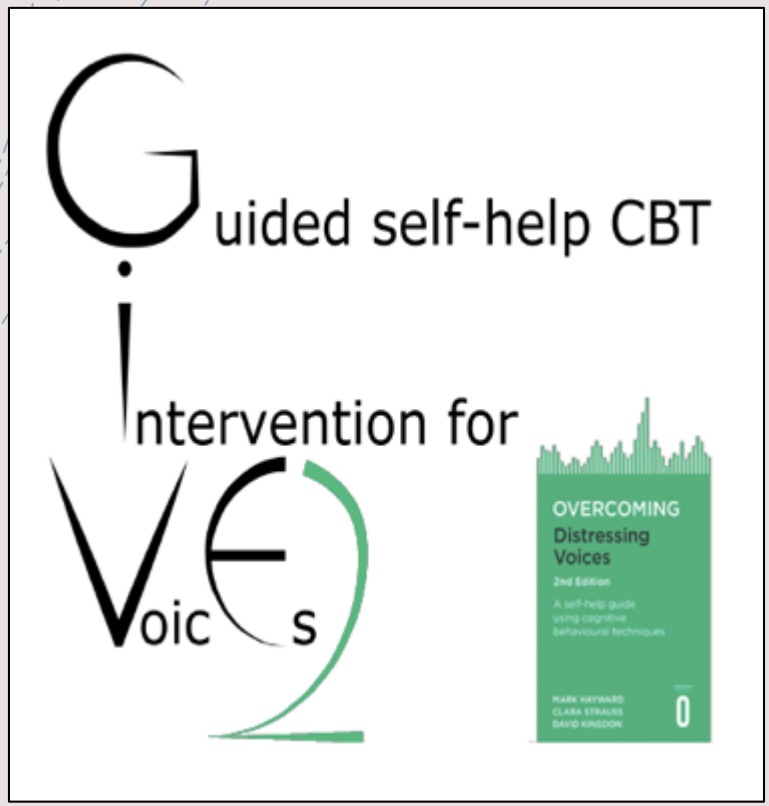

Increasing access to CBT for psychosis: Guided self-help CBT for voices delivered by Assistant Psychologists (the GiVE2 trial)

Mark Hayward & Kathy Greenwood

Sussex Partnership NHS Foundation Trust & University of Sussex

Plan for today's seminar

1) Why do we need to increase access to CBT?

2) Introducing the GiVE intervention

3) Findings from the GiVE2 trial

4) Next steps for our learning

Sussex Voices Clinic

Across diagnoses + lifespan

Starting a conversation (coping)

Continuing a conversation (beliefs/relating)

Extending a conversation (relating/ mindfulness)

Involving a wider workforce

NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

HQIP
Healthcare Quality Improvement Partnership

National Clinical Audit of Psychosis

National report for the core audit

LIMITED RESOURCES

Main Interventions

These are the main treatments that you might expect to be offered routinely, as appropriate to your needs, and taking into account your preferences.

Cognitive Behaviour Therapies

When you're feeling down, fearful or struggling with life

We will offer Cognitive Behaviour Therapy (a type of individual talking therapy focussed on your thoughts, feelings and how you'd like life to be different) delivered by specially trained therapists.

Medication Treatment

To reduce distress and help you to stay well

We will offer information, choice and regular reviews about taking medication, considering the most helpful medications for your experiences and lifestyle, taking into account their side effects and sticking to the lowest possible doses.

Family Intervention

Specialist talking therapies for family, friends and carers

We will offer Family Interventions to boost emotional support, understanding, problem solving & crisis management, delivered by two trained staff together.

Physical Health Intervention

Support for your physical health

We will provide advice, help in getting to your GP, signposting to local community or other health interventions, or provide these ourselves to support you with your physical health, especially diet, exercise and smoking cessation.

Individual Placement Support for education/work

To help you with learning, training or work

We will offer support with work, training or learning. We will help you to choose work, education or training to suit your needs and preferences, and will help your employer or trainer to support you to keep going.

NCAP
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Brief & targeted interventions

Briefly trained therapists

Main Interventions

These are the main treatments that you might expect to be offered routinely, as appropriate to your needs, and taking into account your preferences.

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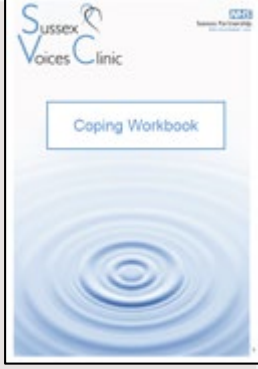
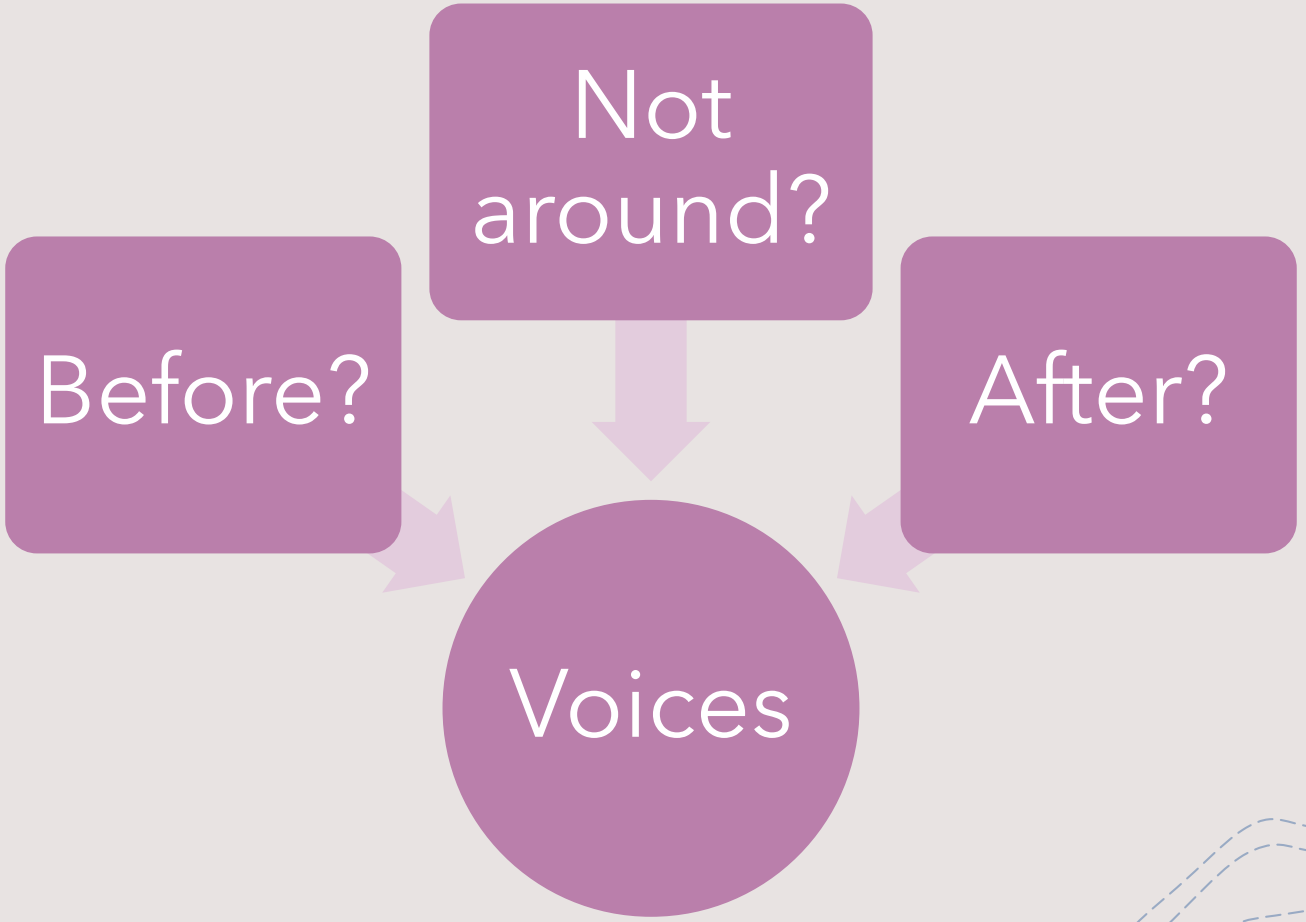
Coping Strategy Enhancement

