Delivery of cognitive-behaviour therapy for psychosis: A service user preference trial

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Delivery preferences for CBT for psychosis

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Abstract

Background: Clinical guidelines recommend cognitive behaviour therapy (CBT) for people with psychosis, however, implementation is poor and not everyone wishes to engage with therapy. Understanding service user (SU) preferences for receiving such treatments is a priority for services.

Aims: To explore SU preferences and outcomes of different methods of delivering CBT for psychosis.

Method: SUs experiencing psychosis could choose between treatment as usual (TAU); TAU plus telephone-delivered CBT with self-help, CBT recovery manual (TS); high support CBT (HS - TAU plus TS plus group sessions); or randomisation. Participants received their option of choice and were followed up on several outcomes over nine and 15 months.

Results: Of 89 people recruited, three chose to be randomised and 86 expressed a treatment preference (32 chose TAU, 34 chose TS, 23 chose HS). There were few differences between those that chose therapy compared to those that chose TAU. Those who had more positive impacts from their symptoms were significantly more likely to choose TAU.

Conclusions: Most people had strong preferences about treatment delivery and a substantial number did not wish to receive additional therapy. These findings have to be considered when planning and allocating resources for people with psychosis.

Declaration of interest: None

Keywords: schizophrenia, CBT, treatment preference, psychosis, preference trial

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1

Delivery preferences for CBT for psychosis

Clinical guidelines recommend psychological therapies, such as cognitive–behaviour therapy (CBT),

to support recovery for individuals with psychosis or schizophrenia (American Psychiatric

Association, 2004; National Institute for Health and Care Excellence, 2014). However,

implementation of CBT for psychosis (CBTp) is poor (Haddock et al., 2014; Prytys et al., 2011) and

there are significant barriers to delivery within services, such as workforce capacity (Berry &

Haddock, 2008), service structure and service user (SU) preferences. The evidence base for CBTp

has mainly been for face to face CBT (individual or group), although we know that CBT delivered by

telephone is effective and acceptable as face-to-face delivery (Lovell et al., 2006). Despite this,

preferences for delivery of CBTp are not well researched, although preferences about treatment

have been explored for other mental health problems. This work has suggested that therapy may

be more acceptable and credible than pharmacological interventions (Landreville et al., 2001;

Lundervold & Lewin, 1990; Rokke & Scogin, 1995; Unützer et al., 2002), and that there are better

outcomes for those receiving a treatment of choice (Swift & Callahan, 2009).

Although little research has been done on preferences for CBTp, some studies suggest that people

have strong opinions about therapy and how it is delivered (Sumner et al, 2014; Byrne et al, 2010;

Byrne et al, 2014). In one study, which explored hypothetical preferences about delivery of CBTp,

SUs were asked, if they were to be offered a treatment, how they would prefer therapy to be

delivered with four possible options: CBTp by telephone, telephone CBTp plus group sessions, both

including the support of a CBTp-focused guided self-help manual, 'no therapy' (TAU) or 'no

preference' (randomly allocated to any treatment; Sumner et al., 2014). All were also asked

whether they would be willing to take part in a trial. Of 81 participants, 97% were willing to be

involved in such a trial, however, 57% were not be willing to be randomised and had preferences

about how they would like to receive CBTp. Twenty two per cent chose TAU alone, 43% chose

2

Delivery preferences for CBT for psychosis

telephone CBT, and 27% preferred telephone therapy plus group sessions. Only one participant had

no preference suggesting important considerations for service deliverers. For example, SUs may

refuse treatment in case they do not receive their preferred option, or, they may drop out because

they are unhappy with their allocation. In addition, although there were no sociodemographic or

clinical differences between preference groups in the Sumner et al study, other studies have shown

that preferences about treatment are associated with patient characteristics (Yung et al, McHugh et

al, 2013). More information about this may help services to plan delivery of treatment based on

specific characteristics.

To take account of treatment preferences, partially randomised Patient Preference Trial (PPT)

designs are used (Brewin & Bradley, 1989). People with treatment preferences are allowed their

treatment without randomisation and those without a preference are randomised in the usual way.

