An Exploration of Treatment for Young People with At Risk Mental State: Experience and Feasibility

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Abstract

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Background: It is possible to identify young people who are at an increased risk of developing psychosis, often referred to as having an At Risk Mental State (ARMS). Research shows that psychological interventions offered to these individuals, can reduce the risk that they will go on to develop psychosis, whilst also reducing their distress. However, the availability of such interventions within the NHS is limited, and those services that do support these individuals are characterised by high levels of disengagement.

Aims: The current portfolio aimed to explore how young people with ARMS experience mental health services, to identify ways of increasing the acceptability of these services to them. It also aimed to develop and trial a brief, benign psychological intervention that could be offered to young people with ARMS by non-registered practitioners, which could ultimately be used to increase the availability of psychological interventions for this population.

Methods: A systematic review was conducted. A thematic synthesis analysed existing qualitative articles to consider young peoples' experience of ARMS, the services offered to them and of being labelled in this way. A feasibility study was also conducted, to assess the viability of offering the intervention, developed for the current portfolio, within the NHS and in a future Randomised Controlled Trial (RCT).

Results: The current findings suggest that young people with ARMS experience high-levels of self-stigma, which delay their help seeking. They highlight the importance of services offering young people the space to talk about and understand their psychotic-like experiences, within a safe and normalising therapeutic relationship. The intervention developed was acceptable to young people and mental health practitioners, with feasible rates of attrition. Recruitment rates were poorer than intended, recommendations for addressing this in future research are made.

Conclusion: Implications for services are highlighted, as are ways of improving the intervention developed. A future RCT evaluating the intervention is recommended.

Contents

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Chapter One - Introduction

This introduction provides a brief outline of the terms psychosis and At Risk Mental State (ARMS), whilst emphasising the importance of early treatment, offering context to the portfolio. It also outlines and provides a rationale for the aims of the thesis.

Psychosis and At Risk Mental State (ARMS)

Individuals experiencing psychosis may have 'positive symptoms,' which include seeing, hearing, smelling or tasting things that other people do not; believing things that others find strange; speaking in a way that is hard for others to follow; or appearing out of touch with reality (these are typically referred to as unusual experiences throughout this portfolio). They may also experience negative symptoms, such as blunted affect, poverty of speech, a-sociality, and limited motivation (Cooke, 2014).

Eighty percent of people with psychosis have their first psychotic-like experience between the age of 15 and 30 (Rethink Mental Illness, 2013). However, for many, the impact of these difficulties on their wellbeing and quality-of-life is long-term, with psychosis considered to be one of the leading causes of disability globally (Mueser & McGurk, 2004). Psychosis is associated with an increased risk of suicide (6.9% long-term risk, compared to 0.3% in individuals with no mental illness (Holmstrand, Bogren, Mattisson, & Brådvik, 2015), and dying 15-20 years younger than the general population (Brown, Kim, Mitchell, & Inskipp, 2010). Individuals with psychosis also commonly have difficulties with socio-occupational functioning, e.g. only 8% of people with psychosis are in employment (Bevan, Gulliford, Steadman, Taskila, & Thomas, 2013), compared to 75% in the general population (Office for National Statistics, 2018).

There are also wider financial costs to society; approximately £11.8 billion per year, resulting from lost productivity and costs associated with health and care (Schizophrenia Commission, 2012).

Tsuang et al., (2013) attributed these poor outcomes to delays in the identification and subsequent treatment of individuals with psychosis. A claim that is supported by findings that the longer an individual's duration of untreated psychosis (DUP[1]), the more negative their outcomes (Marshall et al., 2005). In response to this, specialist Early Intervention in Psychosis (EIP) services are commissioned throughout England to care for people during the first three years of psychosis. These services have specified waiting time standards, to ensure that individuals with first episode psychosis (FEP) have timely access to evidence-based interventions (NHS England, 2016).

The evidence that individuals who receive early interventions have better outcomes, has led to much interest in the early detection of psychosis. As a result, it has become increasingly recognised that frank psychosis is usually preceded by a pre-psychotic period, characterised by a gradual decline in psychosocial functioning and wellbeing (Yung & McGorry, 1996). Such individuals are deemed to have an At Risk Mental State (ARMS) and to be at a high but not inevitable risk of psychosis (Yung et al., 1996). They are usually aged between 14 and 35 and will be experiencing chronic low functioning or a deterioration in functioning, in combination with a genetic vulnerability to psychosis and/or 'positive psychotic symptoms' at a lower intensity or frequency than in frank psychosis (Yung et al., 2003).

Research shows that psychological interventions for individuals with ARMS can reduce the likelihood of them transitioning to frank psychosis, improve their quality of life and reduce their psychotic-like and depressive symptoms (e.g. National

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[1]DUP is the time between the development of psychosis and starting appropriate treatment

Collaborating Centre for Mental Health, 2013). The National Institute of Health and Clinical Excellence (NICE, 2014) recommend that young people considered to be at risk of psychosis are offered individual Cognitive Behavioural Therapy (CBT). According to Wood, Yung, McGorry, and Pantelis, (2011), treatment during this early stage should be more effective than treatment during later stages. Considering this, alongside the significant personal and social costs associated with psychosis, ensuring the effective identification and mental health support for individuals with ARMS is particularly important.

Despite the positive findings of the research just discussed, the current mental health support available for young people with ARMS, within the NHS, is characterised by high levels of disengagement (Connor, 2017) alongside poor availability of CBT (Hazell, Hayward, Cavanagh, & Strauss, 2016). As a result, services are missing opportunities to reduce young people's distress, prevent their symptoms worsening to frank psychosis, and alleviate the long-term impacts associated with this, highlighting the need for improvements.

With this in mind, the current thesis aimed to make a clinically meaningful contribution to the literature through providing information that could be used to increase both the acceptability and availability of mental health support and interventions to young people with ARMS within the NHS. Ultimately, it was hoped that this could be used to facilitate this populations' increased engagement with psychological interventions. These aims are consistent with the British Psychological Society's (2015) recommendations of focusing on prevention, early intervention, and psychological interventions for improving children and young peoples' mental health services.

In achieving these aims, the current portfolio acknowledged the importance of allowing young people the opportunity to express their views and shape the services that are ultimately delivered; 'authentic participation' (British Psychological Society, 2015). Therefore, careful attention is paid to ensuring that young peoples' voices are heard and represented in the findings presented.

Outline of the Portfolio

To achieve its aims, the portfolio reports a systematic review (chapter two) exploring the experience of young people with ARMS, including their experience of mental health services and of being told of their risk for psychosis. The results of a thematic synthesis of qualitative data are outlined and used to make recommendations for improving the acceptability of mental health services for young people with ARMS. A bridging chapter follows, which summarises how these recommendations can be applied to the development of a new psychological intervention.

The following two chapters report on a feasibility study, assessing the viability of delivering a newly developed intervention for young people with ARMS, both within routine NHS services and in a future clinical trial. Chapter four is presented as an empirical paper, which outlines the rationale for developing this brief psychological intervention as well as its content. This paper describes the findings from the feasibility study in relation to recruitment, the acceptability of the intervention to young people, fidelity and indicators of its impact. Chapter five focuses on the acceptability of the intervention to mental health practitioners.

The final chapter provides an overall discussion and critical evaluation, which brings together the results from the whole portfolio, positioning them within the existing literature.

Epistemology and ontology.

This thesis takes a mixed methods approach, combining quantitative and qualitative research paradigms, which traditionally adopt contrasting ontological and epistemological positions (assumptions about the nature of reality and how knowledge can be acquired) (McEvoy & Richards, 2006). Consequently, it is necessary for the researcher's ontological and epistemological position to be made explicit; as such, for this research, this position was underpinned by a philosophy of critical realism. It adopted the view that there is more to reality than can be empirically known, but reality is not entirely constructed through and within human knowledge or discourse (Fletcher, 2017).

A psychological view of psychosis

The author acknowledges the psychological view of psychosis and psychotic-like experiences as outlined by Cooke and Kinderman, (2018) and the British Psychological Society (Cooke, 2014).

The author's view is that there is no clear dividing line between experiences that are considered to be psychotic and other thoughts and beliefs. ARMS and psychosis do not exist as distinct categories in reality but represent different sections of the same continuum.

Despite holding this belief, the author does acknowledge the value of using the ARMS label and it is adopted throughout this portfolio. There are several reasons for this. Firstly, whilst, there may not be a reality to ARMS and psychosis as distinct categories, there is a reality to the distressing unusual experiences that young people labelled with ARMS have, and that for some these worsen, resulting in the long-term impacts outlined above. The planning and commissioning of services uses diagnostic

labelling, thus, categorising people as having ARMS, helps to ensure that those young people who have multiple emerging non-specific pathology (which could exist across a continuum and are likely to get worse over time) are able to receive mental health support/interventions. Moreover, for some service users, being given a label for their difficulties, can be a validating and helpful way for them to make sense of their experiences (Hayne, 2003).

In summary, regardless of whether ARMS and psychosis sit on a continuum or are distinct categories, the ultimate aim of the thesis is the same; to reduce the distress experienced by young people classified as having ARMS, and to prevent their difficulties worsening to the point where they would be labelled as having psychosis.

Young People's Experience of At Risk Mental State (ARMS) and its Application to Improving Services: A Thematic Synthesis of Qualitative Research

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Highlights

- A thematic synthesis of young people's experience of At Risk Mental State (ARMS)

- Fear, social isolation and stigma characterise early experiences of ARMS

- Individuals delay disclosing their ARMS experiences until they reach breaking point

- The chance to talk within a therapeutic relationship and normalisation are valued

- Young people with ARMS want to understand and make sense of their experiences

- The ARMS label should be optional alongside formulation and psychoeducation

Abstract

Mental health services for young people with ARMS are characterised by high levels of disengagement. Understanding the experience of young people with ARMS can provide valuable information for increasing the acceptability of the support available to them. The current review aimed to explore young people's experience prior to accessing services for their ARMS, as well as their experience of receiving support and of being informed of their risk for psychosis. Database searches identified 743 papers for screening, of which 78 were inspected, before a thematic synthesis of ten qualitative studies was completed. The analysis generated a model of eight themes: difficult life; sense-making; anticipated stigma & fear; delayed help seeking until breaking point; disclosure; non-specific therapeutic factors: talking & therapeutic relationship; valuing a new understanding; at risk label: value vs indifference. The results suggest that services should offer young people the opportunity to talk within a trusting therapeutic relationship characterised by empathy, validation and normalisation. Young people should also be provided with information about their difficulties. Ultimately, services must normalise unusual experiences, helping young people to develop new understandings of them that counteracts their initial self-stigma. Future research must investigate the impact of these recommendation on young people's engagement.

Key Words: ARMS; Stigma; Therapeutic relationship; Disclosure; Normalisation; Sense-making

Introduction

There is much interest in the early detection of psychosis, with increasing recognition that it is possible to identify individuals who are at a high (but not inevitable) risk of developing psychosis before they meet the threshold for the disorder (Fusar-Poli et al., 2012). Such individuals are usually referred to as having an At Risk Mental State (ARMS) and/or meeting Ultra High Risk (UHR) criteria (Yung, Yuen, Phillips, Francey, & McGorry, 2005), and are commonly aged between 14 and 35, (Parker & Lewis, 2006). Accessing mental health support is particularly important for this population, as research has shown that psychological interventions can prevent transition to psychosis and improve quality-of-life (Fusar-Poli et al., 2012).

However, the acceptability of the mental health services and interventions offered to young people with ARMS is questionable, due to high levels of disengagement from clinical services in this population (Connor, 2017), as well as high attrition rates in research interventions (Stafford, Jackson, Mayo-Wilson, Morrison, & Kendall, 2013). It has been argued that the perceived stigma associated with being labelled and treated as someone who is at risk of psychosis, may be one explanation for this observed disengagement (Addington et al., 2011; Kim et al., 2017; National Collaborating Centre for Mental Health, 2013; Stafford et al., 2013). This highlights the importance of ensuring that services use language and offer interventions that are non-stigmatising and acceptable to individuals with ARMS (van Os & Guloksuz, 2017). To achieve this, young people at risk of psychosis must be consulted about their needs, preferences and experiences, with the findings used to develop the services that they are offered (Ring, Ritchie, Mandava, & Jepson, 2011)

Qualitative research provides the richest detail about service users' perspectives and their experience of mental health services (Holding, Gregg, & Haddock, 2016), offering valuable insights into the factors that impede and promote their engagement (Russell et al., 2018). Thus, qualitative research seems best placed to gather the information required to inform the development of services and to increase their acceptability to young people with ARMS.

The proposal to include ARMS as a formal diagnosis in the Diagnostic and Statistical Manual (DSM-V) triggered a number of qualitative studies exploring the views and experience of young people with ARMS, and their views of this as a diagnosis (Pyle et al., 2015). However, to date, there has been no synthesis of these findings, which is needed to support their wider generalisability (Ring et al., 2011; Sandelowski, Docherty, & Emden, 1997).

Considering the above, the overarching aim of the current review was to explore the subjective experience of young people meeting criteria for ARMS, and to use this to inform and improve service delivery for this hard to engage population. To support this, there were three review questions:

1. What is the experience of young people with ARMS, particularly before accessing mental health services?

2. How do young people with ARMS experience professional support? How can we ensure that this is acceptable to them and their continued engagement with it?

3. How do young people experience being given the label ARMS/UHR/being told their risk status for psychosis?

Method

Search procedure.

To identify relevant studies, a systematic search of the literature was conducted in June 2017 and updated in October 2017. The following databases were searched: PsychINFO, MEDLINE and CINAHL, using the search terms: '(At risk mental state OR ARMS OR ultra-high risk OR UHR OR Prodrom*) AND (psychosis OR Psychoses OR Psychotic OR Schizophreni*)'. The results were limited to English language and qualitative methodology (best balance). A further search was conducted of the database: Applied Social Sciences Index and Abstracts (ASSIA) using the search terms: '(("At risk mental state") OR ("ARMS") OR ("ultra-high risk") OR ("UHR") OR ("prodrom*")) AND (("psychosis") OR ("psychoses") OR ("psychotic") OR ("schizophreni*")) AND (("Qualitative research") OR ("Qualitative analysis") OR ("Qualitative data") OR ("Qualitative methods")),' the results were again limited to English language. Additional searches, using the same terms, were conducted through Google Scholar and The British Library, and by screening the reference lists of papers accessed in full.

Inclusion and exclusion criteria.

Articles were included where:

(i)   Data were collected using qualitative methodology (including mixed methods)

(ii)   Data were from young people aged between 13 and 35 who were assessed within the last year as being at risk for psychosis (either through meeting At Risk Mental State (ARMS) or Ultra High Risk (UHR) criteria, or deemed to be in a prodromal stage for psychosis/schizophrenia)

(iii) Data explored young people's experience of at least one of the following:

    a. ARMS symptoms and/or unusual experiences

    b. Professional support/interventions

    c. Being labelled as ARMS/informed of their risk for psychosis

(iv) Data were from young people themselves about their own experiences

(v) Data were collected in High Income Countries as defined by The World Bank, (2016)

(vi) They were published in English.

Articles were excluded where:

(i) Only quantitative data were available

(ii) Data were only from individuals who were not at risk for psychosis and/or who had (first episode) psychosis, schizophrenia, bipolar disorder or any other psychotic illness

(iii) Data from individuals with and without ARMS were combined and analysed together, so it was not possible to distinguish that from young people with ARMS and those without

(iv) Data were only collected from informants, e.g. parents, mental health professionals, peers

(v) Data from informants were combined and analysed with data from individuals with ARMS, so it was not possible to distinguish between the two

(vi) Data did not capture the young person's experience (e.g. case studies written about them)

(vii) No original data were provided

Quality appraisal.

Consistent with previous thematic syntheses (e.g. Thomas & Harden, 2008), the studies for the current review were assessed using 12 quality criteria (see appendix B) taken from existing sets of assessment tools (Cherry, Perkins, Dickson, & Boland, 2014; Critical Appraisal Skill Programme, 2017; Garside, 2014; Harden et al., 2006; Horsburgh, 2003; Shaw & Holland, 2014; Thomas & Harden, 2008). Studies were categorised based on how many of the 12 criteria they met; studies meeting between zero and six were deemed to be low quality, those meeting between seven and nine were considered medium quality and those meeting ten or more were classified as high quality (Harden et al., 2006).

Combining quality criteria was advantageous, as it allowed the combination of generic quality criteria (e.g. considering aims, sampling and analysis), with criteria tailored to the purpose of the review (e.g. considering whether young peoples' views are captured and represented, Harden et al., 2006).

Due to the lack of a consensus as to what makes 'good' qualitative research and thus what to base decisions for exclusion on, articles were not excluded on the basis of quality (Sandelowski et al., 1997). However, consistent with Thomas and Harden, (2008), 'sensitivity analysis' was conducted once the thematic synthesis was complete, to assess the possible impact of poorer quality studies on the review's findings.

Data extraction and analysis.

Analysis was approached using Thomas and Harden's (2008) three stages for thematic synthesis ((1) free line-by-line coding; (2) the creation of 'descriptive' themes, (3) the development of 'analytical' themes). This approach was chosen due to its suitability for reviews focusing on questions of acceptability and appropriateness (Ring

et al., 2011). All text labelled as 'results' or 'findings' within each included paper was entered verbatim in to QSR's NVIVO 11 software for the analysis.

An inductive approach to free coding was taken; lines of text were coded according to their content and meaning; they were not fit into existing theoretical frameworks and the reviewer tried to put aside any analytic preconceptions they had (Braun & Clarke, 2006). Initial free codes were later combined into related areas to create hierarchical structures; descriptive themes. As each new study was considered, text was added to existing 'free' codes, new ones were created, or descriptive themes were developed by adjusting and adding to hierarchical structures. Once all studies had been coded, all free codes and descriptive themes were reviewed, looking for similarities and differences between them. The synthesis took place at this stage, with themes from different articles combined to create 'new' information, represented as overarching analytical themes, capturing multiple findings in one idea and answering the review questions.

Results

Search results.

A total of 833 papers were identified, duplicates were removed, leaving 743 papers, which were screened using their title and abstracts. This process left 78 studies, which were accessed in full to determine their eligibility. Sixty eight of these studies did not meet the inclusion criteria (see figure one for descriptions), leaving ten studies for the review. This selection process was audited by the main reviewer's supervisor (see appendix C).

Figure 1

PRISMA Flow Diagram: search procedure and outcome (Moher et al., 2009)
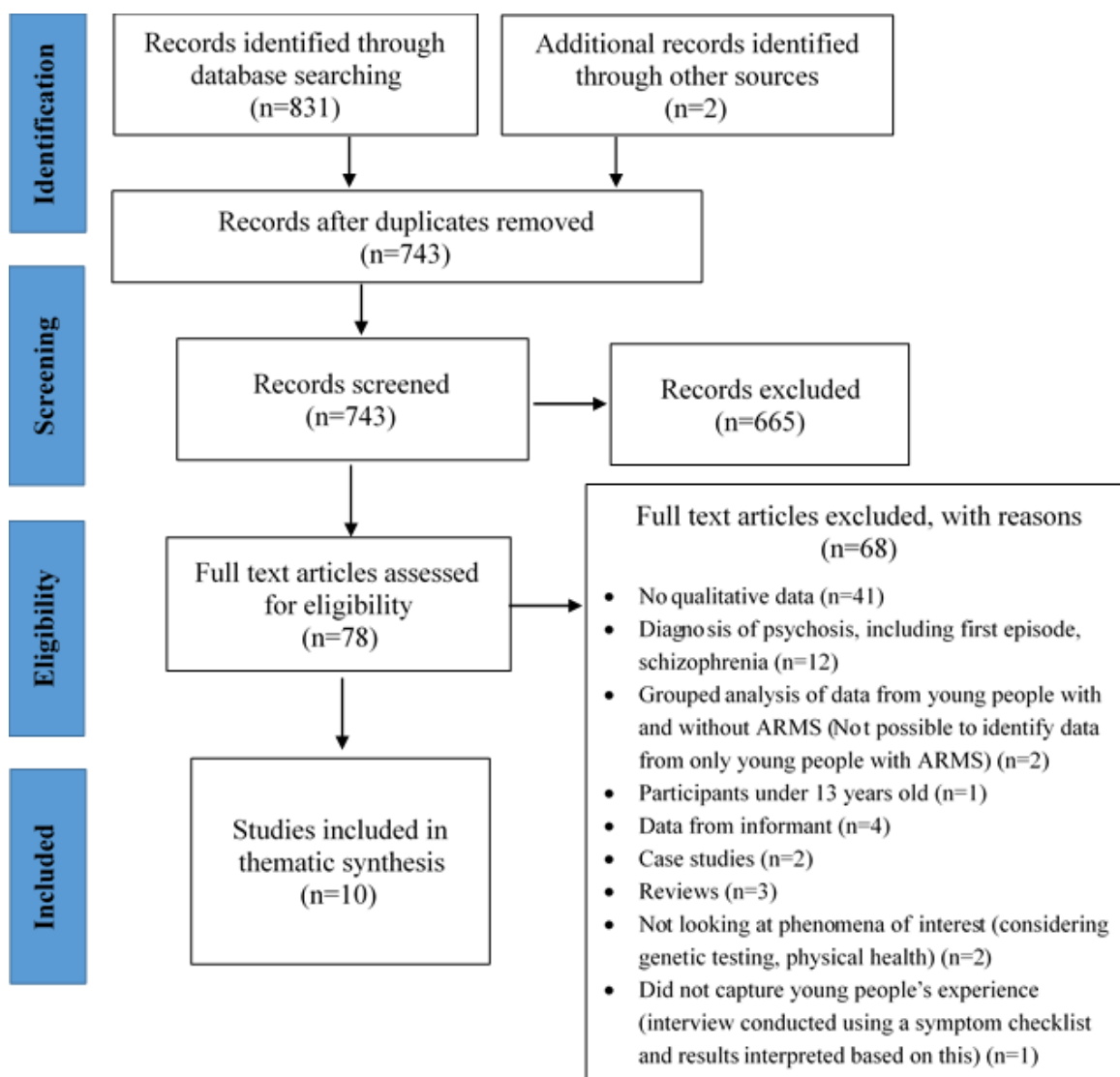
Study characteristics.

The included studies are described in table one, along with numbers to identify them. The ten studies capture the experience of help seeking[2] individuals at risk of developing psychosis in the UK, USA, Canada, Germany and Switzerland. Four of these studies provide data that informs each of the three review questions (studies: 7, 8, 9, 10), three focus on the experience of ARMS 'symptoms' and of service/interventions

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[2] Currently or historically

(2, 3, 5), two specifically focus on the experience of service/interventions (4, 6) and the other focuses specifically on the experience of ARMS 'symptoms' (1).

Outcomes of the quality assessment.

Each study was rated against the 12 quality criteria by the lead author, this was then discussed and finalised with the second author. Table one gives the overall quality rating for all studies. Appendix B shows which of the quality criteria were met by each study.

The only study rated as low quality was that conducted by Hauser et al., (2009), thus an analysis of the impact of this study on the themes generated in the review was conducted. Several tools within QSR's software NVIVO 11 (including cluster analysis of coding, comparison diagrams and a coding group query) were used. These explorations showed that the themes generated from this paper overlapped with themes generated by other studies, with it having very few unique themes, indicating that this study contributed comparatively little to the overall synthesis.

Table 1

Studies included in the current review

Study	Question/Aims	Author(s) and Year	Sample	Method of Data Collection	Type of Analysis	Findings	Quality Rating
1	Aim: To categorise the subjective experience of at risk youths	Ben-David et al., (2014)	27 participants at clinically high risk for psychosis in the USA 15 males, 12 females. Aged:16-27 (Mean age: 21). Ethnically diverse	Open-ended narrative interviews	Thematic Analysis	Themes for males: feeling "abnormal/broken," despair, and alienated; going "crazy;" fantasising/escapism; desiring relationships. Themes for females: psychotic illness among family members, personal trauma, struggles with: relationships, carer and personal development	Medium
2	How do individuals experience their ARMS? How do they make sense of the development of their ARMS?	Brew, Shannon, Storey, Boyd, & Mulholland (2017)	5 participants meeting criteria for ARMS (attenuated symptoms category) in Northern Ireland 4 males, 1 female. Aged: 17-20. No ethnicity information reported	Semi-structured interviews	IPA	Three themes of experience: disturbed world/self; disconnection with the world; thunderstruck. Five themes of understanding: absence of understanding; use of others; identity; forming links; fragmented understanding	High
3	Aim: To explore experiences, and the perception of interpersonal relationships and communication difficulties among young people with ARMS	Byrne & Morrison (2010)	8 participants meeting criteria for ARMS (any category: attenuated symptoms, brief limited intermittent psychosis (BLIPs) or genetic vulnerability) in England 7 males, 1 female. Aged: 16-28 (Mean age: 22.4). All: white British	Semi-structured interviews	Grounded Theory	Individuals with ARMS have often experienced difficulties with interpersonal relationships. Commonly held stigmatising ideas can lead individuals with ARMS to fear that they are going mad and to conceal their difficulties, delaying help seeking. Talking about unusual experiences can improve wellbeing	High

Study	Question/Aims	Author(s) and Year	Sample	Method of Data Collection	Type of Analysis	Findings	Quality Rating
4	Aim: To explore participants' experiences of 'enhanced monitoring' and cognitive behaviour therapy (CBT) within a Randomised controlled trial for people with ARMS	Byrne & Morrison (2014)	10 participants meeting criteria for ARMS (any category) in England 6 males, 4 females. Aged: 14-35 (Mean age: 27.5) 9 white British, 1 black British	Semi-structured interviews	Thematic Analysis	Participants valued 'a chance to talk;' interpersonal engagement, informality and normalisation. Monitoring appointments were a 'therapeutic process,' providing clarity and reassurance. CBT helped to 'rethink things' and to 'move forward' but was hard work	High
5	Aim: To explore how people with ARMS make sense of and understand their experiences	Hardy, Dickson, & Morrison (2009)	10 participants meeting criteria for ARMS (attenuated symptoms) in England 4 males, 6 females. Aged: 16-30 (Mean age: 21.8) 9 white British, 1 black African	Semi-structured interviews	Grounded Theory	Three themes. 'Perception of needs:' recognising difficulties worsening and needing to access a service. 'Participant's subjective journey' through the service: characterised by progression and regression. 'Participant's orientation to the future:' hopes/aspirations and fears of mental health problems returning	High
6	Aim: To evaluate subjective appreciation of a psychoeducational programme for ARMS	Hauser et al., (2009)	16 participants with ARMS (attenuated symptoms, BLIPs or basic symptoms) in Germany 12 males, 4 females Mean age: 26 (SD: 4.9) No ethnicity information reported	Questionnaire (answers in free text)	No Analysis (Results: descriptive)	Participants reported advantages to psychoeducation, including feeling better able to manage their symptoms, and finding the information unburdening	Low

Study	Question/Aims	Author(s) and Year	Sample	Method of Data Collection	Type of Analysis	Findings	Quality Rating
7	Aim: To explore whether individuals with ARMS experience stigmatisation and to what extent being informed about their ARMS is helpful or harmful	Uttinger et al., (2015)	11 participants meeting ARMS criteria (categories not stated) in Switzerland 7 males, 4 females Mean age: 26.7 (SD: 7.72) No ethnicity information reported	Semi-structured interviews	IPA	Participants were relieved that a specific term was assigned to their symptoms. They generally found support from the early detection service helpful. Many reported stigmatisation and discrimination before accessing the service, resulting from altered behaviour and social withdrawal	High
8*	Aim: To explore the experiences and meaning of illness in young people identified as being at ultra-high risk for psychosis. How do participants construct and interpret their experiences and what is the impact of their at-risk label on their sense of self, identity and social relationships?	Volpe (2011)	5 participants identified as being at Ultra High Risk for psychosis (categories not stated) in Canada 1 male, 4 females. Aged: 14-20 Ethnically diverse	In depth life history interviews and a photo elicitation project	Qualitative analysis of photographic and textural data	Participants were aware of the stigma associated with psychosis and used strategies of resistance to avoid stigmatisation and uphold a normal social impression. When offered the at-risk label, young people redefined their experiences to fit with more acceptable and familiar notions of health. Participants appreciated the opportunity to talk to someone confidentially about their difficulties in an unstructured environment	Medium

Study	Question/Aims	Author(s) and Year	Sample	Method of Data Collection	Type of Analysis	Findings	Quality Rating
9**	Aim: To examine the identification and treatment of young people deemed to be at an increased risk of psychosis	Welsh & Brown (2013)	6 participants identified as having ARMS (categories not stated) in England 3 males, 3 females. Aged: 13-18 No ethnicity information reported	Semi-structured interviews	IPA	Three themes: 'It is better to say it;' 'How others would take me;' 'Just to have somebody to talk to.' Participants endorsed the at-risk label to justify and explain their current difficulties, it also provided them with a sense of optimism. Concerns about stigmatisations were raised, but this was rarely experienced	Medium
10**	Aim: To explore how adolescents with ARMS understand their condition medically and personally	Welsh & Tiffin (2012)	As above	As above	IPA	Same themes as above. Participants' respected being labelled/told about their condition and their experiences of this were generally positive, with limited instances of stigmatisation from family/friends. The ARMS label had the potential to generate stigma, although this was rarely observed. Participants valued talking about their experiences.	Medium

*Study 8 was a PhD thesis made up of several articles. Data for analysis were considered to be the results sections for 'Papers 1 and 2,' as these two articles met inclusion criteria.

**Studies 9 and 10 used the same data

Thematic synthesis.

Eight reoccurring analytical themes emerged from the analysis. These are shown in bold in figure two, which shows how the various themes interact and contribute to each other.

Each of the themes is detailed below. The first five themes represent young peoples' experiences before accessing mental health support. The last three themes relate to young peoples' experience of services, with resulting implications summarised in figure two. The narrative below draws links between the themes in an attempt to highlight their interaction.

Developing unusual experiences.

Difficult life.

Many young people discussed difficult, often traumatic, events and experiences during their childhood. This included difficult or absent relationships with their parents, which for some was associated with their parents' own mental health problems. Bereavement, typically of a close family member, was also commonly reported, as was childhood abuse (including sexual and physical), neglect and bullying from peers. E.g.: "I was born into a violent relationship, my mum, my mum and my dad and, really escalated from there because I was neglected and things happened to me," (Byrne & Morrison, 2010, p.164.)

Figure 2

Themes capturing young people's experience of: developing ARMS, accessing mental health services and being told of their risk for psychosis, with resulting implications.

Developing Unusual-Experiences

Difficult Life

Sense-Making ↔ **Anticipated Stigma & Fear**

Delayed Help Seeking until Breaking Point

Disclosure

Accessing Mental Health Services

Non-Specific Therapeutic Factors: talking & therapeutic-relationship

Valuing a new understanding

At Risk Label: Value vs Indifference

- Allowing Space to Talk
- Active Listening
- Everyday Language
- Collaborative Approach
- Understanding/ Empathy, Taking Young Person Seriously. Providing Validation
- Calm, Informal Approach
- Confidentiality
- Consistency of Staff to allow the development of a trusting relationship

- Being given information about the condition
- Being helped to understand their unusual experiences
- Being helped to understand the causes and triggers – linking to life experiences/ context

- Discussion around diagnosis – is it helpful for them?
- Optional
- Alongside formulation, to understand why.

Themes are written in bold.

The colours represent each of the review questions: blue=1; orange=2; green=3.

The bottom three boxes summarise implications for services.

Normalising Unusual Experiences and Difficulties

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Sense-making.

Young people seemed to want to understand and make sense of the causes of their unusual experiences and associated difficulties. For some, this involved linking them to their difficult life events:

"I had also been seeing like demons, demon kind of objects taking my family away and stuff like that after my granda passed away. Because me and my granda were very, very close and that's whenever the depression got even worse," (Brew et al., 2017, p.5).

Whilst some young people saw their difficulties as resulting from stress: "Everything just built up and I just melted down….just like everyone calling, calling me names, it's like picking on me, giving me like judgment, like just school stressing out and everything," (Volpe, 2011, p.65). Others saw their difficulties as inherent within them, either as part of their identity or as resulting from their genetics: "Things that happen in the brain and things that I experience are probably just in my genetic code. I was born with it," (Ben-David et al., 2014, p.1500). Whilst others looked for other biological causes, such as physical illness or side-effects from medications: "Five patients attributed the onset of symptoms to a different illness, medication side effects or drug use," (Uttinger et al., 2015, p.4).

However, some young people seemed unable to understand the cause of their difficulties:

". . .there is nothing I could really link to you know feeling, you know worried about something or you know sad about something you just, you know it happened, but em, yeah there's not really any, I think mainly why is the thought, why it did happen or you know what's happening (laughs) to the world," (Brew et al., 2017, p.6).

Anticipated stigma & fear.

Through these attempts to make sense of their difficulties, young people recognised their experiences as psychotic-like. They were aware that psychosis has a "negative image in the public opinion and the media, as well as of stereotypes about psychosis," (Uttinger, et al 2015, p.4-5). Therefore, they become cognisant of having an attribute that is deeply discredited in society. As a result, young people began to view themselves as "abnormal" and worried that they were going mad, as described by Ben-David et al (2014): "the fear of going crazy was common," (p.1500).

Young people's awareness of the stereotypes associated with psychosis also seemed to fuel several negative expectations. They expected that disclosing their difficulties would be met with rejection, unkind treatment, and ridicule: "I don't bother trying to explain to my family or friends. I just keep it to myself…you feel a bit like, they're gonna think you're going mad," (Byrne & Morrison, 2010, p.165).

This left some young people experiencing symptoms of social anxiety, as highlighted by Byrne and Morrison, (2010): "distressing social anxiety had emerged in relation to the perception of themselves as different or unusual ('not normal'), and to the fear of being perceived as such by others," (p.165). As a result, young people were cautious about getting too close to people and feared being emotionally hurt:

 "I have a boyfriend, but I am scared of getting close to him to the point where he is going to hurt me or he is going to just disappear somehow or something is going to happen to him where he is not in my life anymore," (Ben-David et al., 2014, p.1500).

These difficulties were compounded for the many young people whose unusual experiences included paranoia: "I couldn't do basic things anymore like take the dog out or anything, because I was so paranoid thinking that people were coming after me," (Brew et al., 2017, p.5).

These high levels of fear meant that many young people also displayed high levels of avoidance. They avoided the situations they found difficult, and were socially withdrawn, resulting in social isolation e.g.: "at one point I wouldn't even leave the house," (Byrne & Morrison, 2014, p.366).

Delayed help seeking until breaking point.

The avoidance, fear and stigma just outlined meant that many young people initially avoided seeking help for their difficulties, hoping that they would disappear. Stereotypes meant that many young people feared the consequences of help seeking, anticipating that it would result in them being 'locked away,' and unable to lead a 'normal' life:

"I always thought it was like what you saw on Eastenders and that and that I was going to get arrested and put in a padded call and I was never gonna get out again, and stuff, and I thought if I admit that I am going to be locked away and I am never going to see my family and friends again," (Byrne & Morrison, 2014, p.362).

Many young people found that their unusual experiences worsened over time, and thus these attempts to "passively wait for the situation to get better failed," (Uttinger et al., 2015, p.4). As a result, many described reaching a 'breaking point,' when they felt unable to cope on their own any longer: "I was just getting worse and worse, hearing noise, I just had enough . . . just can't take it, I have to speak to someone" (Hardy et al., 2009, p.54).