(Tarrier et al., 1993, 1998)





Coping Strategy Enhancement = small-medium amount of benefit!

(Hayward et al., 2018)

Table 2. Pre- and post-treatment descriptive statistics and paired sample *t*-test results with standardized effect sizes

	Pre-CSE			Post-CSE			Paired sample *t*-test results							
Outcomes	*n*	*m*	*SD*	*n*	*m*	*SD*	Correlation (*r*)	Unstd effect size (m_{diff})	SE (m_{diff})	m_{diff} 95% CI	*t*-paired (t_c)	*p*-value	Std effect size (*d*)	Complete case Std effect size (*d*)
PSYRATS-AH														
Distress total	93	16.1	3.7	85	14.2	4.6	0.35	–1.73	0.54	–2.8, –0.65	–3.18	0.002	–0.39	–0.37
Frequency total	97	9	2.4	85	8	2.6	0.45	–0.79	0.28	–1.35, –0.23	–2.79	0.006	–0.31	[illegible]
DASS-21														
Depression total	95	13.2	5.8	85	12.1	6.3	0.71	–1.26	0.49	–2.24, –0.28	–2.56	0.012	–0.21	–0.21
Anxiety total	95	11.1	5.2	85	10.2	5.4	0.80	–1.14	0.36	–1.87, –0.42	–3.13	0.002	–0.22	–0.22
Stress total	94	13.1	5	84	12.5	4.6	0.67	–0.76	0.42	–1.6, 0.07	–1.82	0.073	–0.16	–0.16
CHOICE-SF														
Severity mean	98	3.9	1.9	84	4.5	2	0.76	0.65	0.14	0.36, 0.94	4.48	<0.001	0.34	0.34
Goal rating	90	2.9	2.3	68	5.3	2.4	0.27	2.42	0.39	1.62, 3.22	6.13	<0.001	0.74	0.91
SWEMWBS														
SWEMWBS total	91	18	4.7	83	18.6	4.9	0.63	0.39	0.46	–0.53, 1.32	0.85	0.398	0.08	0.10

… irrespective of the training of the therapist

(Clarke, Jones & Hayward, 2021)

	Mean difference	Count (*n*)	*SEM*	Test statistic (*z*)	*p*-value	Mean difference (95% CI) Lower	Upper	Pre-post correlation	Cohen's *d*
HPSVQ (complete cases)									
Baseline - PL1 (all therapists)	-1.26	92	0.34	-3.76	<0.001	-1.92	-0.60	0.555	-0.44
Baseline - PL1 (highly trained)	-1.31	48	0.46	-2.82	0.005	-2.22	-0.40	0.532	-0.48
Baseline - PL1 (briefly trained)	-1.20	44	0.49	-2.48	0.013	-2.16	-0.25	0.566	-0.40
Interaction	-0.11	92	0.67	-0.16	0.87	-1.42	1.21	0.500[1]	-0.04
CHOICE-SF (complete cases)									
Baseline - PL1 (all therapists)	0.99	79	0.15	6.60	<0.001	0.70	1.28	0.696	0.70
Baseline - PL1 (highly trained)	1.13	41	0.21	5.40	<0.001	0.72	1.53	0.578	0.82
Baseline - PL1 (briefly trained)	0.85	38	0.22	3.91	<0.001	0.42	1.27	0.787	0.53
Interaction	0.28	79	0.30	0.93	0.352	-0.31	0.87	0.500[1]	0.17