There are methodological problems with this design, e.g. any comparison that uses non-

randomised groups is potentially unreliable because of unknown confounds. However, there are

ways of reducing the impact of this by performing a comparison of the randomised participants

alone, collecting information on confounds and adjusting for these in the analysis and using

randomisation status as a covariate in analyses (Torgerson & Sibbald, 1998). Prospective

investigations to ascertain expected numbers in each arm, and presenting information to

participants about choices in a standardised way to minimise expectancy bias can help inform the

design of such a trial. This methodology was chosen in the current study on the basis that the

potential benefits outweighed the methodological problems. Benefits included the likelihood that

we might recruit people who would otherwise refuse to take part in a traditional Randomised

Controlled Trial (RCT), thus the sample would be more representative. Also, a PPT might improve

the external validity of the trial i.e. be more commensurate with routine practice. We currently

3

Delivery preferences for CBT for psychosis

have little information about treatment preferences in mental health and initiatives to bring parity

for mental health care with physical health suggests that services should offer psychological

therapy to everyone with psychosis (see National Institute for Health and Care Excellence - Quality

Standard, 2015). Data on the likely uptake of therapy is important as to facilitate modelling of

capacity and demand even though research data is not able to completely model 'real' service

delivery. This information may help to overcome problems with implementation of psychological

treatments for people with psychosis (Haddock et al., 2014). Hence, we aimed to examine SU

characteristics in relation to treatment choice within the context of a real trial (in contrast to the

hypothetical study of Sumner et al, 2014) and explore how this related to feasibility and

acceptability of treatment, and explore outcomes following choice on recovery, symptoms and

functioning. We anticipated that the characteristics of those choosing different options may vary

which may allow us to deliver treatments matched to service user characteristics.

Materials and Methods

Participants

Participants were recruited from three National Health Service mental health trusts in the North

West of England. Inclusion criteria were: ICD-10 (World Health Organisation, 1992) diagnosis of a

schizophrenia spectrum disorder; 18-65 years; under care of a mental health team; use of a

telephone, able to read English and provide informed consent, and stable symptoms for at least

one month (defined as an absence of acute exacerbations of symptoms requiring hospitalisation or

change in medication).

Randomisation and masking

4

Delivery preferences for CBT for psychosis

Following baseline assessment, participants took part in a semi-structured interview to ascertain

preferences for treatment following presentation of a short description of each option. Participants

were offered TAU alone (TAU), TAU plus telephone delivered CBT plus a supported self-help manual

(TS), TAU plus TS plus recovery focused CBT group sessions (HS) or randomisation to any option.

Options were presented in a counterbalanced order to remove order effects. Participants were

asked about reasons for choice and the strength of choice (1-10, 10 being strongest). Participants

were then allocated to their preferred option. Randomisation was conducted remotely by an

independent clinical trials unit using random permuted blocks.

Procedures

Ethical approval for the study was provided by NRES Committee North West – Greater Manchester

North (09/H1011/81; ISRCTN50487713). Participants were given £10 for each assessment at

baseline, post-therapy (9 months) and at 15 months. All assessments were carried out by research

assistants blind to allocation.

Intervention

Further details of each treatment option:

1. Treatment as usual (TAU) consisted of care from a multi-disciplinary mental health team,

   prescriptions for antipsychotic medication, supportive information about medication and

   regular review.

2. Telephone support (TS) comprised weekly, telephone delivered CBTp with a supported self-

   help Recovery Guide delivered over 9 months. One initial and final face-to-face meeting

   were also offered. The Recovery Guide had two core chapters (Meaning of recovery from

   psychosis and goals, resources and understanding development of problems) and two

5

Delivery preferences for CBT for psychosis

further chapters with optional sections (anxiety, paranoia, low self-esteem) or reaching

wider recovery goals (employment, healthy living, social networks). The guide was

developed by academics, clinicians and service user researchers. Participants could work on

the guide independently, and within telephone sessions with a dedicated therapist who

carried out a CBTp intervention. The intervention was intended to provide an equivalent

amount of therapy as that which be carried out in usual face to face CBT for psychosis and

was based on CBT psychosis interventions used in previous trials by the authors (Lewis et al,

2002; Barrowclough et al, 2010; Haddock et al, 2009) which informed UK, NICE guidelines

for the delivery of CBT for people with psychosis (NICE, 2014). Telephone delivery was based

on procedures developed in a CBT equivalence trial carried out by the first author (Lovell et

al, 2006). All seven therapists met British Association for Behavioural and Cognitive

Psychotherapies minimum training standards for CBT. Treatment fidelity was ensured

through a detailed therapy manual, fortnightly group supervisions, individual therapist

supervision and assessment of audio taped therapy sessions using a therapy fidelity scale

(Hartley et al., 2014).

