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# EXPLORING STAFF’S EXPERIENCES OF ADVICE AND RECOMMENDATIONS IN MENTAL HEALTH SERVICES

Section A: A review to examine staff’s attitudes towards mental health guidelines and their usefulness within services

Word Count: 7999 (601)

Section B: Examining the effects of neuropsychological assessment feedback and recommendations within mental health services

Word Count: 7880 (718)

Overall Word Count: 15,879 (1319)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

2025

SALOMONS INSTITUTE FOR APPLIED PSYCHOLOGY
CANTERBURY CHRIST CHURCH UNIVERSITY

# Acknowledgements

I would like to thank all the participants and experts by experience that contributed to the study for their invaluable and insightful discussions. I appreciate the time taken to meet with me and the enthusiasm shown for the project.

I would also like to thank my supervisors for being so supportive throughout the process and helping me to navigate the complex process of this project.

Finally I would like to thank my family and friends for helping me through this stressful period and providing encouragement.

# Summary of the Major Research Project

**Section A** is a systematic review and thematic synthesis examining the qualitative literature around attitudes that staff working in mental health services hold towards clinical guidelines. Overall, 16 papers were reviewed and synthesised, with six overarching themes identified: Working with confusion; Lack of trust; A tool to improve care; Guidelines as a threat; Losing sight of the big picture; and Demands and Resources. Further research could examine how guidelines can be adapted to local services in order to make them more applicable to clinical practice.

**Section B** is a qualitative study examining the expectations of neuropsychologists working in mental health services around the impact of their work on staff and clients. These were compared with the experiences of mental health staff working with these clients. Semi-structured interviews were completed with three neuropsychologists and nine mental health staff. Using Template Analysis six overarching themes were identified: Working within NHS resources; Trying to find certainty; Holding the experience of the client in mind; The impact on professional relationships; Neuropsychology takes care of people; and The influence of power on the feedback process. Findings indicate that increasing systemic awareness and involvement of neuropsychology could be helpful in supporting staff in mental health services.

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**Section A:**

**Section B:**

# MAJOR RESEARCH PROJECT

## Section A: Literature Review

## A review to examine staff's attitudes towards mental health guidelines and their usefulness within services.

Word Count: 7999 (601)

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# Abstract

Clinical guidelines have been used within mental health services for many years. Research has shown that implementing guidelines can help to improve treatment outcomes as well as staff and client satisfaction. However, there is evidence to show that guidelines are not routinely implemented within services, even when staff have the capacity and resources to do so. This suggests that there may be a barrier related to staff's attitude towards guidelines that then affects whether they are implemented. This review sought to gather the current evidence on staff's attitudes towards mental health guidelines and to identify what aspects they find helpful and unhelpful. A systematic search revealed 16 papers that were suitable for inclusion. All papers were qualitative studies and were analysed using thematic synthesis in order to extract themes which appeared across studies. Themes identified included: guidelines being tools for improving standards of care; guidelines being untrustworthy; guidelines failing to see the bigger picture; and guidelines being a threat to professional identity. Overall, it appeared that staff did find guidelines to be helpful in improving standards of care, but there were concerns around the applicability of guidelines within clinical practice especially around adapting standardised recommendations to individual clinical situations.

*Keywords:* elaboration likelihood model, guidelines, attitudes, mental health, staff,

# Introduction

## Clinical Guidelines in Mental Health

Evidence-based treatment has been a part of healthcare for many years as a tool for increasing quality of care and supporting clinicians in making informed decisions. Clinical guidelines were developed to support the dissemination of evidence-based treatments, through synthesising the available research and providing recommendations based on this research (Pilling, 2008; Burgers et al., 2003).

Clinical guidelines are defined as “systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances” (Institute for Medicine, 1992, as cited in Duff et al., 1996, p. 888). Guidelines were developed primarily as a method for producing clinically and cost effective care. The production of guidelines also aimed to address issues of inconsistency in clinical practice through providing a clear set of standards for treatment (Drummond, 2016; Pilling, 2008).

Whilst guidelines aim to provide recommendations for treatment, it was intended for these to be used alongside clinical judgement. Due to the broad and complex nature of mental health difficulties, it is impossible for guidelines to encompass recommendations for every clinical scenario, and so some form of adaptation is expected for clinicians to apply recommendations to their daily practice (Parry et al., 2003).

## The Impact of Using Clinical Guidelines

Research into the effectiveness of using clinical guidelines has shown some positive results on treatment outcomes (Setkowski et al., 2021). One study focusing on the implementation of NICE guidelines for treating experiences of depression and anxiety within Improving Access to Psychological Therapies (IAPT) found that clients who received NICE recommended therapies had higher recovery rates than clients who did not receive these therapies (Clark, 2011). However, this effect was only investigated due to a naturally occurring split within the sample and so the study was not originally set up with this investigation in mind, which calls into question the reliability of the results (Clark, 2011). Nevertheless, this study provides an indication of the potential effectiveness of applying guidelines to mental health treatment.

Further indication of guidelines' effectiveness comes from a systematic review conducted by Girlanda et al., (2017), which examined research on the implementation of mental health guidelines and how this affects provider performance as well as client outcomes. Within this review, they found varying evidence and no significant effect of implementing guidelines on provider behaviour. However, they did find a consistent, positive effect of implementing guidelines on client outcomes such as remission rates and satisfaction with care (Girlanda et al., 2017). This suggests that implementing guidelines can have positive consequences, even though there may still be variation in how clinicians use them.

Studies examining the effects of guideline recommended treatments have also found these have a beneficial impact on staff and clients. A study focusing on therapist training in Cognitive Behavioural Therapy (CBT) for psychosis, which is a NICE recommended treatment for people with a diagnosis of schizophrenia, found that staff viewed having a structured intervention to utilise then enabled them to deliver therapy more confidently and efficiently. It was also found that clients felt this intervention enabled them to learn new skills and gave them greater confidence in the staff who delivered therapy (Waller et al., 2015). Again, this demonstrates how using recommendations from guidelines can improve both staff and client experiences of treatment in mental health services.

In contrast, Waller et al., (2015) found that there were difficulties in relation to implementing NICE recommended treatment. Staff felt that there were some clients with more complex difficulties for whom the intervention did not feel useful. Similarly, clients said that there were multiple factors in their lives that influenced their mood but were not addressed by the intervention (Waller et al., 2015). These findings demonstrate the limitations of guidelines in accounting for greater clinical complexity within mental health services.

## Implementation of Clinical Guidelines

Consistent implementation is a significant issue in the use of clinical guidelines, where they are not routinely used within services and there are several barriers to implementation (Berry & Haddock, 2008). A meta-analysis by Mears et al., (2008) found that several Trusts inconsistently implemented mental health guidelines, with commitment from leadership colleagues to using guidelines being related to higher levels of staff adherence to guidelines. They also found that certain aspects of guidelines were implemented more consistently than others, such as medication and monitoring which were implemented more regularly than therapies for people with a diagnosis of schizophrenia (Mears et al., 2008).

A study examining the implementation of NICE guidelines in relation to schizophrenia also found inconsistent adherence and identified barriers for this. One barrier was the limited availability of certain treatments, especially psychological therapies, and the lack of appropriately trained staff within mental health services to deliver recommended interventions. Additionally, organisational factors were identified including lack of time and resources (Pilling & Price, 2006). However, practical resources are not the only barriers to implementation. There is evidence to show that even when staff are aware of guidelines and have access to resources they still choose not to adhere (Berry & Haddock, 2008). This suggests that there may be an underlying attitudinal barrier, preventing clinical guidelines from being consistently administered in mental health services.

## Role of Attitude in Decision Making

There are several studies demonstrating that professionals have varying attitudes towards the use of evidence-based treatment within mental health services. Whilst professionals acknowledge the importance of research in ensuring high-quality care, they perceive it to be less relevant to their practice than information based more on clinical experience (Lilienfeld et al., 2013). It has also been found that attitudes towards guidelines and using evidence-based treatment can vary depending on professional role and autonomy, which then affects whether guidelines are implemented. A study examining nurses' and psychologists' attitudes towards evidence-based practice found that those who had more clinical autonomy and were able to make independent clinical decisions had less positive attitudes towards evidence-based practice (Rye et al., 2019).

One explanation for the effects of attitude on decision-making comes from the Elaboration Likelihood Model (ELM) of persuasion (Petty & Caccioppo, 1986). This model proposes that people's attitude, and subsequent behaviour, are influenced by their motivation and capacity to think critically about, or elaborate, on a message they are presented with. Where a person is able to think more about the content of a message, it is more likely that they will consider the quality of the information and use this to guide their decision, this is known as central route processing. Where a person is less able to think about the content of a message, they are likely to base decisions on cues associated with the message, such as the source of the message or the medium in which it is received. This is known as peripheral route processing (Kitchen et al., 2014).

The level of elaboration that a person is able to direct towards a message influences which factors affect the persuasiveness of that message, as well as how enduring the influence of the message will be. A variety of factors can influence a person's capacity and motivation to elaborate on a message and so either take a central or peripheral processing route, including mood, personal relevance of the message, and time pressure (Cook et al., 2004). When information is processed through the central route then it is more likely that there will be a stronger link between attitude and behavioural change, and that any changes will be long-lasting (Morris et al., 2005).

It could be argued that within mental health services, clinical guidelines are failing to "persuade" staff to adhere to recommended treatments, which raises questions around how staff process and think about guidelines.

Some factors suggested by the ELM that could influence elaboration and persuasion can be seen within existing studies. For example, the literature has demonstrated negative and ambivalent attitudes towards the relevance of research in clinical practice, and it is possible that this then affects the perception of arguments presented in guidelines which are based on research (Berry & Haddock, 2008). It is possible that guidelines based on research are seen as less credible by clinical staff and so are not implemented (Morris et al., 2005).

Research has consistently found issues in implementation of guidelines between a wide variety of professions, services and therapeutic styles, suggesting that difficulties are not limited to a specific way of working or specific client group (van Fenema et al., 2012). The variety of opinions around guidelines and their variable implementation suggest that a combination of factors are responsible for persuading staff to utilise them. The ELM model states there is a dual processing route to persuasion, where this is not just influenced by level of elaboration, but that different combinations of factors, such as attractiveness of the message and expertise, will lead to different levels of persuasion depending on whether higher or lower levels of elaboration occur (Morris et al., 2005). However, currently it is unclear as to how these different factors influence clinicians' adherence to guidelines and what their attitude is.

Furthermore, it has been shown that adapting guidelines can have a positive effect on implementation. Michie and Lester (2005) found that when the NICE guidelines for the treatment of schizophrenia were re-written for the public in “Plain English”, this led to more positive attitudes from service users and greater perceived behavioural control which was associated with higher levels of guideline implementation. This suggests that increased understanding through the use of “Plain English” aided adoption of guideline implementation. It could be argued that re-writing the guidelines allowed people to more readily access the information and so elaborate more on it, leading to central route processing and more marked attitude behavioural change. Therefore, it is possible that attitude change can result in changes to the way guidelines are used and could be used to encourage the consistent adoption of clinical guidelines in mental health services (Kitchen et al., 2014).

## Rationale for Review

Current research has highlighted the behavioural and organisational barriers to implementing clinical guidelines in mental health services (Pilling & Price, 2006). However, there has been less focus on the attitudes of staff in these services towards receiving and using guidelines, which could then have an impact on behavioural consequences. Studies within physical health services have shown that attitudes towards guidelines can differ depending on various factors such as: scepticism regarding evidence within guidelines; tension between experience and recommendations; importance of preserving professional-patient relationship; risk aversion; and guideline format (Carlsen et al., 2007). Whilst research within mental health has indicated the presence of ambivalent and negative attitudes towards guidelines, it is unclear as to what the current evidence base is and how it can be developed.

This review sought to gather the current evidence on clinicians’ attitudes towards clinical guidelines in mental healthcare and to assess what the perceived benefits and disadvantages are of using guidelines. The aim was to generate a more detailed understanding of how staff in mental health come to use guidelines and the factors that influence how “persuasive” these guidelines are in producing change. This review could inform future guideline development to ensure that clinicians are motivated and able to access the most up to date evidence and treatment recommendations. This could have implications for clinical practice and treatment outcomes.

## Methods

### Researcher Positioning

This review was conducted from an epistemological position known as pragmatism, where knowledge is viewed as being produced from the consequences of human experiences, where things that are perceived to have ‘gone well’ are then likely to be repeated and used as a basis for gathering further knowledge. This position attempts to bridge the gap between more positivist and constructivist philosophies, by considering the interaction between subjective human experience and how this is shaped by practical consequences (Kelly & Cordeiro, 2020). Therefore, this review emphasised examining experiences of receiving and using guidelines based on how ‘well’ these experiences had worked within practical situations.

### Research Aims and Questions

This review aimed to examine and critique the current literature on clinicians’ attitudes towards using clinical guidelines in mental health services by answering the following questions:

1) What do clinicians working in mental health services think about clinical guidelines and their usefulness?
2) What aspects of clinical guidelines do clinicians find helpful?

3) What aspects of clinical guidelines do clinicians not find helpful?

## Inclusion/Exclusion Criteria

### *Types of Studies*

The review focused on examining qualitative studies, or qualitative aspects of mixed methods studies, in order to understand participants' individual attitudes and experiences of clinical guidelines.

The review was focused on attitudes and personal appraisal of guidelines, therefore, studies that were purely focused on awareness or knowledge about guidelines were not included as these would not provide sufficient depth of information to answer the research question.

It was also important to include studies that uncovered new information through directly engaging with participants about their experiences. Therefore, existing reviews and editorials were excluded.

Due to limited research in this area and to ensure the inclusion of a wide range of views, PhD and doctoral thesis projects were included, as these are required to undergo a review process prior to being conducted and written. Conference proceedings were excluded as these did not contain complete enough data to use within the synthesis and had not undergone a rigorous review process.

### *Participants*

As the review was focused on the attitudes of clinicians working within mental health services, only studies where participants were mental health professionals, or were other professionals using mental health guidelines were included.

As clinical guidelines are designed for use across a range of professions and levels of qualification, there were no criteria regarding age, setting, profession, level of qualification or country.

### *Definitions*

To increase consistency when selecting studies for the review the following definitions were used:

Clinical guidelines – "systematically-developed statements to assist practitioner decisions about appropriate health care for specific clinical circumstances" (Institute for Medicine, 1992, as cited in Duff et al., 1996, p. 888).

Qualitative – "an analysis of the meaning and concepts of things from results that are language/text based usually from common methods such as interviews, focus groups and written surveys" (Critical Appraisal Skills Programme, 2023, Glossary under Qualitative Research).

### *Summary*

Inclusion/exclusion criteria for this review are summarised in Table 1.

## Information Sources and Search Strategy

Databases searched include Embase, PsycINFO, CINAHL, Web of Science, and Social Policy & Practice. The selection of these databases are summarised below:

- Embase – provides diverse coverage of medical literature which may have relevance to mental health
- PsycINFO – a large database of psychological literature
- Web of Science – a comprehensive database for life science research

**Table 1**

*A Table to Show the Inclusion and Exclusion Criteria for Selecting Studies*

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| Qualitative studies, or quantitative studies with a qualitative element | Studies that do not include accounts of participants' own views |
| Studies that focus on participants' internal experiences focusing on the use of clinical guidelines | Studies focused on general recommendations or best practice rather than systematically developed guideline documents |
| Studies focused on attitudes towards guidelines | Studies that only look at adherence to or knowledge about guidelines without directly assessing clinician perspectives. |
| Studies where participants are clinicians using guidelines in a mental health context | Studies where participants are not working within mental health services or are not using mental health guidelines |
| Peer reviewed papers or doctoral theses | Papers that are reviews or editorials |
| English language articles | Papers that are not English or translated into English |

- Social Policy & Practice – has particular relevance to examining clinical guidelines and may produce findings not otherwise uncovered in other databases.
- CINAHL – a comprehensive database for nursing and allied health professionals research

An Advanced Search, using keyword search, of each database was conducted using Boolean Operators to narrow down searches and include search terms in sufficient combination. The option to expand search terms within the databases was not used as this created a large volume of papers and too broad a range of references.

In databases containing options for searches of different fields (Web of Science and CINAHL) specific fields were not selected in order to gather as many different sources as possible. Multi-field search was not used in databases EMBASE, PsycINFO and Social Policy & Practice as this was found to be too broad and return an unfeasible number of results. The complete list of search terms is outlined in Table 2.

### Screening Process

Relevant papers were discovered through an initial database search by a single reviewer. The abstract and title of these papers were reviewed and papers were included and excluded according to the previously defined criteria.

Once relevant papers had been filtered, full-text versions of these papers were sought. The full text versions of the remaining papers were reviewed by a single reviewer according to the inclusion and exclusion criteria.

### Data Collection

One researcher extracted the results section from each study using a data extraction form (See Appendix A). This ensured that sufficient qualitative information relating to the review question was retained. Where studies employed a mixed methods approach, only the qualitative component of the results was extracted as the review was concerned with exploring participants' own perspectives rather than relying on evidence from questionnaires where they had to select pre-determined responses.

**Table 2**

*A Table to Show the Search Terms Used in the Literature Search*

| Key Search Terms |
|---|
| clinician* OR professional* OR practitioner* OR staff* OR ‘care coordinator*’ OR ‘key worker*' OR 'frontline worker*' OR 'healthcare assistant*' OR 'psychiatric nurse*' OR 'psychiatrist*' OR 'psychologist*' OR 'healthcare team*' |
| AND |
| attitude* OR perspective* OR belie* OR perception* OR view* OR experience* |
| AND |
| ‘clinical guideline*’ OR ‘practice guideline*’ OR ‘therapy guideline*’ OR ‘treatment recommendation*’ |
| AND |
| ‘mental health’ |

### Quality Assessment

To assess the overall quality of each study, the Critical Appraisal Skills Programme (CASP) tool for qualitative research was used. This tool allows for assessment of how rigorously each study collected and analysed data as well as consideration of how the researchers' own ideas may have influenced the findings of each study (Critical Appraisal Skills Programme, 2022).

### Approach to Analysis

A thematic synthesis was deemed to be most appropriate for this review as the focus was on qualitative experience of clinical guidelines. The review focuses selectively on qualitative research and seeks to understand and aggregate the experiences of how clinicians view clinical guidelines in mental health services (Thomas & Harden, 2008). Thematic synthesis allowed the researcher to gather findings and arrange them into overarching themes which could be used to inform further research. Whilst the researcher used their own judgement to decide upon appropriate themes, this approach to synthesis allows for detailed recording of the analysis so that researchers can examine their judgement and assess whether themes diverge too far from the original qualitative data (Thomas & Harden, 2008).

### Sensitivity Analysis

A sensitivity analysis was conducted to assess each study's contribution to the thematic synthesis. This form of analysis has been used by Thomas and Harden (2008), alongside quality assessment measures, and can help researchers to assess the influence of lower quality studies on the results of a qualitative synthesis. This then provides information on the validity and reliability of these results (Carroll et al., 2012).

# Results

A total of 3826 records were identified within preliminary searches, and 2976 records were left after excluding duplicates. Of these, 2840 records were excluded during a title and abstract review, using the pre-defined inclusion/exclusion criteria. This left 136 records which were deemed appropriate for further examination. Two reports could not be retrieved and so 134 full reports were examined for inclusion in this review. Using the inclusion/exclusion criteria, 16 reports were eventually identified as suitable for inclusion within this review. In total, these 16 papers included 1026 participants. Figure 1 below outlines the study selection process using the PRISMA flowchart (Page et al., 2021).

## Study Characteristics and Quality Assessment

The characteristics of the included studies are summarised in Table 3, including information on the participants, guidelines examined, and type of methods and analysis.

The CASP tool does not give an overall score to determine level of quality and it was decided to assess overall quality based on the answers provided within different sections of the tool  (Critical Appraisal Skills Programme, 2022). Studies were deemed to be of ‘Low’ quality if an answer of ‘No’ was given for either of the first two questions assessing suitability of research aims and methods (Long et al., 2020). Following this, studies were categorised as ‘High’ quality if over half of the remaining questions were answered 'Yes’ and as ‘Medium’ if more than half of the questions were answered ‘No’ or ‘Can’t tell’. The CASP ratings for each individual study can be seen in Appendix B.

Overall, 14 of the 16 studies were assessed to have valid results with clear research aims and appropriate use of qualitative methodology. Two of the studies, Eke et al., (2019) and Haw et al., (2011) were found to use appropriate methodology but did not clearly state the aims of the research.

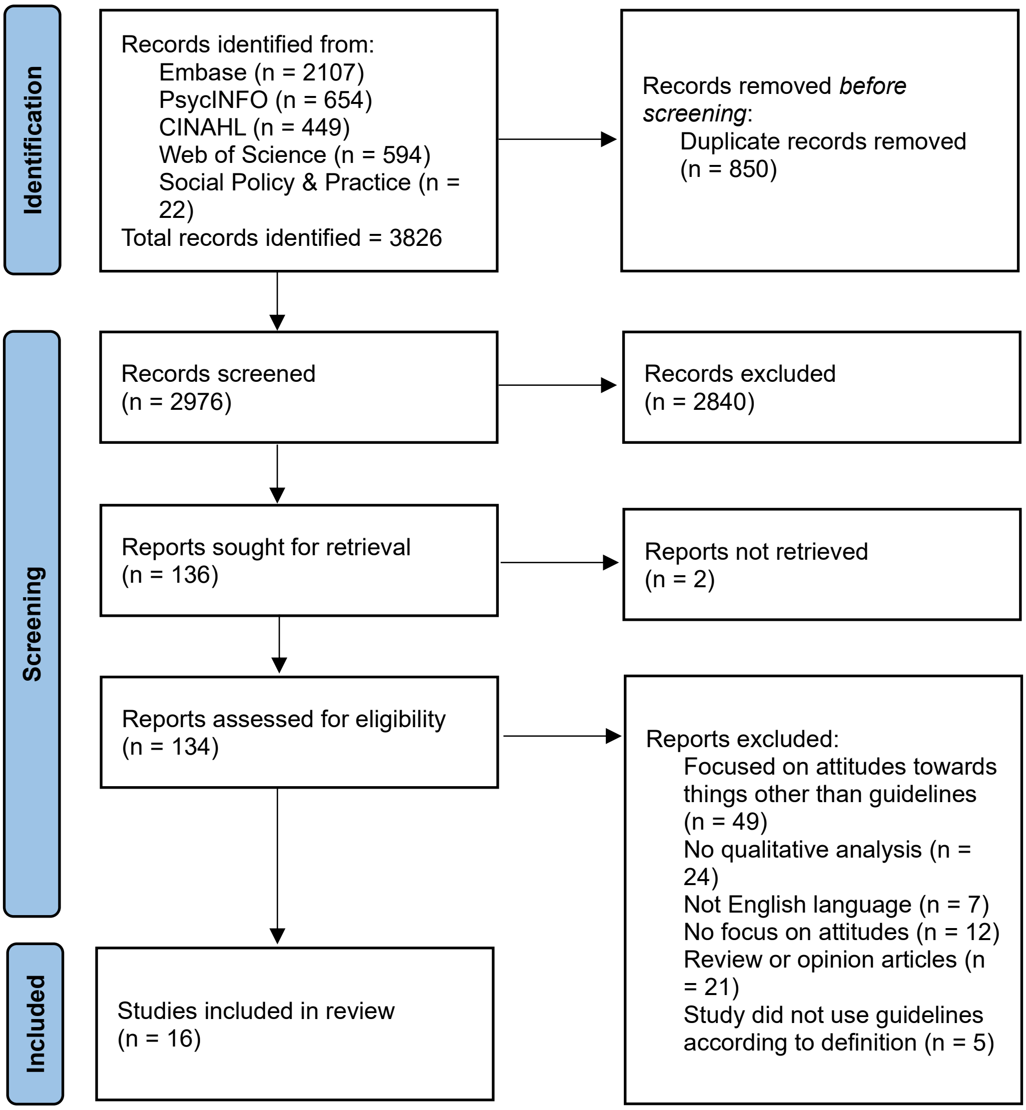
Six studies were assessed to be of high quality in their design and methods, as they had described a design and recruitment procedure that was appropriate to the aims of the study (Cleary et al., 2002; Court et al., 2017; Eke et al., 2019; McCauley & Casson, 2013; Sanchez et al., 2010; Westerlund et al., 2020). Some of these studies provided justification of the design used (Court et al., 2017; Eke et al., 2019; Sanchez et al., 2010; Westerlund et al., 2020). Two of these studies also showed consideration of how the relationship between the research and participants could have affected the results (Court et al., 2017; McCauley & Casson, 2013).

When examining the quality of the results, six studies were assessed to be of high quality, due to appropriate consideration of ethical issues as well as detailed explanations of the analysis. These studies provided a clear statement of findings and a critical examination of the analysis process (Court et al., 2017; Gatej et al., 2020; Lugtenberg et al., 2016; Prytys et al., 2011; Sanchez et al., 2010; Sandström et al., 2014).

Overall, two studies were rated as low value (Eke et al., 2019: Haw et al., 2011). Seven studies were rated as having overall medium value (Cleary et al., 2002; Espeland et al., 2021; Forsner et al., 2010; Gyani et al., 2012; Rhodes et al., 2010; Sandström et al., 2014; Smith et al., 2004). Seven studies were rated as high value (Court et al., 2017; Gatej et al., 2020; Lugtenberg et al., 2016; McCauley & Casson, 2013; Prytys et al., 2011; Sanchez et al., 2010; Westerlund et al., 2020).