Disclosure.

It was at the breaking point just described, that most young people first disclosed their unusual experiences. The word disclosure has been chosen to capture the sense that young people's experience was of opening up about a secret, which they found difficult.

It is therefore unsurprising that young people often thought carefully about who they would share their difficulties with. Many chose a professional, as they hoped that this would bring them help and expected that they would experience a less stigmatised reaction, as highlighted by Byrne and Morrison, (2010):

"Most participants had first disclosed their concerns to a mental health or other professional, rather than to a family member or friend. For some, this was because they lacked adequately supportive relationships; while for others, the potential personal and social costs of disclosure were perceived as being favourably reduced in the context of a professional rather than personal relationship," (p.165).

The professionals' reaction to the disclosure was important in determining whether the young person went on to engage with mental health services. Negative reactions were characterised by the young person feeling misunderstood, dismissed or that they were not taken seriously. This then prevented/delayed further disclosures and thus the young persons' engagement with mental health services:

". . .my old GP I went to him and again I found it really hard to, you know, em express and then he would be like oh there's, he said there's nothing wrong just go for a walk (laughs) and I was like right ok, so I felt really stupid and just didn't talk to anyone about it for ages," (Brew et al., 2017, p.5).

Positive reactions were characterised by young people feeling understood, validated and not judged, leaving them with a sense of relief. These positive experiences were viewed as important for recovery.

Young people did not see disclosure as a one-off event and felt that they continued to disclose specific unusual experiences, as well as their difficult life events throughout their engagement with mental health services. Again, a validating and empathic response to these disclosures was key to continued engagement with services.

Accessing mental health services.

Non-specific therapeutic factors: talking and the therapeutic relationship.

Through being offered empathy, validation and confidentiality from professionals, young people felt listened to, cared for and that their concerns were being taken seriously. Ultimately, this enabled young people to develop a trusting therapeutic relationship, which they particularly valued and saw as important for their continued engagement. Within this, young people valued clinicians who were informal and used 'everyday language.' Byrne and Morrison, (2014) summarised this: "staff members were most consistently characterised in terms of their informality, empathy, and professional understanding," (p.361). For some young people, the mental health professional was the only person they had to talk to, and the relationship gave them a sense of belonging. Others appreciated being able "to share their problems in a safe environment without upsetting others who were close to them," (Welsh and Tiffin, 2012, p.217).

The therapeutic relationship was helpful for normalising young people's difficulties, achieved through clinicians offering a calm and non-catastrophising reaction to any disclosures of unusual experiences. This appeared to counteract young people's self-stigma; reducing their fears that there was something seriously wrong or that they were going mad, and helping them to feel less alone, as highlighted in the following transcript: "it is nice to have someone, who gets it, you know like [therapist],

like when you, to not be shocked and to know why you are saying it and just, to feel normal," (Byrne & Morrison, 2014, p.362.)

A trusting therapeutic relationship was also essential for young people to feel able to talk about their unusual experiences and concerns. This was viewed as one of, if not the, most helpful aspects of accessing professional support. Young people found talking cathartic: "I just get everything out in the open and I don't have to worry about anything," (Welsh & Tiffin, 2012, p.217), and felt it helped them to make sense of their difficulties: "talking to [my therapist], like we have kind of made more sense of it you know," (Brew et al., 2017, p.6).

Valuing a new understanding.

Young people also valued being given information about their difficulties, e.g. "I want to know about my condition" (Uttinger et al., 2015, p.4). As with talking, this helped them to make sense of their experiences. Through which, they were able to develop a new more helpful understanding of them (consistent with the earlier sense-making theme, whilst counteracting the anticipated stigma & fear theme). Conversely, young people expressed frustration if services did not provide them with information about their difficulties and failed to help them to understand them:

"Well, like, I've never gotten the results or anything. I don't really understand it that well. I think they should give a result....I haven't really learned what it was that actually caused it. I just have my own assumptions. To rely on," (Volpe, 2011, p.63).

Young people also valued completing a therapist-led formulation, as this further supported them to develop a new understanding of their difficulties, helping them to make sense of the possible causes and triggers. This was experienced as normalising, as it facilitated young people to recognise that their "psychological problems could be

viewed as fundamentally understandable in the wider context of difficult life experiences" (Byrne & Morrison, 2014. p.364).

At risk label: value vs indifference.

Many young people also valued being informed of their ARMS (or equivalent), citing a variety of reasons for this. For some, the label confirmed their belief that there was something wrong and validated how bad they were feeling. Others were relieved that they did not meet the threshold for psychosis. Whilst the label also confirmed to young people that they could be helped and that they were not the only one experiencing their difficulties:

"He reasoned that if the condition has been recognised and had a name then mental health services should be able to help him. Andy also said that he felt reassured by professional validation of his beliefs that something was wrong," (Welsh & Brown, 2013, p.656).

Other young people reacted to being told of their ARMS with indifference; they felt that it did not matter if they knew about their risk, as it did not change anything. E.g. "It doesn't bother me, it didn't faze me, it means nothing. It's just another thing to add to the list of things that could be wrong with you," (Volpe, 2011, p.68)

Uttinger et al.'s (2015) findings contradicted this theme, reporting that some young people reacted to the label with fear and insecurity.

Discussion

Through the thematic synthesis of qualitative data, a model of themes has been developed (figure two), capturing young people's experience of developing ARMS,

accessing professional support and being told of their risk for psychosis, with implications for increasing young people's engagement with mental health services

Young people reach a breaking point before seeking help.

The current review highlights how understanding and making sense of their difficulties is important for young people with ARMS regardless of where they are in their journey. It found that prior to accessing services, young peoples' attempts at sense-making contribute to them internalising the stigma associated with psychosis, and applying the associated negative stereotypes to themselves; a finding supported by the wider literature (e.g. Ritsher & Phelan, 2004). This is psychologically harmful, as individuals begin to view themselves as abnormal and experience shame. As a result, they conceal their difficulties (Corcoran, 2016), and withdraw from others due to anticipated rejection (Yang et al., 2015). Figure three captures these experiences, showing how the themes of sense-making and anticipated stigma & fear are interdependent, linking together in a cyclical manner. The result is that young people become increasingly withdrawn and fearful, they delay seeking help, remaining trapped in the pre-disclosure phase of figure two, consistent with the first episode psychosis (FEP) literature (Boydell, Stasiulis, Volpe, & Gladstone, 2010).

Becoming trapped within the cycles depicted in figure three contributes to the progressive worsening of young peoples' difficulties (consistent with Corcoran et al., 2003), eventually resulting in them reaching a 'breaking point' when they feel unable to cope any longer (consistent with Cairns et al., 2015). At this point, young people reach the disclosure phase of figure two. In the current review, disclosures were commonly first made to a healthcare professional.

Figure 3

Young people with ARMS: the interaction of their sense-making, fear and stigma

Unusual-experiences are experienced as scary and unpredictable

Seek a cause for and try to make sense of unusual-experiences attempting to reduce their unpredictability

Identify with negative stereotypes associated with psychosis, thus experience internalised stigma

Recognise symptoms as psychotic-like

Become socially isolated

Beliefs of being different, abnormal. Expect discrimination

Avoid others, limit social contact; socially withdraw

Experience social anxiety: fear others' reactions and expect rejection.

Do not access services

Unusual-experiences e.g. paranoia

Key to young people's engagement: professional reaction, the therapeutic relationship and facilitating new understandings.

The current review highlights the importance of professionals' reactions to these disclosures for young people's engagement with mental health services. If young people perceive a negative response from professionals, such as feeling invalidated, it seems likely that it will reinforce their self-stigma and the cycles shown in figure three. It is therefore unsurprising, that negative reactions leave young people reticent to make further disclosures, delaying their receipt of professional help further.

The experience just outlined likely contributes to the high percentage of individuals who have a prolonged Duration of Untreated Psychosis (DUP; the period between the emergence of frank psychosis and the initiation of appropriate treatment, Cotter, Zabel, French, & Yung, 2017).

Therefore, positive reactions to young people's disclosure of unusual experiences are crucial for ensuring services are acceptable to young people and thus for their engagement with them. Within the current review, positive reactions were characterised as being calm, empathic, normalising, and non-catastrophising. These reactions helped young people to challenge the beliefs captured in figure three. They enabled them to recognise that they were not as unusual as they had believed, helping them to develop less harmful appraisals of their unusual experiences (Morrison et al., 2013), to make sense of their difficulties, and to break down figure three.

Young people valued services where professionals continued to adopt the approach just outlined post disclosure. When this was offered alongside validation, confidentiality, and an informal, collaborative way of working, young people were able to build a trusting therapeutic relationship with clinicians. This extends the findings of previous research to the ARMS population (e.g. Boydell et al., 2010; Gee et al., 2016).

This therapeutic relationship was important for young people's continued engagement, as it helped them to feel cared for and gave them a sense of belonging. It also allowed them to talk frankly about their concerns.

Young people valued being able to talk in this way, alongside being given information about their difficulties, as this helped them to better understand and make sense of their concerns. This was further supported when clinicians facilitated the young person to explore and normalise their unusual experiences within the context of their own life. This highlights the importance of services allowing young people with psychotic-like experiences the freedom to talk about them (Cooke, 2014) and to develop an understanding of them as normal and natural reactions to stressful life events (Johnstone, 2011).

Many young people respond positively to the 'At Risk' label.

Telling young people about their risk for psychosis, helped them with their sense-making and understanding, whilst also validating their experiences, consistent with Hayne, (2003). It is also consistent with quantitative research, which found the at risk label to evoke positive emotions, such as feeling hopeful, relieved and understood (Yang et al., 2015).

There is much debate as to the potentially stigmatising impact of labelling young people as being at risk for psychosis (Kim et al., 2017). However, the results of the current review are generally consistent with those of Corcoran, (2016), in that much of the internalised stigma young people experience appears to result from them having unusual experiences, rather than the label. In fact, helping young people to understand their experiences through providing information (including a label) can actually help them to appraise these experiences differently and thus to challenge their self-stigma.

Although, it is important to recognise that some young people did not find the label helpful and instead reacted with indifference or rejection.

Clinical implications and future research.

In addition to the points raised above, the current review highlights the significant levels of internalised and self-stigma experienced by young people with ARMS. A meta-analysis by Livingston and Boyd, (2010) found a robust positive relationship between internalised/self-stigma and symptom severity. This highlights the importance of attempting to reduce self-stigma in young people with ARMS, not only to reduce their delayed help seeking, but also to reduce its impact on their difficulties. Therefore, information and social contact campaigns must continue to target wider societal views about psychosis (Thornicroft et al., 2016). Moreover, interventions for young people with ARMS must focus on improving resilience to stigma as a stressor and reducing self-stigma (Rüsch et al., 2013). The discussion above highlights a number of approaches that would support such an intervention. Future research trials evaluating interventions for young people with ARMS may benefit from including self-stigma as an outcome measure.

As highlighted above, young people want to make sense of and understand their unusual experiences, and being provided with information about their difficulties is one way they can be supported with this. Psychoeducation interventions which provide information about psychotic-like experiences, potential triggers, treatment options and self-management strategies, could provide the information and understanding young people value (Rathod & Pinninti, 2016). The effectiveness of such interventions for the ARMS population could be trialled in future research.

Such interventions would need to take a person-centred approach as to whether they offer young people the ARMS label, as there was individual variation in young peoples' response to this. Providing young people with clear and easy to understand information about the ARMS label before assessing them for it, is crucial. It would ensure that young people can make an informed decision as to whether this is something they wish to pursue, ensuring that the sharing of the label is tailored to each individual, supporting the acceptability of services (Mittal, Dean, Mittal, & Saks, 2015). This should happen alongside the development of a normalising, collaborative formulation (Cooke, 2014).

Limitations

It is important to acknowledge that the current synthesis only captured the experience of young people who were actively help seeking and willing to participate in research, and the views of the many young people with ARMS who disengage from services were not generally captured. Future research may benefit from focusing specifically on this population, as this may offer more detailed insight into the reasons for disengagement. However, it is hoped that through highlighting what young people value in services, the implications of the current review may increase the acceptability of services for all, ultimately decreasing the levels of disengagement.

Another potential limitation of the review is that each study was conducted in a particular context, with geographical and cultural differences. Some would argue against the synthesis of such data on the grounds that concepts identified in one setting may not be applicable to others (Britten et al., 2002). To address this, the current review included only studies that were conducted in high-income countries, attempting to reduce the degree of traditional cultural variability, whilst acknowledging it was still

present. Furthermore, whilst translating themes across the different studies, the reviewer was careful to question whether each transfer was valid and to consider any possible reasons as to why the findings from one context may not be transferable to another (Thomas & Harden, 2008).

Similarly, the review synthesised studies with differing epistemological stances, which could be considered a limitation (Cairns et al., 2015). However, others argue that the value of research findings are enhanced when studies with different epistemological stances are reviewed alongside each other (Sandelowski et al., 1997).

Finally, it is important to acknowledge the context in which this review was written; whilst completing the synthesis, the main reviewer regularly assessed young people with ARMS and conducted research on the feasibility of a novel intervention for these young people. This could have created bias in the researcher resulting from their experiences of working with people with ARMS, and through wanting to find support for the intervention, which they had developed. To decrease this risk of bias, the main reviewer remained cognisant of and reflected on this, sharing their reflections with members of the study team and other colleagues.

Conclusions

The aim of this thematic synthesis was to explore the experience of young people with ARMS, particularly regarding the care they receive.

Prior to disclosing their difficulties to professionals, many young people at risk of psychosis experience high levels of self-stigma and fear, which interact leading them to a psychological 'breaking point.' At this point, they seek help.

Mental health professionals can support engagement in services through an accepting, educational approach, which allows the development of a therapeutic

relationship and helps to normalise the young person's experiences. Ultimately, young people want to be helped to make sense of their difficulties, and engage when services support them to develop new, more helpful understandings.

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Chapter Three - Bridging Chapter

The systematic review has highlighted several recommendations for increasing the acceptability of mental health services to young people with ARMS, and ultimately individuals' engagement with them. Within these recommendations, there are several implications for increasing the acceptability of psychological interventions for young people with ARMS, which are detailed in table two.

The engagement of young people with ARMS in psychological interventions is not only hindered by their withdrawal from services (as outlined in the introduction to the systematic review), but also the poor availability of the recommended intervention within the NHS. The NICE, (2014) guidelines recommend individual Cognitive Behavioural Therapy (CBT) for individuals at risk of developing psychosis. However, CBT is a relatively lengthy intervention, requiring specialist therapists, thus is relatively expensive (Welsh, Kitchen, Ekers, Webster, & Tiffin, 2016). The limited funding available for NHS mental health services, (Roberts, 2015) means that CBT's availability is limited and thus it is not accessible to many who would benefit from it (Hazell et al., 2016).

Consequently, there is a need to develop lower-intensity, briefer interventions for young people with ARMS, which require less specialised therapists, and can form part of a stepped-care approach. The ultimate aim of this would be to increase the availability of psychological interventions for young people with ARMS (Hazell et al., 2016; Stafford et al., 2013). The implications outlined in table two could be incorporated into such an intervention and would help to ensure its acceptability to this population. The empirical paper that follows outlines the development and trial of a psychological intervention consistent with this approach.

Table 2

The implications of the systematic review's findings for psychological interventions

Systematic review finding	Implications for psychological interventions
Young people with ARMS want to be given information about their difficulties, they want to be helped to make sense of them and to develop new, more helpful, understandings of them that counteract stigma.	- Provide psychoeducation - Facilitate the development of a collaborative formulation - Support young people to reduce any negative appraisals they have of their unusual experiences and to develop more helpful alternatives (this would help to counteract self-stigma, Morrison et al., 2013).
Young people with ARMS value being able to talk within a safe therapeutic relationship	- Interventions should emphasise the importance of the therapeutic relationship, allowing opportunities for this to develop and for young people to talk about their concerns - Clinicians should offer young people empathy and validation. They should respond to disclosures of unusual experiences in a non-catastrophising, normalising manner.
Many young people with ARMS experience social anxiety and high levels of social isolation, suggestive of poor functioning.	Interventions should target functioning and increasing social activity (Cotter et al., 2014)

Chapter Four – Empirical Paper

Running head: *The feasibility of a brief novel intervention for young people with ARMS*

Assessing the feasibility of a brief novel intervention for young people with At Risk Mental State: the viability of its use in the NHS and of a future trial

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(See Appendix D for submission guidelines)

Abstract

Objectives: Brief, benign approaches are needed to increase the availability of psychological interventions for young people with At Risk Mental State (ARMS). The current study developed such an intervention and aimed to assess the feasibility of delivering it within the NHS and as part of a clinical trial.

Design: A mixed methods feasibility study was conducted with no randomisation.

Methods: Young people meeting criteria for the attenuated psychosis category of ARMS on the Comprehensive Assessment of At Risk Mental State (CAARMS) were recruited from a NHS Youth Team. Measures of psychotic-like symptoms (CAARMS) and of psychological wellbeing (CORE-OM) were completed pre- and post-intervention. Post-intervention, the Working Alliance Inventory and a non-validated questionnaire were also completed. Participants filled-in the Session Rating Scale after each session.

Results: Eight eligible participants were recruited, seven completed the intervention and six completed all measures. The rate of retention was considered acceptable, as were the inclusion/exclusion criteria. Participants reflected positively on the intervention and the research. They reported experiencing reduced symptoms and new helpful ways of making sense of their difficulties. Participants valued the therapeutic relationship and being given a space to talk. Three participants experienced reliable improvements in their clinical-score on the CORE-OM. Effect sizes were medium or large for improvements in severity of psychotic-like symptoms, as well as for the CORE-OM subscales. There were no adverse effects.

Conclusions: The research and intervention were acceptable to young people with ARMS. A future clinical trial is recommended with suggestions for improvements.

Practitioner Points:

- A brief psychological intervention focusing on normalisation, psychoeducation and the therapeutic relationship, alongside some simple cognitive techniques, delivered by non-registered practitioners, was acceptable to young people.

- The research was not able to recruit its target of 12 eligible participants, which was possibly the result of 'clinical gatekeeping.' However, rates of retention/attrition were acceptable.

- The intervention appeared to have a positive impact, with participants reporting reduced symptoms. There were also some reliable improvements on the CORE-OM and a large effect on severity of psychotic-like symptoms from pre- to post-intervention.

- Conclusions regarding the impact of the intervention are tentative due to the small sample size and the non-experimental approach.

- A future randomised controlled trial is recommended.

Prior to developing psychosis, individuals often experience a gradual decline in their psychosocial functioning and wellbeing (Yung & McGorry, 1996). Research has operationalised criteria which allows the potential identification of people within this stage. Such individuals will be experiencing chronic low functioning or a deterioration in functioning, in combination with one of the following:

1. Trait risk factors (genetic vulnerability).

2. Attenuated positive symptoms. (e.g. unusual perceptual experiences, odd beliefs, referred to as unusual experiences)

3. Brief Limited Intermittent Psychotic Symptoms (BLIPS) which spontaneously resolve

(Yung et al., 2003).

Individuals meeting this criteria are deemed to have an At Risk Mental State (ARMS), to be at a high but not inevitable risk of psychosis and are usually aged between 14 and 35 (Yung et al., 1996). Offering interventions to individuals with ARMS is particularly important, as treatment during this early stage is thought to be more effective than treatment during later stages and can prevent transition to frank psychosis (Wood et al., 2011).

Psychological interventions for young people with ARMS.

The NICE, (2014) guidelines recommend that individual Cognitive Behavioural Therapy (CBT) is offered to young people at risk of developing psychosis, delivered in the same way as for those with psychosis (a minimum of 16 sessions with a qualified therapist). However, the availability of this high-intensity CBT within the NHS is poor, meaning it is not accessible to many (Hazell et al., 2016), particularly within the time frames set out by the Early Intervention in Psychosis (EIP) waiting time standards (NHS

England, 2016). This has been attributed to a lack of financial resources and insufficiently qualified staff (Lamb, 2018). Therefore, a possible solution is to offer lower-intensity, briefer CBT-informed interventions, which require fewer resources, including less specialised staff (Bennett-Levy, Richards, & Farrand, 2010).

Lower-intensity interventions seem particularly appropriate for those with ARMS, as interventions targeting this early stage of difficulties "should be more benign" than those designed for psychosis (Wood et al., 2011, p.261), and should focus on prevention and self-management (Fusar-Poli, Yung, McGorry, & Van Os, 2014).

Moreover, research comparing high-intensity CBT with lower-intensity control interventions, supports a role for these more benign interventions. For example, the National Collaborating Centre for Mental Health, (2013) found that low-intensity control interventions were equally as effective as higher-intensity CBT in reducing psychotic and depressive symptoms in young people with ARMS, whilst improving their quality of life and psychosocial functioning. Such interventions involved monitoring young people, offering them psychoeducation and providing them with a positive therapeutic relationship.

Morrison et al.,'s (2012) study found that a 'control intervention' (deemed monitoring) delivered by non-registered practitioners, was equally as effective as CBT in reducing young people's transition to psychosis, and their symptom related distress. Further exploration of these findings led to conclusions that attributes of the monitoring process were active components through which the risk of transitioning to psychosis was reduced. These attributes included: supportive listening, normalising, non-catastrophising language and a strong therapeutic-relationship, characterised by warmth, empathy and acceptance (Byrne & Morrison, 2014; Morrison et al., 2012).

Research aims.

Development of a new psychological intervention.

Whilst research has demonstrated the potential effectiveness of lower-intensity interventions for young people with ARMS and made suggestions as to the elements that should be included within them, it appears that such an approach has not been developed or researched as an intervention in its own right. Therefore, it will be important to develop a brief, benign, small-scale intervention for young people with ARMS, which can form the initial stage of a stepped-care approach in the NHS (Hazell et al., 2016; Stafford et al., 2013; van Os & Guloksuz, 2017)

Considering this, the current study aimed to develop an intervention that could be delivered by non-registered practitioners, focusing on the attenuated psychotic symptoms experienced by young people with ARMS[3]. Table three summarises the key components of this intervention, many of which were informed by the low-intensity 'control' interventions discussed above.

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[3] Morrison et al (2012) concluded that interventions must target specific presenting difficulties; attenuated psychotic (unusual) experiences were the target of the current intervention.

Table 3

Elements to be incorporated into the intervention for the current research alongside a rationale for their inclusion

Key element[4]	Rationale
Focus on the therapeutic relationship, characterised by warmth, empathy and validation	• Consistent with Morrison et al., (2012) • Research consistently finds that the therapeutic relationship is a key component in the effectiveness of all psychological therapies (Horvath, 2001), accounting for much of the change that occurs in individuals receiving therapy (Budd & Hughes, 2009). • Goldsmith, Lewis, Dunn, and Bentall, (2015) used structural equation modelling to demonstrate that a good therapeutic relationship causes improvements in individuals experiencing psychosis, whilst a poor therapeutic relationship has a detrimental effect. They argued that the therapeutic relationship was the common factor explaining why CBT and a control intervention were similarly beneficial in their study.

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[4] Please note that these key elements are all consistent with the recommendations/outcomes from the Systematic Review as summarised in table two

Key element	Rationale
Offering a normalising and non-catastrophising approach to individuals' psychotic-like experiences, allowing young people to develop new more helpful understandings of them. Achieved through: psychoeducation and thought challenging	• Consistent with Morrison et al., (2012) • Individuals often experience anxiety due to not understanding and fearing their unusual experiences, which can fuel the transition from attenuated to frank psychosis (Watts, 2013). Psychoeducation which explains and normalises unusual experiences can reduce this anxiety, preventing individuals from developing catastrophic delusional explanations, and averting frank psychosis (Rietdijk et al., 2010).unusual experience • The British Psychological Society (BPS) argue that psychotic-like experiences should not be viewed as symptoms of illness; people should be helped to understand and make sense of them (Cooke, 2014).
Completing an individualised psychological formulation and between-session tasks	• Participants in the Morrison et al., (2012) trial reported finding these particular CBT processes helpful (Morrison et al., 2013). • Flach et al., (2015) found there to be a greater treatment effect in young people with ARMS when formulation and between-session tasks were included in therapy.

Key element	Rationale
Behavioural Activation	• Welsh et al., (2016) recommended trialling a low-intensity intervention as a first-step treatment for ARMS, which involved psychoeducation and monitoring alongside behavioural activation to increase social activity. Others have made similar claims (e.g. Fowler et al., 2010; Hodgekins et al., 2015). • Engaging in social activities, means individuals are likely to be exposed to normalising and alternative explanations for their unusual experiences (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001).
Brief: four one-hour long sessions	• On average, individuals indicate a preference for four-sessions of CBT during the initial stages of treatment, (Richards, 2010).

Trialling the new intervention

When evaluating newly developed interventions, the first stage is to conduct a feasibility study (Medical Research Council, 2014). Feasibility studies aim to determine whether a future full scale Randomised Controlled Trial (RCT) is viable and if so to optimise its design and processes (Eldridge et al., 2016). They also aim to assess whether an intervention is safe, has shown efficacy (Lancaster, 2015) and can be administered as intended as part of routine care within NHS settings (O'Cathain et al., 2015).

Therefore, the current research aimed to assess the feasibility of training non-registered practitioners to deliver a newly developed intervention to young people with ARMS (meeting the attenuated psychosis criteria) within the NHS[5] and as part of a clinical trial. It aimed to answer the following research questions:

1. Are the rates of recruitment and retention/attrition feasible for a future RCT?

2. Can non-registered practitioners be trained to deliver the intervention as intended, including the development of a positive therapeutic relationship in only four sessions?

3. What is the acceptability of the intervention and research to young people?

4. What impact does the treatment have? Are there any adverse effects? What is an estimate of the treatment effect?

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[5] The EIP waiting time standards state that young people with ARMS should be seen within EIP services (NHS England, 2016). However, they are referred to a Youth Team within the NHS trust in which this research was conducted, which is where this research took place.

Method

Design.

A feasibility study was conducted. A mixed methods approach was adopted as recommended by the Medical Research Council, (2014). All participants received the intervention with no randomisation to a control condition. National Institute for Health Research, (2017) guidelines state that randomisation is not necessary in feasibility studies and will depend on the aims.

Participants.

An opportunity clinical sample was recruited from a NHS Youth Team (for 14-25-year olds) in the East of England between April and December 2017. The aim was to recruit 12 participants (Julious, 2005). Inclusion and exclusion criteria are shown in table four.

Table 4

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• 16-25 years old • Meeting the attenuated psychosis category of ARMS on the Comprehensive Assessment of At Risk Mental State (CAARMS) (Participants were not excluded if they also met BLIPs and/or genetic vulnerability criteria) • Have an allocated Lead Care Professional (LCP) • Assessed by their LCP as having capacity to consent to research and being appropriate for therapy	• Changed psychiatric medication within the previous three months • Meeting criteria for psychosis on the CAARMS or having a previous/current open referral to an EIP team • Currently receiving psychological therapy • Previously received CBT for ARMS.

Measures.

Table five details the measures used in the research

Table 5

Measures used in the current research

Measure	Details	Use in current study	Psychometric properties
Comprehensive Assessment of At Risk Mental State (CAARMS)[6]	Semi-structured interview, designed to identify individuals meeting criteria for ARMS. A brief-version measuring positive symptoms and functioning was used (Simmons, Montague, & Parker, 2015).	Screening measure: participants were eligible if they met criteria for the attenuated psychosis group. Outcome measure: severity of participants' psychotic-like experiences and the distress caused by them pre- and post-intervention. Identified participants who transitioned to psychosis post-intervention.	Good to excellent concurrent, discriminant and predictive validity, excellent inter-rater reliability (Yung, Yuen, Phillips, Francey, & McGorry, 2005).
Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM)	Self-report questionnaire where participants rate 34 statements, indicating how often they have felt each over the previous week. Measures wellbeing, symptoms, functioning and risk.	Outcome measure: pre/post-intervention changes.	Excellent internal consistency (α=0.94) and 1-week test-retest reliability (Spearman's ρ=0.90), good convergent validity and sensitivity to change (Evans et al., 2002)

[6] Training on the CAARMS was provided by a colleague experienced in using it and training others in its use. Concordance ratings were not completed for the CAARMS, but completed assessments were discussed and verified with a trained rater.

Measure	Details	Use in current study	Psychometric properties
Session Rating Scale (SRS)	A simple four item self-report alliance measure; scored by measuring the mark made by participants on a continuum line (to the nearest centimetre). Each item is out of 10, with a total out of 40. (Higher scores indicate a better alliance)	Completed after each intervention session to give an indication of the acceptability of each session to participants as well as the development of the therapeutic relationship	High internal consistency and test retest reliability, and moderately strong concurrent validity with other measures of alliance (Duncan et al., 2003)
Revised Short Version of the Working Alliance Inventory-Self Report (WAI-SR)	Measure of the quality of the therapeutic alliance, giving a score on three subscales: bond, agreement on therapeutic-goals and agreement on therapeutic-tasks. There are 12 items; four for each of the subscales. Each item is rated between one and five, thus the total for each subscale can vary between four and 20. Higher scores indicate a better therapeutic relationship.	Completed by young people after finishing the intervention to give an overall measure of the therapeutic relationship from their perspective	Good convergent validity with the Helping-Alliance-Questionnaire (r>0.64) (Munder, Wilmers, Leonhart, Linster, & Barth, 2010), as well as high internal reliability for the total scale (α>0.9), and subscales (α=0.8-0.9) (Hatcher & Gillaspy, 2006; Munder et al., 2010; Perdrix, de Roten, Kolly, & Rossier, 2010).

Revised Short Version of the Working Alliance Inventory-Therapist Version (WAI-SRT)	The therapist version of the WAI-SR, measuring the same sub-scales. The WAI-SRT has only ten items; four measuring emotional bond and three measuring each of the other two subscales.	Completed by the non-registered practitioners delivering the intervention for each young person they worked with (post-intervention). To give a measure of the therapeutic relationship from their perspective	Acceptable to good internal consistency (α=0.77-0.86) (Hatcher & Gillaspy, 2006; Jooste, Kruger, Steyn, & Edwards, 2016)
Fidelity Checklists (Appendix E)	Developed for each of the four intervention sessions, aiming to assess whether the intervention could be delivered as intended. It involved ticking/crossing to indicate whether particular aspects of the session had been covered.	Completed by non-registered practitioners after every session they delivered.	Non-validated
Experience Questionnaire (Appendix F)	Developed for the current study. Some questions required a multiple-choice response, some on a five-point Likert scale, others were open ended, providing qualitative data.	It aimed to assess the acceptability of the intervention and research to young people. It was completed post-intervention	Non-validated

Procedure.

Developing the intervention.

The development of the intervention was informed by a review of the literature, including a systematic review considering young peoples' experience of mental health support for ARMS. This led to the identification of a number of key elements, which were to be incorporated into the intervention (table three). Three authors (EB, TC and RL) discussed these elements and consulted two existing manuals (French & Morrison, 2004; van der Gaag, Nieman, & van den Berg, 2013). The result of this was the identification of the intervention's aims; which were to support young people to:

- Explore their unusual experiences

- Recognise how common unusual experiences are

- Make sense of their unusual experiences and why they might be experiencing them

- Challenge any unhelpful beliefs about their difficulties and to consider alternatives

- Recognise the triggers to and the maintenance of their unusual experiences

- Increase their activities and socialisation

Based on these aims, a structure for each of the intervention sessions was then decided upon, before EB developed worksheets which were used to deliver/shape each session. These worksheets are included in appendix G and detail all of the content of the intervention.

Experts by experience (EBEs) (a Peer Support Worker from an EIP team and two former service-users) were invited to contribute to the development and shaping of the intervention, as involvement of young people in this way, has been shown to improve engagement and clinical outcomes (Collins, Notley, Clarke, Wilson, & Fowler,

2017). The EBEs reviewed the intervention worksheets and some changes were made in response to their feedback (see appendix H for detail).

Changes were also made following the piloting of the intervention with a young person with psychotic-like experiences who was accessing the service in which the research was based (conducted by EB). The pilot participant reflected positively on the intervention, reporting small improvements in the way they thought about their unusual experiences and no distress or worsening of their difficulties. See appendix H for details.

Training non-registered practitioners to deliver the intervention.

Seven non-registered practitioners (two Assistant Psychologists, five Assistant Practitioners) attended a four-hour training session facilitated by EB and TC. This involved outlining the rationale behind the research and the overarching approach of the intervention. Each of the four-sessions was also explored in detail. The training included teaching, group discussions, modelling of the intervention and role plays.

Delivering the intervention.

The research was granted approval from the East Midlands, Nottingham, Research Ethics Committee (17/EM/0114) and from the NHS Health Research Authority (appendix I).

Service clinicians identified potential participants, who met with EB to give informed consent (appendices J, K). Participants then attended a screening appointment with EB, in which they completed the CAARMS. If eligible, participants completed the baseline CORE-OM.

Participants were allocated to one of the trained non-registered practitioners. Where possible, sessions were conducted weekly or fortnightly, although this was

flexible to encourage young people's continued engagement. Participants completed the

SRS after each session, and the non-registered practitioner completed the relevant

fidelity checklist. Participants continued clinical treatment as usual within the Youth

Team, which involved meetings with their LCP, some also had reviews with a

Psychiatrist.

Post-intervention, participants met with the primary researcher to re-complete

the CAARMS and CORE-OM. The time between completing these measures at

baseline and again post-intervention was variable across participants (from between five

to 16 weeks). This was due to participants choosing to complete the four intervention

sessions within different time-frames. Participants also completed the WAI-SR and the

experience questionnaire, they were encouraged to complete these independently, but

support was offered if requested. No further follow-up was offered.

The non-registered practitioners completed the WAI-SRT following their final

session with each participant.

Data analysis.

Data from multiple sources were used to answer each of the research questions.

Pre-defined targets were set for some questions; meeting these criteria supported the

feasibility of the research and/or intervention. These targets are shown in table six.

