**EQUITy**

**Enhancing the Quality of Psychological Interventions Delivered by Telephone**

**Designing an intervention to improve patient engagement and quality of telephone delivered psychological interventions: is the intervention feasible, usable and acceptable?**

**EQUITy** is a five-year research programme tasked with designing, implementing and evaluating an intervention that aims to improve the quality of psychological therapies delivered over the telephone at Step 2 (Guided Self-Help) in the UK’s Improving Access to Psychological Therapy (IAPT) services. Phase 1 of the programme examined which aspects of the clinical and organisational contexts of IAPT services act as barriers and facilitators to telephone delivery of therapy in order to shape an evidence based quality improvement intervention. Phase 2 involved the synthesis of knowledge from Phase 1 to co-develop a draft intervention, in collaboration with IAPT practitioners, service leads, clinical academics and patients. This report outlines the next stage of the programme, which is to evaluate the feasibility and acceptability of the draft intervention, and make any necessary amendments, before commencing a full evaluation of the intervention in a cluster randomized trial.

**Introduction**

Despite evidence that telephone delivery can be as effective as face-to-face delivery for psychological therapies 1 2 with the added benefits of access, flexibility and reduction of stigma 3 4, there remained a scepticism among practitioners and patients about remote appointments and the use of the telephone therapy in mental health settings. Concerns centre around the potential difficulties involved in developing a therapeutic alliance at a distance, perceptions of reduced effectiveness, concerns about patient safety, and lack of patient engagement 3-9

Despite these concerns, the COVID-19 outbreak necessitated a sudden shift to remote therapy delivery with therapists receiving limited or no telephone specific training in preparation 5 10 11. Simultaneously, the pandemic brought about an increase in mental health problems in the general population 12-14. There was, and still is, a pressing a need for mental health services to find cost-effective ways of providing evidence-based interventions to an increasingly high volume of patients, without compromising quality of care. Remote delivery of psychotherapy occurred before the pandemic and early indications are that it will continue at a comparable if not greater pace. This means that the development of a sustainable intervention to improve the quality of telephone delivered psychotherapy is more important than ever.

In the first phase of intervention development (prior to the pandemic), we explored the challenges and experiences surrounding the delivery of telephone therapy, examining the perspectives of policy makers, services, practitioners and patients. We assimilated this learning to identify areas of behaviour change that could be incorporated into a quality improvement intervention designed to improve patient and professional engagement with telephone delivered therapy 5 6 15 (see [Rushton et al 2019](https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4824-4); [Faija et al 2020](https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-020-02761-3); [Rushton et al 2020](https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-020-02564-6) for further details).

Using recordings of telephone assessment and therapy sessions, we examined patient-practitioner interaction and identified areas to improve engagement and delivery. The overall theme that ran through the findings was that telephone appointments were often protocol-driven, restricting the delivery of a more patient-centred approach. As a result, therapy was characterised by rigid structures, habitualised practices and an overreliance on prewritten scripts, all of which impacted negatively on patients’ experiences 16 (see [Drew et al 2021](https://sites.manchester.ac.uk/equity/wp-content/uploads/sites/174/2021/07/Telephone-delivery-of-psychological-interventions-SSM-22Sept2020.doc) for further details)

In Phase 2, the findings from the first phase of the EQUITy programme were synthesised using the Behaviour Change Wheel Framework 17 and the integral capabilities (C), opportunities (O) and motivations (M) model of behaviour change (COM-B) 17. From this work, a draft intervention was co-developed with patients and professionals 18 (see [Faija et al 2021](https://implementationscience.biomedcentral.com/track/pdf/10.1186/s13012-021-01122-2.pdf) for further details).

Together, this work identified core areas for behaviour change that needed to be incorporated into the intervention at:

* *Service level:* guidelines and procedures for telephone delivery were needed to ensure practitioners had the most suitable working environment and resources available to them, the provision of clinical support for remote delivery and opportunities for professional development
* P*ractitioner level*: a need to develop practitioner telephone skills, to improve knowledge on the origins, drivers and processes for telephone delivery to address potential negative preconceptions about telephone treatment and improve treatment delivery confidence
* *Patient level:* to increase awareness of different psychological treatments (e.g. counselling, cognitive behavioural therapy, guided-self-help), and their different modes of delivery (e.g. telephone, group), and address beliefs and pre-conceptions that remote delivery is of inferior quality when compared to face-to-face.

**Aims and objectives of the feasibility study**

Before the full evaluation of any new and complex health care intervention, it is important that the components of the intervention, and the processes involved in its implementation, are feasible and acceptable to all parties involved. This ‘feasibility study’ helps safeguard a full evaluation of the intervention at trial stage from unnecessary problems of compliance, delivery, recruitment and retention 19.

The overall aim of this study was to evaluate the feasibility, usability and acceptability of the EQUITy behaviour-change intervention designed to improve engagement in, and the quality of, psychological interventions delivered by telephone. The findings from this study informed changes to a) the content of the intervention b) the process of implementation and c) the evaluation of the intervention, before its full evaluation in a cluster randomised controlled trial.

Specifically, the objectives of this study were to evaluate:

1. service recruitment capabilities
2. the acceptability and suitability of the content of the intervention for services, professionals and patients
3. the acceptability and suitability of the implementation procedures of the intervention for sites, professionals and patients
4. data collection procedures and outcome measures (e.g. time to complete measures during training, accessing anonymous service-collected data)
5. exploratory evaluation of the impact of the intervention on perception of skills.

**Description of the Intervention**

The intervention that was subjected to feasibility testing consisted of 3 components:

1. Training for practitioners on the delivery of therapy by telephone
2. Resources for patients (leaflets, poster, appointment cards)
3. Guidelines for service development

**1. Training for practitioners**

The training materials had been developed prior to the COVID-19 pandemic so were amended to ensure their relevance to the ongoing COVID-19 situation (e.g. wording, images, case examples, and an accessible online format). The training consisted of two sessions of 3-hours each. The first session was made up of 5 sections: 1) Welcome and Introductions 2) Introduction to the EQUITy programme 3) Evidence of the effectiveness of telephone delivered psychological interventions 4) Telephone skills (Introduction and orientation) 5) Managing emotion.

The second session focussed primarily on telephone delivery skills and practice including verbal communication skills; skills to deliver treatment with a personalised approach, delivering formulation and homework without visual aids, dealing with noise and the patient's environment.

**2. Resources for patients**

Materials for patients were co-designed with service users and included a leaflet incorporating information about telephone treatment in IAPT and an appointment card. The leaflet included information on the advantages of telephone appointments; an explanation of ‘guided self-help’ and how it works, and a focus on the credibility of the practitioners who deliver it. It also included a section of ‘frequently asked questions’. A poster was also developed, similar to the leaflet, which was to be used in service premises. However, due to the remote delivery of therapy brought about by the COVID pandemic, this latter element was not used in the feasibility study.

**3. Guidelines for services**

A booklet provided guidelines and recommendations for further changes to service delivery which had specifically been highlighted as being important in our exploratory work, but which could not be addressed directly via our training for practitioners or resources for patients. The booklet addressed five key areas of change which would improve the quality of telephone delivered self-help interventions: 1) Promoting telephone work 2) Incorporating key elements of telephone work 3) Addressing working environment and resources 4) Boosting practitioner telephone skills and 5) Promoting Reflection. An introductory section provided information on how services should use and get the best out of the booklet.

**Methods used in the feasibility study**

**Ethical Approval**

The EQUITy Feasibility Study was approved by North West - Preston Research Ethics Committee REF: 20/NW/0082 IRAS ID: 271710. The study complied with all statutory research governance requirements

*Diagram showing the methods and process of the feasibility study*

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Three IAPT sites took part in the ‘feasibility study’.

