to-date synthesis of existing literature on research that makes reference to the potential barriers to recovery for people with serious mental health difficulties that require secondary care support in the UK. Relevant articles were retrieved by searching a variety of relevant databases. Ten articles met the inclusion criteria and were included in the review. All ten articles were appraised using Critical Appraisal Skills Program (CASP) tools. Findings suggest that there are numerous potential barriers to recovery in relation to both accessing and engaging with secondary care mental health services. Key themes identified were about relationships, communication and clarity of provision and roles of services. Findings suggest that pathway’s and access to care need to be clearer and gaps in services need to be addressed. Finally, meaningful service user involvement is key for positive engagement with services both now and in the future and for individuals’ recovery journeys.

## Introduction

### The concept of Recovery

The concept of recovery from serious mental illnesses (SMIs) is something that arose following the acknowledgement of the rights of marginalised and socially excluded people beginning with the civil right movements in the 60’s and 70’s (Allott & Loganathan, 2002). Since the start of the 21st century concepts and ideas of recovery have been advancing rapidly within mental health settings and communities (Davidson, 2005). For many years, beliefs about mental health and, in particular, serious mental illnesses such as schizophrenia have yielded negative perceptions from the public. Despite attempts to destigmatise mental illnesses via government policies such as the ‘Five Year Forward View’ (NHS England, 2014) and ‘No Health without Mental Health’ (Department of Health, 2011), it is argued that such negative perceptions and poor expectations for recovery still exist in the UK (Allott & Loganathan, 2002).

Recent government policy has focussed on recovery orientated treatment (Department of Health, 2011; Department of Health and Social Care, 1999). The recovery movement has advocated a move toward autonomy for clients and self-directed recovery, with individuals’ own goals guiding treatment (Hamm, Buck, Leonhardt, Luther, & Lysaker, 2018). Recovery itself is difficult to define (Wood, Price, Morrison & Haddock, 2010) and has been approached in numerous ways. Traditionally ‘recovery’ in the context of SMIs has been regarded as symptom alleviation (Silverstein & Bellack, 2008) although some studies have looked into ‘recovery’ being defined more in terms of quality of life (Liberman et al., 2002; Drury et al., 1996; Gee et al., 2016).

### Mental Health in the UK

Approximately one in six adults will experience a common mental health difficulty every week and at some point, one in five adults have considered taking their own life (Mental Health Foundation, 2016). Common mental health disorders defined by the National Institute for Clinical Excellence (NICE, 2011) include depression, generalised anxiety disorder (GAD) and social anxiety disorder amongst others. However, the Mental Health foundation (2016) report that despite significant increases in the number of people accessing mental health services since 2007, a third of all people with mental health difficulties have still never sought professional help. Despite significant efforts to improve public awareness of mental health and to reduce the associated stigma, a proportion of people still do not access support. The Department of Health (2014) report that 75% of people with mental health problems in England may not get access to the treatment they require. More specifically figures suggest that only 65% of people with psychotic mental health conditions and only 25% of adults with depression or anxiety related difficulties are thought to receive any form of treatment (The Mental Health Policy Group, 2015).

The National Institute for Clinical Excellence (NICE) quality standards state that people should have timely access to mental health services when they need them (NICE, 2011). The quality standard notes the impact that delays in care and support can have on individuals stating that timely access is essential for effective treatment of mental health conditions and to avoid crisis. Despite this, service users still report difficulties in accessing services (Department of Health, 2011).

Mental health problems are a growing public health concern (Mental Health Foundation, 2016). Given the ever-growing prevalence of mental health conditions in the UK combined with the seemingly low access to support figures, it is important to explore what prevents people from ‘recovering’. Many studies independently explore the barriers to particular groups of people accessing mental health care but few look at the barriers in a more generic sense. This review will appraise and synthesise the current research available to investigate what might get in the way of people’s recovery journeys.

### Aims/ Research Question

This review will provide an up-to-date synthesis of existing literature to answer the question: What are the barriers to recovery for people with serious mental health difficulties that require secondary care support in the UK?

## Method

### Search terms & databases

A literature search was conducted using PsychINFO, PsychARTICLES, CINAHL Plus and MEDLINE, searched via the host website EBSCOhost and Scopus. Grey literature was searched using OpenGrey. The search was conducted in May 2020. Table 1.1 details the search terms used when searching the previously mentioned databases. All key words pertaining to the same concept were combined using the ‘OR’ Boolean operator. These sets of search terms were then combined using the ‘AND’ Boolean operator in order to ensure a broad search of the literature that would return literature that was most pertinent to the review.

Table 1.1. Details of combined search terms used to search relevant databases.

|  |  |  |
| --- | --- | --- |
|  | Database | Search Terms |
| Peer Reviewed Articles | EBSCOhost | (barriers OR obstacles OR challenges OR difficulties OR issues) AND ("secondary care" OR "secondary care setting") AND ("mental health services" OR "psychiatric services" OR "psychiatric support") AND (uk OR united kingdom OR britain OR england OR wales OR scotland OR northern ireland) |
| Peer Reviewed Articles | Scopus | ( TITLE-ABS-KEY ( barriers OR obstacles OR challenges OR difficulties OR issues ) ) AND ( TITLE-ABS-KEY ( "secondary care" OR "secondary care setting" ) ) AND ( TITLE-ABS-KEY ( "mental health services" OR "psychiatric services" OR "psychiatric support" ) ) AND ( TITLE-ABS-KEY ( uk OR "united kingdom" OR britain OR england OR wales OR scotland OR "northern ireland" ) ) |
| Grey Literature | OpenGrey | (barriers OR obstacles OR challenges OR difficulties OR issues) AND ("secondary care" OR "secondary care setting") AND ("mental health services" OR "psychiatric services" OR "psychiatric support") AND (uk OR united kingdom OR britain OR england OR wales OR scotland OR northern ireland) |

### Inclusion and Exclusion Criteria

*Inclusion Criteria*

Studies were included if they met the following criteria:

1. Empirical studies (research that observes or measures phenomena) relating to the barriers of accessing or engaging with secondary care mental health services.
2. UK based studies; including England, Wales, Scotland and Northern Ireland
3. Focussed on adults aged over 18 years.
4. Looked at access and engagement with secondary care mental health services specifically.
5. The full article was written in English.

*Exclusion criteria*

Studies were excluded if:

1. Data specifically in relation to secondary care was indistinguishable from other services.
2. The article was theoretical only.
3. Evaluated effectiveness of specific interventions or services rather than peoples’ reasons for engaging or not engaging with it.
4. Were commentaries on articles.
5. Concerned physical health services.

### Search Strategy

An initial search of these databases produced 162 results and of those 33 were duplicates. During the first stage of filtering the paper titles were read and a further 95 were excluded on the grounds that they did not meet the criteria. At the second stage of filtering the papers abstracts were read to determine if the inclusion and exclusion criteria were met, a further 19 papers were removed. The final stage of filtering was to screen the remaining 15 papers in full, which resulted in five papers being excluded. One paper was excluded at this final stage due to being unable to gain access to the full text. All known databases were consulted along with Staffordshire University Library and a request was sent via ResearchGate to the author in order to try to obtain access, further contact details for the authors were not available to try and contact them. These avenues were explored before the decision was made to exclude this paper. All reasons for exclusion at both abstract and full text screening phases can be seen in Figure 1.1. This resulted in the retention of 10 papers for inclusion in the literature review. Figure 1.1 details the search strategy.



Figure 1.1. Flow chart diagram of search strategy including reasons for exclusion.

### Quality assessment

Critical Appraisal Skills Programme (CASP, 2018) tools were used as the quality assessment measures to appraise the final articles (Appendices 2 & 3). There were other tools that could have been appropriate to use however the CASP was chosen because it has a number of versions that cover both qualitative studies and randomised control trials (RCT) (see Appendices 1 & 2). This allowed all of the final papers in this review to be appraised using a similar tool meaning scores can be more easily compared. The National Institute for Health and Care Excellence (NICE) also advocate the use of the CASP checklists in their review protocol guidelines (2018). It is important to note that the CASP is not without its limitations and the scoring and percentages should be interpreted alongside the synthesis of findings.

Ten papers were appraised using the relevant CASP tools in order to assess rigour, methodology and application to clinical practice amongst other things. Nine studies were appraised using the qualitative tool and one study was appraised using both the qualitative and RCT CASP tools as it was an RCT trail with a nested qualitative study. Each paper received a scored out of 20, if it used the qualitative CASP, or 22 for the RCT CASP, the paper that was assessed using both measures had a score for each. These scores were converted into percentages to aid accurate comparison across both tools. Each item on the CASP tool could score a maximum of 2 points if it was fully addressed in the paper, 1 point if it was partially addressed and 0 points if it was not addressed or was too unclear to say. Scoring for each paper can be seen in table 1.3 in Appendix 4.

In order to enhance the reliability and validity of the review the final papers titles and abstracts were read by an external peer to check their relevance to the question. The external reviewer agreed the final 10 papers were relevant to the question asked.

## Results

Key details about the final ten papers and their quality scores can be seen in Table 1.2. Overall, the methodological rigour of included research was relatively good, with three studies meeting all the quality criteria measured by the CASP.

##

Table 1.2. Data extraction Table: Characteristics of Reviewed Articles

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Author(s) & Date** | **Title** | **Sample and setting** | **Methods** | **Key Findings** | **Quality** |
| Stanley, N., Borthwick, R. & Macleod A. 2006 | Antenatal depression: Mothers' awareness and professional responses | 28 mothers. 39 community midwives/health visitors | Phase 1 - focus groups with mothers. Phase 2 postal survey with community midwives and health visitors. | Both staff and mothers appeared to have limited knowledge on how to differentiate 'normal' amounts of difficulties form those that would be suggestive of antenatal depression. Midwives and health visitors noted difficulties with knowing where to refer onto and expressed that most of the time they were dismissed (GPs) or didn't meet thresholds for acceptance (CMHTs). Midwives and health visitors identified a need for clear referral pathways in order to improve coordination. | 16/2080% |
| NHS & community groups in Hull, UK. | Thematic analysis. |
| Grundy, A., Bee, P., Meade, O., Callaghan, P., Beatty, S., Olleveant, N. & Lovell, K. 2016 | Bringing meaning to user involvement in mental health care planning: A qualitative exploration of service user perspectives | 42 service users accessing secondary care mental health services.  | Focus groups (n=27) & Interviews (n=23).  | Service users attribute high worth to the quality of the care planning process. Service users identify a lack of recovery focus in care planning and a need for them to be more individualised, holistic and recovery orientated. Users find current systems tokenistic and that they often neglect the service users own expertise. Fundamental changes in professional behaviour and communication styles are required to facilitate this.  | 18/2090% |
| Recruited from two NHS mental health trusts in northwest and central England. | Qualitative framework approach. |
| Simons, L., Lathlean, J. & Kendrick, T. 2006 | Community mental health nurses' views of their role in the treatment of people with common mental disorders | 37 Community Mental Health Nurse (CMHN) participants.  | Focus groups. | There was disagreement between primary care and secondary care staff on CMHNs roles in working with CMDs. CMHNs did not think they should have a role in working with CMDs in primary care and believed they were best placed working with people with SMI. It found CMHNs believed that enhancing the working relationships between primary and secondary care would improve care. | 17/2085% |
| Recruited from four different NHS mental health trusts in the UK. | Thematic analysis. |
| Goward, P., Repper, J., Appleton, L. & Hagan, T. 2006 | Crossing boundaries. Identifying and meeting the mental health needs of Gypsies and Travellers. | 60 gypsies and travellers. 37 health and social care providers. | Survey, Interviews & Focus groups. | Gypsies and Travellers scored significantly lower on all 3 standardised measures and report higher instances of anxiety and depression compared to the general population. Service providers identified a lack of understanding about Gypsy and Traveller issues. Both service providers and members of the community were aware of the lack of ‘‘fit’’ between them. Service providers felt the complex structure of mental health services also made it difficult to find the right service to meet need. | 16/2080% |
| Recruited from the Sheffield area of the UK. | Thematic analysis. Grounded data reduction. |
| Slade, M., Gask, L., Leese, M., Mccrone, P., Montana, C., Powell, R., Stewart, M. & Chew-Graham, C. 2008 | Failure to improve appropriateness of referrals to adult community mental health services-lessons from a multi-site cluster randomized controlled trial | 1055 referral cases from 73 different GP practices. | Mixed method cluster randomised control trial. | The use of TAG did not impact on CMHT views about the ‘appropriateness’ of the referral, and so the intervention was not shown to be effective. Asking GPs to complete a TAG when referring to CMHTs did not improve primary–secondary care agreement on referrals. The nested qualitative study identified two barriers to implementation: professional and organizational. | Qualitative:18/2090%Quantitative:19/2286.4% |
| Recruited from GP practices in Manchester and London. | Chi Squared & independent T-Test. Thematic analysis |
| Lester, H., Tritter, J. & Sorohan, H. 2004 | Managing Crisis: The Role of Primary Care for People with Serious Mental Illness | 45 service users, 39 GPs, 8 Practice nurses | Focus groups | Staff note the difficulties of referring to secondary care services in times of crisis and how time consuming this can be and the delays in care it can cause. GPs that have good relationships with CMHT staff or a particular point of contact in a CMHT noted how this was easier. The view was also held that primary care should not be the gatekeepers to secondary care services at times of crisis. | 17/2085% |
| 6 PCTs across West Midlands in the UK. | Thematic Analysis |
| Loughlin, M., Berry, K., Brooks, J. & Bucci, S. 2019 | Moving on from early intervention for psychosis services: Service user perspectives on the facilitators and barriers of transition. | 15 EIS service users | Semi-Structured interviews | Barriers to transfer of care included clients reluctance to form relationships with new staff based on their experiences with the EI team. A smooth transition was facilitated by a number of factors including the length of time between learning about discharge and actually being discharged, familiarity with the new service, and clarity on who to contact for support and how to do this. | 20/20100% |
| EI & CMHT services in 5 trusts in Northwest England. | Thematic analysis. |
| Baker, E., Gwernan-Jones, R., Britten, N., Cox, M., McCabe, C., Retzer, A., Gill, L., Plappert, H., Reilly, S., Pinfold, V., Gask, L., Byng, R. & Birchwood, M. 2019 | Refining a model of collaborative care for people with a diagnosis of bipolar, schizophrenia or other psychoses in England: A qualitative formative evaluation | 16 service users, 5 family carers, 3 care partners, 3 supervisors, 4 GPs and 6 other primary or secondary care practitioners. | Semi-structured interviews, recordings of consultations and tape-assisted recall interviews | Results indicated that recovery-focussed collaborative care was most likely to be implemented when the primary care teams are receptive and secondary care practitioners are prepared to adopt new working practices. Adequate training and supervision needs to be in place in order to support the implementation of a model such as the PARTNERS model. | 19/2095% |
| 3 primary care trusts/ mental health trusts in the UK. | Deductive thematic analysis. |
| Berry, N., Bucci, S. & Lobban, F. 2017 | Use of the Internet and Mobile Phones for Self-Management of Severe Mental Health Problems: Qualitative Study of Staff Views. | 20 staff | Focus groups | Staff are able to see benefits and drawbacks to the use of digital technologies in managing mental health. Staff were positive about the benefits it could have for supporting psychoeducation but were anxious about the digital divide being increased. Staff were also concerned about managing risk with technologies that they have less control over. | 20/20100% |
| NHS mental health care settings in Northwest England | Thematic analysis. |
| Bucci, S., Berry, N., Morris, R., Berry, K., Haddock, G., Lewis, S. & Edge, D. 2019 | “They are not hard-to-reach clients. We have just got hard-to-reach services.” Staff views of digital health tools in specialist mental health services. | 48 EI staff | Focus groups | Staff working in specialist early intervention for psychosis services found digital tools on the whole acceptable in mental health service provision, but raised a number of concerns about the practicalities of implementation. Organizational support with a clear plan for implementing technological innovations is required for successful adoption. | 20/20100% |
| NHS EI services in Northwest England | Framework analysis |

##

### General critique of key papers

Nine papers used purely qualitative methodological approaches with one paper using a mixed methodology. Thematic analysis was the predominate method of data analysis, used by eight papers, for the qualitative approaches with two papers using framework analysis (Bucci et al., 2019 & Grundy et al., 2016)

Of the final ten papers reviewed, nine offered a clear account of their aims and employed appropriate methods, one paper (Lester et al., 2004) was less clear and only partially met this criteria on the CASP tool. All of the qualitative studies had a sufficient sample size to gather rich qualitative data therefore improving validity and reliability. All papers gave good summaries of their findings, linking this well to previous research in the area, also noting the implication of their findings on clinical practice. All articles reviewed included sufficient low-inference descriptors in the form of quotes to support their findings.

Half of the papers lacked an acknowledgement or discussion about the relationship between the researcher and participants, a key aspect of qualitative studies, resulting in it being difficult to evaluate the impact of the researchers on data collection and interpretation of the findings. Similarly, five of the papers lacked detail on the consideration of ethics beyond a generic statement of ethical approval meaning it was unclear how ethical standards that had been approved had been maintained.

Stanley, et al. (2006), scored 16/20 (80%) on the qualitative CASP tool. It explored both mothers’ and professionals’ knowledge and understandings of antenatal depression using focus groups to explore mothers’ views and postal surveys for professionals’ views. The mothers were recruited from a range of settings and pre-existing groups were used to facilitate focus groups to encourage safe discussion. Within the analysis there was little clarity on how thematic analysis was carried out and elements such as reflexivity, triangulation or verification were not discussed. This paper lacked acknowledgement of the relationship between the researcher and the participants.

Grundy et al. (2016), scored 18/20 (90%) on the qualitative CASP tool. It explored service users’ perspectives on mental health care planning using focus groups and individual interviews. Strengths of the study include the use of two sites for data collection, two means of data collection (focus groups and interviews), service user researchers and ethical considerations. The combination of the two data collection methods allowed data to be gathered that may not have been divulged if only one had been used. This paper scored well on the CASP however it lacked any consideration of the impact of the researcher on data collection and analysis, this was mitigated to some degree by the use of a constant comparative method and regular research team meetings that reviewed the framework and emergent themes.

Simons et al. (2006), scored 17/20 (85%) on the qualitative CASP tool. It explored community mental health nurses (CMHN) views of their role in the treatment of common mental disorders (CMDs). Strengths of this study are that it spanned 4 different NHS trusts and participants had a range of experiences with treating people with CMDs. However, participants were recruited because of their interest in the topic and their willingness to take part thus results may be biased. The study was also conducted in an area in which primary health care provision was being developed; findings may have been different in a location where primary care mental health services were better developed. As with many of the papers in this review this paper did not note any further steps taken to enhance rigour of the study e.g. reflexivity, researcher standpoints or biases, which is reflected in its quality score.

Goward et al. (2006), scored 16/20 (80%) on the qualitative CASP tool. It explored identifying and addressing the mental health needs of Gypsies and Travellers in Nottingham using surveys, interviews and focus groups. Strengths of the study include the use of purposive sampling, a methodology commonly used in qualitative research due to its strength in providing a homogenous sample on which theoretical generalisations can be made, and multiple methods of data collection. The quality score for this paper was impacted due to there being little consideration or explanation of ethical considerations and if or how these were managed. Similarly, the paper offered little consideration of the position of the researcher and the data analysis process could have been clearer.

Slade et al. (2008), scored 18/20 (90%) on the qualitative CASP tool and 19/22 (86.4%) on the RCT CASP tool. It looked into the use of a standardised tool to improve the appropriateness of referrals to adult CMHTs. This was an RCT with a nested qualitative study. The RCT element of the study found the intervention to have been poorly implemented and ineffective when it was used. Having the nested qualitative study allowed for exploration of the subtleties of why this may have been. Strengths of the study include its design and sample size. The use of a cluster design for the RCT helped to minimise within-practice contamination. The inability to be able to fully blind participating CMHTs along with the use of a subjective measure of outcome increases potential bias and reduces the study’s reliability. The low implementation of the TAG (intervention) limits the study’s findings. The qualitative element of the study was less well explained and it was unclear how the interview guide was developed and how data saturation was decided which is reflected in the papers score on the qualitative CASP tool.

Lester et al. (2004), scored 17/20 (85%) on the qualitative CASP tool. It explored views on managing crises in primary care for people with serious mental illnesses (SMIs) using focus groups. Both staff and service users were recruited. A clear process of analysis of the data and actively seeking deviant cases were both strengths of the study. Similarly, piloting the topic guide before use in the study and the use of focus groups for staff and service users separately and combined were strengths. Weaknesses of the study included a lack of acknowledgement of the researcher stance and impact on interpretation of data and the low response rate of clinicians invited to take part and their lack of contribution to focus group discussions if they did.

Loughlin et al. (2019), scored 20/20 (100%) on the qualitative CASP tool. It explored the facilitators and barriers to moving on from early intervention services (EIS) using semi structured interviews. This paper scored full points on the CASP tool due to its acknowledgement of the role and impact of the researchers on the recruitment and data analysis processes and its consideration of ethical issues. Topic guides were developed in consultation with staff and service users and were revised as interviews proceeded to incorporate new information. Reflexivity was very well considered and reflective journals were kept throughout by the researchers. An external researcher was also recruited to add to the rigour of the data analysis process.

Baker et al. (2019), scored 19/20 (95%) on the qualitative CASP tool. It evaluated the use of the PARTNERS model of collaborative care via semi-structured interviews, consultation recordings and tape assisted recall interviews. The use of multiple data collection methods enhanced the rigour of the study. A further strength of the study was that lived experience advisory panel members were consulted on the development of topic guides for interviews. A degree of interpretation was required in the data analysis where there were conflicting accounts but this was mitigated somewhat by returning to field notes and discussions with the researchers that collected the data. This paper did not score full points on the CASP tool due to it not considering ethical implications any further than a standard ethics statement of approval and that informed consent was sought.