Table 6

Feasibility targets to inform conclusions relating to some of the research questions

Research Question	Data	Pre-defined target for feasibility
Are the rates of recruitment and retention/attrition feasible for a future RCT?	Number of participants who consent to and are eligible for the research	12 or more
	Percentage of participants who consent who then meet eligibility criteria	51% or higher*
	Percentage of participants who start the intervention and complete it and all measures	75% or higher*
Can non-registered practitioners be trained to deliver the intervention as intended?	**Fidelity checklists:** The average percentage of items endorsed (ticked) for each of the four sessions.	95% or higher
Can a positive therapeutic relationship be developed in only four sessions? What is the acceptability of the intervention to young people?	**WAI-SR/WAI-SRT:** Mean scores for each of the subscales and the total score (for all participants combined)	4 or above**
	SRS: Mean scores for each of the subscales and the total score for each session (for all participants combined)	9 or above (Duncan et al., 2003)

*There are no standard rates of recruitment/retention that are considered acceptable. Therefore, the latter two criteria are based on the rates of recruitment/retention in Morrison et al's., (2012) study, appendix L

** Neither the WAI-SR or WAI-SRT are standardised measures with cut-offs to determine what can be classed as a strong therapeutic relationship; no measures of therapeutic-alliance are (Horvath, n.d.). Therefore, the means reported in other studies were considered to determine the cut-off for the current study, appendix M

Data from the experience questionnaire were analysed to inform conclusions about the acceptability of the intervention and research. Descriptive statistics were used to analyse questions with multiple-choice responses. Framework analysis was used for the qualitative data (Ritchie and Spencer, 1994). This followed the steps for psychological research outlined by Parkinson et al., (2016):

1. Familiarisation: reading the data

2. Identifying a framework to organise the data

3. Indexing: systematically coding chunks of text to the framework categories

4. Charting: summarising the data for each participant for each of the framework categories

5. Mapping and interpretation: using the chartered data to look for emerging patterns across participants and then developing these into themes (inductively)

The final research question related to the impact of the intervention, which was not the study's primary focus. Thus, the research was not adequately powered *a priori,* and inferential statistics were not conducted. Instead, effect sizes were calculated for pre to post-intervention changes in:

- Each of the CORE-OM subscales

- The CORE-OM clinical score (the mean of all items multiple by ten (Gray & Mellor-Clark, 2007)

- Severity of psychotic-like experiences on the CAARMS (the sum of the frequency and global rating scores for all 'positive symptom' subscales, Morrison et al., 2012)

- Distress caused by psychotic-like experiences on the CAARMS (mean distress score of all 'positive symptom' subscales, Morrison, et al., 2012)

Reliable and clinically significant change calculations were calculated for CORE-OM data for each participant with pre- and post-intervention scores. A change of five or more on the clinical score indicated a reliable change (Gray & Mellor-Clark, 2007), whereas, a change from above to below ten (or vice versa) indicated a clinically significant change (Connell et al., 2007). Reliable change calculations were also conducted by hand for pre/post data for each participant on the CORE-OM subscales, using Jacobson & Truax's (1991) formula.[7]

Finally, serious adverse events (SAEs) and adverse events (AEs) recorded for the study were considered to see if they indicated any adverse effects of the intervention. SAEs/SAs were defined using guidance from The Medicines for Human Use (Clinical Trials) Regulations, (2004).

Results

Recruitment and participants.

Figure four illustrates the flow of participants through the study.

Sample characteristics.

Table seven provides the demographic details of all participants who consented, identifying those who were eligible, those who finished the intervention and those who attended the post-intervention assessment appointment.

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[7] Norms for these calculations were taken from a sample similar to the current research
(as recommended by Heaton et al., 2001). This was a clinical sample of 890 (Evans et al., 2002).

Figure 4
Flow of participants


```
┌─────────────────────────────┐
│  Referred to study (n=16)   │
└─────────────────────────────┘
                │
                │         ┌──────────────────────────────────────────────────┐
                │────────▶│ Excluded before initial appointment (n=4)         │
                │         │                                                    │
                │         │ Medication change within the last 3 months (n=2)  │
                │         │                                                    │
                │         │ Disengaged from service, unable to contact (n=2)  │
                │         └──────────────────────────────────────────────────┘
                │
┌─────────────────────────────┐
│ Consented to participate (n=12) │
└─────────────────────────────┘
                │
                │         ┌──────────────────────────────────────────────────┐
                │────────▶│ Excluded at screening appointment (n=4)           │
                │         │                                                    │
                │         │ Meeting criteria for psychosis on the CAARMS (n=4)│
                │         └──────────────────────────────────────────────────┘
                │
┌─────────────────────────────┐
│ Baseline assessment (n=8)   │
└─────────────────────────────┘
                │
┌─────────────────────────────┐
│ Referred to intervention (n=8) │
│                             │
│ Received full intervention (n=7) │
│                             │
│ Did not attend session four (n=1) │
└─────────────────────────────┘
                │
┌─────────────────────────────┐
│ Completed intervention (n=7) │
│                             │
│ Completed post intervention │
│      measures (n=6)         │
│                             │
│ Did not complete post-intervention │
│      measures (n=1)         │
└─────────────────────────────┘
                │
┌─────────────────────────────┐
│ Analysis of outcome measures (n=6) │
└─────────────────────────────┘
```

Table 7

Demographic details of participants who consented to participant

Participant	Age	Gender	Eligible	Completed intervention	Attended post-intervention assessment
SU1	17	Female	Yes	Yes	Yes
SU2	23	Male	Yes	Yes	Yes
SU3	16	Female	Yes	Yes	Yes
SU4	23	Female	Yes	Yes	Yes
SU5	17	Female	Yes	Yes	Yes
SU6	20	Female	Yes	Yes	Yes
SU7	18	Female	Yes	Yes	No*
SU8	19	Male	Yes	No	No*
SU9	17	Male	No		
SU10	17	Female	No		
SU11	25	Female	No		
SU12	17	Female	No		

* Some data for SU7 and SU8 were available, i.e. fidelity checklists, SRS data. Where available, this is included in analyses and thus the number of participants for which data is reported, is variable across the results.

Are the rates of recruitment and retention/attrition feasible for a future RCT?

Two of the three recruitment targets were met. Sixty-seven percent of participants who consented to the research were assessed as eligible (above the pre-defined target of 51%). The percentage of participants who began the intervention and then completed it and all measures was at the target of 75%. However, it was only possible to recruit eight eligible participants, not the intended 12.

Can non-registered practitioners be trained to deliver the intervention as intended, including the development of a positive therapeutic relationship in only four sessions?

Intervention fidelity.

Eight fidelity checklists were completed for sessions one to three and seven for session four (due to SU8 not attending). Table eight shows that the average percentage of items ticked for each session was high, suggesting it was possible for non-registered practitioners to deliver the intervention as intended. Session two did fall below the target of 95%. However, this value was significantly impacted by one particular session, where it was difficult for the non-registered practitioner to follow the structure due to having to prioritise the participant's more pressing needs. (Additional fidelity data is presented in appendix N).

Table 8

The average percentage of items endorsed (ticked) for each session on the fidelity checklists

Session Number	Average Percentage Ticked for Each Session Conducted	Standard Deviation
One	98.57%	2.16
Two	88.21%	18.79
Three	98.16%	2.19
Four	97.74%	2.81

Session ratings.

Mean scores for each session for the subscales and total score on the SRS were calculated and are shown in figure five. All of the means were above the recommended

cut-off of nine, suggesting the sessions were generally acceptable to participants.

Relationship was generally rated higher than other aspects.

Figure 5
Mean scores on each SRS subscale and the total score for each session
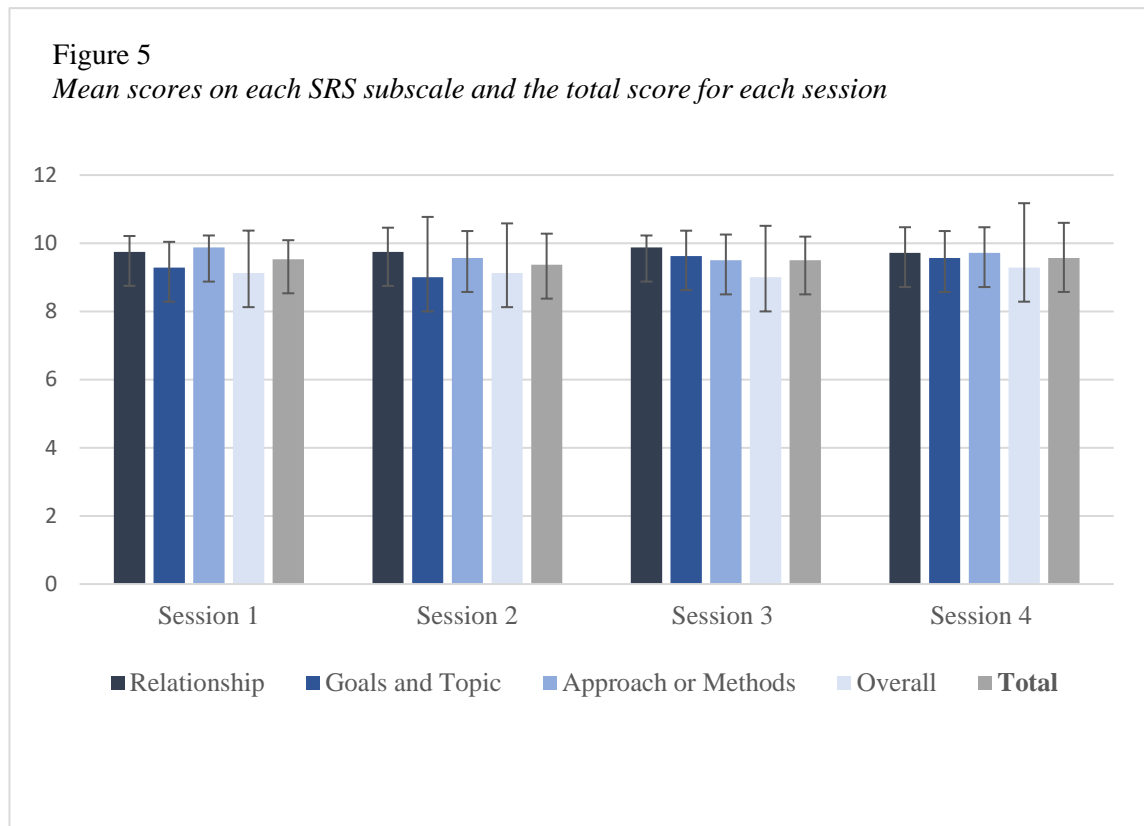
Working alliance.

The mean scores for each of the subscales and the total scale for all participants

on the WAI-SR and WAI-SRT are shown in table nine. The mean on the task subscale

of the WAI-SR fell below the predefined target, suggesting that there was some discord

between the participants' views of the tasks involved in achieving their goals and those

completed within the intervention. However, all other subscale and total means were

above the pre-defined cut-off. Taken with the SRS results, this suggests that it was

possible to achieve a positive therapeutic relationship in four sessions. (Individual

participant's scores on the WAI-SR(T) and SRS are shown in appendix O).

Table 9

Mean subscale and total scores for all participants on the WAI-SR and WAI-SRT

	Mean (SD)	
Subscale	WAI-SR	WAI-SRT
Bond	4.42 (0.97)	5.00 (0)
Goals	4.50 (0.83)	4.10 (0.77)
Task	**3.38 (1.24)**	4.10 (0.70)
Total	4.10 (1.14)	4.46 (0.99)

WAI-SR: N=7. WAI-SRT: N=8

Means in bold are below the pre-defined target of 4.00

What is the acceptability of the intervention and research to young people?

Experience questionnaire: quantitative data.

Participants (n=6) answered questions about the length and number of sessions. Five (83.33%) reported that four sessions were not enough, one (16.67%) felt that this was the right number. Whilst five participants indicated that one hour sessions were the right length and one (16.67%) reported that these were too short.

Participants also used a five-point Likert Scale to indicate their agreement/disagreement[8] with statements about the intervention and research Combining the 'agree' and 'strongly agree' categories, five participants (83.33%) indicated that the intervention was helpful, six (100%) would recommend it to others with similar difficulties and three (50%) found the between-session tasks helpful. Combining the 'disagree' and 'strongly disagree' categories, all participants disagreed that the intervention was distressing.

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[8] Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree

Considering the research, combining the 'agree' and 'strongly agree' categories, all participants were pleased they had participated, would recommend participating to others and found the questions they answered with the researcher relevant. Five (83.33%) participants agreed that these questions were easy to understand.

More detail is included in appendix P.

Experience questionnaire: qualitative data.

Framework analysis (see appendix Q) identified seven themes representing participants' views of the intervention and research, shown in table ten, along with some illustrative quotes from participants. The narrative below summarises the findings.

Table 10

Themes representing participants' views of the research and intervention, with illustrative quotes

Theme	Illustrative Quote
Helpful: experiencing reduced symptoms	"I feel it has decreased my unusual experiences" (SU5)
	"Things feel much brighter and more positive, things used to feel really pointless and dull, but I now feel more upbeat" (SU1)
	"I have been using my coping strategy and this has helped to stop my voices" (SU2)
	"I feel like I can manage better if they [unusual experiences] come up again" (SU3)

Theme	Illustrative Quote
Non-specific therapeutic factors: therapeutic relationship, talking and a friendly, informal approach	"I found her helpful, her tone, how she spoke, that she was friendly" (SU6) "It was very relaxed, felt comfortable, I didn't feel nervous" (SU1) "I think if I wasn't put with *****, I would have found it more difficult to talk about it" (SU3) "The research is good, can talk to people – got the researcher and ****, can talk to them about stuff. Can trust people" (SU2)
Valuing a new understanding	"When I'm walking home at night in the dark, I don't feel as paranoid, as I use the alternative thoughts. I've been able to rationalise a lot of things" (SU1) "Breaking down the unusual experience [was helpful], i.e. what was happening, what it was, what emotions linked in, being able to see the experience in a smaller, explainable way" (SU4) "I can understand/notice the triggers more, so it makes me accept them [unusual experiences] more and less prone to them" (SU5). "It helped me to understand what was going on in my head and the causes" (SU1) "Made me realise that other people experience stuff and it's not just me" (SU3) "I am trying to be more accepting of the fact that causes to my experiences may be down to simpler reasons that I'd like to believe" (SU4)
Between-session tasks: mixed views	"Helps people to keep busy with their homework" (SU2) "I didn't have time for the between session tasks" (SU3)

Theme	Illustrative Quote
Criticisms and improvements	"[I disliked] how much we repeated what we had done in the previous session, went through this in too much depth" (SU1)
	"The content of some of the worksheets - wasn't sure what they were about" (SU2)
	"Maybe too short" (SU5)
	"Would have found more discussion on what to do during experiences helpful" (SU5)
	"maybe a starting appointment without therapy (before) to introduce the therapy/structure and meet therapist" (SU5)
Should be offered to others	"I think, if given the opportunity, they should take it, as it has potential to be a possibly life-saving intervention" (SU3)
	"people don't get lost in the crowd" (SU6)
	"I think it's a good starting point…I think it will set them up with some good tools to use. However…some would need more help analysing what they've learnt, and some would need help on how they would keep using these tools once the sessions had ended" (SU4)
Good to be involved in the research	"Think it's good - new approach to methods is good" (SU6)
	"Really helpful and interesting" (SU5)
	"[the assessment questions] could be a bit clearer/simpler or provide more examples to help" (SU4)

All participants cited examples of ways they had benefited from the intervention, most commonly reporting fewer symptoms (four specifically described a reduction in unusual experiences.)

Non-specific therapeutic factors contributed to the helpfulness of the intervention. A friendly, informal approach allowed the development of a therapeutic relationship in which participants felt as ease, helping them to feel that they "had

someone to talk to" who they were "able to trust" (SU2). This created a "space to openly discuss" their difficulties (SU5), which was particularly valued. This was further highlighted by the three participants who appreciated the two research assessments (pre-post) for providing additional space to talk.

Participants also found the intervention helpful for facilitating new understandings of their difficulties. Three participants specifically related this to the cognitive elements (e.g. thought challenging (SU1), developing a maintenance formulation (SU4)). For many, this was also helped by the normalising aspects, which allowed them to make sense of their experiences in different ways. Being able to identify the triggers and causes to their unusual experiences was also valued by some.

There were mixed opinions as to whether between-session tasks were helpful; some found that they were, whereas others found it difficult to find the time to complete them. The most commonly cited criticism of the intervention related to wanting more than four sessions, other suggestions for improvements were not consistent across participants, but are summarised in table ten.

Despite these criticisms, all participants felt that the intervention should be offered to others. Five of the six, also valued the opportunity to have participated in the research.

Impact of the intervention

Although not a primary aim of the study, data were analysed to consider the potential impact of the intervention, with the aim of providing indicative data for a future RCT.

Reliable and clinically significant change

Each participants' post-intervention clinical score on the CORE-OM was compared to their pre-intervention score (figure six); none made clinically significant change (change from above to below ten or vice versa). However, table 11 shows that three participants (50%) did have a reliable improvement in their clinical-score from pre- to post-intervention.

Figure 6
Participants' clinical-scores on the CORE-OM pre- and post-intervention
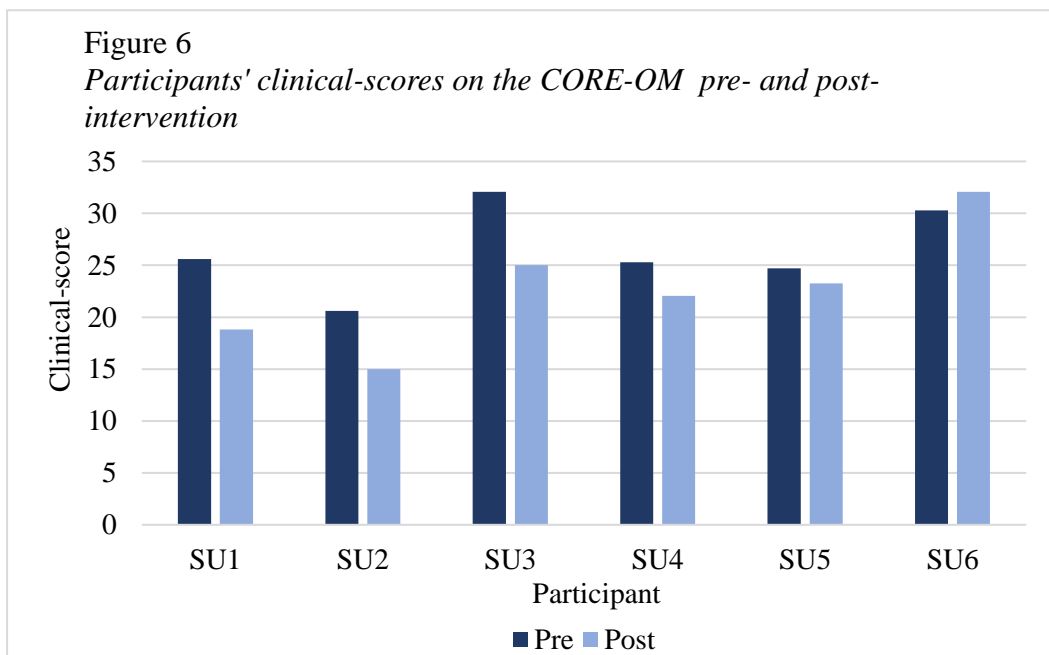
Table 11

Changes in participants' clinical-scores on the CORE-OM from pre- to post-intervention and whether this was a reliable change

Participant	Change in Clinical-score*	Reliable Change?**
SU1	**6.76**	**Yes**
SU2	**5.59**	**Yes**
SU3	**7.06**	**Yes**
SU4	3.24	No
SU5	1.47	No
SU6	-1.76	No

* A positive change is an improvement, a negative is a deterioration
** A change of five or more indicates a reliable change.

Pre- and post-intervention mean scores for each CORE-OM subscale were also compared for all participants, as shown in figure seven. Jacobson and Truax's, (1991) formula was used to calculate reliable change (RC) (appendix R). A RC of above 1.96 or below -1.96 indicates a change that is "unlikely to occur ($p<0.05$) without actual change" (Jacobson and Truax, p.14). Table 12 gives the RC values for changes in participants' subscale scores. It shows that four (66.67%) experienced a reliable decrease (improvement) in one CORE-OM subscale (most commonly functioning)

Any mean subscale scores that moved from above to below the clinical cut-offs (provided by The CORE System Team, n.d.) were considered clinically significant. One participant (SU2) had a clinically significant improvement from pre- to post-intervention, which was in functioning.

Table 12

Participants' RC scores on the CORE-OM subscales and whether the change is reliable

	Wellbeing		Symptoms		Functioning		Risk	
	RC	Reliable?	RC	Reliable?	RC	Reliable?	RC	Reliable?
SU1	-1.10	No	-0.98	No	**-1.98**	**Yes**	-1.69	No
SU2	-0.37	No	-0.38	No	**-2.38**	**Yes**	-1.37	No
SU3	-0.37	No	-1.38	No	**-2.98**	**Yes**	-0.35	No
SU4	**-2.21**	**Yes**	-0.19	No	-0.21	No	-1.02	No
SU5	0	No	-1.00	No	-0.21	No	0.35	No
SU6	0.37	No	-0.40	No	1.40	No	0	No

Figure 7

Participants' mean scores on each of the subscales of the CORE-OM pre- and post-intervention
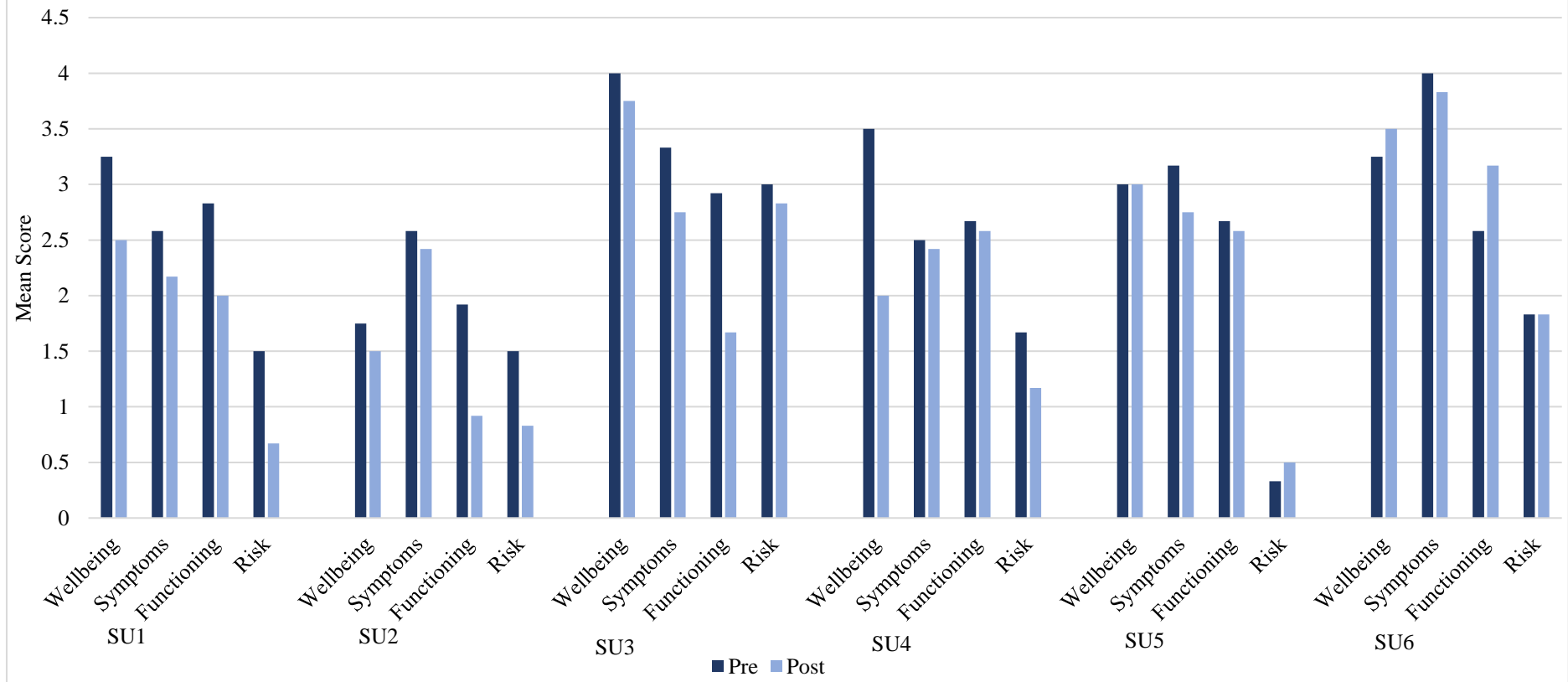
Pre- and post-intervention distress and severity scores were compared on the CAARMS for each participant. Figures eight and nine show that there was a reduction (improvement) in five participant's severity scores, whilst three participants' distress scores reduced and three increased. It was not possible to calculate RC (a search of the literature did not return any values for internal consistency (e.g. Cronbach's alpha); required for RC calculations. The sample size was too small to determine this from the current data.)

Figure 8
Participant's severity scores on the CAARMS pre- and post-intervention

Figure 9
Participants' mean distress scores on the CAARMS pre and post-intervention
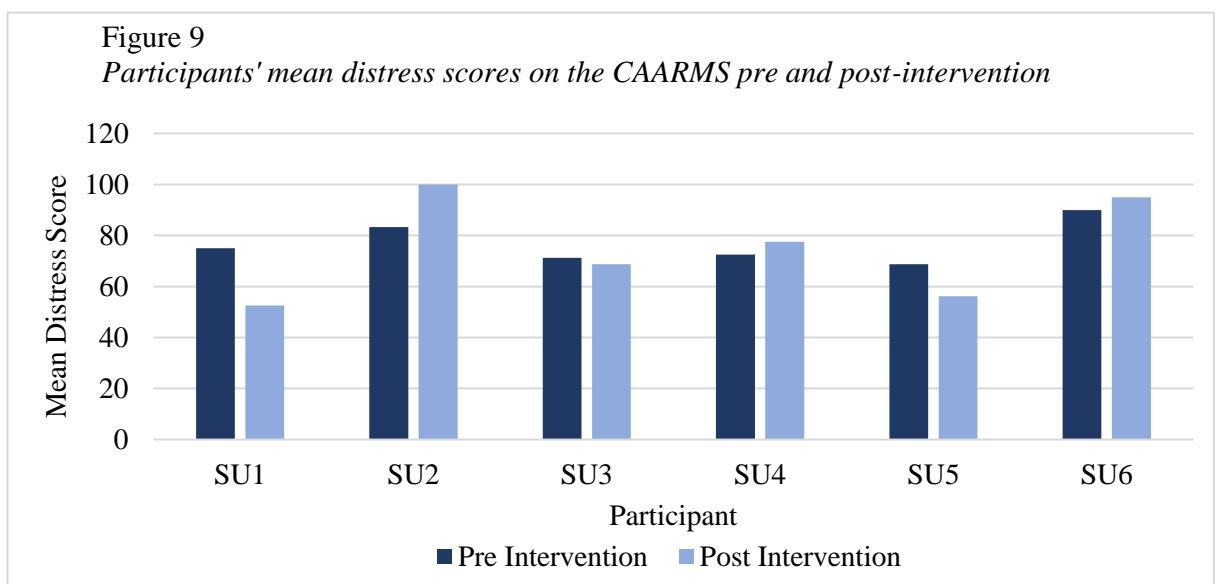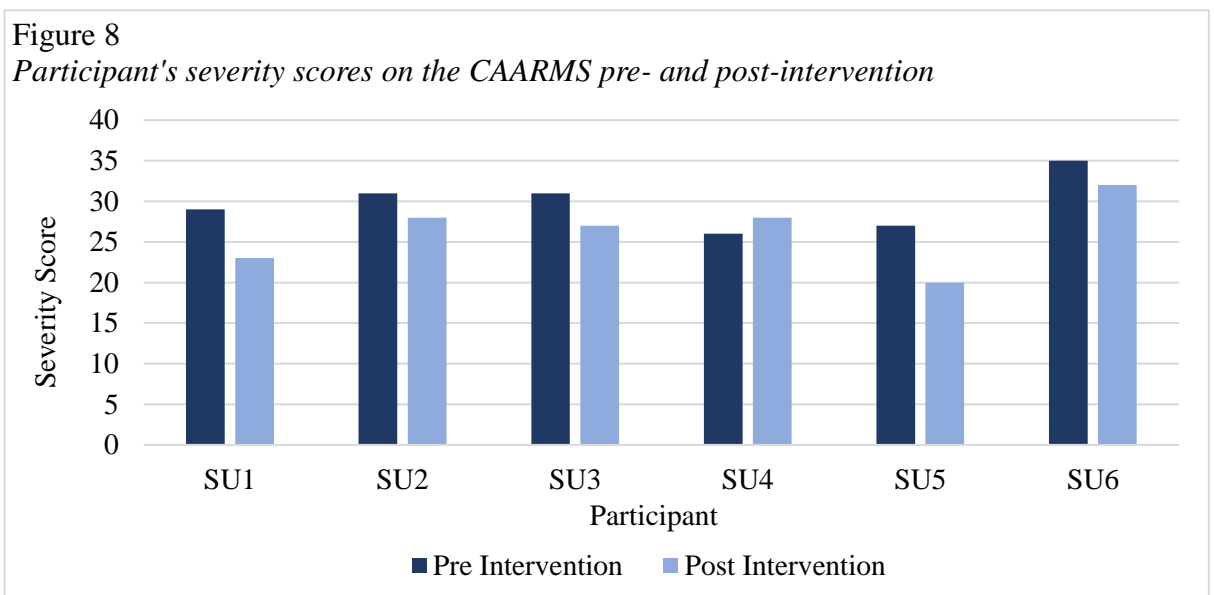
Effect size calculations

Due to the small sample size, it was assumed that data did not meet criteria for normality, therefore effect sizes were calculated using the formula: $r = Z/\sqrt{N}$ as recommended by Rosenthal, (1994). IBM's SPSS statistics version 23 was used to calculate Z, Microsoft Excel was then used for *r*. Table 13 shows the *r* values and the interpretation of the size based on Cohen (1988), for all pre- to post-intervention changes on the CORE-OM and CAARMS. Whilst there are several medium and large effects, the small sample size means it is uncertain whether these are real effects or a result of sampling error. Due to this, it was not possible to calculate meaningful confidence intervals for the effect sizes.

Table 13

Effect sizes and interpretation of these for changes on the CORE-OM and CAARMS

	r	Interpretation of Effect Size
CORE-OM:		
Total	0.51	Large
Wellbeing	0.44	Medium
Symptoms	0.64	Large
Functioning	0.46	Medium
Risk	0.47	Medium
CAARMS:		
Severity	0.58	Large
Distress	0.03	None

Were there any adverse effects?

There was one SAE and two AEs during the research, which related to suicidal ideation or attempts. These events were discussed with the participants' clinical team,

including their LCP, and it was decided that they were not related to the research or intervention, and all participants continued in the study following them.

Only one participant had an increase (deterioration) in their clinical-score on the CORE-OM, which did not meet reliability criteria, thus was more likely the artefact of a measurement error than an actual deterioration in their presentations. No participants 'transitioned' to psychosis according to the CAARMS (conversely, none improved to no longer meeting 'ARMS' criteria). There was a deterioration in one participant's score on CAARMS severity and three participants' scores on CAARMS distress, although it is not clear whether these are reliable changes nor whether they are attributable to the intervention.

Discussion

This study developed a brief psychological intervention for young people with ARMS. It sought to evaluate the feasibility of a future RCT and of offering the intervention as part of routine NHS care.

Acceptability and feasibility.

Research.

Participants' responses on the experience questionnaire suggest they found the research acceptable. All six indicated they were pleased they had participated and they would recommend participating to others, a finding also reflected in their qualitative responses. This acceptability is supported by the rate of retention (75%) which met pre-defined criteria.

The study did not meet its aim of 12 eligible participants, with eight people entering the study post-screening. However, the percentage of participants who

consented to the research and met eligibility criteria was above the pre-defined criteria (suggesting the inclusion/exclusion criteria were feasible). Therefore, these difficulties with recruitment appear to result from insufficient young people being referred into the study. It seems unlikely that this is a result of insufficient eligible young people within the team in which recruitment took place, as there is a large caseload with a high percentage experiencing attenuated psychotic symptoms (Wilson et al., 2017). This suggests the difficulties resulted from the clinical teams' reticence to identify and refer eligible participants within the recruitment window, which is consistent with the recruitment teams' experience. This 'Clinical Gatekeeping' is a common finding in the literature (Robotham et al., 2016), particularly within mental health research, where clinicians may want to protect 'vulnerable' clients from the burdens of research and additional interventions (Borschmann, Patterson, Poovendran, Wilson, & Weaver, 2014).

To increase recruitment rates in future research, clinicians should be provided with information about the study in a way that is consistent with their clinical work and should be helped to feel involved and that their contributions are valued (Robotham et al., 2016).

Intervention fidelity.

The fidelity data suggests that the non-registered practitioners were able to adhere to the planned intervention, with minimal deviations. Considering the therapeutic relationship, data from the SRS, WAI-SR(T) and the participants' qualitative responses on the experience questionnaire, suggest that it was also possible to form a positive therapeutic relationship within four sessions.

Acceptability of the intervention.

The acceptable retention rate supports the acceptability of the intervention to participants; only one of eight participants who started the intervention did not complete it. This participant rated every subscale on the SRS as 10/10 for each session they attended, suggesting their disengagement was not due to them finding the intervention unacceptable.

Participants' responses on the experience questionnaire also suggest that they found the intervention acceptable. All six indicated that they did not find the intervention distressing and they would recommend it to others. Participants' qualitative responses mentioned the value of the intervention with reference to particular aspects, including the therapeutic relationship, having space to talk and being helped to develop new understandings of their difficulties. This is consistent with other research[9] (e.g. Byrne & Morrison, 2014; Cooke, 2014; Horvath, 2001).

Moreover, data from the SRS generally supports the acceptability of each session; all means for all sessions were at or above the recommended cut-offs (Duncan et al., 2003).

Increasing the acceptability of the intervention.

It is important to listen and respond to client preferences over the number of sessions they receive (Carey, 2010). In the current study, most participants indicated that four-sessions was not enough. Consequently, future research could add additional sessions (whilst ensuring the intervention remains short-term to meet its initial aims), investigating the impact on outcome measures, as well as on young peoples' experience.

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[9] It is also consistent with the earlier Systematic Review, with two overlapping themes

Participants rated the task subscale as below the pre-defined target on the WAI-SR, suggesting some potential discord between the tasks included in the intervention and those that young people felt were necessary for achieving their goals. Qualitative data from the experience questionnaire does not highlight any particular elements of the intervention that this may relate to. Therefore, in the future, it will be important that the intervention-deliverers ensure that participants understand the rationale behind all components of the intervention and how these relate to their goals.

Impact of the intervention

Five participants (83.33%) agreed/strongly agreed that the intervention had been helpful, whilst all six reflected on ways they had benefited in their qualitative responses. Most commonly participants mentioned a reduction in unusual experiences/symptoms. This is consistent with the large effect size calculated for the change in severity of unusual experiences (which includes frequency) on the CAARMS.

Three participants' (50%) clinical-score on the CORE-OM reliably decreased from pre- to post-intervention, indicating improvements in their psychological difficulties, which were unlikely an artefact of measurement error. At the subscale level, most reliable improvements happened within the functioning subscale. Whilst tentative, this does raise questions regarding the impact of the intervention on functioning, and possibly the benefits of behavioural activation for this population. It is therefore a limitation of the current study that it did not include a more robust measure of functioning, such as the Time Use Survey. It will be important for future research to include such measures and investigate the impact of behavioural activation on this population, particularly as previous studies have shown interventions to be generally

ineffective at improving functioning in young people with ARMS (Van Der Gaag et al., 2013).

The only variable for which there was no effect was the distress associated with psychotic-like experiences (CAARMS). This contradicts one of the research's expectations; that offering psychoeducation and normalisation would reduce young peoples' distress in relation to their unusual experiences (Rietdijk et al., 2010).

The qualitative data from the experience questionnaire suggests that participants did learn strategies to manage their unusual experiences which may have reduced their frequency. However, this data and feedback from the practitioners delivering the intervention, suggested that participants found it difficult to use these strategies 'in the moment' as they were having unusual experiences, meaning their distress levels remained the same, potentially explaining the unexpected result. Participants may have experienced difficulties using skills when having actual symptoms, because it takes time to practice and for them to become automatic (Hollon, Stewart, & Strunk, 2006). Therefore, future research should include follow-up appointments, to investigate the ongoing impact of the intervention on distress as strategies become more automatic. Furthermore, within the future delivery of the intervention, practitioners must ensure that young people understand the importance of practising strategies so that they become more automatic and potentially more helpful over time (French et al., 2017).