**Figure 1**

*PRISMA Flow Diagram of Study Selection*



*From:* Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

**Table 3**

*A Table to Show the Characteristics of Included Studies*

| Study Title | Authors | Year | Country | Participant Role and Area of work | Aims | Methods | Qualitative Analysis Used | Guidelines (Date Published) | Key Outcomes |
|---|---|---|---|---|---|---|---|---|---|
| Ethical practice guidelines: an evaluation | Cleary, M., Jordan, R., & Horsfall, J. | 2002 | Australia | Registered nurses (n = 121)<br>Areas of work:<br>Psychiatric hospital (58%)<br>Community mental health (20%)<br>Psychiatric unit in general hospital (13%)<br>Child and adolescent setting (6%)<br>Other (3%) | To gain feedback from mental health nurses about their use of ethical practice guidelines in the clinical arena and to obtain baseline data to provide direction for further education and orientation and the development of resource material in this area. | 15-item survey asking questions relating to participants' awareness of EPGs and their confidence in dealing with ethical difficulties in practice situations. | Not stated | Ethical practice guidelines developed for use within the Central Sydney Area Mental Health Service (CSAMHS; 2000). | Ethical Practice Guidelines (EPGs) identified as helpful in providing education and being a tool for supervision.<br>Noted to be helpful in implementing ethical boundaries in clinical practice. |
| They're NICE and Neat, but are they useful? | Court, A. C., Cooke, A., & | 2017 | United Kingdom | Clinical Psychologists (n = 11) | To generate new psychological theory, producing a theoretical | Interviews with an open-ended questioning style | Grounded Theory | NICE guidelines (any) | NICE guidelines seen as having benefits through |

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| A grounded theory of clinical psychologists' beliefs about and use of NICE guidelines | Scrivener, A. | | | Areas of work:<br>Adult mental health (n = 6)<br>Child and adolescent mental health (n = 2)<br>Learning disabilities (n = 1)<br>Forensic (n = 1)<br>Older people mental health (n = 1) | framework which might help explain how NICE guidelines are utilized and which factors might impact upon this.<br>To examine the use of guidelines and explore the benefits and limitations of guidelines and how clinical psychologists manage their use in practice. | and no interview schedule. | | | helping improve care.<br>NICE Guidelines also perceived to provide unrealistic expectation of 'neatness' as well as putting pressure on clinicians to work in a certain way (e.g. CBT).<br>Participants emphasised the need for guidelines to be used flexibly.<br>Guidelines seen as a threat to professional role of clinical psychologist. |
| Clinician perspectives on the use of National Institute for Health and Care Excellence guidelines for the process of transition in Attention Deficit | Eke, H., Janssens, A., Newlove-Delgado, T., Paul, M., Price, A., Young, S., & Ford, T. | 2019 | United Kingdom | Consultant paediatricians, Consultant psychiatrists, Mental health nurses, ADHD practitioners (Total = 38)<br>Areas of work:<br>Adult services (n = 16)<br>Child services (n = 22) | To discuss the views of clinicians working in both child and adult services for ADHD regarding the use of NICE guidelines for ADHD, with a particular focus on the processes and procedures that clinicians implement for transition between | Interviews with a pre-conceived topic guide focusing on experiences of using NICE guidelines in supporting youth with ADHD to transition between child and adult services. | Thematic Analysis and Framework Approach | NICE guidelines for ADHD (any) | Most staff were aware of NICE guidelines, but those in children's services felt they were not specific enough around transition to adult services.<br>Staff in adult services felt guidelines were clear and their service was compliant. |

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| Hyperactivity Disorder | | | | | child and adult services. | | | | Most staff cited workload and resources as a barrier to implementing guidelines.<br>They also cited local commissioning failing to provide support for adults with ADHD, which affected transition between services. |
| A call for change from impersonal risk assessment to a relational approach: professionals' reflections on the national guidelines for suicide prevention in mental health care in Norway | Espeland, K., Hjelmeland, H., & Knizek, B. L. | 2021 | Norway | Psychiatrists, psychologists, mental health nurses and social science professionals (Total = 22)<br>Areas of work: Mental health and social sciences | To explore how professionals experience the influence of the national guidelines on healthcare, and to gather recommendations for which steps to take next. | Semi-structured interviews with a pre-conceived topic guide exploring 4 themes: working with national action plans and strategies; views on suicide rate; views on prevention in the future, and; views on user involvement in suicide prevention. | Thematic Analysis | The National Guidelines for Prevention of Suicide in Mental Health Care from the Norwegian Directorate of Health and Social Affairs (2008) | Guidelines provided a restricted view on risk assessment for suicide.<br>Participants felt that the guidelines increased pressure to use risk assessments as protection for professionals rather than for the benefit of clients.<br>Participants felt guidelines needed to emphasise the more relational aspects of suicide prevention instead of relying on screening measures. |

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|---|---|---|---|---|---|---|---|---|---|
| Implementing clinical guidelines in psychiatry: a qualitative study of perceived facilitators and barriers | Forsner, T., Hansson, J., Brommels, M., Wistedt, A. A., & Forsell, Y. | 2010 | Sweden | Doctors, nurses, counsellors, psychologists, and head of department (Total = 13)<br>Areas of work: General psychiatric outpatient clinics for people with depression. | To investigate perceptions of clinical practice guidelines and to identify barriers to, and facilitators for, their implementation | Focus groups to examine attitudes towards guidelines and implementation.<br>Individual semi-structured interviews to follow up on the focus groups. | Qualitative Content Analysis | Clinical guidelines for depression, developed by the Stockholm Medical Advisory Board for Psychiatry (2003) | Organisational resources affect staff's ability to implement guidelines. Lack of time, resources and familiarity were barriers.<br>There were concerns that guidelines would lead to standardised care and loss of professional autonomy.<br>Support from colleagues and leadership was seen as important in implementing guidelines.<br>Some participants commented that guidelines could help to improve quality of care but there were concerns around the origins of guidelines and their applicability to clinical practice. |
| Perspectives on clinical | Gatej, A., Lamers, | 2020 | Belgium<br>Croatia | Medical doctors, | To collect mental health clinicians' | Brief, semi-structured | Thematic Analysis | Official national guidelines and | Guidelines seen as providing a shared |

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| guidelines for severe behavioural problems in children across Europe: a qualitative study with mental health clinicians | A., Domburgh, L., & Vermeiren, R. | | Denmark<br>Estonia<br>Finland<br>France<br>Germany<br>Greece<br>Hungary<br>Iceland<br>Ireland<br>Italy<br>Kosovo<br>Moldova<br>Netherlands<br>Norway<br>Portugal<br>Republic of Macedonia<br>Romania<br>Serbia<br>Spain<br>Sweden<br>Switzerland<br>United Kingdom | psychotherapists, psychologists, and PhD (Total = 161)<br><br>Areas of work:<br>Outpatient psychiatric clinic (46.5%)<br>Specialised psychiatric hospital (34.1%)<br>Teaching/university hospitals (27.1%)<br>General hospital (11.6%)<br>Forensic hospital (7%)<br>Private practice (16.3%)<br>School and social services (15.5%) | opinions on the awareness and usability of guidelines and to compare the perceptions of clinicians who were aware of severe behavioural problems guidelines and those who were not.<br><br>To map clinicians' awareness of SBPs guidelines against preliminary overview of available guidelines constructed through academic experts' opinions to provide a broader context on guidelines awareness.<br><br>To integrate experts' opinions on guidelines improvement with clinicians' perceptions on challenges and needs to | qualitative questionnaire exploring clinicians' awareness and evaluations of official national guidelines and/or unofficial documents for SBPs. | | unofficial documents for severe behavioural problems in children across 24 European countries (any) | understanding amongst professionals of SBPs and their treatment.<br><br>Participants were concerned about the gap between research the guidelines are based on and working in clinical practice.<br><br>Participants felt guidelines do not capture complexity of presentations and suggested a need for more individualised treatment.<br><br>Participants commented on guidelines improving access to treatment and taking responsibility across services. |

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| | | | | | summarise key suggestions for improving guidelines | | | | |
| Investigating the use of NICE guidelines and IAPT services in the treatment of depression | Gyani, A., Pumphrey, N., Parker, H., Shafran, R., & Rose, S. | 2012 | United Kingdom | GPs (Total = 6)<br>Areas of work: General practice | To investigate whether reading the NICE guidelines has an effect on the self-reported treatments used by GPs. | Interviews to ascertain GP's views towards NICE and IAPT. Semi-structured interviews were used and addressed views on general guidelines and depression specific guidelines. | Interpretative Phenomenological Analysis | NICE guidelines for depression (2009) | NICE guidelines perceived as clear and having a positive impact on how medication is used to treat depression.<br>NICE guidelines allow for consideration of cost-effectiveness for medication.<br>NICE guidelines also perceived as repetitive and unrealistic due to being based on research, and not reflecting local provision of services. |
| Guidance on the use of antidepressants for depression in young people: a survey of the | Haw, C., James, A., & Gralton, E. | 2011 | United Kingdom | Consultant psychiatrists (n = 452)<br>Areas of work: Child and adolescent psychiatry | To ask UK child and adolescent psychiatrists about the impact of the Committee of Safety of Medicines (CSM) and NICE | Questionnaires asking multiple choice and open ended questions regarding participants' views towards the CSM and NICE | Qualitative analysis for commonly occurring themes (not specified) | CSM (2003) and NICE guidance (2005) for depression in children and young people | Both sets of guidelines perceived as too rigid and not being applicable to complex presentations. |

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| views of consultants in child and adolescent psychiatry | | | | | guidance on their prescribing practice and their views on this guidance. | guidance and advice. | | | CSM guidance perceived as reducing inappropriate prescribing and highlighting need for CAMHS input. NICE guidance seen as promoting psychological interventions.<br>However, participants commented on NICE guidelines prioritising CBT over other interventions. |
| Occupational physicians' perceived barriers and suggested solutions to improve adherence to a guideline on mental health problems: analysis of peer group training | Lugtenberg, M., van Beurden, K. M., Brouwers, E. P. M., Terluin, B., van Weeghel, J., van der Klink, J. J. L., & Joosen, M. C. W. | 2016 | Netherlands | Occupational physicians (n = 66)<br>Areas of work: Occupational health services | To provide an overview of the barriers that occupational physicians (OP's) perceived in adhering to the guideline on mental health problems in practice as well as of the solutions they came up with to address them. | Small focus groups focused on discussing the perceived barriers in adhering to guidelines and suggested solutions to address these barriers. | Thematic Content Analysis | Guideline on 'the management of workers with common mental health problems by OP's' developed by the Netherlands Society of Occupational Physicians (2007) | Participants commented on having a lack of knowledge and ability to implement guidelines.<br>Guidelines perceived as too rigid and lacking applicability to clinical situations.<br>Lack of collaboration with other professionals viewed as a barrier |

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| | | | | | | | | | to implementing guidelines.<br>Participants also described feeling a lack of confidence in guideline adherence resulting in positive consequences. |
| A qualitative study into how guidelines facilitate general practitioners to empower women to make decisions regarding antidepressant use in pregnancy | McCauley, C., & Casson, K. | 2013 | United Kingdom | GPs (n = 8)<br>Areas of work: General practice | To develop an in-depth understanding of GP's experience of using guidelines in the treatment of perinatal depression and if this enabled them to empower women to become involved in treatment decisions. | Semi-structured interviews | Colaizzi's (1978) seven-stage process of analysis | NICE guidelines on treating depression in perinatal period (2007) | Participants described receiving many guidelines and having limited time to know them all.<br>Participants felt that guidelines lacked clear guidance on treatment for depression in the perinatal period.<br>Clinical experience perceived as more helpful and less restrictive than guidelines. Although acknowledged that guidelines represent best practice.<br>Guidelines could help involve patients in decision-making, but there is a lack of clear guidance to do this. |

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| Implementing the NICE guideline for schizophrenia recommendations for psychological therapies: a qualitative analysis of the attitudes of CMHT staff | Prytys, M., Garety, P. A., Jolley, S., Onwumere, J., & Craig, T. | 2011 | United Kingdom | Care coordinators (Total = 20):<br>Nurses (n = 11)<br>Social workers (n = 6)<br>Occupational Therapists (n = 3)<br>Areas of work: Community mental health teams | To investigate the factors affecting the implementation of the NICE guideline for CBT and FI for schizophrenia. Another aim was to generate hypotheses for future research in this area. | Interviews with open-ended questions designed to elicit reflections in the following areas: attitudes to course of illness, functioning, wellbeing and recovery from psychosis; perception of the role of care coordinator for clients with psychosis; the nature and role of psychological interventions for psychosis; knowledge of the recommendations for psychological interventions in the NICE schizophrenia guideline; implementation barriers and promoters. | Thematic Content Analysis | NICE guidelines for treatment of schizophrenia (2009) | Guidelines perceived as providing clarity to professionals and improving quality of care.<br>Participants questioned guidelines' relevance to clinical practice as well as the quality of the research they are based on.<br>Care coordinators felt they lacked time, resources and necessary training to implement guideline interventions. |
| Investigating barriers to implementation of the | Rhodes, L., Genders, R., Owen, | 2010 | United Kingdom | Team managers, consultant psychiatrists, | To identify barriers to the implementation of the NICE | Survey using questions around knowledge of and use of NICE | Content Analysis | NICE guidelines on the treatment of depression (2007) | Participants reported that guidelines do not provide advice for the complex |

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| NICE guidelines for depression: a staff survey with community mental health teams | R., O'Hanlon, K., & Brown, J. S. L. | | | clinical psychologists, social workers, CPNs, vocational specialists and dual diagnosis practitioners (Total = 32)<br>Areas of work: Assessment and Brief Treatment Teams in CMHTs | guidelines that may affect where patients are treated. | guidelines and CBT-based interventions. | | | nature of clinical cases.<br>Participants also described a lack of resources and knowledge of guidelines to be able to implement them.<br>Participants often relied on clinical judgement rather than guidelines. |
| Opinions of primary care physicians, psychiatrists, and psychologists about clinical practice guidelines for depression. | Sanchez, A. F., Sanchez-Carracedo, D., Navarro-Rubio, M. D., Pinto-Meza, A., & Moreno-Küstner, B. | 2010 | Spain | Primary care physicians (n = 10), psychiatrists (n = 11), and psychologists (n = 10) who have treated patients diagnosed with a 'depressive disorder'.<br>Areas of work: Public Health Care Network | To know the opinion of primary care physicians, psychiatrists and psychologists working in the public healthcare network about clinical practice guidelines, emphasizing the advantages and disadvantages that, according to professionals, guidelines have in general and specifically about | Semi-structured, individual interviews and group interviews focused on asking participants what they thought a guideline was, their knowledge of guidelines and their use in depression, and the perceived advantages and disadvantages of using clinical practice guidelines. | Content Analysis | NICE guidelines for depression, American Psychiatric Association Guidelines, Sequenced Treatment Alternatives to Relieve Depression, recommendations from the Catalan Society of Psychiatry (any) | Participants' views on the advantages and disadvantages of guidelines did not appear to differ according to professional role.<br>Guidelines viewed as a tool to speed up decision making and provide some certainty and security for professionals.<br>Guidelines seen as written by unknown experts, and not reflecting 'real' |

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| | | | | | guidelines for depression. | | | | cases. Guidelines perceived as being financially motivated by the pharmaceutical industry.<br>Guidelines seen as ‘boring and complex’, as well as not being representative of clinical experiences. |
| ‘How do we know if this is the best?’ Mental health-care professionals’ views on national guidelines for psychosocial interventions | Sandström, B., Willman, A., Svensson, B., & Borglin, G. | 2014 | Sweden | Registered nurses, enrolled nurses, practice development coaches, occupational therapists and social workers (Total = 16)<br>Areas of work: Mental health facilities working with people diagnosed with schizophrenia or schizophrenia-type symptoms. | To highlight professionals’ views about recently-released guidelines for schizophrenia and the implementation of those guidelines. | Group interviews | Qualitative Content Analysis | National guidelines on the treatment of schizophrenia in Sweden (2011) | Guidelines were at times perceived to challenge existing practices and to emphasise professionals working in the same way.<br>Guidelines perceived as useful in setting standards for treatment and coordinating care.<br>Participants reported concerns around how using guidelines could impact the therapeutic relationship and that evidence is not always trustworthy. |

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| | | | | | | | | | Participants reported the need for implementation to be supported from people higher in the organisation and that they should be responsible for monitoring progress. |
| Clinical guidelines on depression: a qualitative study of GP's views | Smith, L., Walker, A., & Gilhooly, K. | 2004 | United Kingdom | GPs (n = 11)<br>Areas of work: General practice | To examine GP's views about the gap between depression guideline recommendations and practice.<br>To examine GP's perspectives on how best to implement clinical guidelines. | Interviews with open-ended questions | Framework Technique | Any guideline on the treatment of depression (since 1991) | GPs felt guidelines were too rigid and were concerned about legal implications if they were not followed.<br>GPs described a lack of time and resources to implement guidelines and felt overwhelmed with the amount of new guidelines they receive.<br>Participants felt there should be a way of measuring progress according to the guideline to assess effectiveness of treatment.<br>Participants commented on how |

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| | | | | | | | | | having GP's involved in guideline production would increase their confidence in the recommendations. |
| Evidence-based practice in child and adolescent mental health services – the challenge of implementing national guidelines for treatment of depression and anxiety | Westerlund, A., Ivarsson, A., & Richter-Sundberg, L. | 2020 | Sweden | Physicians, social workers and psychologists (Total = 18)<br>Areas of work: Child and adolescent psychiatric clinics | Aim 1 - to explore to what extent the depression and anxiety (DA) disorder guidelines were known and adhered to by health professionals in CAMHS.<br>Aim 2 - to investigate factors influencing implementation of these guidelines. | Semi-structured interviews to investigate 3 thematic areas: 1) to what extent the DA guidelines were known and used; 2) the role of the DA guidelines in clinical decision-making for children and adolescents with depression and/or anxiety disorders; 3) factors influencing the use of the DA guidelines in clinical practice. | Content Analysis (Study Aim 1)<br>Directed Content Analysis (Study Aim 2) | National guidelines for the treatment of depression and anxiety disorders in Sweden child and adolescent mental health services (2010) | Participants thought that guidelines were not developed by people working clinically and questioned how inclusive the evidence base is for clinical cases.<br>Participants acknowledged guidelines could be used flexibly and served to increase quality of care.<br>Participants described guidelines as challenging professional autonomy.<br>Participants felt more 'buy-in' from leadership colleagues was necessary for guideline implementation. |

## Themes

A thematic synthesis was conducted according to the steps described by Thomas and Harden (2008). The first stage of the analysis involved line-by-line coding for the results section of each paper. Papers and codes were examined several times to ensure sufficient breadth and accuracy within the coding. A list of 57 codes was produced, which were then re-examined and grouped together under general descriptive themes.

This process involved examining the data multiple times to ensure that codes were not unnecessarily excluded, as well as referring back to the original papers so that the descriptive themes encompassed the meaning and context from which the original codes were developed. A total of 14 descriptive themes were produced from the data. The final stage involved creating analytical themes from the initial codes and descriptive themes (Thomas & Harden, 2008).

In total, six analytical themes emerged which were then categorised according to the original research questions, which are summarised in Table 4.

### *Attitudes Towards Guidelines*

**Working with confusion.** In several of the studies there were comments from participants regarding the lack of clarity in how guidelines can be implemented. Within this broader theme, two sub-themes emerged: confusion around the changing flexibility of guidelines; and lack of clarity around who is responsible for implementing and monitoring guideline use.

Five studies commented on how guidelines can be used flexibly and do not need to be used consistently (Court et al., 2017; Haw et al., 2011; Sanchez et al., 2010; Sandstrom et al., 2014; Westerlund et al., 2020).

**Table 4**

*A Table to Show the Themes and Sub-themes Constructed from the Review*

| Review Question 1: What do clinicians working in mental health services think about clinical guidelines and their usefulness? | |
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| Themes | Sub-themes |
| Working with confusion | Confusion over roles and responsibilities |
| | Changing flexibility of guidelines |
| Lack of trust | Credibility of guidelines authors |
| | Questionable evidence |
| Review Question 2: What aspects of clinical guidelines do clinicians find helpful? | |
| Themes | Sub-themes |
| A tool to improve care | Supporting clinical decision making |
| | Availability of treatment |
| | Working in teams |
| | Improving Quality |
| Review Question 3: What aspects of clinical guidelines do clinicians not find helpful? | |
| Themes | Sub-themes |
| Guidelines are a threat | Caring for service users |
| | Clinical judgement vs guidelines |
| Losing sight of the big picture | Needs are complex |
| | Guidelines restrict clinical practice |
| Demands and Resources | Insufficient resources |
| | Accessing guideline documents |

Some participants felt like recommendations from guidelines did not reflect what interventions were being offered and created a feeling of ambivalence towards the guidelines:

> *"It's a bit of a fudge, I think, because people are trained on the basis that this therapy is NICE approved, but they're then ending up doing it with groups of people that would not be NICE approved." (Court et al., 2017, p. 905).*

Participants in four studies commented on feeling uncertain about who is responsible for ensuring guidelines are implemented, and felt a lack of support from leadership colleagues to establish guidelines (Eke et al., 2019; Forsner et al., 2010; Sandström et al., 2014; Westerlund et al., 2020). Participants in one study highlighted that they expected guidelines to be implemented at all levels of the organisation and expected clarity around manager's responsibility to present and implement guidelines. Alongside this, participants across the studies described a resistance to taking on the responsibility as an individual and felt that clear guidance from leadership was necessary (Sandström et al., 2014; Westerlund et al., 2020).

Another issue that was identified across four of the studies, was confusion around how to adapt guidelines for local services and how clinicians could effectively implement recommendations (Eke et al., 2019; Gatej et al., 2020; Forsner et al., 2010; Lugtenberg et al., 2016). Clinicians' often questioned whether they have the authority in their services to implement guidelines as well as the capability through sufficient training and knowledge to be able to implement recommendations in their practice (Forsner et al., 2010; Lugtenberg et al., 2016).

Two studies found that staff often feel they lack the self-efficacy to implement guideline recommended treatments due to a lack of training and skills in providing these treatments (Forsner et al., 2010; Lugtenberg et al., 2016). Forsner et al., (2010) also highlighted that some professions do not have a history of using clinical guidelines and so may be unfamiliar with how to adapt them in clinical situations.

> *"We have no tradition in psychiatry of following clinical guidelines. It is a new approach and requires great adaptation" (Forsner et al., 2010, p. 7).*

**Lack of trust.** Participants in nine studies questioned the credibility of guidelines and the research they are based on (Court et al., 2017; Forsner et al., 2010; Gatej et al., 2020; Gyani et al., 2012; Haw et al., 2011; Prytys et al., 2011; Sanchez et al., 2010; Sandström et al., 2014; Westerlund et al., 2020). This lack of trust was often related to guidelines being based on RCT's where conditions are very controlled and clients are less "complex". Therefore, clinicians were sceptical about the validity of the research findings and the recommendations contained within clinical guidelines (Court et al., 2017).

They were also concerned about how guidelines that were based mainly on quantitative data could capture and understand the experiences of service users (Court et al., 2017; Sandström et al., 2014; Westerlund et al., 2020).

Clinical psychologists in one study by Court et al., (2017) questioned the credibility of using diagnostic categories within guidelines and felt that this affected their validity:

> *"I think the main criticism at this stage is that it really ought to be under review, and maybe NICE should apply its own methodology to itself. And so what is the evidence base for the diagnostic system? And what is the evidence base for, you know, producing guidelines using a diagnostic system that itself isn't evidence based?" (Court et al., 2017, p. 905).*

Another factor affecting trust in the guidelines was how credible the authors of the guidelines appeared to participants. In six studies, professionals expressed opinions that guidelines were written by researchers who lack knowledge of clinical work (Court et al., 2017; Forsner et al., 2010; Prytys et al., 2011; Sanchez et al., 2010; Smith et al., 2004; Westerlund et al., 2020). There were concerns that those being selected as "experts" to write the guidelines did not work in clinical practice and so did not understand the reality of implementing treatments in services (Court et al., 2017). Participants also expressed suspicion around the lack of transparency about who the authors of the guidelines were:

> *"Well you know, the bodies that produce these guidelines and it can feel like, you know, something we need to know about but do they really know what it is like down on the ground level" (Prytys et al., 2011, p. 54).*

There were also concerns that guidelines are financially motivated which then significantly impacts on the types of treatment that are recommended and researched:

> *"The experts have to agree... But who chooses the experts? And then there is the problem of the pharmaceutical industry, the pressure, because the industry is in all the guides, well, in all of them maybe not, but in many of them the opinion of a laboratory is behind it" (Sanchez et al., 2010, p. 556).*

### ***Useful Aspects of Guidelines***

Within the studies clinicians identified several aspects of guidelines that they found useful and that helped them in their practice. From this, one key theme became apparent, guidelines being a tool to improve standards of care.

**A Tool to Improve Care.** Within this theme four sub-themes became apparent around: guidelines supporting decision-making; increasing availability of treatment; improving team working; and improving quality of interventions.

Within several studies clinicians acknowledged how having guidelines increased treatment availability by allowing suitable interventions to be identified and provided to clients (Court et al., 2017; Espeland et al., 2021; Gatej et al., 2020; Gyani et al., 2012; Haw et al., 2011; Prytys et al., 2011; Sanchez et al., 2010; Sandström et al., 2014). Guidelines were viewed as having the power to promote and direct investment towards specific interventions (Court et al., 2017). In clinicians' views this facilitated access to treatment and also highlighted the effectiveness of specific treatments such as psychological therapies:

> *"...access to psychological therapies for people with a diagnosis of schizophrenia has really increased as a result of NICE guidelines". (Court et al., 2017, p. 902)*

Additionally, guidelines were viewed as facilitating an increase in the quality of interventions through endorsing and recommending evidence-based practice (Court et al., 2017; Forsner et al., 2010; Gatej et al., 2020; Prytys et al., 2011; Sandström et al., 2014; Westerlund et al., 2020). This was seen as providing both clinicians and service users with an increased awareness of what standard of care they should expect from services (Sandström et al., 2014).