3. High Support (HS) consisted of TAU plus telephone delivered CBTp therapy as above plus 12

recovery focused CBTp group sessions delivered over six months, fortnightly, lasting two

hours. Groups were run by a CBT therapist and a researcher with lived experience of

psychosis. The sessions were CBT-based and matched chapters in the guide. Groups were

aimed at encouraging participants to identify areas they would like to change and facilitated

discussion around key CBT strategies. The treatment protocols closely matched that of

traditional CBTp in groups (Barrowclough et al, 2006). Therapy adherence to the group

intervention was ensured through using a detailed manual and supervision sessions as

above.

Delivery preferences for CBT for psychosis

In addition, some participants were offered peer support sessions delivered by service user-

consultants. Up to six peer support sessions were offered, the first in person and the rest by

telephone. However, due to resources, these sessions were only offered to the first 21 participants

(13 = TS, 8 = HS).

Outcomes

Participants' choice and their ratings on strengths of choices (using Likert scales) were recorded

during interview by the researcher. Reasons for choices were recorded verbatim. Data on take up

of therapy sessions, time spent in therapy and therapeutic alliance were recorded. Demographic

characteristics of participants and details of symptoms were recorded.

Self-report mental health measures

1. Questionnaire about the Process of Recovery (QPR; Neil et al., 2009): two sub-scales relating

   to interpersonal and intrapersonal recovery (22 items).

2. Subjective Experiences of Psychosis Scale (SEPS; Haddock et al., 2011): three subscales

   assessing the impact of psychotic symptoms, external factors and severity of psychotic

   symptoms (45 items).

Secondary measures

Structured interviews were used to measure symptom severity using the Positive and Negative

Syndrome Scale (three subscales covering positive, negative and general symptoms, and a total

score; PANSS; Kay et al., 1987) and Psychotic Symptom Rating Scales (an auditory hallucinations and

delusions subscale score and a total score; PSYRATS; Haddock et al., 1999). Functioning was

7

Delivery preferences for CBT for psychosis

measured by the total score of the informant rated Personal and Social Performance Scale (PSP;

Morosini et al., 2000). Depression was assessed using the total score of informant rated Calgary

Depression Scale (Addington et al., 1993) The self-report Beck Anxiety Inventory (BAI; Beck et al.,

1988) and Self Esteem Rating Scale (Lecomte et al., 2006) total scores assessed anxiety and

depression. All outcome measures have been widely used in psychosis samples and have good

psychometric properties.

In addition, socio-demographic information (ethnicity, living arrangements, employment, education,

marital status, religious beliefs) were assessed at baseline. Therapeutic alliance was measured by

the self-report, client and therapist version of the Working Alliance Inventory (WAI; Horvath &

Greenberg, 1989) after the third telephone session. This has been widely used in psychosis samples

and has good psychometric properties.

All assessors received training in the measures to a gold standard. The gold standard was developed

in two previous trials of CBT for psychosis (Lewis et al, 2002 Barrowclough et al, 2010). Assessors

had monthly supervision, where rating ambiguities were discussed and agreed. Inter-rater

reliability was assessed quarterly using randomly selected cases. Average intraclass correlations

from these analyses were .85 for the PANSS, .98 for the PSYRATS, .98 for the PSP and .92 for the

CDS. All symptom measures were administered by blind assessors at baseline, nine months (end of

treatment) and 15 months (follow-up).

Statistical analysis

8

Delivery preferences for CBT for psychosis

Reasons for treatment choices were analysed using content analysis (Hsieh & Shannon, 2005)

involving categorising participants' reasons into mutually exclusive themes. This was carried out by

two researchers including one with lived experience of psychosis.