**Implementation of the EQUITY intervention**

The three ‘feasibility sites’ received the team *training* aspect of the intervention between Nov 2020 and Jan 2021. Information on the training was forwarded to the service leads who in turn informed and recruited practitioners. The training was originally designed to be delivered face to face over 2 days. However, due to the pandemic this was held on-line over two three-hour sessions delivered on two consecutive days. The training content was adapted for on-line delivery (e.g. use of on-line break out room facility; use of ‘chat’ for feedback and questions; an additional facilitator to monitor chat feedback) and made more interactive to support distance learning, optimise engagement and enable contemporaneous skills practice and education.

The *service guidelines* booklet was sent to the service team with a covering letter explaining the purpose and how to use the booklet to improve recovery and retention rates for guided self-help interventions delivered over the telephone. Service were advised to liaise with the research team if they had questions or needed assistance to implement the suggested guidelines that were deemed appropriate for their service. The use of the booklet was discussed in the subsequent interviews with the service leads.

The *patient resources* were sent to the service leads in electronic and/or hard copy format in accordance with the wishes of the service. Services were asked to send the resources out to patients as and when they were sent their referral notification for telephone therapy with the intention that they would receive them prior to their first telephone session.

**Evaluation of the Intervention**

The evaluation of the content and implementation EQUITy Intervention consisted of two parts incorporating qualitative and quantitative methods:

1. Pre-post training measures and questionnaires (quantitative)

2. Post intervention interviews with and patients, practitioners and service leads (qualitative)

Pre-post training measures and questionnaires

Recruitment was evaluated using pre-post training attendance registers and a demographic questionnaire. Outcome measures and questionnaires were completed online to assess the practitioners’ a) view of their organization’s readiness for change b) skills, knowledge and beliefs and c) the suitability and acceptability of the training.

*Organizational Readiness for Implementing Change*

TheOrganizational Readiness for Implementing Change (ORIC) 20 questionnaire was completed before and after training to explore changes in the extent to which the practitioners felt their organization and colleagues were psychologically and behaviorally prepared to implement organizational change. The 12 items of the measure use a 5-point Likert scale ranging from ‘disagree’ (score 1) to ‘agree’ (score 5). The questionnaire can be divided into the two factors related to organizational readiness ‘Change Commitment’ (5 items) and ‘Change Efficacy’ (7 items). Quantitative analysis was conducted on the ORIC measures completed before and after training, using descriptive statistics (means, frequencies).

*Assessment of skills, knowledge and beliefs*

The EQUITy Training Evaluation Questionnaire (TEQ), designed specifically for the study, was completed by practitioners before and after training. The TEQ explored whether the training brought about any change in the practitioner’s own assessment of the areas covered by the training, namely their skills, knowledge, and beliefs related to telephone delivered treatment. Skills related to their own assessment of their verbal communication skills, ability to manage silences and distractions, ability to create a safe space, develop a good relationship, explore patient thoughts and feelings, work collaboratively and mentor other practitioners. The practitioners rated their knowledge of delivery of treatment over the phone, the effectiveness of telephone therapy and of the information provided by their service. Practitioners also indicated their beliefs related to their level of confidence with telephone and other remote technologies (e.g. video), whether they thought patients found it useful and wanted therapy over the telephone, how effective it was, it’s relevance to their role and fit with their way of working, and preferences. Ratings use a 5-point Likert scale ranging from ‘disagree’ (score 1) to ‘agree’ (score 5). Quantitative analysis was conducted on the TEQ questionnaire using descriptive statistics (means, frequencies)

*Suitability and acceptability of the training*

To examine the suitability and acceptability of the training, practitioners completed the Training Acceptability Competency Scale (TARS) 21 22 after the training. The first section (TARS-1)21 consists of six self-report items which assess training ‘appropriateness’ or ‘acceptability’ (covering general acceptability, perceived effectiveness, negative side effects, appropriateness, consistency and social validity). Each of the six items is rated on a six-point Likert scale, ranging from ‘strongly disagree’ (score 1) to ‘strongly agree’ (score 6). Questions 1–6 were summed to calculate an overall acceptability score (possible range 6–36). The second section (TARS-2)22 assessed the practitioners’ overall impressions of the impact of the teaching process and its outcomes. It consists of nine items, rated on a four-point Likert scale from ‘not at all’ (score 0) to ‘a great deal’ (score 3). Questions 7–15 were summed to calculate an overall perceived impact score (possible range 0–27).

**Post-intervention interviews**

Patient Interviews

*Recruitment*: Participant interview information packs were distributed to all patients who received telephone delivered therapy during the intervention period. These were distributed by the service administration team and contained a consent to contact form to complete and return to the research team if interested in taking part. Following declaration of interest in taking part (return of consent to contact form or direct contact with the research team by email or phone), participants were contacted to confirm willingness to participate and arrange the interview/focus group. Semi-structured interviews were conducted with 6 patients, 2 from each of the three feasibility sites, who had received 2 or more sessions of GSH-T from a PWP in receipt of the EQUITy intervention training. All interviews were conducted by telephone and lasted between 40 and 58 minutes.

*Data Analysis:* Interviews were recorded and transcribed verbatim. Analysis was conducted using the Theoretical Framework of Acceptability (TFA) 23. The TFA is a multi-construct theoretical framework used to assess the acceptability of healthcare interventions. Interview data was coded into the 7 domains of the TFA which capture the acceptability of an intervention: affective attitude; ethicality; intervention coherence; self-efficacy; burden; opportunity costs; perceived effectiveness. Sub-codes were developed which fell within each of the 7 domains.

For the findings from the interviews related to each of the domains of the TFA see [here](#TFA)

Practitioner and Service Manager Interviews

*Recruitment*: Participant interview information packs were sent to all practitioners who received the EQUITy intervention training. Practitioners were provided with information about the study by email or hard copy packs distributed by the service or research team (Professional Invitation letter, Information Sheet and Consent to Contact Form). Following declaration of interest in taking part (return of consent to contact form or direct contact with the research team by email or phone), participants were contacted to confirm willingness to participate and arrange the interview. Interviews took place with Service Leads/Managers and PWPs from each of the 3 feasibility sites. Four Service Leads/Managers were interviewed with representation from each service. Five PWPs, who had attended the EQUITy training, were interviewed; 1 from Service 1 (C) and two from each of the remaining two services. The PWPs had varying degrees of experience including 2 supervisors and 1 trainee.

All interviews were conducted over the telephone and lasted between 47 and 69 minutes.

*Data Analysis:* Interviews were recorded and transcribed verbatim. Analysis was conducted using the Consolidated Framework for Implementation Research (CFIR) 24. The CFIR is a pragmatic multi-level framework used to assess the implementation of complex interventions. It brings together the key constructs of published implementation theories and is composed of five major domains: intervention characteristics, outer setting, inner setting, characteristics of the individuals involved, and the process of implementation. Each major domain includes a number of sub-domains. Interview data was coded into the five domains and their respective sub-domains. For the findings from the interviews related to each of the domains of the CFIR see [here](#CFIR)

**Data collection and analysis of routine patient IAPT data**

IAPT services collect outcome data routinely on a session-by-session basis

 We collected data on patient engagement and treatment outcomes to explore the feasibility of our proposed data collection processes and to ensure that all the data required for the trial data analysis was available in the format needed to perform the data analysis required to measure patient engagement (e.g. attended and unattended appointments) and mental health outcomes (e.g. PHQ-9 and GAD-7 change pre to post therapy) as outlined in the trial protocol.