…. but the conversation will need to continue

PSYRATS
Distress scale
MCID = 3

- Hayward et al. (2018) = 1.9 point reduction

HPSVQ
Negative Impact scale
MCID = 2

- Clarke et al. (2021) = 1.2 point reduction

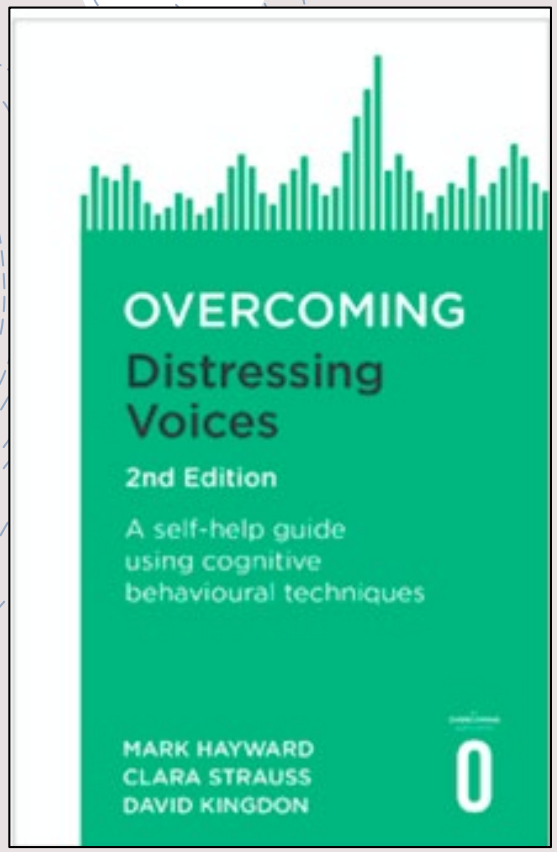
Plan for today's seminar

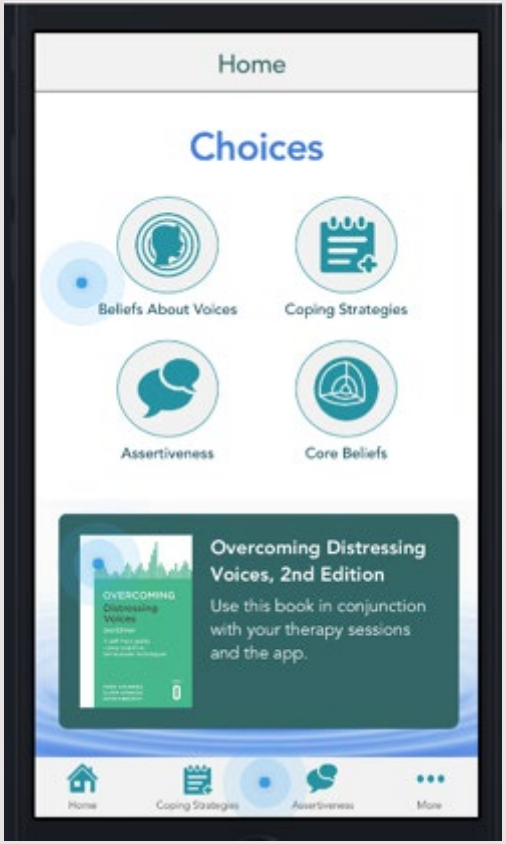
2) Introducing the GiVE intervention

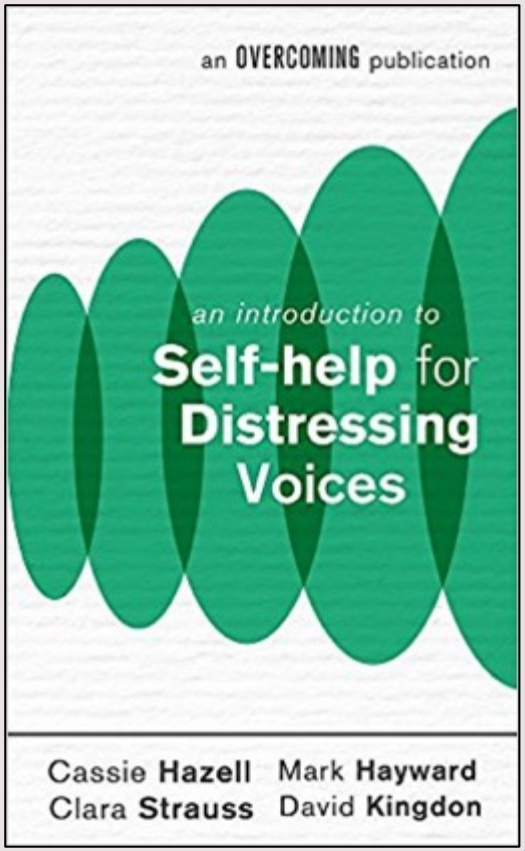
Guided self-help CBT for Voices (the 'GiVE' intervention)

Introduction & Coping	'Me' Beliefs about self	'My Voices' Beliefs about voices	'My relationships' Relating to voices and other people	Moving forward

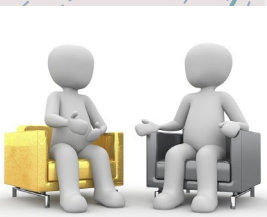
Session 1 (Chapter 4)	Session 2 (Chapter 2)	Session 3 (Chapter 6)	Session 4 (Chapter 1)	Session 5 (Chapter 5)	Session 6 (Chapter 3)	Session 7 (Chapter 7)	Session 8 (Chapter 8)







A 'blended' intervention



Guided self-help CBT for Voices (the 'GiVE' intervention)

Introduction & Coping	'Me' Beliefs about self		'My Voices' Beliefs about voices		'My relationships' Relating to voices and other people		Moving forward
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The Confirmation Bias

Beliefs (I am…, voices are…) are typically **not accurate** – we develop beliefs as a way of making sense of our life experiences

However, the **confirmation bias** (that we all have) means that we all tend to:

- Search for evidence that supports our beliefs
- Either ignore or distort evidence that does not fit with our beliefs

We can therefore **carefully gather and examine all of the available evidence**, including the evidence we usually don't notice because of the confirmation bias

This is **not positive thinking** – it is a process of re-evaluating beliefs in the light of **all** the evidence

Our minds want things to stay the same!

Playing the Curious Detective

The negative core belief that I hold about myself is that . . .

'I am stupid'

How certain are you that this negative core belief is true?

'Right *now* I believe this core belief is true with about 100% certainty.'

After reviewing the evidence, how certain are you that this negative core belief is true?

'Right *now* I believe this core belief is true with about 92 % certainty.'

Evidence and experiences that meant this negative core belief is not completely true all the time . . .
1 Showed a colleague how to do a task
2 Babysat for friend – who asked me to do it again
3 Cooked a meal for self and partner last week – and tasted good
4 Boss gave me extra responsibility and praised my work
5
6

Three ways to ask questions, gather facts and re-evaluate the accuracy of...

Negative beliefs about self

Positive beliefs about self

Beliefs about voices

Guided self-help CBT for Voices (the 'GiVE' intervention)