Berry et al. (2017), scored 20/20 (100%) on the qualitative CASP tool. It explored staff views on the use of the internet and mobile phones for the self-management of SMIs using focus groups. This paper scored extremely well on the CASP tool due to being both valid and reliable as it considered relationships and reflexivity and used inter-rater checking on themes identified. Themes were presented back to some members of the group in order to refine the way in which they were presented. Convenience sampling was used to recruit participants with half of them being psychologists; this could impact on the finding’s generalisability due to potential bias. All members of teams were involved in the focus groups including team managers which may have impacted upon group dynamics and discussion, however, reflective diaries were reviewed during analysis to consider the impact of this. Overall, this was a very strong study which is reflected in its CASP score.

Bucci et al. (2019), scored 20/20 (100%) on the qualitative CASP tool. It explored staff views of barriers to the use of digital health tools in specialist mental health services using focus groups. Again, this paper scored extremely well on the CASP tool. The recruitment and analysis process were rigorous and well described. Topic guides for focus groups were developed with service users, data saturation was discussed and ethical issues were well considered. The researcher’s position and impact of this was noted and reflexivity was discussed improving rigour. Although participants were recruited from a number of NHS trusts they were all located within the northwest of England, the study could have been improved by recruiting across the UK more broadly. Three of the focus groups were carried out during team away days, this raises issues in terms of participants’ ability to be able to decline attending and also the amount of freedom they felt to express their views within their team. Overall, this was a very strong study.

The strengths and weakness of each of the papers are important to consider when synthesising results and considering the findings and their applications to clinical practice.

### Synthesis of findings

A narrative approach to synthesis of results was taken (Cochrane Consumers and Communication Review Group, 2013), similarities and differences in findings will be discussed. Although not all of the ten papers reviewed were specifically about, or conducted within, secondary care mental health services, all of their findings and subsequent discussions highlight potential barriers or difficulties with secondary care or the interface between secondary care services and other services. Headings have been used to structure the synthesis and for ease of reading.

#### Engagement: Interpersonal elements of care - Rapport, communication & previous experiences

Engagement with services was raised in seven of the papers (Grundy et al., 2016; Goward et al., 2006; Lester et al., 2004; Loughlin et al., 2019; Baker et al., 2019; Berry et al., 2017; Bucci et al., 2019) both in terms of clients engagement with services but also services engagement with each other as potential barriers. Many of the papers reviewed made reference to the importance of interpersonal elements, these included three papers discussing confidence and trust in clinicians (Stanley et a., 2006; Goward et al.; 2006; Loughlin et al., 2019), four papers discussing communication between clinicians (Simons et al., 2006; Slade et al., 2008; Lester et al., 2004; Baker et al., 2019) and two papers highlighting the relationship between service users and clinicians (Loughlin et al., 2019; Grundy et al., 2016). The importance of a working alliance and establishing a connection between clinicians and service users was something that service users said was developed over time and was characterised by trust, respect and communication (Grundy et al., 2016). Three of the studies identify the importance these characteristics played in service users feeling included meaningfully in their care (e.g. Stanley et al., 2006; Grundy et al. 2016; Loughlin et al., 2019). Where service users felt communication was effective but there were no tangible outcomes in response to these discussions, the service users felt a sense of disappointment which could lead to a spiral of disengagement or an increase in purely tokenistic involvement (Grundy et al., 2016).

Service users reported requiring regular and meaningful engagement that was initiated from the beginning of their contact with services and throughout their journey. This was also represented by service users desire to be recognised as an active and equal agent in elements of their recovery such as care planning (Grundy et al., 2016) or in transfers of care (Loughlin et al., 2019). Service users generally felt that when involvement in care processes falls short of this, the process of engagement was somewhat superficial and became task orientated. The service users also noted how this affected their degree of engagement in the recovery process here and now and also determined attitudes towards and experiences with services in the future (Grundy et al., 2016; Loughlin et al., 2019; Goward et al., 2006).

Recovery journeys are rarely linear and service users noted how deteriorations in their mental health affected the degree to which they were able to be involved in discussions and decisions about their care. Service users noted the importance of staff adapting their behaviours and communication methods to ensure some degree of collaboration was still occurring in these instances. Service users noted how a decline in their mental health could itself be a barrier to their engagement but they also stressed that the way in which staff responded to this could be another barrier especially if collaboration and communication was reduced (Grundy et al., 2016). Similarly, staff expressed concerns about the impact of service users’ symptoms on their ability to engage with technologies intended to help them take ownership of their own recovery and mental health (Bucci et al., 2019). Interestingly staff expressed a reluctance to use such technologies due to the fear of clinician led care being reduced in favour of these new technologies. Staff felt the new technologies would struggle to replicate the essential elements required to build and maintain therapeutic relationships (Bucci et al., 2019) and thus keep service users engaged and well. When communication and rapport between clinicians and service users was poor service users reported poor experiences of care (e.g. Grundy et al., 2016; Bucci et al., 2019).

Similarly, communication between professionals was a common theme arising in the papers that explored staff views. Primary care staff often noted the difficulties in being able to speak to secondary care staff for advice or guidance in a timely manner (Lester et al., 2004; Slade et al., 2008; Stanley et al., 2006). Conversely, staff who experienced good relationships or had a known point of contact in secondary care teams or vice versa shared the positive impact this had on their interactions and gaining the support or advice they needed to support individuals in their recovery (Lester et al., 2004; Baker et al., 2019).

Studies that explored staff views had commonalities in finding staff often held negative expectations of users’ willingness and ability to be able to engage with services (Goward et al., 2006; Berry et al., 2017; Bucci et al., 2019). Staff feared increasing the ‘digital divide’ (Bucci et al., 2019; Berry et al., 2017) and anticipated that service users may not have the means to access the necessary digital technologies to enhance their care.

#### Access: Provision and structure of services

A lack of clarity around what psychiatric services were or how services were accessed was reported in several papers (e.g. Goward et al., 2006; Lester et al., 2004). Studies reported conflicts in views of what services were responsible for treating what difficulties (Simons et al., 2006; Goward et al., 2006). Specifically, primary and secondary care staff views on whose responsibility it was to work with CMDs was disputed. It appears CMHNs do not feel they have a role in working with CMDs and that their skills are better situated in working with more complex needs. Primary care staff appear to think that they do not have sufficient skills to work with common mental illnesses but CMHNs feel these are not complex enough for them to work with. This lack of agreement seems to be an ongoing struggle with people being able to access the support they need. Slade et al. (2008) reported even with a tool that is designed to improve the agreement on referrals to secondary care that agreement is still not reached, suggesting this could be a significant barrier to recovery for people trying to access secondary care services.

This gap in services was recognised by staff and service users alike. Staff from secondary care mental health services note how current service configuration neglects various groups of people, those with CMDs, hard to reach populations or socially excluded groups such as service users with more serious mental health difficulties, Gypsie Traveller communities and black and minority ethnic minority groups (e.g. Goward et al., 2006). This is something that could be mitigated by improving relationships between services (Simons et al., 2006). Staff think people with CMDs are not getting adequate treatment in primary care services but have nowhere else to support them as those users are not considered ‘severe’ enough to reach secondary care service thresholds. The gap in services created by service user difficulties being ‘too complex’ for primary care services and not complex or ‘severe and enduring’ enough to enable them access to secondary care services is also apparent in the Stanley et al. (2006) study. Staff described ‘disappointing’ interactions between primary and secondary care staff due to the fact the service users often didn’t meet the criteria to receive a service from secondary care providers. This is a concern raised across a number of papers - the threshold to access secondary care services can be too high or that the acceptance criterion is too strict (Lester et al., 2004; Slade et al., 2008; Stanley et al., 2006). Many of the papers identified this lack of flexibility as something that needed to be addressed to improve access to and engagement with services. However, staff also noted that strict eligibility criteria enables secondary care services to remain focussed on their primary purpose of caring for and treating people with significant mental health difficulties, something that can be lost if unnecessary referrals are made resulting in reduced access for necessary referrals (Simons et al., 2006; Slade et al., 2008). If this gap in service provision were to be addressed it was suggested that primary care services may make less inappropriate referrals to secondary care and support from secondary care services when required could be more readily available improving relationships and links between primary and secondary care (Simons et al., 2006).

Baker et al. (2019) when discussing the implementation of the PARTNERS model of collaborative care note how a central feature to improving how primary and secondary care professionals work together is a proactive approach to liaison and a willingness to adopt different working practices. Clearer referral routes or pathways to care was identified by staff as another way in which to improve coordination between services, something that is advocated in government guidance also (Simons et al., 2006). A number of studies, where there were link workers or processes in place to attempt to improve the communication and interface between primary and secondary care services, found this link worker or process to be largely ineffective. Primary care professionals in the Stanley et al. (2006) study noted that they did not see link workers from specialist secondary care services (parent and baby teams) as a potential resource concluding that there was a lack of understanding of what support they could offer.

## Discussion

This review explored the existing literature on potential barriers to recovery for people with serious mental health difficulties in the UK. It focussed primarily on secondary care mental health services or the interface between primary and secondary care services as this is predominantly where the care of people with SMIs lie. The main findings from the papers fell into two connected categories: access and engagement. These categories captured a number of key themes. Within engagement both service users and staff spoke of the importance of effective communication, building relationships and trust. It is particularly important to note that these features were identified to be key elements both between staff and service users and between services. The impact of communication, relationships and trust was wide ranging and had implications at various stages of the recovery journey from referral to discharge. Across the studies that explored service user viewpoints the importance of meaningful involvement and consistent relationships with staff were stressed. Similarly, the literature that explored staff views highlighted the importance of good communication and effective relationships in relation to liaison between services.

Within the access theme, both staff and service users spoke about there being a lack of clarity about who delivered what and difficulties in accessing services. Staff described a lack of clarity both in terms of who was responsible for providing what care, i.e. the role of CMHNs and community mental health teams in the treatment of common mental disorders and with how to speak with someone from a secondary care mental health service i.e. GP’s having to make numerous phone calls to various different people to discuss a case. The relationships staff had with other services also played a part in the access category, if primary care staff had a point of contact in secondary care services they felt discussions about referrals or advice was much easier to access. The Stanley et al. (2009) paper noted the lack of clarity staff felt there was on what services were available to mothers, this is unsurprising given that around 40% of the whole of the UK’s services have no specialist perinatal mental health provision (Bauer et al., 2014). In order to improve access to appropriate services staff need to be aware of what services are available and how to access them, given that commissioning of services differs across the UK this is a complex issue to manage.

The use of digital technologies in mental health care and recovery is growing and has the potential to transform mental healthcare (Hollis et al., 2015). Digital technologies offer the opportunity to improve access to mental health care and to monitor treatment adherence by enabling a degree of flexibility and means care can be tailored to individual needs (Hollis et al., 2015), for this to work staff need to be on board with digital technologies. This review suggests that staff appear to hold a number of scepticisms in relation to digital technologies (Bucci et al., 2019; Berry et al., 2017) including how well NHS services will be able to properly implement the use of such digital technologies, how well service users will be able to engage with the technology and the possibility of increasing the ‘digital divide’. Advances in systems and technology to help service users manage their own care and recovery more independently can be introduced but in order for them to engage with it fully staff too must engage fully with it. Both papers that discuss the increasing use of digital technologies suggest that staff are somewhat resistant to this therefore limiting service users ability.

The findings from this review pertaining to service user views on their role in their care mirror much of what is discussed in the ‘No Health Without Mental Health’ (2011) paper. Particularly the objective that more people will have a positive experience of care and support, and the premise that service users should be at the heart of services, be respected and receive individually focussed care. The paper notes the importance of these principles especially within mental health care and also echo’s how service users and carers often report that services fall ‘a long way short’ of this. Clearly service users and staff place a large emphasis on the importance of good relationships and communication in effective support towards recovery. There is growing acknowledgement that recovery is a principle that applies to mental health settings and service users wish to take an active role and walk alongside staff on this journey. In order for recovery to be a possibility for service users staff need to consider their direct interactions with service users but also their interactions with other services and the wider impact this may have on service users trying to access the support they need. If staff cannot liaise effectively, service users will not be able to access care they require. An element of flexibility is required by staff and services to improve this effective communication and to build relationships.

### Limitations of the review

Half of the articles reviewed failed to consider the relationship between the researcher and participants. The continual process of internal dialogue and critical self-evaluation of the researcher’s position, along with recognition of the effect this position may have on the collection and analysis of data is crucial in research due to the potential impact of bias (Bradbury-Jones, 2007; Berger, 2105). It is said that researchers need to focus on gaining a better understanding of the role of the self in the creation of knowledge and to carefully monitor the impact of their biases, beliefs and personal experiences on their research (Berger, 2015). A lack of reflexivity in these papers decreases their rigour and therefore an element of caution when considering their findings and the resulting findings of this review needs to be applied.

The decision was made to use the two relevant versions of the CASP tool to appraise the papers. Whilst nine of the papers were appraised using only the Qualitative CASP tool one paper was appraised using both the Qualitative version and the RCT version, this allowed for all papers to be measured and compared using a similar standard. There was the potential to have created a single bespoke appraisal tool that could have been used with all papers however, this too would have had its limitations due to it lacking standardisation. In order to maintain reliability and validity, therefore, the two versions of the CASP were chosen as the appraisal tool.

It is important to note that searches, synthesis and conclusions presented in this review were carried out by one reviewer. The process of screening, reviewing and synthesising papers is a subjective one and therefore the findings should be interpreted with that in mind. To mitigate this and increase reliability, a clear search strategy is provided to allow replicability by other researchers who it is hoped could have similar findings. It is also possible that some relevant evidence may have been overlooked during the process of reviewing database lists. Attempts were made however to avoid publication bias by searching for grey literature but no papers made it into the final analysis.

### Clinical implications

The insights gained from this review can be applied to clinical practice when considering how services are designed, how they are accessed and the approach staff working within them use. The findings from this review align with current government policy that stresses putting service users, their families and carers at the centre of their care (Department of Health, 2011). This policy also set out to achieve launching ‘recovery’ pilots to support the recovery of those using mental health services and so it is important these findings are taken into consideration when setting up these services. It is vital that service users are listened to, given adequate information, involved in planning their care and decision making and are treated as equals if involvement is to be truly collaborative. As the ‘No Health without Mental Health’ paper (2011) states, this will include mental health services recognising they need to respond differently to some groups in order to facilitate engagement.

### Future research

This review did not include any research with black and minority ethnic groups (BME), it would be beneficial for future research to seek out the views of these minority groups in order to better understand the potential barriers to accessing and engaging with services from a variety of perspectives, and future research needs to ensure that their voices are represented within the data.

Future research could also consider looking more specifically at the barriers to accessing or engaging with mental health care for specific populations such as those that are harder to reach; BME groups or people diagnosed with Psychosis for example.

## Conclusions

This review highlights a number of difficulties that both service users and staff face in terms of access and engagement with mental health services that need to be considered and addressed when supporting people in their recovery. This review offers some suggestions about concepts that mental health services should consider when thinking about recovery orientated services. Findings suggest access to care needs to be clearer for both staff and service users and there needs to be improved understanding of each other’s roles and communication between services. Gaps in services add pressure to this already difficult relationship between primary and secondary care and this needs to be addressed in order to improve working relationships between existing services and the care they provide.

Service users place high importance on meaningful involvement in care planning and decision making and it is important staff facilitate this if service users are to feel empowered in taking control of their own mental health and journey towards recovery. Users experiences shape their future expectations of services and hope for recovery it is key therefore that every contact and step on the recovery journey is positive to prevent disengagement and a lack of hope for recovery.

## References

Allott, P., & Loganathan, L. (2002). *Discovering hope for recovery from a British perspective: A review of literature*. UCE, Birmingham: Centre for Community Mental Health.

Baker, E., Gwernan-Jones, R., Britten, N., Cox, M., McCabe, C., Retzer, A., Gill, L., Plappert, H., Reilly, S., Pinfold, V., Gask, L., Byng, R. & Birchwood, M. (2019). Refining a model of collaborative care for people with a diagnosis of bipolar, schizophrenia or other psychoses in England: A qualitative formative evaluation.*BMC Psychiatry, 19(7)* https://doi.org/10.1186/s12888-018-1997-z

Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014). *The costs of perinatal mental health problems*. Retrieved from: <https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/costsofperinatal.pdf> [Accessed 23/06/20].

Berger, R. (2015). Now I see it, now I don’t: Researcher’s position and reflexivity in qualitative research.*Qualitative Research, 15*(2), 219-234. <https://doi.org/10.1177/1468794112468475>

Berry, N., Bucci, S., & Lobban, F. (2017). Use of the internet and mobile phones for self-management of severe mental health problems: Qualitative study of staff views.*JMIR Mental Health, 4*(4), e52. <https://doi:10.2196/mental.8311>

Bradbury-Jones, C. (2007). Enhancing rigor in qualitative health research: exploring subjectivity through Peshkin’s I’s. *Journal of Advanced Nursing* 59: 290–298. <https://doi.org/10.1111/j.1365-2648.2007.04306.x>

Bucci, S., Berry, N., Morris, R., Berry, K., Haddock, G., Lewis, S., & Edge, D. (2019). “They are not hard-to-reach clients we have just got hard-to-reach services.” Staff views of digital health tools in specialist mental health services.*Frontiers in Psychiatry, 10*(MAY) <https://doi.org/10.3389/fpsyt.2019.00344>

Cochrane Consumers and Communication Review Group. (2013). Cohrane Consumers and Communication Review group: data synethesis and analysis. *Retrieved from: http://coorg.cochrane.org*. [Accessed 21/05/20].

Critical Appraisal Skills Programme (2018). *CASP Qualitative Checklist*. Retrieved from <https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf> [Accessed 18/06/20].

Crticial Appraisal Skills Programme (2018). *CASP Randomised Control Trial Checklist*. Retrieved from: <https://casp-uk.net/wp-content/uploads/2018/01/CASP-Randomised-Controlled-Trial-Checklist-2018.pdf> [Accessed 18/06/20].

Department of Health (2011). *No health without mental health. A cross-government mental health outcomes strategy for people of all ages.* Retrieved from: [www.gov.uk/government/uploads/system/uploads/attachment\_ data/file/213761/dh\_124058.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_%20data/file/213761/dh_124058.pdf) [Accessed 24/06/20].

Department of Health and Social Care (1999). *National Services Framework: Mental Health*. Retrieved from: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf> [Accessed 24/06/20].

Department of Health. (2014). Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence. Retrieved from: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf> [Accessed 24/06/20].

Drury, V., Birchwood, M., Cochrane, R., & MacMillan, F. (1996). Cognitive Therapy and Recovery from Acute Psychosis: A Controlled Trial: I. Impact on Psychotic Symptoms. *British Journal of Psychiatry,* *169*(5), 593-601. <https://doi:10.1192/bjp.169.5.593>

Gee, B., Hodgekins, J., Fowler, D., Marshall, M., Everard, L., Lester, H., Jones, P. B., Amos, T., Singh, A. P., Sharma, V., Freemantle, N. & Birchwood, M. (2016). The course of negative symptom in first episode psychosis and the relationship with social recovery. *Schizophrenia Research, 174,* 165-171. <https://doi-rg.ezproxy.staffs.ac.uk/10.1016/j.schres.2016.04.017>

Goward, P., Repper, J., Appleton, L., & Hagan, T. (2006). Crossing boundaries. Identifying and meeting the mental health needs of gypsies and travellers.*Journal of Mental Health, 15*(3), 315-327. <https://doi.org/10.1080/09638230600700888>

Grundy, A. C., Bee, P., Meade, O., Callaghan, P., Beatty, S., Olleveant, N., & Lovell, K. (2016). Bringing meaning to user involvement in mental health care planning: A qualitative exploration of service user perspectives.*Journal of Psychiatric and Mental Health Nursing, 23*(1), 12-21. <https://doi.org/10.1111/jpm.12275>

Hamm, J. A., Buck, K. D., Leonhardt, B. L., Luther, L., & Lysaker, P. H. (2018). Self-directed recovery in schizophrenia: Attending to clients’ agendas in psychotherapy. *Journal of Psychotherapy Integration, 28*(2), 188-201. <https://doi.org/10.1037/int0000070>

Hollis, C., Morriss, R., Martin, J., Amani, S., Cotton, R., Denis, M., & Lewis, S. (2015). Technological innovations in mental healthcare: Harnessing the digital revolution. *British Journal of Psychiatry,* *206*(4), 263-265. <https://doi.org/10.1192/bjp.bp.113.142612>

Davidson, L. (2005). Recovery, self management and the expert patient – Changing the culture of mental health from a UK perspective, *Journal of Mental Health*, 14:1, 25-35. <https://doi.org/10.1080/09638230500047968>

Lester, H., Tritter, J. Q., & Sorohan, H. (2004). Managing crisis: The role of primary care for people with serious mental illness.*Family Medicine, 36*(1), 28-34.

Liberman, R. P., Kopelowicz, A., Ventura, J., & Gutkind, D. (2002). Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry*, *14*, 256−272. <https://doi.org/10.1080/0954026021000016905>

Loughlin, M., Berry, K., Brooks, J., & Bucci, S. (2019). Moving on from early intervention for psychosis services: Service user perspectives on the facilitators and barriers of transition.*Early Intervention in Psychiatry, 13*(6), 1396-1403. <https://doi.org/10.1111/eip.12780>

Mental Health Foundation. (2016). *Fundamental Facts About Mental Health 2016.* Mental Health Foundation: London.