We performed analyses on participant demographic characteristics (age, gender, diagnosis, living

arrangements, service type, employment), baseline PANSS, PSYRATS, SEPS, PSP and whether they

had experienced previous psychological therapy in relation to treatment preferences. We used

exploratory analysis to look at differences in therapy uptake between therapy groups, and also

examined therapeutic alliance (TA), using therapist and participant reported WAI (reported in

Mulligan et al., 2014).

The outcome analysis evaluated the effects of the interventions and assessed whether they were

unaffected by the mechanism of treatment selection. As only 3 participants chose randomisation,

this was not carried out. Outcome data were analysed using appropriate regression models to

assess effects of treatment receipt, regardless of the method of treatment selection, using several

baseline covariates (baseline value of the outcome measure being analysed, baseline PANSS

Positive, PSP totals, sex, age, and education) to allow for possible confounding effects. Analyses

were carried out using Stata version 11 (StataCorp, 2009). These outcomes are reported in full in

Morrison et al (2016).

Results

Sample

244 participants were identified as eligible, and, of those, 206 were approached by their care

coordinator to discuss participation (see Figure 1).

9

Delivery preferences for CBT for psychosis

[Insert Figure 1 here]

Of these, 163 people agreed to be approached by the researcher, 25 did not respond to invitation

to discuss participation, 43 refused to take part, leaving 95 people recruited. Of those, six withdrew

from the study prior to therapy allocation. Demographic information is provided in Table 1.

[Insert Table 1 here]

Preferences for delivery of psychological therapy

Only three participants wished to be randomly assigned. A substantial proportion chose to receive

TAU alone. The majority chose the TS option whilst a slightly smaller proportion chose the HS

option (see Table 2). There were no significant differences in the strength of preferences between

any of the three groups (see Table 3).

[Insert Tables 2 and 3 here]

Reasons for choice

All reasons for choice were analysed using content analysis and categorised independently by two

raters (SH and LP) into mutually exclusive themes using the coding framework reported by Sumner

and colleagues (2014) as a guide. The percentage agreement between raters was calculated

representing the proportion of statements where total agreement was reached. The agreement for

each of the categories was: willingness to participate - 84.4%, unwillingness to participate - 69.2%,

10

Delivery preferences for CBT for psychosis

preference for TAU - 70.6%, preference for TS - 91.2%, preference for HS - 73.8%, willingness to be

randomised - 76.7%, and unwillingness to be randomised - 84.4% (see Table 4).

[Insert Table 4 here]

In relation to choice of HS, reasons related to offering the opportunity to engage with others with

similar mental health problems or for social contact. For others, HS was seen as an opportunity to

get more therapy. For TS, reasons related to convenience of delivery e.g. being able to take

advantage of therapy but not having to travel to clinics. Some reported that, while they wanted

therapy, their problems were not severe enough to require additional group sessions. Others

reported a dislike for groups, whilst still wishing to receive therapy. Those that chose TAU alone

reported that therapy was unnecessary and expressed satisfaction with current services. Some

cited reasons for choice directly related to mental health problems e.g. paranoia making it difficult

to attend groups. Other cited reasons such as wanting to understand their illness and learning to

relax as motivators for therapy. A small number reported that they wished to be involved in

research for altruistic reasons but did not wish to take part in therapy.

Preferences, demographics and symptoms

Differences between those who chose therapy (LS + HS) and TAU

We examined the differences in demographic characteristics between those who chose therapy

versus TAU (i.e., age; gender; ICD-10 diagnosis; living arrangement; relationship status; type of

previous and current therapy received (none vs. CBT); service type (early intervention vs.

community care); employment status; and clinical measures (baseline QPR, BAI, BHS, SERS, SEPS,

CDS, PANSS, and PSYRATS). There were no significant differences between participants'

11

Delivery preferences for CBT for psychosis

demographic characteristics and their treatment preference. However, there were significant

differences in BAI, SEPS negative scale, CDS, and PANSS negative scale scores. Those who chose

therapy, rather than TAU, had more negative impact from psychosis symptoms (SEPS; U = 565.5, p

= .01), were more anxious (BAI; U = 570, p = .01), more depressed (CDS; U = 533, p = .004), and

experienced more negative symptoms of psychosis (PANSS; U = 624, p = .04). There were no

significant differences between those who choose TS and those who chose HS on demographic or

clinical measures.