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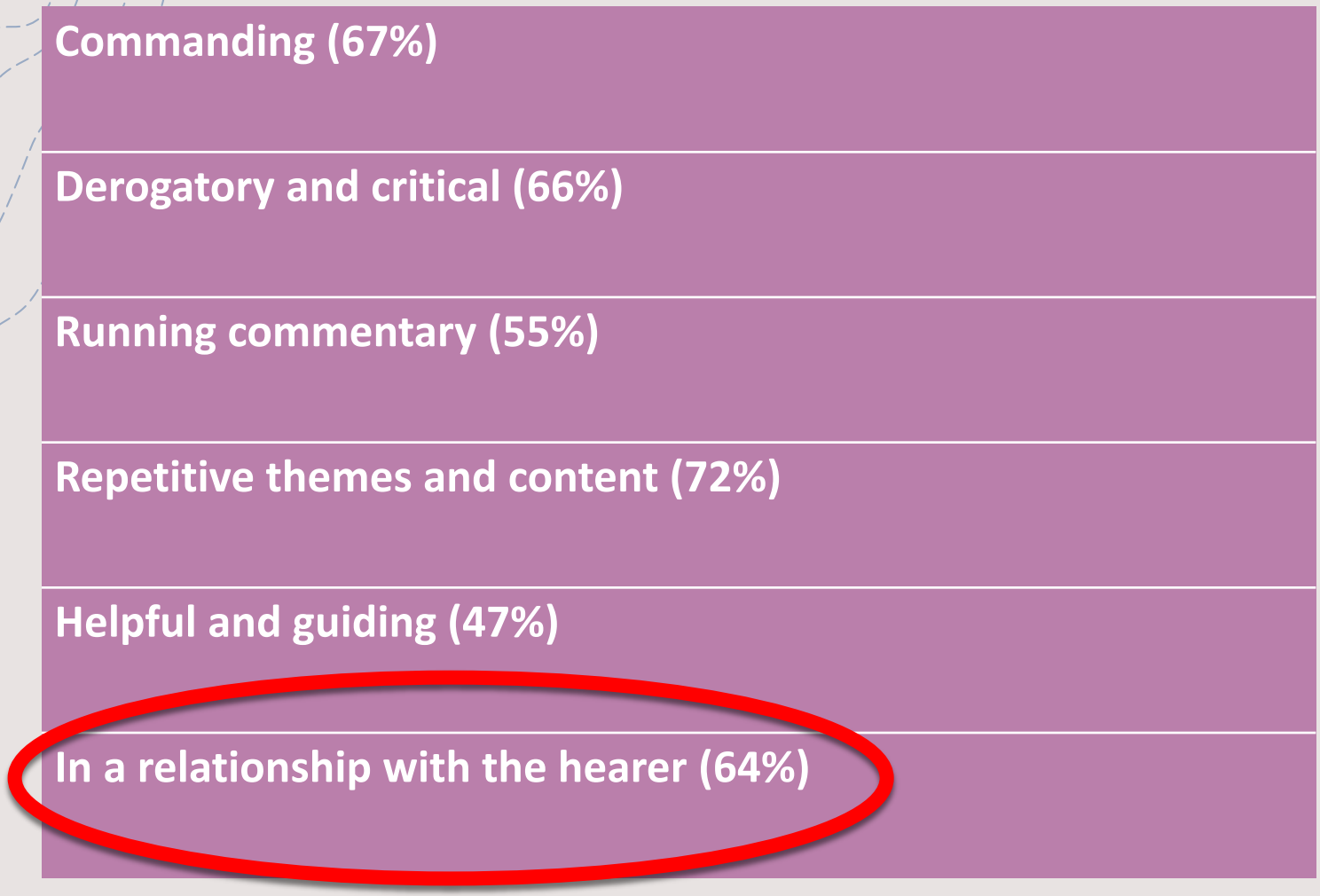
			Session 6 (Chapter 3)	Session 7 (Chapter 7)
				Session 8 (Chapter 8)

Relating with voices – endorsed by hearers?



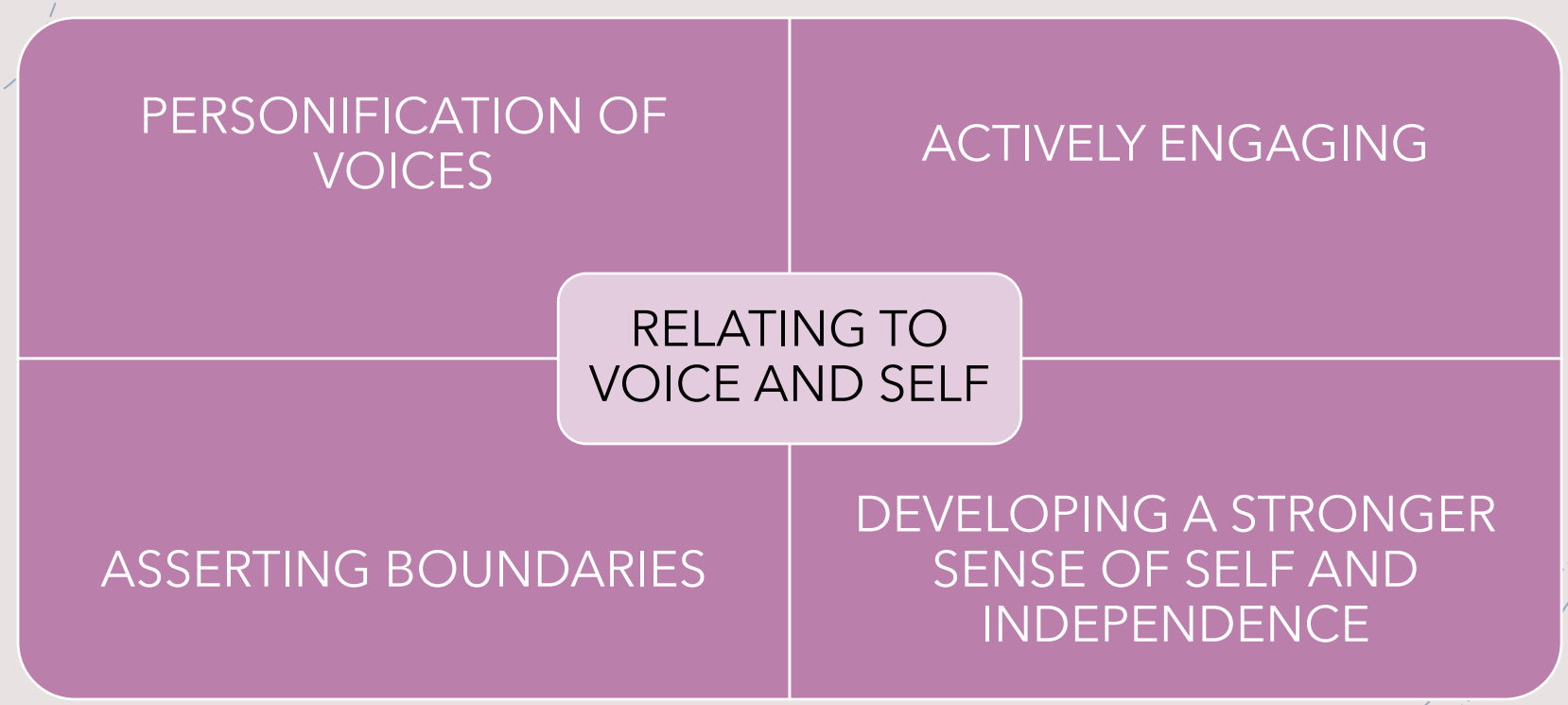
N = 199, users of mental health service or private psychiatrist with auditory hallucinations and any psychiatric diagnosis.