For each site we were looking for the following:

1. Access to anonymous routine IAPT dataset for 6 months prior to receipt of PWP training and 3 months post training to include demographics and all outcome measures.
2. To determine if it was possible to indicate on the dataset which PWPs attended the training
3. To determine how to match extra patient data collected in the trial to the routine service data

**Decisions on amendments to the content and implementation of the intervention**

After compilation of information obtained from the feasibility study, the research team met to interrogate the original Theory of Change, identify what components were working more or less well, and to decide on changes that may need to be made to the existing intervention. The proposed changes were further discussed with the Implementation Reference Group, the Programme Steering Committee and at a team meeting to make final decisions about the required amendments/additions to the intervention in preparation of the main trial.

**What did we learn and what did we change?**

**Content of the EQUITy Intervention**

Service Guidelines Booklet

We found that the relevance of some of the recommendations in the service guidelines differed between services; some of the actions had already been implemented in some services or the guideline was not appropriate for their specific situation. Also, some of the guidelines were more or less relevant depending on whether COVID restrictions were in place (eg related to working environment). A decision was made to retain the recommendations but to put in place a traffic light system by which the relevance and importance of the action could be coded according to service needs at that time. Feedback from the interviews also resulted in some minor changes/additions to the guidelines (see here)

Patient Resources

Feedback from the interviews, from those who recalled and had read the leaflet, indicated that the patient leaflet was informative and well designed, so this was retained without change. There was a mixed response from both PWPs and patients related to the usefulness of the appointment card, mostly dependent upon the reminder systems services had in place. As a result, the card will be retained so that patients have the option to use it if they find it helpful. The patient interviews revealed that they mostly approached telephone delivery of therapy with some uncertainty related to content and effectiveness compared with face to face. Whilst the patient resources addressed this, small changes have been made (e.g. addition of patient quotes) to further consolidate their impact.

Telephone Training for practitioners

There were mixed views on the applicability of the training for newly qualified/trainees compared with those with more experience. One service felt that the training was more suitable for trainees rather than those with experience. However, the most experienced practitioners who attended the training from the other two services were favourable towards the training reporting that it gave them confidence in their current practice and developed new skills and awareness. As part of the interviews and post-training questionnaires practitioners were asked what they found most helpful and what changes they would make. As a result more time will be spent on skill development, role play and practical exercises and also on the delivery of specific interventions such as Behavioural Activation by telephone. Time has been created by moving the section relating to evidence of telephone effectiveness to the new implementation workshop, releasing additional training time to concentrate on skill development.

Practitioners will have a more detailed and advance information about the content of the training so that they can make an informed decision on its applicability to them. Reference was made to the increased uptake of video-conferencing and whilst the emphasis on telephone delivery will remain, there will be greater exploration of the crossover with, and challenges of, other remote delivery modalities

**Implementation of the EQUITy Intervention**

The main challenges encountered in the feasibility study related to the implementation of the intervention. The study took place when COVID-19 restrictions were in place and the services were operating almost entirely remotely, which meant that service networks and communications were disrupted and resources limited. At this time caseloads also increased. As a result, services were struggling with the time, commitment and organisation required to implement new interventions. However, because practitioners had transitioned rapidly, and with little warning, to remote working this did mean that the EQUITY intervention remained contextually compatible and relevant.

The Intervention Package

The main problem encountered in the implementation of the intervention was that it had been perceived and treated primarily as training intervention, meaning that there was a general lack of awareness and engagement with the other two components of the intervention, the patient resources and particularly the service recommendations. This meant that implementation of these components was compromised across the sites, weakening their contribution to the change mechanisms set out in our original theory of change.

The COVID pandemic also played a part – with the majority of staff working from home, team communications were altered and routine team implementation meetings were not able to take place.

Indications are that the move towards remote working is likely to continue for the foreseeable future and it was therefore considered necessary to strengthen information, guidance and support to sites to enhance their engagement and ensure the optimal implementation of all three components of the intervention.

The following amendments were actioned: firstly, the introductory information provided to potential participating services has been modified to further emphasise that the intervention includes three elements (not just the training). The time and commitment required for each is clearly outlined. Information is presented via an initial team workshop, which all staff members (including admin, managers, supervisors, and practitioners) are invited to attend. This means that service staff hear directly about the research from the research team rather than an over reliance on internal communications.

The purpose of the introductory workshop is to a) introduce the services to the EQUITy Research Programme and the 3 components of the EQUITy intervention; b) provide and understanding and rationale on the evidence and policies surrounding telephone therapy interventions and c) to develop a bespoke, in-service action plan to initiate and monitor service culture and environmental improvements. The action plan is co-created with services, but includes mandatory components related to the implementation of the Patient Resources and Service Guidelines components of the EQUITy intervention.

Six to eight weeks following the team workshop, service teams have the opportunity to attend a follow-up session (online or via telephone). During this session general thoughts and feelings related to the implementation of the EQUITy intervention will be explored, a review of proposed action plans will take place and next steps will be identified and discussed. The named action plan lead within each site will be invited to attend, with other team members who attended the workshop/training attending as appropriate. Participation in follow-up sessions is voluntary.

Subsequent bi-monthly follow-up meetings (online or via telephone) with named action plan leads will be offered to examine any barriers and facilitators to success and explore alternative ways of achieving agreed targets.

Service Guidelines

Interviews revealed that service leads found the original Service Guideline booklet was not user-friendly; the format did not allow them to monitor progress effectively or share this with other colleagues. Additionally, in two of the three services the service guidelines booklet was not shared/discussed with practitioners. Engagement with the booklet ranged from reading the booklet (no guidelines implemented) to immediately implementing the most relevant guidelines. Due to the COVID pandemic, some of the guidelines (designed prior to the pandemic) were already in place in some services at their point of study entry.

As a result, the Service Guidelines have been amended to take the form of an interactive document where tasks can be collaboratively prioritized, action plans drawn up and progress recorded and monitored using a traffic light system. Teams are proactively brought together in the first workshop to complete this task. Additionally, to optimise engagement with and implementation of the service guidelines, services are invited to nominate a ‘service champion’ at the first training workshop (an action plan lead) who will take on the responsibility of implementing the action plan and monitoring its progress and follow up.

Patient Resources

The PWP and patient interviews indicated that there was some confusion around the existence and distribution of the patient resources. This was attributed primarily to the fact that most service communications were made by email and the resulting volume of emails making things easy to miss. There was also evidence that where the responsibility of distributing the resources fell to practitioners, there was a level of ‘gatekeeping’ occurring, with some practitioners being reluctant to send patient resources for fear of overburdening patients. At interview, patients often did not recall whether they had received the EQUITy leaflet, or at least could not distinguish it from the other service information they had received.

The planned integration of patient resources into the team workshop, and importantly, into each service’s action plan should aid/resolve most of these challenges. At the workshop, the service team will be encouraged to discuss the delivery format (email or hard copy) and timing (eg at referral/assessment) of the patient resources to reduce patient burden and optimise their implementation. Practitioners will also be encouraged to refer to and/or discuss the EQUITy patient resources with their patients during their first scheduled contact session.

Telephone Training for Practitioners

A total of 51 from 123 eligible practitioners (41%) attended at least one of the two training sessions. Fewer (n=46; 37%) attended the second session. A demographic questionnaire was completed by 35 (67%) practitioners who attended the first session. The majority of attendees were female (89%; n=31) and white (85%; n=30) which is marginally above the national rate of the IAPT workforce (81% and 77% respectively; 25 Health Education England 2020). Age ranged from 22 to 62 with the majority in the younger age range of 20-29 (49%). The majority of attendees were PWPs (86%; n=30) of whom 6 (20%) were trainees which is below the national rate of 33% of PWPs 25.