Within five of the studies, clinicians referred to guidelines as representing best practice advice and providing a benchmark standard for services to aspire to. Participants described that using guidelines can be a tool to advocate for best practice within services (Eke et al., 2019; Forsner et al., 2010; McCauley & Casson, 2013; Sanchez et al., 2010; Sandström et al., 2014):

> *"Furthermore, they were referred to as 'rights for the service users'; that is, what could be expected from mental health care and its professionals" (Sandström et al., 2014, p. 225).*

Guidelines were seen to bring added value to clinical decision-making and being a necessary part of clinical work (Court et al., 2017; Forsner et al., 2010; Haw et al., 2011; Prytys et al., 2011; Sanchez et al., 2010). Guidelines were often referred to as being ‘necessary’ and ‘important’ with one study highlighting that perhaps they are ‘not valued enough’ (Eke et al., 2019).

Clinicians expressed that guidelines provided clarity in decision-making and helped them to prioritise interventions. Participants described that guidelines provided consistency and helped to speed up decision-making in services (Court et al., 2017; Eke et al., 2019; Gatej et al., 2020; Sanchez et al., 2010; Sandström et al., 2014; Westerlund et al., 2020). Participants across several studies also commented on how they felt the guidelines protected them in their decision-making through providing justification for their clinical decisions (Cleary et al., 2002; Espeland et al., 2021; McCauley & Casson, 2013; Sanchez et al., 2010; Smith et al., 2004):

> *"If they have to reference your practice in a case that has become complicated, it is important that you have a scientific endorsement that justifies your practice" (Sanchez et al., 2010, p. 556).*

Participants did state that, despite this feeling of protection, there were times when this felt detrimental to clinical practice as clinicians felt they had to use the guidelines in a defensive way that was not necessarily best for the client (Espeland et al., 2021; McCauley & Casson, 2013; Smith et al., 2004).

There was a sense from clinicians that guidelines could be a useful way of educating and informing staff about recommended treatments, as well as being part of the induction process to provide information about the standards that the service seeks to meet (Cleary et al., 2002; Court et al., 2017; Espeland et al., 2021; Haw et al., 2011).

Another sub-theme that emerged from the data was that guidelines were perceived as facilitating teamwork and collaboration. Participants in two of the studies described that using guidelines enabled the team to work in a more coordinated way and allowed for more systemic and multi-agency ways of working (Gatej et al., 2020; Sandström et al., 2014).

### *Unhelpful Aspects of Guidelines*

Clinicians reported several aspects of guidelines as being unhelpful in their practice. From this, three key themes emerged: guidelines being a threat to professionals and service users; guidelines losing sight of the bigger clinical picture; the tension between demands and resources when implementing guidelines.

**Guidelines are a threat.** Clinicians across three studies highlighted concerns that the use of guidelines will eventually lead to a "loss" of their own individual skills and expertise due to the standardised and general nature of guidelines (Court et al., 2017; Forsner et al., 2010; Westerlund et al., 2020). Within one study by Westerlund et al., (2020), participants highlighted that, if guidelines were followed too rigidly then this could impact on how health professionals are seen within clinical services and could serve to overlook the differences between professionals from different modalities:

> *"Others expressed that guidelines implied de-professionalisation or that guidelines could possibly replace health professionals. "If we only can follow the guidelines a-b-c, then we are soon out of a job". (Westerlund et al., 2020, p. 481).*

One study by Court et al., (2017), focused on clinical psychologists' experiences of guidelines and found there were several concerns around guideline recommendations failing to recognise the differences between single-modality therapists and integrative therapists. Clinical psychologists expressed a wish for guidelines to acknowledge that different professionals, even when working in the same therapeutic modality, will work in different ways:

> *"but there's a danger then, that it's erm, we're not fully understanding the scope of what psychological interventions offer, that it's not just CBT, because then there is the risk that the Trust will just, erm I guess get rid of erm clinical psychologists who are expensive to train and to employ, and just employ CBT therapists… when in reality when you're doing a piece of work, which might be CBT-orientated, as a clinical psychologist I will be bringing in lots of different therapy kind of techniques and models and formulations from different erm models of psychological therapies, so I don't think it's as purist as maybe NICE guidelines might encourage people to think". (Court et al., 2017, p. 905)*

Additionally, clinicians described guidelines as being too rigid and not allowing for flexibility in decision-making. Some clinicians felt that guidelines favoured certain approaches which then excludes people from getting potentially effective interventions because they are not included within the guidelines (Court et al., 2017; McCauley & Casson, 2013):

> *"a lot of the time NICE guidelines are very ...strict and if you go ...strictly by the guidelines then quite often you don't necessarily ... give the patient what they need or what help they need". (McCauley & Casson, 2013, p. 8)*

There were also concerns that guidelines would lead to the restriction of services through influencing commissioning decisions as to what interventions are available in services (Court et al., 2017).

**Losing sight of the bigger picture.** Despite guidelines being perceived as a helpful aid to decision-making, some professionals experienced guidelines as being too restrictive and not allowing them to exercise clinical judgement (Court et al., 2017; Lugtenberg et al., 2016; McCauley & Casson, 2013; Sandström et al., 2014; Smith et al., 2004; Westerlund et al., 2020).

A concern recorded across nine studies was around guidelines being restrictive and providing a narrowed view of issues which can then lead services to place less importance on other significant factors and interventions (Court et al., 2017; Espeland et al., 2014; Haw et al., 2011; Lugtenberg et al., 2016; McCauley & Casson, 2013; Sanchez et al., 2010; Sandström et al., 2014; Smith et al., 2004; Westerlund et al., 2020). The study by Espeland et al., (2021), examining the use of guidelines for managing suicide, found that clinicians felt there was too much emphasis placed on risk assessment and that this then became the focus of interventions to the detriment of other aspects of care:

> *"I think that they [the guidelines] are very, very focused on risk assessments. And I believe maybe they are, that it's an important part, but that it is at the cost of so many other things. It's like that becomes the focus, and I think that the huge focus on these risk assessments means that perhaps you lose sight of the big picture and other aspects that perhaps are just as important when working with suicide prevention in specialist mental healthcare as well". (Espeland et al., 2021, p. 4)*

Most of the studies also noted a tendency of guidelines to ignore how complex clinical cases can be and to not account for the wide variation in difficulties that people will experience (Court et al., 2017; Forsner et al., 2010; Gatej et al., 2020; Haw et al., 2011; Lugtenberg et al., 2016; McCauley & Casson, 2013; Rhodes et al., 2010; Sanchez et al., 2010; Sandström et al., 2014; Smith et al., 2004; Westerlund et al., 2020).

> "*the complex nature of some cases which the guidelines provide no advice for" (Rhodes et al., 2010, p. 149)*

This potentially is a significant issue in the implementation of guidelines as one study by Lugtenberg et al., (2016) highlighted that even when clinicians want to use guidelines they feel they cannot due to the difficulties in applying them to clinical settings:

> *"I notice that I – I do want to apply the guideline, but not as strictly as it's formulated…I mean: you just cannot catch real-life cases in this single guideline. It's always different or more complicated or harder" (Lugtenberg et al., 2016, p. 6)*

**Demands and Resources.** The final key theme that emerged was the idea that there is consistent tension between demands and resources when using guidelines. Two sub-themes emerged around having insufficient resources and being able to access guideline documents.

Within several of the studies, participants described issues with a lack of resources being available to implement guidelines, stating that both limitations in time and funding were barriers to being able to use guideline recommended interventions (Court et al., 2017; Eke et al., 2019; Forsner et al., 2010; Prytys et al., 2011; Sandström et al., 2014; Smith et al., 2004). Three studies cited that a lack of training in the use of guidelines affected staff's confidence in being able to transfer the knowledge contained within the guidelines into their clinical practice (Forsner et al., 2010; Sanchez et al., 2010; Sandström et al., 2014):

> *"The need to bridge the gap between knowledge and skills was a perspective described by participants. "I know it's quite silly. I mean I know it's only a matter of starting to do it, but still we don't change our behaviour. ... I'm not sure that we have the skills.." (Forsner et al., 2010, p. 7)*

Across the studies there were several findings related to how professionals experienced being presented with clinical guidelines as a document. Issues were identified in relation to accessibility, amount of documents produced, length of these documents, and the way they are presented. Participants in seven out of the 16 studies commented that guidelines can be difficult to access and read, which can then lead to poor implementation (Forsner et al., 2010; Gyani et al., 2012; Lugtenberg et al., 2016; Rhodes et al., 2010; Sanchez et al., 2010; Sandström et al., 2014; Smith et al., 2004).

There was a consensus from participants in six of the studies that guidelines were too long, repetitive and complex to follow (Forsner et al., 2010; Gyani et al., 2012; Lugtenberg et al., 2016; Sanchez et al., 2010; Sandström et al., 2014; Smith et al., 2004). However, there were contradicting findings for this with some studies also finding that participants found some guidelines to be written very clearly although they also found them to be repetitive (Gyani et al., 2012; Sandström et al., 2014; Smith et al., 2004).

Five studies specifically elicited views on the amount of guidelines clinicians were faced with and how clinicians can often feel overwhelmed by this (Forsner et al., 2010; McCauley & Casson, 2013; Sandström et al., 2014; Smith et al., 2004; Westerlund et al., 2020). It was considered that this could then affect clinicians' ability to fully understand the guidelines and implement them in practice:

> *"There's a bit of numbing as well: oh no, not another guideline. (GP11)' 'We get flooded with stuff.... With a lot of stuff I bin it or file it (GP05)" (Smith et al., 2004, p. 558).*

**Sensitivity Analysis**

A sensitivity analysis was conducted post-synthesis in order to assess the low quality studies' contributions to the resulting themes and sub-themes (Thomas & Harden, 2008; See Appendix F).

Excluding the two low quality studies, Eke et al., (2019) and Haw et al., (2011), from the analysis did not result in the loss of any themes or sub-themes but did have an impact on the richness of the data within the sub-theme of ‘Credibility of guideline authors’. Exclusion led to omitting a different viewpoint where some participants thought that guidelines weren’t valued enough and should be valued more highly than they were.

Apart from this, it was found that the lower quality studies did not offer a greater richness to the data over and above what the other studies had contributed and so their exclusion did not affect the meanings gathered from the different themes and sub-themes. This indicates a higher level of validity for the themes constructed within this analysis as they are not overly reliant on low-quality data (Thomas & Harden, 2008).

## Discussion

### Summary of Findings

This review aimed to examine how clinicians view clinical practice guidelines and their usefulness in mental health services. Studies have demonstrated how guideline-recommended treatments can have positive effects on treatment outcomes as well as service user and clinician experience (Waller et al., 2015). However, research demonstrates that the implementation and uptake of guidelines is variable (Mears et al., 2008).

Whilst several studies of barriers and facilitators to guideline implementation have been conducted, this review focused more on attitudes towards guidelines as a clinical document and aid in order to provide a more detailed and personal account of the experiences of professionals using these guidelines.

One of the main findings from this review was how confusing guidelines could be in terms of how rigidly they needed to be followed and who is responsible for implementing them. Participants felt this ambiguity was disempowering and that they did not have the authority or role to implement guideline recommendations (Forsner et al., 2010; Westerlund et al., 2020). This could be considered in the context of the Elaboration Likelihood Model

(ELM), where perhaps persuasion and attitude change is low due to the relevance of the message being lost as there is no clear definition of who should be responsible for the guideline. Therefore, clinicians are less likely to attend to and elaborate on the information being provided (Kitchen et al., 2014).

Another finding was that guidelines need to be perceived to come from a credible source and trustworthy evidence in order for clinicians to accept that they can be useful (Court et al., 2017; Prytys et al., 2011). ELM could explain this in terms of clinicians viewing guidelines as being mainly based on research and so being different from clinical work. This discrepancy could reduce the perceived credibility of the source of these guidelines and so lead clinicians to not fully attend to guidelines, which then affects how enduring any potential change is (Morris et al., 2005).

However, clinicians generally agreed that guidelines are useful in improving the quality of care in services, setting a high standard for services and professionals to aspire to (Sandström et al., 2014). This can then have beneficial effects on treatment outcomes, as has been seen in previous studies examining the implementation of NICE recommended treatments, where outcomes have improved (Girlanda et al., 2017; Waller et al., 2015).

However, the finding that there are several aspects of clinical guidelines that clinicians do not find helpful, raises the question of how attainable these standards of care are. The main concern raised by clinicians appeared to be that guidelines do not consider the wider clinical picture and are often not applicable to situations where there is greater complexity and idiosyncrasy between clients (Gatej et al., 2020; Lugtenberg et al., 2016). This seemed to relate to other concerns reported where guidelines were viewed as restrictive through not allowing for clinical judgement and were seen as a threat to professional roles through standardising treatment. It was found that clinicians often defaulted to using their clinical knowledge over guidelines, as they perceived this to have more credibility and validity (Court et al., 2017).

Another factor to consider is the importance that clinicians placed on how guidelines are presented and disseminated. Several comments from participants showed that guidelines are often viewed as difficult to read and access which has implications for practice as this is likely to prevent clinicians from examining guidelines more thoroughly (Forsner et al., 2010; Gatej et al., 2020). This is consistent with an ELM view of persuasion and it could be considered that currently guidelines are not being presented and disseminated in a way that allows clinicians to elaborate on them fully and so are less likely to lead to enduring change (Morris et al., 2005).

## Strengths and Limitations

There were no inclusion/exclusion criteria for study dates within this review so that a wide range of results could be analysed. The studies included span a period of 20 years, during which the climate of healthcare has changed (Klein, 2013; Raphael et al., 2021). It is likely that the purpose of clinical guidelines has shifted during this time, and that findings from earlier studies, and using earlier guidelines, may not be as relevant within current healthcare services.

Studies were also conducted in a variety of countries, which have different processes for developing and using guidelines (Joosen et al., 2015). The researcher's experience of the NHS will have influenced how the themes were constructed, potentially leading to omissions or misunderstandings around attitudes towards guidelines from professionals in other countries whose healthcare systems and practices work in a different way.

The variety of analysis methods between studies within the review also raises questions about the validity and generalisability of the findings. These methods included:

content analysis, grounded theory and interpretative phenomenological analysis (IPA). Using methods like grounded theory and IPA requires more interpretation from the researcher which then alters the meaning of the original data (Urcia et al., 2021). Consequently, the themes in this review are based on some data that has already undergone an interpretive process, where the original meaning of the results has potentially been lost.

However, a large majority of the included studies used content analysis, which requires less interpretation (Vaismoradi et al., 2013). This is more likely to produce results that remain close to the original data within the study and so increase the representativeness of the themes.

One strength of this review is that it was conducted in a systematic way, increasing the quality of the review process and allowing for transparency of the methods so that it could be reproduced. Studies were included regardless of quality to enable a wider range of views to be examined and to allow for a richer analysis of the available data (Harari et al., 2020).

The review also set to examine a defined phenomenon, specifically attitudes towards guidelines, and so provided a more structured set of criteria for inclusion and exclusion. This helped to increase the rigour of the review and helped ensure that research being compared was more likely to be focused on the same phenomenon (Harari et al., 2020). However, it is not possible to set a definitive criteria for “attitude” and, as seen within the search strategy, there are various synonyms and related ideas that could be argued to form part of “attitudes”. This subjectivity could make the findings less reliable.

Also the nature of the analysis relies heavily on researcher interpretation, making the results less reliable. Even though recent developments in techniques have attempted to make the process of thematic synthesis more scientifically rigorous, there is still much criticism regarding the influence of researcher judgement within this approach (Thomas & Harden, 2008).

The use of one researcher within this review means that the results are heavily influenced by one epistemological position. Taking a pragmatic viewpoint, where knowledge is assumed to be constructed around consequences, enables results to highlight the practical implications of attitudes to guidelines and so allow findings to be more easily used by staff within services (Kelly & Cordeiro, 2020). However, there is the potential that the results selected to construct particular themes have a limited focus on the practical aspects of healthcare and how these inform attitudes towards guidelines. Consequently, alternative factors such as personal and cultural values, that could also provide insights into how clinicians view and use guidelines, are potentially overlooked (Hampson & McKinley, 2023).

Additionally, it is up to the researcher to select the ‘successful’ or ‘unsuccessful’ consequences of using guidelines and include these within the themes (Hampson & McKinley, 2023). This process is subjective and so results around what has been helpful and unhelpful in using guidelines will not be generalisable to all clinical situations.

Future reviews would benefit from the involvement of multiple researchers, both within the selection process to agree on judgements regarding inclusion and exclusion criteria, but also for agreement and examination of the final themes.

## Conclusions and Implications

The findings of this review suggest that clinicians feel there is a place for guidelines in clinical practice to aid in making decisions and setting standards of care. However, there are several concerns which need to be explored further in order for staff in mental health services to see guidelines as a more essential part of their practice.

The finding that guidelines are perceived as challenging professional identity could be explored further within research as the results found in this review were mainly related to studies that examined psychologists and other therapeutic professions (Court et al., 2017). As psychological therapy is a distinct form of treatment, it would be helpful to examine if this challenge to professional identity is experienced by staff from other backgrounds who use different forms of treatment such as medication or rehabilitation, which are more well established and can involve more prescriptive guidance (Ahn et al., 2009). This could provide further insight into attitudes around how rigid guidelines are and whether this is more helpful for medical compared to psychological interventions.

The finding that clinicians consistently felt guidelines were not applicable to clinical practice suggests that further work is needed to ascertain if and how guidelines can be adapted within individual services and with particular client groups. This might be through adapting national guidelines to local services, and initial research into this suggests that this can be helpful as an implementation tool (Fischler et al., 2016).

Another implication of this finding is the potential need to further consider the relationship between guideline authors and clinicians. Results suggest there is a need to build better relationships between researchers and clinical staff, in order to facilitate guideline development and implementation (Court et al., 2017). This could be done through increasing familiarity with guidelines authors, making clinicians more aware of their background and expertise in order to increase trust and transparency.

Results also suggest a need to consider how responsibility for implementing and measuring guideline use is managed by staff in leadership roles. This may be through more explicitly identifying who is responsible for disseminating guidelines and measuring their impact (Westerlund et al., 2020). A potential area for future research could be to examine the attitudes towards guidelines of staff in leadership roles, and how these attitudes specifically affect the implementation of guidelines.

In order to further aid the implementation of guidelines within mental health services, understanding the views and motivations behind using or not using guidelines is an important step in promoting high quality, evidence-based treatment.

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# MAJOR RESEARCH PROJECT

## Section B:

## Examining the effects of neuropsychology assessment feedback and recommendations within mental health services

Word Count: 7880 (718)

Potential Journal for submission: The Clinical Neuropsychologist

# Abstract

Objective: the aim of this study was to examine neuropsychologists' expectations on the impact of their work in mental health services and to compare this with the experiences of mental health staff receiving input from them. Another aim was also to examine the perceived barriers to implementing and experiencing change following neuropsychology input.

Method: Semi-structured interviews were completed with 12 participants, three clinical psychologists working in neuropsychology services and nine members of staff working in mental health services. Staff worked across a range of services: drug and alcohol; community mental health; and homelessness services. Professional backgrounds of mental health staff included: psychiatry, psychology, occupational therapy, family interventions and social work.

Results: Mental health staff's experiences of receiving neuropsychology input mostly aligned with the expectations of neuropsychologists. Some differences were apparent in how neuropsychologists expected to be perceived by staff and how they were actually perceived. Neuropsychologists expressed views of not being able to meet expectations and being reliant on teams to take action. Whereas mental health staff viewed neuropsychology very positively and as having the power to enact change.

Conclusions: Discrepancies between expectations and experiences suggest the need for further exploration of power and how this plays a role in services and how neuropsychology feedback is implemented. Results also suggest that further development of neuropsychology within the wider mental healthcare system would be beneficial to increase awareness and knowledge around cognition and mental health.

*Keywords:* Neuropsychology, mental health, perception, experiences, change

# Introduction

## Neuropsychology and Mental Health

Neuropsychology involves the study and treatment of cognitive functioning and its relationship with various behavioural and psychological factors. Clinical neuropsychologists work alongside mental health services to provide assessment and recommendations for clients experiencing a range of difficulties (Kasten et al., 2021).

A significant proportion of people with mental health difficulties experience cognitive deficits and/or have experienced brain damage, which then impacts on their functioning (Proffitt et al., 2018). Several studies have demonstrated the prevalence of neuropsychological diagnoses within mental health populations (Khalily, 2009; Tickell et al., 2017).

Research has also demonstrated a positive association between scores on neuropsychological tests and outcomes related to treatment (Gallant & Good, 2022; Mahmood et al., 2018). This suggests that addressing neuropsychological deficits could play an important role in supporting people with mental health difficulties.

## Experiences of Neuropsychological Assessment

Studies have demonstrated high levels of satisfaction with neuropsychology from clients, family members and professionals (Watt & Crowe, 2018). Helpful aspects identified include the neuropsychologist explaining the findings to them and having an understanding of their behavioural difficulties (Spano et al., 2021; Westervelt et al., 2017).

Whilst a lot of research has been conducted with clients and families, it is important to consider how clinicians experience neuropsychology feedback as they are often in a position to implement advice and influence care for their clients (Laker et al., 2014).

Research indicates that there are aspects of neuropsychology evaluation and recommendations that staff are more likely to implement than others (Allahham et al., 2023). Results highlight several aspects of the evaluation process that staff find less helpful, including feeling uncomfortable with recommendations around laboratory work and medication (Allott et al., 2020; Hilsabeck et al., 2014). This suggests there may be aspects of neuropsychology feedback that are viewed negatively and might not be implemented.

## Issues with Implementation

There is evidence to show feedback implementation is inconsistent and that there are several barriers to this (Elias et al., 2021). Research with clients and families indicates that in some circumstances only half the recommendations are actioned. Barriers to implementation include lack of resources, ambivalence about recommendations and resistance from other professionals which could have negative implications for care (Elias et al., 2021; Quillen et al., 2011). There is less research examining barriers to staff utilising neuropsychology feedback and recommendations.

In addition to resource-oriented barriers, participants also reported attitude-related barriers to implementing recommendations including concerns around the "labels" that would be attached to themselves or a family member and the consequences this would have (Elias et al., 2021; Delagneau et al., 2019). This demonstrates the mixture of practical and attitudinal factors that potentially affect whether feedback is actioned. Attitude has been found to be an important factor in influencing the likelihood of information being acted upon within healthcare services (Olade, 2003).

## The Elaboration Likelihood Model

One explanation for the variation in applying recommendations is that neuropsychology reports are not "persuading" people to act on the information they are given. If this persuasion is not happening then this could have a detrimental impact on care as well as the effectiveness of neuropsychology services.

The Elaboration Likelihood Model (ELM) of persuasion was originally described by Petty and Cacioppo who proposed that there are two routes to persuading someone to act on a message (Petty & Cacioppo, 1986). One route, known as the “central route” occurs with a message that is perceived to be highly relevant to the recipient who is also able to take time to consider and understand the message. Alternatively, another route, known as the “peripheral route” is more likely to occur when there is little perceived relevance to the recipient and they are less likely to be able to consider or elaborate on the message (Morris et al., 2005). Both routes to persuasion are dependent on elaboration, the extent to which a person is able to consider and think about a message. High elaboration and processing through the central route is more likely to result in enduring attitude and behaviour change (Morris et al., 2005).

The factors influencing persuasion differ according to the route that is taken. External cues of source credibility, message structure and attractiveness are likely to impact persuasion on the peripheral route, whereas argument content and quality are more likely to impact persuasion on the central route (Morris et al., 2005).

Several studies in healthcare and neuropsychology have demonstrated how cues within the environment can affect attitudes towards information (Baum et al., 2018; Meth et al., 2016; Susmann et al., 2022). What is less clear is how different factors affect experiences of attending to and acting on information within healthcare. There is limited research examining the experiences of staff who receive neuropsychology feedback in mental health services and what they perceive to be the barriers and possible facilitators of acting on advice.

## Roles and Expectations of Staff in Implementing Recommendations

Another factor to consider in the process of persuasion is whether the recipient of a message acts on this information in the way that it is intended. Staff in mental health services often work amongst a variety of demands and expectations which could influence how they take on board feedback (Hannigan et al., 2018).

There is evidence to show that the expectations placed upon staff do not always reflect the experiences they have in their role (Happell et al., 2012). Discrepancies have been found between the standards that are set for staff within guidelines and the reality of the work they are able to do (Hannigan et al., 2018). This is important to consider as this mismatch between expectations and experiences could have a negative impact on client care.

Findings from studies examining expectations and experiences in neuropsychology services also suggest that neuropsychologists' expectations of how their advice is taken do not always match up with staff's views of this feedback (Mahoney et al., 2017; Postal et al., 2018).This is demonstrated in a study by Postal et al., (2018) who found that neuropsychologists expected referrers to read their reports less often than they actually did. They also found that the majority of neuropsychologists felt they effectively communicated the findings of the results but that patients receiving these results found the recommendations difficult to understand at times.

This highlights a potential discrepancy in how neuropsychologists predict how their feedback will be received and how it is experienced by staff and patients using neuropsychology services.

## Rationale and Aims

Overall, findings suggest that neuropsychology feedback is not persuading people in the way it is intended to. Therefore, it is important to examine expectations and experiences of neuropsychologists and mental health staff as if these experiences are misaligned this might then have negative implications for care and treatment outcomes.