Limitations

The small sample size and the non-experimental approach means the above points regarding impact are made tentatively. No firm conclusions can be drawn regarding the intervention's effectiveness; it cannot be determined whether the intervention caused the reliable improvements, nor whether the effect sizes are accurate

or merely the result of a sampling error. However, it is important to acknowledge that the qualitative data are consistent with and support the quantitative data. Furthermore, whilst participating in the current research, participants had an average of only 1.17 (SD=1.17) other appointments from the mental health service (range 0-3). Whilst this still does not mean the current intervention caused the improvements, it does reduce the likelihood that changes resulted from other interventions/input.

All participants were recruited from the same Youth Mental Health team, which limits the generalisability of the findings. Moreover, the Waiting Time Standards state that young people with ARMS should receive support within EIP teams (NHS England, 2016). Whilst there is nothing to suggest that the intervention could not be delivered in the same way within an EIP team, it will be important for future research to trial it within this service.

The time between the completion of the pre and post-intervention measures varied considerably across participants, meaning that it is not valid to make any comparisons between them. Participants also completed these measures with the primary researcher, which could have biased the data due to participants exhibiting demand characteristics or a social desirability bias.

Summary

Whilst the above limitations must be acknowledged, the aim of this research was not to investigate the effectiveness of the intervention, but to assess feasibility. Regarding this, the following conclusions are drawn:

- It was possible to achieve an acceptable rate of retention

- It was not possible to recruit the anticipated number of participants within the time period of the study

- The intervention and research were acceptable to young people with ARMS

- It appears feasible for non-registered practitioners to deliver the intervention as intended

- Participants experienced no adverse effects due to the intervention

- Results indicated that the intervention may have had a positive impact on participant's wellbeing

These conclusions support the feasibility of delivering the intervention within the NHS and of conducting a future RCT.

Conclusion

The current intervention has the potential to be a low-intensity, first-step approach for young people with ARMS and attenuated psychotic experiences. A future RCT must assess the effectiveness of the intervention, and its impact on young people's unusual experiences, wellbeing and functioning.

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Chapter Five - Additional Methods and Results Chapter

Supplementary Research Questions

The previous chapter supports the acceptability of the research and intervention to young people with ARMS, it suggests the intervention can be delivered by non-registered practitioners and that it has no adverse effects. However, it is also important to assess the practicalities of delivering the intervention as part of routine care within NHS settings (O'Cathain et al., 2015). As part of this, it is necessary to consider the views of clinicians working within the NHS, to assess whether the intervention is acceptable to them, and to hear their suggestions for any improvements. This is important, as it will be these clinicians who refer young people to the intervention (both within routine care and in any future research). Moreover, it is also important to collect the views of those who have experience of delivering the intervention, as its future use will rely on practitioners being willing to deliver it. Based on this, two additional research questions were proposed:

5. What are the views of youth team clinicians (who did not deliver the intervention): Is the intervention and research acceptable to them? What are their views on implementing the intervention within routine care?

6. What are the views of the non-registered practitioners who delivered the intervention: Is the intervention and research acceptable to them? Did they believe the intervention was helpful? What are their views on implementing the intervention within routine care?

This chapter outlines the methods used to collect and analyse data to answer these supplementary questions. It also details the results of this alongside a discussion of them.

Method

Design.

A non-experimental mixed methods approach was adopted with a descriptive cross-sectional design.

Participants.

To answer question five, all clinicians working within three NHS Youth Teams within the East of England were invited to participate (this includes the team in which the intervention was offered). To participate, clinicians had to be employed within a clinical role and could not have delivered the intervention. For simplicity, these participants will be referred to as staff participants.

For question six, participants were non-registered practitioners who had delivered the intervention to at least one young person as part of the current research.

Measures.

Two non-validated questionnaires were developed; one for the staff participants and the other for the non-registered practitioners who delivered the intervention (appendices S, T). Each of these aimed to capture participants' views of the intervention, its implementation into routine care, and their opinions about the research. The questionnaires included a range of types of question; some were multiple-choice, others required a response on a five-point Likert scale and others were open-ended, giving both quantitative and qualitative data.

Procedure

To recruit staff participants, all clinicians within the three youth teams, were sent an email informing them of the research. This email contained contact details for the research team, a participant information sheet (PIS), and a document outlining the intervention/aims of the research (appendix U). There was also a link to an online version of the non-validated questionnaire. Participants followed this link, completing an online consent form (appendix V) before they were able to access the questionnaire

The non-registered practitioners were also emailed a PIS (appendix W), which was sent once they had finished delivering the intervention. Interested practitioners then met with EB where they signed consent (appendix X) to participate and were given the non-validated questionnaire. These practitioners were left to complete the questionnaire independently to encourage honest answers. They passed it to the primary researcher on completion.

Data analysis

Quantitative data were analysed using descriptive statistics, which considered the frequency/percentage of participants answering each of the multiple-choice/Likert-scale questions in a particular way.

The qualitative data were analysed using framework analysis, which was deemed an appropriate method for several reasons. Parkinson, Eatough, Holmes, Stapley, and Midgley, (2016) concluded that framework analysis is a valuable qualitative method for psychology, "offering a pragmatic, flexible and rigorous approach to data analysis" (p.109). It was specifically designed to address four types of research question, two of which fit with the aims of the current study: 'Evaluative' (asking clinicians to evaluate the intervention and research), and 'Strategic:'

(identifying ways of improving the intervention and implementing it into routine care, Ritchie & Spencer, 1994). The approach outlined in the previous chapter was used, and was conducted using Microsoft Excel (Swallow, Newton, & Van Lottum, 2003).

Results

Recruitment of staff participants.

A total of 27 clinicians from the three youth teams consented to participate and completed at least part of the experience questionnaire. All answered responses are included in the analysis below. Staff participants came from a variety of professional backgrounds, and included psychological therapists, allied health professionals, psychiatrists and non-registered staff.

Recruitment of non-registered practitioners

Two Assistant Psychologists and three Assistant Practitioners delivered the intervention to at least one participant as part of the current research, all of whom consented to participate. There were four females and one male.

What are the views of staff participants?

Quantitative data.

Staff (n=27) answered multiple-choice questions about the number and length of sessions. Nine (33.33%) answered that four sessions were not enough, the other 18 (66.67%) said that this was the right number. One (3.7%) felt that one-hour sessions were not long enough, 24 (88.89%) answered that this was the right length, the other two (7.41%) felt that this was too long.

Staff used a five-point Likert Scale to indicate their agreement/disagreement[10] with statements about the intervention and research. Combining the 'agree' and 'strongly agree' categories, 92.31% (24 out of the 26 answering this question) indicated that they thought the intervention would be helpful to young people with ARMS; 96.3% (26 out of 27) said they would consider referring young people to the intervention and 63% (17 out of 27) were interested in being trained to deliver the intervention.

Staff (n=26) also used a five-point Likert Scale to indicate how helpful[11] they believed certain components of the intervention would be. Combining the 'helpful' and 'very helpful' categories:

- 100% rated psychoeducation, normalisation and the therapeutic relationship as helpful

- 88.47% rated formulation, increasing social activity and between-session tasks as helpful. (One staff participant rated between-session tasks as unhelpful.)

Appendix Y gives more detail regarding these results.

Qualitative data.

Twenty-two staff participants provided qualitative data on the experience questionnaire. Framework analysis identified five themes representing their views of the intervention and research. These are shown in table 14, along with a brief description of what each theme captures and some illustrative quotes from the participants. Although not all themes were found in every staff participant's response, they represent the most salient themes for the group as a whole (Midgley et al., 2015). To give an indication of

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[10] Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree
[11] Very Unhelpful, Unhelpful, Neither Helpful nor Unhelpful, Helpful, Very Helpful

the frequency of the views described, the system adopted by Midgley et al was used in

the 'captures' column of table 14[12]:

- *Most:* findings based on data from 17 or more of the 22 participants

- *Many:* between ten and 16 participants

- *Some:* between five and nine participants

- *A few:* between one and four participants

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[12] The percentage of participants represented by each of the four categories in Midgley et al's., research was calculated and used to determine the figures used for the current study.

Table 14

Themes representing staff participants' views of the intervention and research, detail of what each theme captures and illustrative quotes

Theme	Captures	Illustrative Quotes
Welcomed research	• Many reflected positively on the research	"I welcome this research and feel it will be beneficial in supporting an accessible and feasible intervention for young people" "The research is a really good idea and I look forward to hearing the outcomes"
Helpfulness of the intervention at multiple levels	• Most believed the intervention would be helpful • Many mentioned specific benefits to young people • Some commented on benefits to the service • A few commented on the intervention's relevance within the current NHS	"Facilitating the client to have a better understanding of their difficulties" "Not feeding into fears about being 'really unwell'" "Allowing the person to feel less alienated and different" "I feel it would be very beneficial to have this within the youth team. It could potentially shorten peoples' episodes of care or prevent them from accessing secondary mental health services" "Interesting to have an early brief intervention to support normalise and educate young people with their mental health, with the hopeful potential to identify those who may benefit from further therapeutic input" "It is simple enough for a range of clinicians to offer it, and seems more likely to be commissioned because of low cost implications"

Theme	Captures	Illustrative Quotes
Filling a gap	• Some believed the intervention would fill gaps in current provision • A few highlighted a gap the intervention training would fill • One response contradicted this theme	"ARMS cases are not usually identified as such, therefore not given a distinct package of care" "It would be great to have something that could be offered to ARMS clients" "I think having a specific space for young people to talk about any unusual experiences and to feel understood is beneficial" "The confidence of some practitioners working with psychotic symptoms is low, so they feel they do not know what to say or do" "It seems we already offer similar interventions that are helpful"
Valued approach	• Most highlighted particular aspects of the intervention that they valued/believed would be helpful • Normalisation was the most commonly valued aspect • Some valued psychoeducation • A few valued focusing on the relationship and engagement	"I am excited by the approach the intervention offers" "The emphasis on psychoeducation and normalisation is really important. Then personalising it with the formulation" "I like the focus on psychoeducation and normalisation and in my experience of working with young people who experience these types of symptoms, this work is what they have reported to be most helpful" "I like the aim to intervene early and to not medicalise but help individuals understand why they are experiencing symptoms. Efforts to engage and focus on relationship as being important"

Theme	Captures	Illustrative Quotes
Implementation: changes/ considerations	- Some emphasised that the intervention must be flexible - Some believed four-sessions was not enough - A few suggested six sessions - One suggested a group component - A few questioned whether homework would be completed - A few highlighted concerns with defining and identifying appropriate young people	"For some, four-sessions may not be enough, for others, four may not be needed" "I wonder how flexible the approach will be in engaging people who are not good at turning up to appointments at clinic" [Have] "more than 4 sessions but remain short term" "I wonder whether four-sessions plus then a couple of follow ups at one month and two months to support with change" "A group component with fellow intervention "graduates" as a way of normalising and increasing social interaction" "I anticipate that very few will do the homework tasks!" "For a tailored intervention to be delivered cases would need to be identified. This could be done by assessing them using the CAARMS measure but this in itself would be a large piece of work" "Choosing between those that receive the treatment and those that don't could be an ethical dilemma as there are over 100s of service users who have ARMS."

What are the views of the non-registered practitioners who delivered the intervention?

Quantitative data.

The non-registered practitioners (n=5) answered multiple-choice questions about the length of the intervention and the number of sessions. Three (60%) indicated that four sessions were not enough; two (40%) said this was the right number. One felt that one hour sessions were not long enough, the other four (80%) felt that this was the right length.

The non-registered practitioners used the five-point agree/disagree Likert scale (mentioned above) to respond to questions about the research and intervention. Combining the 'agree' and strongly 'agree categories,' all said that they believed the intervention was helpful, they would offer it to others and they were pleased they had been involved in the research. Four (80%) agreed that future research should be conducted on the intervention.

The non-registered practitioners used the 'helpful/unhelpful' five-point Likert Scale to indicate how helpful they believed certain components of the intervention were. Combining the 'helpful' and 'very helpful' categories, all rated psychoeducation, normalisation, the therapeutic relationship and increasing social activity as helpful. Four rated formulation and between-session tasks as helpful. Appendix Y gives more detail regarding these results.

Qualitative data.

Framework analysis identified seven themes representing the non-registered practitioners' views of the intervention and research. These are shown in table 15 along with a brief description of what each theme captures, the number who commented on it and some illustrative quotes from the participants.

Table 15

Themes representing non-registered practitioners' views of the intervention and research, detail of what each theme captures and illustrative quotes

Theme	Captures	Illustrative Quotes

Helpful for young people: giving strategies and lowering distress	• All felt the intervention had been helpful for young people:
	   o Four felt it had reduced distress
	   o Three felt it had reduced symptoms
	• Two mentioned young people learning coping strategies
		"I think it really made a difference to the two participants I worked with"
		"The young person I worked with felt reassurance and noticed a decrease in the distress associated with their unusual experiences"
		"'*****'s number of unusual experiences diminished, and their intensity lowered"
		"The young person would think about or use the different strategies that we had discussed, and this helped reduce their symptoms"

Helpful core aspects: normalising, relationship and between-session tasks	• Four saw the normalising approach as helpful • Four reflected on building a good relationship and the benefits of this • Two believed between-session tasks ensured change	"I think the normalising approach was incredibly important, most participants seemed to feel quite isolated with their experiences and all of them were surprised to hear how common they are" "I felt that the young person and I had built up a good therapeutic relationship and were working well together" "The intervention allowed my participant to feel heard and validated" "Practical homework tasks reinforced everything" "The most noticeable outcomes occurred following completion of the in-between tasks"

Theme	Captures	Illustrative Quotes
Thinking differently: making sense of unusual experiences	- All mentioned benefits of cognitive tools - Two felt young people learnt to recognise triggers to their unusual experiences	"The young person was able to think of alternative ideas for what might be causing them to have unusual experiences" "They were able to reflect on their experiences afterwards and understand them in a different way" "**** understands the effect trauma/lack of sleep can have on her unusual experiences,"
Structured but flexible	- Four valued the intervention's structure - Three valued the intervention's flexibility	"I like the manualised and brief focused approach of the intervention. It is easy to follow" "I think it had been well thought through and structured - very contained!" "I liked that the intervention was really structured; it ensured we covered all the material we needed to." "Flexible enough to deal with issues when they arose" "It was really useful having space for the young person to add their own items onto the agenda…so that they feel listened to"

Theme	Captures	Illustrative Quotes
More time needed	- Four felt the intervention needed more time, making suggestions for how this could be utilised - Two reported finding the ending difficult - One reflected positively on ending after four-sessions	"I would offer longer appointments than an hour (probably 90minutes) for those who were bringing a lot of unusual experiences to explore as I think it's important to go through homework in detail" "I would have more sessions (6 not 4) as it's enough time to build a good rapport, but then ending can be quite difficult with only 4 sessions" "I think 6 sessions at least would be preferable to 4. More time to build rapport in an initial session would be good" "Look into extending it. Some practical elements, such as doing a behavioural experiment with the participant might also be interesting" "You have to finish the work you have been doing after session four, so not continuing with the momentum you have both built up" "Something about it being four-sessions…meant higher levels of engagement?…no awkwardness around ending after four-sessions due to clarity from the beginning"
Future research	Four made suggestions for future research	"Future research should focus on the intervention being used more within the Youth Team" "I feel future research should be developed to explore the ongoing impact of the intervention."

Theme	Captures	Illustrative Quotes
Value for routine care	• All responded positively when asked if the intervention should be offered as routine	"Definitely it should be!...It's a very useful took for clinicians to use and so much of it (I think) is really useful for people having unusual experiences" "I think it is a great idea. There are so many young people who have unusual experiences but these aren't often quickly addressed by teams" "I have used the worksheets as a one-off or more casual/informal intervention to a couple of my first clients who have been experiencing voices - really useful!" "Young people with ARMS seem to get lost in the system" "I feel that this intervention is offering something that is currently missing, a brief structured piece of work at the earliest possible opportunity to hopefully prevent young people from developing psychosis" "really useful in terms of managing the waitlist"

Discussion

The views of staff participants who did not deliver the intervention.

Acceptability of the intervention.

A high percentage of staff participants indicated that they believed that the intervention would be helpful to young people and that they would refer them to it. No staff participants disagreed with these statements. These findings were also reflected in the qualitative data, where staff identified several potential benefits to young people with ARMS. This supports the acceptability of the intervention to staff participants, suggesting they are likely to refer young people to it.

Feasibility studies should consider the value clinicians place on particular interventions (O'Cathain et al., 2015), which appears to be high for the current intervention. Staff participants valued the rationale behind developing a brief intervention for the initial stage of stepped-care approach for young people with ARMS. They linked this to the current NHS climate, acknowledging the likely commissioning of such an intervention. Within their qualitative responses, staff participants also valued the intervention for offering psychoeducation, a normalising approach and focusing on the therapeutic relationship. This was consistent with their quantitative responses, with all staff participants indicating that these components would be helpful to young people.

Critiques of the intervention and suggestions.

It is important for feasibility studies to assess whether clinicians are unhappy with any aspect of an intervention (O'Cathain et al., 2015). In the current study, some staff had concerns about between-session tasks, with one indicating that they believed they might actually be unhelpful.

Staff felt that the intervention needed to be flexible in adapting to individuals, particularly around engaging them and in the length and number of sessions. Staff disagreed as to whether four sessions was enough. In the qualitative data, six sessions were suggested. One staff participant proposed having two additional follow-up sessions, another suggested having a post-intervention group to complement and continue what young people learnt within the individual sessions. These are proposals that can be considered in future research.

Implementing the intervention into routine care.

Staff identified a gap in existing provision, believing that the current intervention could fill this. However, they did raise some concerns over the practicalities of allocating young people to the intervention within routine care, e.g. questioning how appropriate individuals would be identified, and how it would be managed if there were too many young people wanting the intervention. This highlights a future area that must be explored with clinicians and managers within relevant teams if the intervention is to be offered routinely. Potential ways of addressing these concerns could also be considered in future research.

Acceptability of the research.

With regards to the research, staff participants appeared positive and welcoming of this. This is a surprising finding, as it seems contradictory to the difficulties with recruitment described in the previous chapter.

Clinicians are more likely to respond positively to research studies when they are consulted about their implementation and rationale (Howard, de Salis, Tomlin, Thornicroft, & Donovan, 2009). Thus, it seems possible that the process of asking staff

participants to complete the questionnaire, actually contributed to the positivity they expressed within it. Considering the difficulties with recruitment highlighted in the previous chapter, this involvement and the positivity observed will be helpful for ensuring successful recruitment to a future RCT if it is conducted within the same teams (Borschmann et al., 2014). This highlights the value of including staff participants within the current study, and also the importance of consulting with staff in the early stages of any future RCT.

The views of non-registered practitioners who delivered the intervention.

Helpfulness and acceptability of the intervention.

All five of the non-registered practitioners indicated that they would consider delivering the intervention to other young people with ARMS, supporting the acceptability of the intervention to them. This is further supported by both the quantitative and qualitative findings, in which all indicated that they believed the intervention had been helpful to the young people they worked with. Non-registered practitioners most commonly said that young peoples' distress around their unusual experiences had decreased following the intervention, whilst some said that their symptoms had lessened, and they had learnt helpful strategies.

All non-registered practitioners commented on the helpfulness of taking a normalising approach and of building a strong therapeutic relationship with the young people they worked with. This is consistent with previous research which highlights the therapeutic-relationship as a key component in the effectiveness of all therapies (Horvath, 2001) and Rietdijk et al.,'s (2010) claim that normalising unusual experiences is helpful for reducing anxiety in young people with ARMS.

The cognitive elements of the intervention were considered a valuable tool, particularly for helping young people to develop new understandings of their difficulties, consistent with French and Morrison, (2004).

Between-session tasks were generally rated as helpful in the quantitative data, however when compared to the other aspects, their helpfulness was rated the lowest, which was also the case for staff participants. Despite this, two non-registered practitioners emphasised the value of between-session tasks for bringing about and reinforcing improvements in young people. This anecdotal evidence is supported by Kazantzis, Whittington, and Dattilio's (2010) meta-analysis, which found that between-session tasks make clinically meaningful contributions to outcomes in therapy.

As outlined above, the staff participants' qualitative data purported that the intervention needed to be flexible. The qualitative feedback from the non-registered practitioners suggests that the intervention achieved this flexibility, whilst also maintaining a structured approach. It seems an appropriate balance was struck; the intervention was focused, felt contained and all of the necessary content was covered, alongside having the flexibility to allow young people to bring their own content, which was valued by the non-registered practitioners.

Critiques and suggestions for the intervention.

Four of the five non-registered practitioners suggested that the intervention should have more time allocated to it, either through additional or longer sessions. There was a sense that this would allow more time for working on some of the existing aspects of the intervention, e.g. building the therapeutic relationship. Two non-registered practitioners commented that ending the intervention was difficult. This is consistent with Waller et al., (2015) who sought clinicians' views on delivering a short-

term intervention for individuals with psychosis. It is likely the result of the brief nature of the intervention, the complexity of the client group (Waller et al.,) and the practitioners' own anxieties around endings (Baum, 2007).

Conversely, one non-registered practitioner reflected positively on the time allocated to the intervention, questioning whether offering a brief intervention actually increased young peoples' engagement. It seems possible that the limited-nature of the intervention meant that young people felt they had to engage quickly to make use of the sessions, which is consistent with claims that brief interventions increase initial treatment engagement and quickly enhance the overall therapeutic relationship (Substance Abuse and Mental Health Services Administration, 2012). This non-registered practitioner also commented on the value of being clear about the limited number of sessions from the start of the intervention. This may explain why they did not report finding the ending difficult, as research shows that therapists who are clear with clients about the termination of treatment from the beginning, experience the ending more positively (Gould, 1977). This has clear implications for the future delivery of the intervention; future training must normalise staff anxiety around managing endings (Waller et al., 2015) and should ensure that those delivering it, are clear with young people about the intervention's time-limited nature from session one.

Future research and implementation into routine care.

Non-registered practitioners were generally positive about future research on the intervention. Most of their suggestions around this were consistent with the likely aims of a future RCT, e.g. offering to more young people, assessing the long-term impact through follow-up assessments.

Furthermore, all non-registered practitioners were positive about offering the intervention within routine care. One clinician had already used some components from the intervention in their routine work, highlighting the value and need for this type of approach. This need was further supported by another non-registered practitioner, who highlighted a gap in existing provision and the potential for the current intervention to fill this, consistent with the staff participants' views.

Limitations.

All participants were recruited from three Youth Teams within the same NHS trust in the same region of the UK. The Early intervention in Psychosis (EIP) Waiting Time Standards state that young people with ARMS should be offered treatment within EIP teams, not Youth (NHS England, 2016). Therefore, the views captured may not be representative of those who work with young people with ARMS in other parts of the UK or internationally. For example, the current study highlighted a need for the intervention, which was used to support its value, this need may not be present in EIP or other services.

All data could have been subjected to social-desirability. Moreover, participants may have exhibited an acquiescence bias; a tendency to agree with survey rating questions (Holbrook, 2008), although qualitative responses were consistent with survey ratings, contradicting this.

Conclusion.

The results outlined within this chapter support the acceptability of the intervention and of future research to those working with young people with ARMS across three NHS Youth Teams. Staff participants who did not deliver the intervention,

valued its approach, believing it would be helpful for young people and for their service more widely. They felt the intervention was able to fill a gap within existing provision, ensuring that young people with ARMS received an appropriate service. Likewise, the practitioners who delivered the intervention, valued many of its components and felt that it was helpful for the young people who they delivered it to. They also saw the intervention as having value as part of routine care. Furthermore, both participant groups were positive about future research on the intervention, which could be used to address some of their suggestions for improving it.

These findings support the acceptability of both the intervention and research to clinicians, supporting the feasibility of both a future RCT and of implementing the intervention into routine care (O'Cathain et al., 2015).

Chapter Six

Discussion and Critical Evaluation

This chapters aims to bring the findings from the previous chapters together, to position them within the existing literature, to discuss their clinical implications and to evaluate the approach and methods taken. It starts by summarising the findings from the empirical paper and the additional methods/results chapters to draw conclusions about the overall feasibility of the intervention developed, and of a future clinical trial. The next section explores how the intervention can be adapted to increase its acceptability and effectiveness, incorporating the findings from the feasibility aspect of this portfolio, alongside the findings from the systematic review and the existing literature. Within this section, the wider implications for clinical services are also explored and discussed. The chapter then explores some of the limitations of the approaches taken within the current portfolio, leading to recommendations for addressing these, followed by a discussion of the dissemination of the results. The chapter finishes with an overall conclusion to the portfolio.

Outcomes of the Feasibility Study

There is no systematic guidance available on how to categorise and draw conclusions regarding the outcomes of feasibility studies. However, Shanyinde, Pickering, and Weatherall, (2011) reported 14 methodological issues that should be evaluated as part of feasibility outcomes. These 14 methodological issues were applied as an analytic framework to the current findings (consistent with Bugge et al., 2013). The results are outlined in Table 16 which summarises information presented in the previous chapters. Issues not addressed in the current study are listed below the table, whilst additional issues are included in italics.

Table 16

Summary of findings against 14 methodological issues for feasibility research

Methodological Issues	Findings	Evidence
Did the feasibility/pilot study allow a sample size calculation for the main trial?	No. Sample-size calculations conducted were not meaningful, suggesting a very small sample (e.g. 7)	Feasibility studies should not be used in this way, as they do not provide meaningful effect size estimates due to the small sample sizes (Leon, Davis, & Kraemer, 2011)
What factors influenced eligibility and what proportion of those approached were eligible?	The proportion of eligible service-user participants met the pre-defined target and was consistent with other research on the same population (Morrison et al., 2012) Generally, inclusion and exclusion criteria were acceptable.	Eight out of 12 service-user participants who consented to the study were eligible (66.67%). All four who were not, met criteria for psychosis on the CAARMS. Two service-user participants referred to the study were excluded prior to consenting due to a recent medication change.
Was recruitment successful?	Insufficient young people were referred into the study to the meet the recruitment target. This was likely the result of 'clinical gatekeeping.'	Eight eligible service-user participants were recruited instead of the intended 12. See discussion in the Empirical Paper

Methodological Issues	Findings	Evidence
Did eligible participants consent?	Yes	All 12 service-user participants who met with the primary researcher consented to the study.
Did participants adhere to the intervention?	Generally, service-user participants adhered to the intervention.	Seven of the eight service-user participants who started the intervention completed it. Fidelity-data suggest that most service-user participants engaged with most aspects/tasks of the intervention within sessions. Responses on the service-user's experience questionnaire and the fidelity-data suggest that whilst young people did not always complete between-session tasks, they did adopt aspects and make changes in their everyday lives.
Was the intervention acceptable to participants?	Yes	All six service-user participants completing the experience questionnaire indicated that they would recommend the intervention to others and they did not find it distressing. All service-users commented on benefits they experienced due to the intervention. Total means on the session rating scales (SRS) were all above the recommended cut-offs.

Methodological Issues	Findings	Evidence
Was it possible to calculate intervention costs and duration?	Intervention costs were not calculated. Four-sessions appeared adequate, although additional sessions could be trialled.	Five out of the six service-user participants completing the experience questionnaire indicated they would have preferred more than four-sessions, this view was shared by most of the non-registered practitioners
Were outcome assessments completed?	All measures were completed by all but one of the service-user participants who completed the intervention.	Six out of the seven service-user participants who were invited to complete outcome measures completed them. All six young people completed all measures.
Were outcomes measured those that were the most appropriate outcomes?	They appeared to be. Making questions more concrete when administering the CAARMS may improve this for future research.	All 12 participants who consented to the research completed the necessary measures at baseline. Tentative data suggest changes on both outcome measures from pre/post intervention. Service-user participants found some assessment questions vague.
Was retention to the study good?	The retention rate met the pre-defined target and was consistent with previous research on the same population (Morrison et al., 2012)	Six of the eight eligible participants completed the intervention and all outcome measures, this was at the pre-defined target; 75%.

Methodological Issues	Findings	Evidence
Did all components of the protocol work together?	All components included in the current study worked well together.	No difficulties were identified in the various study processes. Recruitment was helped by having members of the clinical team as part of the research team.
Was the intervention acceptable to clinicians?	*The intervention appeared acceptable to both groups of practitioners (those who delivered the intervention and those working in NHS Youth Teams)*	***Staff participants:*** *92.31% believed the intervention would be helpful; 96.30% would refer young people to it. They valued core aspects of the intervention: psychoeducation, normalising and the therapeutic relationship, and saw it as useful to the service.* ***Non-registered practitioners:*** *all five agreed they would offer the intervention to others and that it had been helpful for young people. They valued core aspects of the intervention (as above) but also cognitive elements.*
Was the intervention administered as intended by non-registered practitioners?	*Generally, non-registered practitioners delivered the intervention in a way that was consistent with the intended approach.*	*The percentage of items endorsed on the fidelity checklists was high. SRS and Working-Alliance Inventory data suggest non-registered practitioners were able to develop positive therapeutic relationships with the young people in only four-sessions.*

Methodological issues proposed by Shanyinde et al., (2011) not addressed by the current research: 'Were participants successfully randomised and did randomisation yield equality in groups?' 'Were blinding procedures adequate?' 'Was the logistics of running a multicentre trial assessed?'

Table 16 and the discussions throughout this portfolio suggest that both the intervention and research were acceptable to all three participants groups. The intervention had no adverse impacts and non-registered mental-health workers were successfully trained to deliver it as intended. The rates of consent and retention were acceptable, as were the inclusion and exclusion criteria. Findings also supported a gap in existing services which the intervention could fill. Consequently, the intervention and research appear feasible, and thus a future Randomised Controlled Trial (RCT) should take this further.

Therefore, one of the overarching aims of this portfolio has been met in supporting the viability of a future RCT (Eldridge et al., 2016).

Recruitment in a Future RCT.

The Empirical Paper concluded that 'clinical gatekeeping' caused difficulties with recruitment. However, this seems contradictory to the finding that staff participants were generally welcoming and positive about the research. It could be that the latter finding was the result of a social desirability or recruitment bias, which meant that staff who were more positive about the research, were more likely to participate. Or staff responded in a positive way 'to look good.' Alternatively, it could be that involving clinicians in the research led them to become more positive about the study (Howard et al., 2009). Yet, this did not filter through to increasing the recruitment of service-user participants, because staff and service-user recruitment happened parallel to each other.

Regardless, careful attention must be paid to recruitment in a future RCT. Clinicians should be consulted about the research before it commences and should be supported to feel that their contributions are valued. Information presented to clinicians should be framed in a way that is consistent with their clinical work (Robotham et al.,

2016). Moreover, the RCT should be advertised to young people directly so that they are able to refer themselves. Whilst, particular attention will need to be paid to the ethics around this, there is also an ethical need to ensure that young people are able to make their own informed choice about participating in research, particularly as the current findings suggest that they value this.

The Future Delivery of the Intervention and Clinical Implications

Between-session tasks.

The quantitative data from the non-validated questionnaires showed that for all three groups of participants, there was the biggest variation in responses relating to the helpfulness of between-session tasks. Overall, they were rated as less helpful than other components of the intervention. There was also a sense that some staff participants expected young people not to complete them.

It is of note, that the variation in service-user participants' views of between-session tasks seemed to echo that of the non-registered practitioner they worked with. E.g. the only three service-users who rated between-session tasks as helpful, received the intervention from the only two non-registered practitioners who reflected positively on them in their qualitative data. The fidelity-data suggest that these three service-user participants also attempted most of the between-session tasks, which was not the case for others. Conversely, the only service-user to rate between-session tasks as unhelpful, worked with the non-registered practitioner who rated them lower than all other practitioners (neither helpful nor unhelpful) and this young person did not complete the tasks.

These findings suggest that practitioners' views about the helpfulness of between-session tasks are mixed, although generally their attitudes are less positive

towards them than other elements of therapy. Practitioners' beliefs and attitudes impact on their behaviour and the way they deliver therapy (Waller & Turner, 2016), with claims that "a therapists own beliefs about the role of homework can influence the successful use of these tasks" (Kazantzis & Shinkfield, 2007, p.323). Therefore, it seems possible that within the current study, clinician's views towards between-session tasks influenced young people's views and ultimately whether they completed the tasks or not (potentially a bidirectional relationship).

Despite some negative views, it is important to keep between-session tasks as part of the intervention, as the literature consistently shows that homework compliance makes clinically meaningful contributions to outcomes in therapy (Kazantzis et al., 2010), and is an active component in treatment for young people with ARMS (Flach et al., 2015). Findings that were supported anecdotally be two of the non-registered practitioners who delivered the intervention in the current study.

To encourage young people to complete between-session tasks, the intervention-protocol must be adapted so that more time is spent exploring their benefits, and helping young people to feel more confident in completing them (Kazantzis & Shinkfield, 2007). Future training for those delivering the intervention must also emphasise these benefits This is crucial, as therapists are more likely to adhere to intervention-protocols if they understand their rationale and hold a positive attitude towards them (Waller & Turner, 2016).

Number of sessions.

Within the current study, all three groups of participants raised concerns about the length of the intervention. Both service-users and those delivering the intervention, suggested introducing an additional session at the beginning to focus on developing the

therapeutic relationship. This seems unnecessary, as the data suggest that a positive therapeutic-relationship was achieved in only four sessions. However, the fidelity-data did show that session one often did not last the full hour, meaning there is opportunity for this session to incorporate more of a focus on the therapeutic relationship.

With regards to adding additional sessions for other reasons, such as adding more practical elements or spending more time discussing homework, it is not certain as to whether this would be beneficial or not. Whilst the literature demonstrates that shorter psychological interventions can be equally as effective as longer ones (Waller et al., 2018), it is not clear that this is the case for the current intervention nor what the optimum number of sessions would be. Therefore, a future RCT could trial the current four-session intervention alongside a longer version, assessing whether there is any difference in effectiveness.

However, it is important to acknowledge the purpose of designing a brief time-limited intervention, which has the potential to be more efficient, cost-effective and accessible than others (Öst & Ollendick, 2017); an approach that was valued by staff participants. As observed by a non-registered practitioner in the current study, brief time-limited therapy also helps young people to focus their attention and energy on the therapy (Öst & Ollendick), increasing their engagement (Substance Abuse and Mental Health Services Administration, 2012). Moreover, attrition rates increase with therapy length (particularly for young people), thus, time-limited therapy reduces attrition (Swift & Greenberg, 2012). Disengagement is generally high in young people with psychotic-like experiences (Connor, 2017), yet only one (out of eight) service-user participants did not complete the intervention in the current study, supporting a role for brief, time-limited, therapy for reducing drop-outs. Therefore, even if additional sessions are added to the current intervention, it must remain brief and time-limited.

Adding a group component.

A staff participant suggested adding a group component for intervention graduates. The potential benefits of a group component for young people with ARMS is highlighted by the findings of the Systematic Review. This found that young people's social-isolation and self-stigma are partly fuelled by their beliefs that they are abnormal. Therefore, young people valued services that offered a normalising approach and a label, as this confirmed that they were not the only one with their difficulties. (A statement echoed by service-users and non-registered practitioners in the current study). Groups are ideal for offering this type of approach; they normalise symptoms, helping individuals to see that they are not alone through being with others experiencing similar difficulties (McEvoy, 2007).