The remaining attendees described themselves as Third Sector Therapists (n=2) and Well Being Coaches (n=3). All attendees reported that they had some experience of delivering therapy over the telephone but the majority (69%) had received no dedicated telephone training.

One of the main implementation concerns was the low rate of practitioners who attended from two of the three feasibility sites; 9 (18%) and 5 (28%) respectively of those eligible. At these two sites attendance was voluntary which compared with 37 (67%) from the third site where attendance was made mandatory by the service lead. The potential reasons for the low numbers were given as increased caseloads limiting availability; conflict with scheduled appointments; participation in the training or research interview impacting on externally governed ‘contact’ targets; and information about the training being buried in a high volume of emails. To try to maximise attendance practitioners will be offered flexibility regarding training dates, including the opportunity to attend training alongside other services. All eligible practitioners will be invited to attend the initial team workshop, increasing their individual and collective investment in the whole intervention. Whether the dedicated skills training sessions are presented as mandatory or voluntary will remain a service decision, however all practitioners, supervisors and managers will be invited and encouraged to attend. A CPD certificate will be issued for attendance.

Recruitment of PWPs for post intervention interviews

Low recruitment to the training sessions had repercussions for the pool of PWPs who were eligible for a post-intervention interview. Nine interviews took place from a target of 20. However, the proportion of PWPs who were interviewed from the two sites were attendance at the training had been voluntary (28%; n=4) was higher than the service where attendance had been mandatory (3%; n=1). It is anticipated that the measures taken to increase attendance at the training (described above) will also result in greater opportunity for the recruitment targets for interviews nested within the full trial to be met.

Patient Recruitment for post intervention interview and ‘enriched sample’ follow up data

Recruitment of patients for post intervention interview was low (n=6 from a target of 20; 2 from each service; all female; 1 x non-white; 4 x employed; all with anxiety, 2 with additional depression). It is possible that this may have implications for the trial; feedback from the patient and PWP interviews indicated that patients were often overburdened with information when first referred to the service, meaning that opportunities to participate in research can easily be missed or ignored. The most effective, efficient and appropriate process for recruiting patients to the trial will be discussed with each service team prior to commencing the trial, and revisited at the initial workshop in those services allocated to the experimental arm. The aim is to ensure that information/invitations reaches patients at the optimal time. Some flexibility will be offered around this, to ensure that patients are not burdened and the approach works with service protocols and constraints, but this will be balanced with a need to limit, as much as is pragmatically possible, the variation between services. Additionally, a proactive approach to research recruitment will be adopted, in which practitioners will be encouraged to mention the study and discuss participation with their patients at their first appointment.

Only sites who can give prior commitment to recruit 100 patients for the ‘enriched sample’ will be entered into the trial. All patients who have accessed telephone treatment following the implementation of the EQUITy intervention will be asked to participate in the trial by providing quantitative outcome data as part of the ‘enriched sample’ and/or qualitative evaluation data by interview. Separate consent will be sought for each.

**Measures used to evaluate the impact of the EQUITy Intervention**

*Organizational Readiness for Implementing Change*

Readiness for change was measured using the validated Organizational Readiness for Implementing Change (ORIC) questionnaire 20. The brief 12 item instrument was completed before and after training to explore the extent to which practitioners felt their organization was committed to making a change and had the capability to do so. Prior to training the practitioners indicated a high level of readiness for implementing telephone delivery of therapy with an overall mean score of 4.2 (SD= .66) and similar scores for commitment and efficacy [4.2 (SD= .69) and 4.1 (SD= .71) respectively] with very little difference between the three services. Post training this declined slightly with an overall mean score of 3.8 (SD= .69) a ‘change commitment’ mean score of 3.9 (D= .73) and ‘change efficacy’ mean score of 3.7 (sd.70). This measure was primarily introduced to the feasibility study to check the impact of the pandemic on the feasibility sites and will be administered pre-intervention only in the trial.

*Self-assessment of skills, knowledge and beliefs*

The practitioners’ own assessment of their level of skills, knowledge and beliefs about telephone delivery of therapy was assessed using the EQUITy Training Evaluation Questionnaire (TEQ) developed specifically for the evaluation. Prior to the training practitioners rated their level of knowledge and skills as relatively high with overall mean scores of 4.0 (SD= .75) and 4.1 (SD= .64) respectively and positive beliefs related to telephone therapy (mean = 4.2; SD= .51). Post training mean scores were slightly higher for knowledge and skills and remained constant for beliefs: Skills 4.4 (SD= .68); Knowledge 4.5 (SD=.70); Beliefs 4.2 (sd .52). One aim of the feasibility study was to ascertain the viability and usefulness of this measure, particularly in an environment impacted by COVID. Upon reflection the TEQ was considered to not add anything to the other measures administered; a decision was made to drop these in the main trial which will reduce measurement burden on participants

*Acceptability and Suitability of the Training*

The acceptability and suitability of the training was evaluated using the Training Acceptability Competency Scales 21 22. Responses to the first six statements (acceptability, effectiveness, absence of side effects, appropriateness, consistency and social validity) indicated that the training was regarded as being acceptable and suitable by most attendees (see table below). The majority also indicated that they were satisfied with the training, thought the trainers were competent, related to the group, were motivating and covered the topics they set out to cover. A majority also thought that the training had practical and professional relevance and had, to some degree, improved their understanding, developed their skills, increased their confidence. Only one person thought the training did not develop their skills and three did not feel more confident. These divergent views may in part be explained by incomplete training attendance, specifically missed role play and practice opportunities. It is anticipated that the increased time that will be spent on skill development in the training conducted with the trial sites, will result in the training being acceptable and suitable to all attendees.

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| **Question/Domain** | **N** | **Mean (sd)**(range 1-6) | **N (%) agree** (strongly, moderately or slightly) | **N (%) disagree** (moderately or slightly) |
|  1 Acceptability | 19 | 5.16 (1.3) | 17 (89.5%) | 2 (10.5%) |
|  2 Effectiveness | 18 | 5.28 (.96) | 17 (94.4%) | 1 (5.6%) |
|  3 Negative Side Effects | 19 | 5.05 (1.3) | 17 (89.5%) | 2 (10.5%) |
|  4 Inappropriateness | 19 | 5.32 (.89) | 18 (94.7%) | 1 (5.6%) |
|  5 Consistency | 19 | 5.68 (.75) | 18 (94.7%) | 1 (5.6%) |
|  6 Social Validity | 19 | 5.47 (.91) | 18 (94.7%) | 1 (5.6%) |
| **Question/Domain** | **N** | **Mean (sd)**(range 1-3) | **N (%) quite a lot/ a great deal/a little** | **N (%) not at all** |
|  7 Improve Understanding | 19 | 1.74 (.73) | 19 (100%) | 0 (0.0%)  |
|  8 Develop skills | 19 | 1.63 (.83) | 18 (94.7%) | 1 (5.3%) |
|  9 Increase confidence | 19 | 1.58 (1.0) | 16 (84.2%) | 3 (15.8%) |
| 10 Make use of things learned | 19 | 1.95 (.78) | 19 (100%) | 0 (0.0%) |
| 11 Competence of trainers | 19 | 2.68 (.67) | 19 (100%) | 0 (0.0%) |
| 12 Overall Satisfaction | 19 | 2.37 (.83) | 19 (100%) | 0 (0.0%) |
| 13 Topic coverage | 19 | 2.53 (.61) | 19 (100%) | 0 (0.0%) |
| 14 Trainers relate to group | 19 | 2.74 (.65) | 19 (100%) | 0 (0.0%) |
| 15 Trainers motivating | 19 | 2.47 (.84) | 19 (100%) | 0 (0.0%) |