McCarthy-Jones et al. (2014)

‘Natural’ responses to a threatening other!

What can facilitate positive relating to voices?

(Jackson, Hayward & Cooke, 2011)



Making assertive responding available as a third option

passive

- Giving in!
- Allowing the needs and views of others to be prioritized
- Natural and instinctive ('flight')

assertive

- Calmly and respectfully standing up for my own needs and views
- Un-natural and requires effort!

aggressive

- Fighting back!
- Prioritizing my own needs and views to the neglect of the needs and views of others
- Natural and instinctive ('fight')

Select a conversation and script a different response

They say...	I respond by... Feelings, actions, what I say	Is my response: passive, aggressive or assertive?	An assertive response would be...
You are useless and worthless, and deserve to die	Feelings: frightened	Passive	I hear what you're saying...I have made a lot of mistakes and do feel useless sometimes. I see things a bit differently.....and have evidence to support my view
	Actions: go to bed		
	What I say: try to say nothing		

Use roleplay to bring the conversation to life!

- The patient in their ‘own chair’:
  - saying the assertive statements previously created – and reflecting upon the experience.
  - Being aware of body language and how to adopt an assertive posture.
  - Drawing upon evidence to support their view.

Guided self-help CBT for Voices (the 'GiVE' intervention)

Introduction & Coping	'Me' Beliefs about self	'My Voices' Beliefs about voices	'My relationships' Relating to voices and other people	Moving forward

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Moving forwards

+Review of learning

+Call to action

+Goal planning

+ Small steps…

Schizophrenia Research 195 (2018) 441–447

Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

Guided self-help cognitive-behaviour Intervention for VoicEs (GiVE): Results from a pilot randomised controlled trial in a transdiagnostic sample

Cassie M. Hazell [a], Mark Hayward [a,b], Kate Cavanagh [a], Anna-Marie Jones [b], Clara Strauss [a,b,*]

Results: Recruitment and retention was feasible with low study (3.6%) and therapy (14.3%) dropout. There were large, statistically significant between-group effects on the primary outcome of voice-impact ($d = 1.78$; 95% CIs: 0.86–2.70), which exceeded the minimum clinically important difference. Large, statistically significant effects were found on a number of secondary and mechanism measures.

Received 9 January 2017
Received in revised form 29 September 2017
Accepted 6 October 2017
Available online 13 October 2017

Keywords:
CBT
Psychosis
Distressing voices
Auditory hallucinations
RCT
Self-help

16 sessions of CBTp is recommended in treatment guidelines. Briefer CBTp could improve access as the same number of therapists could see more patients. In addition, focusing on single psychotic symptoms, such as auditory hallucinations ('voices'), rather than on psychosis more broadly, may yield greater benefits.

Method: This pilot RCT recruited 28 participants (with a range of diagnoses) from NHS mental health services who were distressed by hearing voices. The study compared an 8-session guided self-help CBT intervention for distressing voices with a wait-list control. Data were collected at baseline and at 12 weeks with post-therapy assessments conducted blind to allocation. Voice-impact was the pre-determined primary outcome. Secondary outcomes were depression, anxiety, wellbeing and recovery. Mechanism measures were self-esteem, beliefs about self, beliefs about voices and voice-relating.

Results: Recruitment and retention was feasible with low study (3.6%) and therapy (14.3%) dropout. There were large, statistically significant between-group effects on the primary outcome of voice-impact ($d = 1.78$; 95% CIs: 0.86–2.70), which exceeded the minimum clinically important difference. Large, statistically significant effects were found on a number of secondary and mechanism measures.

Conclusions: Large effects on the pre-determined primary outcome of voice-impact are encouraging, and criteria for progressing to a definitive trial are met. Significant between-group effects on measures of self-esteem, negative beliefs about self and beliefs about voice omnipotence are consistent with these being mechanisms of change and this requires testing in a future trial.

Candidate workforces for the briefly trained therapists

Case managers

(Jolley et al., 2015; Harding et al., 2018)

Graduate psychologists

('Assistant Psychologists' in the UK)

Feasibility RCT

(Hayward et al., 2020)