Moreover, the Systematic Review found that young people valued services for providing them with interpersonal engagement, and a sense of belonging. Landa et al., (2016) found that groups for young people with ARMS can facilitate such support.

Therefore, a future RCT could include a group component alongside the current intervention.

Non-specific therapeutic factors: talking and the therapeutic relationship.

There are two themes which have re-occurred throughout this portfolio. The first relates to the importance of providing young people with ARMS, a safe, empathic therapeutic relationship in which they feel able to talk freely about their difficulties. On both working-alliance measures included in the feasibility study, the relationship between the non-registered practitioners and the service-users was rated at an acceptable level. This suggests that it was possible to develop a positive therapeutic relationship within only four sessions. This is also supported by the qualitative data from both

parties. The importance of this for positive outcomes is well documented in the literature (Horvath, 2001), and was reflected in staff participants' responses; with all believing that this would be a helpful component of the intervention.

Achieving this relationship is also important in light of the systematic review's findings; that for young people with ARMS to be able to disclose their concerns and to ultimately engage with psychological support, they need to have built a trusting relationship.

Service-user participants reflected on the value of this relationship in ways that mirrored the findings of the systematic review. Results from both suggest that young people are put at ease by therapists adopting a friendly and informal approach. They value having a safe space to openly and confidentially discuss their difficulties and to be met with empathy and understanding. In the feasibility study, non-registered practitioners perceived the benefits of this in ways that were also consistent with the systematic review, e.g. allowing young people to feel heard and validated. These findings are consistent with the literature for first episode psychosis (FEP) and young people with severe mental health difficulties more generally (Boydell et al., 2010; Gee et al., 2016). They also support the British Psychological Society, who highlighted the importance of allowing individuals with psychotic-like experiences the freedom to talk about their difficulties (Cooke, 2014).

Furthermore, in the feasibility study there was a sense that some service-user participants valued the research appointments for providing opportunities to talk within a warm relationship. This is consistent with Byrne and Morrison's, (2014) findings, and highlights the value of participating in research for some young people.

Taken together, the findings of this thesis portfolio highlight the value and importance that young people with ARMS place on the therapeutic relationship and of

being able to talk about their experiences, as well as the helpfulness of this. In doing so, the results extend the existing literature to young people with ARMS, with obvious clinical implications for the delivery of services to them. Moreover, it is essential that the future delivery of the intervention developed for the current study, maintains its focus on the development of a positive therapeutic relationship and continues to offer young people the opportunity to talk freely about their difficulties.

Valuing a new understanding.

The second re-occurring theme found within this portfolio, relates to the value young people with ARMS place on being supported to make sense of and develop new understandings of their unusual experiences and difficulties; a finding that is consistent with the FEP literature (Kilkku, Munnukka, & Lehtinen, 2003). Both the feasibility study and the systematic review, suggest various ways that this understanding can be facilitated for young people with ARMS.

They both suggest that young people value being offered psychoeducation and information about their difficulties, as well as being offered normalising explanations and help to recognise any triggers. For example, within the feasibility study, two service-user participants reflected on how recognising triggers helped them to develop new understandings, which enabled them to accept and feel more in control of their difficulties; consistent with the FEP literature (Boydell et al., 2010).

One study within the Systematic Review reported that young people found developing a therapist-led formulation (maintenance or longitudinal) normalising and helpful for making-sense of their difficulties. The empirical paper adds further support to the helpfulness of developing maintenance formulations; service-user participants

reflected on their value for breaking down their unusual experiences, understanding them and identifying their triggers. These findings are consistent with (Cooke, 2014).

Within the current study, service-user participants also commented on the value of cognitive tools for helping them to understand and explain their unusual experiences. Non-registered practitioners also believed that this aspect was helpful for young people in their attempts to make sense of their difficulties.

It seems that what is important to young people, is to be supported to develop new, more helpful understandings of their unusual experiences, which enable them to better make sense of them. This can be facilitated through developing a shared formulation, psychoeducation, normalisation and challenging thoughts. This has obvious implications for the future delivery of the intervention, which must continue to include these components, as well as for clinical services more generally.

Services for young people with ARMS.

The Early Intervention in Psychosis Access and Waiting Time Standards (NHS England, 2016) state that young people meeting the criteria for ARMS should receive interventions within an Early Intervention in Psychosis (EIP) service. The current research was conducted within a youth team (rather than an EIP service), as this is where young people with ARMS receive support within the geographical area of the research. As mentioned in the empirical paper, this does potentially limit the implications of the current findings. However, EIP services do employ non-registered practitioners, who could be trained in the same way as those in the current study, and there is nothing to suggest that the intervention could not be delivered within an EIP service. In fact, considering the aims of the intervention (in terms of being readily available and quick to administer), it could potentially be used to help EIP services meet

the government target of offering interventions within two weeks of referral (NHS England, 2016).

However, the findings from the systematic review suggest that labelling a service as being for psychosis could be a barrier to young peoples' engagement with it. The review concluded that young people with ARMS associate psychosis with high levels of stigma, fearing they may be psychotic and then worrying what this and accessing support for it could mean. Therefore, these young people may be reluctant to access support within an EIP service and offering this could potentially fuel/reinforce their self-stigma. Consequently, if young people with ARMS are to be seen within EIP teams, careful attention must be paid to explaining the purpose and role of the service to them, using language that is normalising and non-catastrophising

Limitations

Limitations of aspects of this portfolio have been highlighted throughout, and for brevity shall not be repeated; the focus will be on more general, wider limitations.

This thesis portfolio aimed to explore the experience of young people with ARMS, focusing on their experience of interventions and services. Whilst this has been explored in depth from several vantage points, both within local services and international ones (through the systematic review), what is missing, is the experience of young people who disengage from services, and who choose not to participate in research. Considering the high levels of disengagement from services (Connor, 2017), the experience of a potentially large group is missing. The implications from the current findings can be applied to services, with potential benefits. However, to truly understand why some young people disengage from services, we need to hear and

understand their experience. Future research must think of creative ways to recruit and engage these young people.

With regards to the feasibility aspect of the current project, a future RCT has been recommended, however, the current study failed to assess the viability of certain aspects of this, including the feasibility of randomisation, blinding and of conducting a multicentre trial. The difficulties with recruitment could potentially be made worse by including randomisation, as clinicians seem more likely to want to protect 'vulnerable' clients from the burdens of research when they might not receive the active treatment (Borschmann et al., 2014). Moreover, any future RCT will need to carefully consider and plan the blinding and multi-centre aspects before commencing.

The current study used the CAARMS to identify young people meeting criteria for ARMS. However, staff participants raised concerns about the practicalities of administering the CAARMS to identify young people for the intervention within routine care. Consistent with these concerns, the literature also argues that the CAARMS and other well-established interview measures for identifying individuals at risk of psychosis (e.g. the Structured Interview for Psychosis Risk Syndromes, SIPS) are not well suited to routine clinical settings, as they are time consuming and require specialist training (Mcglashan, Walsh, & Woods, 2010). This highlights a lack of ecological validity within the current study.

With regards to the most suitable measures for routine settings, brief self-report screening measures are best suited for use in clinical services, yet a systematic review found that none of these can reliably predict the result of the CAARMS or SIPS across all contexts and populations. (Kline & Schiffman, 2014). This raises a wider issue, as it means that services are not able to quickly and effectively identify those young people who are at risk of psychosis, suggesting that many who meet this criterion may not be

identified. Within the current study, four of the 12 young people who had been identified as meeting criteria for ARMS by the clinical team, actually met criteria for psychosis on the CAARMS. This suggests that without formal measures, young people with ARMS or psychosis may be wrongly categorised meaning they do not receive the appropriate evidence-based treatment they should. Moreover, the findings from the Systematic Review highlighted that some young people value being informed of their ARMS, thus, an assessment for this should be available to them.

Subsequently, future research must investigate which of the current screening measures is most suited to routine services within the UK. Alternatively, it could develop new tools for this purpose. In the meantime, services should discuss the possibility of screening for ARMS with young people. Those who decide to complete an assessment should be supported to complete one of the three screening measures that currently have the most support within ecologically valid settings; the Prodromal Questionnaire, PQB or PQ-16 (Kline & Schiffman.

Dissemination

The systematic review and empirical paper have been written for specific journals and will be submitted to them for review. Results will be shared with the teams in which the research was conducted and will be disseminated to the service-user participants who requested this. The research team are also likely to submit a request for funding to conduct a future RCT on the intervention developed for the current study. This is likely to be through the National Institute for Health Research, Research for Patient Benefit funding source. This would result in further dissemination.

Overall Summary

Current support and interventions for young people with ARMS are characterised by high levels of disengagement and poor availability within the NHS. Through exploring young people's experience of these services, the current portfolio, has made recommendations for how they can be shaped so that they are more acceptable to young people. Most importantly, practitioners working with young people with ARMS must adopt a friendly, informal approach, offering empathy and validation, so that a positive therapeutic relationship can develop, allowing young people to talk openly about their experiences. Services must take a normalising approach to an individuals' psychotic-like experiences, providing young people with information about their difficulties and ultimately helping them to develop new, more helpful understandings of them.

In an attempt to increase the availability of interventions for this population, the current portfolio also developed and trialled a brief, benign psychological intervention, delivered by trained non-experts. This focused on normalising young people's unusual experiences using a psychoeducational and CBT-informed approach. Findings supported the acceptability of this to both service-users and mental health practitioners and recommendations for a future RCT were made.

Overall Conclusion

Mental health services must support young people with ARMS to develop a trusting therapeutic relationship, allow them to talk about and make sense of their difficulties and to develop new understandings of them. A future RCT should further investigate the effectiveness of the brief, benign intervention developed for the current research, which seemingly has the potential to increase the availability of psychological

interventions for young people with ARMS and attenuated psychotic experiences. Adopting these recommendations within the NHS could increase both the acceptability and availability of psychological support for this population. It is hoped that ultimately, this would help to reduce the number of young people whose difficulties worsen to meet criteria for psychosis, and alleviate the long-term impacts associated with this.

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Appendices

Appendix	Description
A	Journal submission guidelines for Clinical Psychology Review (Systematic Review)
B	Quality Assessment for Systematic Review
C	Agreement Between Raters - Selection of Papers for the Systematic Review
D	Journal submission guidelines for British Journal of Clinical Psychology (Empirical Paper)
E	Fidelity Checklists
F	Service-user participant experience questionnaire
G	Intervention protocol and worksheets
H	Feedback from the Experts by Experience and the pilot of the intervention
I	Letters confirming ethical, and HRA approval. NSFT Letter of Access.
J	Service-user participant consent form
K	Service-user participant information sheet
L	Morrison et al., (2012) recruitment rates
M	Determining the acceptability criteria for the WAI-SR and WAI-SRT
N	Additional Fidelity data
O	Additional SRS, WAI-SR and WAI-SRT data
P	Additional data from the service user experience questionnaire
Q	Illustrative example of framework analysis
R	Calculations of Reliable Change: CORE-OM
S	Staff participant non-validated questionnaire

T	Non-registered practitioner non-validated questionnaire
U	Staff participant information sheet
V	Staff participant (online) consent form
W	Non-registered practitioner information sheet
X	Non-registered practitioner consent form
Y	Additional data from the staff participants' and non-registered practitioners' non-validated questionnaires

Appendix A: Journal submission guidelines for Clinical Psychology Review

(Systematic Review)

Guide for Authors – Clinical Psychology Review

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[dataset] Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T. (2015). *Mortality data for Japanese oak wilt disease and surrounding forest compositions.* Mendeley Data, v1. http://dx.doi.org/10.17632/xwj98nb39r.1

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Appendix B: Quality Assessment for Systematic Review

The twelve criteria used to assess the quality of each study:

1. *Clearly Reported Aims and Objectives*

    a. Are the aims of the research clear?

    b. Are there clearly defined research questions?

2. *Appropriate Research Design for Addressing the Aims*

    a. Has the design been justified?

    b. Is it outlined how the design was decided on?

    c. Is it clear how the design can answer the research's aims?

3. *Adequate Description of the Context of the Research (including a rationale for why the research was conducted)*

    a. Is there a clear rationale as to why the research was conducted? E.g. Why it was thought to be important, its relevance.

    b. Are connections made to a wider body of knowledge or existing theoretical approaches?

4. *Adequate Description of the Sample and the Methods that were used to Identify and Recruit it. Detail of measure of ARMS used/criteria met. This was Appropriate for the Research Aims.*

    a. Is it clear who made up the sample, e,g. age, gender, ethnicity, socio-economic status? Are the location and number in the sample described?

    b. Is a description given of how participants were identified and selected?

  c. Is it clear why these are the most appropriate participants for answering the research's aims?

5. *Adequate Description of the Methods used for Data Collection and these were Appropriate Considering the Research Aims.*

  a. Is it clear how data was collected (e.g. focus groups, semi-structured interviews?)

  b. Is it clear what form the data was in (e.g. written, tape recordings, video materials?)

  c. Does the data collected directly relate to the aims of the research? E.g. Can the data answer the research questions?

6. *Adequate Description of the Methods used for Data Analysis and these were Appropriate Considering the Research Aims.*

  a. Is there an in-depth description of the analysis process?

  b. Does the analysis process seem suitable considering the research's aims?

  c. Is sufficient data presented to support the findings?

  d. Is any contradictory data taken in to account?

7. *Attempts were Made (and Reported) to Ensure the Reliability and Validity of Data Collection and Analysis Tools*

  a. E.g. were interview topic guides used?

  b. E.g. were pilot interviews conducted?

  c. E.g. were independent coders used?

  d. E.g. were searches for negative cases made?

8. *There is Evidence of Reflexivity and Consideration of the Researchers'*
Relationship with Participants

   a. Do the researchers critically examine their own role, potential bias and influence during: formulation of the research aims/questions, data collection, data analysis and interpretation/reporting of results.

9. *Ethical Issues are Taken in to Consideration and Reported*

   a. Is sufficient detail given for the reader to assess whether ethical standards were maintained?

   b. Are any pertinent ethical issues discussed?

   c. Was approval sought from an ethics committee?

10. *Appropriate Data Collection and Analysis to Allow Young People to Express their*
Views and for this to be Captured in the Results

    a. Do young people appear to engage well with the research?

    b. Are their views/words adequately represented in the report?

11. *There is a Clear Statement of the Research Findings, which is Supported by the*
Data and its Analysis

    a. Are the findings clear and explicit?

    b. Are the conclusions consistent with the data and its analysis?

    c. Are the findings discussed in relation to the original research aims?

    d. Is there adequate discussion of the evidence for and against the conclusions drawn?

12. *Wider Implications of the Findings are Discussed, Highlighting the Research's Value*

a. Are the contributions the study makes to existing knowledge or understanding discussed? E.g. are the findings considered in relation to current practice/policy or relevant research-based literature?

b. Are new areas for research suggested?

Outcomes of the quality assessment

Table 17 shows which of the quality criteria were met by each of the studies. Within this table, each of the studies is numbered as follows:

Study one: Ben-David et al., (2014)

Study two: Brew et al., (2017)

Study three: Byrne and Morrison (2010)

Study four: Byrne and Morrison (2014)

Study five: Hardy et al., (2009)

Study six: Hauser et al., (2009)

Study seven: Uttinger et al., (2015)

Study eight: Volpe (2011)

Study nine: Welsh and Brown (2013)

Study ten: Welsh and Tiffin (2012)

Table 17

Quality assessment: the quality criteria used, whether each study meets it and an overall quality rating

Quality Criteria	Study Number									
	1	2	3	4	5	6	7	8	9	10
Aims and objectives clearly reported	x	✓	✓	✓	✓	x	✓	✓	✓	x
Appropriate design for addressing aims	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Adequate description of the research context	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Adequate description of the sample and sampling methods	✓	✓	✓	✓	✓	x	✓	✓	x	x
Adequate description of data collection methods, which were appropriate considering the aims	✓	✓	✓	✓	✓	x	✓	✓	✓	✓
Adequate description of data analysis methods, which were appropriate considering the aims	✓	✓	✓	✓	✓	x	✓	✓	✓	✓
Attempts made to ensure the reliability and validity of data collection and analysis tools	✓	x	x	x	✓	x	✓	x	x	x
Evidence of reflexivity and consideration of the researcher's relationship with participants	x	x	x	x	✓	x	x	x	x	✓
Ethical issues considered and reported	✓	✓	✓	✓	✓	x	✓	✓	✓	✓
Appropriate data collection/analysis to allow young people to express their views and for this to be captured in the results	x	✓	✓	✓	✓	x	x	✓	x	x
Clear statement of research findings, supported by the data and its analysis	✓	✓	✓	✓	✓	x	✓	x	x	✓
Wider implications of the findings are discussed, highlighting the research's value	✓	✓	✓	✓	✓	✓	✓	✓	✓	x
Total number of criteria met	9	10	10	10	12	3	10	9	7	7
Overall quality rating*	**M**	**H**	**H**	**H**	**H**	**L**	**H**	**M**	**M**	**M**

*Rating categories taken from Harden et al., (2006) - less than 7 criteria met: low quality (L); 7-9 criteria met: medium quality (M) and 10-12 criteria met: high quality (H).

Appendix C: Agreement Between Raters - Selection of Papers for the Systematic Review

The final ten papers included in the systematic review were deemed to be eligible by both raters. The exclusion of all other papers was also agreed by both. Table 18 shows the included papers and whether each or both of the two raters identified them in the literature search. Papers that were only identified by one of the raters were discussed to determine their eligibility (all were included).

Table 18

The ten papers included in the Systematic Review and which author identified them

Paper	Identified by EB	Identified by BT
Ben-David et al., (2014)	Yes	Yes
Brew et al., (2017)	No	Yes
Byrne & Morrison (2010)	Yes	Yes
Byrne & Morrison (2014)	Yes	No
Hardy, Dickson & Morrison (2009)	Yes	Yes
Hauser et al., (2009)	Yes	Yes
Uttinger et al., (2015)	Yes	Yes
Volpe (2011)	Yes	Yes
Welsh & Brown (2013)	Yes	Yes
Welsh & Tiffin (2012)	Yes	Yes

Appendix D: Journal submission guidelines for British Journal of Clinical Psychology (Empirical Paper)

British Journal of Clinical Psychology: *Author Guidelines*

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

All papers published in The British Journal of Clinical Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).
The following types of paper are invited:

• Papers reporting original empirical investigations

• Theoretical papers, provided that these are sufficiently related to the empirical data

• Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications

• Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

The word limit for papers submitted for consideration to BJCP is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, figures, or tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length. In such a case, the authors should contact the Editors before submission of the paper.

3. Submission and reviewing

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use the Submission Checklist to help you prepare your paper.
4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use this template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the Project CRediT website for a list of roles.

• The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

• All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

• All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

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5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

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Appendix E: Fidelity Checklists

Session One	✘ or ✔
What should I expect from the intervention?	
Offered an explanation of what unusual experiences are	
The participant appeared to understand and relate to this	
Explained the structure of the intervention:	
4 sessions, 1 hour each	
Use of worksheets and why	
Between session tasks and the importance of these	
Agenda and its purpose	
Talked though what will be covered in the intervention	
The participant appeared to understand and reflect on this	

Discussed the **Agenda** for the session	
Invited the participant to add items to the agenda	

Starting the sessions	
Supported the participant to explore how they were feeling about starting the sessions, eliciting their feelings before making suggestions	
Offered empathy in response to their feelings	
Normalised their feelings (whilst still validating them)	
Addressed any worries/concerns that the participant raised	
Invited the participant to discuss their expectations	
Addressed any inappropriate expectations sensitively	

Unusual experiences fact sheet	
Discussed the participant's reaction to facts on the sheet – were they surprised, how did it make them feel	
The participant appeared to understand/accept that unusual experiences are common	
The participant appeared to understand/accept that unusual experiences can disappear over time and be helped by psychological therapy	
The participant appeared to understand/accept that unusual experiences are made worse by stress, anxiety	

Your unusual experiences	
The participant was able to identify their feelings in response to having an unusual experience	
The participant acknowledged that negative feelings may make them more likely to have further unusual experiences	
Used prompts to help the participant acknowledge this, rather than telling them	
The participant appeared to understand the vicious cycle	
Offered empathy and validation when participants discussed their feelings	
If appropriate, normalised the participant's feelings and the vicious cycle	

How does the way we think about a situation impact on how we feel about it?	
The participant was able to identify feelings for person A and person B	
Helped the participant to acknowledge that the way a person interprets a situation impacts on how they feel about it	

Between session tasks	
Talked through the between session tasks	
Offered the opportunity to practice a thought record in the session	
Discussed any potential obstacles to the participant completing the between session tasks	

General Points	
Invited the participant to ask any questions they may have at regular points	
Checked the participant's understanding regularly	
Gave the participant the option to write on their sheet or for you to write for them	

What went well?

_____

_____

_____

_____

What did not go well?

_____

_____

_____

_____

Session Two	✘ or ✔
Discussed the **Agenda** for the session	
Invited the participant to add items to the agenda	

Review of between session tasks	
Had the participant attempted the between session tasks	
If not, explored why the participant had not attempted them	
Completed them in the session	
If so, explored how the participant found completing them	
Offered empathy and validation when discussing the examples of unusual experiences sheet	

Normalised the participant's unusual experiences on the examples sheet	
Acknowledged that the thought record had been completed	

Maintenance cycles	
Explored the example maintenance cycle with the participant (both the content and the process)	
Made links to discussions in session 1	
Invited the participant to reflect how they might feel or behave if this was them.	
The participant appeared to understand how the maintenance cycle works	
The participant appeared to understand that the vicious cycle can be broken	

Your maintenance cycle	
The participant took the lead in completing this, using their thought record.	
Offered empathy, validation as the participant discussed their cycle	
Maintenance cycle was completed fully.	

Breaking the maintenance cycle	
Supported the participant to explore what they could change in their maintenance cycle	
The participant was able to acknowledge that they could change their behaviour and/or thoughts	
Helped the participant to acknowledge that a way of challenging their interpretation is to think of all possible alternative explanations for the experience	
Generating alternative explanations: example	
Explained that some sections can be taken from the thought record, pointing out that rating the strength of the belief is an addition on this sheet	

Explained to the participant that the person has included alternative interpretations that they do not believe and this is ok. But must still consider associated mood.	
Explained that the belief in the original interpretation can no longer be 100%, as considering alternatives introduces some doubts.	
Explained that the alternative belief can combine more than one interpretation	

Generating alternative explanations: your example	
Used the example from the maintenance cycle to complete this	
The participant was able to identify some alternatives with minimal prompting	
You suggested alternative explanations	
The participant was able to rate their belief and mood for each alternative	
The participant's belief in their original interpretation decreased	
The participant identified an alternative belief with minimal prompting	
The participant identified some more positive feelings associated with this	
Offered reassurance that practising this sheet makes it easier to apply 'in the moment'	

Between session tasks	
Talked through the between session tasks (told to use a previous experience if no new ones)	
Discussed any potential obstacles to the participant completing the between session tasks	

General Points	
Invited the participant to ask any questions they may have at regular points	
Checked the participant's understanding regularly	

What went well?

_____

_____

_____

_____

What did not go well?

_____

_____

_____

_____

Session Three	✘ or ✔
Discussed the **Agenda** for the session	
Invited the participant to add items to the agenda	

Review of between session tasks	
Had the participant attempted the between session tasks	
If not, explored why the participant had not attempted them	
If not, completed a **'Generating Alternative Explanations'** sheet in the session	
If so, explored how the participant found completing 'generating alternative explanations,' using the questions on the sheet as prompts	
Offered empathy and validation when discussing this	
Explored any difficulties the participant had completing this sheet and how to address these	
Encouraged the participant to continue practising this skill, offering more sheets	
Encouraged the participant to try to use this skill 'in the moment'	
Do you feel that the participant benefited from this task?	

The participant wanted to complete another in the session	
Discussed how the participant found completing their **Activity Diary** or considered what would have been on there (if they didn't complete it between sessions)	
Helped the participant to acknowledge that certain activities are associated with better moods (without telling them this – used questions to prompt them)	
Helped the participant to recognised that certain activities were associated with fewer unusual experiences (without telling them this – used questions to prompt them)	
The participant appeared to understand/accept the rationale for participating in more enjoyable activities	

The impact of increasing activity and socialisation	
Talked through this worksheet with the participant	
Asked the participant about their thoughts and feelings in response to the sheet	
The participant appeared to understand/accept the content of this sheet	
You gave the participant the option to consider people who they might like to share their difficulties with	
The participant discussed the people that they may want to share their difficulties with	

Between session task: behavioural experiment	
Talked through this sheet with the participant	
The participant appeared to understand what behavioural experiments are and their purpose	
Explained the example to the participant	
Supported the participant to generate their own thought/belief that they wanted to test	
Helped the participant to decide how they would test this belief	
Used the additional prompts on page 7 to help the participant decide on an experiment	

Talked through the example 'experiment sheet' with the participant	
Supported the participant to begin to complete the 'experiment sheet' for their particular experiment:	
The participant identified a specific thought to test	
The participant identified any problems with testing this thought and acknowledged ways of dealing with these	
The participant made a prediction about the 'expected outcome'	
Discussed any potential obstacles to the participant completing this between session task	

General Points	
Invited the participant to ask any questions they may have at regular points	
Checked the participant's understanding regularly	
Offered empathy and validation frequently	
Took a normalising approach to the participant's unusual experiences	

What went well?

_____

_____

_____

_____

What did not go well?

_____

_____

_____

_____

Session Four	✘ or ✔
Discussed the **Agenda** for the session	
Invited the participant to add items to the agenda	

Review of between session tasks	
The participant had attempted the behavioural experiment	
The participant had completed the 'experiment sheet'	
If not, explored why the participant had not attempted this	
If not, discussed the participant attempting this experiment or another after the session	
If so, explored what the participant tried and how they found this	
Discussed the participant's original prediction compared to the actual outcome	
The participant was able to reflect on new thoughts that they had developed as a result of completing the experiment	
The participant's belief (%) in their original thought had changed positively	
Encouraged the participant to continue completing behavioural experiments, offering more sheets	
Do you feel that the participant benefited from this task?	

Maintaining progress	
Explained the purpose of completing the 'maintaining progress' sheets to the participant	
The participant appeared to acknowledge this purpose	
The participant was able to generate the majority of the information included on the sheets, with some prompting from me	
I feel that completing this sheet was a useful exercise for the participant	
Please list any questions that did not appear helpful/relevant to the participant:	

Please list any questions that the participant seemed to find particularly helpful/relevant:

Ending	
The ending went well and felt positive	
Congratulated the participant on their progress	
Encouraged the participant to continue using/practising their new skills	
Invited the participant to ask any questions they may have	
Offered the participant spare copies of sheets	
The participant wanted additional sheets to use	
It feels that the positive benefited from the intervention	

General Points	
Offered empathy and validation frequently	
Took a normalising approach to the participant's unusual experiences	

What went well?

_____

_____

_____

_____

What did not go well?

_____

_____

_____

_____

Appendix F: Service User Experience Questionnaire

Participant Number:_____

One of the aims of this research is to see how young people experience the intervention that has been developed, and whether they find it helpful and acceptable. We are also interested in finding out how young people found being part of the research. These findings will help us to decide whether a bigger piece of research on the intervention should be done in the future and whether we should consider offering the intervention as part of routine care in the NHS.

To help us with this, we would really appreciate it if you could answer the following questions.

Questions about the intervention

For questions 1-4, please circle your answer to indicate how much you agree with each statement.

1. Overall, I found the intervention I received helpful

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

2. I found the intervention I received distressing

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

3. I would recommend the intervention to someone else with similar difficulties to me

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

4. I found the between session tasks helpful

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

For questions 5 and 6, please circle your answer

5. I found that having 4 intervention sessions was….

| Not enough | The right number | Too many |

6. I found that having 1 hour long sessions was….

| Too short | The right length | Too long |

For questions 7-12, please write your answer in the space provided. If you require more space, please use a blank sheet of paper, making sure to write the question number on this.

7. Have you noticed any changes in yourself or your symptoms as a result of receiving the intervention? If so, please explain what these changes have been.

_____
_____
_____
_____
_____
_____

8. What did you like about the intervention?

_____
_____
_____
_____
_____

9. What did you dislike about the intervention?

_____
_____
_____
_____
_____

10. What did you find helpful about the intervention?

_____
_____
_____
_____

11. What did you find unhelpful about the intervention?

_____
_____
_____
_____
_____
_____

12. What is your opinion of other young people being offered the intervention as part of their care from the Youth Team?

_____
_____
_____
_____
_____
_____
_____

Questions about the research

For questions 13-16, please circle your answer to indicate how much you agree with each statement.

13. Overall, I am pleased that I participated in the research

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

14. I would recommend participating in the research to others

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

15. I found the questions/questionnaires I answered with the researcher relevant

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

16. I found the questions/questionnaires I answered with the researcher easy to understand

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

For questions 17 and 18, please write your answer in the space provided. If you require more space, please use a blank sheet of paper, making sure to write the question number on this.

17. Do you have any other opinions about the question/questionnaires you answered with the researcher?

_____
_____
_____
_____

18. What is your overall opinion of this research?

_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this questionnaire.

Appendix G: Intervention Protocol and Worksheets

Intervention Protocol

Study Title: *Assessing the feasibility of a brief novel intervention for young people with At Risk Mental State and attenuated positive psychotic symptoms*

The theoretical ideas behind the intervention are based on a review of the current literature. The reasoning for the development of the intervention, its aims, content and delivery are outlined in the Thesis Proposal document – see the introduction. These will not be repeated here.

Key components of the intervention

The intervention will target the participant's attenuated positive psychotic symptoms, which will be referred to as: 'unusual' experiences (unless the participant prefers an alternative).

The therapist will focus on creating a therapeutic relationship in which the participant experiences them as warm, accepting and empathic. The aim is for the participant to feel listened to and understood.

The intervention will focus on taking a normalising and non-catastrophising approach to the individual's unusual experiences. The participants will be provided with psychoeducation to support this aim.

Aims of the intervention

The intervention aims to:

- Support the participant to explore any unusual experiences they are having
- Reduce the distress or anxiety participants feel in response to their unusual experiences, through:
  - Helping them to recognise how common these unusual experience
  - Supporting them to make sense of their unusual experiences
  - Supporting them to understand why they may be experiencing these symptoms

o Challenging any unhelpful beliefs they hold about their symptoms

- Help the participant to recognise the triggers to their unusual experiences
- Support the participant to increase their activities and socialisation

The intervention is not aiming to 'get rid' of the participant's symptoms, but to reduce their distress in response to them, which may result in improved wellbeing and reduced symptoms.

How will the sessions be delivered?

The sessions will be delivered either by an Assistant Practitioner or an Assistant Psychologist from the Norfolk and Suffolk NHS Foundation Trust (NSFT) Central Norfolk Youth Team. The non-registered practitioner will have to attend a mandatory 4 hour training session before offering the intervention.

The intervention is structured around a number of worksheets, which contain all of the necessary information for the intervention. Participants will be supported to explore the content of these worksheets and to complete the activities included on them by the non-registered practitioner, who will respond to them in a warm, empathic and accepting way.

Participants will also be asked to complete activities (also included on the worksheets) at home between each session. This will help them to generalise their learning outside of the sessions and enable them to practise any new skills they develop.

There will be 4 sessions in total, each will last approximately one hour. It is hoped that participants will attend sessions on a weekly basis, but the frequency can be adapted to suit the participant if necessary.

Aims for each session

Session 1

- For the non-registered practitioner to build rapport with the participant and engage them in the intervention
- The participant to be provided with an introduction to the intervention

- To explore the participant's feelings about starting the intervention and their expectations of it
- To provide the participant with information regarding the prevalence of unusual experiences
- To explore the participant's feelings about their unusual experiences
- To begin to explore how the way we think about unusual experiences may impact on how we feel about them

Session 2

- To help participants to understand how their responses (thoughts, feelings, behaviour) interact to maintain their unusual experiences and distress
- To support the participant to start to think differently about their unusual experiences and to challenge their assumptions

Session 3

- To support the participant to continue to think differently about their unusual experiences and to continue to challenge their assumptions
- To help the participant begin to see the links between their levels of activity/socialisation and their mood, distress and unusual experiences
- To introduce the idea of behavioural experiments and support the participant to plan one.

Session 4

- To consolidate what has been covered in the previous 3 sessions
- To have a successful ending to therapy

For specific intervention content, please see the worksheets. These include everything that will be covered during each session.

The Intervention Worksheets are included below:

What Should I Expect from the Intervention?

- We will meet for **4 Sessions** (including today)
- Each session will be about **1 hour long**

The focus of the sessions will be on any unusual experiences you are having or have had.

What do we mean by unusual experiences?

We may refer to these as strange or extraordinary experiences as well. They refer to experiences such as seeing or hearing things that others cannot see or hear, or having thoughts which might seem unusual to others. Unusual experiences may also refer to feeling worried or paranoid that others are out to get you. Quite often these experiences are distressing and difficult to understand, but are actually a lot more common than most people realise.

What will I do in each session?

We will work our way through a number of worksheets which will work as a guide to each session. This will help to make sure that we cover everything that we need to over the 4 sessions, to try to make them as helpful for you as possible.

The worksheets will help us to use the sessions to:

- Explore any unusual experiences you might have
- Explore how common unusual experiences are for other people
- Understand and make sense of your unusual experiences
- Reduce any distress or anxiety you may feel about these experiences
- Begin to understand why people might experience these symptoms
- Understand what may trigger you to experience symptoms

Between sessions tasks

To help you to get the most out of sessions together, I will ask you to complete some tasks after each session. This will help you to start to make some changes outside of the sessions and to use the ideas that you learn in the sessions. This is important, as we will only see each other for an hour at a time, and this will help you to apply what you learn to other areas of your life.

Agendas

At the start of each session, we will set an agenda or plan together for that particular session. As part of this, I will explain what worksheets we will be looking at and what sort of things we will be talking about so that you know what to expect. Please feel free to add items to the agenda.

Any questions?

Session One

Today's Agenda:

- How are you feeling about starting these sessions?

- What are unusual experiences? How common are they? Why do people experience them?

- Exploring your beliefs about your unusual experiences. What do you think they mean?

- Does the way we think about an unusual experience affect how we feel about it?

- Between Session Tasks

- Anything else? ......

-

-

Starting the Sessions:

How are you feeling about beginning these sessions?

You might be feeling:

Nervous

Curious

Worried

Unsure

Eager

Hopeful

Anything else?

