




ORIGINAL RESEARCH

# Utilising patient and public involvement to increase the acceptability of brief CBT for OCD in young people

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## Abstract

Obsessive-compulsive disorder (OCD) is a common and debilitating disorder that frequently begins in childhood and adolescence. Previous work (Bolton *et al.*, 2011) has demonstrated that brief CBT (5 sessions), supplemented by therapeutic workbooks, is as effective as more traditional length (12 sessions) therapist-delivered treatment for adolescents with OCD. However, as was typical at the time, the treatment was developed with very limited patient and public involvement (PPI) and was delivered in the context of a randomised controlled trial which might affect translation to routine child and adolescent mental health services (CAMHS). To be able to implement such treatment within routine clinical services, it is crucial that it acceptable to young people, their families and the clinicians delivering the treatment. The aim of this project was to improve the acceptability of the brief treatment through PPI and consultation with clinicians, and consider issues relating to implementation. This was done through written feedback, interviews and focus groups with five adolescents and two parents, and a focus group and a half-day workshop with 12 clinicians. This led to revisions to the workbooks and materials to improve (a) acceptability by updating the design through changes to wording, language and images, and to ensure that they were consistent with values of equality, diversity and inclusion, and (b) usability by clarifying, adding, removing content, and organising the materials in new ways. We emphasise the importance of continued PPI throughout the project to maximise the translation of findings into practice.

## Key learning aims

- (1) To understand the issues surrounding the delivery of brief CBT to young people with OCD.
- (2) To understand ways of reviewing, developing and improving the CBT materials with a range of young people, their parents, and clinicians.
- (3) To understand how to consult with clinicians in relation to the implementation of the treatment.
- (4) To consider how the process of this type of work can assist in the next steps of implementing a manualised intervention in routine CAMHS.

**Keywords:** Adolescents; Brief; Cognitive behavioural therapy; Implementation; Obsessive-compulsive disorder; Patient and public involvement; PPI; Young people

## Introduction

Obsessive-compulsive disorder (OCD) is a debilitating disorder (Torres *et al.*, 2006), affecting around 1% of adolescents aged 11–19 years (Sadler *et al.*, 2018). Fifty per cent of those experiencing OCD in their lifetime will have developed it by the age of 19 years (Kessler *et al.*, 2005) and the first

peak of onset is commonly around 9–10 years before a second peak around 20 years (Dell’Osso *et al.*, 2016).

OCD can result in functional impairments in a variety of settings in young people’s lives, affecting school, family, and social settings (Piacentini *et al.*, 2003). If left untreated, OCD persists into adulthood, typically worsening in symptom severity (Abramowitz *et al.*, 2009; Visser *et al.*, 2014). It is therefore imperative that young people can access effective treatment, in a timely manner, to mitigate impact on other areas of development.

The first line recommended treatment for OCD is cognitive behavioural therapy (CBT) (NICE, 2005), which has been shown to be an effective treatment not only for working age adults but also for adolescents. A number of systematic reviews and meta-analyses evaluating CBT for OCD in young people have concluded that it is effective (Iniesta-Sepúlveda *et al.*, 2017; Öst *et al.*, 2016; Uhre *et al.*, 2020). For example, Öst and colleagues conducted a meta-analysis of CBT and pharmacological treatments (selective serotonin re-uptake inhibitors, SSRIs) for OCD in young people and found that CBT provided large effect sizes compared with both a waitlist ( $d = 1.53$ ) and placebo alternatives ( $d = 0.93$ ). Post-treatment, 53% of those who received CBT no longer met diagnostic criteria for OCD, compared with 49% of those who received CBT+SSRI, suggesting that there is no additional benefit in combining CBT with a pharmacological treatment. Notably, the degree of parental involvement in treatment and the treatment delivery format (i.e. whether it was individual, group or family-based) did not appear to affect the effectiveness of treatment.