*Capability, Opportunity and Motivation*

The development of the EQUITy Intervention was theory driven, using the COM-B theory of behaviour change. A measure of capability (e.g. knowledge and skills), opportunity (e.g. external factors) and motivation (e.g. attitude) has recently been developed and validated 26 and will be utilized in the trial study before and after the implementation of the intervention

**Frameworks used for patient and professional interviews**

The structure and analysis of the patient and professional interviews professional interviews was guided by the Consolidated Framework for Implementation Research (professionals) and the Theoretical Framework of Acceptability (patients). The CFIR provides a standardised list of constructs compiled from previous implementation research to support the identification of factors that are of most salience to the implementation of a particular intervention 24. CFIR comprises a taxonomy of 39 operationally-defined constructs across five domains which influence the implementation of complex interventions. The domains relate to the planned intervention, the contexts in which the implementation activities will occur (the ‘inner’ and ‘outer’ settings), the individuals involved and the process of intervention delivery. For the trial study professional interviews the CFIR will be used in combination with the Normalisation Process Theory 27. NPT provides a more detailed focus on the process of implementation and seeks to provide and in-depth understanding of the process of introducing and maintaining new practices and places particular importance on how people understand the intervention, how it is assimilated into daily practices and how the intervention effects relationships in the clinical context 28. The use of both allows for the identification of individual and organisation contextual factors related to implementation (CFIR) and the development of an in-depth understanding of how differences in context affect implementation over time (NPT). The TFA was considered an appropriate framework to examine the implementation of the intervention from the patient’s perspective.

**Collection and analysis of routine patient IAPT data**

The data collection process was largely positive. A few changes were identified that would need to take place to ensure the data required for the trial was received effectively. It was determined that it was necessary to identify a data manager at each individual site and for discussions to start with them at the earliest opportunity. This was to ensure that data and procedures were in place to allow the matching of patient datasets (carried out by the service) and to be able to identify PWPs who had, and had not, received the training. It was also identified that as individual services were providing the data that formatting of the data may vary between sites and thus we will need to allocate time to managing the data and combining multiple datasets.

**Summary of changes to the EQUITy Intervention and Evaluation**



A summary table of the changes made to the content and implementation of the intervention can be found [here](#CHANGES)

**What’s next?**

The updated EQUITy Intervention will be evaluated in a cluster randomised trial involving 26 services; 13 services will receive the intervention and 13 services will act as control sites. Data will be collected and analysed to evaluate whether the intervention improves health outcomes, engagement with telephone therapy delivered at Step 2 in IAPT services, is acceptable to patients, practitioners and services as a whole, and is also cost effective.

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*Table 1: Key findings and respective amendments made to the Intervention resulting from the patient post intervention interviews utilizing the Theoretical Framework of Acceptability (TFA)*

|  |  |  |
| --- | --- | --- |
| **TFA DOMAIN** | **KEY FINDINGS****from post intervention patient interviews** | **See Change** **Table No\*** |
| **Ethicality** **The extent to which the intervention has good fit with an individual’s value system** | **Therapy should be face to face**One of the older participants had strong feelings that therapy should always be face to face. Other participants were young and/or relatively new to receiving therapy and although they were slightly sceptical or unsure they did not have a deep set value system that prevented them from being open to the therapy being conducted over the phone  | **19****26** |
| **Affective Attitude** **How an individual feels about the intervention, prior to and after taking part**  | **It was better than I thought it would be**Although many had initial doubts, all but one reported the therapy, had been ‘better than they thought’, would choose it again and recommend it to others.  | **19****26** |
|  | **Telephone is safe and convenient** The convenience and flexibility of conducting therapy over the telephone was regarded as a distinct advantage by most. Not having to travel, take time away from work/childcare, out of hour’s sessions and feeling relaxed at home removed some of the barriers to accessing therapy. It was also a safe option during the COVID pandemic | **19** |
| **Ease of completing outcome measures**Participants had differing preferences for the method used for completing the outcome measures (portal app, email, during session)  | **19** |
| **Opportunity Costs** **The extent to which benefits, profits, or values must be given up to engage in the intervention**  | **Telephone or nothing**During the COVID pandemic the one thing that some participants had to forego in order to receive therapy was freedom of choice regarding the mode of therapy and the opportunity for face to face therapy. For some this was fundamental, but for others it was less important, so long as they were able to access some form of therapy.  | **25****35** |
| **Perceived effectiveness** **The extent to which the intervention is perceived to be likely to achieve its purpose** | **I was a bit sceptical about whether therapy would work for me**Most of the participants expressed come scepticism about the potential effectiveness of the therapy but not enough to put them off ‘giving it a go’.  | **19****30****32** |
|  | Some thought that having more information about the therapy may have helped to allay their fears. In particular evidence of the effectiveness of GSH for certain conditions  |  |
|  | Of the six participants, only one had their fears born out and remained sceptical about the effectiveness of a telephone intervention and still considered F2F to be far superior. The other participants were ‘happy’ and ‘pleasantly surprised’ with how much the therapy had helped them |  |
| **Self-efficacy** **The participant’s confidence that they can perform the behaviour(s) required to participate in the intervention** | **Not being able to see the therapist helped me engage** Not being able to see the therapist, and the communication problems, that might ensue had been an initial concern for some, however they reported that in actual fact it turned into an advantage; it was easier to talk when they did not have eye contact with the therapist; they did not have to worry about how they were presenting themselves; it was easier if they could not see the therapist’s reactions to things they said; were able to take notes without feeling rude. | **19** |
|  | **I would have preferred video but was not given the choice**One participant felt that not being able to see the therapist was a distinct disadvantage and negatively impacted her engagement with therapy. In retrospect she thought that, as a compromise, video-conferencing may have been better for her. She felt this would have made her more receptive. (P04P) | **25** |
|  | **I connected with my therapist**As part of the EQUITy intervention PWPs had received training which would improve their skills communicating and connecting with the patient when they could not see them. Five out of six of the participants reported a good relationship with their practitioner. The skills reported by the participants which they said aided this relationship were: going at a pace that suited; guiding things along without pushing; keeping focused; listening and responding; being patient and understanding; being genuinely caring and empathetic; providing reassurance; informal warm and friendly.  | **19****15** |
|  | **I could tell the therapist cared**The participants stated that the way they could tell that the PWP cared, and was listening to them was by their verbal skills – having a soothing voice, remembering and recapping what they had said, checking they were ok, using appropriate utterances and changing tone of voice. In turn, this meant that the participant felt comfortable and relaxed, less anxious, more positive, less isolated, more normal, and trusted the PWP that they were there to help. This all meant that the participant was able to open up and engage in the therapy and feel that their problems were being resolved.  | **19****15** |
|  | Not being informed of a change of practitioner had an initial negative impact on feeling a connection with the 2nd therapist | **25** |
|  | **The therapy felt personal to me**All but one of the participants indicated that they felt the PWP personalised the intervention to their own individual needs. The skill the participants mentioned most frequently was the PWPs ability to remember, or take the time to look at notes, what they had said in previous sessions. This meant that they did not have to repeat things which gave a sense of continuation and moving on. It also meant that there was a sense that the PWP understood them and ‘knew what was going on’ which in turn meant gave a feeling of being ‘a person, not a number’ and a sense that the therapist ‘was on the journey’ with them. A further aspect of the intervention which made it feel more personal to them was how the PWP stopped and focussed on, or was able to identify, the individual needs of the participant; they didn’t ‘just work through the book’ | **19****15** |
|  | **Monitoring Progress**A way of maintaining engagement was by reviewing progress with the PWP during the sessions. Having a sense that there had been some improvement gave a sense of reassurance and/or achievement which gave them the incentive to continue. This could be either through use of the measures or reviewing goals | **25** |
|  | **Appointment Card**As part of the EQUITY study an appointment card was developed as it was considered important for engagement in therapy; those with anxiety and depression often have difficulties with memory and concentration. Four out of the 6 participants either did not receive or could not remember receiving the appointment card. The remaining two participants did remember and found it useful. Those who could not remember receiving the appointment card indicated that they did not feel it was necessary as they received emails and text messages which they considered adequate | **31** |
| **Intervention Coherence** **The extent to which the participant understands the intervention and how it works** | **Understanding of intervention from GP**Participants reported that the GP tended not to give them very much information about what types or modes of therapy the local IAPT service provided, other than to inform them that they could self-refer and directed them to the website.  | **26** |
|  | **Pre-conceptions of therapy**Some participants had some pre-conceptions of what therapy involved, either that it was always face to face, or that a telephone intervention would be little more than a ‘chat’. For the former exploring the service website gave them a better insight, for the latter, it wasn’t until therapy commenced that they learned what the intervention involved | **28****32** |
|  | **Knowledge and information received from service leaflets and documents**Because it was often sometime after the participant had received information from the service about their impending therapy, their memory had faded and it was difficult to ascertain to which documents the participant was referring, whether this be the standard service information or the leaflet which was part of the EQUITy intervention. The participants did however give feedback which was relevant to any information provided by the service or the EQUITy study.  | **29****30** |
|  | *When I am feeling unwell clear, user friendly information is needed*Participants valued information that was presented clearly and simply in a user friendly manner. The difficulty of finding the balance between providing a lot of information without this being overwhelming was appreciated. Some found the information provided easy to read and understand and was sufficient for their needs. Others, however, pointed out that understanding information was much more difficult when not feeling mentally well. It was thought that text heavy documents could be broken down into sections and the use of colour and diagrams helped make the information less intimidating. A colourful leaflet softened the impact of the stark impersonal nature of the NHS appointment letter.  | **29****30****36** |
|  | *What is ‘guided self help’ and what does it involve?*There was some uncertainty surrounding what was meant by ‘guided self help’ and what it involved. In particular there was confusion about the differences and similarities between ‘guided self-help’ and ‘CBT’.  | **32** |
|  | **Information and knowledge provided by EQUITy Leaflet**The majority of the participants could not recall receiving the EQUITy leaflet This may have been because the interviews took place sometime after they would have received this. Those who had some recollection reported that they found the leaflet informative, reassuring, easy to understand and liked the colourful layout. One possible reason for non-recollection of the leaflet could be that it was sent by email amongst other information | **28****30** |
|  | **Email or paper?**Participants had various reasons for either preferring paper or digital copies of the information they received**.** Digital copies had the advantage of being quickly scanned, were accessible on the phone so could be read anywhere, and were a safe way of receiving information during the pandemic (didn’t have to be cleaned). However, some of the participants indicated that in some instances paper copies would also have been useful even though they had access to a computer and emails. The reasons given were: they were a ‘visual’ type of person; so that they could easily make notes; felt less formal and made it easier to engage. As a result, those who had access to a printer printed out some of the documents they received | **27** |