A combination of these things?
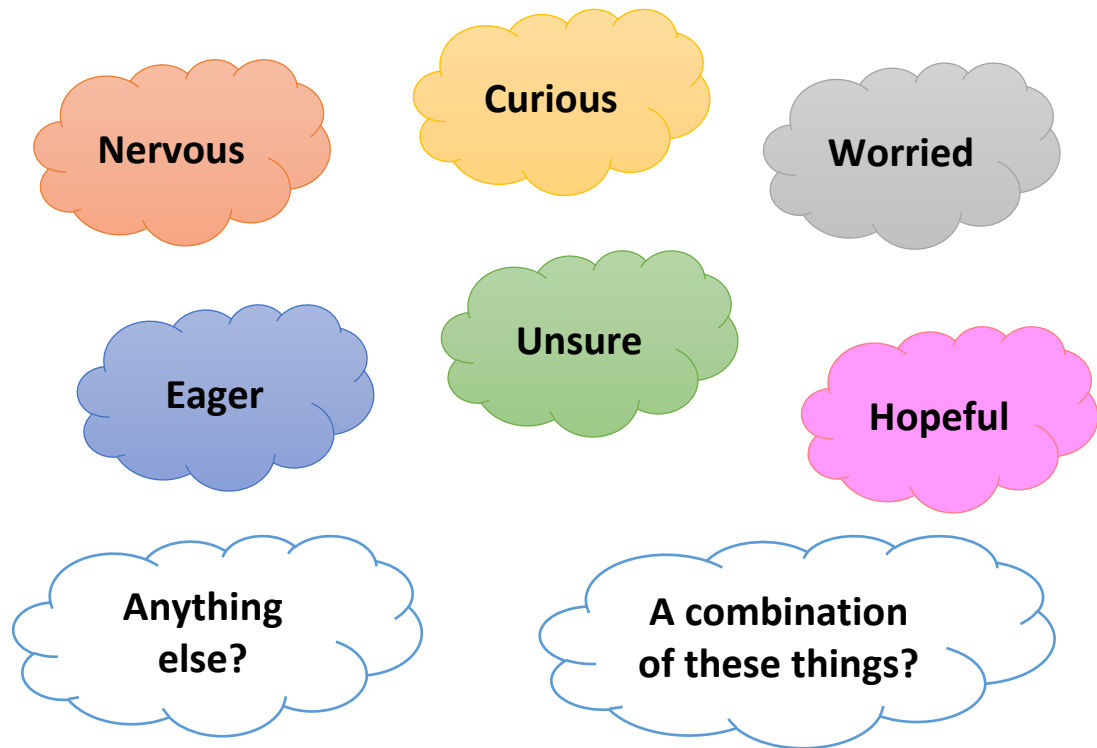
Do you have any expectations about the sessions? What would you like to get from them?

Do you have any particular worries or concerns?

Unusual Experiences Fact Sheet

How common do you think unusual experiences are in the general population?

Fact or Fiction: Research shows that more than 25% of adolescents report some unusual experiences?

This is a **fact**, unusual experiences are actually quite common in the general population. For example:

- About 1 in 6 people experience periods where they hear voices or sounds with no one there.

- About 10% of people sometimes feel that people are watching them, staring at them, deliberately acting to harm them or trying to control their thoughts.

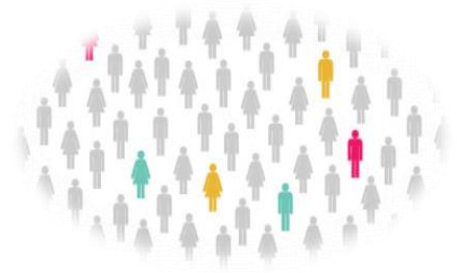- About 50% of the general population believe in telepathy/mind reading, e.g. many people have had the experience of thinking about someone and then the phone ringing and it being that person.

Are you surprised by this?

Many of the people who experience extraordinary experiences do not have a diagnosable mental health problem and are able to get on with their life with little difficulty. In fact, most people with these experiences find that they **disappear** with time and they do not require any treatment. For a much smaller number of people they may become worse. Although research shows that **psychological therapy can stop this from happening**.

> **Important to remember:** Unusual experiences can be really frightening, but are usually harmless and experienced by many.

What things make you more likely to have an unusual experience?

- Stress
- Worry
- Grief

At what age do you think people are most likely to start having unusual experiences?

Under 14   14-35   36-50   Over 50

Unusual experiences are particularly common during adolescence (between ages 14-35), as this is a time when individuals tend to have lots of changes happening in their life, which can cause stress and anxiety.

Your Unusual Experiences

When you have an unusual experience, how does it make you feel?

-
-
-
-
-

Happy	Sad	Angry
Worried	Confused	Excited
Surprised	Embarrassed	
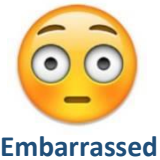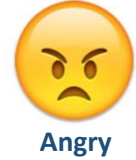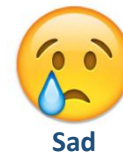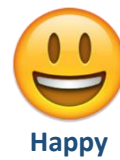
What impact do these feelings have on you? Do you think your feelings make you more or less likely to have more unusual experiences?

Some common feelings in response to an unusual experience are:

Worry, Distress

Considering that we know that people are more likely to have an unusual experience when they are worried, stressed or experiencing negative emotions, what do you think the impact of these feelings are?

This can become a vicious cycle:

Unusual or extraordinary experience → Feel Worried, Distressed → (cycle back)
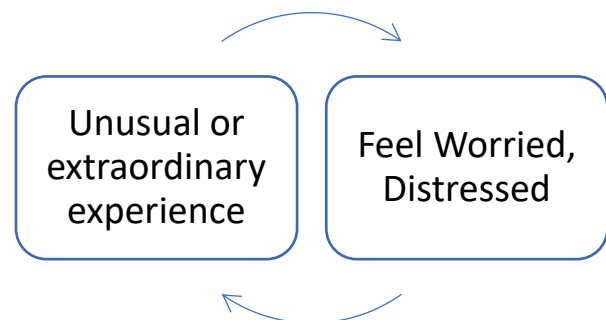
How does the way we think about a situation impact on how we feel about it?

Situation:
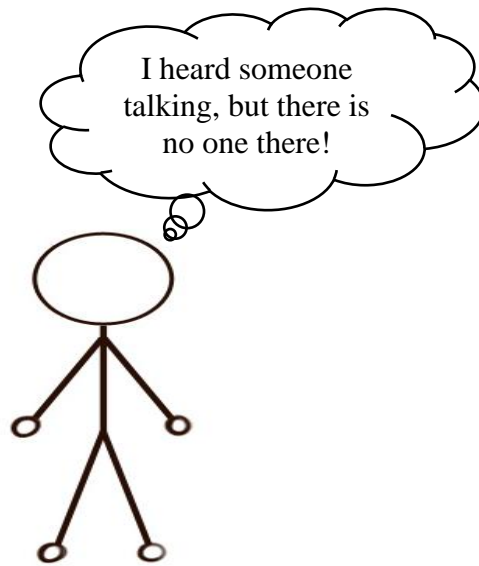
Interpretation of situation:
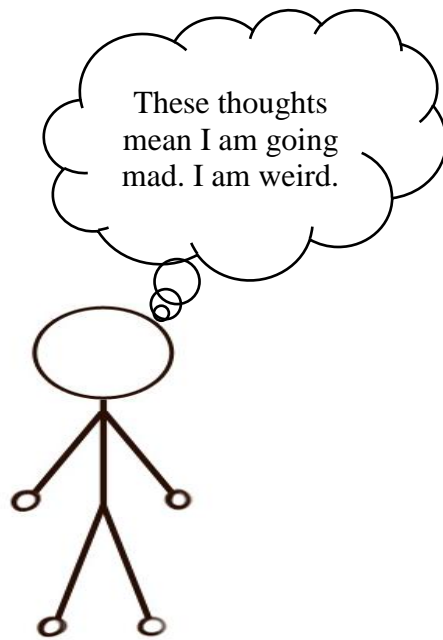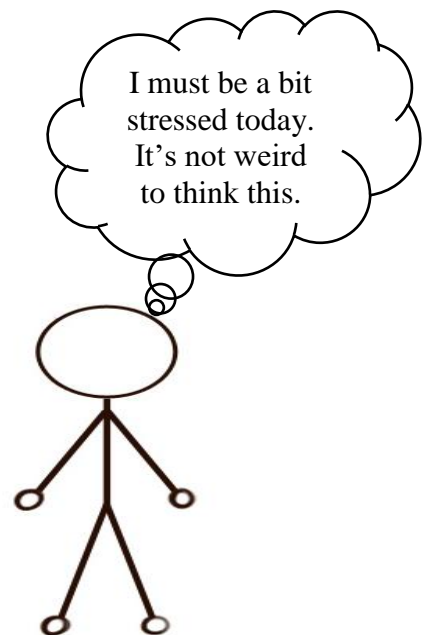
Person A   Person B

Feelings:

Person A:	Person B:

Between Session Tasks

Examples of Unusual Experiences

There is a sheet containing a list of examples of common unusual and extraordinary experiences. Please read through the sheet and tick any of the experiences you have had had. Please add any others that you may have had which are not included on the sheet.

Thought Record

Please complete the thought record sheet if you have any unusual experience before our next session. Please record the situation, including where you were, who you were with and when it was. Record the unusual experience you had and how you made sense of it, i.e. what thoughts did you have about the experience, yourself and what the experience may mean. Finally record any emotions or feelings you had at the time and how intense each of these were (on a scale of 1-10, where 10 is very high and 1 is very low).

Please complete this sheet each time you have an unusual experience before our next session.

Would you like to complete one for practice in the session?

Do you feel able to complete these tasks?
Do you have any questions or concerns about completing them?
Is there anything that might make it difficult or stop you from completing these tasks?

Examples of Unusual Experiences

Below is a list of examples of unusual and extraordinary experiences that are common for people. Please read through them and put a tick in the box next to any that you have experienced. There is space at the end to add any others that you may experience.

Unusual experiences:	
Your surroundings seem strange, new and not familiar	
Time seems to pass quicker, and then slower	
You feel like you are not in touch with reality or yourself	

Experiences of being influenced:	
You do not feel in control of your own thoughts and feelings, it seems like they have been taken over or inserted there	
Experiences that make you think about telepathy	
Thoughts that you are being sent messages which are meant specifically for you through the radio or television	

Experiences of threat:	
Thoughts that people are plotting against you	
Believing that others are 'out to get you'	

Confusion and difficulties with concentrating:	
Feeling confused, having difficulty choosing the right words. Others saying they cannot understand you properly	

Sensory perceptions that others you are with do not have:	
Hearing sounds, whispering or a voice in or outside of your head. Hearing your own thoughts spoken out loud	
Seeing strange things or having visions	
Any other sensory perception (e.g. taste, smell) which seems strange or seems to have no (external) cause	

Changed experiences in contact with other people	
Experiencing little pleasure or enjoyment from the company of others	
Feeling nervous when physically close to others	
Others saying that you do not express your feelings enough	
Others saying that you act strangely, or have unusual habits	
It feels more difficult to cope with everyday problems and worries	
Having difficulties interacting with others at work, school or college	

Others:

Thought Record

Situation Where? When? Who with?	Unusual Experience	How did I make sense of this experience? What did I think about it? What does having the experience mean to me? Does it say anything about me?	Feelings What emotions did I feel at the time? How intense were they? (Rate on a scale of 1-10, where 10 is high and 1 is low)

Session Two

Today's Agenda:

- Review of Between Sessions Tasks from last session

  - Examples of Unusual Experiences

  - Thought Record

- Maintenance Cycle

- Generating Alternative Explanations

- Between Session Tasks

- Anything else? ......

-

-

Maintenance Cycles

A maintenance cycle helps us to explore how our thoughts, feelings and behaviours interact with each other to keep any difficulties going. They show how we can get stuck in vicious cycles.
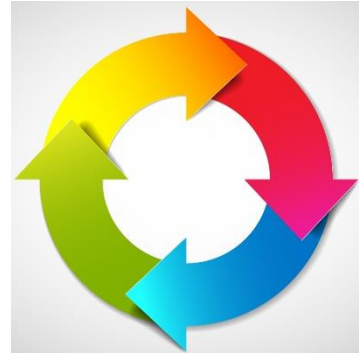
Look at the example on the next page:

Situation/Trigger

Home alone. Just had an argument with my friend

The trigger to the unusual experience is a stressful event

Behaviours can also make people more likely to have future unusual experiences. E.g. through isolating themselves, this person will have more time to think about their unusual experiences, increasing their distress. Socialising may also help to improve their mood, decreasing their distress.

Unusual or extraordinary experience

Hearing someone say something, but there is no one there.

As we discussed in session 1, when a person has an unusual experience, they try to make sense of it

Behaviour

Lock myself in my room. Cancel my plans to go out later

Feeling distressed makes the unusual experience more likely to happen again

Interpretation of the event. How do I make sense of it?
Thoughts: this means I am going mad, there must be something wrong with me

How the person feels, will impact on how they behave. In this case, they feel scared and anxious, so understandably they lock themselves away.

Feelings
Scared, Anxious, Frightened, Distressed

The way the person makes sense of the experience will impact on how they feel (think of the stick person example from session1)

From this we can see how we get stuck in vicious cycles. However, changing any one component of the diagram will break the cycle.

Break The Cycle

Your Maintenance Cycle

Situation/Trigger

Unusual or extraordinary experience

Behaviour

Interpretation of the event.
How do I make sense of it?
Thoughts:

Feelings
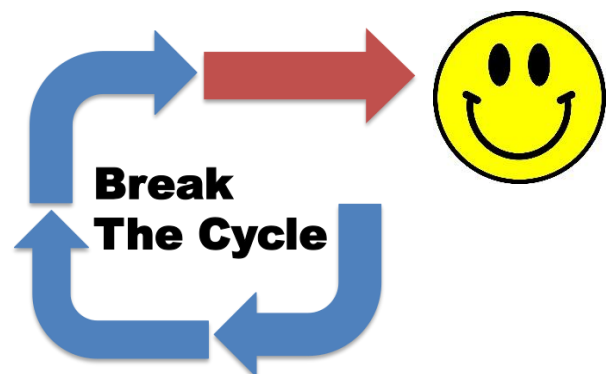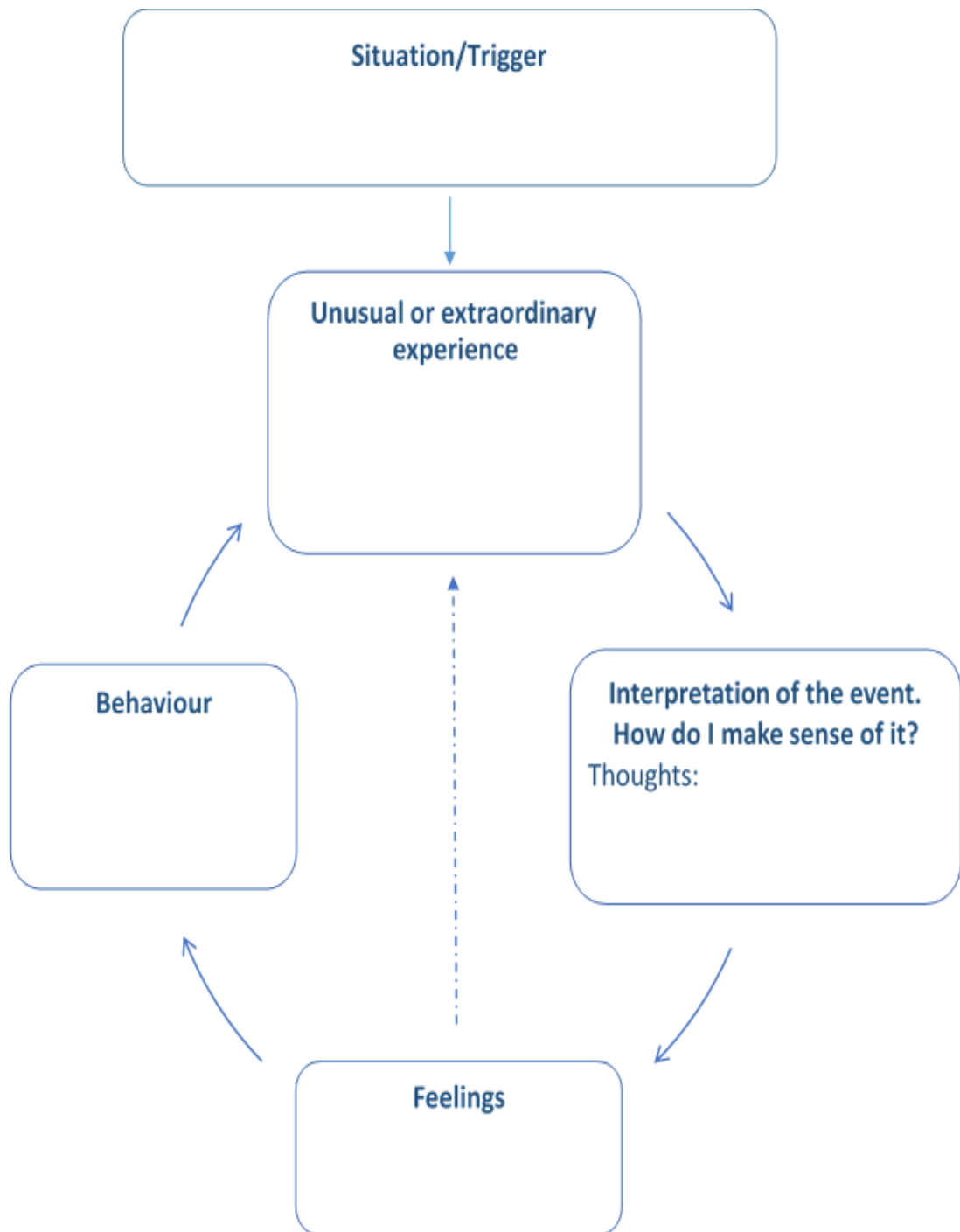
Breaking the Maintenance Cycle

We have said that changing any one component of the diagram will lead to breaking the vicious cycle.

Which parts of your cycle do you think we can try and change?

Behaviour?

This is something we will talk a bit more about next week.

Interpretation of the unusual experience?

We know from last session that changing the interpretation of the event can change how we feel about it. If we can use this to reduce anxiety and distress then this may reduce the unusual experiences you have.

But how do we change our interpretations of experiences?

To do this, it is helpful to explore all the possible explanations for the unusual experience (however unlikely they may seem).

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Generating Alternative Explanations: Example

Unusual experience identified	Hearing someone say something but there is no one there
Current interpretation of the experience and belief rating (0-100)	I am going mad, there is something wrong with me (100%)
Feelings associated with this interpretation	Scared, anxious, frightened, distressed

Alternative explanations for the experience

Alternative interpretations and explanations of the experiences	Belief rating 0 = this is not the reason for this experience 100 = this is definitely the reason for this experience	Associated mood
It was a ghost	50%	Frightened, scared
I am a bit stressed today, that is why I had the experience	85%	Relieved, calm
I was replaying the argument in my head, maybe the noise was from inside my head	10%	Unsure
There was someone in the house	5%	Scared

Re-rate the belief in your original interpretation: 60%	
Can you think of an alternative belief?	I just had an argument with my friend, which made me feel angry, upset and stressed. When I feel like this, I am more likely to hear things that are not there.
Associated Mood	Relieved and more relaxed

Generating Alternative Explanations: Your Example

Unusual experience identified	
Current interpretation of the experience and belief rating (0-100)	
Feelings associated with this interpretation	

Alternative explanations for the experience

Alternative interpretations and explanations of the experiences	Belief rating 0 = this is not the reason for this experience 100 = this is definitely the reason for this experience	Associated mood

Re-rate the belief in your original interpretation:	
Can you think of an alternative belief?	
Associated Mood	

Between Session Tasks

Generating Alternative Explanations

Complete the sheet we started in the session (if necessary) and complete another for an unusual experience that happens before our next session.

Activity Diary

Complete an Activity Diary sheet for one week. This involves recording (briefly) what you have been doing during set time periods throughout the day. Please also write your mood and its intensity (as on the thought record). It would be great if you could also record:

- The sense of achievement you are getting from the activity
- How close you feel to others
- The sense of enjoyment you are feeling

Each of these can be scored out of 10 (where 0 is very low and 10 is very high.)

Try to record if you have any unusual experience. Also try to see if you can notice any patterns in how your mood varies. What is the impact of particular activities on your mood?

Do you feel able to complete these tasks?

Do you have any questions or concerns about completing them?

Is there anything that might make it difficult or stop you from completing these tasks?

Generating Alternative Explanations

Unusual experience identified	
Current interpretation of the experience and belief rating (0-100)	
Feelings associated with this interpretation	

Alternative explanations for the experience

Alternative interpretations and explanations of the experiences	**Belief rating** 0 = this is not the reason for this experience 100 = this is definitely the reason for this experience	**Associated mood**

Re-rate the belief in your original interpretation:	
Can you think of an alternative belief?	
Associated Mood	

Activity Diary (Adapted version based on: www.getselfhelp.co.uk)

In each box, write a brief description of what you did. Write one word to describe your mood at the time and record the intensity of this mood on a scale of 1-10 (where 1 is low and 10 is high). Please also rate your sense of achievement (A), closeness to others (C), and enjoyment (E) on the same scale E.g.: Cleaning the house, Sad=6, A7, C0, E1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6am – 8am							
8am – 10am							
10am – 12pm							
12pm – 2pm							
2pm – 4pm							
4pm – 6pm							
6pm – 8pm							
8pm – 10pm							
10pm – 12am							

Can you notice any patterns in how your mood varies? How do particular activities affect your mood?

Session Three

Today's Agenda:

- Review of Between Sessions Tasks from last session
  - Generating Alternative Explanations – Complete another?
  - Activity Diary
- The impact of increasing activity and socialisation
- Between Session Tasks
- Anything else? ......
-
-

Review of: Generating Alternative Explanations

How did you find completing this?

Any difficulties?

What impact did it have on you and how you felt?

Would you like to practice completing another one in the session?

Review of: Activity Diary

How did you find completing this?

Did you notice anything in particular?

Were there any links between particular activities and your mood?

When did you feel best/worst? What were you doing?

Did you notice any links between your unusual experiences and your mood or activities?

What have you learnt from this?

_____

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The Impact of Increasing Activity and Socialisation

Some Facts:

- Participating in enjoyable activities and socialising with others is linked to:

  - Increased mood – feeling happier and less distressed
  - A decrease in unusual experiences
  - Less time to think about any unusual experiences or thoughts you may have had, meaning these cause you less distress.

- It can be helpful to share any unusual experiences or thoughts with people you trust. Individuals who have done this, have found that others have been able to help them to generate alternative reasons for their unusual experiences. (Just as you have been practising.)

- Despite this, many individuals who are having unusual experiences do not share these with friends or family members because they are unsure how they will react.

- Are there people you feel able to share your difficulties with?

- If not, it might be helpful to think of some people you feel able to trust who you could share your unusual experiences with. We can list the names below:

_____

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Between Session Task: Behavioural Experiment

A behavioural experiment is a planned activity or behaviour in an ordinary situation, which is used to test an idea or to gather new information (think of it like a Scientist conducting an experiment).

Typically, a behavioural experiment might involve being in an everyday situation, but behaving differently to how you would normally, to test out what happens. Before doing this, it is important to identify a particular idea that you wish to test and to make a prediction about what might happen. You can then carry out the experiment to see if your prediction comes true and to find out if your idea is supported or not.

One way of using a behavioural experiment is to test out a **new** idea to see if you can gather any evidence to support or dispute it.

Example: Through using the activity schedule, Fred noticed that his mood had increased when he went swimming. Fred thinks this might just be a coincidence, but is going to complete a behaviour experiment to test out the idea that going swimming increases his mood. To do this, Fred will go swimming, he will record his mood and its intensity before and after this to see if there is any change.

Planning your own Behavioural Experiment

Consider what you have found out from completing your activity diary and what you have learnt from the fact sheet we have just discussed. Have you developed any new beliefs that you would like to try out?

Or

Consider what you have learnt in previous sessions about the impact of how we interpret unusual experiences on how we feel about them and how likely they are to occur again. What new beliefs have you developed in response to this?

Or

Consider what we discussed in session 1, where we considered facts about unusual experiences. Did you develop any new beliefs in response to this?

Whatever you choose, it is important to make a prediction before you participate in the activity and then use the experiment to test this prediction out. There is a sheet to help you with this and a completed example of this sheet is included.

Prediction → Experiment → Outcome
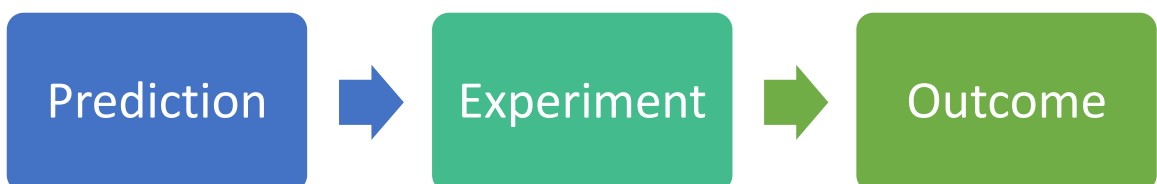
If you are finding it difficult to think of something, here are some suggestions:

- Was there an activity on your diary that you found increased your mood?
    - Could you participate in the activity to test out the belief that it makes you feel better?
- Is there an activity you used to enjoy that you've stopped doing?
    - Could you try out this activity again, testing out whether you still enjoy it?
- Are there some friends/family that you would like to meet with?
    - You could use this to test the statement on the fact sheet that socialising increases mood?
- Is there someone on your list of trusted people who you might be able to share an unusual experience with?
    - What would your predictions about this be? Could you test out these predictions?
- Do you believe that unusual experiences really are as common as the research suggests?
    - Could you conduct a survey to test this?

How do you feel about trying to complete a behavioural experiment?

Do you feel able to try the experiment?

Do you have any questions or concerns about trying this?

Is there anything that might make it difficult or stop you from completing this task?

Behaviour Experiment Worksheet

There is a Behaviour Experiment worksheet to complete. Please complete this to help you monitor the outcomes of your experiment and to see how they compare to your expectations.

Experiment Sheet – EXAMPLE

Thought to be tested: Going swimming again will have a positive impact on my mood

Belief in thought (0-100%) before experiment: 10%	**Belief in thoughts (0-100%) after experiment:** 90%

Experiment to test thought	*Likely problems with trying this. How will I deal with these?*	*Expected outcome*	*Actual outcome*	*Any new thoughts?*
Go swimming, record my mood and intensity before going and again once I have been.	I will not get around to going and I will be too tired to go swimming – plan in advance when I am going to go. Plan to go in the morning when I am less tired.	Going swimming will have no impact on my mood. My mood and its intensity will be the same or worse if I go swimming.	My mood changed from sad (6), anxious (9) before going swimming to pleased with myself (9), happy (7) afterwards	Going swimming did make me feel better. Maybe trying to go out more will be helpful.

Experiment Sheet				
Thought to be tested:				
Belief in thought (0-100%) before experiment:		**Belief in thoughts (0-100%) after experiment:**		
Experiment to test thought	*Likely problems with trying this. How will I deal with these?*	*Expected outcome*	*Actual outcome*	*Any new thoughts?*

Session Four

Today's Agenda:

- Review of Between Sessions Tasks from last session
    - Behavioural Experiment
- Therapy Blue Print
- Ending
- Anything else? ......
-
-

Review of: Behavioural Experiment

What did you try?

How did you find it?

What was your prediction? Did it come true?

Did you develop any new thoughts?

Maintaining Progress

Adapted from French and Morrison (2004) and www.getselfhelp.co.uk

What are the unusual experience that I have had?

- _____

  _____

- _____

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What have I learned from the sessions?

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What has been most helpful to me?

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What are my high-risk situations? What makes my difficulties more likely to occur?

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What are the alternative thoughts and beliefs that I have generated?

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- _____

What is the evidence that I have collected to support the new beliefs that I have developed?

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What should I continue to do to help me now the sessions have finished? What further evidence can I collect to support my new beliefs?

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Who can I talk to about my difficulties? Who can help me if I am struggling?

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Well done for reaching the end of the intervention.

You have learnt many new skills, which I hope you will be able to continue to use. Doing so will mean that you can keep making positive changes.

It can be difficult at times, but this does not undo the progress you have made or the hard work you have put in.

Remember to be kind to yourself.

Appendix H: Feedback from the Experts by Experience and the Pilot of the

Intervention

Table 19 summarises the involvement of Experts by Experience (EBEs) in the development of the research and intervention. Detailed feedback given by two of the EBEs regarding the intervention worksheets is included below table 19, separated by session.

Table 19

EBE involvement in the development of the intervention

EBE and their involvement	Summary of feedback and changes made in response
Peer Support Worker from an Early Intervention in Psychosis Team (an NHS employee with lived experience of mental health problems). *Involvement:* Reviewed the intervention worksheets	• Could be a potentially useful booklet, easy to understand • Concerned about the use of the word 'odd' in relation to experiences; participants may view themselves as odd. The word 'odd' was removed; experiences were described as unusual or extraordinary instead. • 'Examples of Experiences' worksheet - unsure what the following phrase means: "having an unusual bodily perception with no external cause." This phrase was replaced with specific examples of 'unusual bodily perceptions,' e.g. 'taste/smell without a cause'

Two young people who had previously met criteria for ARMS *Involvement:* Met with the primary researcher: discussed the research, its purpose and reviewed the intervention worksheets	• Liked:
	  o focus on normalising unusual experiences
	  o brief intervention aiming to increase availability to young people
	  o emphasis on the therapeutic relationship.
	• Recommended:
	  o some changes to wording and layout of the worksheets, which were made as suggested
	  o participants and practitioners should each have their own worksheets, which was adopted
	  o ways the practitioners should approach delivering the intervention, which were shared during the practitioners' training session.

Feedback on Session 1

Feedback	Changes made in response
Like that unusual experiences are described as common.	N/A
Do not expect all participants to complete the between session tasks (homework)	Training of practitioners to deliver the intervention will address this and how to proceed with the next session if the homework has not been completed. This will mainly involve completing the homework in the next session.
Agenda Setting – Use the word together, make it a joint project. Ensure that the agenda is flexible enough to adapt to each participant.	'Together' has been added to this section. Sentence added to encourage participants to add items to the agenda. Piloting the intervention showed that there is time available in each session to be flexible and allow the participant to add items.
Add positives to the example feelings that participants might be experiencing starting the intervention to ensure the intervention does not seem negative.	'Eager' and 'Hopeful' added.
'Do you have any thoughts about starting the sessions?' - This is too vague.	Changed to: Do you have any expectations about the session. What would you like to get from them? Do you have any particular worries or concerns?
Do not include references on the fact sheet.	References removed
Rather than saying that treatment can stop unusual experiences from getting worse, be specific and say psychological therapy, otherwise participants may think this refers to medication. Emphasise that therapy can help.	Treatment changed to psychological therapy and this put in a blue and bold font.

Do not use an exclamation mark	Changed to a full stop
Do not say: 'Other negative emotions,' – be more specific	Removed and grief added alongside stress and worry.
Examples of Unusual Experiences sheet – emphasise that many people have these experiences	Word 'common' added
Change the word stressors to worries	Changed as recommended
Thought record sheet: change rating of intensity of emotions from a scale of 0-100 to 1-10.	Changed as recommended

Feedback on Session 2

Feedback Given by Youth Council Members	Changes made to Address Feedback
Do not use the word formulation	Changed to cycle (maintenance cycle)
Use colours as well as numbers to link maintenance cycle to descriptors	Colours added

Feedback on Session 3

Feedback Given by Youth Council Members	Changes made to Address Feedback
Do not put too much pressure on participants to identify people to share their unusual experiences with	To be included in the training.
When talking about behaviour experiments, the word idea is better than belief.	'Belief' changed to 'idea.'
Behaviour experiments can be particularly anxiety provoking.	Section added to explore how the participant is feeling about conducting a behaviour experiment to allow this to be explored. Also, to be covered in training.

Feedback on Session 4

Feedback Given by Youth Council Members	Changes made to Address Feedback
If participant has not completed a behaviour experiment for homework, explore with them what they could do in the future.	To be included in the training for practitioners delivering the intervention.
Include space for a list of participant's unusual experiences in the blue print.	Added
Include a positive quote at the end. Finish on a high.	Statement added at the end of the therapy blueprint.

Feedback from the Pilot of the Intervention

What did Sarah[13] find helpful about the intervention?

- Recognising that her thoughts are not always true and that her predictions will not necessarily come true.

- Recognising that having unusual experiences is quite normal and does not mean that there is something wrong with her.

- Coming to terms with her unusual experiences and recognising that it does not matter what other people think about them.

What did Sarah like about the intervention?

- Having sheets in the sessions and for homework that she could write on. This helped Sarah to make sense of her thoughts, feelings and experiences.

- Sarah commented that she liked that the intervention did not tell her what to do or tell her the reasons for her experiences. She said that she felt that the intervention left room for her to figure things out for herself rather than being told.

---

[13] Sarah is a pseudonym for the service user who piloted the intervention

- Sarah particularly liked the 'Examples of Unusual Experiences' tick sheet (from session 1). She commented that she found this helpful, as she did not know what some of her experiences were and it was helpful to be able to recognise them.

- Sarah also liked considering the percentages of how much she believes particular thoughts. She found that this helped her to think.

What did Sarah dislike about the intervention?

- Sarah reported that she found completing the Activity Schedule (homework for session 2) difficult and this was mainly because she found it difficult to remember to complete it. Sarah was unsure how this could be made better, and thought it should remain part of the intervention, as she did find it helpful.
    - To address this, staff delivering the intervention in the research will be told to reassure participants that it is ok if they do not fill in every slot on the activity schedule.

- Sarah felt that having 4 sessions made the intervention quite short. However, she understood the rationale behind this and felt that it will be important for participants to be encouraged to continue using the techniques after the intervention has finished, as she felt that improvements will continue afterwards.

- Sarah felt that the worksheets for each session should be stapled together.

Other comments from Sarah:

- The worksheets were helpful, but it was good that these were used as prompts and not wholly relied on.
    - This will be incorporated in to the training

- Sarah feels that it is a good idea to offer the intervention to others.

- Sarah reported that overall, she feels that the intervention is good, and she was grateful that she was offered it.

- Sarah stated that there had been small improvements in how she thought about her unusual experiences, and that the intervention had not increased her distress nor caused her symptoms to worsen.