Therapy uptake

Descriptive statistics for therapy uptake are in Table 5. The TS group completed significantly more

telephone sessions overall compared to the HS group (F(1,55)= 4.72, p = .034). There was a high

level of variability in therapy attendance, with a range of 1–30 telephone support sessions attended

and a range of 0–11 group sessions attended.

Therapeutic alliance (TA) was comparable to previously reported in other CBTp trials. Consistent

with previous studies (Barrowclough et al., 2010), therapist alliance scores were significantly lower

than client-rated alliance (see Mulligan et al., 2014).

[Insert Table 5 here]

Recovery and symptom outcomes following preferential allocation

Linear regression models were fitted to estimate the treatment differences adjusted for age, sex,

education and baseline scores for PANSS positive, PSP and corresponding baseline. There was no

evidence of an overall treatment effect for the QPR total at nine months (p = .58) and 15 months (p

12

Delivery preferences for CBT for psychosis

= .82) or on any comparisons between the groups at either point. The same analyses were

performed on SEPS. The only significant finding was for the SEPS negative impacts outcome at 15-

month follow-up, where there was an estimated difference in adjusted means comparing HS to TAU

of 16.85 units (95% CI 1.36 to 32.35, *p* = .03) in favour of the control group. However, given multiple

testing, this must be interpreted with caution. Similarly, there were no other secondary outcome

differences between groups. (see Morrison et al., 2016 for a full description).

Discussion

Participants had strong preferences about treatment with most expressing a preference about

treatment, rather than randomisation. Given the paucity of patient preference trials with people

with psychosis, it is unclear whether this finding is generalizable, although other mental health

trials have found higher rates of participants willing to be randomised (Bedi et al, 2000). This is

important, given that little choice is usually offered for people with psychosis. Although the finding

may be limited to CBTp, it suggests that preferences for other treatments may be an important

topic for future research in this client group. The preferences varied slightly from those reported by

Sumner and colleagues (2014) who found that 43% of participants were willing to be randomised,

compared to just 3% in the present study, suggesting that asking people hypothetical questions

about treatment preferences is not useful if we wish to know real figures for the purposes of a trial

or service planning. We also found more people who opted for TAU rather than therapy, although

overall treatment choices were similar across the three options.

The finding that a significant number of people did not choose to have therapy is important as the

drive to improve access to CBTp assumes people all want it but cannot get it. There may have been

other reasons for their refusal which we are not aware of, hence, fuller exploration of this may be

Delivery preferences for CBT for psychosis

needed. However, it may suggest that more indirect working is warranted e.g. ensuring that

individual's care is psychologically informed without providing one-to-one therapy. This has been

shown to have some value in influencing outcomes (Berry & Haddock, 2008; Berry et al., 2015). In

addition, any participants who were in services were offered the opportunity to take part without

consideration of whether they had been requesting therapy or not. This may well have influenced

the findings. A future trial may examine choice and preference in a help seeking population which

may provide different results.

Participants had varied reasons for their preferences and they were often strongly endorsed. Some

of these related to personal preferences such as feeling satisfied with their current treatment or

wanting someone to talk to. However, others expressed more external reasons, such as a desire to

contribute to the research, rather than a desire to gain treatment. Clearly, the reasons for an

individual's choice of treatment need to be carefully discussed with them. This may be an

important consideration for rolling out CBTp interventions within routine services where SU

treatment preferences are not always considered. This may result in poor take up of treatments

which could, in part, account for the poor implementation of recommended psychological

treatments for psychosis.

There were also no significant relationships between SU characteristics (e.g. diagnosis, age) and

treatment preferences suggesting SUs' treatment choices cannot be easily predicted. It may

therefore be important to offer treatment choices to SUs with psychosis on an individual basis, as

the same modes of therapy may not be suitable for everyone.