* See Table 3 – table of changes to the EQUITy Intervention

***Table 2****: Key findings and respective amendments made to the Intervention resulting from the IAPT professional (Service Leads/PWPs) post intervention interviews utilizing the Consolidated Framework for Implementation Research (CFIR)*

|  |  |  |  |
| --- | --- | --- | --- |
| **CFIR DOMAIN** | **KEY FINDINGS** **from post intervention professional interviews** |  | **Se**e **Change** **Table No\*** |
| **1. INTERVENTION CHARACTERISTICS** |
| **Innovation Source** | * Previous positive experience of previous training by KL encouraged some to attend training
 | **14** |
| **Adaptability** | * On-line training offered greater flexibility than face to face and was regarded as a safe and appropriate mode of delivery during COVID
 | **13** |
|  | * Some items in the Service Recommendations were not to applicable to some services
 | **26** |
| **Complexity** | * The majority of suggestions and advice contained in the training were considered to be ‘feasible’ and ‘do-able’
 | **19** |
| **Design Quality & Packaging** | *Intervention Package** The intervention was largely perceived as “telephone training” only, denoting the lack of awareness/relevance placed in the other two components of the package.
 | **1, 5** |
|  | *Patient Resources** Not all participants (PWPs) had seen the patient resources. Those who had gave positive feedback about the leaflet, including being informative, clear, understandable, non-technical and easy to follow. The breakdown into ‘bite size’ chunks were considered to be good for those with dyslexia.
 | **30** |
|  | *Service Recommendations* * Positive feedback was received from the service leads about the content of the service recommendation booklet. Sections about “Promoting telephone work”, “Working environment”, “Time for reflection/ discussion on telephone delivery within supervision perceived”, “Skills” and “Training” as particularly relevant during the COVID pandemic when face-to-face delivery was restricted due to the pandemic.
 | **25, 26** |
|  | * Some services highlighted that there were things included in the booklet that they were already doing and some of them that they never thought about but would be feasible to implement
 | **26** |
|  | * The electronic version of the Service Recommendation Booklet was considered difficult to use for its intended purpose (eg confusion around naming of columns ‘now, next, not now’, difficult to navigate, record information on progress)
 | **21, 22, 23** |