Although CBT is an effective treatment for OCD, lack of resources, poor availability of trained therapists, and long waiting lists in CAMHS, severely limit access for young people seeking help (Baker and Waite, 2020; Frith, 2016; Merikangas *et al.*, 2011). Brief CBT is an effective option for treating adolescent OCD, which could more effectively and efficiently deploy resources in stretched mental health settings whilst maintaining treatment fidelity. In a randomised controlled trial, Bolton *et al.* (2011) found that a brief treatment, adapted from an adult-focused treatment approach (Salkovskis, 1999), involving five sessions with a therapist and supplemented by workbooks was significantly better than the waitlist control, and there was no significance difference between the brief version and the full 12-session version in the treatment of OCD in young people aged 10–18 years. Immediately after treatment, both the brief and full treatments were associated with large effect sizes (brief CBT  $d = 1.6$ ; full CBT  $d = 2.2$ ) compared with the waitlist control on the primary outcome measure (the Children’s Yale-Brown Obsessive Compulsive Scale; CY-BOCS). The difference between the brief and full treatments was not statistically significant. Interestingly, there was a significant difference in the way the two groups changed between the end of treatment and the 3-month follow-up period; while the full CBT group lost some gains (CY-BOCS mean total increased from 9.5 post-treatment to 12.1 at follow-up), the brief CBT group continued to improve over this period (CY-BOCS mean total decreased from 13.0 post-treatment to 11.0 at follow-up). This may be consistent with the possibility that the brief workbook enhanced treatment may increase self-led treatment skills, perhaps by appropriately transferring more responsibility for the treatment tasks onto the young person.

To implement this brief treatment successfully within CAMHS settings, it is important to consider factors related to the intervention itself, as well as those related to the individuals delivering the intervention, the setting in which they work and processes of implementation (Damschroder *et al.*, 2009; Harvey and Kitson, 2016). Implementation theories (e.g. diffusion of innovation theory; Rogers, 2003) and frameworks (e.g. the Consolidated Framework For Implementation Research (CFIR); Damschroder *et al.*, 2009) emphasise how an intervention must be tailored in terms of factors such as the strength of evidence, cost effectiveness, ability to be ‘tried out’, relative advantage over existing treatments, degree of fit with existing practices and values, design quality and usability.

As was typical at the time, the workbooks and materials that were used in the brief CBT intervention for OCD, evaluated by Bolton *et al.* (2011), were developed with very limited patient and public involvement. Patient and public involvement (PPI) is defined as research being carried

out ‘with’ or ‘by’ patients and members of the public rather than ‘to’, ‘about’ or ‘for’ them (NIHR, 2021). As well as involvement activities (e.g. identifying research priorities, contributing to study design and carrying out research activities), this may also include engagement activities (‘PPIE’), where information and knowledge about research is provided and disseminated (NIHR, 2021). It is therefore likely that the design quality, usability, and overall acceptability of brief CT for adolescent OCD could be improved through PPI. The young people in the trial conducted by Bolton *et al.* (2011) did not include those with ‘marked symptoms of autistic spectrum disorder’ and so materials are likely to require revision to meet the needs of autistic young people, who appear to make up around 25% of those in CAMHS presenting for the treatment of OCD (Martin *et al.*, 2020). In addition, it is important to note that the clinicians in that study were all highly trained and experienced clinical psychologists receiving high levels of supervision, and therefore it will be important to ensure that materials are also appropriate for, and acceptable to, clinicians delivering the treatment within routine services.

PPI activities, such as co-design and co-production of resources, have been demonstrated to greatly improve the acceptability of interventions and processes in research (Barnes and Cotterell, 2012; Ennis and Wykes, 2013). This is likely to be especially important when interventions are designed by adults for use with young people. Young people themselves can provide particularly relevant information and recommendations on the content, aesthetics, and overall experience of using or engaging with an intervention. This can aid the development of materials which are more engaging for young people (O’Dea *et al.*, 2018; Tighe *et al.*, 2017). Similarly, it has also been demonstrated that it is important to involve other stakeholders, such as parents and therapists, to understand their needs and develop and tailor interventions for delivery in routine services (e.g. Brookman-Frazee *et al.*, 2012a; Brookman-Frazee *et al.*, 2012b).

The aim of the current work, therefore, was to review, develop and improve the workbooks with PPI input from a range of young people, their parents, and clinicians. We also consulted with clinicians in relation to the implementation of the treatment. The present paper is intended to provide a roadmap of our PPI work and reflections on the process.