Most studies to date have focused mainly on report feedback and have utilised brief qualitative methods to understand expectations and experiences separately. This study sought to go beyond experiences of reports to examine experiences and expectations of the broader process of neuropsychology input and feedback to determine if there were other aspects of this process that potentially influence how information is taken forward (Prigatano & Morrone-Strupinsky, 2010).

The purpose of this study was to examine both neuropsychologists' and professionals' experiences of providing and receiving feedback and to investigate any differences or similarities in these experiences. This would then allow for further examination of the possible reasons for any differences in order to provide a starting point for future development of neuropsychology services.

The study aimed to address the following questions:

1. What changes do clinical neuropsychologists expect to happen as a result of providing feedback from their assessments with clients in mental health services?
2. What changes do staff working within these mental health services experience and implement as a result of receiving this feedback from clinical neuropsychological assessment of their clients?
3. Are there differences between what changes clinical neuropsychologists expect to be experienced and implemented as a result of their assessments with clients in mental health services and the changes that are experienced and implemented by staff in mental health services who receive the outcomes of these assessments? If so, what are these differences?

4. Are there similarities between what changes clinical neuropsychologists expect to be experienced and implemented as a result of their assessments with clients in mental health services and the changes that are experienced and implemented by staff in mental health services who receive the outcomes of these assessments? If so, what are these similarities?
5. What are the perceived factors that influence whether change occurs following neuropsychological input and whether this change is in line with what is expected?

## Methods

### Design

A qualitative methodology was used to gain an in-depth exploration of participants' experiences of working in neuropsychology and mental health services (Groenewald, 2004).

A phenomenological design was considered, as this seeks to understand a phenomenon through the lived experiences, perceptions and beliefs of those who have experienced it, which was essential to addressing the study's aims (Laverty et al., 2003; Teherani et al., 2015). However, the methodology used lacked the specific philosophical underpinnings of phenomenology, as well as specific methods such as bracketing interviews (Groenewald, 2004).

An Exploratory Descriptive Qualitative (EDQ) approach was used within the study, which focuses on investigating less well-researched phenomena for which there is little current information. The design involves exploring these areas to gain initial and more comprehensive insights into a phenomenon and to use this information to identify further avenues for exploration and understanding (Hunter et al., 2019). This design appears in multiple studies and is not aligned to a specific method or philosophical position (Etemadifar et al., 2015; Hunter et al., 2019; Karahan et al., 2022).

Data were collected using semi-structured interviews which suit an EDQ approach (Hunter et al., 2019). This provided some structure in having questions related to the research topic, but also enabled participants to discuss what they felt was important (Lambert & Loiselle, 2008).

The study was conducted in two stages. The first stage involved a focus group with clinical neuropsychologists discussing their general expectations of how feedback impacts care in mental health services. This initial focus group was conducted to gain information from staff who have had rich experience working within this area and to test out potential interview questions. Adaptations were then considered to prevent exclusion of important areas of questioning from the study.

For data collection, individual interviews were then held with the same clinical neuropsychologists as well as staff working in mental health services who had received feedback from these neuropsychologists. Individual interviews were likely to produce a more in-depth account of expectations and experiences around working with individual clients following neuropsychology feedback, compared to a focus group (Lambert & Loiselle, 2008).

The type of neuropsychology feedback that mental health staff received could be from any type of assessment, due to the diverse nature of neuropsychology services and how formal cognitive assessment represents a small part of what neuropsychologists offer (Kubu et al., 2016). Cases were included if the goal of the interaction had been to assess the client's needs and provide advice, where the assessment followed a recognised protocol such as an interview schedule or questionnaire. These criteria were set in order to differentiate between assessments and more general conversations with staff and clients that were not necessarily intended to produce feedback and recommendations. All mental health participants received feedback on a cognitive assessment, except one who received feedback from an interview with the client and a screening tool.

Professionals received feedback from neuropsychology in a variety of ways, which reflects the reality of providing feedback in healthcare amongst limited time and resources (Postal et al., 2018).

The format of feedback was considered suitable if it was done in a way that formed part of the client's clinical record such as through a report or a professionals meeting, rather than general conversations or emails. This ensured that participants were being interviewed about feedback where there was an expectation that the information from neuropsychology would inform the client's care.

Five mental health participants received reports, three of whom stated that they met with the neuropsychologist to discuss the report. Four participants received verbal feedback within a meeting with the neuropsychologist.

## Participants

Within qualitative approaches there are no definitive guidelines on sample size, therefore previous sample sizes were used as a guide (Braun & Clarke, 2019). The average sample size used in studies utilising an EDQ approach is 15-16 participants, similar to those seen in thematic approaches (Braun & Clarke, 2019; Hunter et al., 2019). Sample sizes in Template Analysis vary from 10 to 79 (Brooks et al., 2015; King & Brooks, 2017).

It was also important to consider the variety within the sample to provide enough breadth and depth of information to address the research questions (Braun & Clarke, 2019). It was decided that a sample of at least 12 would include participants from a sufficient variety of available services such that greater detail around this little known area of neuropsychology and mental health could be obtained. This sample size also fitted within the practical constraints of the project, enabling completion of recruitment, data collection and analyses within the time limit.

Fewer neuropsychologists were included than mental health staff as each neuropsychologist had provided input to multiple cases and so held more information specific to the study aims compared to mental health staff who were likely to have only referred 1 or 2 clients each (Malterud et al., 2016).

Overall, 17 participants were approached, 14 agreed to take part and 12 were interviewed. Four clinical neuropsychologists were approached and three were interviewed whereas 10 members of mental health staff were approached and nine were interviewed. Two participants were unable to attend their interviews, one due to illness and one due to changing roles. Demographic data for participants has been presented in an aggregate form to prevent any one individual from being identified.

Mental health staff were recruited from drug and alcohol, homelessness, and community mental health services. The sample consisted of two psychiatrists, two occupational therapists, one social worker, three clinical psychologists and one family intervention worker. Neuropsychology participants were three qualified clinical psychologists who had completed their post-doctoral diploma, or equivalent, in clinical neuropsychology. In the overall sample, three participants identified as male and nine identified as female. The frequency of referrals to neuropsychology amongst the mental health staff participants varied between an average of once a week to a few people within a few years.

Purposive sampling, often seen within an exploratory descriptive design, was used to address the aim of examining experiences of staff working in mental health and neuropsychology services who had worked with the same clients (Campbell et al., 2020; Hunter et al., 2019).

Neuropsychologist participants were recruited first, according to the criteria outlined in Table 1 below. Participants were emailed information about the study and then participated in an online discussion to obtain consent.

Subsequently, these clinical neuropsychologists identified potential mental health staff participants from examining their recent caseloads and identifying clients to discuss in the interviews, according to the criteria outlined in Table 2. The member of mental health staff who had worked with each client was then identified as a potential participant if they met the inclusion criteria outlined in Table 3.

**Table 1**

*Inclusion/Exclusion Criteria for Neuropsychologist Participants*

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| Worked for 2 years post-qualification in a clinical neuropsychology service | No longer a practicing psychologists in clinical neuropsychology services |
| Provides assessments within mental health services | Still in training or have not received their post-doctoral diploma or equivalent in clinical neuropsychology |

**Table 2**

*Inclusion/Exclusion Criteria for Identifying Clients to Discuss in Individual Interviews*

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| Case is currently open to the service which referred them for neuropsychological assessment and has received an assessment within the last year. | Case that has received a neuropsychological assessment over a year ago. |
| Case has been closed to the referrer in the past 6 months but has had neuropsychological assessment within the last year. | |

The clinical neuropsychologists made initial contact with mental health staff where consent was obtained to pass contact details on to the researcher, who then met with them to provide further information and obtain consent. There was no financial incentive to take part within the study.

Data were analysed using Template Analysis which involves constructing themes from the data and organising these into a hierarchical structure known as a template, which is then applied to further data. This process is repeated several times and allows for continuous evaluation of the data and construction of detailed themes around areas of interest (Brooks et al., 2015).

**Table 3**

*Inclusion/Exclusion Criteria for Mental Health Staff Participants*

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| Staff who have referred and subsequently received neuropsychology input related to clients they are treating OR | Staff members who have referred to neuropsychology but then have not been involved in feedback from neuropsychological input |
| Staff who have not themselves referred to neuropsychology but have received neuropsychological input for a client where they are the lead professional and/or hold the main responsibility for treatment | Staff who are not the lead professional or are not significantly involved in the client's treatment |

Hunter et al., (2019) describe that Thematic Analysis, as outlined by Braun and Clarke (2006), is best used within an EDQ approach. Whilst Braun and Clarke outline a specific method of analysis, known as reflexive thematic analysis, Thematic Analysis is generally described as a 'family of methods' (Braun & Clarke, 2023, p. 1). This approach seeks to establish and notice patterns within a data set that will help the researcher to understand more about a particular topic (Braun & Clarke, 2022).

Template analysis is a form of thematic analysis and utilises many of the same steps which allows for exploration and description of a phenomenon according to the EDQ design (King & Brooks, 2017).

However, within Template Analysis different versions of a template are developed which constructs codes and themes in varying levels. Therefore, more levels of codes are created around particular aspects of the data, providing more detail in areas that are relevant to the research question (King & Brooks, 2017). This is not typically seen in Braun and Clarke's thematic analysis, where broader themes are more commonly used (Braun & Clarke, 2022).

This hierarchical coding structure and ability to adapt the template around areas of the data that seem most rich, allows for greater exploration of unknown aspects of a phenomenon to be focused on within an EDQ approach. Consequently, a more detailed description of different aspects of a phenomenon can be outlined (King & Brooks, 2017).

## Procedure

### ***Recruitment and Initial Focus Group***

Once neuropsychologists had been recruited, a focus group was held online and findings were used to inform the development of the interview questions.

The researcher used a pre-planned list of questions on expectations around implementing neuropsychological recommendations within mental health services, to conduct the focus group (See Appendix L). These questions were developed through examining previous studies looking at satisfaction with recommendations made in neuropsychology reports and identifying the different areas in which recommendations are made. This was used to develop questions around changes that would be expected to occur in different areas of care.

### *Service User Involvement and Interview Protocol Development*

An online meeting was then held with a service user involvement representative who had experience of psychological assessment and feedback. They reviewed an initial list of interview questions developed from the focus group, and assessed how well these considered feedback and its impact on treatment from a service user perspective. Three new questions were added, relating to how services share information with each other and the different formats in which this information is shared (See Appendices M, N).

### *Further Recruitment and Interviews*

Mental health staff were then recruited and were all provided with the same information sheet outlining the purpose of the study and consequences of participating.

Interviews ranged from 45 to 90 minutes in length and were conducted online. The variation in times was due to staff's availability within their service. The interviews were all audio recorded and transcribed by the researcher.

### *Analysis*

Interview transcripts were analysed using Template Analysis as outlined in King and Brooks (2017). The steps are outlined in Table 4 below. One template was constructed to compare similarities and differences between groups. This is something that has been used in previous studies and allows for drawing out of the nuances within the data (Paz et al., 2020).

**Table 4**

*A Table Outlining the Six Stages of Template Analysis as Set Out in King and Brooks (2017)*

| Step Number | Stage of Analysis |
|---|---|
| 1 | Familiarisation with the data |
| 2 | Preliminary coding |
| 3 | Clustering |
| 4 | Producing an initial template |
| 5 | Applying and developing the template |
| 6 | Final interpretation |

### *Quality Checks*

Several quality appraisal tools for qualitative data were used as reference for evaluating the quality of the process and analysis, considering factors including researcher reflexivity, suitability of approach to the research question, and the quality of data collection (Critical Appraisal Skills Programme, 2022; Lockwood et al., 2015; NICE 2012).

Using multiple templates in Template Analysis allows the researcher to continuously re-assess their themes and track changes throughout the analysis (Brooks et al., 2015).

Additionally, a reflective diary was kept to record the researcher's experiences and consider their impact on the process and results (See Appendix O).

## Researcher Positioning

Throughout my training and career I have come to develop a view that knowledge is useful in terms of its practical applications. Pragmatism attempts to bridge the gap between more positivist and constructionist approaches by considering how knowledge is constructed through human experiences and that it is the consequences of these experiences that then lead to further knowledge development (Kelly & Cordeiro, 2020).

In pragmatism it is less important how the knowledge is acquired, and more important how that knowledge is individually perceived, and how it influences actions and experiences of the people applying it. Furthermore, pragmatism also holds that there could be a shared reality among people coming to that knowledge from different perspectives and experiences. To me this seemed an appropriate lens through which to work with the data in this project in order to consider how staff are experiencing feedback from neuropsychology and how their subsequent actions and consequences affect their future attitude towards neuropsychology (Kaushik & Walsh, 2019).

## Ethical Considerations

The study received ethical approval from Salomons Institute for Applied Psychology, in July 2023. Prior to this, the study received approval from the Health Research Authority in May 2023 (See Appendices P, Q).

It was explained to participants that the clinical neuropsychologist who identified them was also supervising the study, but would only have access to anonymised data. All information was kept anonymous and confidential.

# Results

The aim of this analysis was to examine the expectations that neuropsychologists have of the impact of their feedback in mental health services and to compare this with the changes experienced by mental health staff as a result of receiving this feedback. It was also the aim to consider the perceived factors affecting change following feedback.

The analysis eventually led to the development of a 'final' version of the template. Whilst this is called the 'final' version, in Template Analysis it is not considered that there can ever be a final version of the template, due to the subjective and interpretative nature of analysis (King & Brooks, 2017). All versions of the template are presented in Appendix R.

It is common in Template Analysis to only select the most salient and relevant themes for interpretation in order to address the specific aims of the study (King & Brooks, 2017). Therefore, a simplified version of the template is presented in Figure 1 below. Highlighted sections within the template indicate when themes were identified from just one participant group. A key has been included within Figure 1 to explain this further.

## Themes

Six overarching themes were constructed from the data (See Appendix R). The four themes most relevant to the research aims and questions are presented below, with a brief explanation of each theme and how it relates to the participants' experiences and expectations. Further description of omitted themes can be found in Appendix S.

Participants were given identifiers, "CP" for neuropsychologist participants, and "MH" for mental health staff.

**Figure 1**

*A simplified version of the Thematic Template to show themes around expectations and experiences of change following neuropsychology feedback.*

**Trying to find certainty**

- Neuropsychology feedback increases certainty
    - Making things clear
        - *Providing answers*
        - *Moving away from mental health*
        - *Moving back to mental health*
    - Revealing what's hidden
        - *Uncovering risk*
        - *Uncovering new information*
        - *Getting beneath the surface*
- Neuropsychology brings up uncertainty
    - Being asked to do new things
        - *How to apply information to practice*
        - *Working in a different way*

**The impact on professional relationships**

- Increasing connection
    - Opening up professional communication
    - Bringing services together

**Neuropsychology takes care of people**

- Providing support
    - Reducing concerns
    - Validating professionals' experiences
    - Feedback increases professionals' confidence
- Keeping people safe

**The influence of power on the feedback process**

- Neuropsychology seen as powerful
    - Having the power to change things
        - *Neuropsychology feedback produces change*
- Neuropsychology seen as lacking power
    - A limited presence
        - *Short-term work limits impact*
    - Lacking a sense of influence
        - *Being on the outside of the MDT*
        - *Lack of systemic impact*
        - *Neuropsychology are reliant on the MDT to make things happen*
- Neuropsychology empowers staff

- Being informed
    - *Assessment feedback informs capacity decisions*
    - *Increasing access to knowledge*
- Being prepared
    - *Saving resources for the team*
    - *Removing barriers to support*
    - *Streamlining care*
- Being allowed
    - *Satisfactory recommendations*
    - *Increasing self-efficacy*
    - *Giving permission for making restrictions*

KEY:

Green = Only mentioned by Mental Health Staff

Yellow = Only mentioned by Neuropsychologists

No Colour = Mentioned by both

### *Trying to Find Certainty*

One of the central themes that came out of this study was around how neuropsychology feedback influences staff's sense of certainty amongst a confusing clinical picture.

**Neuropsychology Feedback Increases Certainty.** Mental health staff described that neuropsychology feedback helped to make things clearer to them through providing answers about clients' presentations:

> *"they were able to describe those presentations in the context of a brain injury, so that kind of gave a bit of clarity to the situation for everyone as well, rather than people battling against each other in a way" MH06*

This was similar to the expectations of neuropsychologists who expressed a hope that their input would result in more clarity around clients' formulations.

Neuropsychologists described that they expected their input would help provide some clarity around whether a client required more cognitive or mental health related treatment:

> *"I hope that it would just make people pause and think 'could there be something going on, (...) that isn't purely psychological'" CP01*

Mental health staff also reported that feedback resulted in a reformulation of their client's difficulties which led to a different way of working. Sometimes this was a more cognitive-based intervention, and at others a more psychologically focused intervention:

> *"there was a question around her diagnosis, because all along we've been thinking that she had a psychotic depression, so could it be that it wasn't really psychotic depression that it was more something else to do with cognition and stuff, but yeah we began to query that" MH08*

> *"I think that it was more about her state of mind and emotional state rather than it being about a, kind of, an injury or a neurological problem that's fixed and static" MH07*

There was also a view that neuropsychology was able to get beneath the surface level presentation of the client and uncover further information around their difficulties. There was an expectation from neuropsychologists that this would highlight difficulties for clients who presented as cognitively able at a surface level, and so would influence the type of support they received:

> *"I think particularly when someone's cognitive presentation might suggest that their surface verbal skills are quite strong, but they struggle with things like, you know, complex reasoning or they struggle with understanding like they can repeat stuff back to you and they can remember stuff, but actually when you dig deeper they're not really understanding the depth of the concepts, then I would hope that would influence capacity" CP02*

This was also commented on by mental health staff who described how neuropsychology feedback brought up questions for them, that had not previously been considered, regarding clients' abilities to make decisions and process information:

> *"they can now clearly say that there is impairment and that this person has good verbal skills, which makes him sound quite plausible, but actually there's all these other things going on underneath" MH06*

There was an expectation from neuropsychologists that their input would highlight how vulnerable clients are and the potential risks that are present:

> *"at that point my hope was more about saying 'this is somebody who's more vulnerable than we think he is', or confirming, I think everybody thought that, but confirming 'yeah he's got lot of vulnerabilities," CP02*

This was something that mental health staff also commented on:

> *"we've still got the report to draw on in terms of this chap has cognitive difficulties, he masks a lot of the information, his responses are either impulsive or inconsistent and therefore that helps us assess risk" MH01*

Mental health staff also remarked on how sometimes the process of assessment uncovered new information that added something to their formulation of the client and allowed staff to provide further explanation of their client's presentation:

> *"so it [neuropsychology feedback] gave me additional clinical information to put forward those, not arguments, but that side of the discussion so it helped to get language to explain what we were seeing" MH01*

**Neuropsychology Brings up Uncertainty.** One theme that came up frequently as an issue in implementing change following neuropsychology feedback was a sense of not knowing what to do with the feedback in practice.

Mental health staff reported feeling like there was a lack of support in transferring the clinical information from a neuropsychology report into practical tasks that could be carried out by the team:

> *"I suppose, the one thing I'd say we need to get better at is, what does it [neuropsychology assessment] mean functionally, and what should the team be doing about it, so how should we be responding differently," MH10*

The neuropsychologist participants acknowledged this in their comments, and had limited expectations around what staff would be able to achieve with this information:

> *"I think we'd be keen to move away from just doing assessments on people to spending more time formulating with the teams around, like how do you manage these difficulties because often the assessment, sort of, standing alone is not particularly helpful it needs to be, like the assessment needs to be interpreted and, kind of, formulated in order for it to be meaningful" CP01*

Both mental health staff and neuropsychologists identified that recommendations could require staff to work outside of their usual clinical role, which was another identified barrier to successfully implementing changes following feedback. Neuropsychologists expected that this would create some stress for mental health staff, which was also commented upon within the mental health staff group.

> *"we were risk assessing, we were doing a whole bunch of things that, like I said, wasn't the intervention that she was there for, we found ourselves doing that because if we didn't there was nobody else to do it" MH08*

### *The Impact on Professional Relationships*

Another theme consistently seen within participants' accounts was around the impact that neuropsychology feedback had, or was expected to have, on relationships with other professionals.

Both neuropsychologists and mental health professionals identified that neuropsychology feedback was intended to and experienced as increasing communication between professionals as well as bringing together different services to support the client.

**Increasing Connection.** Mental health staff reported that neuropsychology feedback enabled them to have discussions with other services around the client and their treatment:

> *"that was much easier then to have those discussions with social services" MH10*

Neuropsychologists expressed an expectation around this but were unsure as to whether this happens in practice:

> *"I guess my hope was that the mental health team, whether that's psychology or the wider team, then maintained the relationship with the (clinician) to say 'well what's the treatment plan and how does this relate to her [client] mental health treatment', I think I recommended they have a professionals meeting, if I'm honest I'm not sure if that ever did happen" CP03*

Neuropsychologists expressed a hope that they would provide information on services that mental health staff had not been aware of before and that this would lead to different services becoming involved with the client's care:

> *"I'd expect them to know about the their own in-house OT, but I wouldn't have expected them to know, well I hope that they were then enlightened, about the presence of community based OT's who are more rehab oriented" CP03*

Mental health staff commented on how it was not always possible to link up with other services, due to limits in information sharing or issues with time waiting for a response. However, they reported that the neuropsychology feedback did change their view on reaching out to different services:

> *"I did request that [previous notes], but we've had nothing, and I think that's just where things fall down sometimes, because we all share different systems (...) you can't share that information so you don't get that full picture of the person but, I suppose, I wouldn't have thought to go back and request any information or have that discussion, but that was useful to discuss with the (name) team what difficulties he was having at that time" MH05*

### *Neuropsychology Takes Care of People*

Both mental health staff and neuropsychologists referred to neuropsychology providing support and validation in a number of ways, especially through providing emotional support to professionals and through ensuring clients are kept safe.

**Providing Support.** Both neuropsychologists and mental health staff spoke about expecting or experiencing validation within the feedback process. Mental health staff described how feedback validated some of their concerns and difficult experiences of working with a client:

> *"I think from (neuropsychologist)'s assessment and feedback it was quite validating because she acknowledged some of the difficulties in working with this lady and, through the assessment, my understanding about her presentation and reasons for why I've struggled to engage her, my understanding around that increased" MH03*

This was also something that neuropsychologists hoped their feedback would provide to staff:

> *"I did get that sense when the referral came in 'we just can't make sense of this lady, there's something there' like they're a very attuned team but it was 'there's something else going on here and we can't put our finger on it', so I think I hoped that there would be some like an aha moment like 'yes there was something else', a validation of their confusion and concern that they were missing something" CP03*

Another aspect of feedback that was mentioned by both groups was around how feedback increased staff's confidence in their own formulation and decision-making. This was remarked upon consistently by mental health staff:

> *"that [neuropsychology feedback] provides a bit more evidence, it's helpful, it gives you a bit of confidence that you were on the right lines, to an extent or your arguments are somewhat justified" MH01*

> *"with the mental health team, we felt that we were more on the right track with what we were trying to do" MH09*

Only mental health staff referred specifically to neuropsychology feedback helping to reduce some of the concerns they had about their clients and how risky they were. This had an impact on the levels of stress experienced by staff, especially in situations where there were high levels of risk:

> *"I suppose so on an emotional level, for me, it alleviated a lot of stress and it made me feel a lot more confident in the person's delivery of care moving forwards, especially knowing that they're on board, so yeah it actually made me, although it feels like a, kind of, horrible situation, it made me feel quite happy (laughs) that something was happening to prevent this vulnerable person's death" MH06*

**Keeping people safe.** Neuropsychologists reported that they hoped any risk information that came out of their feedback would help increase support. Mental health staff reported on how the feedback and reports helped them to argue for more support for their clients:

> *"what it did do is avoid discharge or a risky discharge into the community" MH01*

### *The Influence of Power on the Feedback Process*

One of the most detailed themes constructed within the template was around the distribution and influence of power on implementing changes following neuropsychology feedback. Throughout participants' accounts, staff in both groups commented on several factors that either contributed to or took away power and so affected their ability to action feedback from neuropsychology.

**Neuropsychology Seen as Powerful.** Mental health staff perceived neuropsychology as having the power to produce change for them and their clients. They spoke about how having the information of clients' difficulties, and the backing of a neuropsychology assessment report, then led to things being able to change and other services providing support:

> *"when the units are then making a decision over whether they could take somebody, the neuropsychological report's quite important, so it, like a full neuropsychological report kind of supports all that decision-making because it's quite weighty evidence that somebody has these specific needs" MH04*

**Neuropsychology Seen as Lacking Power.** In contrast, the neuropsychologist participants frequently commented on feeling as if they had little influence over implementing change and that they often felt reliant on the team to action changes or communicate with services, which was not commented on by mental health staff:

> *"so I'm reliant, particularly on our consultants, to feed that back maybe through the ward rounds where they do have some contact, or through our social work colleagues, so sometimes our social work colleagues, we have a social worker, social worker assistant, on the unit and they're often a bit more involved so we're sort of dependent on them" CP02*

One of the factors the neuropsychologists attributed to this was the short-term nature of neuropsychology work, which usually consists of assessment and feedback with no opportunity for long-term follow-up with a team:

> *"not being there as more of a constant presence I think limits the impact" CP03*

Mental health staff also acknowledged the short-term nature of neuropsychology input and the limits this can have in implementing changes:

> *"it's really that planning for the future that's the difficult thing (...) we've got a tiny resource here and it's really more about testing, the assessment, the analysis, that's really all they've [neuropsychologist] got the time to do" MH10*

Another area in which participants from both groups viewed neuropsychology as being limited was in having a more systemic impact. Neuropsychologists hoped that their feedback would have an effect on the wider system around the client and also the team's wider thinking around cognitive difficulties and their presentation. However, neuropsychologists also reported that they did not expect this to happen in reality:

> *"whether they [mental health staff] can then generalise that [neuropsychology feedback] to other clients or feel like they can talk around the topic beyond the stuff they've heard me say, I'm not sure" CP02*

Mental health staff described that whilst they felt neuropsychology had an impact on their individual knowledge and experience around certain cases, this did not generalise to wider systemic thinking about neuropsychological deficits in mental health populations.