National Institute for Clinical Excellence. (2011). *Common mental health disorders: Guidance and guidelines*. Retrieved from: https://[www.nice.org.uk/guidance/cg123](http://www.nice.org.uk/guidance/cg123) [Accessed 23/06/20].

National Institute for Clinical Excellence. (2011). *Service user experience in adult mental health services.* Retrieved from: <https://www.nice.org.uk/guidance/qs14/chapter/Quality-statement-5-Access-to-services> [Accessed 23/06/2020]

National Institute for Health and Care Excellence. (2018). *Developing NICE guidelines: the manual (NICE Process and Methods No. 20).* Retrieved from <https://www.nice.org.uk/process/pmg20/chapter/reviewing-research-evidence> [Accessed 24/06/20].

NHS. (2014). *Five Year Forward View*. Retrieved from: <https://www.england.nhs.uk/publication/nhs-five-year-forward-view/> [Accessed 23/06/2020]

Silverstein, S. M., & Bellack, A. S. (2008). A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review*, 28(7), 1108-1124. <https://doi.org/10.1016/j.cpr.2008.03.004>

Simons, L., Lathlean, J., & Kendrick, T. (2006). Community mental health nurses' views of their role in the treatment of people with common mental disorders.*Primary Care Mental Health, 4*(2), 121-129. <https://doi.org/10.3310/hta9370>

Slade, M., Gask, L., Leese, M., Mccrone, P., Montana, C., Powell, R., Stewart, M. & Chew-Graham, C. (2008). Failure to improve appropriateness of referrals to adult community mental health services-lessons from a multi-site cluster randomized controlled trial.*Family Practice, 25*(3), 181-190. <https://doi.org/10.1093/fampra/cmn025>

Stanley, N., Borthwick, R., & Macleod, A. (2006). Antenatal depression: Mothers' awareness and professional responses.*Primary Health Care Research and Development, 7*(3), 257-268.

The Mental Health Policy Group. (2015). *A manifesto for better mental health*. Retrieved from <https://www.omega.uk.net/admin/uploads/file/a%20manifesto%20for%20better%20mental%20health.pdf> [Accessed on 23/06/2020]

Wood, L., Price, J., Morrison, A., & Haddock, G. (2010). Conceptualisation of recovery from psychosis: A service-user perspective. *The Psychiatrist*, *34*(11), 465–470.

## Appendices

### Appendix 1: British Journal of Clinical Psychology Author Guidelines

**AUTHOR GUIDELINES**

 **Sections**

1. [Submission](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_1._SUBMISSION)
2. [Aims and Scope](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_2._AIMS_AND)
3. [Manuscript Categories and Requirements](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_3._MANUSCRIPT_CATEGORIES)
4. [Preparing the Submission](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_4._PREPARING_YOUR)
5. [Editorial Policies and Ethical Considerations](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_5._EDITORIAL_POLICIES)
6. [Author Licensing](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_6._AUTHOR_LICENSING)
7. [Publication Process After Acceptance](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_7._PUBLICATION_PROCESS)
8. [Post Publication](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_8._POST_PUBLICATION)
9. [Editorial Office Contact Details](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_9._EDITORIAL_OFFICE)

 1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

**Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at**[**http://www.editorialmanager.com/bjcp**](http://www.editorialmanager.com/bjcp)

[**Read**](https://authorservices.wiley.com/author-resources/Journal-Authors/submission-peer-review/editorial-manager.html) more details on how to use Editorial Manager.

All papers published in the British Journal of Clinical Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

**Data protection:**

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at [**https://authorservices.wiley.com/statements/data-protection-policy.html**](https://authorservices.wiley.com/statements/data-protection-policy.html).

**Preprint policy:**

This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The British Journal of Clinical Psychology publishes original research, both empirical and theoretical, on all aspects of clinical psychology:

* clinical and abnormal psychology featuring descriptive or experimental studies
* aetiology, assessment and treatment of the whole range of psychological disorders irrespective of age group and setting
* biological influences on individual behaviour
* studies of psychological interventions and treatment on individuals, dyads, families and groups

For specific submission requirements, [**read**](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html) the Author Guidelines.

The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

The following types of paper are invited:

* papers reporting original empirical investigations;
* theoretical papers, provided that these are sufficiently related to empirical data;
* review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
* Brief Reports and Comments.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Articles should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Refer to the separate guidelines for [**Registered Reports**](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/registeredreportsguidelines.htm).

All systematic reviews must be pre-registered.

4. PREPARING THE SUBMISSION

**Free Format Submission**

British Journal of Clinical Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

* Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
* The title page of the manuscript, including a data availability statement and your co-author details with affiliations. (Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.) You may like to use [this template](https://onlinelibrary.wiley.com/pb-assets/assets/2044835X/Sample_Manuscript_Title_Page%20-%20revised-1556026160210.docx) for your title page.

**Important: the journal operates a double-blind peer review policy. Anonymise your manuscript and prepare a separate title page containing author details.**(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)

* An ORCID ID, freely available at [https://orcid.org](https://orcid.org/). (Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)

To submit, login at [**https://www.editorialmanager.com/bjcp/default.aspx**](https://www.editorialmanager.com/bjcp/default.aspx) and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

**Revised Manuscript Submission**

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author’s discretion. They should be pasted into the ‘Comments’ box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use [**this template**](https://bpspsychub.onlinelibrary.wiley.com/pb-assets/assets/20448260/Sample_Manuscript_Title_Page%20-%20revised-1556025388890.docx) for your title page. The title page should contain**:**

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's [best practice SEO tips](http://www.wileyauthors.com/seo));
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. The author's institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;
5. Abstract;
6. Keywords
7. Data availability statement (see [Data Sharing and Data Accessibility Policy](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#data_share));
8. Acknowledgments.

**Authorship**

Please refer to the journal’s Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the [**Project CRediT**](https://casrai.org/credit/) website for a list of roles.

**Abstract**

Please provide a structured abstract under the headings: Objectives, Methods, Results, Conclusions. For Articles, the abstract should not exceed 250 words. For Brief Reports, abstracts should not exceed 120 words.

Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

**Keywords**

Provide appropriate keywords.

**Acknowledgments**

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

1. Title
2. Main text
3. References
4. Tables and figures (each complete with title and footnotes)
5. Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

* As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Do not mention the authors’ names or affiliations and always refer to any previous work in the third person.
* The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

**References**

References in published papers are formatted according to the Publication Manual of the American Psychological Association (6th edition). However, references may be submitted in any style or format, as long as it is consistent throughout the manuscript.

**Tables**

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and \*, \*\*, \*\*\* should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

**Figures**

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

 [**Basic figure requirements**](http://media.wiley.com/assets/7323/92/electronic_artwork_guidelines.pdf) for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

**Colour figures.** Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

**Supporting Information**

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

[**Wiley’s FAQs**](http://www.wileyauthors.com/suppinfoFAQs) on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the [**APA Publication Manual**](http://www.amazon.co.uk/gp/product/1433805618?ie=UTF8&tag=thebritishpsy-21&linkCode=xm2&camp=1634&creativeASIN=1433805618) published by the American Psychological Association. The following points provide general advice on formatting and style.

* **Language:** Authors must avoid the use of sexist or any other discriminatory language.
* **Abbreviations:**In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
* **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the [Bureau International des Poids et Mesures (BIPM) website](http://www.bipm.org/en/about-us/) for more information about SI units.
* **Effect size:** In normal circumstances, effect size should be incorporated.
* **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

**Wiley Author Resources**

**Manuscript Preparation Tips:**Wiley has a range of resources for authors preparing manuscripts for submission available [**here.**](http://www.wileyauthors.com/prepare) In particular, we encourage authors to consult Wiley’s best practice tips on [**Writing for Search Engine Optimization**](http://www.wileyauthors.com/seo).

**Article Preparation Support:**[**Wiley Editing Services**](https://wileyeditingservices.com/en/article-preparation/?utm_source=wol&utm_medium=backlink&utm_term=ag&utm_content=prep&utm_campaign=prodops)offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for [**Preparing Your Article**](https://authorservices.wiley.com/author-resources/Journal-Authors/Prepare/index.html?utm_source=wol&utm_medium=backlink&utm_term=ag&utm_content=prepresources&utm_campaign=prodops)for general guidance and the [**BPS Publish with Impact infographic**](https://pericles.pericles-prod.literatumonline.com/pb-assets/hub-assets/bpspubs/BPS_SEO_Interactive-1545065172017.pdf) for advice on optimizing your article for search engines.

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double blind) peer review. Please ensure that any information which may reveal author identity is blinded in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, read [**the terms and conditions of submission**](https://wol-prod-cdn.literatumonline.com/pb-assets/assets/2044835X/BPS_Journals_Terms_and_Conditions_of_Submission%20-%20addition%20for%20authorship.doc) and the [**declaration of competing interests**](https://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%292044-835X/homepage/BPS_Journals_Declaration_of_Competing_Interests.doc).

We aim to provide authors with a first decision within 90 days of submission.

Further information about the process of peer review and production can be found in ‘[**What happens to my paper?**](https://onlinelibrary.wiley.com/store/10.1111/%28ISSN%292044-8295/asset/homepages/What_Happens_to_My_Paper.pdf?v=1&s=c77109ea36e8cfc16344d763454bc917e5147cec)’ Appeals are handled according to the [**procedure recommended by COPE**](https://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%292044-8295/homepage/How_to_handle_appeals.pdf). [**Read**](https://authorservices.wiley.com/Reviewers/journal-reviewers/tools-and-resources/review-confidentiality-policy.html) Wiley's policy on the confidentiality of the review process.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

* [Future of Research Communications and e-Scholarship (FORCE11)](http://www.force11.org/node/4433)
* [The Gold Standard Publication Checklist from Hooijmans and colleagues](https://www.ncbi.nlm.nih.gov/pubmed/20507187)
* [FAIRsharing website](http://www.biosharing.org/)

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: [**https://www.crossref.org/services/funder-registry/**](https://www.crossref.org/services/funder-registry/)

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

“Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed (APA Ethics Code Standard 8.12a, Publication Credit). Authorship encompasses, therefore, not only those who do the actual writing but also those who have made substantial scientific contributions to a study. Substantial professional contributions may include formulating the problem or hypothesis, structuring the experimental design, organizing and conducting the statistical analysis, interpreting the results, or writing a major portion of the paper. Those who so contribute are listed in the byline.” (p.18)

Data Sharing and Data Accessibility Policy

The British Journal of Clinical Psychology recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

It is not necessary to make data publicly available at the point of submission, but an active link must be included in the final accepted manuscript. For authors who have pre-registered studies, please use the Registered Report link in the Author Guidelines.

In some cases, despite the authors’ best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or laws, or the nature of data gathered. In such cases, authors must inform the editors at the time of submission. It is understood that in some cases access will be provided under restrictions to protect confidential or proprietary information. Editors may grant exceptions to data access requirements provided authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

Finally, if submitting authors have any questions about the data sharing policy, access the [**FAQs**](https://bpspsychub.onlinelibrary.wiley.com/hub/datasharingfaqs) for additional detail.

Publication Ethics

Authors are reminded that the British Journal of Clinical Psychology adheres to the ethics of scientific publication as detailed in the [**Ethical principles of psychologists and code of conduct**](http://www.apa.org/ethics/code/index.aspx) (American Psychological Association, 2010). The Journal generally conforms to the Uniform Requirements for Manuscripts  of the International Committee of Medical Journal Editors ([**ICJME**](http://www.icmje.org/urm_main.html)) and is also a member and subscribes to the principles of the Committee on Publication Ethics ([**COPE**](http://www.publicationethics.org/resources/code-conduct)).  Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county.

Note this journal uses iThenticate’s CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. [**Read**](http://www.wileyauthors.com/ethics) Wiley’s Top 10 Publishing Ethics Tips for Authors. [**Read**](http://authorservices.wiley.com/ethics-guidelines/index.html) Wiley’s Publication Ethics Guidelines can be found.

ORCID

As part of the journal’s commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. This takes around 2 minutes to complete. [**Find more information here.**](http://olabout.wiley.com/WileyCDA/Section/id-828034.html)

6. AUTHOR LICENSING

**WALS + standard CTA/ELA and/or Open Access for hybrid titles**

You may choose to publish under the terms of the journal’s standard copyright agreement, or Open Access under the terms of a Creative Commons License.
Standard [**re-use and licensing rights**](https://authorservices.wiley.com/author-resources/Journal-Authors/licensing/licensing-info-faqs.html) vary by journal. Note that [**certain funders**](https://authorservices.wiley.com/author-resources/Journal-Authors/open-access/author-compliance-tool.html) mandate a particular type of CC license be used. This journal uses the CC-BY/CC-BY-NC/CC-BY-NC-ND [**Creative Commons License**](https://authorservices.wiley.com/author-resources/Journal-Authors/licensing/open-access-agreements.html).
Self-Archiving Definitions and Policies: Note that the journal’s standard copyright agreement allows for [**self-archiving**](https://authorservices.wiley.com/author-resources/Journal-Authors/licensing/self-archiving.html) of different versions of the article under specific conditions.

**BPS members and open access:** if the corresponding author of an accepted article is a Graduate or Chartered member of the BPS, the Society will cover will cover 100% of the APC allowing the article to be published as open access and freely available.

7. PUBLICATION PROCESS AFTER ACCEPTANCE

Accepted Article Received in Production

When an accepted article is received by Wiley’s production team, the corresponding author will receive an email asking them to login or register with [**Wiley Author Services**](http://www.wileyauthors.com/). The author will be asked to sign a publication license at this point.

Proofs

Once the paper is typeset, the author will receive an email notification with full instructions on how to provide proof corrections.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process – authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt of first proof.

Publication Charges

**Colour figures.**Colour figures may be published online free of charge; however, the journal charges for publishing figures in colour in print. If the author supplies colour figures, they will be sent a Colour Work Agreement once the accepted paper moves to the production process. If the Colour Work Agreement is not returned by the specified date, figures will be converted to black and white for print publication.

Early View

The journal offers rapid publication via Wiley’s Early View service. [**Early View**](http://olabout.wiley.com/WileyCDA/Section/id-404512.html#ev) (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Before we can publish an article, we require a signed license (authors should login or register with [**Wiley Author Services**](http://www.wileyauthors.com/)). Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

8. POST PUBLICATION

Access and Sharing

When the article is published online:

* The author receives an email alert (if requested).
* The link to the published article can be shared through social media.
* The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
* For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

**Promoting the Article**

To find out how to best promote an article, click [**here**](http://www.wileyauthors.com/maximize).

[**Wiley Editing Services**](https://wileyeditingservices.com/en/article-promotion/?utm_source=wol&utm_medium=backlink&utm_term=ag&utm_content=promo&utm_campaign=prodops)offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

Measuring the Impact of an Article

Wiley also helps authors measure the impact of their research through specialist partnerships with [**Kudos**](http://www.wileyauthors.com/kudos) and [**Altmetric**](http://www.wileyauthors.com/altmetric).

9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (**bjc@wiley.com**) or phone +44 (0) 116 252 9504.

Author Guidelines updated 14th October 2019

### Appendix 2: Critical Appraisal Skills Programme Qualitative Checklist

Can be accessed here: <https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf>

### Appendix 3: Critical Appraisal Skills Programme Randomised Controlled Trial Checklist

Can be accessed here: <https://casp-uk.net/wp-content/uploads/2018/01/CASP-Randomised-Controlled-Trial-Checklist-2018.pdf>

##

### Appendix 4: Quality Scores for articles reviewed

Table 1.3. Qualitative CASP Scoring Sheet

2 points = question criteria fully met

1 point = question criteria partially met

0 points = question criteria not met, or too unclear for the reviewer to tell

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CASP (2018) Quality Checklist – Qualitative Research | Stanley et al., 2006 | Grundy et al., 2016 | Simons et al., 2006 | Goward et al., 2006 | Slade et al., 2008 | Lester et al., 2004 | Loughlin et al., 2019 | Baker et al., 2019 | Berry et al., 2017 | Bucci et al., 2019 |
| Was there a clear statement of the aims of the research? | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 |
| Is a qualitative methodology appropriate? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Was the research design appropriate toaddress the aims of theresearch? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Was the recruitment strategy appropriate to the aims of the research? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Was the data collected in a way that addressed the research issue? | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 |
| Has the relationship between researcher and participants been adequately considered? | 0 | 0 | 0 | 0 | 2 | 0 | 2 | 2 | 2 | 2 |
| Have ethical issues been taken into consideration? | 1 | 2 | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 2 |
| Was the data analysis sufficiently rigorous? | 1 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 |
| Is there a clear statement of findings? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| How valuable is the research? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Total | 16 | 18 | 17 | 16 | 18 | 17 | 20 | 19 | 20 | 20 |
| % | 80 | 90 | 85 | 80 | 90 | 85 | 100 | 95 | 100 | 100 |

Table 1.4. Quantitative CASP Scoring Sheet

2 points = question criteria fully met

1 point = question criteria partially met

0 points = question criteria not met, or too unclear for the reviewer to tell

|  |  |
| --- | --- |
| CASP (2018) Quality Checklist – Randomised Control Trials | Slade et al., 2008 |
| Did the trial address a clearly focused issue? | 2 |
| Was the assignment of patients to treatments randomised? | 2 |
| Were all of the patients who entered the trial properly accounted for at its conclusion? | 2 |
| Were patients, health workers and study personnel ‘blind’ to treatment? | 1 |
| Were the groups similar at the start of the trial**?** | 2 |
| Aside from the experimental intervention, were the groups treated equally? | 2 |
| How large was the treatment effect? | 1 |
| How precise was the estimate of the treatment effect? | 1 |
| Can the results be applied to the local population, or in your context? | 2 |
| Were all clinically important outcomes considered? | 2 |
| Are the benefits worth the harms and costs? | 2 |
| Total | 19 |
| % | 86.36364 |

# Paper 2: Empirical Paper.

## Exploring the barriers to ‘recovery’ from psychosis as told by clients who experience psychosis using Q Methodology.

The following paper has been broadly prepared in accordance with the requirements of *The British Journal of Clinical Psychology* (see Appendix 1 for journal guidelines). Supplementary material is included for thesis purposes and will be removed for publication.

Word count: 8,017 (Exclusive of references and appendices)

#

## Abstract

Psychosis is one of the most life-impacting and arguably the most significant mental health conditions there is (Public Health England, 2016), for people who experience these difficulties there is often an associated lack of hope for recovery. This is despite recent government policy and NICE recommended guidelines encouraging a recovery approach (NICE, 2014; Department of Health, 2011; Department of Health and Social Care, 1999). This research uses q-methodology to investigate the views of people who experience psychosis and the barriers to their recovery.

Twelve participants completed an online Q study exploring their views on the barriers to recovery from psychosis. Data was analysed using KenQ statistical analysis package and three factors were identified, one being a bipolar factor and as such was split. These were: ‘Hopelessness for recovery’; ‘Interpersonal elements of care and feeling powerless’; ‘“Shameful feelings” and the views of others’ and ‘Negative experiences of care’. The findings revealed that despite there being no one universally agreed set of barriers to recovery, the impact of stigma on hope for recovery was evident across experiences. Experienced, perceived and internal/self-stigma all featured to differing degrees as barriers to recovery. Further research into the views held by staff working with this population would be beneficial.

#

## Introduction

### Psychosis

Psychosis is an umbrella term used in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V) (American Psychiatric Association [APA], 2013) and the International Statistical Classification of Diseases and Related Health Problems, tenth edition (ICD-10) (World Health Organisation [WHO], 1992) to describe a combination of symptoms that include hallucinations, delusions, disorganised thinking or behaviour, negative symptoms and functional impairment.

Public Health England (2016) described Psychosis as one of the most life-impacting and arguably the most significant mental health conditions there is affecting approximately 0.7% of adults over 16 in England in 2014 (McManus et al., 2016). Impact on life outcomes was the poorest for this group and they had the greatest variation in access to evidence-based care. They do however, state that people can and do recover. The National Institute for Health and Care Excellence (NICE), describe diagnoses that fall under the psychosis umbrella term are ‘associated with considerable stigma, fear and limited public understanding’ (2014: 6).

### Recovery and Psychosis

People who experience longstanding difficulties associated with psychosis and the associated stigma, have historically fostered ideas of hopelessness for ‘recovery’ (Vass et. al., 2015, Wood et. al., 2017 & Noordsy et. al., 2002). The concept of ‘recovery’ has been difficult to define (Wood et al., 2010). A Mind (Baker & Strong, 2001) survey suggested that ‘recovery’ was understood differently from person to person but that despite the differing definitions there were commonalities in strategies used to work towards individuals’ versions of ‘recovery’. Traditionally, within the domain of psychosis, ‘recovery’ has predominantly focussed on symptom alleviation (Silverstein & Bellack, 2008) with many clinical and randomised control trials (RCTs) adopting this stance (e.g. Liberman et al., 2002; Drury et al., 1996; Gee et al., 2016; Zhang et al., 1994). Whilst this has clinical relevance, focussing purely on symptom alleviation can lead to missing critical personal, psychological and social dimensions of recovery. As such, many researchers have explored the importance of quality of life as an indicator of recovery (e.g. Kukla, Lysaker & Roe, 2014; Roe, Mashiach-Eizenberg & Lysaker, 2011).