Outcome from treatment

14

Delivery preferences for CBT for psychosis

There were no differences between groups in terms of treatment outcome. Group averages

suggested that people within the study remained stable through to the 15 month follow-up,

without significant improvement or deterioration, although this was variable with a wide range of

outcomes across groups (see Morrison et al, 2016). It is possible that the sample recruited differed

from those who would normally be recruited into psychological treatment trials, given that they

were aware that they could choose their treatment option. What is unknown, is the effect of having

treatment choice on outcomes. As such a small number chose to be randomised, it was not possible

to fully explore outcomes against participants who were assigned to the treatment they may not

have wanted. Hence, we do not know whether the outcomes would be different between those

who received their choice compared to those who did not. This could only be overcome by having

two samples i.e. one with randomisation only and one sample with choices.

Limitations

The findings are limited due to the PPT design and the low numbers choosing to be randomised,

limiting the potential to make comparisons between groups. As a result, the findings are purely

observational and, although conclusions can be made in relation to some aspects of the results,

such as those relating to choice, it is not possible to make conclusions about specific outcomes from

treatment. However, this method may be good for observational studies of clinical decision-making,

especially if we consider the drive to improve delivery of psychological therapy i.e., we may be able

to plan the provision of therapy just to those who want it. Hence, determining how many people

want therapy and what is best suited to whom, is important. This could be enhanced by not just

exploring uptake and engagement in therapy, but by exploring why people drop out or withdraw

from therapy. In addition, we offered CBTp by telephone and group in this study, rather than

traditional face to face therapy. Whilst, we know that telephone therapy has demonstrated

15

Delivery preferences for CBT for psychosis

equivalence to face to face therapy in other patient groups, it's possible that this may not be the

case in this sample. Further research could ensure this was explored together with other delivery

options e.g. CBT delivered via internet or via app.

Finally, although we wished to deliver peer support as part of the treatment package, estimates of

resources required to deliver this was below that which was actually required, resulting in this not

being delivered to all participants as planned. As peer support is suggested in some guidelines (e.g.

NICE), careful thought needs to be given to the resources required.

Implications

This study was the first of its kind with people experiencing psychosis and one of few conducted in

mental health. It showed that SUs have strong preferences about treatment which are difficult to

anticipate on participant characteristics alone. Although there were no significant differences

between therapy groups in outcomes, the TS group was the most popular choice which may

indicate that a similar format could be beneficial if refined and evaluated in a manner that

permitted unconfounded analysis of treatment effects. Although telephone delivery of CBT has

been little evaluated with this group, the findings showed it was acceptable and feasible with a

similar therapeutic alliance to that observed in face-to-face CBT. Further research should explore

several issues highlighted. For example, the effectiveness of telephone CBT in an RCT, feasibility

and acceptability of peer support and its value in addition to CBT, and further exploration of patient

preferences and their impact on implementation.

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16

Delivery preferences for CBT for psychosis

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17

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20

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Disclaimer

23

Delivery preferences for CBT for psychosis

The authors wish to recognise that the terms and language used in this article such as service

user/client/psychosis are not universally endorsed by all. Where differences of opinion arose in

preparation of this work, the authors decided to use the term that was agreed by the majority,

while also respecting the views of others.