## Method

### Research plan/design

The process involved three main steps: (1) written feedback from adolescents and parents on the workbooks, (2) semi-structured one-to-one interviews and focus groups with adolescents and parents, and (3) a focus group and a half-day workshop with clinicians from NHS CAMHS. We adopted an iterative approach whereby the workbooks were updated based on feedback received after each point of consultation with participants. According to the Health Research Authority Tool (<http://www.hra-decisiontools.org.uk/research/>), this work was classed as an involvement activity rather than research, therefore ethical approval was not required. To ensure rigour, the GRIPP2 checklist (Staniszewska *et al.*, 2017) was used for reporting (see online [Supplementary material](#)).

### Participants

Participants were five young people aged between 12 and 22 years of age. We recruited three young people (aged 19–22 years) who had been diagnosed with OCD and had received CBT as an adolescent (when under the age of 18 years), including one autistic young person. None of them had received the brief form of CBT or used the original forms of the workbooks, but they were familiar with the concepts covered in the workbooks. We also recruited two adolescents who did not have lived experience of CBT for OCD and so were able to give feedback around the OCD terminology and principles of treatment without this being affected by having previously acquired

knowledge and experience, as a result of treatment. In addition, these adolescents were younger (aged 12 and 14 years) and therefore also able to provide feedback on whether the level, style and design were appropriate for those in early adolescence. Two parents of young people who had experienced treatment for OCD also participated, including a parent of an autistic young person.

We also recruited clinicians working in NHS CAMHS services. To be included, they were required to be working with young people with OCD using a cognitive-behavioural approach and to have had training in CBT. In total, 12 clinicians participated (nine females and three males). Nine were clinical psychologists and three were CBT therapists.

### **Recruitment**

Young people were contacted through S.W. and P.W.'s personal and professional connections. Those with lived experience of having CBT for OCD were recruited from a PPI group attached to a national and specialist OCD service. Clinicians were contacted by P.W. and S.W. through their professional contacts from CAMHS teams in two local NHS trusts. All potential participants were provided with written information about the project via email. If the young person was under the age of 18 years, the information was emailed to their parent, and the parent was asked to complete a written consent form for the young person to participate. Participants were recruited from January to May 2022.

### **Procedure**

#### *Written feedback (young people; parents)*

Young people were emailed copies or provided with hard copies of the workbooks depending on their preference and asked to provide written feedback on the workbooks, either by annotating the hard copies or emailing their responses to the research team. They were asked to make comments on the appearance, accessibility, and areas for improvement to support young people to overcome their OCD. Parents were asked the same questions as young people about the adolescent workbooks but were also asked specifically about the parent handout in terms of accessibility and content. Where there was direct experience of autism, individuals were asked about the appropriateness and potential modifications for autistic young people. In line with NIHR payment guidelines and the UK Public Involvement Standards (NIHR, 2022; UK Public Involvement Standards Development Partnership Group, 2019), participants were financially reimbursed for their time in taking part. This phase was conducted between January and March 2022.

#### *Interviews/focus groups (young people; parents; clinicians)*

If participants agreed to take part in a follow-up focus group, this was arranged to be at a time convenient for the participants. These were conducted separately for young people, parents and clinicians. All interviews were conducted online using Microsoft Teams. Prior to the interview or focus group, the interviewers (S.W. and M.-L.K. jointly) asked the participant(s) to provide verbal consent to take part and for the interview to be recorded and transcribed through Microsoft Teams. Clinicians were sent the workbooks and asked to look over them before meeting for a focus group. If the participants were under the age of 18 years, their parent provided consent and they provided assent. The interview began with some general questions to build rapport and facilitate discussion. A topic guide (see [Supplementary material](#)) was developed by the research team. This was used flexibly to gain information on participants' views on the workbooks. Parents were also asked about how the workbooks could be improved to better support parents in their role as co-therapist. Clinicians were also asked questions related to training and implementation in routine services. M.-L.K. made notes during the interview of information for follow-up questions and to facilitate the transcription process. Interviews lasted around an hour. As with the written

feedback, young people and parents were reimbursed for their time in taking part. Instead of payments, clinicians were given a two-hour skills workshop on treating adolescent OCD. Interviews and focus groups were conducted between February and March 2022.