During the 1980s a number of first-hand accounts of recovery from mental distress were published (Deegan, 1988; Leete, 1989; Unzicker, 1989). In the early 1990’s Anthony (1993) began raising awareness of the need for recovery orientated mental health services. Initially this was more influential in the USA and New Zealand, however by the early 2000’s it became more prominent in the UK (Allott et al., 2002; Turner-Crowson & Wallcraft, 2002; Repper & Perkins, 2003). There was growing recognition that recovery does not just mean symptom alleviation or ‘cure’ but also involves personal change and the ‘development of a new sense of self that can lead to the establishment of a fulfilling life, whether or not symptoms are present’ (Pitt et al., 2007). Pitt et al. (2007), emphasised the concept of empowerment in rebuilding the self when conducting their user-led research into recovery from psychosis. Since then, government policy and NICE guidance have recommended the use of a recovery approach when working with psychosis (Department of Health and Social Care, 1999; Department of Health, 2011; NICE, 2014) and the recovery movement has advocated a move towards autonomy for clients with individuals’ own goals guiding treatment (Hamm et al., 2018).

Research highlights the impact of stigma associated with psychiatric diagnosis (Crisp et al., 2005) and how damaging this can be for individuals, resulting in a negative internalised sense of self with increased shame (Knight et al., 2003). Brohan et al. (2010) reviewed survey measurement of mental illness stigma, prejudice and discrimination experienced by people with lived experience in order to aid researchers in their use of such measures. They conceptualised stigma as comprising three categories; experienced, perceived and internal/self-stigma. Experienced stigma is described as the *‘experience of actual discrimination and/or participation restrictions’* (Van Brakel et al., 2006). Perceived stigma is seen as encompassing both what an individual thinks most people believe about the stigmatised group in general and how the individual thinks society views him/her personally as a member of the stigmatised group (LeBel, 2008). Internal or self-stigma is described as the internalisation of external stigma and is defined by Corrigan (1998) as *‘the product of internalisation of shame, blame, hopelessness, guilt and fear of discrimination associated with mental illness’.* The importance of the impact of internalised stigma on psychological well-being and recovery was noted in a further systematic review and meta-analysis of literature (Livingston & Boyd, 2010) concerning the relationship between internalised stigma and a range of sociodemographic, psychosocial, and psychiatric variables for people who live with mental illness.

Much of the research to date has tended to look at barriers to clients accessing specific services, such as Early Intervention (EI) (Anderson et al., 2013; Connell et al., 2015; Lucksted et al., 2015) and as such understanding barriers to recovery is much more advanced in these settings. The existing body of research also looks at the barriers to delivering particular therapeutic interventions such as medication or specific psychological therapies (Bucci et al., 2016; Jones et al., 2019; Lecomte et al., 2018). Bucci et al. (2016) identified barriers to implementation and engagement with Family Interventions specifically, such as poor staff training and confidence and staff attitudinal barriers such as favouring a more medicalised model. Studies looking at barriers to recovery within different services identified similar obstacles to engagement (Jones et al., 2019; Lecomte et al., 2018).

### Gaps in Literature and Research Rationale

Notably, there is little published research, exploring the barriers to recovery for people who have lived with a long-term diagnosis of psychosis, or who are accessing services outside EI services. Given current policies and guidelines such as ‘No Health without Mental Health’ (Department of Health, 2011), encourage a move towards a recovery orientated approach for all, it would be helpful to begin to gain the views of service users on what blocks recovery in a more chronic population.

### Research Aims

This study will explore the barriers to recovery for people who have lived long-term with a diagnosis of psychosis. Participant preconceptions and views around medication, ideas of hope, accessibility of services, support and relationship elements will be identified and views of those as barriers to recovery will be explored.

## Method

### Ethics

Staffordshire University’s Research and Ethics Committee provided full ethical approval for the study (Appendix 2) and subsequent minor amendment (Appendix 3). The research was conducted in line with the British Psychological Societies Code of Human Research Ethics (2014). The study was overseen by clinical and academic supervisors.

### General overview of Q-Methodology

Q method was developed by William Stephenson in 1935 and is described as a “qualiquantological” method (Watts & Stenner, 2005). According to Stenner et al., ‘Q methodology was designed expressly to explore the subjective dimension of any issue towards which different points-of-view can be expressed’ (2017: 12). They describe how methodologically, human subjectivity is the centre of concern and that participants are the variables. Q methodology aims to explore an individual’s subjectivity in a systematic way and then uses statistical methods to identify patterns in the data (Brown, 2008).

Participants’ subjective views and beliefs are collected via completion of a ‘Q-sort’; a collection of statements that are sorted into a predefined distribution by a participant according to a subjective dimension such as “agreement/disagreement”. Each individual Q-sort is then compared through intercorrelations and by-person factor analysis to provide an overall understanding of the different viewpoints (Watts & Stenner, 2012).

Given the target population for this research Q methodology was felt to be appropriate as it looks at the different ways an idea can be construed. This methodology enables subjugated voices to be heard and captures a variety of beliefs contributing to a better understanding of any shared viewpoints without losing a person’s subjectivity. The methodology allows participants to self-categorise into groupings that emerge as part of the analysis process rather than being placed into any predefined groups (Watts & Stenner, 2012).

### Service user involvement

In the early stages of the project the researcher had discussions with relevant service user groups about potential research questions, methodology and their views on the importance/relevance of the proposed question. These service users felt that the question posed was of importance to them and something they felt would be beneficial to explore, the methodology, despite being a new concept to the members, was thought to be an interesting and helpful way to explore views. Following completion of the research, findings were shared and discussed with these service user groups and the executive summary was commented on by them.

### Q-set design and content

The Q-Statements (Q set) (Appendix 4) were developed and informed by a comprehensive literature review, discussions with the research team and members of relevant service users groups (Peter Bullimore & colleagues at the National Paranoia Network). Discussions with relevant service-user groups were carried out to ensure there was an appropriate number of statements, that they cover the breadth of the subject and that each item made a unique contribution to the Q set (Watts & Stenner, 2012). The final Q set was agreed to be representative of the topic: barriers to recovery for individuals who experience psychosis. Statements were then worded to answer the question ‘From your own personal experiences, what are the barriers to recovery from psychosis?’.

The final number of statements in the Q set should not be too many to take up considerable amounts of time or overwhelm the participant. Curt (1994) and Stainton Rogers (1995) recommend between 40-80 statements. The final Q set in this study contained 56 statements.

### Participants

The target population were people who experience psychosis, with or without a diagnosis. Eleven participants took part in the study and recruitment took place between October 2020 and January 2021. Q-methodology does not dictate a set sample size, however it does advise between 12-40 participants (Webler, Danielson et al. 2009; Cairns 2012). The sample aims to establish the existence of different viewpoints and understand and compare these rather than requiring a certain number of participants to be associated with each viewpoint (Watts & Stenner 2012) and is underpinned by a social constructionist ontology, where by there is no one ‘truth’ to be discovered.

The inclusion criteria were as follows; adults aged over 18, diagnosed with schizophrenia or who experience auditory and/or visual hallucinations commonly associated with psychosis, have experience seeking help for their mental health in the UK and understand and write using the English language. Exclusion criteria included; those whose experiences are as a result of an organic impairment, have a primary diagnosis of addiction or are accessing Early Intervention (EI) services, inpatient mental health care or crisis/home treatment care at the time of recruitment. Those accessing EI services are excluded on the basis that this research is seeking the views of those that have lived with the diagnosis longer term and therefore would not be accessing EI services. Similarly, people that are accessing inpatient mental health care or crisis/home treatment care are excluded as their views at this time may bring about views that are excessively coloured by their current situation. It was also felt that it would not be appropriate to involve people who are actively in crisis.

### Procedure

Participants were recruited via an online advert posted on the researchers’ social media pages including Facebook and Twitter. The advert was shared on relevant open Facebook groups such as Hearing Voices Network: England. Permission was obtained from the leaders of the National Paranoia Network and London Hearing Voices Network for the advert to be shared in their monthly newsletters. This ensured access to a wide range of participants with varying backgrounds and experiences and meant recruitment was not limited to social media. Details of participant demographics can be found in Table 2.1 below.

Table 2.1 Participant demographic details

|  |  |  |
| --- | --- | --- |
| Gender | Male | 7 |
| Female | 5 |
| Age | Range | 24-59 |
| Mean | 38.3 |
| Ethnicity | White British | 10 |
| Black British | 1 |
| Jewish | 1 |
| Employment status | Employed (including self-employed) | 6 |
| Unemployed | 4 |
| Voluntary/Unpaid Work | 2 |
| Years with experiences | Range | 1-32 years |
| Mean | 16 years |

Participants clicked a hyperlink from the online study adverts (Appendix 5) or typed this into their web browser if they saw the advert in the newsletters. A Qualtrics survey page then detailed the participant information sheet (Appendix 6) and the researchers contact details. Participants were not required to give any identifiable information and remained anonymous. They made up a unique participant ID and noted this for future reference should they wish to withdraw. Participants were aware that extracts from post-sort questions may be used in the write up. Participants were aware who would have access to the anonymised electronic data they provided and that it would be stored in password protected electronic documents. After this, participants completed the online consent form (Appendix 7), demographic questions (Appendix 8) and study itself.

#### Administering the Q sort

The Q sort was delivered using Q-sortware (Pruneddu, 2011). Prior to commencing the Q-sort, participants were given written instructions detailing how to use the software and informed they would be guided through how to complete it stage by stage.

Participants were initially required to sort statements into three categories: those they agree with, those they disagree with and those they feel indifferent about. Following this they were asked to further sort these into a forced distribution (see Figure 1) based on how much they felt them to be a barrier to their recovery, ranging from -5 completely disagree to +5 completely agree.



Figure 2.1 Q sort response matrix.

Immediately following this, the participants completed a brief post-sorting questionnaire (Appendix 9) to gain additional information regarding the participants’ perceived meanings of the statements and explanations for the placement of statements. This helps when interpreting the factors (van Exel & de Graaf, 2005). Following completion of this participants were debriefed (Appendix 10).

## Results

### Statistical Analysis

Data was first exported from Q-sortware, and the resulting Microsoft Excel document was password protected and saved on the researcher’s secure password protected laptop. The relevant information was then uploaded to Ken-Q (Banasick, 2016), an online Q-sort statistical analysis package, used to carry out statistical analysis of the Q sorts. Given the methodology and sample size the role of the researcher is key. An interpretivist epistemological position was taken whereby meaning is created between rather than within people and as such a different researcher may likely make a different interpretation of the factors presented.

#### Correlation

A total of twelve Q sorts were intercorrelated to show the extent of the relationships between the individual Q sorts (Appendix 11). All twelve sorts correlated with at least one other sort.

#### Factor Loadings

Principal Component Analysis (PCA) was used to identify the number of potential factors within the data. Four factors were initially identified by the analysis package as being over the eigenvalue (the strength of the factor) of one. Table 2.2 shows the eigenvalues and cumulative percentages and amount of variance they explained.

Table 2.2. Initial PCA Factor Analysis

|  |  |  |  |
| --- | --- | --- | --- |
| Component  | Eigenvalue | Cumulative percentage | Variance explained (%) |
| 1 | 3.4356 | 29 | 29 |
| 2 | 1.8295 | 44 | 15 |
| 3 | 1.2532 | 54 | 10 |
| 4 | 1.2215 | 64 | 10 |

### Initial Analysis

Initial results of the PCA suggested a four-factor model explaining 64% of the variance. A varimax rotation was conducted with automatic flagging to ensure there were factor loadings for all four factors. A three-factor model was decided to be most appropriate to interpret, with all twelve Q sorts loading significantly onto one or other of these factors. A three-factor model explains 54% of the data variance, in line with guidance that suggests factors should account for at least 35-40% of the total study variance (Kline, 1994). Factor three is a bipolar factor, with two sorts loading positively and one loading negatively. As such, it was decided to split this factor, resulting in factor 3a and 3b.

The decision to use a three factor model was determined by considering statistical methods of extraction including; the eigenvalues (EVs), the scree plot and the percentage of the total variance the factors accounted for, along with the researcher exploring the data and potential factor solutions to see which made the best sense of the data (Watts & Stenner, 2012). Appendix 12 shows the factor loadings for each Q sort on each factor. The loadings represent the extent to which the Q sort is typical of that factor.

#### Correlation between Factors

Table 2.3 confirms there is no correlation between factors selected and so each is distinct from each other.

Table 2.3. Correlations between factors

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Factor | 1 | 2 | 3a | 3b |
| 1 | 1 | 0.3383 | 0.2929 | 0.1596 |
| 2 | 0.3383 | 1 | 0.1088 | 0.2164 |
| 3a | 0.2929 | 0.1088 | 1 | -0.0632 |
| 3b | 0.1596 | 0.2164 | -0.0632 | 1 |

#### Consensus & Disagreement Statements

There were a number of consensus statements (Appendix 13) that were identified in the data, these are statements that are ranked similarly across factors and are non-Significant at P > 0.01 or P > 0.05. These are of interest as they are not specific to any one factor and will be discussed in more detail shortly.

### Interpretation

Three factors were identified from the data. The factor which explained the greatest variance, 29%, was factor 1. Factor 2 accounts for 15% of the variance and factor 3 the bipolar factor, accounted for 10% of the variance. Factor arrays (Appendices 14 & 15) were created for each factor, this is a visual representation of the viewpoint of the specified factor and is created from the average loadings of the Q sorts onto each factor. This helps with interpretation of the factors and ensures a holistic understanding of the factor. Each factor will now be discussed in turn.

#### Factor 1. Hopelessness for recovery.

Factor 1 explains 29% of the variance with four Q sorts loading significantly. This factor represents a viewpoint that emphasises the hopelessness for recovery for people with psychosis. Those loading onto this factor express a hesitation to seek help for fear of seeming weak or ‘crazy’ and convey a sense of powerlessness.

Stigma was a key concept in this view, with participants believing they cannot get better. Participants strongly agreed ‘The stigma of my diagnosis’ (S8;+5) and ‘Lack of treatment options’ (S43;+4) were barriers to recovery, conveying a sense of hopelessness and that treatment options are few. Qualitative feedback supports this this with participant 12 writing “I didn’t think psychosis was something you could get better from, it’s something you're stuck with for life”. Similarly, participant 6 wrote “My diagnosis left me feeling like it was something I would never get better from...I didn't feel like there was hope that I could get better...”. People believed treatment options were limited with little other than medication being considered (S47;+3), thus reinforcing the stigma that recovery is impossible. ‘Thinking I can’t recover from psychosis’ (S55;+4) was a distinguishing statement for this factor and further evidences this point, ranking higher on this factor than any other.

With the concept of stigma and hopelessness came a feeling of shame. People agreed that ‘feeling embarrassed or ashamed to ask for help’ (S9;+2) was a barrier to recovery and that they would seem weak if they sought help (S22;+2). The placement of these statements coupled with thinking they may be put in hospital against their will (S11;+3), further confirms the individual’s belief that recovery is impossible.

Participants believe they can’t lead a fulfilling life with psychosis (S56;+5) however, professional care was believed to be helpful (S29;-4) and they felt listened to (S6;-2) and understood (S51;-3). The neutral placement of ‘the emotional connection with my key worker’ (S7;0), ‘not feeling involved in my care’ (S5;0), ‘my opinion wasn’t valued’ (S50;0) and ‘care staff didn’t respond to my needs’ (S42;-1) further support this. All participants here reported contact with Community Mental Health Teams (CMHTs) and ranked ‘Previous experiences with mental health care’ (S32;-2) low, not finding it to be a barrier, indicating a positive relationship with services.

Three of the four participants had not had psychological therapy. This may explain the agreement with ‘medication alternatives were not encouraged’ (S47;+3), a ‘lack of treatment options’ (S43;+4) and ‘I didn’t know what services were there to help me’ (S53;+4) as barriers, the latter statement was a distinguishing statement of the factor. It seems participants are not aware of what services are available and medical treatment options seen as being favoured, suggesting a dominant medical model. Consequentially, service users appear not to see the range of alternative treatments available to them, which risks confirming to them that recovery is impossible. This coupled with participants’ belief that professional support would be helpful, offers support to the idea that this view is primarily concerned with the lack of hope for recovery.

Concerns about work were less of a feature with people disagreeing with ‘Not wanting to take time off work’ (S33;-3) and ‘What people at work might say’ (S23;-3). These were distinguishing statements of the factor, and participants ranked these, along with statements about parental roles, lower on this factor therefore not experiencing them as barriers. All except one participant on this factor were unemployed and had no children.

#### Factor 2. Interpersonal elements of care and feeling powerless.

Factor 2 explains 15% of the variance with five Q sorts loading significantly. This factor places strong emphasis on interpersonal elements of care delivery. Thinking they didn’t have a problem or not wishing to talk about their difficulties were not barriers. Participants experience a sense of powerlessness and lack autonomy in their care, both of which are barriers to their recovery.

As with factor 1, stigma (S8;+2) and lack of hope for living a fulfilling life (S56;+3) feature as barriers to recovery within this factor. Participants loading onto this factor seem to express more interpersonal elements than other factors. They ranked ‘the emotional connection with my keyworker’ (S7;+4) and ‘staff talked down to me’ (S48;+1) higher on this factor than any other, with the latter being a distinguishing statement.

Linked with this, statements concerning the autonomy participants had in their care were viewed as barriers to recovery, ‘not feeling listened to’ (S6;+3) and ‘care staff didn’t recognise or respond to my needs’ (S42;+3) were agreed with, further conveying a sense of powerlessness and a lack of control over their care. Participant 9 illustrated this describing a “loss of control over the course of my life”. This is further evidenced by the strong agreement with ‘Thinking I will be put in hospital against my will’ (S11;+5), a distinguishing statement of the factor. This negative view of interactions and treatment options is further illustrated by participant’s responses on the post-sort questionnaire. Participant 10 wrote “the relationship with a professional is key. Poor communication can be very damaging” and participant 7 describing their hospital experience as “the worst experience of my life and made me very reluctant to ever use mental health services again”.

Participants believed both they and staff were aware of what services were available to them (S52;-1, S53;0). This is perhaps representative of the fact all participants in this factor had accessed talking therapies and therefore were aware of medication alternatives. Despite their access to talking therapies, these people held similar beliefs to those in factor 1 believing medical treatments were dominant, agreeing with ‘Lack of treatment options’ (S43;+3), ‘Medication alternatives were not encouraged’ (S47;+1) and ‘I didn’t want to take medication’ (S44;+1). Participant 5 evidenced this writing “I found appointments to be very medically focused…alternatives weren't prioritised or offered in the same way”. Participant 5 told of how they wished to engage in therapy but “this [therapy] was not offered and I had to request this”.

Overall, within this factor people have a negative view of relationships with staff and services, with care being seen as generic rather than individualised (S40;+2) and participant’s views not being valued (S50;+1) or heard (S6; +3), leaving them feeling uninvolved in their care (S5;+2) and thinking they can’t lead a good and fulfilling life (S56;+3).

This view is less concerned with the views of others than other factors, evidenced by the neutral placement of statements concerning this (S12;-1, S19;-1). All except one of these participants were in some form of employment either paid or unpaid, which perhaps explains the slight agreement with ‘what people at work might say’ (S23;+1) despite them being unconcerned about the views of friends or family.

‘I don’t like talking about my feelings, emotions or thoughts’ (S30;-4) ranked lower here than on any other factor and was a distinguishing statement. This suggests people were comfortable discussing these things, something that the other factors disagreed with. Similarly, ‘Thinking I didn’t have a problem’ (S13;-5) was not felt to be a barrier evidenced by participant 8 writing “From the outset I always felt that I had an illness or that something was wrong”. These participants acknowledge their difficulties and believe recovery is possible, disagreeing with ‘thinking I can’t recover from psychosis’ (S55;-1) and ‘thinking the problem would get better by itself’ (S27;-2) as barriers.

The full array tells us people are aware of their difficulties and are willing to discuss them believing this will be beneficial. However, services are seen as unresponsive to their needs and opinions leaving people feeling powerless with a lack of control.

#### Factor 3.

Factor 3 explains 10% of the variance and was a bipolar factor. This factor was split into factor 3a and 3b. Two Q sorts loaded significantly onto factor 3a and one Q sort loaded significantly onto factor 3b.

##### 3a. ‘Shameful feelings’.

The two participants that loaded onto factor 3a began experiencing their difficulties within the last two years, distinguishing them from other participants. Shame is a strong feature in this view, with participants being concerned about the opinions of key others. Those loading onto this factor seem more optimistic about the prospect of recovery and are more positive about experiences with staff and services than other factors.

Within this factor participants appeared to struggle with accepting their difficulties seeing this as a barrier to their recovery, evidenced by their agreement with ‘thinking I didn’t have a problem’ (S13;+1). This may be related to the time they have experienced symptoms for. They also agreed with ‘wanting to solve the problem myself’ (S14;+3) and ‘thinking the problem would get better by itself’ (S 27; +4).

Participants within this factor believe recovery is possible, evidence by the neutral placement of ‘thinking I can't recover from psychosis’ (S55;0). Interestingly though, participants from this viewpoint agreed ‘the stigma of my diagnosis’ (S8; +3) was a barrier to recovery.

Statements concerned with experiences of staff and services were not seen as barriers to recovery and ranked lower on this factor than others (S42;-2, S48;-3, S51;-1). Participant 4 spoke of how the psychological care they received outside of the NHS was “tailored to me” and that they felt able to advocate for their needs. This was further evident in the disagreement with ‘Generic care that wasn’t individualised’ (S40;-1). The positive experience of services and concept of feeling heard was further evidenced by participants’ strong disagreement with ‘my opinion wasn’t valued’ (S50;-5) which was a distinguishing statement ranking lower on this factor than any other. Participant 2 offered support to this writing ‘…my limited experience was relatively positive’. Unlike all other factors, ‘treatment side effects’ (S28;-4) and ‘medication alternatives were not encouraged’ (S47;-1) were not felt to be barriers in this view.