24

Delivery preferences for CBT for psychosis

Figure 1: CONSORT diagram to show participant flow throughout the trial. TAU – treatment as ususal; TS – Telephone Therapy; HS – High Support therapy.
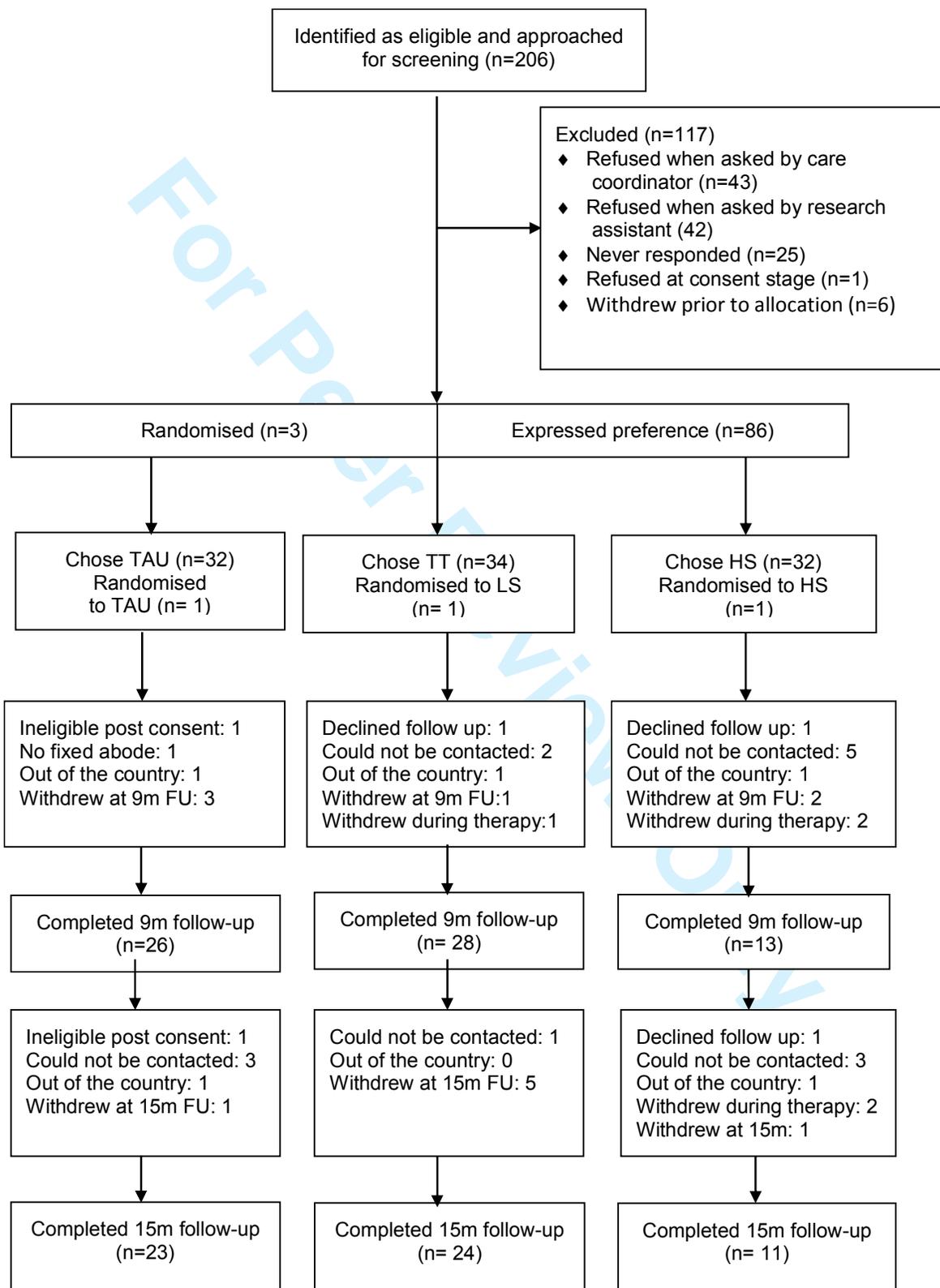
Delivery preferences for CBT for psychosis

Table 1: Sample demographics

Participant characteristics at the time of consent		Total		TAU		TS		HS	
		N	%	N	%	N	%	N	%
Age	*Mean (SD)*	36 (10.9)		35 (11.2)		38 (9.7)		33.3 (10.6)	
Gender	Male	60	63	25	28.1	20	22.5	14	15.7
	Female	35	37	8	9	13	14.6	9	10.1
	White	76	80	26	29.2	26	29.2	21	23.6
Ethnicity	Black/ Minority Ethnic Group	13	14	7	7.9	4	4.5	3	3.4
	Mixed race	4	4	0	0	3	3	1	1
	Not reported	2	2	-	-	-	-	-	-
	Employed/studying	24	73	9	10	6	7	6	7
Occupation	Not working/studying	69	25	24	27	27	30	17	19
	Not reported	2	2	-	-	-	-	-	-
	Post-16 education	51	44	19	21.3	18	20.2	11	12.4
Education	No post-16 education	42	54	14	15	15	17	12	13
	Not reported	2	2	-	-	-	-	-	-
	Alone	60	63	21	2	18	20.2	19	21.3
Living Arrangements	With family members/ partner	31	33	12	13.5	14	15.7	4	4.5
	Supported accommodation	2	2	0	0	1	1.1	0	0
	Not reported	2	2	-	-	-	-	-	-
Marital status	Married/civil partnership/ cohabiting	10	11	4	4.5	4	4.5	2	2.2
	Single	83	87	29	32.6	29	32.6	21	23.6
	Not reported	2	2						
	Schizophrenia	39	41	15	17	14	15.9	7	8
	Schizoaffective disorder	12	13	2	2.3	5	5.7	2	2.3
Diagnosis	Psychosis NOS	35	36	13	14.8	13	14.8	10	11.4
	Delusional disorder	3	3	0	0	2	2.3	1	1.1
	Paranoid schizophrenia	6	6	2	2.3	1	1.1	3	3.4
	Bipolar disorder	1	1	0	0	0	0	0	0