### **Half-day workshop (clinicians)**

A half-day in-person workshop was held in May 2022 at an NHS site. Clinicians were shown the workbooks and asked to consider the design, delivery and content of the workbooks. Two discussion groups were held, to split the participating clinicians into smaller groups. Each group was led by a researcher, P.S. and P.W., alongside M.-L.K.; P.S. and a group of five clinicians covered the first to third children's workbooks, whilst P.W. and M.-L.K. and a group of six clinicians covered the fourth, fifth and parents' workbook. As well as being asked for feedback on the workbooks, clinicians were asked about implementation of the treatment into their services.

### **Revisions to materials**

Transcripts were saved on Microsoft Teams and then corrected, using interview notes and recordings. M.-L.K. read through transcripts to identify key ideas and recurrent themes that reflected the aims of the project. The data were then thematically analysed and synthesised using a 'framework' approach to extract and organise summarised information (including suggestions for revisions by participants) into categories (Pope *et al.*, 2000). Workbook revisions were made in consultation with the wider research team (S.W., P.W. and P.S.) to ensure that adaptations maintained the integrity of the CBT approach. These edited versions were then revised by a designer to make them visually appealing, and these versions were reviewed by P.W. and P.S. and further edits made to be consistent with the PPI feedback (e.g. delivering the content more succinctly, eliminating unnecessary material and making concepts more understandable).

## **Results**

### **Workbooks and treatment approach: what worked well**

Young people, parents and clinicians were positive about the original workbooks overall, in that they found them easy to understand, clear and gave detailed important information to help understand and treat OCD. Young people liked the use of colour and the images alongside the text. Young people, parents and clinicians liked the use of case examples throughout the workbooks and valued them having a 'wide range of different kind of issues' rather than being focused on 'stereotypes' of OCD, such as concerns around contamination and handwashing. Parents and clinicians noted how it was particularly helpful to see a case example of a young person with sexual obsessions, given that they are common, can be hard for young people to talk about, and are deeply stigmatising. One clinician commented how 'it's really nice for them to see, you know, somebody with an OCD problem that's more similar to theirs written down. And I think it helps them feel like they're not going mad'.

Parents valued having a parent workbook, as well as accessing the young person's workbooks and stressed how important it was for them to learn what OCD is and to understand CBT and what it involves so that they could appropriately support the young person's treatment.

Clinicians also noted benefits of key material being delivered through workbooks rather than verbally for young people and clinicians. For young people, it could demonstrate that it is 'a viable treatment. It's not just this random mad therapist who's come up with this idea that you've got to go and, you know, touch something dirty or whatever'. This could be helpful in terms of engagement and expectations around the effectiveness of the treatment. It could also ensure the treatment was delivered with high levels of fidelity. For example, one clinician described how, 'as a therapist, it would help you stay on track as well'. For therapists with less experience of treating

OCD there could be ‘a lot of fear . . . that OCD is really complicated’ and having the structure of the sessions and the workbooks could help clinicians to feel more confident in delivering the treatment.

### *Revisions to the workbooks: design*

All the young people felt that there needed to be improvements to the wording and language, e.g. ‘it looks kind of old English’ and the design. For example, images were seen as ‘maybe a bit outdated’ and headings needed to be more colourful. Parents also felt that ‘heavy grey titles’ needed changing and that the use of capital letters for emphasis could be seen as patronising. Clinicians also identified this as being a problem, with one person saying, ‘I kind of stopped using the old ones and giving them out to people just because I felt they looked too dated’ and another, ‘the names John and Sally, you know. Is anyone under 50 called John and Sally?’. Clinicians also felt it would be important to be clear about the age range that the workbooks should be used for and queried the use of the term ‘homework’, generally preferring ‘home tasks’.

For autistic young people or those with language difficulties, clinicians and one of the parents emphasised the importance of language being clear, avoiding using excessive metaphors or pictorial language, and using more images to support the text. They also described how using real-life examples, such as Mother Teresa, could be confusing or distracting, especially where there might be controversies associated with the person, that the young person could get overly focused on.

Young people and parents identified a lack of diversity in the case examples and that there were stereotypes in terms of race and gender. For example, one young person noted that teachers were all women, and that parents and carers were often referred to as ‘your mum’. Clinicians also emphasised needing to give examples of other carers and using the term ‘parents and carers’ to be more inclusive.