Mental health staff also spoke about how they felt neuropsychology should be involved in decisions at different organisational levels, not just at an individual client level but at a leadership level, in order to inform broader care decisions for services who see clients requiring neuropsychological support:

> *"I think just engaging in these kinds of discussions and being involved in management decisions and thinking about pathways and assessments and undertaking research like this I think as well is really important" MH04*

There was a sense of neuropsychology not being embedded within the teams they are providing support to and that this then limits the extent to which they can have an impact through ongoing discussion and action within the team:

> *"you aren't on the ground yourself to say 'have you done this' or 'shall we do that' or 'how about this professionals meeting', because you're often in some other site, in some other team, doing some other urgent thing" CP03*

**Neuropsychology Empowers Staff.** Participants spoke about the ways in which neuropsychology empowers them to support their clients. Both neuropsychologists and mental health staff identified that feedback helped, or was expected to help, inform them of knowledge and different perspectives that would enable them to identify appropriate treatment.

Participants from both groups also described how they expected and experienced feedback as preparing them for working with clients through removing barriers to care and saving resources. They also commented on how feedback made treatment more streamlined through supporting staff to use the skills they already have to help clients:

> *"I expected there to be a lot more adaptations needed in order to work with her [client] and I thought it might limit what we were able to do" MH07*

Neuropsychologists similarly expected that their input would allow for clients to access support they would not have been able to before:

> *"armed with that knowledge that actually that we were working with somebody who, even if he's not using any substances, has significant cognitive problems which I predicted would lead to him having quite high support needs, that that would open doors to maybe him being offered (...) it would be decided that he could have a twenty four hour supported placement" CP02*

Only participants from the mental health group described how neuropsychology feedback allowed them to justify placing more restrictions on clients and their care in order to keep them safe. Staff described how neuropsychology feedback could be used to inform capacity assessments and further decisions around treatment:

> *"it meant that the individual was then placed on a DoLS, so I would say that that was, had a direct impact on the capacity assessment that led to that" MH06*

Neuropsychologists brought up expectations around increasing self-efficacy for staff and helping them to use the skills they have to feel like they can manage treatment independently:

> *"it allows people to feel confident that they can use what they know, which is the mental health stuff and it still applies, and that we don't have to be specialist in this brain injury thing or neurological illness thing, in order to do what works for the person" CP02*

This was also mentioned by mental health staff who felt that neuropsychology feedback had made them more hopeful that they could produce some change and that their clients could be taught the skills to manage their difficulties:

> *"I just think it felt more hopeful, that I was likely to be able to affect a change with her [client]" MH07*

## Discussion

### Key Findings

It was found that the expectations of neuropsychologists and the experiences of mental health staff following neuropsychology feedback were similar. Both groups described how neuropsychology was able to provide certainty amongst confusion and allowed for greater communication and coordination between different professionals. Whilst previous studies have focused on how well neuropsychology can provide answers to specific referral questions, these findings provide more detail around why that is important such as through uncovering unknown information and clarifying differences between cognitive and psychological difficulties (Mahoney et al., 2017; Tremont et al., 2002).

The influence of power in providing and implementing feedback was the most detailed theme in this study. Participants from both groups identified that neuropsychology feedback has the power to produce change through increasing access to knowledge as well as providing a further rationale for decision-making.

However, it seemed that neuropsychologists perceived themselves as having limited influence over the team and the decisions they made, whereas staff in mental health services viewed neuropsychology as the source of change, having the power and expertise to make things happen. Mental health staff expressed that neuropsychology feedback gave them confidence and permission to make decisions that they wouldn’t have been able to make previously such as in determining a client’s capacity.

These differences in the perception of power and who holds it is important to consider as, according to the ELM model, persuasion can be influenced by both relevance of the message as well as expertise of the source (Morris et al., 2005).

Staff are potentially more likely to be persuaded if they perceive neuropsychology as holding more power and expertise. However, if staff perceive themselves as lacking the influence to enforce changes, then this might reduce the perceived relevance of the information provided and so be less likely to persuade them to act on it (Cook et al., 2004). This is particularly relevant to mental health, as studies have demonstrated how members of staff who hold different positions perceive themselves to have more or less power to induce change (Laker et al., 2014).

Another difference between participants' accounts was the description from mental health staff of neuropsychology feedback having an emotional impact on them through alleviating stress and reducing concerns, which was not mentioned by the neuropsychologists.

The ELM acknowledges that emotion plays a significant role in persuasion and attitude change, with more positive emotions being associated with higher levels of persuasion (Manca et al., 2020; Petty et al., 1993). The fact that neuropsychology was commonly perceived as having a positive emotional impact suggests that this could encourage staff to continue processing and implementing feedback.

One factor that was identified to affect change following neuropsychology feedback was how embedded neuropsychologists perceived or were perceived to be within teams. Neuropsychologists felt limited in their role and did not expect to be part of the system around the client. This was also acknowledged by mental health staff. Again, this builds on previous studies that have looked at referral processes but have not examined the more personal experiences of staff who refer to and work with neuropsychology (Ostojic-Aitkens et al., 2022).

Within the ELM model of persuasion, perceptions of the source of information can have a significant impact on levels of attitude and behaviour change, particularly in situations where the level of elaboration is limited (Cook et al., 2004). It is possible that neuropsychologists becoming more embedded and familiar within a team is then more likely to lead to change following feedback.

Neuropsychologists and mental health staff perceived a lack of systemic impact as being a barrier to increasing awareness of referring to neuropsychology as well as general knowledge around the role of cognition in mental health. This is an important consideration, as clients are often engaged with teams and a more systemic approach may facilitate further involvement with neuropsychology interventions (Brown et al., 2000; Johnson-Greene, 2018).

Having more systemic influence could help to “persuade” staff to seek out neuropsychology support and to consider adaptations they can make for their clients. Raising awareness of neuropsychology could increase its perceived relevance to client care, helping to persuade people to communicate and action feedback (Morris et al., 2005).

Accounts consistently identified how a lack of resources limited the length and breadth of work that neuropsychology could complete which also contributes to difficulties in applying feedback to clinical practice. Lack of resources is well-identified in the literature and this study provides further examination of how this impacts staff and neuropsychologists when trying to provide and action feedback (Allahham et al., 2023; Elias et al., 2021).

A lack of ongoing support was linked to difficulties in acting on recommendations even when they were perceived as reasonable, potentially due to staff feeling they are working outside of their expertise and not having long-term support from neuropsychology.

The results of this study identified a mixture of resource and attitude related barriers to change, similar to previous research (Delagneau et al., 2019). This study also highlights different findings around the emotional impact of neuropsychology feedback on staff and the importance of taking a more systemic approach to neuropsychology in order to facilitate ongoing feedback and changes.

## Strengths and Limitations

This study took a novel approach to examining neuropsychology in mental health services by obtaining detailed accounts from both neuropsychologists and mental health staff on the role of neuropsychology feedback on client care. This provided an in-depth insight into the personal experiences of those working with clients receiving support from neuropsychology and mental health. This has highlighted other avenues of enquiry to further develop research and service development.

The study's exploratory-descriptive design allowed several potentially unknown areas of participant experiences to be explored, in this case changes following a neuropsychological assessment (Willis et al., 2016). However, the protocols for monitoring researcher bias within this approach are not as rigid as those within other methods like phenomenology (Neubauer et al., 2019). This potentially increased the influence of researcher bias on the results.

The researcher's epistemological position potentially emphasised the short-term practical applications of neuropsychology feedback within mental healthcare (Hampson & McKinley, 2023). This was perhaps to the detriment of long-term effects that could influence neuropsychology feedback such as cultural values in healthcare and the meaning staff place on what neuropsychology is and how it can help.

However, the recording of multiple templates enabled data to be continuously checked. This allowed for recording of the researcher's thinking as well as greater flexibility in considering the commonalities and differences amongst the data by constantly having to revisit and revise the template (Brooks et al., 2015).

Despite this, qualitative approaches are still subjective and rely heavily on researcher judgement. One researcher was involved in data collection and analysis which does question the quality and validity of the data and findings. However, steps have been taken throughout the study to ensure high quality data and rigorous analysis have taken place (Levitt et al., 2017).

Multiple services were involved in the study, involving clients from a variety of backgrounds, enabling greater richness in the data, a more rigorous analysis and greater generalisability of the findings. This did also bring up difficulties in comparing the experiences of participant groups as the variety of services could account for some of the differences observed, especially between short-stay inpatient services and long-term community services.

The involvement of neuropsychologists and an expert by experience within the development of interview questions helped to ensure that the focus of the study remained relevant to the topic area and was not too heavily influenced by the researcher's personal biases and experiences.

However, the inclusion of the same three neuropsychologists within the focus group and the individual interviews does limit the variety of experiences within the study and led to the interview questions being developed from the views of a small number of people.

This questions how well the findings of this study apply across different services, as the views of mental health staff might differ when working with different neuropsychologists. Additionally, involving more neuropsychologists could have led to additional data being uncovered around different ways of working and providing neuropsychology feedback in mental health services.

Having the neuropsychologist participants involved in identifying mental health staff to participate in the study could have led to an overly complimentary view of neuropsychology. Participants were possibly recruited due to their willingness to participate, which might have been influenced by how positively they regarded neuropsychology.

## Practice Implications

Results highlighted the limited systemic impact of neuropsychology in mental health services, therefore, it could be useful to consider having more embedded neuropsychology input within teams. This could be through increasing the presence of neuropsychology by ensuring representation at different levels of organisational work, which has been found to have positive effects for teams (Kubu et al., 2016).

This could help in establishing more training and raised awareness of neuropsychological issues to support mental health staff in considering cognitive deficits in their work (Delagneau et al., 2019). Training could potentially form part of routine induction or educational practices for mental health staff (Savage, 2009). Issues of power presented within the findings also suggest the need to consider ways to empower staff to act on feedback through more practical empowerment or knowledge.

Being able to apply information to practice is important and if neuropsychologists become more embedded this may allow for longer term work and support (Glen et al., 2019). It may also be helpful, when giving feedback, to identify practical steps that need to be taken for staff to support clients. This may require the support of management in order to implement recommendations, especially if this falls outside of the staff member’s usual role. Therefore, another implication is the involvement of management staff early on in the assessment process in order to support implementing feedback and to consider what is possible.

### Future Research

Future research should consider the client's experience of receiving neuropsychology feedback and how this affected them. This could then be compared with how staff perceived feedback to affect the client and whether there are any differences here.

Research should also examine different roles within mental health services in more detail and consider the different experiences of professionals at all levels of the organisation in referring to and receiving feedback from neuropsychology. This could include considering how managers and people with higher levels of power consider neuropsychology and its impact on mental health care and see if this matches with expectations and other staff's experiences.

It could also be helpful to further examine whether neuropsychology is perceived to lack a systemic impact in other teams and trusts through comparing teams with differing levels of neuropsychology presence within the MDT to see if these issues still arise and the reasons for this. This might identify whether systemic issues are more resource based or if other factors impact on this such as communication.

The emotional impact of receiving feedback provides an important insight into how staff are personally affected by neuropsychology feedback which may have longer-term implications for overall staff wellbeing and ultimately client wellbeing (Mistry et al., 2015). Therefore, future studies should explore these emotional reactions further to establish if and how they impact on client care following neuropsychology feedback.

## Conclusion

The findings of this study highlight similarities and differences in expectations and experiences around perceptions of neuropsychology as part of the MDT as well as how empowered staff feel to act on feedback. Barriers to change following neuropsychology feedback were also identified including resourcing, adapting information to practice, and neuropsychology being embedded within teams.

Implications for practice and future research include considering how neuropsychology can be embedded within the wider mental health system and so provide more long-term input and enhance support in implementing changes for clients.

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# Appendices

## Appendix A

Data Extraction Form

| | |
|---|---|
| **Study Title (Authors)** | |
| **Study Aims** | |
| **Research Questions** | |
| **Participants** | Role –<br>Service –<br>Client group – |
| **Guidelines used** | |
| **Methods of data collection** | |
| **Methods of data analysis** | |
| **Results** | |

# Appendix B

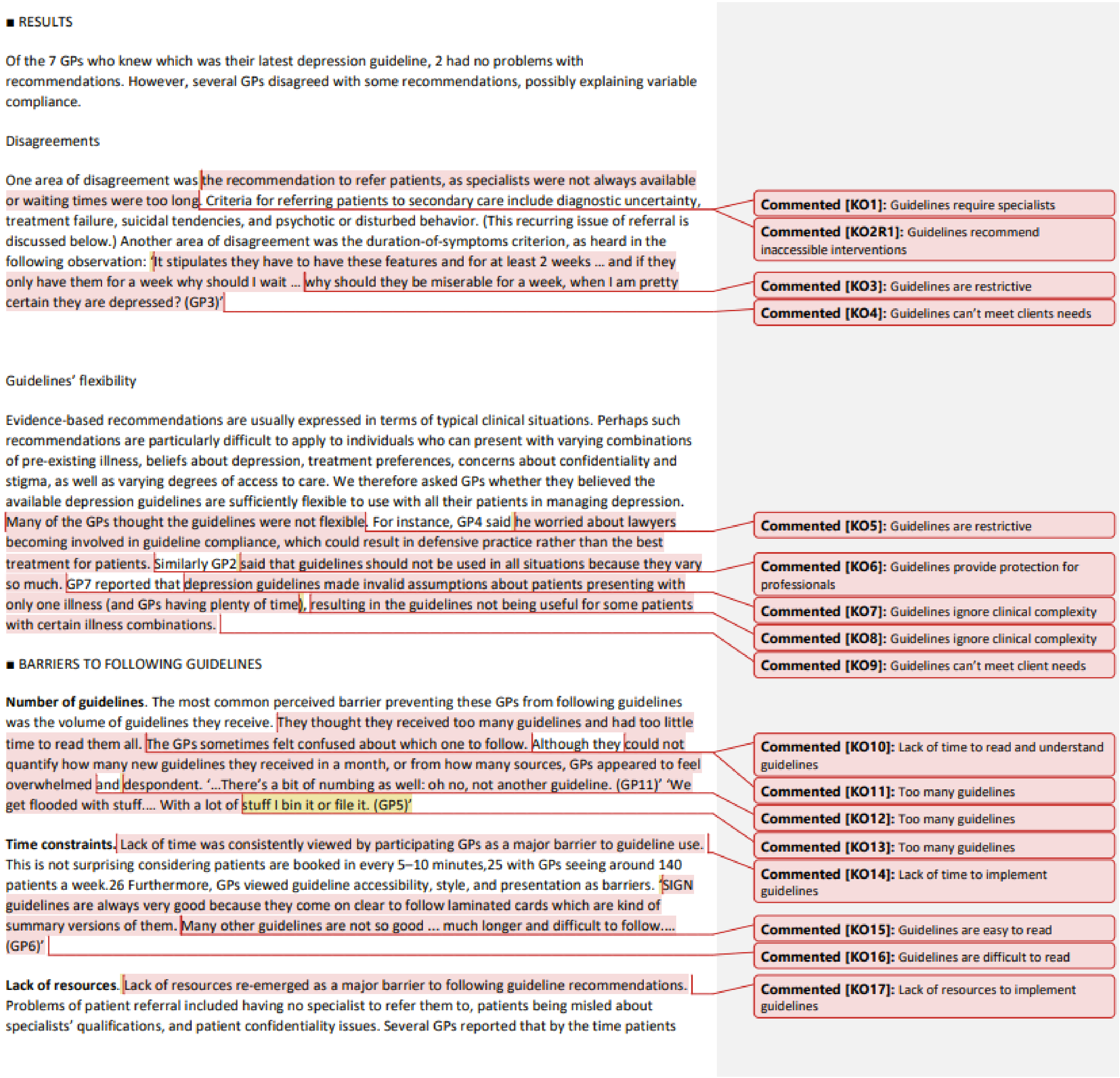
Critical Appraisal Skills Programme (CASP) Checklist for Qualitative Research - Quality Ratings

| | Was there a clear statement of the aims of the research? | Is a qualitative methodology appropriate? | Was the research design appropriate to address the aims of the research? | Was the recruitment strategy appropriate to the aims of the research? | Was the data collected in a way that addressed the research issue? | Has the relationship between researcher and participant been adequately considered? | Have ethical issues been taken into consideration? | Was the data analysis sufficiently rigorous? | Is there a clear statement of findings? | How valuable is the research? |
|---|---|---|---|---|---|---|---|---|---|---|
| Cleary et al., (2002) | Yes | Yes | Yes | Yes | Yes | No | No | No | No | Medium |
| Court et al., (2017) | Yes | Yes | Yes | Yes | Yes | Yes | Can’t tell | Yes | Yes | High |
| Eke et al., (2019) | No | Yes | Yes | Yes | Yes | No | Can’t tell | Can’t tell | Yes | Low |
| Espeland et al., (2021) | Yes | Yes | Can’t tell | Yes | Yes | No | Can’t tell | Can’t tell | Can’t tell | Medium |
| Forsner et al., (2010) | Yes | Yes | Yes | Can’t tell | Yes | No | Can’t tell | Yes | No | Medium |
| Gatej et al., (2020) | Yes | Yes | Can’t tell | Yes | Yes | No | No | Yes | Yes | High |
| Gyani et al., (2012) | Yes | Yes | Yes | Can’t tell | Yes | No | No | Can’t tell | Can’t tell | Medium |
| Haw et al., (2011) | No | Yes | Can’t tell | Can’t tell | Can’t tell | No | No | No | Can’t tell | Low |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Lugtenberg et al., (2016) | Yes | Yes | Yes | Can’t tell | Yes | No | No | Yes | Yes | High |
| McCauley & Casson (2013) | Yes | Yes | Can’t tell | Yes | Yes | Yes | Yes | Can’t tell | Can’t tell | High |
| Prytys et al., (2011) | Yes | Yes | Can’t tell | Yes | Yes | Can’t tell | Yes | Yes | Yes | High |
| Rhodes et al., (2010) | Yes | Yes | Yes | Can’t tell | Yes | No | No | Can’t tell | Yes | Medium |
| Sanchez et al., (2010) | Yes | Yes | Yes | Yes | Yes | Can’t tell | Can’t tell | Yes | Yes | High |
| Sandstrom et al., (2014) | Yes | Yes | Can’t tell | Yes | Can’t tell | No | Can’t tell | Yes | Yes | Medium |
| Smith et al., (2004) | Yes | Yes | Can’t tell | Yes | Yes | No | No | Can’t tell | Yes | Medium |
| Westerlund et al., (2020) | Yes | Yes | Yes | Yes | Yes | No | Can’t tell | Can’t tell | Yes | High |

# Appendix C

## Example of Coded Results Section



■ RESULTS

Of the 7 GPs who knew which was their latest depression guideline, 2 had no problems with recommendations. However, several GPs disagreed with some recommendations, possibly explaining variable compliance.

Disagreements

One area of disagreement was the recommendation to refer patients, as specialists were not always available or waiting times were too long. Criteria for referring patients to secondary care include diagnostic uncertainty, treatment failure, suicidal tendencies, and psychotic or disturbed behavior. (This recurring issue of referral is discussed below.) Another area of disagreement was the duration-of-symptoms criterion, as heard in the following observation: 'It stipulates they have to have these features and for at least 2 weeks … and if they only have them for a week why should I wait … why should they be miserable for a week, when I am pretty certain they are depressed? (GP3)'

Guidelines' flexibility

Evidence-based recommendations are usually expressed in terms of typical clinical situations. Perhaps such recommendations are particularly difficult to apply to individuals who can present with varying combinations of pre-existing illness, beliefs about depression, treatment preferences, concerns about confidentiality and stigma, as well as varying degrees of access to care. We therefore asked GPs whether they believed the available depression guidelines are sufficiently flexible to use with all their patients in managing depression. Many of the GPs thought the guidelines were not flexible. For instance, GP4 said he worried about lawyers becoming involved in guideline compliance, which could result in defensive practice rather than the best treatment for patients. Similarly GP2 said that guidelines should not be used in all situations because they vary so much. GP7 reported that depression guidelines made invalid assumptions about patients presenting with only one illness (and GPs having plenty of time), resulting in the guidelines not being useful for some patients with certain illness combinations.

■ BARRIERS TO FOLLOWING GUIDELINES

**Number of guidelines**. The most common perceived barrier preventing these GPs from following guidelines was the volume of guidelines they receive. They thought they received too many guidelines and had too little time to read them all. The GPs sometimes felt confused about which one to follow. Although they could not quantify how many new guidelines they received in a month, or from how many sources, GPs appeared to feel overwhelmed and despondent. '…There's a bit of numbing as well: oh no, not another guideline. (GP11)' 'We get flooded with stuff…. With a lot of stuff I bin it or file it. (GP5)'

**Time constraints**. Lack of time was consistently viewed by participating GPs as a major barrier to guideline use. This is not surprising considering patients are booked in every 5–10 minutes,25 with GPs seeing around 140 patients a week.26 Furthermore, GPs viewed guideline accessibility, style, and presentation as barriers. 'SIGN guidelines are always very good because they come on clear to follow laminated cards which are kind of summary versions of them. Many other guidelines are not so good … much longer and difficult to follow…. (GP6)'

**Lack of resources**. Lack of resources re-emerged as a major barrier to following guideline recommendations. Problems of patient referral included having no specialist to refer them to, patients being misled about specialists' qualifications, and patient confidentiality issues. Several GPs reported that by the time patients

**Commented [KO1]:** Guidelines require specialists

**Commented [KO2R1]:** Guidelines recommend inaccessible interventions

**Commented [KO3]:** Guidelines are restrictive

**Commented [KO4]:** Guidelines can't meet clients needs

**Commented [KO5]:** Guidelines are restrictive

**Commented [KO6]:** Guidelines provide protection for professionals

**Commented [KO7]:** Guidelines ignore clinical complexity

**Commented [KO8]:** Guidelines ignore clinical complexity

**Commented [KO9]:** Guidelines can't meet client needs

**Commented [KO10]:** Lack of time to read and understand guidelines

**Commented [KO11]:** Too many guidelines

**Commented [KO12]:** Too many guidelines

**Commented [KO13]:** Too many guidelines

**Commented [KO14]:** Lack of time to implement guidelines

**Commented [KO15]:** Guidelines are easy to read

**Commented [KO16]:** Guidelines are difficult to read

**Commented [KO17]:** Lack of resources to implement guidelines received appointments, they reported their problems had disappeared and they no longer wanted appointments. '…a guideline might come through and I've followed the protocol … and arranged a referral … then the reply has come back from the hospital that they don't have the resources for this at the moment. So it [the guideline] has fallen flat on its face and that is extremely disappointing when we in primary care are trying our best. (GP2)' Waiting times reported were between 2 to 26 weeks for psychiatrists or community psychiatric nurses and 9 to 12 months for psychologists. Perceived delays or deficiencies in specialist services may partially explain GPs' tendency to over prescribe relative to recommendations.