Hope for recovery is clouded by a sense of shame, which can be seen in participants’ agreement with ‘feeling embarrassed or ashamed to ask for help’ (S9;+4). Participant 4 highlighted this writing ‘Shameful feelings were really dominant for me…’. Shame appears to be associated primarily with what others think. Worries about what friends (S12;+4), family (S19;+5) and co-workers (S23;+3) might say were ranked highly in this factor and were significant distinguishing statements of the factor. Furthermore, people agreed ‘wanting to solve the problem myself’ (S14;+3) was a barrier to recovery. It is likely they believe this will enable them to keep the problem to themselves and thus means they will not have to encounter the views of others. Participant 2 gave further support to this writing ‘I am worried about what my family would say…I have avoided seeking further support due to fear of what others might think’. In the same vein, ‘thinking I would be seen as crazy’ (S10;+5) was completely agreed with as a barrier, ranking higher on this factor than any other, further adding to the concept of stigma and shame around what others will think. Looking at the array holistically alongside participant post-sort responses reflects a fear of the judgement of others, particularly their family friends and colleagues.

The impact of difficulties on work was notable within this factor with both participants being employed. ‘Thinking it might impact my chances of getting a job’ (S21;+3) and ‘Not wanting to take time off work’ (S33;+2) were viewed as barriers to recovery. This may be related to the placement of being embarrassed to seek help (S9;+4), ‘thinking the problem would get better by itself’ (S27;+4) and wanting to fix the problem themselves (S14;+3) suggesting this view is concerned with the views of others and the shame or negative consequences that may result.

##### 3b. Negative experiences of care.

This factor represents one participant’s viewpoint. This participant had lived with their experiences for 18 years, were male and were in unpaid/voluntary work. What differentiates factor 3b from 3a are the almost oppositional experiences described about services.

Initially this factor seemed somewhat confused with statements appearing contradictory. Statement placement taken together with post-sort information gave a clearer view. ‘I didn’t know about talking therapies’ (S45;+5) was agreed with as a barrier despite the participant declaring in initial demographic questions they had accessed talking therapies. This is at odds with completely agreeing ‘I don’t like talking about my feelings, emotions or thoughts’ (S30;+5) was a barrier. Post-sort feedback where participant 3 described how they had to ‘learn to use therapy before it was helpful’ offered insight into this. This person spoke about how they didn’t like to talk about their difficulties which they saw as a significant barrier to recovery, but once they had ‘learnt to use therapy’ they were able to see how beneficial it was.

This participant reported ‘previous experiences with mental health services’ (S32;+3) were barriers to their recovery. They also believed professional care would not be helpful (S29; +1) and ‘Care staff didn’t recognise or respond to my needs’ (S42;+3) highlighting the impact that previous experiences have on future hope and recovery. The participant’s agreement with thinking they could not get better (S54;+2) and that it is not possible to live a fulfilling life with psychosis (S56;+3) further evidence this.

Despite a generally negative view of recovery and seeking help, communication from care providers (S39;-2) was not thought to be a barrier and this participant did not relate to feelings of shame (S9;0) or powerlessness (S49;-3). This participant feels involved in their care despite not feeling understood or heard by staff, they do not think feeling ashamed to seek help or feeling powerless were barriers to recovery.

This participant said they were in unpaid or voluntary work. As with factor 3a, work seems important for this person and statements related to employment ranked highly as barriers to recovery. This individual didn’t want seeking support to impact on their future job opportunities (S21;+4) and they agreed ‘what people might say at work’ (S23;+2)and ‘not wanting to take time off from work’ (S33;+4) were barriers to recovery.

### Consensus Statements

Being too unwell to ask for help (S15; 0, -1, -3, -1) was a statement that no participant had a strong opinion on. This suggests people in this sample do not feel that being too unwell to seek help is an issue. Rather for these people it is the view people hold of themselves and the experience of the help they receive that can be a barrier. This will be discussed further in the discussion.

There was a slight agreement by most people that not wanting a mental health problem on their records (S20, +1, +3, +3, 0) was a barrier, with only the one participant that loaded onto factor 3b neither agreeing nor disagreeing. This perhaps underpins the concept of stigma that runs through all the factors and explains that generally people are slightly concerned about what having a mental health problem on their records would mean. Similarly, the impact it may have on chances of getting a job (S21; +1, +3, +3, +4) was something that all participants felt was to some degree a barrier.

Language barriers (S38; -5, -5, -3, -5) were not reported by any participant to be a barrier. This is representative of the lack of diversity in the sample. Similarly, and perhaps also related to the lack of diversity in the sample, all participants agreed that preferring to use alternative forms of care such as religious healing or complimentary therapies (S26; -1, -3, -3, -4) was not a barrier.

There was consensus across factors that wishing to seek support from family and friends (S31; -3, -3, -1, -3) was not a barrier. In the same vein all participants either agreed or felt neutrally that having no one to help them get help (S35; -1, -2, -1, -3) was not a barrier.

The vast majority of participants found long waiting times (S37; +2, +4, +2, +3) to be a barrier to their recovery, indicating wherever support is accessed people feel they wait too long. Thinking it is a waste of time (S46; -1, -3, +1, 0) was something that participants tended not to have strong opinions on either way. With the exception of two participants, all others felt neutrally or slightly disagreed this was a barrier to recovery.

All factors agreed a lack of treatment options (S43; +4, +3, +1, +2) was a barrier, the degree of agreement varied however. This is likely due to the different importance people placed with other statements within their sorts that they felt were more problematic a barrier.

All factors express no strong view on ‘Staff didn’t know what services were available to help me’ (S52; 0, -1, 0, -2). Individual participant’s views on this were mixed with some finding it to be a slight barrier and others slightly disagreeing.

Although not a consensus statement it is important to note that all factors allude to the impact of stigma (S8; +5, +2, +3, -2). All but two participants, agreed this gets in the way of their recovery. The way in which participants placed other statements sheds more light on what elements of stigma they considered to be the most problematic. The two participants that did not agree with this as a barrier to recovery did however convey a sense of stigma based on the placement of other statements.

## Discussion

### Summary of Findings

Three factors explained 54% of the data variance and sorts, factor three was a bipolar factor and so was split into factor 3a and 3b. Factor 1: *‘Hopelessness for Recovery’,* factor 2: *‘Interpersonal elements of care and feeling powerless’,* factor 3a: *‘“Shameful feelings” and the views of others’* and factor 3b: *‘Negative experiences of care’*. Whilst all factors express different views on what impacts recovery, there appears to be underlying similarities that link them all. These are stigma, lack of treatment options and associated hope for recovery and a sense that people with psychosis cannot live a fulfilling life.

Past research highlights the impact of stigma associated with psychiatric diagnosis (Crisp et al., 2005). Knight et al. (2003) note how the impact of diagnosis on the individual is often damaging, affecting things such as employment and leading to a negative internalised sense of self and associated shame. Specifically, in relation to the stigma associated with psychotic diagnoses there are perceptions of dangerousness, unpredictability and permanence (Crisp et al., 2000; Crisp et al., 2005) further contributing to a negative sense of self. Within these sorts all factors rank ‘Thinking I can’t lead a good, fulfilling life with psychosis’ (S56;+5,+3,+1,+3) as a barrier to recovery. This implies participants felt their difficulties were eternal and would prevent them living their lives the way they would like to. Despite Public Health England (2016) suggesting that people can and do recover from psychosis, it appears people themselves do not believe this to be true.

The current research adds to the work of Brohan et al. (2010) and Livingston & Boyd (2010) on the impact of stigma on psychological wellbeing and recovery. Findings show experienced, perceived and internal stigma all contribute to a lack of hope for recovery. Findings offer insight into the subtle nuances of the various types of stigma, with factor arrays and individual participant sorts giving more in depth views of the specifics of experienced, perceived and internal stigma and what contributes to creating and maintaining these types of stigma as barriers to recovery.

Experienced and internal stigma are evident in factor one where participants expressed a lack of hope for recovery. They suggest services reinforce this through favouring a medical model and offering limited treatment options, adding to previous research by Bucci et al. (2016), where staff attitudinal barriers such as favouring a medical model were perceived to be a barrier by service users. Both factor one and two further evidence the role of experienced stigma, with participants reporting medication alternatives and talking therapies were not encouraged. Participant 5 captures this well writing “I found appointments to be very medically focused and treatments to be medication only. I also felt that alternatives weren't prioritised or offered in the same way as medication. I wanted to engage in therapy to learn ways to manage my experience and this was not offered and I had to request this”.

This brings us back to the concept of recovery and how it is defined. It appears that services and individuals accessing them may hold different views on this, which may contribute to why individuals are left with a sense they cannot live a fulfilling life with psychosis and that recovery isn’t possible. It also offers a further example of experienced stigma. Participants describe a tendency for services to not encourage medication alternatives suggesting recovery is potentially being understood from the more traditional symptom alleviation stance. This is in contrast with participants who are viewing recovery from a quality of life perspective, evidenced by the placement across factors of ‘thinking I can’t lead a good and fulfilling life with psychosis’.

The recovery movement has advocated a move towards autonomy for clients and for self-directed recovery, with individuals’ own goals guiding treatment (Hamm et al., 2018), however this does not seem to be participants’ experience. NICE guidelines (2014) stress that taking time to build supportive and empathic relationships with service users is an essential part of care and the service users experience. This is something that current findings suggest is lacking in some experiences, with participants feeling they are not understood and that their opinions were not valued. If true recovery orientated care is to be achieved this needs to be addressed. Even where clients feel heard and understood by services there is still a sense that there is a lack of treatment options for people with psychosis and that medication alternatives are not encouraged further contributing to experienced, perceived and internal stigma. Furthermore, this does not fit with recommended NICE guidelines that state all persons experiencing psychosis should be offered CBT and that all services providing support for people with psychosis should offer a comprehensive range of interventions (NICE, 2014).

A survey carried out by Mind (Baker & Strong, 2001) suggested that what recovery looked like was indeed different from person to person but that helpful strategies included talking to family and friends, eating well, working and volunteering, hobbies and physical activity. It is important therefore that services and staff are discussing with service users what they see in their recovery, fostering a sense of hope that things can be different and a vision of what could be done rather than what cannot. If not these disempowering experiences of services result in internalised stigma and a sense that things cannot get better, in turn this can impact on employment and social networks, perpetuating this lack of hope for living a meaningful or fulfilling life.

The results of the current research support Pitt et al. (2007), in relation to the importance of empowerment in rebuilding the self. The notion of loss of self and the disempowering experiences of mental health services that Pitt (2007) identifies is something that resonated with many of the participants in this research and was particularly evident in factor 2 and 3b. These factors reported the impact of interpersonal elements of care as barriers to recovery suggesting disempowering encounters with staff and services blocked their recovery. Slade & Heywood (2007, pp.82) detailed how a recovery approach in practice should *‘mean clinicians basing decisions less on professionally-defined goals and more on listening to and acting on the service user’s wishes’*. This is supported by the current research with people generally agreeing that care was generic and not individualised suggesting there is some way to go before services achieve truly recovery focussed care.

### Implications for Clinical Practice

Stigma was a key feature of these findings and was seen as a barrier to recovery. It is therefore important that clinicians assess the impact different types of stigma play in a person’s presentation in order to better plan individualised care. The staff in mental health services must be willing to have open discussions and work in partnership with service users about recovery and what that means to the individual. Taking into consideration and advocating that this may be in terms of both symptom reduction strategies and meaningful occupation or life fulfilment goals. It is vital staff are working towards the same recovery goals as the service user and maintain a sense of hope in line with NICE guidelines that a service users experience is delivered in an atmosphere of hope and optimism (NICE, 2014).

Perhaps most importantly service users must feel listened to, understood and involved in their care and receive a greater access to alternative treatment options. This mirrors Hamm et al. (2018) and the idea that recovery orientated care needs to be user-directed and with individuals’ own goals guiding treatment. This will give the individual a sense of control over their recovery journey and foster ideas of hope for recovery. In order to do this staff must be aware of all the treatment options available to people with psychosis and ensure the client is well informed of their options. Staff should resist not discussing options because they have preconceptions that it will not be beneficial or that the service users doesn’t want to pursue it.

Previous studies have explored the impact of interventions such as psychoeducation and cognitive behavioural therapy (Knight et al., 2006; Lucksted et al., 2011) for people with psychosis. Having a more positive understanding of individual experiences can help in defending against the pathologising influence of stigma (Brett et al., 2013). Clinicians have a key role to play in promoting this with service users and in noting how this can be played out in services and the impact it can have on service users experiences.

### Methodological Considerations and Limitations

A strength of the research is that Q methodology has yet to be used to explore service users views of the barriers to recovery from psychosis. Q methodology allows underrepresented or subjugated views to be heard and as such this research has captured the voices of those who are typically not well heard. Existing literature has tended to research the views of people who are already accessing services and the barriers to people accessing EI services in particular. This research has opened this discussion up to see what the barriers are to accessing any form of support with psychosis and thus hearing the voices of people who have lived longer term with their difficulties who would have been excluded from any EI research.

Gender was well balanced within the sample however there is a lack of diversity within the sample with the majority of participants identifying as white British. Similarly, the age range of participants was limited, with no one over the age of 59 participating. Future studies should broaden access to a wider range of participants.

### Statement about impact of global pandemic 2019-2021

COVID-19 had a significant impact on the way in which this research was conducted. People who experience psychosis are a hard to reach population and so trying to do this online had its difficulties. The post-sort questionnaire was hard to administer via the software and as such participant responses were not as in depth as they would have perhaps been if this had been done in person. Similarly some of the participants reported difficulties using the software and that it was not that ‘user friendly’. The nature of carrying out purely online research meant that only people with access to a laptop, PC or tablet with internet connection could take part resulting in the research not being accessible to all. This in itself could be seen as a barrier, particularly if services have had to move online.

### Recommendations for Future Research

Given the impact of carrying out this research online it would be interesting to repeat the same project in person to see if the post-sort questionnaire brings about any further information. This may give further context to why people placed statements where they did.

It may also be beneficial to carry out this research with staff working with people with psychosis to ascertain their views on the barriers to recovery. This could contribute to building a more complete picture of the barriers from both perspectives.

### Conclusion

Clearly, given the complexities of recovery and the meaning attached to it, there will never be one explanation of the barriers to recovery for people with psychosis. There does however, appear to be commonalties across views in relation to difficulties with access and engagement. People appear to share feelings of ambivalence about the help services can offer them and if it recovery is possible. Whilst services and staff can help to some degree with managing these barriers, there is still a long way to go in reducing the external stigma associated with psychosis diagnoses in the general population. Whilst this is present, barriers will persist around not wanting to seem ‘crazy’ or being fearful of what others may think.

These findings emphasise the need for holistic treatment options and may seem to infer a resistance to the medical model. It is vital that as guidelines suggest, a combination of medication and alternative treatment options are considered for people who experience psychosis.

This research fulfilled its aim of exploring the barriers to recovery from psychosis and to see if there were any significantly different views held, discovering there were not. Stigma was found to have impacted hope for recovery in all views. It was clear from the findings that a person’s individual experience of help was crucial to their sense of self and thus ability to consider recovery from their difficulties.

## References

Allott, P., Loganathan, L. & Fulford, K.W.M. (2002). Discovering hope for recovery from a British perspective: a review of a selection of recovery literature, implications for practice and systems change. *Canadian Journal of Community Mental Health, 21*, 13-33. <https://doi.org/10.7870/cjcmh-2002-0014>

American Psychiatric Association. (2013). Anxiety Disorders. In *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington DC: American Psychiatric Association Publishing.

Anderson, K. K., Fuhrer, R., & Malla, A. K. (2013). “There are too many steps before you get to where you need to be”: Help-seeking by patients with first-episode psychosis. *Journal of Mental Health*, *22*(4), 384-395. DOI: 10.3109/09638237.2012.705922

Anthony, W.A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1900s. *Psychosocial Rehabilitation Journal, 16*, 11-23. <https://doi.org/10.1037/h0095655>

Baker, S. & Strong, S. (2001). *Roads to Recovery: How People with Mental Health Problems Recover and Find Ways of Coping*. London: Mind.

Banasick, S. (2016). *Ken-Q Analysis.* Retrieved from <https://shawnbanasick.github.io/ken-q-data/index.html#section1>

Brett, C., Heriot-Maitland, C., McGuire, P., & Peters, E. (2013). Predictors of distress associated with psychotic-like anomalous experiences in clinical and non-clinical populations. *British Journal of Clinical Psychology, 53*, 213–227. doi:10.1111/bjc.12036

British Psychological Society (BPS). (2014). *Code of Human Research Ethics*. Leicester: British Psychological Society.

Brohan, E., Slade, M., Clement, S., & Thornicroft, G. (2010). Experiences of mental illness stigma, prejudice and discrimination: A review of measures. *BMC Health Services Research,**10*, 80. doi:10.1186/1472-6963-10-80

Brown, S.R. (1980). *Political Subjectivity: Applications of Q Methodology in Political Science*. New Haven, CT: Yale University press.

Brown, S.R. (2008). Q Methodology. In L.M. Given (Ed.) *The Sage Encyclopedia of Qualitative Research Methods*. California: SAGE Publications Inc.

Bucci, S., Berry, K., Barrowclough, C. & Haddock, G. (2016) Family interventions in psychosis: a review of the evidence and barriers to implementation. *Australian Psychologist,* *51*, 62–68. <https://doi.org/10.1111/ap.12172>

Cairns, R.C. (2012). Understanding Science in Conservation: A Q Method Approach on the Galápagos Islands. *Conservation and Society, 10(3*), 217-231.

Connell, M., Schweitzer, R., & King, R. (2015). Recovery from first-episode psychosis and recovering self: A qualitative study. *Psychiatric Rehabilitation Journal*, *38*(4), 359. <https://doi.org/10.1037/prj0000077>

Corrigan P.W. (1998). The impact of stigma on severe mental illness. *Cognitive and Behavioral Practice*, 5, 201-222.

Corrigan, P.W., & Watson, A.C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*, 35–53. doi:10.1093/clipsy.9.1.35

Crisp, A.H., Gelder, M.G., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illnesses: A follow-up study within the changing minds campaign of the royal college of psychiatrists. *World Psychiatry, 4,* 106–113. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414750/

Crisp, A.H., Gelder, M.G., Rix, S., Meltzer, H.I., & Rowlands, O.J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry, 177*, 4–7. doi:10.1192/bjp.177.1.4

Curt, B. (1994). *Textuality and tectonics: troubling social and psychological science*. Buckingham: Open University Press.

Deegan, P.E. (1988) Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*, 11-19. <https://doi.org/10.1037/h0099565>

Department of Health (2011). *No health without mental health. A cross-government mental health outcomes strategy for people of all ages.* Retrieved from: www.gov.uk/government/uploads/system/uploads/attachment\_ data/file/213761/dh\_124058.pdf

Department of Health and Social Care (1999). *National Services Framework: Mental Health*. Retrieved from: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf>

Drury, V., Birchwood, M., Cochrane, R., & MacMillan, F. (1996). Cognitive Therapy and Recovery from Acute Psychosis: A Controlled Trial: I. Impact on Psychotic Symptoms. *British Journal of Psychiatry,* *169*(5), 593-601. doi:10.1192/bjp.169.5.593

Flanagan, E.H., & Davidson, L. (2007). "Schizophrenics," "Borderlines," and the lingering legacy of misplaced concreteness: An examination of the persistent misconception that the DSM classifies people instead of disorders. *Psychiatry – Interpersonal and Biological Processes, 70* (2), 100-112. <https://doi.org/10.1521/psyc.2007.70.2.100>

Gee, B., Hodgekins, J., Fowler, D., Marshall, M., Everard, L., Lester, H., Jones, P. B., Amos, T., Singh, A. P., Sharma, V., Freemantle, N. & Birchwood, M. (2016). The course of negative symptom in first episode psychosis and the relationship with social recovery. *Schizophrenia Research, 174,* 165-171. <https://doi.org/10.1016/j.schres.2016.04.017>

Hamm, J. A., Buck, K. D., Leonhardt, B. L., Luther, L., & Lysaker, P. H. (2018). Self-directed recovery in schizophrenia: Attending to clients’ agendas in psychotherapy. *Journal of Psychotherapy Integration, 28*(2), 188-201. <https://doi.org/10.1037/int0000070>

Jones, N., Rosen, C., Helm, S., O’Neill, S., Davidson, L., & Shattell, M. (2019). Psychosis in public mental health: Provider perspectives on clinical relationships and barriers to the improvement of services. *American Journal of Orthopsychiatry*, *89*(1), 95–103. <https://doi.org/10.1037/ort0000341>

Kline, P. (1994). *An Easy Guide to Factor Analysis.* London: Routledge.

Knight, M. T. D., Wykes, T., & Hayward, P. (2003). ‘People don’t understand’: An investigation of stigma in schizophrenia using Interpretative Phenomenological Analysis (IPA). *Journal of Mental Health, 12* (3). 209-222. <https://doi.org/10.1080/0963823031000118203>

Knight, M.T.D., Wykes, T., & Hayward, P. (2006). Group treatment of perceived stigma and self-esteem in schizophrenia: A waiting list trial of efficacy. *Behavioural and Cognitive Psychotherapy, 34*, 305–318. <https://doi.org/10.1017/S1352465805002705>

Kukla, M., Lysaker, P.H. & Roe, D. (2014). Strong subjective recovery as a protective factor against the effects of positive symptoms on quality of life outcomes in schizophrenia. *Comprehensive Psychiatry*. 55 (6), 1363-1368. <https://doi.org/10.1016/j.comppsych.2014.04.022>

LeBel, T. (2008). Perceptions of and responses to stigma. *Sociology Compass,* 2, 409-432.