GiVE intervention

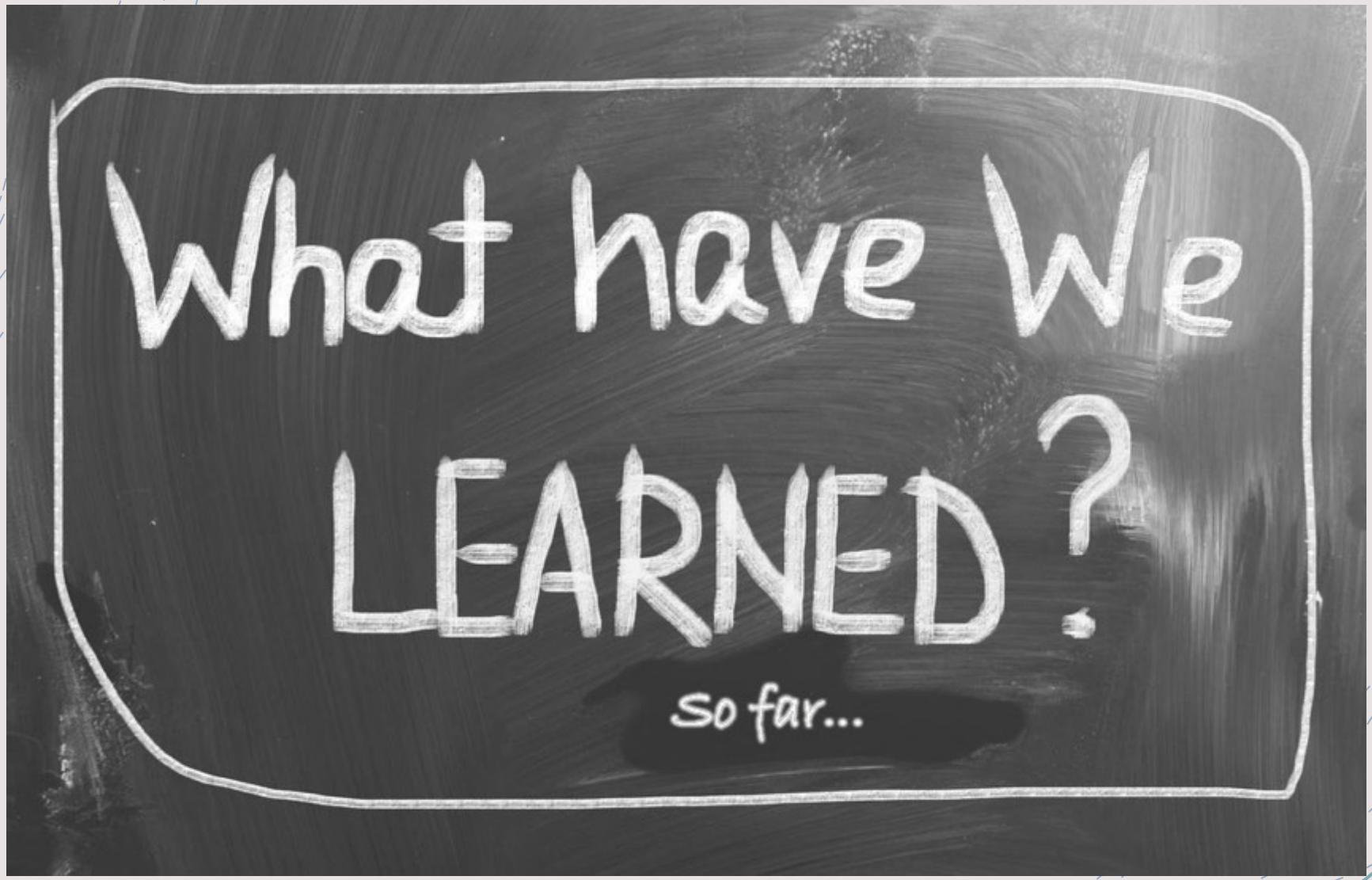
- N=30
- Delivered by APs

Supportive Counselling

- N=30
- Delivered by APs

Treatment-As-Usual

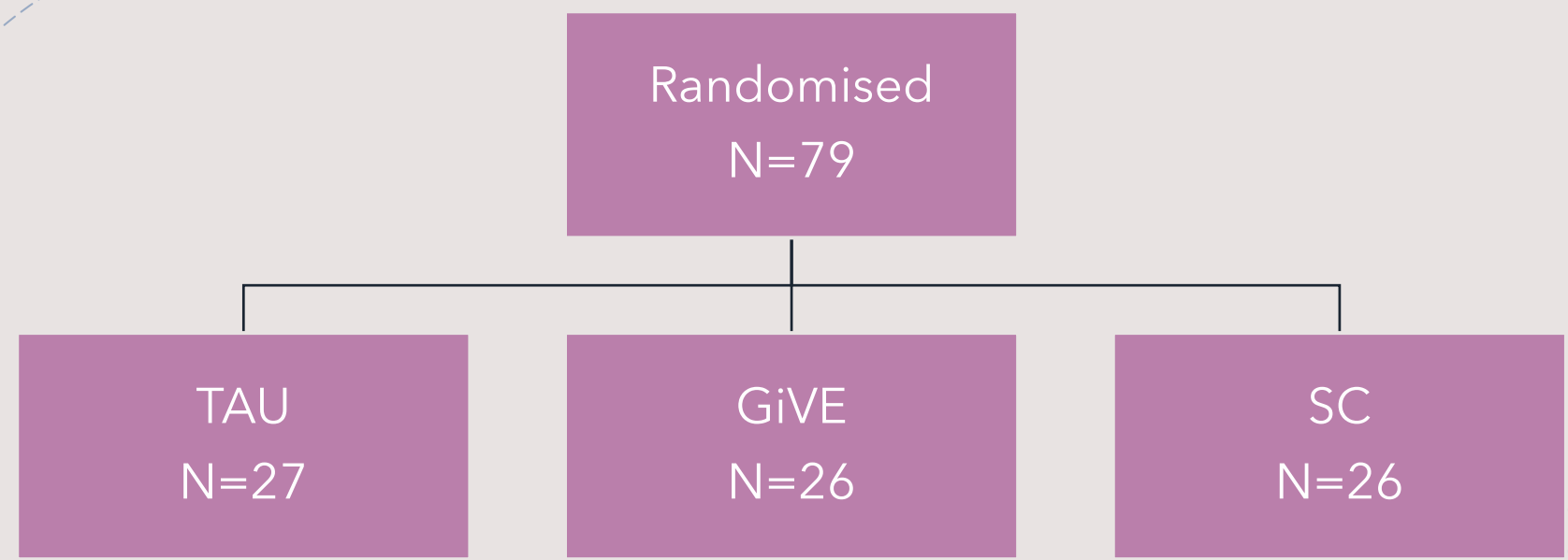
- N=30


What have We
LEARNED?
So far...

Plan for today's seminar

3) Findings from the GiVE2 trial

Can we recruit patients?