**Commented [KO18]:** Lack of resources to implement guidelines

Increasing guideline use

For guideline use to increase, GPs in this study thought that more resources needed to be put in place (particularly mental health professionals); the number of guidelines issued should be reduced; and guidelines should be produced and sent from a central body with a multidisciplinary team including some GPs, to reduce problems of perceived unrealistic assumptions. Incorporation of guideline recommendations onto computer systems with prompts and flow charts was also suggested by several GPs as method to promote guideline use. The majority of interviewed GPs also said they would like some form of audit and feedback. 'We really need some kind of measure.… We're all meant to audit our work, but again its time and we audit what we have to. If someone could demonstrate that I'm not managing depression well, then I might sit up and think I need that guideline there. We need all the feedback we can get really. (GP9)'

**Commented [KO19]:** Lack of resources to implement guidelines

**Commented [KO20]:** Too many guidelines

**Commented [KO21]:** Guidelines authors lack realistic understanding of clinical practice

**Commented [KO22]:** Guideline implementation needs to be measured

**Commented [KO23]:** Guidelines implementation needs to be measured

# Appendix D

Table of Themes, Sub-themes and Codes

| Theme | Sub-theme | Codes |
|---|---|---|
| Working with confusion | Confusion over roles and responsibilities | Guidelines should be supported by management or leadership |
| | | Unclear who is responsible for implementing guidelines |
| | | Guidelines should be adapted for local services |
| | | Lack of perceived efficacy over guidelines implementation |
| | | Guidelines implementation needs to measured |
| | Changing flexibility of guidelines | Guidelines are not rules |
| | | Guidelines can be used to suit clinician needs |
| | | Guidelines can be used flexibly |
| Lack of trust | Credibility of guideline authors | Guidelines are financially motivated |
| | | Guidelines authors lack a realistic understanding of clinical practice |
| | | Authors lack credibility |
| | | Lack of transparency on who has created guidelines |
| | | Guidelines are not valued |
| | Questionable evidence | Guidelines are based on unreliable evidence |

| | | |
|---|---|---|
| | | Guidelines are based on quantitative research |
| A tool to improve care | Supporting clinical decision making | Guidelines provide protection for professionals |
| | | Guidelines provide consistency |
| | | Guidelines aid clinical decision making |
| | | Useful for education and information |
| | | Guidelines are helpful |
| | Availability of treatment | Guidelines are powerful |
| | | Guidelines promote interventions |
| | | Guidelines improve access to treatment |
| | Working in teams | Guidelines can hinder collaboration |
| | | Guidelines can foster collaboration |
| | | Guidelines improve the working environment |
| | Improving quality | Guidelines help evaluate clinical practice |
| | | Guidelines promote evidence-based practice |
| | | Guidelines help improve quality of care |
| | | Guidelines provide a benchmark for best practice |
| | | Adapting guidelines could reduce effectiveness of interventions |

| | | |
|---|---|---|
| Guidelines are a threat | Caring for service users | Guidelines can harm service users |
| | | Following guidelines threatens the therapeutic relationship |
| | | Guidelines can’t meet client needs |
| | Clinical judgement vs. guidelines | Guidelines are a threat to professional identity |
| | | Professional background affects attitude towards guidelines |
| | | Clinical judgement is more important than guidelines |
| | | Guidelines challenge established practice |
| | | Guidelines invalidate clinical experience |
| Losing sight of the big picture | Needs are complex | Guidelines prevent individualised treatment |
| | | Guidelines ignore clinical complexity |
| | Guidelines restrict clinical practice | Guidelines impede the use of alternative interventions |
| | | Guidelines are restrictive |
| | | Guidelines are over medical |
| | | Guidelines are not optional |
| Demands and Resources | Insufficient resources | Guidelines recommend inaccessible interventions |
| | | Lack of funding to implement guidelines |

| | | |
|---|---|---|
| | | Lack of time to implement guidelines |
| | | Guidelines require specialists |
| | | Lack of resources to implement guidelines |
| | | Lack of training on using guidelines |
| | | Lack of time to read and understand guidelines |
| | Accessing guideline documents | Guidelines are difficult to access |
| | | Guidelines are difficult to read |
| | | Too many guidelines |
| | | Guidelines are vague |
| | | Guidelines are easy to read |

# Appendix E

Examples of Themes and Quotes for Thematic Synthesis

## Theme: Working with confusion

### Sub-theme: Confusion over roles and responsibilities

**Supporting Quotes:**

*One factor reported to be successful was an active leadership with senior administration supporting clinical guidelines. This served to increase awareness and willingness to change clinical practice Support from the local leader and at department level was deemed important. (Forsner et al., 2010)*

*Although acknowledging their responsibility to remain updated on research, the expectation still remained that someone higher up in the organization bore primary responsibility: However, the manager needs to be updated. It is for her to know about this and that. If she doesn't know, it's out in the ether somewhere (Sandstrom et al., 2014)*

*Child clinicians also believed that the NICE guidelines would be better known and implemented if local protocols were in place (Eke et al., 2019)*

*commonly perceived attitude-related barrier was lack of self-efficacy, i.e. not feeling capable of performing certain guideline recommendations due to a perceived lack of training or experience. OPs indicated, for example, that they did not know how to educate or provide information to the working environment of the workers and that they lacked tools to assist them in this: "I am still not sure how to explain supervisors in like half an hour….I want to guide them and show them a better way to handle the situation" (Lugtenberg et al., 2016)*

*Informants from all clinics described that the implementation of the DA guidelines was given low or no priority, was not supported by incentives, goals or feedback systems within or outside the organisation (Westerlund et al., 2020)*

### Sub-theme: Changing flexibility of guidelines

**Supporting Quotes:**

*This tension led CPs to use guidelines flexibly. Some CPs ignored them. Others drew on them selectively according to the needs of the individual client, emphasising that they are guidelines rather than instructions (Court et al., 2017)*

*participants described using guidelines selectively as a 'rhetoric of justification' for practices that they believed were helpful. 'Well, it supports EMDR, but the CBT therapists will discount that, just as I discount the CBT promotion…Yes. That's the problem is that we actually use it to suit ourselves. Yeah, I do. (Court et al., 2017)*

*that the guidance isn't rigid and it is appropriate to deviate from it in specialist settings and for complex cases (Haw et al., 2011)*

### Theme: Lack of trust

**Sub-theme: Credibility of guideline authors**

**Supporting quotes:**

*'(I use the guidelines) to look at the cost effectiveness of various drugs cause that's what it's all about really.'' (Gyani et al., 2012)*

*It was suggested that CPs who contribute to the development of NICE guidelines may have different viewpoints to CPs in routine practice. 'Maybe they're more in their ivory towers, as people call it, doing their research, you know, rather than being on the frontline seeing how things actually are. (Court et al., 2017)*

*When referring to the specific guideline development procedure leading to the guidelines, informants perceived that there was a lack of transparency and diversity in stakeholder involvement (e.g. clinical expertise). Guidelines need to be developed by people who are working clinically and reflect the diversity. It can't just be researchers. (Westerlund et al., 2020)*

*especially when CPGs are defined as expert recommendations and these experts are not known (Sanchez et al., 2010)*

*Like or dislike? I don't really have any sort of feelings of liking about them: they are as they are (Gyani et al., 2012)*

**Sub-theme: Questionable evidence**

**Supporting Quotes:**

*Can't they ... it's like any research, can't you almost get your results to say what you want to say? (Gyani et al., 2012)*

*You might think: 'Is it these quantitative studies that will be the foundation of what will count as evidence based and the treatment you can adopt? It's difficult to research things that are a little different. (Sandstrom et al., 2014)*

### Theme: A tool to improve care

**Sub-theme: Supporting clinical decision making**

**Supporting Quotes:**

*They described all guidelines by providing a professional reference point, which can be used as a defence against litigation in case of adverse reactions. Some GPs acknowledged that, in this regard, they offer protection, but it was not their ideal way to practice. ... I suppose in a* *way guidelines protect you a bit, in terms of if you do something that is recommended in the guidelines you have that protection (McCauley & Casson, 2013)*

*I think they (guidelines) are great – I love these types of documents. Since we have a somewhat fuzzy clinical expertise, I believe we should do whatever possible to achieve some structure and systematics.. (Westerlund et al., 2020)*

*clinicians have become more thoughtful and cautious in their prescribing practice (7 respondents); the advice has reduced inappropriate prescribing in primary and secondary care (Haw et al., 2011)*

*but it led to a new conceptualization of the discipline and generated new practice-based knowledge (Forsner et al., 2010)*

**Sub-theme: Availability of treatment**

**Supporting Quotes:**

*'So, it's almost as if, the, erm, the fact that something features in NICE is your kind of political doorway into, into the er heavenly realms. And you know, once you're in, you know, you can kind of play around a bit, kind of thing (Court et al., 2017)*

*several participants stated that the national guidelines were important because they draw attention to the topic and put suicide prevention on the agenda more systematically (Espeland et al., 2021)*

*and GPs, instead of just prescribing antidepressants, now refer patients to Child & Adolescent Mental Health Services (CAMHS) for full assessment (Haw et al., 2011)*

**Sub-theme: Working in teams**

**Supporting Quotes:**

*OPs mentioned that the policy of other disciplines, for instance psychologists, sometimes interfered with their own ideas (e.g. treatment takes too long, no attention is being paid to work): "Eventually he goes to see a psychologist. Well, after 8 visits I call him to ask about the situation and to make sure things are beginning to make progress. What are you doing because this doesn't work at all? I mean, treatment right, but it's not helping!" (Lugtenberg et al., 2016)*

*Guidelines were viewed as useful tools that provide a base for the teams to work in a more coordinated way (Sandstrom et al., 2014)*

*improving job satisfaction (e.g. by feeling more professional) (Westerlund et al., 2020)*

**Sub-theme: Improving quality**

**Supporting Quotes:**

*"...The clinical guidelines really help us to understand that there is a gap between what we do and the evidence... It's clear what we are supposed to do... It's also fascinating to suddenly understand that there is a large gap between what we think we are doing and what we really do..." (Forsner et al., 2010)*

*expressed positive perceptions of clinical guidelines in the context of their basis in research (Prytys et al., 2011)*

*One of the practitioners said: "At first, I thought it was very difficult... Then we started to get the hang of things, and really saw that we all were improving..." (Forsner et al., 2010)*

*they acknowledged that, despite the limitations of the guidelines, they represent best practice advice (McCauley & Casson, 2013)*

*The informants stated that it was important not to transform a well-described intervention into something mediocre and then assume it was the same, or that it would produce the result originally anticipated (Sandstrom et al., 2014)*

## Theme: Guidelines are a threat

### Sub-theme: Caring for service users

**Supporting Quotes:**

*There was concern by four respondents that the CSM guidance had resulted in an increase in suicide and self-harm among young people (Haw et al., 2011)*

*In contrast to the current emphasis on standardization and risk-factor-based suicide risk assessment in the national guidelines, the participants in this study called for an emphasis on relational aspects in suicide prevention in mental healthcare: 'I am very opposed to those screening measurements [risk assessments] now, that are introduced everywhere. It is completely hopeless (. . .) And it becomes so impersonal because I believe in the relation between people if one should manage to prevent suicide (Espeland et al., 2021)*

*So I think that the guidelines in many cases have been more for the system than for the patient (Espeland et al., 2021)*

### Sub-theme: Clinical judgement vs. guidelines

**Supporting Quotes:**

*clinical practice guidelines conflicted with the basic call for autonomy among health professionals (Westerlund et al., 2020)*

*"...We need to work more systematically and structured in our clinical work... It is a tradition in psychiatry to choose treatment and methods based on one's own clinical experience... (Forsner et al., 2010)*

*But you know, I do ******* 1 with all kinds of people who fall outside of what NICE say I should be using. I do ******* with all kinds of people. I use other approaches that aren't in the NICE guidelines at all. Er, I do what I see to be effective (Court et al., 2017)*

*Some OPs reported to experience difficulties with changing habits and routines in order to learn new things, (Lugtenberg et al., 2016)*

*you should be able to justify things outta your own knowledge without having to ... fall back on guidelines. (McCauley & Casson, 2013)*

### Theme: Losing sight of the big picture

**Sub-theme: Needs are complex**

**Supporting Quotes:**

*This included a concern that CBT might be seen a panacea rather than part of a holistic package of treatment (Prytys et al., 2011)*

*depression guidelines made invalid assumptions about patients presenting with only one illness (and GPs having plenty of time) (Smith et al., 2004)*

**Sub-theme: Guidelines restrict clinical practice**

**Supporting Quotes:**

*'So obviously a lot of the NICE guidance, CBT is the recommended line of treatment… But I think that is to the detriment of the other types of work which can be incredibly effective for a lot of people. (Court et al., 2017)*

*Some informants found the DA guidelines static and could identify few or no guideline components as adaptable. (Westerlund et al., 2020)*

*'I think CBT also fits very nicely because it's the most medical of the erm therapies I think, and so I think it's attractive to psychiatrists and other professionals who can understand then, when it's in units, isn't it, it's almost like so many sessions is almost like a dose, of how much medication you need, erm, so it is, it's easy to communicate what psychology does if it's all languaged in this way. (Court et al., 2017)*

*some participants the CPG is mandatory (Sanchez et al., 2010)*

### Theme: Demands and Resources

**Sub-theme: Insufficient resources**

**Supporting Quotes:**

*a lack of funding and resources limiting the availability of the recommended treatments (Rhodes et al., 2010)*

*more funding to improve implementation. (Gatej et al., 2020)*

*training has to be carried out according to the clinical guidelines, because handing in the guidelines and leaving is not very useful" (Sanchez et al., 2010)*

*six referred to the lack of specialist workers in the team as a barrier to implementing the NICE guideline. (Prytys et al., 2011)*

*…a guideline might come through and I've followed the protocol … and arranged a referral … then the reply has come back from the hospital that they don't have the resources for this at the moment. So it [the guideline] has fallen flat on its face and that is extremely disappointing when we in primary care are trying our best. (Smith et al., 2004)*

*I presume there probably are guidelines but at times there's that many guidelines that it can be slightly overwhelming, and ye don't have time to read them all (McCauley & Casson, 2013)*

**Sub-theme: Accessing guideline documents**

**Supporting Quotes:**

*great drawback of clinical practice guidelines is the dissemination of them. In order for it to be accessible to everyone, for us to be able to use them, they have to be accessible (Sanchez et al., 2010)*

*it's just the repetitiveness of them, you know, you feel you've got to read through quite a lot until you get to the bones of the guideline. (Gyani et al., 2012)*

*Then it's a job every time. As soon as a new guideline is released, we have to reorganize practice, and then it's going to be a reorganization with every new guideline. (Sandstrom et al., 2014)*

*guidelines are very generic, very vague (Eke et al., 2019)*

*Others stated that the guidelines were easy to understand and were written in plain Swedish (Sandstrom et al., 2014)*

# Appendix F

## Sensitivity Analysis

**Key:**

Red = Paper does not contribute to theme/sub-theme

Green = paper does contribute to theme/sub-theme

Number = occurrences paper contributes to theme/sub-theme

| | Working with confusion | | Lack of trust | | A tool to improve care | | | | Guidelines are a threat | | Losing sight of the big picture | | Demands and Resources | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Confusion over roles and responsibilities | Changing flexibility of guidelines | Credibility of guideline authors | Questionable evidence | Supporting clinical decision | Availability of treatment | Working in teams | Improving quality | Caring for service users | Clinical judgement vs. guidelines | Needs are complex | Guidelines restrict clinical practice | Insufficient resources | Accessing guideline documents |
| Cleary (2002) | 🟥 | 🟥 | 🟥 | 🟥 | 4 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 |
| Court (2017) | 🟥 | 12 | 5 | 7 | 3 | 12 | 1 | 2 | 3 | 9 | 8 | 8 | 3 | 1 |
| Eke (2019) | 3 | 🟥 | 2 | 🟥 | 2 | 🟥 | 1 | 1 | 🟥 | 🟥 | 🟥 | 1 | 6 | 2 |
| Espeland (2021) | 🟥 | 🟥 | 🟥 | 🟥 | 2 | 2 | 🟥 | 🟥 | 2 | 🟥 | 🟥 | 4 | 🟥 | 🟥 |
| Forsner (2010) | 3 | 🟥 | 4 | 2 | 2 | 🟥 | 1 | 11 | 3 | 10 | 2 | 1 | 7 | 3 |
| Gatej (2020) | 1 | 🟥 | 2 | 1 | 2 | 1 | 2 | 1 | 🟥 | 🟥 | 4 | 1 | 1 | 🟥 |
| Gyani (2012) | 🟥 | 🟥 | 2 | 1 | 🟥 | 1 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 1 | 2 |
| Haw (2011) | 🟥 | 1 | 🟥 | 2 | 1 | 3 | 🟥 | 🟥 | 2 | 🟥 | 1 | 3 | 1 | 🟥 |
| Lugtenberg (2016) | 4 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 2 | 🟥 | 🟥 | 4 | 🟥 | 2 | 2 | 3 |
| McCauley (2013) | 🟥 | 🟥 | 🟥 | 🟥 | 4 | 🟥 | 🟥 | 1 | 3 | 5 | 1 | 3 | 2 | 9 |
| Prytys (2011) | 🟥 | 🟥 | 2 | 1 | 2 | 1 | 1 | 2 | 3 | 🟥 | 1 | 🟥 | 6 | 🟥 |
| Rhodes (2010) | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 1 | 1 | 🟥 | 2 | 1 |
| Sanchez (2010) | 🟥 | 2 | 4 | 1 | 12 | 1 | 🟥 | 3 | 1 | 5 | 4 | 3 | 3 | 3 |
| Sandstrom (2014) | 9 | 1 | 🟥 | 6 | 3 | 1 | 1 | 3 | 3 | 4 | 1 | 3 | 7 | 2 |
| Smith (2004) | 2 | 🟥 | 1 | 🟥 | 1 | 🟥 | 🟥 | 🟥 | 2 | 🟥 | 2 | 2 | 7 | 6 |
| Westerlund (2020) | 8 | 4 | 2 | 2 | 3 | 🟥 | 2 | 3 | 🟥 | 8 | 7 | 2 | 1 | 5 |

# Appendix G

Study Advert

# *Participants needed for a study on assessment feedback in neuropsychology services*

We are looking for staff to interview about their experiences of receiving feedback about neuropsychological assessments for their clients.

## What is the study about?

The study seeks to understand how staff working in mental health services experience feedback from neuropsychological assessments for their clients. The study also seeks to understand what factors staff perceive as affecting this experience.

Participants would be asked to attend an online interview focusing on their experience of receiving feedback for a specific client they have worked with who has undergone neuropsychological assessment.

## Who can be a participant?

To participate in the study you will need to be:

1) A member of staff who is either the Lead Practitioner or who has been significantly involved in care planning for a client who has received a neuropsychological assessment within the last 12 months; AND
2) A member of staff who has received feedback and/or recommendations from their client's neuropsychological assessment.

## What are the benefits?

The study aims to provide further understanding about how staff experience receiving feedback from neuropsychological assessment within mental health services and to develop ways to improve how this feedback is provided.

As a participant, you will have the opportunity to discuss your personal experiences in a confidential environment.

*If you would be interested in participating or would like to discuss anything further then please contact: Karen O'Reilly (Trainee Clinical Psychologist at Salomons Institute for Applied Psychology, Canterbury Christ Church University) on* ***k.oreilly238@canterbury.ac.uk***

# Appendix H

## Clinical Psychologist Participant Information Sheet

Canterbury Christ Church University

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

www.canterbury.ac.uk/appliedpsychology

### Information about the research

### Staff experiences of neuropsychological feedback and recommendations.

Hello. My name is Karen and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

The study is sponsored by Canterbury Christ Church University, therefore, any reference to 'we' within this information sheet refers to the research team at the University.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study).

**What is the purpose of the study?**
The purpose of this study is to explore what impact clinical psychologists working within neuropsychology services expect their assessments to have on staff within mental health services. The study also seeks to explore what changes mental health staff experience as a result of receiving the outcomes of neuropsychological assessments for their clients.

This will then help to examine what similarities/differences exist between what change is expected and what change is experienced and/or implemented as a result of neuropsychological assessment, and what the perceived factors are that influence this change.

**Why have I been invited?**
You have been invited to take part in this study because you are a clinical psychologist who provides neuropsychological assessment and recommendations for treatment to staff within mental health services. We are aiming to recruit and speak to 4 clinical neuropsychologists in total as well as 16 members of staff within mental health services.

**Do I have to take part?**
Taking part in this study is entirely voluntary and it is up to you to decide whether to join or not. If you agree to take part, I will then ask you to sign a consent form. You are free to

withdraw at any time, without giving a reason.

**What will happen to me if I take part?**
If you choose to take part then we would ask you to attend an initial focus group with 3 other clinical psychologists. The purpose of this group would be to gather information on your general expectations of how neuropsychological assessment impacts staff's attitude and behaviour towards clients within mental health services. This group will last for up to 60 minutes and will be conducted online.

Following this we would also invite you to attend an individual interview, lasting for approximately 90 minutes, to discuss your expectations of changes that should occur following neuropsychological assessment for specific clients under mental health services who you have assessed. These interviews would also be conducted online.

You would usually only be required to attend one interview, however, if circumstances arise which make it difficult to cover the relevant topics then you may be asked to attend a second interview.

**What will I be asked to do?**
We would ask you to attend an online interview with a member of our research team, which will involve answering some questions related to what changes you would expect staff within mental health services to implement and/or experience, following a neuropsychological assessment for their clients. This would involve asking how you expect recommendations to be implemented following these assessments, as well as any changes you would expect in the way staff think about and/or engage with their clients.

All interviews will be audio-recorded for the purposes of data collection. Generally, we would only need to meet with you once except in circumstances where we would need to seek further clarification on information given within your interview. In this case we would attempt to contact you by phone and discuss this further.

**What are the possible disadvantages and risks of taking part?**
The interview process will involve asking about your personal experience of working with clients in mental health services, and it may be that conversations bring up difficult feelings and/or experiences. All care will be taken to approach discussions sensitively, and for participants to raise any concerns they have about the interview process.

It is beyond the scope of the research team to provide supervision for staff working with clients with neuropsychological difficulties in mental health services and it is expected that any ongoing issues will be brought up with the appropriate member of staff within your service.

If you feel you require further support during or following the interview process then you can go to the [redacted] staff intranet for further details of where you can access support such as [redacted] and the [redacted] hub.

You can also visit the following websites for further information and support:

- SANEline, a confidential support service offering emotional support and information to anyone affected by mental illness. Website: www.sane.org.uk, Phone: 0300 304 7000.

- MIND, an organisation providing information and advice on various aspects of mental health and support. Website: www.mind.org.uk.

- Samaritans, a support line offering emotional support to anyone in need. Open 24 hours a day, 365 days a year. Website: www.samaritans.org, Phone: 116 123.

**What are the possible benefits of taking part?**
It is hoped that this study will provide a more in-depth examination of the effects of clinical neuropsychological assessment within mental health treatment and whether these effects are similar or different to what is expected. Participation within this study may allow you to provide unique information on your expectations of working within this area within a confidential environment.

**What if there is a problem?**
Steps will be taken to ensure that any harm encountered by staff within this study will be addressed through conversation with research supervisors as well as staff managers.

If you wish to make a complaint about the way you have been treated during the study then contact details are provided in Part 2 of this information sheet.

**Will information from or about me from taking part in the study be kept confidential?**
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. There are some rare situations in which information would have to be shared with others. The details are included in Part 2.

This completes part 1.
*If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.*

**Part 2 of the information sheet**
**What will happen if I don't want to carry on with the study?**
If you no longer wish to participate in the focus group and/or interview then you may withdraw at any time either before or during these activities, without giving a reason. If you do withdraw from the focus group and/or interview we will retain any data that you have provided for inclusion in the analysis and final report unless you request for this to be removed.

You can request for your group data to be removed from the study any time within 48 hours of concluding the focus group. You can request for your interview data to be removed any time within 48 hours of concluding your final interview. After this time the data will have been anonymised and it will no longer be possible to remove it from the analysis.

To withdraw from the study and request for your data to be removed, you can contact me by email at [redacted]. I will then send you an email acknowledging your withdrawal from the study. I will not be able to respond to any requests to remove data that are received over 48 hours after the specified research activity.

**What if there is a problem?**
If you encounter a problem during the study then you can contact me by leaving a message on a 24-hour-phone line [redacted]. Please leave a contact number and say that the message is for me [Karen O'Reilly] and I will get back to you as soon as possible.

Alternatively, you can email me at [redacted].

**Concerns and Complaints**

If you have a concern about any aspect of this study, you can speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number [redacted]. Please leave a contact number and say that the message is for me [Karen O'Reilly] and I will get back to you as soon as possible. Alternatively, you can send me an email at [redacted].

If you remain dissatisfied and wish to make a formal complaint, you can do this by contacting Dr [redacted], Clinical Psychology Programme [redacted], Salomons Institute for Applied Psychology at [redacted]

**How will you use information about me?**

We will need to use information from you for this research project. This information will include your:

- Name
- Gender
- NHS email address
- Professional Role
- Professional Qualifications
- Team in which you work and how long you've worked there
- Experiences of working with clients who have received neuropsychological assessment or consultation as well as staff who have received feedback from these assessments/consultations.

People will use this information to do the research. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write out reports in a way that no-one can work out that you took part in the study.

**What are my choices about how my information is used?**

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

**Where can I find out more about how my information is used?**

You can find out more about how we use your information:

- At www.hra.nhs.uk/information-about-patients/
- Leaflet available from www.hra.nhs.uk/patientdataandresearch
- By asking one of the research team
- By sending an email to dp.officer@canterbury.ac.uk, or
- By ringing us on 01227 927070

**Will information from or about me from taking part in the study be kept confidential?**
All information which is collected from or about you during the course of the research will be kept strictly confidential. The only time when I would be obliged to pass on information from you to a third party would be if, as a result of something you told me, I were to become concerned about your safety or the safety of someone else. If I did have to pass on information to a third party then I would try to notify you of this beforehand where possible.

Data will be recorded through written notes and audio recordings, which will only be available to the research team. These notes and recordings will be stored securely by the research team on a password-protected computer, and identifying details (e.g. name, profession etc…) will be stored separately from the interview data so that comments cannot be identified as being made by a specific individual. All information included in the final report will be anonymised.

All interviews and focus groups will be transcribed by me [Karen O'Reilly]. Information you provide in the interviews will be used by the research team to identify themes that appear across conversations with participants and to compare how these themes are different and/or similar.

Only members of the research team will be able to view this data, as well as staff in the Trusts' Research & Development department in order to monitor data quality. The research team consists of 2 external supervisors who are clinical psychologists and who will also be participating in the study. These 2 members of the research team will not have access to any transcripts or raw data generated by the study in order to maintain confidentiality for participants. However, for the purposes of providing supervision for the project, these 2 members of the research team will have access to the analysed version of the data which will be anonymised so that individuals cannot be identified.

Once the project has been completed the anonymised transcripts will be retained for 10 years by Canterbury Christ Church University and will be stored in a secure filing facility.

**What will happen to the results of the research study?**
We plan to publish the results of this study as a Journal Article. This article would contain themes identified from the interviews but you will not be identified within the article unless you have given your consent. We may include quotations from specific interviews that demonstrate the themes that emerge and any quotations used would be anonymised so that the individual who made them could not be identified.

We also plan to disseminate a report of these results to participants and will make them available to you by emailing the final report.

**Who is sponsoring and funding the research?**
This research project is sponsored and funded by Canterbury Christ Church University.

**Who has reviewed the study?**
This study has been reviewed and approved by the Research Ethics Panel at the Salomons Institute for Applied Psychology which is part of Canterbury Christ Church University. Additionally, the study has also received approval from the Health Research Authority.