Lecomte, T., Samson, C., Naeem, F., Schachte, L., & Farhall, J. (2018). Implementing cognitive behavioral therapy for psychosis: An international survey of clinicians’ attitudes and obstacles. *Psychiatric Rehabilitation Journal*, *41*(2), 141–148. <https://doi.org/10.1037/prj0000292>

Leete, E. (1989) How I perceive and manage my illness. *Schizophrenia Bulletin, 15*, 197-200. <https://doi.org/10.1093/schbul/15.2.197>

Liberman, R. P., Kopelowicz, A., Ventura, J., & Gutkind, D. (2002). Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry*, *14*, 256−272. <https://doi.org/10.1080/0954026021000016905>

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social science & medicine, 71*(12), 2150-2161. <https://doi.org/10.1016/j.socscimed.2010.09.030>

Lucksted, A., Drapalski, A., Calmes, C., Forbes, C., DeForge, B., & Boyd, J. (2011). Ending self-stigma: Pilot evaluation of a new intervention to reduce internalized stigma among people with mental illnesses. *Psychiatric Rehabilitation Journal, 35*, 51–54. <https://doi.org/10.2975/35.1.2011.51.54>

Lucksted, A., Essock, S.M., Stevenson, J., Mendon, S.J., Nossel, I.R., Goldman, H.H., Goldstein A.B., & Dixon, L.B. (2015). Client views of engagement in the RAISE connection program for early psychosis recovery. *Psychiatric Services, 66*(7), 699-704. <https://doi.org/10.1176/appi.ps.201400475>

McManus S., Bebbington P., Jenkins R., Brugha T. (eds.) (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital

Noordsy, D., Torrey, W., Mueser, K., Mead, S., O'Keefe, C., & Fox, L. (2002). Recovery from severe mental illness: An intrapersonal and functional outcome definition. *International Review of Psychiatry, 14(4)*, 318-326. <https://doi.org/10.1080/0954026021000016969>

Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A. P. (2007). Researching recovery from psychosis: a user-led project. *Psychiatric Bulletin*, *31*(2), 55-60. <https://doi.org/10.1192/pb.bp.105.008532>

Pruneddu, A. (2011). *Q-sortware*. Retrieved from <http://www.qsortware.net>.

Public Health England. (2016). *Psychosis data report*. Retrieved from: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774680/Psychosis_data_report.pdf>

Repper, J. & Perkins, R. (2003). *Social Inclusion and Recovery: A Model for Mental Health Practice.* Imprint: Bailliere Tindall.

Roe, D., Mashiach-Eizenberg, M., & Lysaker, P.H. (2011). The relation between objective and subjective domains of recovery among persons with schizophrenia-related disorders. *Schizophrenia Research, 131*(1), 133-138. <https://doi.org/10.1016/j.schres.2011.05.023>

Silverstein, S. M., & Bellack, A. S. (2008). A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review*, 28(7), 1108-1124. <https://doi.org/10.1016/j.cpr.2008.03.004>

Slade, M., & Hayward, M. (2007). Recovery, psychosis and psychiatry: research is better than rhetoric. *Acta Psychiatrica Scandinavica*, *116*(2), 81-83. <https://doi.org/10.1111/j.1600-0447.2007.01047.x>

Stainton Rogers, R. (1995). Q methodology. In J.A. Smith, R. Harre & L. Van Langenhove (Eds.), *Rethinking methods in psychology*. London: Sage.

Stenner, P., Watts, S. & Worrell, M. (2017). Q methodology. In The SAGE Handbook of qualitative research in psychology (pp. 212-235). SAGE Publications Ltd, <https://www.doi.org/10.4135/9781526405555>

The National Institute for Clinical Excellence (NICE) (2014). Psychosis and schizophrenia in adults: prevention and management (Clinical Guide CG178). Available at: <https://www.nice.org.uk/guidance/cg178>

Turner-Crowson, J. & Wallcraft, J. (2002). The recovery vision for mental health services and research: a British perspective. *Psychiatric Rehabilitation Journal, 25*, 245-255. <https://doi.org/10.1037/h0095018>

Unzicker, R. (1989). On my own: a personal journey through madness and re-emergence. *Psychosocial Rehabilitation Journal, 13*, 71-77. <https://doi.org/10.1037/h0099512>

Van Brakel, W.H., Anderson, A.M., Mutatkar, R.K., Bakirtzlef, Z., Nicholls, P.G., & Raju, M.S. (2006). The participation scale: Measure a key concept in public health. *Disability and Rehabilitation, 28*, 193–203. <https://doi.org/10.1080/09638280500192785>

Van Exel, J., & de Graaf, G. (2005). *Q methodology: A sneak preview*. Online document retrieved from https://www.researchgate.net/profile/Gjalt\_Graaf/publication/228574836\_Q\_Methodology\_A\_Sneak\_Preview/links/02bfe50f946fc9978b000000.pdf

Vass, V., Morrison, A. P., Law, H., Dudley, J., Taylor, P., Bennett, K. M., & Bentall, R. P. (2015). How stigma impacts on people with psychosis: The mediating effect of self-esteem and hopelessness on subjective recovery and psychotic experiences. *Psychiatry Research, 230(2)*, 487-495. doi://doi.org/10.1016/j.psychres.2015.09.042

Watts, S. & Stenner, P. (2005). Doing Q methodology: theory, method and interpretation. *Qualitative Research in Psychology*, 2, 67-91. <https://doi.org/10.1191/1478088705qp022oa>

Watts, S. & Stenner, P. (2012). *Doing Q Methodological Research. Theory, Method and Interpretation.* London: SAGE Publications Ltd.

Webler, T., Danielson, S., & Tuler, S. (2009). *Using Q method to reveal social perspectives in environmental research.* Greenfield MA: Social and Environmental Research Institute.

Wood, L., Byrne, R., Burke, E., Enache, G., & Morrison, A. P. (2017). The impact of stigma on emotional distress and recovery from psychosis: The mediatory role of internalised shame and self-esteem. *Psychiatry Research, 255*, 94-100. <https://doi.org/10.1016/j.psychres.2017.05.016>

Wood, L., Price, J., Morrison, A., & Haddock, G. (2010). Conceptualisation of recovery from psychosis: A service-user perspective. *The Psychiatrist*, *34*(11), 465–470. <https://doi.org/10.1192/pb.bp.109.027409>

World Health Organisation. (1992). *The ICD-10 classification of mental and behavioural disorders. Clinical descriptions and diagnostic guidelines.* Geneva: World Health Organisation.

Zhang, M., Wang, M., Li, J. & Phillips, M. R. (1994). Randomised control trial of family intervention for 78 first-episode male schizophrenic patients. An 18-month study in Suzhou, Jiangsu. *British Journal of Psychiatry* *(Suppl.),* 96–102. <https://doi.org/10.1192/S0007125000293045>

## Appendices

### Appendix 1 - British Journal of Clinical Psychology Author Guidelines

**AUTHOR GUIDELINES**

 **Sections**

1. [Submission](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_1._SUBMISSION)
2. [Aims and Scope](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_2._AIMS_AND)
3. [Manuscript Categories and Requirements](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_3._MANUSCRIPT_CATEGORIES)
4. [Preparing the Submission](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_4._PREPARING_YOUR)
5. [Editorial Policies and Ethical Considerations](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_5._EDITORIAL_POLICIES)
6. [Author Licensing](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_6._AUTHOR_LICENSING)
7. [Publication Process After Acceptance](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_7._PUBLICATION_PROCESS)
8. [Post Publication](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_8._POST_PUBLICATION)
9. [Editorial Office Contact Details](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#_9._EDITORIAL_OFFICE)

 1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

**Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at**[**http://www.editorialmanager.com/bjcp**](http://www.editorialmanager.com/bjcp)

[**Read**](https://authorservices.wiley.com/author-resources/Journal-Authors/submission-peer-review/editorial-manager.html) more details on how to use Editorial Manager.

All papers published in the British Journal of Clinical Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

**Data protection:**

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at [**https://authorservices.wiley.com/statements/data-protection-policy.html**](https://authorservices.wiley.com/statements/data-protection-policy.html).

**Preprint policy:**

This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The British Journal of Clinical Psychology publishes original research, both empirical and theoretical, on all aspects of clinical psychology:

* clinical and abnormal psychology featuring descriptive or experimental studies
* aetiology, assessment and treatment of the whole range of psychological disorders irrespective of age group and setting
* biological influences on individual behaviour
* studies of psychological interventions and treatment on individuals, dyads, families and groups

For specific submission requirements, [**read**](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html) the Author Guidelines.

The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

The following types of paper are invited:

* papers reporting original empirical investigations;
* theoretical papers, provided that these are sufficiently related to empirical data;
* review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
* Brief Reports and Comments.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Articles should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Refer to the separate guidelines for [**Registered Reports**](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/registeredreportsguidelines.htm).

All systematic reviews must be pre-registered.

4. PREPARING THE SUBMISSION

**Free Format Submission**

British Journal of Clinical Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

* Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
* The title page of the manuscript, including a data availability statement and your co-author details with affiliations. (Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.) You may like to use [this template](https://onlinelibrary.wiley.com/pb-assets/assets/2044835X/Sample_Manuscript_Title_Page%20-%20revised-1556026160210.docx) for your title page.

**Important: the journal operates a double-blind peer review policy. Anonymise your manuscript and prepare a separate title page containing author details.**(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)

* An ORCID ID, freely available at [https://orcid.org](https://orcid.org/). (Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)

To submit, login at [**https://www.editorialmanager.com/bjcp/default.aspx**](https://www.editorialmanager.com/bjcp/default.aspx) and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

**Revised Manuscript Submission**

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author’s discretion. They should be pasted into the ‘Comments’ box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use [**this template**](https://bpspsychub.onlinelibrary.wiley.com/pb-assets/assets/20448260/Sample_Manuscript_Title_Page%20-%20revised-1556025388890.docx) for your title page. The title page should contain**:**

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's [best practice SEO tips](http://www.wileyauthors.com/seo));
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. The author's institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;
5. Abstract;
6. Keywords
7. Data availability statement (see [Data Sharing and Data Accessibility Policy](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448260/homepage/forauthors.html#data_share));
8. Acknowledgments.

**Authorship**

Please refer to the journal’s Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the [**Project CRediT**](https://casrai.org/credit/) website for a list of roles.

**Abstract**

Please provide a structured abstract under the headings: Objectives, Methods, Results, Conclusions. For Articles, the abstract should not exceed 250 words. For Brief Reports, abstracts should not exceed 120 words.

Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

**Keywords**

Provide appropriate keywords.

**Acknowledgments**

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

1. Title
2. Main text
3. References
4. Tables and figures (each complete with title and footnotes)
5. Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

* As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Do not mention the authors’ names or affiliations and always refer to any previous work in the third person.
* The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

**References**

References in published papers are formatted according to the Publication Manual of the American Psychological Association (6th edition). However, references may be submitted in any style or format, as long as it is consistent throughout the manuscript.

**Tables**

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and \*, \*\*, \*\*\* should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

**Figures**

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

 [**Basic figure requirements**](http://media.wiley.com/assets/7323/92/electronic_artwork_guidelines.pdf) for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

**Colour figures.** Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

**Supporting Information**

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

[**Wiley’s FAQs**](http://www.wileyauthors.com/suppinfoFAQs) on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the [**APA Publication Manual**](http://www.amazon.co.uk/gp/product/1433805618?ie=UTF8&tag=thebritishpsy-21&linkCode=xm2&camp=1634&creativeASIN=1433805618) published by the American Psychological Association. The following points provide general advice on formatting and style.

* **Language:** Authors must avoid the use of sexist or any other discriminatory language.
* **Abbreviations:**In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
* **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the [Bureau International des Poids et Mesures (BIPM) website](http://www.bipm.org/en/about-us/) for more information about SI units.
* **Effect size:** In normal circumstances, effect size should be incorporated.
* **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

**Wiley Author Resources**

**Manuscript Preparation Tips:**Wiley has a range of resources for authors preparing manuscripts for submission available [**here.**](http://www.wileyauthors.com/prepare) In particular, we encourage authors to consult Wiley’s best practice tips on [**Writing for Search Engine Optimization**](http://www.wileyauthors.com/seo).

**Article Preparation Support:**[**Wiley Editing Services**](https://wileyeditingservices.com/en/article-preparation/?utm_source=wol&utm_medium=backlink&utm_term=ag&utm_content=prep&utm_campaign=prodops)offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for [**Preparing Your Article**](https://authorservices.wiley.com/author-resources/Journal-Authors/Prepare/index.html?utm_source=wol&utm_medium=backlink&utm_term=ag&utm_content=prepresources&utm_campaign=prodops)for general guidance and the [**BPS Publish with Impact infographic**](https://pericles.pericles-prod.literatumonline.com/pb-assets/hub-assets/bpspubs/BPS_SEO_Interactive-1545065172017.pdf) for advice on optimizing your article for search engines.

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double blind) peer review. Please ensure that any information which may reveal author identity is blinded in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, read [**the terms and conditions of submission**](https://wol-prod-cdn.literatumonline.com/pb-assets/assets/2044835X/BPS_Journals_Terms_and_Conditions_of_Submission%20-%20addition%20for%20authorship.doc) and the [**declaration of competing interests**](https://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%292044-835X/homepage/BPS_Journals_Declaration_of_Competing_Interests.doc).

We aim to provide authors with a first decision within 90 days of submission.

Further information about the process of peer review and production can be found in ‘[**What happens to my paper?**](https://onlinelibrary.wiley.com/store/10.1111/%28ISSN%292044-8295/asset/homepages/What_Happens_to_My_Paper.pdf?v=1&s=c77109ea36e8cfc16344d763454bc917e5147cec)’ Appeals are handled according to the [**procedure recommended by COPE**](https://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%292044-8295/homepage/How_to_handle_appeals.pdf). [**Read**](https://authorservices.wiley.com/Reviewers/journal-reviewers/tools-and-resources/review-confidentiality-policy.html) Wiley's policy on the confidentiality of the review process.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

* [Future of Research Communications and e-Scholarship (FORCE11)](http://www.force11.org/node/4433)
* [The Gold Standard Publication Checklist from Hooijmans and colleagues](https://www.ncbi.nlm.nih.gov/pubmed/20507187)
* [FAIRsharing website](http://www.biosharing.org/)

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: [**https://www.crossref.org/services/funder-registry/**](https://www.crossref.org/services/funder-registry/)

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

“Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed (APA Ethics Code Standard 8.12a, Publication Credit). Authorship encompasses, therefore, not only those who do the actual writing but also those who have made substantial scientific contributions to a study. Substantial professional contributions may include formulating the problem or hypothesis, structuring the experimental design, organizing and conducting the statistical analysis, interpreting the results, or writing a major portion of the paper. Those who so contribute are listed in the byline.” (p.18)

Data Sharing and Data Accessibility Policy

The British Journal of Clinical Psychology recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

It is not necessary to make data publicly available at the point of submission, but an active link must be included in the final accepted manuscript. For authors who have pre-registered studies, please use the Registered Report link in the Author Guidelines.

In some cases, despite the authors’ best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or laws, or the nature of data gathered. In such cases, authors must inform the editors at the time of submission. It is understood that in some cases access will be provided under restrictions to protect confidential or proprietary information. Editors may grant exceptions to data access requirements provided authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

Finally, if submitting authors have any questions about the data sharing policy, access the [**FAQs**](https://bpspsychub.onlinelibrary.wiley.com/hub/datasharingfaqs) for additional detail.

Publication Ethics

Authors are reminded that the British Journal of Clinical Psychology adheres to the ethics of scientific publication as detailed in the [**Ethical principles of psychologists and code of conduct**](http://www.apa.org/ethics/code/index.aspx) (American Psychological Association, 2010). The Journal generally conforms to the Uniform Requirements for Manuscripts  of the International Committee of Medical Journal Editors ([**ICJME**](http://www.icmje.org/urm_main.html)) and is also a member and subscribes to the principles of the Committee on Publication Ethics ([**COPE**](http://www.publicationethics.org/resources/code-conduct)).  Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county.

Note this journal uses iThenticate’s CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. [**Read**](http://www.wileyauthors.com/ethics) Wiley’s Top 10 Publishing Ethics Tips for Authors. [**Read**](http://authorservices.wiley.com/ethics-guidelines/index.html) Wiley’s Publication Ethics Guidelines can be found.

ORCID

As part of the journal’s commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. This takes around 2 minutes to complete. [**Find more information here.**](http://olabout.wiley.com/WileyCDA/Section/id-828034.html)

6. AUTHOR LICENSING

**WALS + standard CTA/ELA and/or Open Access for hybrid titles**

You may choose to publish under the terms of the journal’s standard copyright agreement, or Open Access under the terms of a Creative Commons License.
Standard [**re-use and licensing rights**](https://authorservices.wiley.com/author-resources/Journal-Authors/licensing/licensing-info-faqs.html) vary by journal. Note that [**certain funders**](https://authorservices.wiley.com/author-resources/Journal-Authors/open-access/author-compliance-tool.html) mandate a particular type of CC license be used. This journal uses the CC-BY/CC-BY-NC/CC-BY-NC-ND [**Creative Commons License**](https://authorservices.wiley.com/author-resources/Journal-Authors/licensing/open-access-agreements.html).
Self-Archiving Definitions and Policies: Note that the journal’s standard copyright agreement allows for [**self-archiving**](https://authorservices.wiley.com/author-resources/Journal-Authors/licensing/self-archiving.html) of different versions of the article under specific conditions.

**BPS members and open access:** if the corresponding author of an accepted article is a Graduate or Chartered member of the BPS, the Society will cover will cover 100% of the APC allowing the article to be published as open access and freely available.

7. PUBLICATION PROCESS AFTER ACCEPTANCE

Accepted Article Received in Production

When an accepted article is received by Wiley’s production team, the corresponding author will receive an email asking them to login or register with [**Wiley Author Services**](http://www.wileyauthors.com/). The author will be asked to sign a publication license at this point.

Proofs

Once the paper is typeset, the author will receive an email notification with full instructions on how to provide proof corrections.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process – authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt of first proof.

Publication Charges

**Colour figures.**Colour figures may be published online free of charge; however, the journal charges for publishing figures in colour in print. If the author supplies colour figures, they will be sent a Colour Work Agreement once the accepted paper moves to the production process. If the Colour Work Agreement is not returned by the specified date, figures will be converted to black and white for print publication.

Early View

The journal offers rapid publication via Wiley’s Early View service. [**Early View**](http://olabout.wiley.com/WileyCDA/Section/id-404512.html#ev) (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Before we can publish an article, we require a signed license (authors should login or register with [**Wiley Author Services**](http://www.wileyauthors.com/)). Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

8. POST PUBLICATION

Access and Sharing

When the article is published online:

* The author receives an email alert (if requested).
* The link to the published article can be shared through social media.
* The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
* For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

**Promoting the Article**

To find out how to best promote an article, click [**here**](http://www.wileyauthors.com/maximize).

[**Wiley Editing Services**](https://wileyeditingservices.com/en/article-promotion/?utm_source=wol&utm_medium=backlink&utm_term=ag&utm_content=promo&utm_campaign=prodops)offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

Measuring the Impact of an Article

Wiley also helps authors measure the impact of their research through specialist partnerships with [**Kudos**](http://www.wileyauthors.com/kudos) and [**Altmetric**](http://www.wileyauthors.com/altmetric).

9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (**bjc@wiley.com**) or phone +44 (0) 116 252 9504.

Author Guidelines updated 14th October 2019

### Appendix 2 - Ethical Approval



### Appendix 3 - Amendment Approval



### Appendix 4 - Q set (List of Statements)

1. Building relationships with new staff
2. Being prepared for my transfer to another service
3. Knowing who to contact
4. Thinking services wouldn’t be able to help me
5. Not feeling involved in my care
6. Not feeing listened to
7. The emotional connection with my key worker
8. The stigma of my diagnosis
9. Feeling embarrassed or ashamed to ask for help
10. Thinking I would be seen as crazy
11. Thinking I may be put in hospital against my will
12. What my friends might say or think
13. Thinking I didn’t have a problem
14. Wanting to solve the problem myself
15. Being too unwell to ask for help
16. I couldn’t get to appointments
17. Financial implications
18. Unsure where to get help
19. What my family might think
20. I didn't want a Mental Health problem on my records
21. Thinking it might impact my chances of getting a job
22. Thinking I would seem weak
23. What people at work might say
24. Thinking I would be seen as a bad parent
25. Thinking I might lose custody of my children or they would go into care
26. Preferring to use alternative forms of care (religious healing, complimentary therapies etc)
27. Thinking the problem would get better by itself
28. Treatment side effects
29. Thinking that professional care wouldn’t help
30. I don’t like talking about my feelings, emotions or thoughts
31. Preferring to get help from friends or family
32. Previous experiences with mental health care
33. Not wanting to take time off work
34. Problems getting childcare
35. No one to help me get help
36. Professionals from my own ethnic or cultural group not being available
37. Long waiting times
38. Language barriers
39. Poor communication from care providers
40. Generic care that wasn’t individualised
41. Care providers didn’t want to help
42. Care staff didn’t recognise or respond to my needs
43. Lack of treatment options
44. I didn’t want to take medication
45. I didn’t know about talking therapies
46. Thinking it's a waste of time
47. Medication alternatives were not encouraged
48. Staff talked down to me
49. Feeling powerless
50. My opinion wasn’t valued
51. Staff didn’t understand me and my experiences
52. Staff didn’t know what services were available to help me
53. I didn’t know what services were there to help me
54. Thinking I couldn’t get better
55. Thinking I can't recover from psychosis
56. Thinking I can’t lead a good, fulfilling life with psychosis

### Appendix 5 - Study Advert



### Appendix 6 - Participant Information Sheet

**Exploring the barriers to ‘recovery’ from psychosis as told by clients who experience psychosis using Q Methodology.**

I would like to invite you to take part in a piece of research that forms part of my Doctorate in Clinical Psychology. Before you decide whether you would like to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information using the contact details on this form.