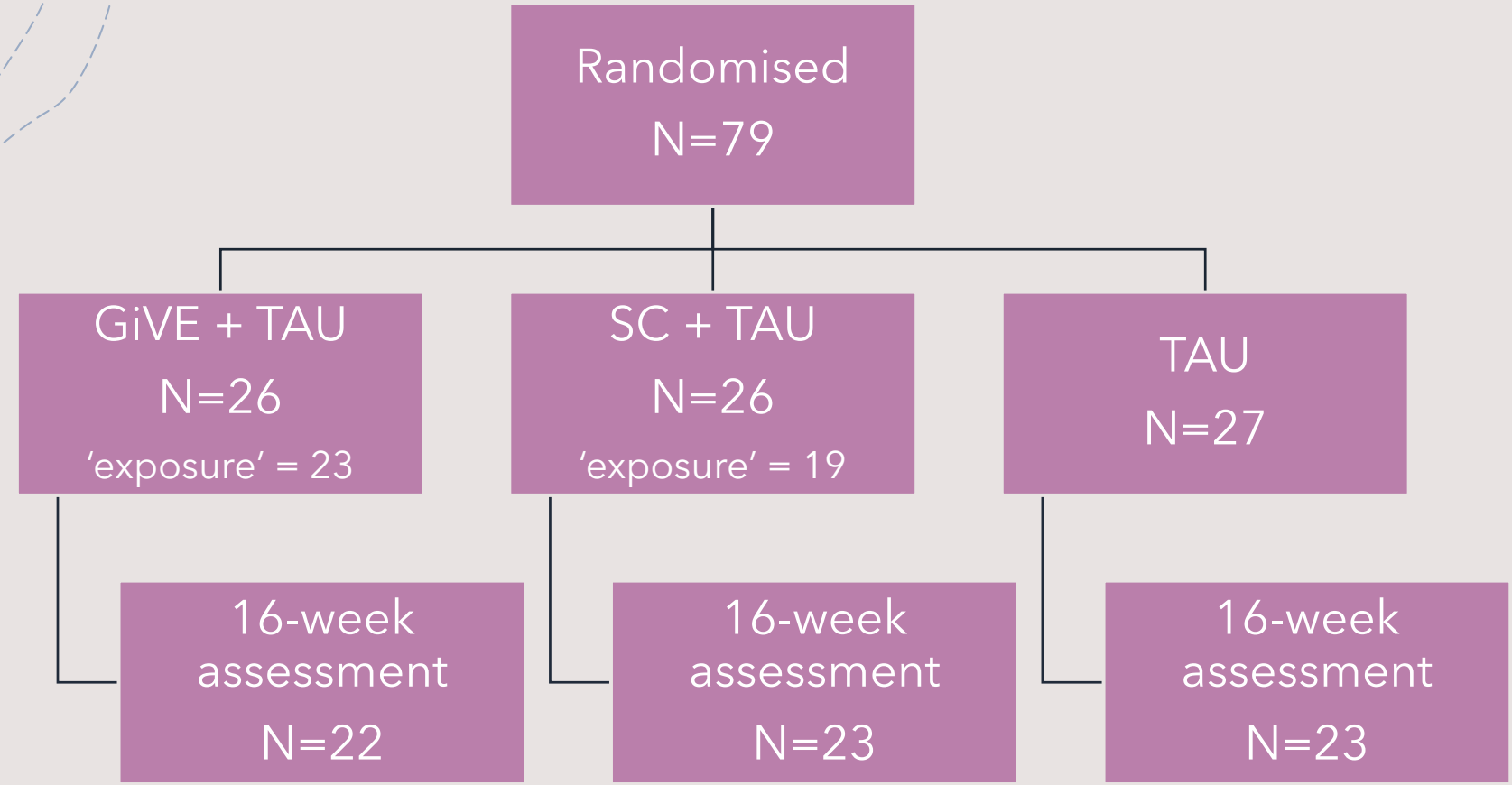
	TAU (N=27)	GiVE (N=26)	SC (N=26)
Age (years; SD)	42 (13)	40 (11)	38 (15)
Gender			
Male	19 (70%)	15 (58%)	11 (42%)
Female	8 (30%)	11 (42%)	15 (58%)
Ethnicity			
White British/White Other	23 (85%)	23 (89%)	20 (77%)
Black/Asian & Minority Ethnic	3 (11%)	3 (11%)	4 (15%)
Other	1 (4%)	0 (0%)	2 (8%)
Marital status			
Single/ Separated/ Divorced	24 (89%)	18 (69%)	20 (80%)
Married/Civil Partnership/ Cohabiting	3 (11%)	8 (31%)	5 (20%)
Whether in employment			
Yes	2 (7%)	2 (8%)	1 (4%)
No	25 (93%)	24 (92%)	25 (96%)
Time since onset of voices (years; SD)	22 (11)	22 (13)	23 (13)

Therapist fidelity to intervention and supervision protocols

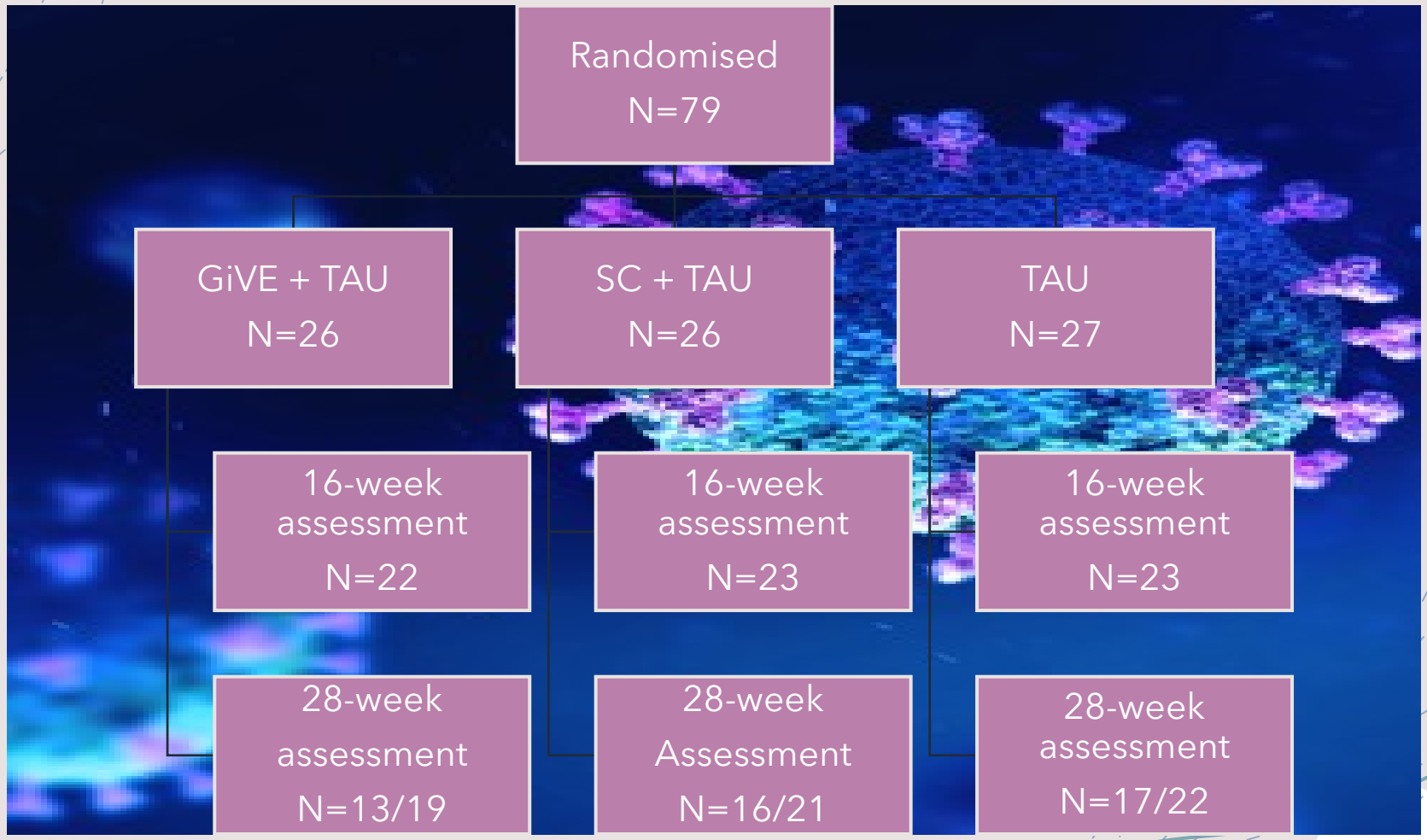
Fidelity to intervention was assessed by completion of self-report session checklists

Fidelity to supervision was assessed by attendance at weekly clinical supervis

Can we retain participants to 16-weeks?