|  |  |  |
| --- | --- | --- |
|  | *Training –Content** Overall positive feedback was received for the training. If a particular section wasn’t suitable for them they felt it would be for others. Provided a good balance between theory and practical skills
 | **19** |
|  | * All skills sections were given favorable feedback by one or more participant – some reported they would like more time on this particularly ‘developing formulations
 | **15, 16** |
|  | * Participants liked the open interactive nature of the training
 | **14** |
|  | * There were mixed views on the applicability of the training for newly qualified/trainees compared with those with more experience
 | **10, 12** |
|  | *Suggested additions/amendments** More on core therapeutic interventions– eg behavioural activation, graded exposure
 | **17** |
|  | * Include information/skills on remote delivery in general rather than telephone only
 | **18** |
|  | *Training-Format** Timing/Length of training: PWPs indicated thatsome of the skills sections felt rushed, including after role-play/breakout rooms
 | **15** |
|  | * PWPs stated they would be happy with training being longer to ensure full coverage of all sections
 | **1, 15** |
|  | * Positive feedback received on the overall format of the training eg length, break between sessions, use of role plays, interactive nature,; sharing of experiences with colleagues, use of chat function, size of groups, breaks between
 | **19** |
|  | * Facilitators: were knowledgeable of the role and limitations of PWPs, were informative, approachable, encouraging, reassuring and supportive.
 | **14** |
| **2. OUTER SETTING** |
| **Patient Needs and Resources** | * Information sent to patients can be overwhelming: it was thought that the patient was being emailed a lot of information with their appointment letter, which could be overwhelming, especially for people with mental health problems who are feeling anxious already. It was suggested that having the leaflet as a link on a website or on a text message reminder prior to their appointment and sending out patient resources after assessment and are on the WL would give patients more time to digest the information
 | **28** |
| **External policy & Incentives** | * It is anticipated that the predominance of remote delivery of therapy will continue due to cost cutting efficiencies. Video-conferencing may be encouraged for Step 3 interventions, particularly trauma
 | **18** |
|  | * There was a disincentive to take part in a research interview as it is not counted as a ‘contact’ and could not be included in targets
 | **34** |
| **3. INNER SETTING** |
| **Structural Characteristics** | * There had been considerable disruption to the sites due to the COVID pandemic which impacted on the implementation of the intervention. In particular, one site was described as ‘unstable’ with staff moves and changes.
 | **4, 36** |
|  | * The sites had different structures being made up of one or more teams which may have impacted on the implementation of the intervention (easier the more ‘compact’ the site)
 | **1, 2, 36** |
| **Networks and Communications** | * Service networks and communications were disrupted due to the COVID pandemic. There was less opportunity for both formal and informal discussions about the intervention
 | **3, 36** |
|  | * Change of service leads in one service resulted in communication difficulties
 | **3** |
|  | * A lot of information is received by email so correspondence about the intervention could be easily missed
 | **3** |
|  | * Suggested that as well as providing information by email, researchers to attend PWP remote team meeting(s) and inform them directly of EQUITY intervention. This may be via video conference
 | **1, 2, 3** |
| **Culture** | * IAPT service is all about targets but Service 3 reported that unlike in some services the managers hold this and don’t make it the PWPs problem
* Positive friendly relationships between managers and PWPs – feel valued and supported
* Service 3 reported as being ‘is open to change’ – difficulties openly discussed and appropriate changes made.
 | **36** |
| **Implementation Climate** |
|  **Tension for Change** | * Some services mentioned that prior to COVID might not have been doing much delivery by telephone, so it was a change/barrier for some practitioners to quickly switch from f2f to telephone without training
* Prior to the pandemic, the lack of clinic space had been one of the main drivers for telephone delivery but adequate training had not been put in place
 | **36** |
|  **Compatibility** | * **Compatible with increased delivery of interventions by phone:** Due to COVID most interventions are now conducted remotely. Primarily over the phone, but also video conferencing. They all report it is likely to remain this way.
 | **18** |
|  | * **Compatible with services with different levels of telephone experience.** EQUITy intervention was identified as compatible with services less used to telephone treatment but also for those services were telephone was already an established practice, where EQUITy was perceived as a way to help clinicians improve their current practices and belief that the intervention is effective
 | **19** |
|  | * **Compatibility with current training:** Whereas it was thought that current trainees would get more training on their competencies related to phone work, given that they had not been able to do any face to face work, and also on the theory this was not born out by the responses of the trainee interviewed
 | **36** |
|  | * **Telephone delivery compatible with cost cutting requirements:** Telephone delivery and working from home results in cost efficiencies - less requirement for office space, heating and parking
 | **36** |
|  | * **Compatible with change in patient attitudes:** Patients seem to be more accepting of the telephone – can see the benefits of not having to travel, pay, park, comfort. Changed expectations - realise they can get a good service on the phone.
 | **19** |
|  | * **Incompatibility with working practices:** Challenges sending out patient resources and return of consent forms when all staff were working from home
 | **28** |
|  **Relative Priority** | * **Clinical contact vs Research**: Service 1(C) reported that during the COVID pandemic implementing the EQUITy intervention was not a priority.
 | **5** |
|  | * In Service 1 (C) there was a disincentive to take part in the research interview as it was not counted as a clinical contact-impacting on targets. In the other two services it was counted as a contact but the same number of patients needed to be fitted in.
 | **34** |
|  | * **Service targets vs Training:**  allowing all PWPs to take a day-off for training was not possible due to targets or other clinical responsibilities.
 | **8** |
|  | * **Mandatory vs choice:** There was a difference in how EQUITy training was approach, i.e. one service decided that EQUITy training was mandatory while the others was the practitioner’s choice.
 | **10** |
| **Learning Climate** | * PWPs at Services 2 & 3 reported that their service was good at offering training, they felt well supported by supervisors and service leads, and were supportive of reflective practice in CPD
* Service 3 was reported as promoting autonomy and individual decision making.
 | **36** |
| **Readiness for Implementation** |
| **Leadership Engagement** | * Positive engagement at Service X was indicated by the service lead attending the training (this had been recommended for all services)
 | **10** |
|  | * The clinical lead at Service 2, who is overseeing implementation, was reported as being ‘really involved’ and ‘supportive’.
 | **1, 3,36** |
| **Available Resources** | * Due to COVID pandemic and increasing caseloads services reported difficulty coping with any extra work required to implement an intervention including attendance at the training
 | **4, 5, 6, 36** |
|  | * Due to COVID pandemic and staff working from home there were challenges distributing patient resources and whose responsibility this could/should be
 | **6, 28** |
| **Access to Knowledge and Information** | *Awareness of whole intervention*There was a general lack of awareness surrounding the patient resources and service recommendations aspects of the intervention* None of the service leads shared the patient resources with their clinicians and only one service lead presented and discussed the service recommendation booklet.
 | **1, 3, 7** |
|  | *Awareness of content of training** PWPs at Service 2 reported limited knowledge of the content of the training apart from when/how long/facilitators
 | **1, 12** |
| **4. INDIVIDUAL CHARACTERISTICS** |
| **Knowledge and Beliefs about Intervention** | * Overall there was a positive attitude towards the training; most of the participants reported that they enjoyed the training finding it useful and informative
 | **19** |
|  | * There were mixed views on the value of the training for services/PWPs with a lot of experience of telephone interventions; most experienced PWPs who attended had the attitude that there was always something new to learn and it was easy to get stuck in your ways, whereas some thought training was geared towards and most useful for trainees and newly experienced
 | **2, 12** |
|  | * EQUITy was a way of enhancing the value of telephone therapy for clinicians, allowing them space to discuss experiences related to telephone work, encourage them to talk about their feelings and needs (e.g. equipment, training)
 | **19** |
|  | * Participants were generally in favour of telephone interventions at the time of doing the training, and also the ensuing benefits of working from home and away from the noise and distractions of the office
 | **19** |
|  | * Although they were in favour of telephone interventions felt many in her service (S3 P) were reluctant
 | **8, 10** |
| **Impact of Intervention (added)** | *Change in knowledge and beliefs** PWP Participants who had reported some doubts indicated a positive shift in attitude towards telephone interventions after the training, particularly in relation to establishing a positive relationship, access and stigma and effectiveness
 | **19** |
|  | * Being involved with EQUITy encouraged reflection on beliefs and practices
 | **19** |
|  | * Providing PWPs with the opportunity to attend the training made them feel valued and promoted the value of telephone interventions
 | **19** |
|  | *Change in Clinical Practice** All the participants reported at least one change in practice after receiving the training.
 | **19** |
|  | * Most said they couldn’t think of anything that was suggested that they didn’t think they could, or wouldn’t want to, implement – all seemed feasible and do-able.
 | **19** |
|  | *Reported Impact on Patients** Skills and procedures covered in the training had a positive impact on patient engagement (eg addressing patient expectations, giving patients time and space to talk about concerns re telephone therapy; reassurance re effectiveness; finding a quiet space).
 | **19** |
| **Self-Efficacy** | * Some practitioners reported feeling more confident with telephone work and others reported that the training reassured them they were ‘doing the right things’.
* There was a good balance between learning/ developing skills and feeling reassured/confirming what they are doing is effective and right.
 | **19** |
| **Individual Identification with Organization** | * Responses given by PWP participants at Services 2 & 3 indicated a positive identification with and commitment to their service (feeling supported, looked after, positive relationships with managers/supervisors)
 | **36** |
| 1. **Other Personal Attributes**
 | * Positive personal attributes that influenced their attendance at the training included: wanting to take up any training opportunities, positive attitude towards training in general, liking to push themselves, interested in views and experiences of others, interested in research.
 | **36** |
| **5. PROCESS** |
| **Engaging Leaders and Champions** | * None identified
* Suggestion that a key person be responsible for the implementation of the service recommendations
 | **24** |
| **Engaging Key Stakeholders** | *Service Leads/Managers** Service leads felt comfortable with communication via email with the research programme manager, and it was always a quick response to queries. There were clear pathways and clear communication between leads and research manager.
 | **3** |
|  | * Advantageous that clinical supervisors and supervisors attend the training so they are ‘on the same page’ as the PWPs
 | **2, 12** |
|  | PWPs* Would normally hear about and discuss implementation of new interventions at team meetings which had been disrupted because of COVID pandemic – instead learned about training via email and as a result less likely to engage
 | **1, 4** |
|  | * Some confusion over eligibility for attendance at training
 | **2** |
|  | * May get more researcher involvement in training if it is part of their CPD
 | **11** |
|  | * Scheduled patient appointments prevented attendance at training
 | **4, 7, 8** |
|  | * Lack of involvement in all aspects of the EQUITy intervention at one service may have been deliberate to reduce burden on PWPs with heavy case-loads: PWPs would like to be more involved in research but heavy work-loads made this difficult
 | **4, 6** |
|  | * PWPs would get more involved if they were encouraged and given permission/ time within the working day.
 | **21** |
|  | Patients* At Service 2 uncertainty around whether and how patients were being recruited and who was responsible
 | **1, 4** |
|  | * Patients being recruited primarily be email rather than by post as originally intended – may have impacted on low numbers recruited
 | **27** |
|  | * Mixed responses on the usefulness of the appointment card in engaging patients in therapy. It was considered potentially useful for people with memory problems and those not using technology. It was thought to be less relevant for services that have the appointment text reminder or other systems in place.
 | **31** |