Appendix I: Letters confirming ethical and HRA approval

NHS

Health Research Authority

East Midlands - Nottingham 1 Research Ethics Committee

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

> **Please note:** This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

10 April 2017

Miss Emma Burton
Department of Clinical Psychology
Norwich Medical School
University of East Anglia
NR4 7TJ

Dear Miss Burton,

Study title:	Assessing the feasibility of a brief novel intervention for young people with At Risk Mental State and attenuated positive psychotic symptoms: The viability of its use in the NHS and of a future trial
REC reference:	17/EM/0114
IRAS project ID:	212935

Thank you for your letter of 05 April 2017, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet completed any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as an SSA application(s) has been reviewed. In the meantime no study procedures should be initiated at non-NHS sites.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Certificate from UEA]	1	22 February 2017
GP/consultant information sheets or letters [Letter to GP informing them of their patient's participation in the research]	1.0	11 December 2016
IRAS Application Form [IRAS_Form_04042017]		04 April 2017
IRAS Application Form XML file [IRAS_Form_04042017]		04 April 2017
IRAS Checklist XML [Checklist_05042017]		05 April 2017
Non-validated questionnaire [Experience Questionnaire for Service User Participants (post intervention measure)]	1	14 February 2017
Other [VALIDATED QUESTIONNAIRE:. CORE-OM - Pre/Post outcome measure]		
Other [VALIDATED QUESTIONNAIRE: SRS - Sessional Rating Scale for Each Intervention Session]		
Other [VALIDATED QUESTIONNAIRE: WAI-SR (Client Version) - Measure of working alliance (post intervention measure)]		
Other [VALIDATED QUESTIONNAIRE: WAI-SRT (Therapist version). Measure of working alliance (for clinicians delivering the intervention). Post intervention measure]		
Other [NON-VALIDATED QUESTIONNAIRE: Experience questionnaire for clinicians from youth teams]		11 December 2016
Other [Broad Timetable of Research Activities]		11 December 2016
Other [Cover Sheet Explaining Changes to the proposal/protocol following feedback from UEA Lecturers]		27 August 2016
Other [Intervention Session One]	3.0	11 December 2016
Other [Feedback from the Pilot of the intervention and adaptations made in response]		09 December 2016
Other [Feedback from the Experts by Experience (Youth Council) and the adaptations made in response]		22 November 2016
Other [I I letter TM - E Burton]		22 February 2017
Other [Consent to Contact form]		
Other [Clarification emial from EB]		01 March 2017

Other [NON-VALIDATED QUESTIONNAIRE: Experience questionnaire for intervemtional therapist participants (post intervention measure)]	1	14 February 2017
Other [NON-VALIDATED QUESTIONNAIRE: Experience questionnaire for staff participants]	2	02 April 2017
Other [Intervention Session One]	3	31 January 2017
Other [Intervention Session Two]	3	31 January 2017
Other [Intervention Session Three]	3	31 January 2017
Other [Intervention Session Four]	3	31 January 2017
Other [Primary Supervisor CV]	1	14 February 2017
Other [Service User Participants Consent to Contact]	1	14 February 2017
Other [Intervention Protocol]	1	31 March 2017
Other [Training and Supervision Protocol]	1	31 March 2017
Other [Training Powerpoint Presentation]	2	31 March 2017
Other [Survey Monkey Website Contents]	1	04 April 2017
Other [Letter - Response to REC Review]	1	01 April 2017
Participant consent form [Participant Consent Forms for the three types of participants]	3	02 April 2017
Participant information sheet (PIS) [Participant Information Sheets for the three types of participants]	3	02 April 2017
Referee's report or other scientific critique report [Review of Proposal from UEA Lecturers]	1.0	21 June 2016
Research protocol or project proposal [Research Proposal]	3	04 April 2017
Summary CV for Chief Investigator (CI) [Research CV - CI and Student]	1.0	27 August 2016
Summary CV for student [Student CV]		
Summary CV for supervisor (student research) [Secondary Supervisor CV]		
Summary CV for supervisor (student research) [BT]		01 December 2016
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Flowchart of Research Protocol]	2	02 April 2017
Validated questionnaire [CAARMS - Screening and outcome assessment]		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators

- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

17/EM/0114	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely,

pp

Mr John Aldridge
Chair

Email:NRESCommittee.EastMidlands-Nottingham1@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Miss Yvonne Kirkham
Dr Jon Wilson, Norfolk and Suffolk NHS Foundation Trust

Miss Emma Burton
Department of Clinical Psychology
Norwich Medical School
University of East Anglia
NR4 7TJ

Email: hra.approval@nhs.net

10 April 2017

Dear Miss Burton

Letter of HRA Approval

Study title:	Assessing the feasibility of a brief novel intervention for young people with At Risk Mental State and attenuated positive psychotic symptoms: The viability of its use in the NHS and of a future trial
IRAS project ID:	212935
REC reference:	17/EM/0114
Sponsor	University of East Anglia

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read *Appendix B* carefully, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

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It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **212935**. Please quote this on all correspondence.

Yours sincerely

Michael Pate
Assessor

Email: hra.approval@nhs.net

Copy to: Miss Yvonne Kirkham – University of East Anglia – Sponsor contact
             Dr Jon Wilson - Norfolk and Suffolk NHS Foundation Trust – Lead NHS R&D contact.

Research and Development
The Knowledge Centre
Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE

Telephone 01603 421255
E mall: RDofficemailbox@nsft.nhs.uk

Emma Burton
ClinPsyD Trainee
Department of Clinical Psychology
Elizabeth Fry Building
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

11th April 2017

Dear Emma,

Re: NSFT Letter of Access for research

This letter should be presented to each participating organisation before you commence your research at that site. The participating organisation is: **Norfolk and Suffolk NHS Foundation Trust.**

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 11th April 2017 and ends on 30th September 2018 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from **Norfolk and Suffolk NHS Foundation Trust.** Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation from the individual organisation of their agreement to conduct the research.

The information supplied about your role in research at the organisation has been reviewed and you do not require an honorary research contract with the organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. Evidence of checks should be available on request to the organisation.

You are considered to be a legal visitor to the organisations premises. You are not entitled to any form of payment or access to other benefits provided by the organisation or this organisation to employees and this letter does not give rise to any other relationship between you and the organisation, in particular that of an employee.

While undertaking research through the organisation you will remain accountable to your substantive employer but you are required to follow the reasonable instructions of the organisation or those instructions given on their behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the organisations policies and procedures, which are available to you upon request, and the Research Governance Framework.

Chair: Gary Page
Chief Executive: Michael Scott
Trust Headquarters: Hellesdon Hospital,
Drayton High Road, Norwich, NR6 5BE
Tel: 01603 421421 Fax: 01603 421440 www.nsft.nhs.uk

Stonewall
DIVERSITY CHAMPION

You are required to co-operate with the organisation in discharging its/their duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the organisations premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each organisation prior to commencing your research role at that organisation.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the organisations premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation(s) do not accept responsibility for damage to or loss of personal property.

This organisation may revoke this letter and any organisation(s) may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation(s) or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

No organisation will indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in each participating organisation] and [the R&D office] in this organisation.

Yours sincerely

Tom Rhodes
Senior Research Facilitator

cc: Resourcing, NSFT HR

UEA
University of East Anglia

Appendix J: Service User Participant Consent Form

Title of Project: *Assessing the feasibility of a brief novel intervention for young people with At Risk Mental State and attenuated positive psychotic symptoms: The viability of its use in the NHS and of a future trial*

Name of Researcher: Emma Burton, Trainee Clinical Psychologist

Please Initial Each Box

1. I confirm that I have read the information sheet dated 02/04/17 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time (until data analysis begins) without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant data and information collected during the study, may be looked at by clinicians from Norfolk and Suffolk NHS Foundation Trust (NSFT) Central Norfolk Youth Team, where it is relevant to my routine care. I give permission for these individuals to have this access

4. I understand that information collected about me during the study will remain private and will not be shared with anyone outside of the research team or the NSFT Central Norfolk Youth Team unless there are concerns for mine or someone else's safety.

5. I agree to my General Practitioner being informed of my participation in the study

6. *I agree to take part in the above study.

_____   _____   _____

Full Name of Participant   Date   Signature

_____   _____   _____

Full Name of Person Taking Consent   Date   Signature

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.
IRAS project ID: 212935

Appendix K: Service-User Information Sheet for Research

Study Title: *Assessing the feasibility of a brief novel intervention for young people with At Risk Mental State and attenuated positive psychotic symptoms: The viability of its use in the NHS and of a future trial.*

My name is Emma Burton and I am a Trainee Clinical Psychologist based at the University of East Anglia (UEA). I am writing to invite you to take part in a research project, which is aiming to develop and try out a new psychological treatment for young people who are having unusual thoughts and experiences, which they may be finding upsetting. This information sheet is to help you to decide if you are happy to participate. Please take time to read it carefully. Please feel free to contact me if you require any further information.

My research supervisors are Dr Bonnie Teague (Senior Teaching Fellow in Research Methods at UEA), Dr Richard Meiser-Stedman (Reader in Clinical Psychology at UEA) and Dr Timothy Clarke (Clinical Psychologist at Norfolk and Suffolk NHS Foundation Trust, (NSFT)).

What is the purpose of the study?
Some young people have what health professionals call At Risk Mental State (ARMS). These young people might have changes in the way they see or hear things, which they might find odd and/or distressing. They might also be feeling tense, worried and unhappy, they may not feel like socialising and be experiencing difficulties with eating and sleeping. For many people these symptoms might not last very long but for a small number of people, they might last longer and could become worse (health professionals call this psychosis).

Psychological therapy can help to reduce these symptoms and stop them from getting worse. Some research has shown that brief therapy with a therapist who is warm and accepting and helps the young person to understand their symptoms may be helpful for young people with ARMS. The aim of this study is to develop a new intervention which is like this and then to offer this intervention to 12 young people to see how they find it. This would help us to see if such an intervention is helpful and acceptable to young people, whether a bigger piece of research on it could be done in the future and whether it could be offered in the NHS.

Why have I been invited to take part?

You have been asked to take part because you are currently receiving support from a Youth Team in NSFT and are having some of the difficulties outlined above. To take part, you will be asked to read and then sign a consent form to show that you understand what the study involves and would like to take part.

Do I have to take part?

It is important that you are aware that your choice to be involved in the study is voluntary. You are able to change your mind and withdraw from the research, without giving a reason, at any point, up until data analysis starts.

What would the study involve?

If you agree for a member of staff from the Youth Team to pass on your details to me, I will contact you by telephone to arrange to meet.

This appointment would last about 55 minutes. I would answer any questions you have about the research and ask you to sign the consent form if you still wanted to take part. After this, I would complete an assessment with you to see if you are eligible to take part. This would involve me asking you some questions about the symptoms outlined above. It is possible that this assessment may show that you are not eligible to take part in the study. Unfortunately, if this happened your involvement with the research would end at this point and you would not be able to receive the intervention. If this happens it may be disappointing for you, but you will be provided with reasons why you are unable to take part. A likely reason is that the symptoms you are experiencing do not fit with those the intervention is targeting. All information collected about you would be destroyed confidentially.

If you are eligible to take part, I would then complete a questionnaire with you, which asks about how you have been feeling during the past week.

You would then be contacted by one of four members of staff from NSFT who will be offering the intervention. They would arrange four appointments with you to complete the intervention, each would last for about an hour. They would start as soon as possible after your initial appointment with me and would hopefully be once a week or once a fortnight.

Once you had had the four intervention sessions, I would meet with you again. We would repeat the assessment and questionnaire from our first session to see if there had been any change in

these. You would also be asked to complete a questionnaire asking you about your relationship with the person delivering the intervention. Finally, you would be asked to complete another questionnaire, which asks about your experience of receiving the intervention and gives you the opportunity to feedback your thoughts about others receiving it in the future and how it may be improved. You would be left to complete this on your own and would be given an envelope to put it in to ensure your answers are completely anonymous. This session would take about 1 hour 35 minutes. At this point you would be given the opportunity to be entered into a prize draw to win a £25 Amazon voucher. This would be a gesture to thank you for your time.

What is the intervention?
The intervention will involve working through a number of worksheets with either an Assistant Practitioner or an Assistant Psychologist. They will aim to develop a relationship with you in which you feel safe, understood and at ease.

You will be supported to explore any symptoms you are experiencing and be helped to understand and make sense of these, including what may trigger them and strategies you can use to reduce them. The intervention also involves exploring how common these types of symptoms are, and possible reasons why people experience them. The ultimate aim is to reduce any anxiety and distress you feel about your symptoms, as it is hoped that this will reduce further symptoms and increase your wellbeing.

What happens when the research study stops?
After the final appointment with me (as outlines above), your involvement in the study would be finished and we are unfortunately not able to offer any follow up appointments. However, if you were interested in hearing about the outcomes of the research, we would be able to post you a summary of the findings.

Will this research impact on the care I receive from the Youth Team or NHS?
If you choose to not participate in the study or withdraw from it, this will have no impact on the care you receive from the Youth Team or NHS currently or at any point in the future. If you do participate in the study, your care from the Youth Team and NHS will continue as it was before. The only exception will be that you are unable to receive any other psychological therapy (from a Clinical/Trainee/Assistant Psychologist or other psychotherapist) during the time that you are involved with this research, however, it is still possible for you to receive another form of therapy once your involvement in this research has concluded. Taking part in the study will have no impact on the future care you receive from the Youth Team or NHS.

What are the possible disadvantages and risks of taking part?

The intervention being offered is being developed for this research and has only been tested on one individual before, so treatment benefits cannot be guaranteed, and the impact of the intervention is unknown. We cannot guarantee that you will benefit from taking part in the study. You are encouraged to say any concerns you have about this during your involvement in the research and are reminded that you are able withdraw at any point. As with any psychological therapy, you are likely to talk about things that you find upsetting. We also acknowledge that you will be giving up your time to take part in the study to receive the intervention and attend sessions to complete questionnaires and measures. Your total involvement in the study is expected to take approximately 7 hours and 45 minutes.

Unfortunately, we are unable to refund any travel expenses that you may incur when attending appointments as part of the research.

What are the possible benefits of taking part?

The intervention has been developed using existing treatments and it is not expected to cause any more distress than other routinely offered interventions. It is hoped that the intervention will be a positive and helpful experience for those receiving it, although this cannot be guaranteed. It is also hoped that this study will inform future research and practice within the NHS and so be helpful to individuals accessing support in the future. You can choose to be entered into a prize draw to win a £25 Amazon voucher, which will be won by one participant.

Will information be kept confidential?

All information will be private and safe, unless you tell us information which causes concern for yours or someone else's safety. In this case, the information would need to be passed onto a relevant professional, but we would attempt to discuss this with you before doing so. We will also ask you to give consent for your GP to be informed of your involvement in the study and for your wellbeing to be shared with the clinicians who are supporting you within the Youth Team, which is likely to be helpful for informing the care you receive from them.

All information about you will be stored securely and anonymously (with no identifying information, such as your name, included), you will be allocated a number. Electronic information will be stored on a password protected memory stick. All non-electronic data will be stored in a locked filing cabinet at the UEA and will be destroyed 10 years after the study is completed.

What will happen to the results of this research?

The results of the research will be written up as part of my doctoral thesis, it is hoped that they may also be published in academic journals or presented at conferences (all information will remain anonymous for this.) Ultimately, it is hoped that the results will be used to inform how future research on the intervention should be conducted and how the intervention might be improved for this.

Relevant Contact Details

Thank you for taking the time to read this information sheet, I hope you will decide to participate. If you have any questions, I would be very happy to discuss my project with you and can be contacted at: emma.burton@uea.ac.uk, or you can ask a member of staff from the Youth Team to get me to call you. If you would like to speak to one of my supervisors, please email: B.Teague@uea.ac.uk.

If you would like to speak to someone independent about taking part in this research, you could contact INVOLVE by telephone: 023 8059 5628, email: involve@nihr.ac.uk or their website: www.invo.org.uk.

If you are unhappy about the way you have been treated or wish to make a complaint, please contact me, using the details above, and I will do my best to resolve any problems. If you would like to complain formally you can contact the Patient Advice and Liaison Service (PALS) for further advice and information: 01603 421191 or pals@nsft.nhs.uk. Complaints can also be made directly to Professor Ken Laidlaw (Course Director, Doctoral Program in Clinical Psychology, UEA) by telephone: 01603 593600 or email: K.Laidlaw@uea.ac.uk.

Thank you for your interest in this study!

Appendix L: Morrison et al (2012) rates of recruitment

If the following criteria are met, the rates of recruitment and attrition/retention will be considered feasible in the current study:

- At least 51% of participants who consent are assessed as eligible

- 75% of participants who start the intervention complete it/all measures

Morrison et al (2012) assessed 634 potential participants for eligibility; 346 were excluded from the research. Of these, 36 were excluded due to taking anti-psychotic medication, which is not an exclusion criteria in the current study, thus these participants would have been included in this research. Consequently, for the purposes of this study, 310 participants would have been excluded (346 minus 36). As a percentage, this is 49% of participants. Therefore, 51% would have been included, so the pre-specified criteria will be defined as 51%.

Of the 144 participants who were allocated to the intervention arm of the Morrison et al (2012) study, 108 (75%) attended for four or more intervention sessions. The current study has only four intervention sessions, so the pre-specified feasibility criteria for completing the study will be 75%. Morrison et al., had also allowed for a 25% drop out rate in their study, which suggests this is an acceptable figure.

Morrison, A. P., French, P., Stewart, S. L. K., Birchwood, M., Fowler, D., Gumley, A. I., . . . Dunn. G. (2012). Early detection and intervention evaluation for people at risk of psychosis: multisite randomised controlled trial. *BMJ, 344,* e2233. doi:10.1136/bmj.e2233

Appendix M: Determining the Acceptability Criteria for the WAI-SR and WAI-SRT

With regards to the WAI-SR reported means range from 3.43 to 4.53 (e.g. (Karlin et al., 2015; White et al., 2011). Furthermore, Addington et al., (2011) used an earlier version of the WAI-SR (answers were rated out of seven, rather than five) with an ARMS population. They concluded that total subscale scores between 21 and 27 suggested a positive relationship. In this instance, the mean score on each item on the subscales would have been between 5.25 and 6.75 out of seven. Considering all of this together, it was decided that for the current study, a mean score of four for each subscale and overall score on the WAI-SR would be considered to indicate a positive therapeutic-alliance.

Likewise, for the WAI-SRT, studies have reported means for each of the subscales and the total score that vary between 3.33 and 4.75 (e.g. (Davison, 2008; McNaughton, 2016; Vizina-Roubal, 2017). Therefore, as with the WAI-SR, mean scores above four were considered to indicate a positive therapeutic-alliance.

Appendix N: Additional Fidelity Data

Commonly crossed items on the fidelity checklists (across sessions) included:

- Inviting participants to add items to the agenda

- Offering additional worksheets to encourage additional practice at home

- Young people being able to take the lead or requiring minimal prompting when completing tasks within session two.

Table 20 summarises the non-registered practitioners' qualitative feedback on the fidelity checklists, highlighting their perception of what went well in each session and what did not.

Table 20

Non-registered practitioners' qualitative feedback for each session on the fidelity checklists

Session Number	What went well	What did not go well
One	- Service-user participants engaged well, they were motivated, open and honest - Beginning to develop rapport - Service-users understood and attempted all tasks	- Worked through worksheets quickly, session did not last full hour - Two service-user participants found it difficult to identify different feelings associated with different interpretations of unusual experiences
Two	- Service-user participants were engaged - Developing a therapeutic-relationship - Most service-users had completed between-session task - Service-users identified changes they had made in response to session one: - Sharing difficulties with a parent (which was helpful) - Feeling less distressed in response to unusual-experiences - Different young people responded well to different parts, e.g. maintenance cycle, considering alternative explanations for unusual-experiences	- Some service-user participants struggled to identify alternative explanations for their unusual-experiences - One service-user seemed sceptical about the intervention and was unwilling to challenge some of their thoughts - One interventional-therapist found the paperwork interrupted the flow of the session and was time-consuming - One interventional-therapist was unable to follow the structure due to the service-user's presentation

Session Number	What went well	What did not go well
Three	- Service-user participants were engaged and generally positive - Service-users appeared more comfortable and able to be more open and honest than in previous sessions - One service-user attended the clinic for the first time (previous sessions had been at their home) - One service-user attended alone for the first time (previously they had always attended with a family-member) - Service-user participants seemed to have a better understanding of generating alternative explanations for their unusual-experiences than in session two.	- Several service-user participants had not completed the between-session tasks and/or had forgotten the worksheets - One service-user continued to present as sceptical - One participant disagreed that socialising can increase mood, seemingly disengaging at this point
Four	- Service-user participants were engaged - Interventional-therapists commented on the progress service-user participants had made, and how this had manifested in sessions. - Service-users reflected positively on the intervention - Service-users explored what they had learnt and considered how they would continue and develop this going forward. - Some service-users made plans for additional behavioural-experiments, others asked for additional alternative explanation worksheets	- Some service-user participants had not completed the between-session tasks and one had forgotten the worksheets - The ending was experienced as difficult by some service-user and interventional-therapist participants

Appendix O: Additional SRS and WAI-SR(T) Data

The SRS data was considered for each participant individually for all sessions. Table 21 shows that four participants (50%) rated all subscales for all the sessions they attended at an acceptable level. One participant's total score was below the cut-off of 36 for all sessions. Considering the total score for every session conducted (regardless of session number), nine out of the 31 sessions rated (29.03%) could be considered a source of concern.

The mean scores for each of the subscales and the total scale for each participant on the WAI-SR and the WAI-SRT are shown in table 22.

Table 21

Participants' total scores on the SRS along with details of subscales rated below the cut-off

Participant	Session One		Session Two		Session Three		Session Four	
	Total Score	Subscales below cut-off (score)	Total Score	Subscales below cut-off (score)	Total Score	Subscales below cut-off (score)	Total Score	Subscales below cut-off (score)
SU1	**35**	Goals/Topic (8) Overall (8)	40	None	40	None	39	None
SU2	40	None	40	None	40	None	40	None
SU3	40	None	40	None	40	None	40	None
SU4	**35**	Overall (7)	**34**	Goals/Topic (8) Approach/Method (8) Overall (8)	**34**	Approach/Method (8) Overall (8)	**29**	Relationship (8) Goals/Topic (8) Approach/Method (8) Overall (8)
SU5	37	Overall (8)	**31**	Goals/Topic (5) Overall (6)	**35**	Overall (6)	40	None
SU6	38	None	**35**	Relationship (8)	**35**	Goals/Topic (8) Overall (8)	40	None
SU7	40*	None	40*	None	40	None	40	None
SU8	40	None	40	None	40	None	Missing	

* Indicates one piece of missing data (replaced with the average score). Total Scores in bold are below the cut-off (Duncan et al., 2003).

Table 22

Mean subscale and total scores on the WAI-SR and WAI-SRT for each service-user participant, along with the overall

means for each subscale and total score

Service-user Participant	WAI-SR (Self-rated) Mean (SD)				WAI-SRT (Therapist Rated) Mean (SD)			
	Bond	Goals	Task	Total	Bond	Goals	Task	Total
SU1	5.00 (0)	4.75 (0.50)	4.25 (0.96)	4.67 (0.65)	5.00 (0)	4.33 (0.58)	4.33 (0.58)	4.60 (0.52)
SU2	5.00 (0)	5.00 (0)	5.00 (0)	5.00 (0)	5.00 (0)	**3.33 (1.15)**	**3.67 (0.58)**	4.10 (0.99)
SU3	5.00 (0)	4.75 (0.50)	**3.25 (1.26)**	4.33 (1.07)	5.00 (0)	4.33 (0.58)	**3.67 (0.58)**	4.40 (0.70)
SU4	**3.75 (0.96)**	**3.25 (0.96)**	**2.25 (0.50)**	**3.08 (1.00)**	5.00 (0)	**3.33 (0.58)**	**3.33 (0.58)**	4.00 (0.94)
SU5	4.50 (0.58)	4.25 (0.96)	**2.25 (0.50)**	**3.67 (1.23)**	5.00 (0)	4.33 (0.58)	4.33 (0.58)	4.6 (0.52)
SU6	**3.25 (1.50)**	5.00 (0.00)	**3.25 (0.96)**	**3.83 (1.27)**	5.00 (0)	4.67 (0.58)	5.00 (0)	4.90 (0.32)
SU7	Missing				5.00 (0)	4.33 (0.58)	4.33 (0.58)	4.60 (0.52)

Means in bold are below the pre-defined target of 4.00.

Appendix P: Additional data from the service user experience questionnaire

Service user participants used a five-point Likert Scale to indicate their agreement/disagreement with several statements. Figures 10 and 11 show the frequency of responses to statements about the intervention and research respectively

Figure 10

Frequency of participants' responses to questions about the intervention
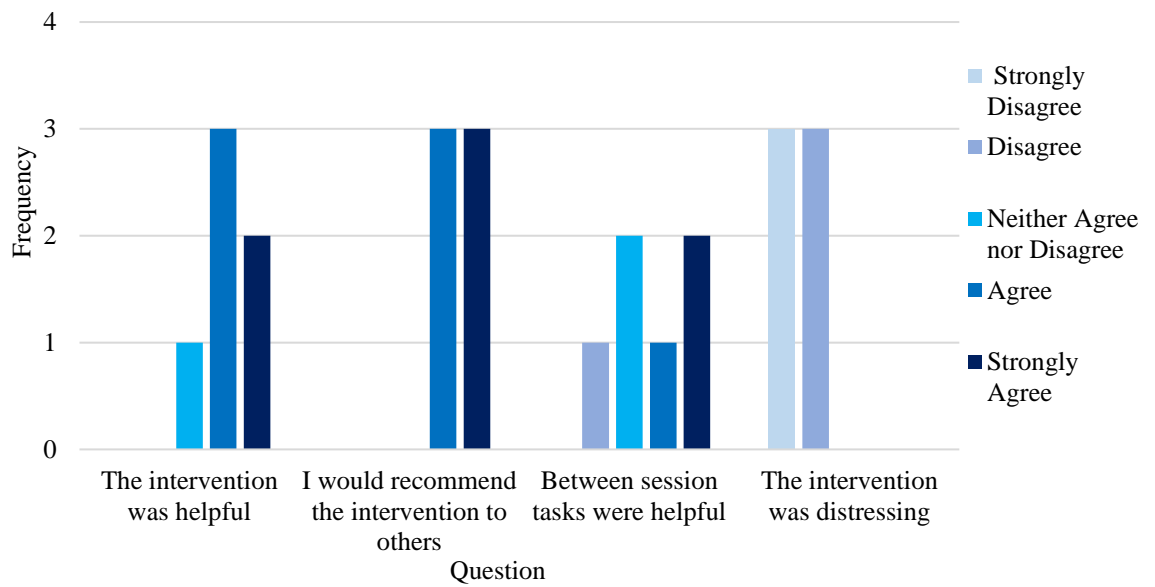
Figure 11

Frequency of participants' responses to questions about the intervention
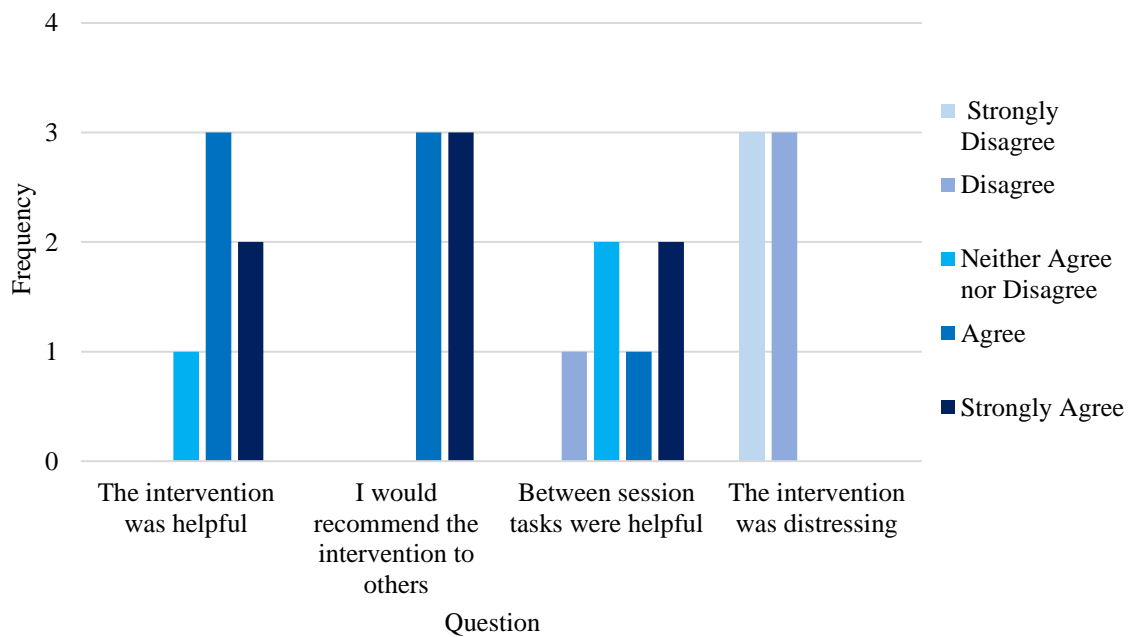
Appendix Q: Illustrative example of framework analysis

The analysis conducted on the qualitative data from the service-user participants' experience questionnaire is shown below. This is to illustrate how framework analysis was conducted for this portfolio, highlighting the various steps.

The cells vary in colour; each colour relates to a different participant.

Identified Framework and Indexing the Data

What changed	Positives of intervention	Negatives of Intervention	What helped	Routine care	Research
When I'm walking home at night in the dark, I don't feel as paranoid, as I use the alternative thoughts.	It was very relaxed	How much we repeated what we had done in the previous session, went through this in too much depth.	Alternative thoughts	I think they should do it,	They can be vague - think about asking them to a younger person.
I've been able to rationalise a lot of things, which has reduced how much I've been hearing voices and stuff.	Felt comfortable	I struggled to find the time to do the activity diary.	It made me feel more confident and comfortable talking about unusual experiences and what was going on.		I think it's good. I think it's honestly really good - it has helped.
It helped me look at things from a different view point.	I didn't feel nervous.				
It helped me to understand what was going on in my head and the causes.					
It made me feel more confident and comfortable talking about unusual experiences and what was going on					
it helps me look differently at all of the unusual experiences - helped reduce them as I've thought about them more.					

What changed	Positives of intervention	Negatives of Intervention	What helped	Routine care	Research
Now, I think about what is happening at the moment and avoid situations that cause them.					
Things feel much brighter and more positive, things used to feel really pointless and dull, but I now feel more upbeat.					
Yeah. I could trust someone - I could tell her about my coping strategy, talk about it.	The diary thing (Activity Diary) - she wanted to know what I was doing.	The thought diary = difficult.	Having someone to talk to. Easy. Helpful.	Good thing -	Relationship. Someone to talk to.
I have been using my coping strategy and this has helped to stop my voices, helped me not self-harm	The relationship with **** - having someone to talk to and being able to trust someone	The content of some of the worksheets - wasn't sure what they were about.	Not stressful	help people to keep busy with their homework.	All been ok
		Thought Diary		Diary thing - can write it down, then the counsellor will know what they are doing.	Good - talk to people - got researcher and *****, can talk to them about stuff. Can trust people.
Yes, the unusual experiences have become less common	I liked how well **** and I got on and how easy he was to talk to.	I didn't have time for the between session tasks	Made me realise that other people experience stuff and it's not just me.	I think, if given the opportunity, they should take it as it has potential to be a possibly lifesaving intervention	For me, very successful, as I feel like I can manage better if they come up again.
I feel like I can manage better if they come up again.		I think if I wasn't put with ****, I would have found it more difficult to talk about it.			

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What changed	Positives of intervention	Negatives of Intervention	What helped	Routine care	Research
Yes - I am trying to be more accepting of the fact that causes to my experiences may be down to simpler reasons that I'd like to believe.	The fact you look directly at unusual experiences and try to dissect them a bit more than you probably would on your own.	It does cover looking at unusual experiences and links with activity, but I disliked there wasn't links to things like diet	Breaking down the unusual experience, i.e. what was happening, what it was, what emotions linked in - being able to see the experience in a smaller, explainable way.	I think this intervention may young people get a better grasp and understanding on their unusual experiences early on which would help overall.	Think they could be a bit clearer/simpler or provide more examples to help.
I'm finding it slightly easier to explain my experiences now I've written them down and looked over them		I felt there wasn't enough analyse done on the links between mood/activity in regards to unusual experiences.		t may make it easier for them to discuss unusual experiences, especially once they've had the chance to break them down and understand them more themselves.	
		The simple feedback questions asked about the between session tasks - felt like could have been more in depth/more analyse.		I think it's a good starting point in helping people understand and to help them generate different viewpoints on their unusual experiences.	
		The activity diary - more room to write and maybe include diet.		I think it will set them up with some good tools to use	

What changed	Positives of intervention	Negatives of Intervention	What helped	Routine care	Research
				However, it is more of just a starting point for some and some would need more help analysing what they've learnt, and some would need help on how they would keep using these tools once the sessions had ended.	
I feel it has decreased my unusual experiences as I can understand/notice the triggers more, so it makes me accept them more and less prone to them	The introductions and the goal setting/chance to have control in objectives	Maybe too short		I think it would be good,	Some of them seemed quite random but then again wouldn't be for some people and they might think that with ones I found helpful
	space to openly discuss	a lot of paperwork	I thought it was helpful and made me address things I haven't thought are relevant before.	maybe a starting appointment without therapy (before) to introduce the therapy/structure and meet therapist.	Good having research appointments
		wasn't sure about the sheets for homework (would have preferred to not have to write for homework)			Really helpful and interesting :)
		Would have found more discussion on what to do during experiences			

What changed	Positives of intervention	Negatives of Intervention	What helped	Routine care	Research
		Would have preferred more talking and less sheets.			
I haven't noticed any changes. I already knew most of the information, because my Dad is a nurse and helps me.	Having goals set.	Nothing really	***** - I found her helpful, her tone, how she spoke, that she was friendly.	I think it is good - not everyone else has a nurse as a Dad and it can be scary if you don't know what is going on.	Helps people to get an understanding of what is going on
	Having support.	It was all important	Having small goals and building up to them	It's good for people to be told it's going to be ok.	Think it's good - new approach to methods is good.,
	I liked that there was lots of information			Goals - help people - slowly go back to being functional	I like it because it takes a lot of information
				will be good for people	People involved in the research are friendly
				people don't get lost in the crowd.	
				People get a true understanding of what is going on	

Charting Data

What changed	Positives of intervention	Negatives of Intervention	What helped	Routine care	Research
Feel less paranoid	very relaxed	Too much repetition from previous session	Alternative thoughts	I think they should do it,	RQs can be vague - think about asking them to a younger person.
Rationalising things	Felt comfortable	Difficult to find time for activity diary	Identifying triggers, avoiding them		I think it's good. I think it's honestly really good
Reduced how much I've been hearing voices and stuff. Reduced unusual experiences	I didn't feel nervous.		It made me feel more confident and comfortable talking about unusual experiences and what was going on.		It has helped
Look at things and UEs differently			Thinking about UEs		
Understand what was going on in my head			Rationalising things		
Understand the causes			It has helped		
Avoid triggers					
more confident and comfortable talking about unusual experiences					
Thinking about Ues more = reduced them					
Now, I think about what is happening at the moment					

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What changed	Positives of intervention	Negatives of Intervention	What helped	Routine care	Research
Things feel much brighter and more positive, things used to feel really pointless and dull, but I now feel more upbeat.					
Someone to trust, someone to talk to, tell difficult things	The diary thing (Activity Diary) - she wanted to know what I was doing.	The thought diary = difficult.	Having someone to talk to. Easy. Helpful.	Good thing -	Relationship. Someone to talk to.
I have been using my coping strategy	The relationship with ***** - having someone to talk to and being able to trust someone	The content of some of the worksheets - wasn't sure what they were about.	Not stressful	help people to keep busy with their homework.	All been ok
Helped stop voices			Someone interested	Diary thing - can write it down, then the counsellor will know what they are doing.	Good - talk to people - got researcher and *****, can talk to them about stuff. Can trust people.
Helped stop self-harm					
Use = less common	I liked how well ***** and I got on and how easy he was to talk to.	I didn't have time for the between session tasks	other people experience stuff and it's not just me.	I think, if given the opportunity, they should take it	For me, very successful,
I can manage better if they come up again.		I think if I wasn't put with *****, I would have found it more difficult to talk about it.		Has potential to be a possibly lifesaving intervention	

What changed	Positives of intervention	Negatives of Intervention	What helped	Routine care	Research
Trying to accept that the causes to my experiences may be down to simpler reasons that I'd like to believe.	Looking directly at UEs - dissect them more than you would on your own	Link UEs to diet	Breaking down the unusual experience, i.e. what was happening, what it was, what emotions linked in - being able to see the experience in a smaller, explainable way.	I think this intervention may young people get a better grasp and understanding on their unusual experiences early on which would help overall.	Think they could be a bit clearer/simpler or provide more examples to help.
I'm finding it slightly easier to explain my experiences now I've written them down and looked over them	Writing down and looking at Ues	not enough analyse done on links between mood/activity in regards to UEs	Being able to see the experience in a smaller explainable way	make it easier for them to discuss unusual experiences, especially once they've had the chance to break them down and understand them more themselves.	
	UEs and links with activity	The simple feedback questions asked about between session tasks - could have been more in depth/more analyse.	Writing down and looking at UEs	Chance to break down UEs and understand them more	
		The activity diary - more room to write and maybe include diet.		I think it will set them up with some good tools to use	
				more of just a starting point for some	

What changed	Positives of intervention	Negatives of Intervention	What helped	Routine care	Research
				I think it's a good starting point in helping people understand and to help them generate different viewpoints on their unusual experiences.	
				Some would need more help analysing what they've learnt	
				some would need help on how they would keep using these tools once the sessions had ended.	
decreased my unusual experiences	The introductions and the goal setting/chance to have control in objectives	Maybe too short	Helpful	I think it would be good,	Some of them seemed quite random but then again wouldn't be for some people and they might think that with ones I found helpful
I can understand/notice the triggers to my UEs more	space to openly discuss	a lot of paperwork	made me address things I haven't thought are relevant before.	maybe a starting appointment without therapy (before) to introduce the therapy/structure and meet therapist.	Good having research appointments
makes me accept my UEs more and less prone to them		wasn't sure about the sheets for homework (would have preferred to not have to write for homework)			Really helpful and interesting :)

What changed	Positives of intervention	Negatives of Intervention	What helped	Routine care	Research
		more discussion on what to do during experiences			
		more talking and less sheets.			
I haven't noticed any changes. I already knew most of the information, because my Dad is a nurse and helps me.	Having goals set.	Nothing really	***** - I found her helpful, her tone, how she spoke, that she was friendly.	I think it is good -	Helps people to get an understanding of what is going on
	Having support.	It was all important	Having small goals and building up to them	It's good for people to be told it's going to be ok.	Think it's good - new approach to methods is good.,
	lots of information			Goals - help people - slowly go back to being functional	I like it because it takes a lot of information
				will be good for people	People involved in the research are friendly
				people don't get lost in the crowd.	
				People get a true understanding of what is going on	
				not everyone else has a nurse as a Dad and it can be scary if you don't know what is going on.	