The young people, parents and clinicians all described how they felt that there was ‘an awful lot of information’ in the workbooks, which could potentially be overwhelming for a young person. However, there was a general recognition that it was better to provide clear, detailed information rather than trying to condense it and risk it being more difficult to understand. Young people described getting a bit confused about who was who in the case studies as they were introduced at different points in the workbooks. There were suggestions that material that did not relate directly to OCD, such as problem-solving, could potentially be removed. Clinicians wondered whether it could be possible to modularise the workbooks so there was some discretion about what was given to the young person. They also emphasised how the therapist could help the young person to navigate the workbooks and make adjustments if the person was finding the amount of content difficult to manage.

### *Revisions to the workbooks: content*

Young people and clinicians identified some material that was hard to understand, such as whether a person should use distraction as a way of dealing with OCD. Clinicians described not being clear about whether exposure should be done as part of a hierarchy, with a focus on anxiety habituation, or through behavioural experiments with the onus being on testing beliefs and how the world really works. Clinicians who had used the workbooks also reported having had some difficulties with the parts that related to developing an individual model with the young person. For example, the ‘nasty flower’ diagram was seen as confusing, with one clinician indicating they told their clients to ‘skip it . . . do a line through it ’cause like that’s just too complicated to give somebody’.

Young people and parents identified material that they felt would be helpful to include. Young people felt it would be helpful to add sections on reassurance seeking and emotional reasoning. Young people and parents also felt it would be helpful to have all the key terms together in the form of a glossary to 'cement understanding' and so that they could refer to this without having to track through the workbooks. For the parents' workbook, parents wanted the content to include broader information on the causes of OCD and felt that it would be important to reassure parents and address feelings of being to blame for the young person's OCD. They also felt it would be helpful to understand the evidence base for medication. Parents felt they needed more information about how to manage situations when their child may ask for reassurance in a way that was still supportive, without giving into OCD. They also wanted advice around what to do if their child became highly distressed or aggressive in this situation.

Clinicians emphasised the importance of information such as empirical data on the prevalence of intrusive thoughts in the general adult population (e.g. data from Rachman and de Silva's (1978) study) and content on 'just right' experiences, as one clinician mentioned that this was frequently experienced by the young people in their service. They also highlighted how it would be helpful to integrate measures that were required within the service into the materials, such as tracking goal progress each week, given the 'need to be goal based' in routine CAMHS settings. Clinicians also felt it would be helpful to have materials to record progress with behavioural experiments and this would help make it clear that doing experiments was a crucial part of treatment, and that potentially these sheets could be included in an additional workbook.

### **Implementation in routine child and adolescent mental health services**

The workbooks were designed to be delivered within a brief treatment, delivered by a trained clinician, and both young people and clinicians emphasised the importance of sticking to this model of delivery. Young people emphasised that there was a lot of new information to digest and that 'if this is our first time learning about OCD then there would be a lot of questions and things like that' to ask the clinician. As a result of long waiting times for treatment within routine services, some clinicians had experimented with giving out the workbooks to young people while waiting for therapy to begin but found that this had been detrimental. For example, one clinician described how a young person could then start therapy and then think, 'well, I've seen all this before and it didn't work' and reported that 'I know this is that's not what it's designed for, but I think we've definitely found that they don't, they're not self-help on their own'.

In terms of the training and supervision required to implement this approach in routine services, clinicians emphasised how stretched services are and that 'there's always those time barriers and people having space in their job plans'. Clinicians valued having 'a lovely clear manualised program so you know what you are doing' and felt that training that involved video feedback was found to be highly beneficial for some but hated by others. Clinicians also emphasised how the appropriate training model was likely to need to differ depending on the clinician's skill level and experience. Clinicians had some concerns about condensing sessions down to only five, when they had previous experience of delivering therapy in '20 to 30 plus' sessions. One clinician suggested that because of this, it may be most sensible to have the most experienced clinicians delivering the treatment. However, other clinicians thought that it was likely to be delivered within their services by assistant psychologists and therapists trained in CBT (such as children's wellbeing practitioners). For example, 'we've got CBT therapists or trainee CBT therapists who again could absolutely just pick up and probably run with this with the supervision'. Ongoing supervision was seen as important for everyone, including more experienced therapists 'who sometimes go off piste and need reminding, you know, to help to stay on track a bit'.