Can we retain participants to 28-weeks?



The findings from the primary outcome analysis are currently under peer review and cannot be distributed. We will share these findings as soon as they have been peer-reviewed.

Process Evaluation study

Following MRC guidelines

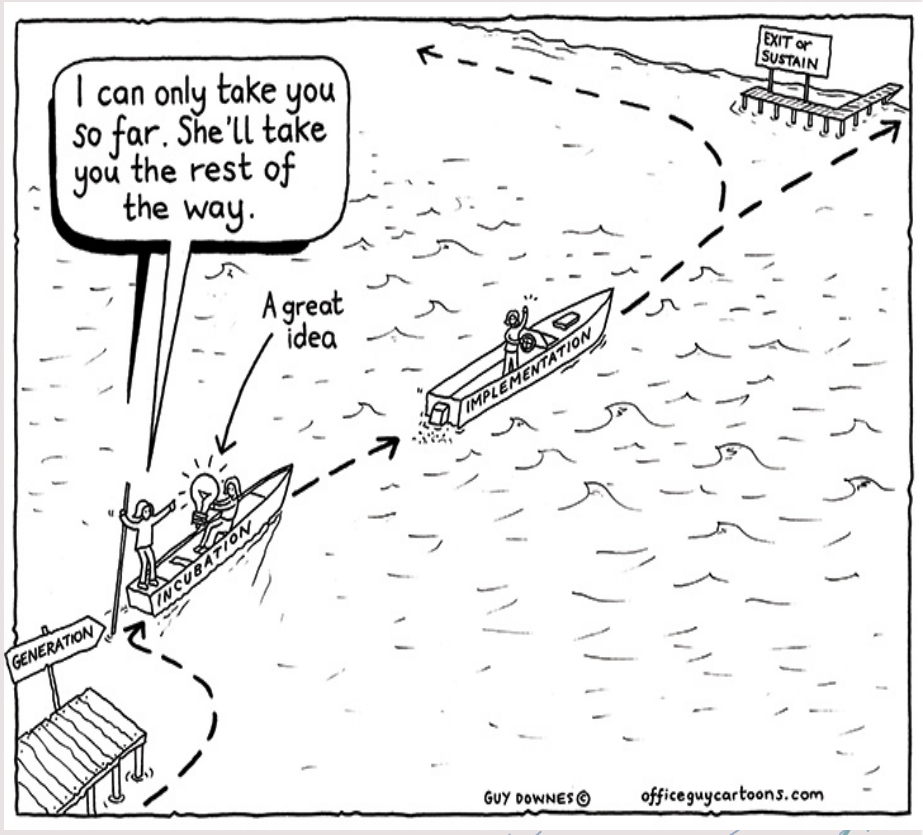
aims to understand real functioning of intervention, by examining

+Implementation,

+mechanisms of impact,

+ contextual factors.

Complementary to outcomes evaluation



Process Evaluation Methodology

Explored attitudes of key stakeholders:

+Referring clinicians

+AP Therapists

+Service users

Process evaluation: methodology

Service users

- Aim – explore experience of receiving GiVE/SC
- 10 GiVE/10 SC participants
- Early and late experiences

- Interviews, transcribed and analysed thematically

Assistant Psychologists

- Aim - to explore experience of delivering GiVE
- 4 APs early delivery and 2 late delivery

- Interviews, transcribed and analysed thematically

Clinicians

- Aim - explore attitudes to GiVE, psychological therapies, RCT, referrals
- 7 clinicians in Pennine and 7 in Sussex

- Interviews, transcribed and analysed thematically

Process evaluation: views of GiVE participants

Positive hopes and expectations for GiVE/therapy	Positive experience of assessments, start and therapy	Positive Impacts of GiVE
• Hopes for allocation to GiVE/therapy • Expectations of positive outcomes	• Acceptance of length and challenges of assessment • Important role of GiVE-2 therapist • Workbook essential beyond therapy	• Different experience surpassed expectations • Learning tools • Increasing understanding • Changing outlook

Process evaluation: views of SC participants

Strong alliance	Resolving allocation issue	Influences on outcome	Positive vs adverse outcomes
• Skilled therapist • Safe space	• Surprise at getting anything • My problems are other than voices • Shape SC/Self-help to voice focus (buying book)	• Expectations • Trust/openness in talking • Timing • Acceptance	• Positive outlook, coping, voices, wellbeing, social thinking • Adverse effect on voices, nightmares, mood • Dislike disclosing, repetition, being short on things to say

Process evaluation: Views of Clinicians

Value and positioning of GiVE	Challenges for GiVE and research	Critical components of GiVE
• Positive for access and well-being outcomes • A foundation to psychological therapy	• Need for embedding in team practice • Need for referral criteria and reminders • Tight on time	• Trust in personal qualities of therapist • Supervision and competence • Manualised intervention focus makes AP delivery possible

Process evaluation: Views of AP therapists

Training was comprehensive and thorough

Supervision supported the growth of confidence

Workbook: supportive framework vs sometimes restrictive

Short modular therapy makes sense vs challenges with time, match and flow

APs can deliver and develop skills

Next steps from process evaluation

SeNSS
South East Network for Social Sciences

+ PhD studentship
+ Investigating models of implementation of graduate psychologist roles in the NHS
+ Investigating qualities of AP that engender trust in clinicians and service users

Plan for today's seminar

4) Next steps for our learning

Changes for GiVE3

- Removal of the SC arm
- Adaptations to the GiVE intervention
- Flexible delivery of the GiVE intervention
- More robust assessment of therapist fidelity

Curiosity beyond interventions

National survey of patient preferences for how CBT for voices is offered

Qualitative study of patient and clinician views about the outcomes that CBT for voices should achieve

Thanks to the research team, our collaborators and funder

- David Fowler
- Clara Strauss
- Heather Gage
- Cassie Hazell
- Suzanne Neumann
- Clio Berry
- Sam Robertson
- Kate Cavanagh
- Katherine Berry
- Anna-Marie Jones
- Stephen Bremner
- Becky Whitfield

NHS Sussex Partnership NHS Foundation Trust
NHS Pennine Care NHS Foundation Trust
University of Sussex
NHS National Institute for Health Research