**What is the project about?**
This study wants to speak to people who experience psychosis or hearing voices and to hear their views on what gets in the way of them getting better or heading towards ‘recovery’ and improving quality of life.

**Why have I been invited to take part?**
You can take part in this study if you are over 18, have a diagnosis of psychosis **or** experience auditory and/or visual hallucinations that may be associated with psychosis (eg. hearing voices or seeing things in the absence of their presence) and you have tried to seek help for your mental health in the UK. You will need to be able to understand and write using the English language.

**What will happen if I take part?**
Participation is completely voluntary and you don’t have to take part if you don’t want to. If you choose not to you will not be disadvantaged in any way. Once you have read this information sheet you can contact me if you have any questions that will help you to make a decision about taking part.

If you decide to take part after reading this information sheet you will be asked to sign a consent form to show that you have agreed to take part.

If you agree to take part you will be asked to complete an online demographic questionnaire and ‘Q Sort’. The Q Sort involves you reading short statements and sorting them according to how much you agree or disagree with them. You will be asked a small number of questions about the activity. This will take approximately an hour in total.

**What are the possible risks of taking part?**
The statements themselves should not be offensive or upsetting, however, the way in which your personal experiences relate to them may bring up difficult memories.

If you wish to take a break or stop the q-sort or post-sort questionnaire at any point, you can do this. Should you become upset during the session and feel you need support I would encourage you to contact:

•            The Samaritans – 116 123 (24 hours, 7 days a week) www.samaratins.org

•            Mind – 0300 123 3393 or text 86463 (9am-6pm Monday-Friday except for bank holidays) www.mind.org.uk

If you feel you need additional support to this you should contact your GP or local mental health care provider.

You will also be required to look at some sort of screen for a period of time, this may cause some discomfort if you have to sit at a computer for long periods of time.

**What are the possible benefits of taking part?**
Taking part is unlikely to benefit you directly; however it might help us to understand the perspectives and experiences of people who live with a diagnosis of psychosis better. The information gathered and results of the study may then contribute to improving the ways in which services are delivered.

**Data handling and confidentiality**
Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).All data relating to you will be kept anonymised under an assigned participant number. The electronic data will be kept under password protected files and on a password protected USB stick. Only myself as the researcher and my supervisor will have access for the data. As this project is part of my course, it is possible that in some cases second markers and external examiners may require access to data. This data will be kept for 10 years following the completion of the study, as per Staffordshire University guidelines. Following this, all electronic files and memory sticks will be destroyed.
**Data Protection Statement**
The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form that will be provided to you.

**What if I change my mind about taking part?**
You are free to withdraw from the study within two weeks of completing it without having to give a reason. Withdrawing from the study will not affect you in any way. After this withdrawal of your data will no longer be possible due to the fact your data will already be committed to and included in the final thesis submission.

If you choose to withdraw from the study you will need to contact the principle investigator using the details below. If you chose to do so, we will not keep any information that you have provided as a part of this study.

**PLEASE NOTE:**You will be asked to record and remember your assigned participant number when you complete the study to ensure we can identify your data should you wish to withdraw it at a later date.

**What will happen to the results of this study?**

This study is being completed as part of my Doctorate in Clinical Psychology. The results will be disseminated within my department and submitted for potential publication within peer-reviewed journals. It is also possible that the findings of this study may be shared in teaching sessions or at conferences.

**Who should I contact for further information?**

If you have further questions or would like more information about this study you can contact me, the researcher Philippa Lawton, using the following contact details: l024471i@student.staffs.ac.uk

**What if I have further questions, or if something goes wrong?**

If this study has upset you in any way or if you have any concerns about the conduct of the study and you wish to complain, you can contact the study supervisor: Dr Helen Combes, h.a.combes@staffs.ac.uk or the Chair of the Staffordshire University Ethics Committee: Tim Horne, Tim.horne@staffs.ac.uk for further advice and information.

**Thank you for taking the time to read this information and for considering taking part in the research.**

**Please note, it is recommended you complete this on a computer/laptop due to the software used for some of this study.**

### Appendix 7 - Consent Form

If after reading the information sheet you are willing to participate, please read the statements below and put your initials in each box to give your consent to participate in the study.

1. I confirm that I have read the information sheet 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 within two weeks of completing the study without giving any reason and without my rights being affected.
3. I understand that anonymised direct quotations may be used in the reporting and/or presentation of the findings, including publication in scientific journals.
4. I agree to the anonymised raw-data collected in this study to be used in subsequent research projects for up to 10 years.
5. I confirm I am over 18 years of age and meet all of the eligibility criteria set out in the Participant Information Sheet above.
6. I agree to take part in the above study.

### Appendix 8 - Demographic questions

1. What gender do you identify with?
2. What is your age? (in years)
3. What is your ethnicity?
4. What is your geographical location?

North east

North West

Yorkshire and the Humber

East Midlands

West Midland

East of England

London

South East

South West

Wales

Scotland

Northern Ireland

1. What is your employment status?

Employed (including self-employed)

Unemployed

Student

Voluntary/unpaid work

Retired

1. How long have you had a diagnosis of psychosis or lived with symptoms of psychosis? (e.g. Auditory [hearing voices] or visual [seeing things] hallucinations) (please state in approximate years)
2. Have you ever had talking therapies to help with your difficulties?

Yes

No

1. Do you take medication for your difficulties?

Yes currently

Yes previously

No never

1. What would you describe as your main problematic symptom/experience?
2. Please select from below, any of the services you have had contact with:

Early intervention

Community Mental Health Teams

Addiction Services

Psychology Services

Group therapy

Other (please specify)

1. Did you find accessing services for support

Easy

Somewhat difficult

Difficult

### Appendix 9 - Post-Sort Questionnaire

Why did you rank the two statements as most significant?

Why did you rank the two statements as least significant?

Is there anything else you would have liked to have included?

Is there anything else you would like to comment on?

How did you find the Q sort procedure overall?

### Appendix 10 - Debrief Sheet

​**DEBRIEF INFORMATION**

**Exploring the barriers to ‘recovery’ from psychosis as told by clients who experience psychosis using Q Methodology**.

Thank you for participating inthis online study. We hope that you have found it interesting and have not been upset by any of the topics discussed. However, if you have found any part of this experience to be distressing the following agencies may be able to offer you some support:

|  |  |
| --- | --- |
| **Organisations** | **Contact Details** |
| The Samaritans | Telephone: 116 123 (24 hours, 7 days a week)Website: [www.samaritans.org](http://www.samaritans.org/) |
| Mind | Telephone: 0300 123 3393Text: 86463 (9am-6pm Monday-Friday except for bank holidays)Website: [www.mind.org.uk](http://www.mind.org.uk/) |

If you feel you need additional support to this you should contact your GP or local mental health care provider.

If you have any concerns about the conduct of the study and you wish to complain, you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

***Study Supervisor:***Dr Helen Combes, h.a.combes@staffs.ac.uk

***Chair of the Staffordshire University Ethics Committee:***Tim Horne, Tim.horne@staffs.ac.uk

Please remember you are free to withdraw from this study within two weeks of completing it without having to give a reason. Withdrawing will not affect you in any way. It will not be possible to withdraw after two weeks due to the fact your data will already be committed to and included in the final thesis submission.

If you choose to withdraw from the study, you will need to contact the principle investigator via email at: l024471i@student.staffs.ac.uk. If you chose to do so, we will not keep any information that you have provided as a part of this study.

**PLEASE NOTE:** You will need to provide the unique assigned participant number you created when you completed the consent form to ensure we can identify your data should you wish to withdraw.

**Please click okay to continue and then re enter the made up email address and click 'YES' to save your data.**

**Thank you again for your participation in this study.**

### Appendix 11 - Correlations between Q sorts

Table 2.4 Correlations between Q sorts.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Participant | mor694 | hor850 | lav293 | cha713 | nan494 | lav473 | mad094 | dol832 | may854 | new647 | sai976 | dry661 |
| mor694 | 100 | 13 | 19 | 12 | 1 | 32 | 12 | 15 | 9 | 8 | 23 | 31 |
| hor850 | 13 | 100 | -5 | 53 | 13 | 38 | 7 | 25 | 33 | 24 | 34 | 29 |
| lav293 | 19 | -5 | 100 | -6 | -4 | 10 | 3 | 24 | 14 | 27 | 2 | 17 |
| cha713 | 12 | 53 | -6 | 100 | -6 | 13 | -23 | -1 | 5 | 0 | 14 | 5 |
| nan494 | 1 | 13 | -4 | -6 | 100 | 20 | 27 | 12 | 34 | 16 | 14 | 23 |
| lav473 | 32 | 38 | 10 | 13 | 20 | 100 | 19 | 44 | 36 | 16 | 35 | 81 |
| mad094 | 12 | 7 | 3 | -23 | 27 | 19 | 100 | 37 | 19 | 31 | -22 | 14 |
| dol832 | 15 | 25 | 24 | -1 | 12 | 44 | 37 | 100 | 28 | 39 | 11 | 44 |
| may854 | 9 | 33 | 14 | 5 | 34 | 36 | 19 | 28 | 100 | 30 | 27 | 45 |
| new647 | 8 | 24 | 27 | 0 | 16 | 16 | 31 | 39 | 30 | 100 | -19 | 25 |
| sai976 | 23 | 34 | 2 | 14 | 14 | 35 | -22 | 11 | 27 | -19 | 100 | 42 |
| dry661 | 31 | 29 | 17 | 5 | 23 | 81 | 14 | 44 | 45 | 25 | 42 | 100 |

### Appendix 12 - Varimax Rotation Factor Loadings

Table 2.5. Varimax Rotation Factor Loadings

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Q sort | Factor 1 | Factor 2 | Factor 3a | Factor 3b |
| mor694 | **0.6058\*** | -0.0268 | -0.09 | 0.09 |
| hor850 | 0.2443 | 0.3118 | **0.7746\*** | -0.7746 |
| lav293 | 0.3772 | 0.1456 | -0.4135 | **0.4135\*** |
| cha713 | 0.0618 | -0.0877 | **0.7755\*** | -0.7755 |
| nan494 | 0.0521 | **0.4932\*** | 0.1553 | -0.1553 |
| lav473 | **0.7537\*** | 0.3193 | 0.1764 | -0.1764 |
| mad094 | -0.0521 | **0.7184\*** | -0.2354 | 0.2354 |
| dol832 | 0.3956 | **0.5989\*** | -0.0736 | 0.0736 |
| may854 | 0.3486 | **0.5215\*** | 0.2457 | -0.2457 |
| new647 | 0.0177 | **0.7314\*** | -0.0358 | 0.0358 |
| sai976 | **0.6644\*** | -0.2272 | 0.3511 | -0.3511 |
| dry661 | **0.8017\*** | 0.338 | 0.0927 | -0.0927 |

### Appendix 13 - Consensus statements

Those That Do Not Distinguish Between ANY Pair of Factors

All listed statements are non-significant at P > 0.01, and those flagged with an \* are also non-significant at P > 0.05

Table 2.6. Consensus Statements

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Statement Number | Significance | Statement | Statement Number | factor1 Q-SV | factor1 Z-score | factor2 Q-SV | factor2 Z-score | factor3a Q-SV | factor3a Z-score | factor3b Q-SV | factor3b Z-score |
| 15 |  | Being too unwell to ask for help | 15 | 0 | 0.08 | -1 | -0.265 | -3 | -0.87 | -1 | -0.38 |
| 20 |  | I didn't want a Mental Health problem on my records | 20 | 1 | 0.402 | 1 | 0.23 | 3 | 1.09 | 0 | 0 |
| 21 |  | Thinking it might impact my chances of getting a job | 21 | 1 | 0.43 | 3 | 0.898 | 3 | 1.087 | 4 | 1.52 |
| 26 |  | Preferring to use alternative forms of care (religious healing, complimentary therapies etc) | 26 | -1 | -0.54 | -3 | -1.31 | -3 | -1.084 | -4 | -1.522 |
| 31 | \* | Preferring to get help from friends or family | 31 | -3 | -1.036 | -3 | -0.87 | -1 | -0.655 | -3 | -1.141 |
| 35 | \* | No one to help me get help | 35 | -1 | -0.374 | -2 | -0.513 | -1 | -0.653 | -3 | -1.141 |
| 37 | \* | Long waiting times | 37 | 2 | 0.708 | 4 | 1.173 | 2 | 0.868 | 3 | 1.141 |
| 38 |  | Language barriers | 38 | -5 | -1.97 | -5 | -1.99 | -3 | -1.08 | -5 | -1.902 |
| 43 |  | Lack of treatment options | 43 | 4 | 1.37 | 3 | 1.064 | 1 | 0.44 | 2 | 0.761 |
| 46 |  | Thinking it's a waste of time | 46 | -1 | -0.489 | -3 | -0.98 | 1 | 0 | 0 | 0 |
| 52 |  | Staff didn’t know what services were available to help me | 52 | 0 | 0.29 | -1 | -0.23 | 0 | -0.001 | -2 | -0.76 |

### Appendix 14 - Factor Arrays for Factor 1, 2, 3a & 3b

Table 2.7 Factor arrays for all factors

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Statements | Factor 1 | Factor 2 | Factor 3a | Factor 3b |
| 1 | Building relationships with new staff | 2 | 2 | 1 | -4 |
| 2 | Being prepared for my transfer to another service | -2 | 0 | 0 | 1 |
| 3 | Knowing who to contact | 2 | 0 | 2 | -1 |
| 4 | Thinking services wouldn’t be able to help me | -2 | 2 | 1 | 2 |
| 5 | Not feeling involved in my care | 0 | 2 | -1 | -2 |
| 6 | Not feeing listened to | -2 | 3 | 0 | 2 |
| 7 | The emotional connection with my key worker | 0 | 4 | 0 | 4 |
| 8 | The stigma of my diagnosis | 5 | 2 | 3 | -2 |
| 9 | Feeling embarrassed or ashamed to ask for help | 2 | 0 | 4 | 0 |
| 10 | Thinking I would be seen as crazy | 3 | 0 | 5 | -2 |
| 11 | Thinking I may be put in hospital against my will | 3 | 5 | -4 | -1 |
| 12 | What my friends might say or think | -1 | -1 | 4 | -2 |
| 13 | Thinking I didn’t have a problem | 0 | -5 | 1 | 0 |
| 14 | Wanting to solve the problem myself | -1 | -2 | 3 | 0 |
| 15 | Being too unwell to ask for help | 0 | -1 | -3 | -1 |
| 16 | I couldn’t get to appointments | -2 | -1 | -3 | 1 |
| 17 | Financial implications | 1 | -1 | 2 | 1 |
| 18 | Unsure where to get help | 1 | -2 | 2 | -1 |
| 19 | What my family might think | -4 | -1 | 5 | -4 |
| 20 | I didn't want a Mental Health problem on my records | 1 | 1 | 3 | 0 |
| 21 | Thinking it might impact my chances of getting a job | 1 | 3 | 3 | 4 |
| 22 | Thinking I would seem weak | 2 | -3 | -4 | 0 |
| 23 | What people at work might say | -3 | 1 | 3 | 2 |
| 24 | Thinking I would be seen as a bad parent | -4 | -4 | -1 | 1 |
| 25 | Thinking I might lose custody of my children or they would go into care | -3 | -4 | -2 | 0 |
| 26 | Preferring to use alternative forms of care (religious healing, complimentary therapies etc) | -1 | -3 | -3 | -4 |
| 27 | Thinking the problem would get better by itself | 0 | -2 | 4 | 1 |
| 28 | Treatment side effects | 3 | 1 | -4 | 3 |
| 29 | Thinking that professional care wouldn’t help | -4 | 0 | -2 | 1 |
| 30 | I don’t like talking about my feelings, emotions or thoughts | 2 | -4 | 0 | 5 |
| 31 | Preferring to get help from friends or family | -3 | -3 | -1 | -3 |
| 32 | Previous experiences with mental health care | -2 | 5 | -5 | 3 |
| 33 | Not wanting to take time off work | -3 | 0 | 2 | 4 |
| 34 | Problems getting childcare | -4 | -4 | -2 | 0 |
| 35 | No one to help me get help | -1 | -2 | -1 | -3 |
| 36 | Professionals from my own ethnic or cultural group not being available | -5 | -2 | -2 | -5 |
| 37 | Long waiting times | 2 | 4 | 2 | 3 |
| 38 | Language barriers | -5 | -5 | -3 | -5 |
| 39 | Poor communication from care providers | 1 | 2 | 0 | -2 |
| 40 | Generic care that wasn’t individualised | 1 | 2 | -1 | -1 |
| 41 | Care providers didn’t want to help | -1 | 0 | -4 | 1 |
| 42 | Care staff didn’t recognise or respond to my needs | -1 | 3 | -2 | 3 |
| 43 | Lack of treatment options | 4 | 3 | 1 | 2 |
| 44 | I didn’t want to take medication | 0 | 1 | 2 | -3 |
| 45 | I didn’t know about talking therapies | 1 | -2 | -2 | 5 |
| 46 | Thinking it's a waste of time | -1 | -3 | 1 | 0 |
| 47 | Medication alternatives were not encouraged | 3 | 1 | -1 | 4 |
| 48 | Staff talked down to me | -2 | 1 | -3 | -4 |
| 49 | Feeling powerless | 3 | 4 | 4 | -3 |
| 50 | My opinion wasn’t valued | 0 | 1 | -5 | -1 |
| 51 | Staff didn’t understand me and my experiences | -3 | 4 | -1 | 2 |
| 52 | Staff didn’t know what services were available to help me | 0 | -1 | 0 | -2 |
| 53 | I didn’t know what services were there to help me | 4 | 0 | 1 | -3 |
| 54 | Thinking I couldn’t get better | 4 | -3 | 0 | 2 |
| 55 | Thinking I can't recover from psychosis | 4 | -1 | 0 | -1 |
| 56 | Thinking I can’t lead a good, fulfilling life with psychosis | 5 | 3 | 1 | 3 |

### Appendix 15 - Factor Array Grids

#### Factor 1 Factor Array.

The distribution grid for factor one’s factor array would look as follows:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| -5 | -4 | -3 | -2 | -1 | 0 | +1 | +2 | +3 | +4 | +5 |
| 36 | 29 | 51 | 48 | 42 | 44 | 45 | 22 | 49 | 55 | 8 |
| 38 | 24 | 33 | 4 | 35 | 52 | 39 | 3 | 11 | 54 | 56 |
|   | 19 | 31 | 6 | 46 | 27 | 17 | 9 | 47 | 43 |   |
|   | 34 | 25 | 32 | 12 | 7 | 40 | 37 | 28 | 53 |   |
|   |   | 23 | 16 | 41 | 15 | 21 | 1 | 10 |   |   |
|   |   |   | 2 | 26 | 5 | 18 | 30 |   |   |   |
|   |   |   |   | 14 | 13 | 20 |   |   |   |   |
|   |   |   |   |   | 50 |   |   |   |   |   |

Figure 2.2 Factor array for factor 1.

Highest Ranked Statements

#8 The stigma of my diagnosis

#56 Thinking I can’t lead a good, fulfilling life with psychosis

Positive Statements Ranked Higher in factor 1 Array than in Other Factor Arrays

#55 Thinking I can't recover from psychosis

#54 Thinking I couldn’t get better

#43 Lack of treatment options

#53 I didn’t know what services were there to help me

#28 Treatment side effects

#22 Thinking I would seem weak

#3 Knowing who to contact

#1 Building relationships with new staff

#52 Staff didn’t know what services were available to help me

#15 Being too unwell to ask for help

Negative Statements Ranked Lower in factor 1 Array than in Other Factor Arrays

#7 The emotional connection with my key worker

#4 Thinking services wouldn’t be able to help me

#6 Not feeing listened to

#2 Being prepared for my transfer to another service

#51 Staff didn’t understand me and my experiences

#33 Not wanting to take time off work

#31 Preferring to get help from friends or family

#23 What people at work might say

#29 Thinking that professional care wouldn’t help

#24 Thinking I would be seen as a bad parent

#19 What my family might think

#34 Problems getting childcare

Lowest Ranked Statements

#36 Professionals from my own ethnic or cultural group not being available

#38 Language barriers

#### Factor 2 Factor Array

The distribution grid for factor two’s factor array would look as follows:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| -5 | -4 | -3 | -2 | -1 | 0 | +1 | +2 | +3 | +4 | +5 |
| 38 | 30 | 31 | 36 | 52 | 2 | 47 | 8 | 6 | 7 | 11 |
| 13 | 34 | 54 | 14 | 15 | 29 | 48 | 4 | 43 | 51 | 32 |
|   | 24 | 46 | 35 | 55 | 9 | 44 | 39 | 42 | 37 |   |
|   | 25 | 22 | 18 | 16 | 41 | 50 | 40 | 56 | 49 |   |
|   |   | 26 | 27 | 17 | 33 | 28 | 1 | 21 |   |   |
|   |   |   | 45 | 12 | 53 | 23 | 5 |   |   |   |
|   |   |   |   | 19 | 10 | 20 |   |   |   |   |
|   |   |   |   |   | 3 |   |   |   |   |   |

Figure 2.3 Factor array for factor 2.