### Revisions to the workbooks based on the feedback

Updating the workbooks was a multi-faceted process. The team reviewed all the feedback provided through written answers, semi-structured interviews and focus groups and the workshop, along with the modifications suggested by participants. The aim was to utilise all feedback that focused on improving the acceptability of the workbooks whilst still maintaining the original empirically grounded delivery format.

In terms of the design of the workbooks, the formatting was updated, involving changing the font, formatting text, adding colourful headings and text boxes to record answers, and updating the images. The language and images were changed to avoid gender and racial stereotypes. We removed or explained any expressions that contained a figurative meaning that differed from the phrase's literal meaning to make the workbooks more accessible to autistic young people or those with language difficulties. For example, we replaced the heading 'Trust me I'm a doctor' with '*Time for you to test out what we've talked about*'. We cut down the amount of information presented overall to make it less overwhelming, by deleting repeated information (for example the repetition that '1 in 100 teenagers has OCD' in the introductory workbook), taking out sections that did not directly relate to OCD, as well as by adding more space between sections of texts. We also put all the case studies into a separate section at the beginning of the introductory workbook so that they were easier to refer to.

We revised the workbook content, mainly by adding topics not dealt with in depth in the original workbooks. In response to parent feedback, we added a brief section on medication, on reducing blame and on managing challenging behaviour in the parent workbook. We also added a 'managing reassurance seeking' section into the parents' and young people's workbooks and a section on emotional reasoning in one of the young people's workbooks. Some metaphors were changed to make the workbook more accessible to young people, for example a metaphor on insurance was replaced by a story about salt and dragons that young people found easier to understand. We added more explanation to some sections (e.g. theory A versus theory B, where 'how OCD sees the problem' is set in contrast to 'a different way of making sense of the problem') so it included more instructions to make it easier for clinicians to use this alongside their therapy sessions. We also added the data from the Rachman and de Silva (1978) study to improve the psychoeducation content of the introductory workbook. As clinicians had almost all agreed that the 'nasty flower' diagram was confusing, we added a filled-out example in the workbooks (and a copy for clinicians in the manual) to ensure it was easier to understand and use. We also created an additional 'Progress Tracker' workbook for young people to track their goals and evidence from their behavioural experiments, and a 'Jargon Buster' workbook that explained all key terms.

### Discussion

To increase the likelihood of successful implementation of an evidence-based brief therapist guided CBT treatment for adolescent OCD within CAMHS settings, we worked with young people, parents and clinicians to improve aspects of the intervention (i.e. design quality, usability and degree of fit with existing practices and values) that have been shown to be important in the later adoption of new treatments (Damschroder *et al.*, 2009; Rogers, 2003). We gathered feedback and suggestions for modifications through interviews and focus groups and used this to revise the workbooks and materials to improve acceptability by updating the design through changes to wording, language and images used. This was especially important to address the needs of autistic young people for whom the use of metaphors, ambiguous and pictorial language could, at times, be especially confusing. It was also important to update all



materials to ensure that they were consistent with values of equality, diversity and inclusion. We improved usability by clarifying content (e.g. around using distraction; the development of an individualised model), adding content (e.g. on reassurance-seeking), removing superfluous content (e.g. problem-solving), and organising the materials in new ways (e.g. combining all the measures and weekly materials into one 'Progress Tracker' document). We also consulted with clinicians around who might deliver the treatment and their training and supervision needs (e.g. having different training models depending on clinicians' skills and experience).

Reflecting on the process, we considered that it was important to take time to build rapport with the people we interviewed, especially young people who may find the interview situation stressful. It worked well to interview two of the young people who knew each other together. For future activities, where appropriate, we will consider interviewing young people in a pair with someone they already know and feel comfortable with to help build confidence and share negative as well as positive feedback. Interviews were conducted online using Microsoft Teams and although this appeared to work well, there may be benefits to offering in-person interviews for those who may find online communication difficult or lack access. While the use of a professional designer has ensured that the workbooks and materials are now much more visually appealing, this will limit the number of iterations and updates to the workbooks and mean that in the future we will have to secure further funding to take account of further feedback from young people and other stakeholders when piloting the intervention with the new materials. As we move forward with the project, we will look for further opportunities (and funding) to support greater use of PPI throughout, e.g. as members of the project advisory/steering group, taking a more active role in carrying out future research and participation in dissemination activities and plan to examine the impacts of PPI on the individuals involved in the PPI activities, as well as on the research and implementation in services.