**Further information and contact details**

1. General information about research.

For further general information on participating in research, please visit the Health Research Authority (HRA) website: https://www.hra.nhs.uk/about-us/what-we-do/taking-part-or-getting-involved-research/

2. Specific information about this research project.

If you would like to speak to me for further information about this research project then you can leave a message for me on a 24-hour-voicemail phone line at [redacted]. Please say that the message is for me [Karen O'Reilly] and leave a contact number so that I can get back to you. Alternatively, you can email me at [redacted].

3. Who they should approach if dissatisfied with the study and want to complain.

If you are dissatisfied with any aspect of the study and wish to raise a complaint then please contact [redacted] at the Salomons Institute for Applied Psychology, Canterbury Christchurch University at [redacted]

*If you consent to participate in this study then you will be provided with a copy of this information sheet as well as your signed consent form to keep for your records.*

# Appendix I

## Mental Health Staff Participant Information Sheet

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

www.canterbury.ac.uk/appliedpsychology

### Information about the research

### Staff experiences of neuropsychological feedback and recommendations.

Hello. My name is Karen and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

The study is sponsored by Canterbury Christ Church University, therefore, any reference to 'we' within this information sheet refers to the research team at the University.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study).

### What is the purpose of the study?

The purpose of this study is to explore what impact clinical psychologists working within neuropsychology services expect their assessments to have on staff within mental health services. The study also seeks to explore what changes mental health staff experience as a result of receiving the outcomes of neuropsychological assessments conducted for their clients.

This will then help to examine what similarities/differences exist between what change is expected and what change is experienced and/or implemented as a result of neuropsychological assessment, and what the perceived factors are that influence this change.

### Why have I been invited?

You have been invited to take part in this study because you are a member of staff working within mental health services who has referred a client to neuropsychological services and they have gone on to receive an assessment. You will also have received feedback from this assessment and/or recommendations for treatment. In total, we are aiming to involve 20 people within this study, 4 clinical psychologists and 16 members of staff from mental health services.

**Do I have to take part?**

Taking part in this study is entirely voluntary and it is up to you to decide whether to join or not. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

**What will happen to me if I take part?**

If you choose to take part then we would ask you to attend an interview to discuss your experiences of changes that have occurred following receipt of feedback from a neuropsychological assessment for your clients. Interviews will be conducted online and are likely to last for up to 90 minutes. You would usually only be required to attend one interview, however, if circumstances arise which make it difficult to cover the relevant topics then you may be asked to attend a second interview.

**What will I be asked to do?**

We would ask you to attend an online interview with a member of our research team, which will involve answering some questions related to how you have experienced receiving feedback from neuropsychological assessments for your clients and what change, if any, you experienced and/or implemented as a result of this feedback. You would also be asked questions relating to your experience of implementing any recommendations from these assessments.

All interviews will be audio-recorded for the purposes of data collection. Generally, we would only need to meet with you once except in circumstances where we would need to seek further clarification on information given within your interview. In this case we would attempt to contact you by phone and discuss this further.

**What are the possible disadvantages and risks of taking part?**

The interview process will involve asking about your personal experience of working with clients in mental health services, and it may be that conversations bring up difficult feelings and/or experiences. All care will be taken to approach discussions sensitively, and for participants to raise any concerns they have about the interview process.

It is beyond the scope of the research team to provide supervision for staff working with clients with neuropsychological difficulties in mental health services and it is expected that any ongoing issues will be brought up with the appropriate member of staff within your service.

If you feel you require further support during or following the interview process then you can go to the [redacted] staff intranet for further details of where you can access support such as [redacted], and the [redacted] hub.

You can also visit the following websites for further information and support:

- SANEline, a confidential support service offering emotional support and information to anyone affected by mental illness. Website: www.sane.org.uk, Phone: 0300 304 7000.
- MIND, an organisation providing information and advice on various aspects of mental health and support. Website: www.mind.org.uk.
- Samaritans, a support line offering emotional support to anyone in need. Open 24 hours a day, 365 days a year. Website: www.samaritans.org, Phone: 116 123.

### What are the possible benefits of taking part?

It is hoped that this study will provide a more in-depth examination of the effects of clinical neuropsychological assessment on mental health treatment and whether these effects are similar or different to what is expected. Participation within this study may allow you to provide unique information on your experiences in a confidential environment, and potentially inform the way in which neuropsychological feedback is provided within mental health services.

### What if there is a problem?

Steps will be taken to ensure that any harm encountered by staff within this study will be addressed through conversation with research supervisors as well as staff managers.

If you wish to make a complaint about the way you have been treated during the study then contact details are provided in Part 2 of this information sheet.

### Will information from or about me from taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. There are some rare situations in which information would have to be shared with others. The details are included in Part 2.

This completes part 1.
*If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.*

## Part 2 of the information sheet

### What will happen if I don’t want to carry on with the study?

If you no longer wish to participate in the interview then you may withdraw at any time either before or during this activity, without giving a reason. If you do withdraw from the interview we will retain any data that you have provided for inclusion in the analysis and final report unless you request for this to be removed.

You can request for your interview data to be removed any time within 48 hours of concluding your final interview. After this time the data will have been anonymised and it will no longer be possible to remove it from the analysis.

To withdraw from the study and request for your data to be removed, you can contact me by email at [redacted]. I will then send you an email acknowledging your withdrawal from the study. I will not be able to respond to any requests to remove data that are received over 48 hours after your final interview.

### What if there is a problem?

If you encounter a problem during the study then you can contact me by leaving a message on a 24-hour-phone line [redacted]. Please leave a contact number and say that the message is for me [Karen O’Reilly] and I will get back to you as soon as possible. Alternatively, you can email me at [redacted].

**Concerns and Complaints**
If you have a concern about any aspect of this study, you can speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number [redacted]. Please leave a contact number and say that the message is for me [Karen O'Reilly] and I will get back to you as soon as possible. Alternatively, you can send me an email at [redacted].

If you remain dissatisfied and wish to make a formal complaint, you can do this by contacting Dr [redacted], Clinical Psychology Programme [redacted], Salomons Institute for Applied Psychology at [redacted]

### How will you use information about me?

We will need to use information from you for this research project. This information will include your:

- Name
- Gender
- NHS email address
- Professional Role
- Professional Qualification
- Team in which you work and how long you have worked there
- Experiences of working with clients who have received neuropsychological assessment or consultation and your role in their care.

People will use this information to do the research. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write out reports in a way that no-one can work out that you took part in the study.

### What are my choices about how my information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

### Where can I find out more about how my information is used?

You can find out more about how we use your information:

- At www.hra.nhs.uk/information-about-patients/
- Leaflet available from www.hra.nhs.uk/patientdataandresearch
- By asking one of the research team
- By sending an email to dp.officer@canterbury.ac.uk, or
- By ringing us on 01227 927070

### Will information from or about me from taking part in the study be kept confidential?

All information which is collected from or about you during the course of the research will be kept strictly confidential. The only time when I would be obliged to pass on information from you to a third party would be if, as a result of something you told me, I were to become concerned about your safety or the safety of someone else. If I did have to pass on information to a third party then I would try to notify you of this beforehand where possible.

Data will be recorded through written notes and audio recordings, which will only be available to the research team. These notes and recordings will be stored securely by the research team on a password-protected computer, and identifying details (e.g. name, profession etc…) will be stored separately from the interview data so that comments cannot be identified as being made by a specific individual. All information included in the final report will be anonymised.

All interviews will be transcribed by me [Karen O'Reilly]. Information you provide in the interviews will then be used by the research team to identify themes that appear across conversations with participants and to compare how these themes are different and/or similar. Only members of the research team will be able to view this data, as well as staff in the R&D department in order to monitor data quality. The research team consists of 2 external supervisors who are clinical psychologists and who will also be participating in the study. These 2 members of the research team will not have access to any transcripts or raw data generated by the study in order to maintain confidentiality for participants. However, for the purposes of providing supervision for the project, these 2 members of the research team will have access to the analysed version of the data which will be anonymised so that individuals cannot be identified.

Once the project has been completed the anonymised interview transcripts will be retained for 10 years by Canterbury Christchurch University and will be stored in a secure filing facility.

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

We plan to publish the results of this study as a Journal Article. This article would contain themes identified from the interviews but you will not be identified within the article unless you have given your consent. We may include quotations from specific interviews that demonstrate the themes that emerge and any quotations used would be anonymised so that the individual who made them could not be identified.

We also plan to disseminate a report of these results to participants and will make them available to you by emailing the final report.

**Who is sponsoring and funding the research?**

This research project is sponsored and funded by Canterbury Christ Church University.

**Who has reviewed the study?**

This study has been reviewed and approved by the Research Ethics Panel at the Salomons Institute for Applied Psychology which is part of Canterbury Christ Church University. Additionally, the study has also received approval from the Health Research Authority.

**Further information and contact details**

4. General information about research.

For further general information on participating in research, please visit the Health Research Authority (HRA) website: https://www.hra.nhs.uk/about-us/what-we-do/taking-part-or-getting-involved-research/

5. Specific information about this research project.

If you would like to speak to me for further information about this research project then you can leave a message for me on a 24-hour-voicemail phone line at [redacted]. Please say that the message is for me [Karen O'Reilly] and leave a contact number so that I can get back to you. Alternatively, you can email me at [redacted].

6. Who they should approach if dissatisfied with the study and want to complain.

If you are dissatisfied with any aspect of the study and wish to raise a complaint then please contact [redacted] at the Salomons Institute for Applied Psychology, Canterbury Christchurch University at [redacted].

*If you consent to participate in this study then you will be provided with a copy of this information sheet as well as your signed consent form to keep for your records.*

# Appendix J

Clinical Psychologist Consent Form

Canterbury
Christ Church
University

Salomons Institute for Applied Psychology

One Meadow Road, Tunbridge Wells, Kent TN1 2YG

Ethics approval number:
Version number: 3
Participant Identification number for this study:

## CONSENT FORM

Title of Project: Staff experiences of neuropsychological assessment and feedback.

Name of Researcher: Karen O’Reilly

Please initial box

1. I confirm that I have read and understand the information sheet dated 29/06/23 (version 4.0) 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 from the interview and/or focus group at any time without giving a reason. ☐

3. I understand that if I do withdraw from the interview and/or focus group, any data already collected from me will be included in the final analysis and report unless I inform the research team that I would like this removed.

4. I understand that I can request for my group data to be removed from the study at any time without giving a reason, up until 48 hours after concluding the focus group

5. I understand that I can request for my interview data to be removed from the study at any time without giving a reason, up until 48 hours after concluding my final interview.

6. I understand that data collected during the study will be looked at by the researcher (Karen O’Reilly) and lead supervisor [Dr [redacted]]. I give permission for these individuals to have access to my data. ☐

7. I understand that all information which is collected from or about me during the course of the research will be kept strictly confidential, except in circumstances where, as a result of information I have given, there is a concern about my safety or the safety of someone else. I understand that in these circumstances the researcher (Karen O’Reilly) will be obliged to pass this information on to a third party.

8. I agree for my interview to be audio-recorded and transcribed as part of data collection. ☐

9. I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings ☐

10. I agree for my anonymous data to be used in further research studies ☐

11. I agree to take part in the above study. ☐

12. I would like to be contacted about the study results once it has been completed and assessed by the researcher’s University. I agree to being contacted by the following methods:
Email Phone Online Meeting

Name of Participant____________________

Date________________ Signature ___________________

Name of Person taking consent ______________

Date_____________ Signature

**File Note***

*One copy of this signed consent form will be held by the research team, and you will be provided with another copy for your records.*

# Appendix K

## Mental Health Staff Consent Form

Canterbury
Christ Church
University

Salomons Institute for Applied Psychology

One Meadow Road, Tunbridge Wells, Kent TN1 2YG

Ethics approval number:
Version number: 3
Participant Identification number for this study: MH05

## CONSENT FORM

Title of Project: Staff experiences of neuropsychological assessment and feedback.

Name of Researcher: Karen O'Reilly

Please initial box

1. I confirm that I have read and understand the information sheet dated 30/06/23 (version 4.0) 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 from the interview at any time without giving a reason. ☐

3. I understand that if I do withdraw from the interview, any data already collected from me will be included in the final analysis and report unless I inform the research team that I would like this removed.

4. I understand that I can request for my interview data to be removed from the study at any time without giving a reason, up until 48 hours after concluding my final interview.

5. I understand that data collected during the study will be looked at by the researcher (Karen O'Reilly) and lead supervisor [Dr [redacted]]. I give permission for these individuals to have access to my data. ☐

6. I understand that all information which is collected from or about me during the course of the research will be kept strictly confidential, except in circumstances where, as a result of information I have given, there is a concern about my safety or the safety of someone else. I understand that in these circumstances the researcher (Karen O'Reilly) will be obliged to pass this information on to a third party.

7. I agree for my interview to be audio-recorded and transcribed as part of data collection. ______

8. I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings ☐

9. I agree for my anonymous data to be used in further research studies ☐

10. I agree to take part in the above study. ☐

11. I would like to be contacted about the study results once it has been completed and assessed by the researcher’s University. I agree to being contacted by the following methods:
Email Phone Online Meeting

Name of Participant____________________

Date________________ Signature ___________________

Name of Person taking consent ______________

Date_____________ Signature ____________________

**File Note***

*One copy of this signed consent form will be held by the research team, and you will be provided with another copy for your records.*

## Appendix L

### Focus Group Questions

In general, what is your expectation of the effects that a neuropsychological assessment could have for staff working with clients in mental health services?

1. Treatment

Do you expect that feedback from neuropsychological assessment could influence staff's decisions around treatment for their clients? If so, what effects do you expect this to have?

2. Emotional Changes

Do you expect that feedback from neuropsychological assessment could change the way in which staff feel about their clients' difficulties? If so, what changes do you expect?

Do you expect that feedback from neuropsychological assessment could change the way in which staff react emotionally towards their clients? If so, what changes do you expect?

3. Understanding and Knowledge

Do you expect that feedback from neuropsychological assessment could affect staff's understanding of their clients' difficulties? If so, what changes do you expect?

4. Medication and Diagnosis

Do you expect that feedback from neuropsychological assessment could affect staff's views and/or decisions around their clients' medication? If so what changes do you expect?

Do you expect that feedback from neuropsychological assessment could affect staff's views and/or decisions around their clients' diagnosis? If so, what changes do you expect?

5. Engagement/Communication

Do you expect that feedback from neuropsychological assessment could change the way staff communicate with their clients? If so what changes do you expect?

Do you expect that feedback from neuropsychological assessment could change the way in which staff behave towards their clients? If so, what changes do you expect?

## **6.** Involvement and Liaison

Do you expect that feedback from neuropsychological assessment could affect staff decisions to involve and/or liaise with other services regarding their clients' care? If so what changes do you expect?

## **7.** Recommendations

When making recommendations, is it expected that all recommendations will be followed?

Who would you expect to implement these recommendations?

Are there any other changes that you would expect staff to experience and/or implement as a result of receiving feedback from neuropsychological assessments for their clients?

# Appendix M

## Clinical Psychologist Interview Questions

1. Background Questions

What is your professional role and qualifications?

Which team do you work in?

2. General

In general, what was your expectation of the effects that a neuropsychological assessment could have for staff working with these clients in mental health services?

3. Treatment

Did you expect that feedback from neuropsychological assessment would influence staff's decisions around mental health treatment for these clients? If so, what effects did you expect this to have?

4. Emotional Changes

Did you expect that feedback from neuropsychological assessment would change the way in which staff felt about these clients' difficulties? If so, what changes did you expect?

Did you expect that feedback from neuropsychological assessment would change the way in which staff reacted emotionally towards these clients? If so, what changes did you expect?

5. Understanding and Knowledge

Did you expect that feedback from neuropsychological assessment would affect staff's understanding of these clients' difficulties? If so, what changes did you expect?

6. Medication and Diagnosis

Did you expect that feedback from neuropsychological assessment would affect staff's views and/or decisions around these clients' medication? If so what changes did you expect?

Did you expect that feedback from neuropsychological assessment would affect staff's views and/or decisions around these clients' diagnosis? If so, what changes did you expect?

## **7.** Engagement/Communication

Did you expect that feedback from neuropsychological assessment would change the way staff communicated with these clients? If so what changes did you expect?

Did you expect that feedback from neuropsychological assessment would change the way in which staff behaved towards these clients? If so, what changes did you expect?

Did you expect that feedback from neuropsychological assessment would change the way in which staff communicated with other professionals about their clients care?

## **8.** Involvement and Liaison

Did you expect that feedback from neuropsychological assessment would affect staff decisions to involve and/or liaise with other services regarding these clients' care? If so what changes did you expect?

Did you expect that feedback from neuropsychological assessment would affect staff's knowledge about which services could be involved in these client's care? If so, what changes did you expect?

## **9.** Recommendations / Report

How was feedback from neuropsychological assessment provided? (For example: a report, a meeting, audio recording, video presentation, etc…)

When making recommendations for these client, was it expected that all recommendations would be followed?

Who did you expect to implement these recommendations?

Did you expect the entirety of your report to be read and shared with all members of the team?

Did you expect the report to be shared will all members of the team?

## **10.** Closing Question

Are there any other changes that you expected staff to experience and/or implement as a result of receiving feedback from neuropsychological assessments for these clients?

# Appendix N

## Mental Health Staff Interview Questions

1. Background Questions

What is your professional role and qualifications?

Which team do you work in?

Approximately how many clients have you worked with who need input from the (name of neuropsychology service)?

2. General

In general, what effects did receiving a neuropsychological assessment have on you as a staff member working with clients in mental health services?

3. Treatment

Did you experience any changes in your decisions around treatment for your client(s) as a result of receiving feedback from neuropsychological assessment? If so, what changes did you experience?

4. Emotional Changes

Did you experience any changes in the way you felt about your client(s) difficulties after receiving feedback from neuropsychological assessment? If so, what changes did you experience?

Did you experience any changes in the way you reacted emotionally towards your client(s) after receiving feedback from neuropsychological assessment? If so, what changes did you experience?

5. Understanding and Knowledge

Did you experience any changes in your understanding of your client(s) difficulties as a result of receiving feedback from neuropsychological assessment? If so, what changes did you experience?

6. Medication and Diagnosis

Did you experience any changes in your view and/or decisions around your client(s) medication as a result of receiving feedback from neuropsychological assessment? If so, what changes did you experience?

Did you experience any changes in your views and/or decisions around your client(s) diagnosis as a result of receiving feedback from neuropsychological assessment?

7. Engagement/Communication

Did you experience or implement any changes in the way you communicated with your client(s) as a result of receiving feedback from neuropsychological assessment? If so, what changes did you experience/implement?

Did you experience or implement any changes in the way you behaved towards your client(s) as a result of receiving neuropsychological assessment? If so, what changes did you experience/implement?

Did you experience or implement any changes in the way you communicated with other professionals regarding information about your clients care? If so, what changes did you experience/implement?

8. Involvement and Liaison

Did you experience or implement any changes in your decisions to involve/liaise with other services in relation to your client(s) care? If so, what changes did you experience/implement?

Did you experience any changes in your knowledge about other services that could be involved in your client(s) care as a result of receiving neuropsychological feedback? If so, what changes did you experience?

9. Recommendations/Reports

How did you receive feedback from the neuropsychological assessment? (For example: a report, a meeting, audio recording, video presentation, etc…)

When receiving recommendations from neuropsychological assessment for your client(s), did you implement all recommendations? What allowed you or prevented you from doing this?

Were others involved in implementing the recommendations? Who was involved and why?

When receiving a report from the neuropsychological assessment for your client(s), did you read the whole report? Why/why not?

Was this report shared with other members of the team? Why/why not?

10. Closing Question

Are there any other changes you experienced or implemented as a result of receiving feedback from neuropsychological assessment for your client(s)?

# Appendix O

## Abridged Research Diary

*This has been removed from the electronic copy.*

# Appendix P

Approval Letter from the Health Research Authority

*This has been removed from the electronic copy*

# Appendix Q

Ethics Approval Letter from Salomons

*This has been removed from the electronic copy*

# Appendix R

Template versions 1, 2, 3 and 4

## Initial Template

1. **Resources**
   - 1.1 Limited resources prevent communication
   - 1.2 NHS resources limit impact

2. **Trying to find certainty**
   - 2.1 Neuropsychology provides the answers
     - 2.1.1 Providing focus
       - *2.1.1.1 Making things clear*
       - *2.1.1.2 Clear reports*
       - *2.1.1.3 Being specific has a greater impact*
       - *2.1.1.4 Summaries are helpful*
     - 2.1.2 Revealing what's hidden
       - *2.1.2.1 Exposing the gaps*
       - *2.1.2.2 Uncovering risk*
       - *2.1.2.3 Getting beneath the surface*
   - 2.2 We can't be certain
     - 2.2.1 Too much variety
       - *2.2.1.1 Conflicting priorities*
       - *2.2.1.2 Variation in services leads to a variation in impact*
       - *2.2.1.3 Making things less clear*
       - *2.2.1.4 Complexity limits impact*
       - *2.2.1.5 Cognition needs to be linked with behaviour*
     - 2.2.2 Changing the focus
       - *2.2.2.1 Providing a different perspective*
       - *2.2.2.2 Moving away from mental health*
       - *2.2.2.3 Academic vs clinical experiences*

3. **Holding the client in mind**
   - 3.1 Noticing change in the client
     - 3.1.1 Noticing the impact on clients
   - 3.2 Implementing change for the client
     - 3.2.1 Facilitating communication with the client
     - 3.2.2 Adapting information for the client
     - 3.2.3 Changing the narrative around clients

4. **The impact of relationships with professionals and services**
    - 4.1 Increasing connection
        - 4.1.1 Opening up professional discussions
        - 4.1.2 Bringing services together
        - 4.1.3 Improving working relationships
        - 4.1.4 Increasing shared understanding amongst professionals
    - 4.2 Familiarity as a facilitator
        - 4.2.1 A familiar face
        - 4.2.2 A therapeutic focus makes things easier

5. **Neuropsychology takes care of people**
    - 5.1 Being close by
        - 5.1.1 Easy access to neuropsychology
    - 5.2 Providing emotional support
        - 5.2.1 A reassuring presence for professionals and clients
        - 5.2.2 Reducing concerns
        - 5.2.3 Validating professionals' experiences
        - 5.2.4 Feedback increases professionals' confidence
    - 5.3 Keeping people safe
        - 5.3.1 Protecting client safety

6. **The distribution of power**
    - 6.1 Staff require support
        - 6.1.1 Support needed to share feedback amongst professionals
        - 6.1.2 Professionals are not brain experts
    - 6.2 Neuropsychology seen as powerful
        - 6.2.1 Knowledge is power
            - *6.2.1.1 Neuropsychology seen as infallible*
            - *6.2.1.2 Neuropsychologists are experts*
        - 6.2.2 Having the power to act
            - *6.2.2.1 Neuropsychology makes things happen*
    - 6.3 Neuropsychology seen as powerless
        - 6.3.1 A fleeting presence
            - *6.3.1.1 Not enough time for reports to inform decisions*
            - *6.3.1.2 Neuropsychology is a limited resource*
            - *6.3.1.3 Short-term work limits impact*
        - 6.3.2 Not meeting expectations
            - *6.3.2.1 Not feeling good enough*
        - 6.3.3 Lacking a sense of influence
            - *6.3.3.1 No sense of impact on the client*
            - *6.3.3.2 Being on the outside*
            - *6.3.3.3 Lack of systemic impact*
            - *6.3.3.4 Neuropsychology are reliant on the MDT to make things happen*
    - 6.4 Neuropsychology empowers staff

6.4.1 Being informed
  *6.4.1.1 Assessment feedback informs capacity decisions*
  *6.4.1.2 Increasing access to knowledge*
  *6.4.1.3 Moving back to mental health*
6.4.2 Being prepared
  *6.4.2.1 Saving resources for the team*
  *6.4.2.2 Removing barriers to support*
  *6.4.2.3 Streamlining care*
6.4.3 Being allowed
  *6.4.3.1 Satisfactory recommendations*
  *6.4.3.2 Increasing self-efficacy*
  *6.4.3.3 Giving permission for making restrictions*

Green = Mental Health Staff

Yellow = Clinical Psychologists

No Colour = both

# Template (Version 2)

1. **Resources**
    - 1.1 Limited resources prevent communication
    - 1.2 NHS resources limit impact
        - 1.2.1 Staff turnover limits long-term impact
        - 1.2.2 Lack of available care
        - 1.2.3 Lack of time in busy services

2. **Trying to find certainty**
    - 2.1 Neuropsychology provides the answers
        - 2.1.1 Providing focus
            - *2.1.1.1 Making things clear*
            - *2.1.1.2 Clear reports*
            - *2.1.1.3 Being specific has a greater impact*
            - *2.1.1.4 Summaries are helpful*
        - 2.1.2 Revealing what's hidden
            - *2.1.2.1 Exposing the gaps*
            - *2.1.2.2 Uncovering risk*
            - *2.1.2.3 Uncovering information*
            - *2.1.2.4 Getting beneath the surface*
    - 2.2 We can't be certain
        - 2.2.1 Too much variety
            - *2.2.1.1 Conflicting priorities*
            - *2.2.1.2 Variation in services leads to a variation in impact*
            - *2.2.1.3 Making things less clear*
            - *2.2.1.4 Complexity limits impact*
        - 2.2.2 Changing the focus
            - *2.2.2.1 Providing a different perspective*
            - *2.2.2.2 Moving away from mental health*
        - 2.2.3 Being asked to do new things
            - *2.2.3.1 How to apply theory to practice*
            - *2.2.3.2 Working with vague recommendations*
            - *2.2.3.3 Working outside area of expertise*