Highest Ranked Statements

#11 Thinking I may be put in hospital against my will

#32 Previous experiences with mental health care

Positive Statements Ranked Higher in factor 2 Array than in Other Factor Arrays

#7 The emotional connection with my key worker

#51 Staff didn’t understand me and my experiences

#37 Long waiting times

#49 Feeling powerless

#6 Not feeing listened to

#42 Care staff didn’t recognise or respond to my needs

#4 Thinking services wouldn’t be able to help me

#39 Poor communication from care providers

#40 Generic care that wasn’t individualised

#1 Building relationships with new staff

#5 Not feeling involved in my care

#48 Staff talked down to me

#50 My opinion wasn’t valued

Negative Statements Ranked Lower in factor 2 Array than in Other Factor Arrays

#9 Feeling embarrassed or ashamed to ask for help

#55 Thinking I can't recover from psychosis

#17 Financial implications

#14 Wanting to solve the problem myself

#18 Unsure where to get help

#27 Thinking the problem would get better by itself

#45 I didn’t know about talking therapies

#31 Preferring to get help from friends or family

#54 Thinking I couldn’t get better

#46 Thinking it's a waste of time

#30 I don’t like talking about my feelings, emotions or thoughts

#34 Problems getting childcare

#24 Thinking I would be seen as a bad parent

#25 Thinking I might lose custody of my children or they would go into care

Lowest Ranked Statements

#38 Language barriers

#13 Thinking I didn’t have a problem

#### Factor 3a Factor Array

The distribution grid for factor three a’s factor array would look as follows:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| -5 | -4 | -3 | -2 | -1 | 0 | +1 | +2 | +3 | +4 | +5 |
| 32 | 22 | 15 | 25 | 5 | 7 | 43 | 3 | 8 | 12 | 19 |
| 50 | 11 | 26 | 29 | 47 | 39 | 53 | 17 | 14 | 27 | 10 |
|   | 41 | 38 | 34 | 51 | 52 | 56 | 33 | 23 | 49 |   |
|   | 28 | 16 | 36 | 35 | 30 | 1 | 37 | 21 | 9 |   |
|   |   | 48 | 42 | 40 | 54 | 4 | 44 | 20 |   |   |
|   |   |  | 45 | 31 | 55 | 13 | 18 |   |   |   |
|   |   |   |   | 24 | 6 | 46 |   |   |   |   |
|   |   |   |   |   | 2 |   |   |   |   |   |

Figure 2.4 Factor array for factor 3a.

Highest Ranked Statements

#19 What my family might think

#10 Thinking I would be seen as crazy

Positive Statements Ranked Higher in factor 3a Array than in Other Factor Arrays

#12 What my friends might say or think

#27 Thinking the problem would get better by itself

#49 Feeling powerless

#9 Feeling embarrassed or ashamed to ask for help

#14 Wanting to solve the problem myself

#23 What people at work might say

#20 I didn't want a Mental Health problem on my records

#3 Knowing who to contact

#17 Financial implications

#44 I didn’t want to take medication

#18 Unsure where to get help

#13 Thinking I didn’t have a problem

#46 Thinking it's a waste of time

#52 Staff didn’t know what services were available to help me

Negative Statements Ranked Lower in factor 3a Array than in Other Factor Arrays

#7 The emotional connection with my key worker

#47 Medication alternatives were not encouraged

#40 Generic care that wasn’t individualised

#42 Care staff didn’t recognise or respond to my needs

#45 I didn’t know about talking therapies

#15 Being too unwell to ask for help

#16 I couldn’t get to appointments

#22 Thinking I would seem weak

#11 Thinking I may be put in hospital against my will

#41 Care providers didn’t want to help

#28 Treatment side effects

Lowest Ranked Statements

#32 Previous experiences with mental health care

#50 My opinion wasn’t valued

#### Factor 3b Factor Array

The distribution grid for factor three b’s factor array would look as follows:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| -5 | -4 | -3 | -2 | -1 | 0 | +1 | +2 | +3 | +4 | +5 |
| 36 | 1 | 31 | 5 | 3 | 9 | 2 | 4 | 28 | 7 | 30 |
| 38 | 19 | 35 | 8 | 11 | 13 | 16 | 6 | 32 | 21 | 45 |
|   | 26 | 44 | 10 | 15 | 14 | 17 | 23 | 37 | 33 |   |
|   | 48 | 49 | 12 | 18 | 20 | 24 | 43 | 42 | 47 |   |
|   |   | 53 | 39 | 40 | 22 | 27 | 51 | 56 |   |   |
|   |   |   | 52 | 50 | 25 | 29 | 54 |   |   |   |
|   |   |   |   | 55 | 34 | 41 |   |   |   |   |
|   |   |   |   |   | 46 |   |   |   |   |   |

Figure 2.5 Factor array for factor 3b.

Highest Ranked Statements

#30 I don’t like talking about my feelings, emotions or thoughts

#45 I didn’t know about talking therapies

Positive Statements Ranked Higher in factor 3b Array than in Other Factor Arrays

#7 The emotional connection with my key worker

#21 Thinking it might impact my chances of getting a job

#33 Not wanting to take time off work

#47 Medication alternatives were not encouraged

#28 Treatment side effects

#42 Care staff didn’t recognise or respond to my needs

#4 Thinking services wouldn’t be able to help me

#2 Being prepared for my transfer to another service

#16 I couldn’t get to appointments

#24 Thinking I would be seen as a bad parent

#29 Thinking that professional care wouldn’t help

#41 Care providers didn’t want to help

#25 Thinking I might lose custody of my children or they would go into care

#34 Problems getting childcare

Negative Statements Ranked Lower in factor 3b Array than in Other Factor Arrays

#9 Feeling embarrassed or ashamed to ask for help

#20 I didn't want a Mental Health problem on my records

#3 Knowing who to contact

#40 Generic care that wasn’t individualised

#55 Thinking I can't recover from psychosis

#5 Not feeling involved in my care

#8 The stigma of my diagnosis

#10 Thinking I would be seen as crazy

#12 What my friends might say or think

#39 Poor communication from care providers

#52 Staff didn’t know what services were available to help me

#31 Preferring to get help from friends or family

#35 No one to help me get help

#44 I didn’t want to take medication

#49 Feeling powerless

#53 I didn’t know what services were there to help me

#1 Building relationships with new staff

#19 What my family might think

#26 Preferring to use alternative forms of care (religious healing, complimentary therapies etc)

#48 Staff talked down to me

Lowest Ranked Statements

#36 Professionals from my own ethnic or cultural group not being available

#38 Language barriers

# Paper 3: Executive Summary

## Exploring the barriers to ‘recovery’ from psychosis as told by clients who experience psychosis using Q Methodology: Executive Summary.

For this Paper references will be completed in Vancouver referencing style.

Word count: 2,043

## Introduction & Background

This executive summary is an overview of research conducted that explored the barriers to recovery from psychosis from service users’ points of view. It is written primarily with service users in mind and is hoped it will be a succinct summary of the study and findings. It may also be of use to clinicians working within relevant services that are looking for a summary of what might block their clients’ recovery journeys.

Psychosis is a term used to describe a number of mental health diagnoses where people lose some contact with reality. This might involve seeing or hearing things that other people cannot see or hear (hallucinations) and believing things that are not actually true (delusions). Psychosis affects approximately 0.7% of adults over 16 in England in 2014 (1). Psychosis can be one of the most life-impacting mental health conditions there is (2) and often there is a lack of hope for recovery for people (3, 4, 5).

Recovery is about the realisation of goals, and the development of relationships and skills that support a positive life, with or without ongoing mental health problem

Since the 1990’s there has been more interest in recovery orientated care for people living with psychosis (6, 7, 8, 9). Government policy and NICE guidance have recommend the use of a recovery approach when working with psychosis (10, 11, 12) and the recovery movement has pushed for independence for clients and for them to be able to direct their own recovery, with individuals’ own goals guiding treatment (13).

Recovery has different meanings to different people (14) and historically in terms of psychosis it has been mainly about symptom reduction (15). More recently research has highlighted the importance of other aspects of recovery that are important such as quality of life (16, 17) and being able to live a fulfilling life whether or not symptoms are present (18). The stigma that comes with a diagnosis of psychosis can be difficult for people and can impact their wellbeing and recovery (19).

Stigma is when someone views you negatively because of a characteristic you have such as a mental health illness.

Most of the current research looks at barriers for people using Early Intervention (EI) services (20, 21, 22) or the barriers to particular therapies (23, 24, 25). There is little published research that looks at the experiences of people who have lived with a long-term diagnosis of psychosis. Given that current policies and guidelines such as ‘No Health without Mental Health’ (11), encourage a move towards a recovery orientated approach for all, it would thought it would be helpful to gain the views of service users on what blocks recovery for people who have lived with psychosis longer term.

This study explored the barriers to recovery for people who have lived long-term with a diagnosis of psychosis. Participant views about medication, ideas of hope, accessibility of services, support and relationship elements were identified and views of those as barriers to recovery were explored.

## Method

Q-methodology was used to gather participants’ views on the barriers to recovery form psychosis. Q-methodology is used to investigate different perspectives participants have on a specific topic. It requires participants to sort a set of statements into a predefined grid like the one below (Figure 1), based upon how much they agree or disagree with them being a barrier to their recovery form psychosis. These individual sorts are then compared with every other completed sort to look for similarities in views and grouped accordingly. Due to the impact of COVID-19 the sort was delivered online using a programme called Qsortware (26).



*Figure 1.* Q-sort grid.

The statements that were used were created from completing a search of all research there already is on barriers to recovery and from discussions with the research team and people who experience psychosis themselves. There were 56 statements in total for participants to sort.

People could take part if they experienced psychosis or symptoms associated with psychosis, with or without a diagnosis. Twelve participants took part in the study and it was carried about between October 2020 and January 2021. In order to take part people had to meet certain criteria.

**Inclusion criteria**

- Adult aged over 18

- Diagnosed with schizophrenia or experience symptoms associated with psychosis

- Sought help for their mental health in the UK

- Can understand and write using the English language

**Exclusion criteria**

- People whose experiences are as a result of an injury or disease in the brain

- Have a diagnosis of substance addiction

- People who are accessing EI, Inpatient mental health or crisis or home treatment services

The study was advertised online on social media platforms like Facebook and Twitter and was shared on groups on these sites. The study was also advertised in the National Paranoia Network and London Hearing Voices Network’s monthly newsletters. This was to try and reach as many people as possible. Details of participants that took part can be found in Table 1 below.

Table 1 Participant demographic details

|  |  |  |
| --- | --- | --- |
| Gender | Male | 7 |
| Female | 5 |
| Age | Range | 24-59 |
| Mean | 38.3 |
| Ethnicity | White British | 10 |
| Black British | 1 |
| Jewish | 1 |
| Employment status | Employed (including self-employed) | 6 |
| Unemployed | 4 |
| Voluntary/Unpaid Work | 2 |
| Years with experiences | Range | 1-32 years |
| Mean | 16 years |

People that wanted to take part clicked a link from the online study adverts or typed this into their internet browser if they saw the advert in the newsletters. They then read the participant information sheet online which had the researchers contact details on if they had any questions. People that chose to take part were able to do so anonymously. Participants then completed an online consent form, and some questions about themselves such as age, gender etc. and then did the study itself where they sorted the statements into the grid above. Before completing the study and sorting the statements, participants were given instructions of how to use the software and were guided through how to complete it at each stage with written instructions. After sorting the statements participants completed 5 questions to gain additional information on why they placed things where they did and if there was anything they would like to add to help when looking at the results (27). After this participants were given information on who they could contact if they had been upset by completing the study and the researchers details again if they had any questions.

## Key findings

Each person’s grid was compared with the others and statistically analysed using a computer programme (Ken-Q (28)) to get an understanding of the different viewpoints (29). Principal Component Analysis (PCA) was used to identify the number of potential factors within the data. Three factors were identified from the data, these three-factors explain 54% of the data variance, in line with guidance that suggests factors should account for at least 35-40% of the total study variance (30). Factor three is a bipolar factor, so it was decided to spit this factor, resulting in factor 3a and 3b.

### Factor 1. Hopelessness for recovery.

This viewpoint emphasises the hopelessness for recovery for people with psychosis. Participants here express a hesitation to seek help for fear of seeming weak or ‘crazy’ and convey a sense of powerlessness. Stigma was a key concept in this view, with participants believing they cannot get better.

### Factor 2. Interpersonal elements of care and feeling powerless.

This view placed more emphasis on the interpersonal elements of care and their impact on recovery. In this view people were aware of their difficulties and were willing to discuss them believing it would be beneficial. However, services are seen as unresponsive to their needs and opinions leaving people feeling powerless with a lack of control.

### Factor 3.

Factor 3 explains 10% of the variance and was a bipolar factor, as such this factor was split into factor 3a and 3b. Two Q sorts loaded significantly onto factor 3a and one Q sort loaded significantly onto factor 3b.

#### 3a. ‘Shameful feelings’.

Shame was a strong feature in this view, with participants being concerned about the opinions of key others. This view seemed more optimistic about the prospect of recovery and more positive about experiences with staff and services than other factors.

#### 3b. Negative experiences of care.

This respondent believes that previous experiences with mental health services impacted on their future hopes for recovery. The participant believed that thinking they could not get better and that it is not possible to live a fulfilling life with psychosis were barriers to recovery.

## Conclusion

Whilst all factors expressed different views on what impacts recovery, there appeared to be underlying similarities that link them all. These are stigma, lack of treatment options and associated hope for recovery and a sense that people with psychosis cannot live a fulfilling life.

Clearly there will never be just one explanation of the barriers to recovery for people with psychosis. The complexities of recovery and what it means to any given individual will mean there will always be differing viewpoints. There does however appear to be commonalties across views about; not knowing what is available, a lack of treatments options and negative experiences with services. These all leave people feeling ambivalent about the help services can offer them and if it recovery is possible. Whilst services and staff can help in some ways with managing these barriers, there is still a long way to go in reducing the huge external stigma associated with psychosis diagnoses in the general population. Whilst this is present, barriers will persist for people who experience psychosis or symptoms associated with it, in regards to not wanting to seem ‘crazy’ or being fearful of what others may think.

This research fulfilled its aim of exploring the barriers to recovery from psychosis and to see if there were any significantly different views held, discovering there were not. What was found was the stigma impacted hope of recovery in all views. It was clear from the findings that a person’s individual experience of help was crucial to their sense of self and thus ability to consider recovery from their difficulties.

## Recommendations

Recommendations based on the findings include:

* Clinicians should consider the impact stigma is potentially playing in service users presentations in order to better plan individualised care
* A clear understanding of what recovery means to the individual accessing services must be clarified in order to ensure everyone is working towards the same end goal.
* Service users must feel listened to, understood and involved in their care and receive a greater access to alternative treatment options.
* Staff must be aware of all the treatment options available to people with psychosis and ensure the client is well informed of their options. Staff should resist not discussing options because they have preconceptions that it will not be beneficial or that the service users doesn’t want to pursue it

## Limitations

Gender was well balanced within the sample however there is a lack of diversity within the sample with the majority of participants identifying as white British. Similarly, the age range of participants was limited, with no one over the age of 59 participating. Future studies should broaden access to a wider range of participants.

### Statement about impact of global pandemic 2019-2021

COVID-19 had a significant impact on the way in which this research was conducted. People who experience psychosis are a hard to reach population and so trying to do this online had its difficulties. The post-sort questionnaire was hard to administer via the software and as such participant responses were not as in depth as they would have perhaps been if this had been done in person. Similarly some of the participants reported difficulties using the software and that it was not that ‘user friendly’. The nature of carrying out purely online research meant that only people with access to a laptop, PC or tablet with internet connection could take part resulting in the research not being accessible to all. This in itself could be seen as a barrier, particularly if services have had to move online.

## Dissemination

The results will be disseminated within the researchers department and submitted for potential publication within peer-reviewed journals. It is also possible that the findings of this study may be shared in teaching sessions or at conferences.

## References

1. McManus S., Bebbington P., Jenkins R., Brugha T. (eds.) (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital
2. Public Health England. *Psychosis data report*. Available from: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774680/Psychosis_data_report.pdf> [Last Accessed: 27th April 2021]
3. Vass, V., Morrison, A. P., Law, H., Dudley, J., Taylor, P., Bennett, K. M., & Bentall, R. P. How stigma impacts on people with psychosis: The mediating effect of self-esteem and hopelessness on subjective recovery and psychotic experiences. *Psychiatry Research.* 2015; 230(2): 487-495.
4. Wood, L., Byrne, R., Burke, E., Enache, G., & Morrison, A. P. The impact of stigma on emotional distress and recovery from psychosis: The mediatory role of internalised shame and self-esteem. *Psychiatry Research.* 2017; 255: 94-100.
5. Noordsy, D., Torrey, W., Mueser, K., Mead, S., O'Keefe, C., & Fox, L. Recovery from severe mental illness: An intrapersonal and functional outcome definition. *International Review of Psychiatry.* 2002;14(4*)*: 318-326.
6. Anthony, W.A. Recovery from mental illness: the guiding vision of the mental health service system in the 1900s. *Psychosocial Rehabilitation Journal.* 1993;16: 11-23
7. Allott, P., Loganathan, L. & Fulford, K.W.M. Discovering hope for recovery from a British perspective: a review of a selection of recovery literature, implications for practice and systems change. *Canadian Journal of Community Mental Health.* 2002;21: 13-33.
8. Turner-Crowson, J. & Wallcraft, J. The recovery vision for mental health services and research: a British perspective. *Psychiatric Rehabilitation Journal.* 2002;25: 245-255
9. Repper, J. & Perkins, R. *Social Inclusion and Recovery: A Model for Mental Health Practice.* Imprint: Bailliere Tindall; 2003.
10. The National Institute for Clinical Excellence (NICE). Psychosis and schizophrenia in adults: prevention and management (Clinical Guide CG178). Available from: <https://www.nice.org.uk/guidance/cg178> [Last Accessed: 27th April 2021]
11. Department of Health. *No health without mental health. A cross-government mental health outcomes strategy for people of all ages.* Available from: [www.gov.uk/government/uploads/system/uploads/attachment\_ data/file/213761/dh\_124058.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_%20data/file/213761/dh_124058.pdf) [Last Accessed: 27th April 2021]
12. Department of Health and Social Care . *National Services Framework: Mental Health*. Available from: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf> [Last Accessed: 27th April 2021]
13. Hamm, J. A., Buck, K. D., Leonhardt, B. L., Luther, L., & Lysaker, P. H. Self-directed recovery in schizophrenia: Attending to clients’ agendas in psychotherapy. *Journal of Psychotherapy Integration*. 2018;28(2): 188-201.
14. Wood, L., Price, J., Morrison, A., & Haddock, G. Conceptualisation of recovery from psychosis: A service-user perspective. *The Psychiatrist*. 2010;34(11): 465–470.
15. Silverstein, S. M., & Bellack, A. S. A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review*. 2008;28(7): 1108-1124
16. Kukla, M., Paul H. Lysaker, P.H. & Roe, D. Strong subjective recovery as a protective factor against the effects of positive symptoms on quality of life outcomes in schizophrenia. *Comprehensive Psychiatry*. 2014;55 (6): 1363-1368
17. Roe, D., Mashiach-Eizenberg, M., & Lysaker, P.H. The relation between objective and subjective domains of recovery among persons with schizophrenia-related disorders. *Schizophrenia Research*. 2011;131(1): 133-138.
18. Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A. P. (2007). Researching recovery from psychosis: a user-led project. *Psychiatric Bulletin*. 31(2): 55-60.
19. Livingston, J. D., & Boyd, J. E. Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social science & medicine*. 2010;71(12): 2150-2161.
20. Anderson, K. K., Fuhrer, R., & Malla, A. K. “There are too many steps before you get to where you need to be”: Help-seeking by patients with first-episode psychosis. *Journal of Mental Health*. 2013;22(4): 384-395.
21. Connell, M., Schweitzer, R., & King, R. Recovery from first-episode psychosis and recovering self: A qualitative study. *Psychiatric Rehabilitation Journal*. 2015;38(4): 359.
22. Lucksted, A., Essock, S.M., Stevenson, J., Mendon, S.J., Nossel, I.R., Goldman, H.H., Goldstein A.B., & Dixon, L.B. Client views of engagement in the RAISE connection program for early psychosis recovery. *Psychiatric Services.* 2015:66(7); 699-704.
23. Bucci, S., Berry, K., Barrowclough, C. & Haddock, G. Family interventions in psychosis: a review of the evidence and barriers to implementation. *Australian Psychologist*. 2016;51: 62–68.
24. Jones, N., Rosen, C., Helm, S., O’Neill, S., Davidson, L., & Shattell, M. Psychosis in public mental health: Provider perspectives on clinical relationships and barriers to the improvement of services. *American Journal of Orthopsychiatry*. 2019; 89(1): 95–103.
25. Lecomte, T., Samson, C., Naeem, F., Schachte, L., & Farhall, J. Implementing cognitive behavioral therapy for psychosis: An international survey of clinicians’ attitudes and obstacles. *Psychiatric Rehabilitation Journal.* 2018;41(2): 141–148.
26. Pruneddu, A. *Q-sortware*. Available from <http://www.qsortware.net> [Last Accessed: 27th April 2021]
27. Van Exel, J., & de Graaf, G. *Q methodology: A sneak preview*. Available from: <https://www.researchgate.net/profile/Gjalt_Graaf/publication/228574836_Q_Methodology_A_Sneak_Preview/links/02bfe50f946fc9978b000000.pdf>
28. Banasick, S. *Ken-Q Analysis*. Available from: https://shawnbanasick.github.io/ken-q-data/index.html#section1 [Last Accessed: 27th April 2021]
29. Watts, S. & Stenner, P. *Doing Q Methodological Research. Theory, Method and Interpretation.* London: SAGE Publications Ltd; 2012.
30. Kline, P. *An Easy Guide to Factor Analysis.* London: Routledge; 1994.