In terms of limitations, we were limited in the number of young people who took part. All the young people identified as girls/young women and we lacked data on their socio-economic status and ethnicity. As a result, this group of young people lacks (or is likely to lack) representativeness. Further funding and time would have allowed us to reach out to a larger group of young people and ensure that there was representation across a broad range of important characteristics, including demographics (e.g. ethnicity and socio-economic status), type of OCD and co-morbidity (e.g. as well as autism, including young people with ADHD, tic disorders and other internalising and externalising disorders). The two youngest participants had not been diagnosed with OCD and it would have been beneficial to have been able to involve young people with OCD waiting for treatment in the project. Although we were able to involve a range of clinicians, we did not involve service managers or commissioners, and this would be important to ensure that we understand and take account of the needs of all those who have a role in maximising adoption in services. While many of the modifications made were suggested by participants, other revisions were based upon more general feedback and unfortunately, we were not able to follow up the interviews and focus groups with co-design workshops to co-adapt and co-create materials with participants. This means that we cannot be sure that we have optimally addressed all concerns. Further feedback at the piloting stage will be important.

The next step in this project is to continue to work with young people, families, clinicians, as well as service managers and commissioners to develop a training programme for clinicians and an implementation strategy to ensure sustainability. For example, this will involve a consideration of how the intervention will be applied in local contexts and understanding and addressing the barriers and facilitators in using this treatment (e.g. needs and resources) (Graham *et al.*, 2006). We then aim to pilot and evaluate the intervention with clinicians in routine services, for example, within a feasibility study (Skivington *et al.*, 2021). We hope that by considering implementation

issues throughout this process, working with young people and other key individuals/teams, we can maximise the adoption of this brief treatment in services to improve both access and outcomes for young people with OCD.

#### Key practice points

- (1) OCD is a common and debilitating disorder, which can be treated effectively with CBT. Due to barriers to disseminating treatment, brief CBT supplemented with workbooks may be a viable option for improving access to therapy within routine clinical services.
- (2) To increase the likelihood of successful implementation of an evidence-based brief CBT treatment for adolescent OCD within CAMHS settings, we worked with young people, parents and clinicians to improve aspects of the intervention (i.e. design quality, usability, and degree of fit with existing practices and values).
- (3) We revised the workbooks and materials to improve (a) acceptability by updating the design through changes to wording, language and images, and to ensure that they were consistent with values of equality, diversity and inclusion, and (b) usability by clarifying, adding, removing content and organising the materials in new ways.
- (4) We consulted with clinicians about who might deliver the treatment and their training and supervision needs (e.g. having different training models depending on clinicians' skills and experience).
- (5) The next step in this project is to continue to work with young people, families, clinicians, as well as service managers and commissioners, to develop a training programme for clinicians and an implementation strategy to ensure sustainability.

## Further reading

### Brief CBT for OCD

**Bolton, D., Williams, T., Perrin, S., Atkinson, L., Gallop, C., Waite, P., & Salkovskis, P.** (2011). Randomized controlled trial of full and brief cognitive-behaviour therapy and wait-list for paediatric obsessive-compulsive disorder. *Journal of Child Psychology and Psychiatry*, 52, 1269–1278.

### PPI

**Crocker, J., Boylan, A., Bostock, J., & Locock, L.** (2017). Is it worth it? Patient and public views on the impact of their involvement in health research and its assessment: a UK-based qualitative interview study. *Health Expectations*, 20, 519–528.

### Implementation science

**Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C.** (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science*, 4, 1–15. <https://doi.org/10.1186/1748-5908-4-50>.

**Supplementary material.** The supplementary material for this article can be found at <https://doi.org/10.1017/S1754470X23000363>

**Data availability statement.** Project materials can be accessed by contacting the corresponding author.

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