\*See table 3 – Table of changes to the EQUITy Intervention

**Table 3 – Summary of Changes to EQUITy Intervention**

|  |  |
| --- | --- |
|  | **Intervention ‘Package’ - Implementation** |
| **1** | To facilitate the implementation and knowledge surrounding the whole intervention package two team workshops have been added, one pre training and another 6-8 weeks later. At the first workshop the 3 elements of the intervention are introduced and the most effective way to implement the patient resources and service guidelines will be discussed. This will be followed by the drawing up of an action plan. The second workshop will discuss and troubleshoot the implementation of the intervention.  |
| **2** | To maximise service involvement all team members (admin, managers, supervisors, practitioners, trainees) will be invited and encouraged to attend the workshops) |
| **3** | Teleconference (Zoom/Microsoft Teams) meetings will be encouraged with key or new personnel responsible for implementation to discuss progress and help to overcome any potential difficulties and obstacles related to the implementation of changes (this includes the non-intervention control sites’ recruitment of follow up patient research participants) |
| **4** | Prior to the workshops sites will work closely with research programme manager to discuss the timing of and best methods for implementing the intervention (this includes liaison with the site data managers at the control sites for the collection of patient data) |
| **5** | Information circulated to sites has been modified to emphasise that the intervention includes 3 elements (not just the training) and outlines the time and commitment required for each |
| **6** | EQUITy team to do as much as possible to reduce the burden on participating sites (e.g. making up research packs, taking consent, flexible working) |
|  | **Training – Implementation and Delivery**  |
| **7** | To maximise attendance practitioners will be offered flexibility regarding training blocks e.g. if not all PWPs can attend one block of training sessions some can attend another with a different site |
| **8** | Site managers/service leads will be encouraged to organise a training date well in advance that enables the most practitioners to attend  |
| **9** | The number of people/sites attending each training session will vary according to the availability of dates, individual site numbers, and practitioners attending from other services. (see 7) |
| **10** | All practitioners, supervisors and managers will be invited and encouraged to attend the training, whether the training is mandatory or voluntary will be guided by site preference  |
| **11** | To encourage attendance participants will receive a certificate post training detailing their involvement in the EQUITy programme which will count towards CPD.  |
| **12** | The content of the training sessions will be circulated well in advance to aid decision making around attendance |
| **13** | Training will continue to be offered on line  |
| **14** | As a result of the positive feedback from the feasibility study the format of the training (e.g. break between sessions, use of chat function for discussions) trainers and style of delivery (non-judgemental, supportive) will be retained. |
|  | **Training - content** |
| **15** | Extension of skill practice, role-plays and practical exercises (made possible by moving ‘Evidence’ section to Workshop 1 (see 13) |
| **16** | Retention but relocation of the section relating to evidence and effectiveness of telephone treatment to ‘Introductory Workshop’ session |
| **17** | Addition of a section related to telephone delivery of ‘Behavioural Activation’ interventions |
| **18** | There will be reference made to the crossover with and challenge of other remote delivery modalities, but the emphasis on telephone working to be maintained as it is the focus of the EQUITy programme and considered by the research team to be the most common and challenging mode of delivery |
| **19** | Most items included in the training and or service guidelines have been retained, either because they were reported as being valuable by the practitioners (e.g. skills training (extended); time to discuss and share experiences with other practitioners ; to identify and discuss beliefs, assumptions and clinical drivers underlying (dis)engagement; encouragement of self-reflection), or were highlighted as problematic or beneficial to patients (e.g. managing time effectively; use of routine outcome measures) or both (e.g. addressing patient expectations; managing emotion; patient acceptability of TT; use of examples from conversation analysis; promoting change, motivational interviewing)  |
|  | **Service Guidelines - Implementation** |
| **20** | Change name of booklet from ‘Service Recommendations’ to Service Guidelines to better indicate the optional and less directive nature of the document |
| **21** | The service guidelines document has been re-designed to make it more user friendly by being easier to use, share and discuss with colleagues within an online format |
| **22** | Columns labelled ‘Now, Next, Not now’ changed to low, medium and high priority |
| **23** | Addition of an ‘action plan’ table at the end of each section to report and track progress |
| **24** | A key person will be nominated to be responsible for implementation and tracking of the progress made  |
|  | **Service Guidelines - Content** |
| **25** | Specific small changes were made to the service recommendations in accordance with feasibility study findings (e.g. ‘working environment’ to include challenges related to working from home environment; item on well-being/work-life balance; offering choice of mode of delivery; informing patient of any change of therapist; monitoring of progress) |
| **26** | Not all the service guidelines were applicable to all services (e.g. may already be implemented). All the guidelines have been retained but services *will* now rate the importance/priority of each item using a traffic light system and draw up an action plan accordingly. |
|  | **Patient Resources - Implementation** |
| **27** | Both paper and electronic versions to be available to services who can choose to use one or both methods of delivery as appropriate to the individual service |
| **28** | The delivery of patient resources and optimal timing to be discussed at workshops and sites will decide the best and most efficient way for them to be implemented |
| **29** | Practitioners will be encouraged to refer to and/or discuss the EQUITy patient resources during the first treatment session and subsequently if raised by patients |
|  | **Patient Resources - Content** |
| **30** | Feedback from the interviews indicated that the patient leaflet was informative and well designed so this was retained without change.  |
| **31** | Appointment card to remain as part of the patient resources so that patients have the choice of whether or not to use it dependent upon other service reminder systems in place. |
| **32** | Additions to patient resources: patient quote about effectiveness of TT, and clarification of relationship of CBT and Guided Self Help. |
|  | **Recruitment - patients** |
| **33** | Services will make initial contact with the patient, if the patient wishes to take part they will return a consent to contact form to the research team or they may contact the research team directly by phone/email |
|  | **Recruitment – Practitioner interviews** |
| **34** | To be addressed and encouraged in workshop and training sessions – including discussion around managers allowing a research interview to be counted as a contact. |
| **35** | Formal acknowledgement of their contribution to research. |
|  | **Other** |
| **36** | Contextual information that may be indicative of the level of success of the implementation of a new intervention. In most instances there is little the research team can do to instigate changes as they are service specific and/or governed by service/national policy (e.g. service structure, staffing levels, workloads, internal staff relations, WFH policy, COVID restrictions). These issues will continue to be discussed within the practitioner and service lead interviews and can be taken into consideration in relation to the amount of site support provided (see item 3).  |