Delivery preferences for CBT for psychosis

Table 2: Therapy preferences and allocation

Allocations	Frequency (%)
Not allocated	6 (6)
TAU	31 (33)
Low support	33 (35)
High support	22 (23)
Randomised	3 (3)

27

Delivery preferences for CBT for psychosis

Table 3: Strength of Preferences

Treatment Group	Strength of option preference			Strength of therapy preference		
	Mean	SD	Range	Mean	SD	Range
TAU	8.58	1.38	5 – 10	n/a	n/a	n/a
TS	8.3	1.31	5 – 10	8.19	2.02	2 – 10
HS	8.34	1.19	5 – 10	8.24	1.09	5 – 10

Delivery preferences for CBT for psychosis

Table 4: Themes arising from analysis of reasons for treatment preference

Major themes (frequency of statements)		Examples
TAU (35)		
1.	Dislike of/lack of desire for aspect of therapy/ therapy in general (16)	'I don't want telephone therapy and wouldn't like a group' 'I don't like it on the phone, would prefer face to face'
2.	Therapy viewed as unnecessary at present (8)	'I feel I'm doing so well, feel I don't need any other support at the moment' 'Feel I'm doing ok at the moment, don't want to jinx it'
3.	Satisfaction with current support (10)	'What I'm getting at the moment is good, in the past I didn't want help, now I receive a lot of help and this is working' 'I'm getting enough support at the moment- helping with practical support like finding work. Want to get out of psychiatric services'
4.	Assist the research (1)	'Because I don't mind doing the questionnaires'
LS (39)		
1.	Dislike of/lack of desire for group support (23)	'Sounds like the group might be a lot of travelling and too much time' 'I'm very paranoid- don't like meeting new people so I wouldn't like the group'
2.	Desire to receive therapy/ therapy viewed as helpful (13)	'I don't usually go out of the house so phone support might be good' 'The CBT calls- I can talk through problems' useful'
3.	Desire to receive self-help manual (1)	'Get to do the Recovery Guide because I think it might be helpful'
4.	Group support unnecessary (2)	'I would have chosen high support but I'm more well now- I'm past that stage, I don't need it.' '...the high support would be a bit too much time for me'

29

Delivery preferences for CBT for psychosis

Major themes (frequency of statements)	Examples
HS (74)	
1. Social aspect/ normalising/ sharing experiences (11)	It's a chance to meet people and discuss what support they have and share problems' 'It would be good to meet other people who have similar experiences- I don't know anyone who has gone through the same things'
2. Benefits to self/highest level of support is most beneficial (8)	'More stuff to help me' 'Want to try and stabilise me- deal with the pressure of
3. To gain knowledge/ information/ understanding (1)	'I want to understand it more- what triggers my illness, how to relax- want to get well'
4. For an experience/activity/ out of interest (4)	'High support will get me out doing something within group sessions' 'Don't usually get involved but like the idea of it an psychological support'
5. Desire for group support (2)	'I want to try out the group sessions' 'It's got the most activities to be involved in'

Delivery preferences for CBT for psychosis

Table 5: Therapy uptake

	Therapy Group	
	Telephone mean (*SD*)	High Support mean (*SD*)
Number of telephone sessions attended	15.82 (10.77)	9.78 (9.54)
Number of group sessions attended	n/a	2.96 (3.60)
Total number of all sessions attended*	13.39 (10.64)	12.68 (12.92)
Total number of telephone session DNAs	4.35 (4.96)	4.48 (4.88)
Average telephone session length (minutes)	40.56 (9.23)	39.55 (1.32)

* Group + telephone sessions.