3. **Holding the client in mind**
    - 3.1 Noticing emotional changes
        - 3.1.1 Noticing the impact on clients
        - 3.1.2 Increasing empathy
    - 3.2 Implementing practical changes
        - 3.2.1 Facilitating communication with the client
        - 3.2.2 Adapting information for the client
        - 3.2.3 Changing the narrative around clients

**4. The impact of relationships with professionals and services**

- 4.1 Increasing connection
  - 4.1.1 Opening up professional discussions
  - 4.1.2 Bringing services together
  - 4.1.3 Improving working relationships
  - 4.1.4 Increasing shared understanding amongst professionals
- 4.2 Familiarity as a facilitator
  - 4.2.1 A familiar face
  - 4.2.2 A therapeutic focus makes things easier

**5. Neuropsychology takes care of people**

- 5.1 Being close by
  - 5.1.1 Easy access to neuropsychology
- 5.2 Providing emotional support
  - 5.2.1 A reassuring presence for professionals and clients
  - 5.2.2 Reducing concerns
  - 5.2.3 Validating professionals' experiences
  - 5.2.4 Feedback increases professionals' confidence
- 5.3 Keeping people safe
  - 5.3.1 Protecting client safety
- 5.4 Providing help amongst limited resources

**6. The distribution of power**

- 6.1 Imbalance of power within mental health services
  - 6.1.1 Support needed to share feedback amongst professionals
  - 6.1.2 Professionals are not brain experts
  - 6.1.3 Different staff hold different levels of power
- 6.2 Neuropsychology seen as powerful
  - 6.2.1 Knowledge is power
    - *6.2.1.1 Neuropsychology feedback seen as infallible*
    - *6.2.1.2 Neuropsychologists are experts*
  - 6.2.2 Having the power to act
    - *6.2.2.1 Neuropsychology makes things happen*
- 6.3 Neuropsychology seen as powerless
  - 6.3.1 A fleeting presence
    - *6.3.1.1 Not enough time for reports to inform decisions*
    - *6.3.1.2 Neuropsychology is a limited resource*
    - *6.3.1.3 Short-term work limits impact*
  - 6.3.2 Not meeting expectations
    - *6.3.2.1 Not feeling good enough*
  - 6.3.3 Lacking a sense of influence
    - *6.3.3.1 No sense of impact on the client*
    - *6.3.3.2 Being on the outside*
    - *6.3.3.3 Lack of systemic impact*

        - *6.3.3.4 Neuropsychology are reliant on the MDT to make things happen*
- 6.4 Neuropsychology empowers staff
    - 6.4.1 Being informed
        - *6.4.1.1 Assessment feedback informs capacity decisions*
        - *6.4.1.2 Increasing access to knowledge*
        - *6.4.1.3 Moving back to mental health*
    - 6.4.2 Being prepared
        - *6.4.2.1 Saving resources for the team*
        - *6.4.2.2 Removing barriers to support*
        - *6.4.2.3 Streamlining care*
    - 6.4.3 Being allowed
        - *6.4.3.1 Satisfactory recommendations*
        - *6.4.3.2 Increasing self-efficacy*
        - *6.4.3.3 Giving permission for making restrictions*
    - 6.4.4 Being Collaborative

Green = Mental Health Staff

Yellow = Clinical Psychologists

No Colour = both

## Template (Version 3)

1. **NHS Resources Limit Impact**
    - 1.1 Staff turnover
    - 1.2 Lack of available care
    - 1.3 Lack of time
    - 1.4 Lack of staff

2. **Trying to find certainty**
    - 2.1 Neuropsychology feedback increases certainty
        - 2.1.1 Making things clear
            - *2.1.1.1 Providing answers*
            - *2.1.1.2 Clear reports*
            - *2.1.1.3 Being specific has a greater impact*
            - *2.1.1.4 Summaries are helpful*
            - *2.1.1.5 Moving away from mental health*
            - *2.1.1.6 Moving back to mental health*
        - 2.1.2 Revealing what's hidden
            - *2.1.2.1 Exposing the gaps*
            - *2.1.2.2 Uncovering risk*
            - *2.1.2.3 Uncovering information*
            - *2.1.2.4 Getting beneath the surface*
    - 2.2 Neuropsychology brings up uncertainty
        - 2.2.1 Too much variety
            - *2.2.1.1 Conflicting priorities*
            - *2.2.1.2 Variation in services leads to a variation in impact*
            - *2.2.1.3 Making things less clear*
            - *2.2.1.4 Complexity limits impact*
        - 2.2.2 Being asked to do new things
            - *2.2.2.1 How to apply information to practice*
            - *2.2.2.2 Working with vague recommendations*
            - *2.2.2.3 Working in a different way*

3. **Holding the experience of the client in mind**
    - 3.1 Noticing changes
        - 3.1.1 Noticing the impact on clients and their family
    - 3.2 Implementing changes
        - 3.2.1 Facilitating communication with the client and their family
        - 3.2.2 Adapting information for the client and their family
    - 3.3 Experiencing changes
        - 3.3.1 Increasing empathy
        - 3.3.2 Changing the narrative around clients

4. **The impact on professional relationships**

- 4.1 Increasing connection
    - 4.1.1 Opening up professional communication
    - 4.1.2 Bringing services together
    - 4.1.3 Increasing shared understanding amongst professionals
- 4.2 Familiarity as a facilitator
    - 4.2.1 A therapeutic focus makes things easier

**5. Neuropsychology takes care of people**

- 5.1 Being close by
    - 5.1.1 Easy access to neuropsychology
    - 5.1.2 A familiar face
- 5.2 Providing emotional support
    - 5.2.1 A reassuring presence for professionals and clients
    - 5.2.2 Reducing concerns
    - 5.2.3 Validating professionals' experiences
    - 5.2.4 Feedback increases professionals' confidence
- 5.3 Keeping people safe
    - 5.3.1 Protecting client safety
- 5.4 Providing help amongst limited resources

**6. The distribution of power**

- 6.1 Imbalance of power within mental health services
    - 6.1.1 Support needed to share feedback amongst professionals
    - 6.1.2 Not all professionals are experts
    - 6.1.3 Different staff hold different levels of power
- 6.2 Neuropsychology seen as powerful
    - 6.2.1 Knowledge is power
        - *6.2.1.1 Neuropsychology feedback seen as infallible*
        - *6.2.1.2 Neuropsychologists are experts*
    - 6.2.2 Having the power to act
        - *6.2.2.1 Neuropsychology makes things happen*
- 6.3 Neuropsychology seen as powerless
    - 6.3.1 A fleeting presence
        - *6.3.1.1 Not enough time for reports to inform decisions*
        - *6.3.1.2 Neuropsychology is a limited resource*
        - *6.3.1.3 Short-term work limits impact*
    - 6.3.2 Not meeting expectations
        - *6.3.2.1 Not feeling good enough*
    - 6.3.3 Lacking a sense of influence
        - *6.3.3.1 No sense of impact on the client*
        - *6.3.3.2 Being on the outside*
        - *6.3.3.3 Lack of systemic impact*
        - *6.3.3.4 Neuropsychology are reliant on the MDT to make things happen*
- 6.4 Neuropsychology empowers staff

- 6.4.1 Being informed
  - *6.4.1.1 Assessment feedback informs capacity decisions*
  - *6.4.1.2 Increasing access to knowledge*
  - *6.4.1.3 Providing a different perspective*
- 6.4.2 Being prepared
  - *6.4.2.1 Saving resources for the team*
  - *6.4.2.2 Removing barriers to support*
  - *6.4.2.3 Streamlining care*
- 6.4.3 Being allowed
  - *6.4.3.1 Satisfactory recommendations*
  - *6.4.3.2 Increasing self-efficacy*
  - *6.4.3.3 Giving permission for making restrictions*
- 6.4.4 Being Collaborative

Green = Mental Health Staff

Yellow = Clinical Psychologists

No Colour = both

# Template Version 4 (Final Version)

1. **Working within NHS Resources**
    - 1.1 Resources limit impact
        - 1.1.1 Staff turnover
        - 1.1.2 Lack of available care
        - 1.1.3 Lack of time
        - 1.1.4 Lack of staff
    - 1.2 Neuropsychology provides help amongst limited resources

2. **Trying to find certainty**
    - 2.1 Neuropsychology feedback increases certainty
        - 2.1.1 Making things clear
            - *2.1.1.1 Providing answers*
            - *2.1.1.2 Writing clear reports*
            - *2.1.1.3 Being specific has more of an impact*
            - *2.1.1.4 Summaries are helpful*
            - *2.1.1.5 Moving away from mental health*
            - *2.1.1.6 Moving back to mental health*
        - 2.1.2 Revealing what's hidden
            - *2.1.2.1 Exposing the gaps in services*
            - *2.1.2.2 Uncovering risk*
            - *2.1.2.3 Uncovering new information*
            - *2.1.2.4 Getting beneath the surface*
    - 2.2 Neuropsychology brings up uncertainty
        - 2.2.1 Variety in services
            - *2.2.1.1 Not knowing what to expect*
        - 2.2.2 Being asked to do new things
            - *2.2.2.1 How to apply information to practice*
            - *2.2.2.2 Working in a different way*
        - 2.2.3 Making things less clear
            - *2.2.3.1 Not having definite answers*
            - *2.2.3.2 Different expectations around outcomes*

3. **Holding the experience of the client in mind**
    - 3.1 Noticing changes
        - 3.1.1 Noticing the impact on clients and their family
    - 3.2 Implementing changes
        - 3.2.1 Facilitating communication with the client and their family
        - 3.2.2 Adapting information for the client and their family
    - 3.3 Experiencing changes
        - 3.3.1 Increasing empathy
        - 3.3.2 Changing the narrative around clients

4. **The impact on professional relationships**
    - 4.1 Increasing connection
        - 4.1.1 Opening up professional communication
        - 4.1.2 Bringing services together
        - 4.1.3 Increasing shared understanding amongst professionals
    - 4.2 Familiarity as a facilitator
        - 4.2.1 A therapeutic focus facilitates the process

5. **Neuropsychology takes care of people**
    - 5.1 Being close by
        - 5.1.1 Easy access to neuropsychology
        - 5.1.2 Neuropsychology is a familiar face
    - 5.2 Providing support
        - 5.2.1 A reassuring presence for professionals and clients
        - 5.2.2 Reducing concerns
        - 5.2.3 Validating professionals' experiences
        - 5.2.4 Feedback increases professionals' confidence
    - 5.3 Keeping people safe
        - 5.3.1 Protecting client safety

6. **The influence of power on the feedback process**
    - 6.1 Imbalance of power within mental health services
        - 6.1.1 Support needed to share feedback amongst professionals
        - 6.1.2 Limits in expertise
        - 6.1.3 Different staff hold different levels of power
    - 6.2 Neuropsychology seen as powerful
        - 6.2.1 Knowledge is seen as powerful
            - *6.2.1.1 Neuropsychology feedback seen as infallible*
            - *6.2.1.2 Neuropsychologists seen as experts*
        - 6.2.2 Having the power to change things
            - *6.2.2.1 Neuropsychology feedback produces change*
    - 6.3 Neuropsychology seen as lacking power
        - 6.3.1 A limited presence
            - *6.3.1.1 Not enough time for reports to inform decisions*
            - *6.3.1.2 Neuropsychology is a limited resource*
            - *6.3.1.3 Short-term work limits impact*
        - 6.3.2 Not meeting expectations
            - *6.3.2.1 Not feeling like support is good enough*
        - 6.3.3 Lacking a sense of influence
            - *6.3.3.1 No sense of impact on the client*
            - *6.3.3.2 Being on the outside of the MDT*
            - *6.3.3.3 Lack of systemic impact*
            - *6.3.3.4 Neuropsychology are reliant on the MDT to make things happen*

- 6.4 Neuropsychology empowers staff
  - 6.4.1 Being informed
    - *6.4.1.1 Assessment feedback informs capacity decisions*
    - *6.4.1.2 Increasing access to knowledge*
    - *6.4.1.3 Providing a different perspective*
  - 6.4.2 Being prepared
    - *6.4.2.1 Saving resources for the team*
    - *6.4.2.2 Removing barriers to support*
    - *6.4.2.3 Streamlining care*
  - 6.4.3 Being allowed
    - *6.4.3.1 Satisfactory recommendations*
    - *6.4.3.2 Increasing self-efficacy*
    - *6.4.3.3 Giving permission for making restrictions*
  - 6.4.4 Being Collaborative

Green = Mental Health Staff

Yellow = Clinical Psychologists

No Colour = both

## Appendix S

Table of Omitted Themes and Sub-Themes in Final Analysis

| Themes and Subthemes | Explanation | Reasons for Omission |
|---|---|---|
| **Theme of 'Working within NHS Resources':**<br>- Resources limit impact<br>➢ Staff turnover<br>➢ Lack of available care<br>➢ Lack of time<br>➢ Lack of staff<br>- Neuropsychology provides help amongst limited resources<br>KEY:<br>Yellow – Clinical psychologists only<br>Green – Mental health staff only<br>No Colour - both | Participants in both groups brought up the difficulties and limitations of working within NHS resources.<br>Participants experienced or expected that their work would be limited due to a lack of resources. Only neuropsychologists commented on their expectation that there would not be appropriate care available to clients and that this influenced what they expected staff to be able to implement.<br>Mental health staff reported concerns around a lack of staff being available within services to communicate with and action feedback.<br>Some participants across the groups identified that neuropsychology was trying to provide help amongst limited resources and that it was beneficial for staff. | Knowledge of limited resources within the NHS is well-established within services and the wider literature. Participant accounts here echoed that of previous studies where change has been limited by the available time, funding and staff (Happell et al., 2012).<br>Whilst this is an important consideration, it is not a particularly novel discovery and so did not add new information to the existing body of research in this area. |
| **Theme of 'Holding the experience of the client in mind':** | Neuropsychologists and mental health staff both commented on how neuropsychology feedback didn't just influence changes for | This theme provided some interesting insights into how mental health staff noticed the changes that neuropsychology feedback had on the clients and |

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|---|---|---|
| - Noticing changes<br>➢ Noticing the impact on clients and their family<br>- Implementing changes<br>➢ Facilitating communication with the client and their family<br>➢ Adapting information for the client and their family<br>- Experiencing changes<br>➢ Increasing empathy<br>➢ Changing the narrative around clients<br><br>KEY:<br><br>Yellow – Clinical psychologists only<br><br>Green – Mental health staff only<br><br>No Colour – both | staff but was also expected to and experienced as producing changes for clients.<br><br>Mental health staff described directly noticing the impact that neuropsychology input had on their clients including feeling less distressed and improving their awareness of their difficulties.<br><br>Neuropsychologists described how they hoped that their input would increase communication with clients around the reasons behind their difficulties. Mental health staff did explain that receiving feedback led to more open discussions with clients and their families around cognitive difficulties and adaptations to support.<br><br>Only mental health staff commented that neuropsychology feedback led them to make adaptations to the way they presented information to clients and their families.<br><br>Neuropsychologists described that they expected their feedback to lead to staff experiencing changes in the way they thought about their clients. They also hoped that their feedback would increase empathy for clients, which is also | families they were working with. Whilst this does provide some new information, it was not specifically related to the staff's own experience of change following neuropsychology feedback and so did not seem as relevant to the specific research questions as other themes which have been examined more closely within this report.<br><br>The themes around empathy and changing narratives demonstrate important emotional changes for staff which are less well recorded. However, these specific themes covered this at a more general level whereas other themes which have been included in the analysis have considered this in more detail and provide further information. |

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| | something that mental health staff reported. | |
| **Subthemes under the theme of 'Trying to find certainty':**<br>➢ *Writing clear reports*<br>➢ *Being specific has more of an impact*<br>➢ *Summaries are helpful*<br>➢ *Exposing the gaps in services*<br>➢ *Variety in services/Not knowing what to expect*<br>- Making things less clear<br>➢ *Not having definitive answers*<br>➢ *Different expectations around outcomes*<br>KEY:<br>Yellow – Clinical psychologists only<br>Green – Mental health staff only<br>No Colour – both | Neuropsychology was expected and experienced as providing some certainty to staff when they were not sure about their client's needs. This increase in certainty was due to a variety of factors.<br>Mental health staff commented on how clearly feedback was provided through clear reports and helpful summaries. This matched with the expectations of neuropsychologists who commented on writing shorter and clearer reports.<br>All of the neuropsychologists commented that providing specific instructions and information would have more of an impact on changes to care for clients. One member of mental health staff also commented on this.<br>However, participants from both groups also commented on how different expectations around neuropsychological assessment could lead to things becoming more uncertain. Neuropsychologists expressed that they did not always have definitive answers and that this could lead | Aspects of this theme have been well researched in previous literature. Style of neuropsychology reports, as well as the gaps and limitations of services are well documented within the literature and findings have already described potential solutions (Allott et al., 2020).<br>The theme of lacking definitive answers also does not provide much further insight into how recommendations and feedback influence change, as the variety seen within services and interventions offered is also well known (Hilsabeck et al., 2014).<br>Therefore, these sub-themes appear to add limited new information compared to other sub-themes within the study. |

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| | to further confusion when implementing changes to client care. | |
| **Subthemes under the theme of 'Impact on professional relationships':**<br>- Increased shared understanding amongst professionals<br>- Familiarity as a facilitator<br>- A therapeutic focus facilitates the process<br>KEY:<br>Yellow – Clinical psychologists only<br>Green – Mental health staff only<br>No Colour – both | Participants spoke about how they had expected or noticed changes to professional relationships following neuropsychology assessment feedback.<br>There was an expectation from neuropsychologists that there would be an increase in professionals' shared understanding of clients' difficulties and needs. This was something that was also commented on by mental health staff.<br>Participants from both mental health staff and neuropsychologists mentioned feeling that the process of providing and receiving feedback was more straightforward, or was expected to be more straightforward, when feedback was discussed amongst professionals from a psychological background.<br>Neuropsychologist participants expected that it would be easier to understand and tailor the needs of their recommendations to other psychological professionals due to the similarity in training and knowledge. Whilst this was not directly mentioned by mental health staff participants, some | These themes do provide helpful information on factors that help put changes into place such as a therapeutic background. However, the themes do not go above describing this and participant accounts do not offer much further insight into why this is or the experiences of those who come from a non-therapeutic background.<br>Instead, the theme of increasing connection was kept within the report as this better demonstrated the nuance of participants' experiences and went into greater detail about the reasons for increasing professional connection and how this helped implement changes. |

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| | mental health staff did report experiencing similarities in professional background as facilitating their access to neuropsychology and discussions around clients. | |
| **Subthemes under the theme of ‘Neuropsychology takes care of people’:**<br>- Being close by<br>- Easy access to neuropsychologist<br>- Neuropsychology is a familiar face<br>- A reassuring presence for professionals and clients<br>- Protecting client safety<br>KEY:<br>Yellow – Clinical psychologists only<br>Green – Mental health staff only<br>No Colour – both | There was a sense from participants in both groups that neuropsychology feedback was intended to be supportive and to help staff with supporting their clients.<br>Mental health staff commented on how easy it was to access support from neuropsychology, although this was not mentioned by the neuropsychologist participants.<br>Mental health staff also described how helpful it was that they knew the neuropsychologists and felt comfortable in approaching them for support.<br>Neuropsychologists described how they expected their input to provide some reassurance to professionals that this would validate their confusion around certain clients. Mental health staff’s experiences matched these expectations. | These subthemes mainly centred on staff’s experiences of accessing neuropsychology in order for their client to have an assessment and to receive feedback. This brought up useful information on staff’s experiences and the facilitators and challenges of this. However, the research questions were focused on the feedback process and so this theme was not as relevant to the specific aims of the research but could be a helpful starting point to consider in future studies to examine experiences of accessing neuropsychology support.<br>Protecting client safety was an important consideration to staff in helping them to manage risk. However, this was explored in more detail in the theme of ‘Keeping people safe’ so this additional theme was not explored further within the analysis. |
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| **Subthemes under the theme of 'The influence of power on the feedback process':**<br>- Imbalance of power within mental health services<br>- Support needed to share feedback amongst professionals<br>- Limits in expertise<br>- Different staff hold different levels of power<br>- Knowledge seen as powerful<br>- Neuropsychology feedback seen as infallible<br>- Neuropsychologists seen as experts<br>- Not enough time for reports to inform decisions<br>- Neuropsychology is a limited resource<br>- Not meeting expectations<br>- Not feeling like support is good enough<br>- No sense of impact on the client<br>- Satisfactory recommendations<br>- Being collaborative<br>KEY:<br>Yellow – Clinical psychologists only<br>Green – Mental health staff only | An idea that was frequently acknowledged amongst mental health staff and neuropsychologists was around the varying levels of power that staff working in mental health services have over their client's care and how much they feel they can influence treatment decisions.<br>Neuropsychologists expected that certain members of staff would hold more power to enact changes in clients' care. This feeling was matched by the experiences of some staff working in mental health services who felt that having the consultant psychiatrist or someone more senior involved would facilitate communication and action.<br>Mental health staff also mentioned feeling that they lacked the expertise to be able to implement information gathered from the neuropsychological assessment.<br>Neuropsychologists expressed an expectation that sometimes there are unrealistic expectations of neuropsychology and its role in mental health services. Mental health staff often referred to neuropsychologists as being experts and the knowledge held by them as being "evidence". | The differing levels of expertise and power in the roles within healthcare is also well documented and known (Laker et al., 2014). Therefore, this sub-theme did not seem like it added much further new information to address the research questions.<br>Staff commented frequently on the expertise of neuropsychology and how they viewed this as infallible. However, this did not provide too much insight into how this affects change to the extent that other themes did and so was not as relevant to the research questions.<br>Similarly to the theme around working within NHS resources, themes around neuropsychology lacking time and resources is already well known and so does not add further to the existing knowledge-base (Happell et al., 2012).<br>The theme around sensing an impact on the client is also omitted due to the focus on changes for the client rather than the staff.<br>Being collaborative as a theme highlighted the importance for mental health staff and neuropsychologists of working together following feedback, but did not offer new information into how this helped or did not help and what influenced their ability to be collaborative.<br>Overall, other aspects of this overall theme were included within the report which provided further |

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| No Colour – both | Neuropsychologists, but not mental health staff, commented on feeling like neuropsychology support was not good enough. They described feeling like they were not meeting expectations and attributed this to limits on time as well as not being embedded within the teams. The neuropsychologists also described that they are not involved in cases for long enough to see the impact on the client.<br>Comments across both groups described expecting and experiencing neuropsychology as a limited, short-term resource. Mental health staff participants described that the time limitations with neuropsychology then leads to a delay in reports which impacts on decision-making. Neuropsychologists reported that they expected this would impact on how helpful their recommendations would be.<br>Only mental health staff commented on the recommendations given to them by neuropsychologists, saying they were mostly satisfied with them. | detail on the experiences of power and action following neuropsychology feedback. |

# Appendix T

Example of a coded transcript

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# Appendix U

Table of Themes, Sub-themes and Quotes from Interviews

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# Appendix V

End of Study Report for Ethics Panel

## Research Summary

### Background

Neuropsychological assessment and feedback has been a useful part of healthcare services for many years, with clients, families and referrers expressing high levels of satisfaction with this intervention.

However, research has demonstrated inconsistency in the way feedback and recommendations are implemented following neuropsychology input. Accounts from clients and staff indicate that recommendations are not always viewed as appropriate or feasible, and more recent studies have shown there are discrepancies in how neuropsychologists expect their reports to be received and how they are actually received by staff in services.

This indicates that feedback may not always have the impact it is intended to have which could have detrimental consequences for treatment. However, this has yet to be directly explored with neuropsychologists and staff in mental health services.

### Aims

The study aimed to examine the following:

1. Clinical neuropsychologists' expectations of the impact of providing feedback from their assessments with clients in mental health services.
2. Mental health staffs' experiences of receiving feedback from clinical neuropsychological assessment of their clients.
3. Any differences and similarities that were identified between these groups of participants.
4. The perceived reasons for whether change occurs following neuropsychological input and whether it aligns with expectations.

### Methods

Semi-structured interviews were conducted with 12 participants, three neuropsychologists and nine staff from mental health services. Neuropsychologists were asked about their expectations of the impact of their input with specific clients and mental health staff were asked about their experiences of receiving neuropsychology input for the same clients.

### Analysis

Template analysis was used to identify recurring themes within the data that would help illustrate the diversity of participants' experiences and expectations of neuropsychology within mental health services.

Six overarching themes were constructed around: working within limited resources; trying to find certainty; holding the experience of the client in mind; the impact on professional relationships; neuropsychology taking care of people; and the influence of power on the feedback process.

**Conclusions**

Differences were identified in how participants perceived the influence and helpfulness of neuropsychology. Neuropsychologists expected to have limited influence over treatment decisions and felt their support was insufficient. Mental health staff viewed neuropsychology support as helpful and described it as providing evidence for accessing further support. Issues of power and who holds enough power to effect change came up within discussions, with certain members of the MDT being identified as holding more power than others. This was then perceived to either limit or facilitate change.

Participants commented that issues with service structure prevented neuropsychology from having a more long-term and systemic impact, and this is something that could be considered for further examination and service development. This was especially important to participants in terms of supporting staff to apply the feedback to clinical practice, which is something they identified as difficult to do.

Differences were observed in how much feedback was perceived to impact on the client and it could be helpful for further research to examine client experiences to compare whether these align with those mentioned by staff.

# Appendix W

Author Guidelines for The Clinical Neuropsychologist Journal

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