Mapping and Interpretation of the Data

Relationship and someone to talk to	Reduced Symptoms	Cognitive tools = helpful	Between Session Tasks	Routine Care	Research	Improvements	Helpful
more confident and comfortable talking about unusual experiences = helpful	Feel less paranoid	Rationalising things	Difficult to find time for activity diary	I think they should do it,	RQs can be vague - think about asking them to a younger person.	Too much repetition from previous session	It has helped
very relaxed	Reduced how much I've been hearing voices and stuff. Reduced unusual experiences	Look at things and UEs differently	The diary thing (Activity Diary) - she wanted to know what I was doing.	Good thing -	I think it's good. I think it's honestly really good	The thought diary = difficult.	I have been using my coping strategy
Felt comfortable	Avoid triggers	Understand what was going on in my head	help people to keep busy with their homework.	I think, if given the opportunity, they should take it	It has helped	The content of some of the worksheets - wasn't sure what they were about.	I can manage better if they come up again.
I didn't feel nervous.	Thinking about UEs more = reduced them	Understand the causes	Diary thing - can write it down, then the counsellor will know what they are doing.	has potential to be a possibly life saving intervention	All been ok	Link UEs to diet	other people experience stuff and it's not just me. (normalising)
Someone to trust, someone to talk to, tell difficult things	Now, I think about what is happening at the moment	Alternative thoughts	I didn't have time for the between session tasks	help young people get a better grasp and understanding on their unusual experiences **early** on which would help overall.	For me, very successful,	not enough analyse done on links between mood/activity in regard to UEs	Very successful

Relationship and someone to talk to	Reduced Symptoms	Cognitive tools = helpful	Between Session Tasks	Routine Care	Research	Improvements	Helpful
The relationship with ***** - having someone to talk to and being able to trust someone	Things feel much brighter and more positive, things used to feel really pointless and dull, but I now feel more upbeat.	Identifying triggers, avoiding them	UEs and links with activity = helpful	make it easier for them to discuss unusual experiences	Think they could be a bit clearer/simpler or provide more examples to help.	Maybe too short	Trying to accept that the causes to my experiences may be down to simpler reasons that I'd like to believe.
Having someone to talk to. Easy. Helpful.	Helped stop voices	I'm finding it slightly easier to explain my experiences now I've written them down and looked over them	The simple feedback questions asked about between session tasks -could have been more in depth/more analyse.	Chance to break down Ues and understand them more	Some of them seemed quite random but then again wouldn't be for some people and they might think that with ones I found helpful	a lot of paperwork. More talking, less sheets	The introductions and the goal setting/chance to have control in objectives
Not stressful	Helped stop self-harm	Looking directly at UEs - dissect them more than you would on your own	The activity diary - more room to write and maybe include diet.	I think it will set them up with some good tools to use	Good having research appointments	wasn't sure about the sheets for homework (would have preferred to not have to write for homework)	Helpful
Someone interested	Ues = less common	Writing down and looking at Ues		More of just a starting point for some	Really helpful and interesting :)	more discussion on what to do during experiences	made me address things I haven't thought are relevant before.

Relationship and someone to talk to	Reduced Symptoms	Cognitive tools = helpful	Between Session Tasks	Routine Care	Research	Improvements	Helpful
Relationship. Someone to talk to.	decreased my unusual experiences	Breaking down the unusual experience, i.e. what was happening, what it was, what emotions linked in - being able to see the experience in a smaller, explainable way.		good starting point in helping people understand and to help them generate different viewpoints on their UEs.	Helps people to get an understanding of what is going on	maybe a starting appointment without therapy (before) to introduce the therapy/structure and meet therapist.	I haven't noticed any changes. I already knew most of the information, because my Dad is a nurse and helps me.
Good - talk to people - got researcher and *****, can talk to them about stuff. Can trust people.		Writing down and looking at Ues		Some would need more help analysing what they've learnt	Think it's good - new approach to methods is good.,	Nothing really	Having goals set.
I liked how well ***** and I got on and how easy he was to talk to.		I can understand/notice the triggers to my UEs more		some would need help on how they would keep using these tools once the sessions had ended.	I like it because it takes a lot of information	It was all important	lots of information
I think if I wasn't put with *****, I would have found it more difficult to talk about it.		makes me accept my UEs more and less prone to them		I think it would be good,			Having small goals and building up to them
space to openly discuss				I think it is good -			

Relationship and someone to talk to	Reduced Symptoms	Cognitive tools = helpful	Between Session Tasks	Routine Care	Research	Improvements	Helpful
Having support.				It's good for people to be told it's going to be ok.			
***** - I found her helpful, her tone, how she spoke, that she was friendly.				Goals - help people - slowly go back to being functional			
People involved in the research are friendly				will be good for people			
				people don't get lost in the crowd.			
				People get a true understanding of what is going on			
				not everyone else has a nurse as a Dad and it can be scary if you don't know what is going on.			

Appendix R: Calculations of Reliable Change: CORE-OM

Reliable change calculations were conducted by hand using the following formula proposed by Jacobson and Truax, (1991):

$$RC = \frac{X_2 - X_1}{S_{DIFF}}$$

Where, $S_{DIFF} = \sqrt{2}(S_E)^2$

And, $S_E = SD \sqrt{1 - \alpha}$

Key for these calculations

RC = Reliable Change

X_1 = Participant's Pre-Intervention Mean

X_2 = Participant's Post-Intervention Mean

S_{DIFF} = Standard Error of Difference between the two means

S_E = Standard Error of the Measurement

SD = Standard Deviation from the Normative Sample

α = Alpha Coefficient from the Normative Sample

Wellbeing Subscale

SD from Normative Sample: 0.96

Alpha Coefficient from Normative Sample: 0.75

$S_E = 0.96 \sqrt{1-0.75}$

$S_E = 0.96 \sqrt{0.25}$

$S_E = 0.96 \times 0.9$

$S_E = 0.48$

$S_{DIFF} = \sqrt{2}(0.48^2)$

$S_{DIFF} = \sqrt{2} \times 0.2304$

$S_{DIFF} = \sqrt{0.4608}$

$S_{DIFF} = 0.68$

SU1

Pre-Intervention Mean Score: 3.25

Post-Intervention Mean Score: 2.5

RC = $\dfrac{2.5 - 3.25}{0.68}$

RC = -1.10

SU2

Pre-Intervention Mean Score: 1.75

Post-Intervention Mean Score: 1.5

RC = $\dfrac{1.5 - 1.75}{0.68}$

RC = -0.37

SU3

Pre-Intervention Mean Score: 4.00

Post-Intervention Mean Score: 3.75

RC = $\dfrac{3.75 - 4.00}{0.68}$

RC = -0.37

SU4

Pre-Intervention Mean Score: 3.50

Post-Intervention Mean Score: 2.00

RC = $\dfrac{2.00 - 3.50}{0.68}$

RC = -2.21

SU5

Pre-Intervention Mean Score: 3.00

Post-Intervention Mean Score: 3.00

RC = $\dfrac{3.00 - 3.00}{0.68}$

RC = 0

SU6

Pre-Intervention Mean Score: 3.25

Post-Intervention Mean Score: 3.50

$RC = \dfrac{3.50 - 3.25}{0.68}$

RC = 0.37

Symptoms Subscale

SD from Normative Sample: 0.88

Alpha Coefficient from Normative Sample: 0.88

$S_E = 0.88 \sqrt{1-0.88}$

$S_E = 0.88 \sqrt{0.12}$

$S_E = 0.88 \times 0.3464$

$S_E = 0.30$

$S_{DIFF} = \sqrt{2(0.30^2)}$

$S_{DIFF} = \sqrt{2 \times 0.09}$

$S_{DIFF} = \sqrt{0.18}$

$S_{DIFF} = 0.42$

SU1

Pre-Intervention Mean Score: 2.58

Post-Intervention Mean Score: 2.17

$RC = \dfrac{2.17 - 2.58}{0.42}$

RC = -0.98

SU2

Pre-Intervention Mean Score: 2.58

Post-Intervention Mean Score: 2.42

$RC = \dfrac{2.42 - 2.58}{0.42}$

RC = -0.38

SU3

Pre-Intervention Mean Score: 3.33

Post-Intervention Mean Score: 2.75

$RC = \dfrac{2.75 - 3.33}{0.42}$

RC = -1.38

SU4

Pre-Intervention Mean Score: 2.50

Post-Intervention Mean Score: 2.42

$RC = \dfrac{2.42 - 2.50}{0.42}$

RC = -0.19

SU5

Pre-Intervention Mean Score: 3.17

Post-Intervention Mean Score: 2.75

$RC = \dfrac{2.75 - 3.17}{0.42}$

RC = -1.00

SU6

Pre-Intervention Mean Score: 4.00

Post-Intervention Mean Score: 3.83

$RC = \dfrac{3.83 - 4.00}{0.42}$

RC = -0.40

Functioning Subscale

SD from Normative Sample: 0.84

Alpha Coefficient from Normative Sample: 0.87

$S_E = 0.84\sqrt{1-0.87}$

$S_E = 0.84 \sqrt{0.13}$

$S_E = 0.84 \times 0.3606$

$S_E = 0.30$

$S_{DIFF} = \sqrt{2(0.30^2)}$

$S_{DIFF} = \sqrt{2} \times 0.09$

$S_{DIFF} = \sqrt{0.18}$

$S_{DIFF} = 0.42$

SU1

Pre-Intervention Mean Score: 2.83

Post-Intervention Mean Score: 2.00

$RC = \dfrac{2.00 - 2.83}{0.42}$

RC = -1.98

SU2

Pre-Intervention Mean Score: 1.92

Post-Intervention Mean Score: 0.92

$RC = \dfrac{0.92 - 1.92}{0.42}$

RC = -2.38

SU3

Pre-Intervention Mean Score: 2.92

Post-Intervention Mean Score: 1.67

$RC = \dfrac{1.67 - 2.92}{0.42}$

RC = -2.98

SU4/SU5

Pre-Intervention Mean Score: 2.67

Post-Intervention Mean Score: 2.58

$RC = \dfrac{2.58 - 2.67}{0.42}$

RC = -0.21

SU6

Pre-Intervention Mean Score: 2.58

Post-Intervention Mean Score: 3.17

$RC = \dfrac{3.17 - 2.58}{0.42}$

RC = 1.40

Risk Subscale

SD from Normative Sample: 0.75

Alpha Coefficient from Normative Sample: 0.79

$S_E = 0.75\sqrt{1 - 0.79}$

$S_E = 0.75\,\sqrt{0.21}$

$S_E = 0.75 \times 0.46$

$S_E = 0.35$

$S_{DIFF} = \sqrt{2(0.35^2)}$

$S_{DIFF} = \sqrt{2} \times 0.1225$

$S_{DIFF} = \sqrt{0.25}$

$S_{DIFF} = 0.49$

SU1

Pre-Intervention Mean Score: 1.50

Post-Intervention Mean Score: 0.67

$RC = \dfrac{0.67 - 1.50}{0.49}$

RC = -1.69

SU2

Pre-Intervention Mean Score: 1.50

Post-Intervention Mean Score: 0.83

$RC = \dfrac{0.83 - 1.50}{0.49}$

RC = -1.37

SU3

Pre-Intervention Mean Score: 3.00

Post-Intervention Mean Score: 2.83

$$RC = \frac{2.83 - 3.00}{0.49}$$

RC = -0.35

SU4

Pre-Intervention Mean Score: 1.67

Post-Intervention Mean Score: 1.17

$$RC = \frac{1.17 - 1.67}{0.49}$$

RC = -1.02

SU5

Pre-Intervention Mean Score: 0.33

Post-Intervention Mean Score: 0.50

$$RC = \frac{0.50 - 0.33}{0.49}$$

RC = 0.35

SU6

Pre-Intervention Mean Score: 1.83

Post-Intervention Mean Score: 1.83

$$RC = \frac{1.83 - 1.83}{0.49}$$

RC = 0.00

Appendix S: Staff Participant Non-Validated Questionnaire

One of the aims of this research is to seek the opinions of clinicians who work in NSFT Youth Teams. We are interested to hear your thoughts on the intervention that has been developed and on the research that is being conducted. This will help us to decide whether a bigger piece of research on the intervention should be done in the future and whether we should consider training clinicians to offer the intervention as part of routine care in the NHS.

To help us with this, we would really appreciate it if you could complete the following questionnaire.

Introduction to the intervention

As explained in the participant information sheet, this research has developed an intervention for young people who are experiencing At Risk Mental State (ARMS) and are having attenuated psychotic symptoms, often referred to as unusual perceptual experiences and thoughts that they are finding odd and distressing. The intervention has been developed in response to claims in the academic literature that psychological interventions are one of the most effective ways of treating ARMS, but are often unavailable due to their cost and the length of time they take. This research has aimed to develop a brief intervention with the hope of increasing the accessibility of psychological therapy for young people with ARMS.

The intervention that has been developed is a manualised four session intervention with each session lasting for approximately an hour. Four practitioners (without previous training in psychotherapy) will be trained to deliver it for this stage of the research. Details of the content of the intervention are as follows:

- Some basic Cognitive Behavioural Therapy (CBT) principles will be adopted.
- Young people will be supported to understand the unusual experiences they are having, through exploring them and their possible meanings. (normalisation)
- The clinicians delivering the intervention will offer information about the prevalence of unusual experiences and the idea of them being on a continuum with 'normal' experiences. They will also provide the young people with information about the outcomes for people who experience psychotic type symptoms, explaining that in most cases these resolve and do not result in psychosis. (Psychoeducation)

- Biological explanations for unusual experiences will also be considered. (Psychoeducation)

- The clinician delivering the intervention will work with the young person to develop a simple CBT formulation of their difficulties with an emphasis placed on the interpretation of unusual experience and how this may increase distress, resulting in further symptoms. (formulation)

- The intervention will consider the impact of the young person's symptom on their social activity and the impact of this on how they feel. Young people will be supported to increase their social participation. (Increasing social activity)

- A key focus throughout the intervention will be on the non-catastrophising and normalising approach taken by the intervention clinician. There will also be an emphasis on the development of a strong therapeutic alliance between the clinician and the young person. The clinician will aim to achieve this through showing warmth and having an empathetic understanding and acceptance of the young person's difficulties. (Therapeutic relationship)

Overall, I believe that the intervention will be helpful for young people with ARMS.

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

I would consider referring the young people who I work with to the intervention if they were experiencing symptom of ARMS

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

I would be interested in being trained to deliver the intervention

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

Considering that this intervention is trying to strike a balance between being brief to increase its availability whilst still being effective and helpful to young people, I believe that 4 intervention sessions is….

| Not enough | The right number | Too many |

I believe that one hour sessions are….

Too short   The right length   Too long

How helpful do you believe each component of the intervention will be? (Please refer to the 'introduction to the intervention' for details of each component.)

	Very Unhelpful	Unhelpful	Neither helpful nor unhelpful	Helpful	Very Helpful
Psychoeducation					
Normalisation					
The therapeutic relationship					
Formulation					
Increasing social activity					
Between session tasks					

What do you like about the intervention?

_____

_____

_____

_____

_____

_____

What do you dislike about the intervention?

_____

_____

_____

_____

_____

_____

Would you make any changes to the intervention? If so, what would these be?

_____

_____

_____

_____

_____

What is your opinion of the intervention being offered as part of routine care in the Youth Team?

_____

_____

_____

_____

_____

What is your overall opinion of this research?

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire.

Your views and opinions will help us to evaluate the acceptability of the intervention we have developed and whether this should be modified or changed. They will also help us to determine whether future research should be conducted in this area and if so the best ways of doing this.

If you have any concerns or queries after completing this survey please contact either:

The Chief Investigator: Emma Burton, Trainee Clinical Psychologist: emma.burton@uea.ac.uk

Primary Academic Supervisor: Dr Bonnie Teague, Senior Teaching Fellow in Research Methods at UEA: B.Teague@uea.ac.uk.

Dr Tim Clarke or Dr Rebecca Lower (Clinical Psychologists), NSFT Central Norfolk Youth Team: (01603) 201400

Appendix T: Non-Registered Practitioners Non-Validated Questionnaire

One of the aims of this research is to see how clinicians experience delivering the intervention that has been developed, and their thoughts on the research more generally. This will help us to decide whether a bigger piece of research on the intervention should be done in the future and whether we should consider training clinicians to offer the intervention as part of routine care in the NHS.

To help us with this, we would really appreciate it if you could answer the following questions.

Questions about delivering the intervention

For questions 1 – 4, please circle your answer to indicate how much you agree with each statement.

1. Overall, I believe that the intervention was helpful to the young people who I delivered it to.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

2. The training I received on the intervention meant that I felt confident delivering it.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

3. It was difficult to be consistent with the manual when delivering the intervention

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

4. I would offer the intervention to other young people with symptoms of ARMS in the future

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

For questions 5 and 6, please circle your answer

5. I found that having 4 intervention sessions was….

Not enough	The right number	Too many

6. I found that 1 hour long sessions was….

    Too short   The right length   Too long

7. How helpful would you rate each component of the intervention? Please indicate your answer by putting a cross in the appropriate box for each aspect.

	Very Unhelpful	Unhelpful	Neither helpful nor unhelpful	Helpful	Very Helpful
Psychoeducation					
Normalisation					
The therapeutic relationship					
Formulation					
Increasing social activity					
Between session tasks					

For questions 8 - 12, please write your answer in the space provided. If you require more space, please use a blank sheet of paper, making sure to write the question number on this.

8. How do you think the intervention impacted on the young people who received it? Do you think that there were changes in their symptoms as a result of receiving the intervention? If so please describe these changes.

_____

_____

_____

_____

9. What did you like about the intervention?

_____

_____

_____

10. What did you dislike about the intervention?

_____

_____

_____

11. Would you make any changes to the intervention? If so, what would these be?

_____

_____

_____

_____

12. What is your opinion of the intervention being offered as part of routine care in the Youth Team?

_____

_____

_____

_____

Questions about the research

For questions 13 and 14, please circle your answer to indicate how much you agree with each statement.

13. Overall, I am pleased that I was involved in the research

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

14. I think that future research should be carried out on the intervention

| Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |

For question 15, please write your answer in the space provided. If you require more space, please use a blank sheet of paper, making sure to write the question number on this.

15. What is your overall opinion of this research? What are your thoughts on how future research on the intervention should be conducted?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire.

Appendix U: Staff Participant Information Sheet for Research

University of East Anglia

Study Title: *Assessing the feasibility of a brief novel intervention for young people with At Risk Mental State and attenuated positive psychotic symptoms: The viability of its use in the NHS and of a future trial*

Name of Researcher: *Emma Burton, Trainee Clinical Psychologist, University of East Anglia (UEA)*

Research Supervisors: *Dr Bonnie Teague (Senior Teaching Fellow in Research Methods at UEA), Dr Richard Meiser-Stedman (Reader in Clinical Psychology at UEA) and Dr Timothy Clarke (Clinical Psychologist at Norfolk and Suffolk NHS Foundation Trust, (NSFT)).*

What is the purpose of the study?

This study aims to develop and trial a brief intervention for young people (aged 16-25) who are considered to have an At Risk Mental State (ARMS) (that is, they are at a high but not inevitable risk of psychosis). The intervention will be designed for individuals experiencing attenuated positive psychotic symptoms, who will be experiencing the perceptual disturbances, such as hallucinations, associated with psychosis, but they will be at a lower frequency or intensity than if they were experiencing florid psychosis.

Research has shown that psychological therapy for young people who are experiencing these symptoms can help in reducing them and prevent them from getting worse and leading to psychosis. The literature suggests that brief and simple interventions with a therapist who is warm and accepting and helps the young person to understand their unusual experiences through psychoeducation and normalisation, may be helpful in reducing these symptoms. Such an intervention would be relatively cheap (due to being brief and not requiring specialist therapists) and thus, it is hoped that it would increase the availability of psychological therapies for young people with ARMS.

This study aims to develop an intervention that is consistent with the one just outlined. It aims to assess how young people with ARMS experience the intervention and being part of

a study investigating it. It also seeks to understand what clinicians working in youth teams think about such an intervention. It is hoped that the findings from this study will inform whether a future larger scale piece of research can be conducted on the intervention and whether it could be adopted as part of routine clinical care within NHS Youth Teams.

Why have I been chosen to take part?

You have been asked to participate in this research, as you are a clinician working in a NHS Youth Team. We are interested in hearing the opinions of the clinicians who work in the teams where the intervention is intended to be delivered.

Do I have to take part?

It is important that you are aware that being involved in the study is voluntary. Even if you consent to take part, you are able to withdraw from the research, without giving a reason, at any point, up until you submit your survey.

What would participation involve?

If you would like to participate in the study, you are directed to the following website: …..
Where you will be asked to give consent to participate. You will then be asked to complete an online survey, asking you about your views on particular aspects of the intervention that is being developed as part of this research.

What are the possible risks/disadvantages of taking part?

Completing the questionnaire will require you to give up approximately 30 minutes to complete the survey. Your total involvement in the study, including reading this information sheet, completing an online consent form and reading a debrief statement is not expected to exceed one hour 10 minutes.

What are the possible benefits of taking part?

It is hoped that this study will inform future research and practice within the NHS and therefore, be helpful to individuals accessing support in the future.

Will my participation in the research be kept confidential?

Your answers will be completely anonymous and you will **not** be asked to give your name. When completing the online consent form, you will be asked to tick this, rather than

providing your initials or name, this is to protect your anonymity. You will have the option of giving your job role, but this is optional.

Electronic information will be stored on a password protected memory stick. All non-electronic data will be stored in a locked filing cabinet at the UEA and will be destroyed 10 years after the study is completed.

What will happen to the results of this research?

The results of the research will be written up as part of my doctoral thesis, it is hoped that they may also be published in academic journals or presented at conferences (all information will remain anonymous for this.) Ultimately, it is hoped that the results will be used to inform how future research on the intervention should be conducted and how the intervention might be improved for this.

Relevant Contact Details

Thank you for taking the time to read this information sheet, I hope you will decide to participate. If you have any questions, I would be very happy to discuss my project with you and can be contacted at: emma.burton@uea.ac.uk. If you would like to speak to one of my supervisors, please email: B.Teague@uea.ac.uk.

If you are unhappy about the way you have been treated or wish to make a complaint, please contact me, using the details above, and I will do my best to resolve any problems. If you would like to complain formally you can contact Professor Ken Laidlaw (Course Director, Doctoral Program in Clinical Psychology, UEA) by telephone: 01603 593600 or email: K.Laidlaw@uea.ac.uk.

<div align="center">

Thank you for your interest in this study

</div>

Appendix V: Staff Participant Consent Form

Title of Project: *Assessing the feasibility of a brief novel intervention for young people with At Risk Mental State and attenuated positive psychotic symptoms: The viability of its use in the NHS and of a future trial*

Name of Researcher: Emma Burton, Trainee Clinical Psychologist

Please Tick Each Box

I confirm that I have read the information sheet dated 02/04/17 (version 2) for the above study. I have had the opportunity to consider the information and have the contact details of the researcher who I could contact to ask questions.

I understand that my participation is voluntary and that I am free to withdraw from the questionnaire at any time, up until I submit it.

I understand that I will remain anonymous throughout my participation in this research and therefore any data relating to me will be confidential.

*I agree to take part in the above study.

Study Title: *Assessing the feasibility of a brief novel intervention for young people with At Risk Mental State and attenuated positive psychotic symptoms: The viability of its use in the NHS and of a future trial*

Name of Researcher: *Emma Burton, Trainee Clinical Psychologist, University of East Anglia (UEA)*

Research Supervisors: *Dr Bonnie Teague (Senior Teaching Fellow in Research Methods at UEA), Dr Richard Meiser-Stedman (Reader in Clinical Psychology at UEA) and Dr Timothy Clarke (Clinical Psychologist at Norfolk and Suffolk NHS Foundation Trust, (NSFT)).*

What is the purpose of the study?

This study aims to develop and trial a brief intervention for young people (aged 16-25) who are considered to have an At Risk Mental State (ARMS) (that is, they are at a high but not inevitable risk of psychosis). The intervention will be designed for individuals experiencing attenuated positive psychotic symptoms, who will be experiencing the perceptual disturbances, such as hallucinations, associated with psychosis, but they will be at a lower frequency or intensity than if they were experiencing florid psychosis.

Research has shown that psychological therapy for young people who are experiencing these symptoms can help in reducing them and prevent them from getting worse and leading to psychosis. The literature suggests that brief and simple interventions with a therapist who is warm and accepting and helps the young person to understand their unusual experiences through psychoeducation and normalisation, may be helpful in reducing these symptoms. Such an intervention would be relatively cheap (due to being brief and not requiring specialist therapists) and thus, it is hoped that it would increase the availability of psychological therapies for young people with ARMS.

This study aims to develop an intervention that is consistent with the one just outlined. It aims to assess how young people with ARMS experience the intervention and being

part of a study investigating it. It also seeks to understand what clinicians working in youth teams think about such an intervention and how they experienced administering it. It is hoped that the findings from this study will inform whether a future larger scale piece of research can be conducted on the intervention and whether it could be adopted as part of routine clinical care within NHS Youth Teams.

Why have I been invited to take part?

You have been asked to participate as you received training on administering the intervention developed in this study and also offered the intervention to some of the participants. We are interested in hearing about your experience of receiving the training and offering the intervention, as well as your views on future research and on the intervention being offered as part of routine care in NHS Youth Teams.

What would participation involve?

If you would like to take part in the study as a participant, you will be asked to sign a consent form. If you consent to participate, you will then be asked to complete a questionnaire asking you about the training you received and your experience of delivering the intervention.

Do I have to take part?

It is important that you are aware that being involved in the study is voluntary. Even if you consent to take part, you are able to withdraw from the research, without giving a reason, at any point up until data analysis commences (this withdrawal would mean the data from your questionnaire would be withdrawn. Data from participants who received the intervention from you, as well as the WAI-SR and fidelity checklists you completed as a researcher, would remain as part of the study).

What are the possible disadvantages/risks of taking part?

Completing the questionnaire will require you to give up additional time (over and above that given up to offer the intervention). Your total involvement as part of this process is not expected to exceed 1 hour 45 minutes (including reading this sheet, giving your consent to participate and meeting with me after you have completed the questionnaire to discuss this if you wish.)

What are the possible benefits of taking part?

It is hoped that this study will inform future research and practice within the NHS and therefore, be helpful to individuals accessing support in the future.

Will information be kept confidential?

All information will be private and safe, as with any research, the only exception would be if there were concerns about yours or anyone else's safety. In this case, we would attempt to discuss this with you before passing the concerns on to the relevant professional. All information about you will be stored securely and anonymously (with no identifying information, such as your name, included), you will be allocated a number. Electronic information will be stored on a password protected memory stick. All non-electronic data will be stored in a locked filing cabinet at the UEA and will be destroyed 10 years after the study is completed.

What will happen to the results of this research?

The results of the research will be written up as part of my doctoral thesis, it is hoped that they may also be published in academic journals or presented at conferences (all information will remain anonymous for this.) Ultimately, it is hoped that the results will be used to inform how future research on the intervention should be conducted and how the intervention might be improved for this.

Relevant Contact Details

Thank you for taking the time to read this information sheet, I hope you will decide to participate. If you have any questions, I would be very happy to discuss my project with you and can be contacted at: emma.burton@uea.ac.uk. If you would like to speak to one of my supervisors, please email: B.Teague@uea.ac.uk.

If you are unhappy about the way you have been treated or wish to make a complaint, please contact me, using the details above, and I will do my best to resolve any problems. If you would like to complain formally you can contact Professor Ken Laidlaw (Course Director, Doctoral Program in Clinical Psychology, UEA) by telephone: 01603 593600 or email: K.Laidlaw@uea.ac.uk.

Thank you for your interest in this study!

UEA
University of East Anglia

Appendix X: Non-registered practitioner consent form

Title of Project: *Assessing the feasibility of a brief novel intervention for young people with At Risk Mental State and attenuated positive psychotic symptoms: The viability of its use in the NHS and of a future trial*

Name of Researcher: Emma Burton, Trainee Clinical Psychologist

Please Initial Each Box

1. I confirm that I have read the information sheet dated 02/04/17 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time (up until data analysis) without giving any reason

3. I understand that information collected about me during the study will remain private and confidential unless there is a concern for mine or someone else's safety.

4. *I agree to take part in the above study.

_____   _____   _____
Full Name of Participant   Date   Signature

_____   _____   _____
Full Name of Person Taking Consent   Date   Signature

Appendix Y: Additional data from the staff participants' and non-registered practitioners' non-validated questionnaires

Staff participants and the non-registered practitioners who delivered the intervention used five-point Likert scales to answer questions about the intervention and research. Figures 12 and 13 show the staff participants' responses, figures 14 and 15 show those from the non-registered practitioners.

Figure 12

Frequency of staff participants' responses to questions about the intervention and research
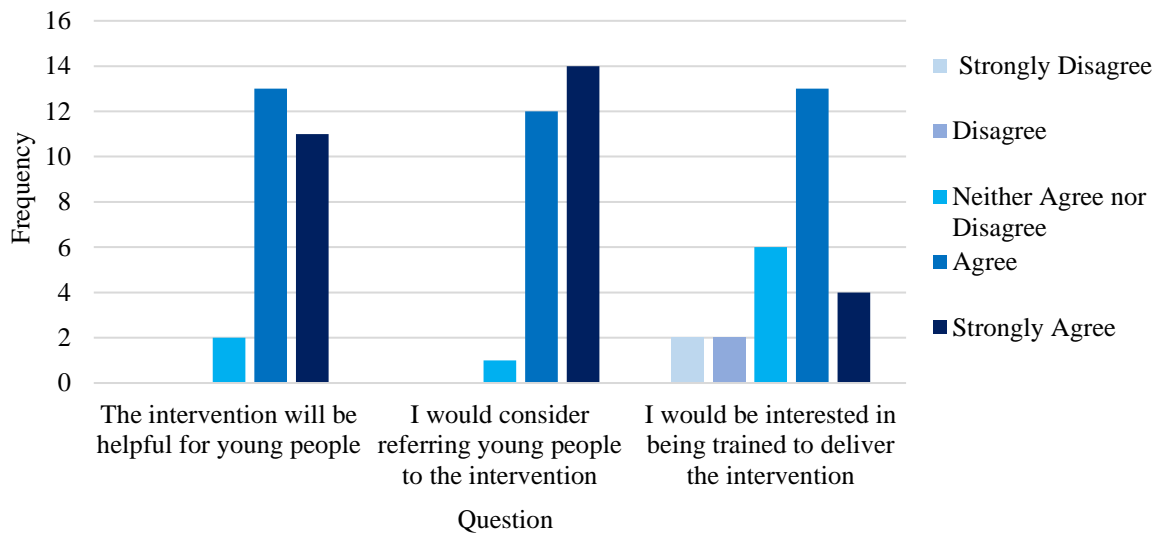

Figure 14

Frequency of non-registered practitioners' responses to questions about the intervention and research
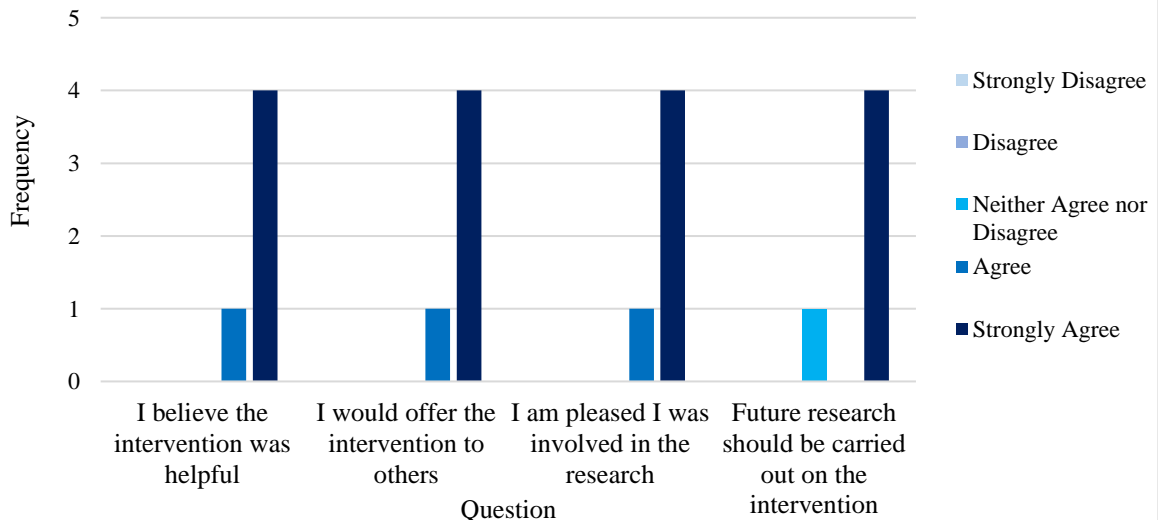
Figure 13

Helpfulness of components of the intervention: frequency of staff participants' responses
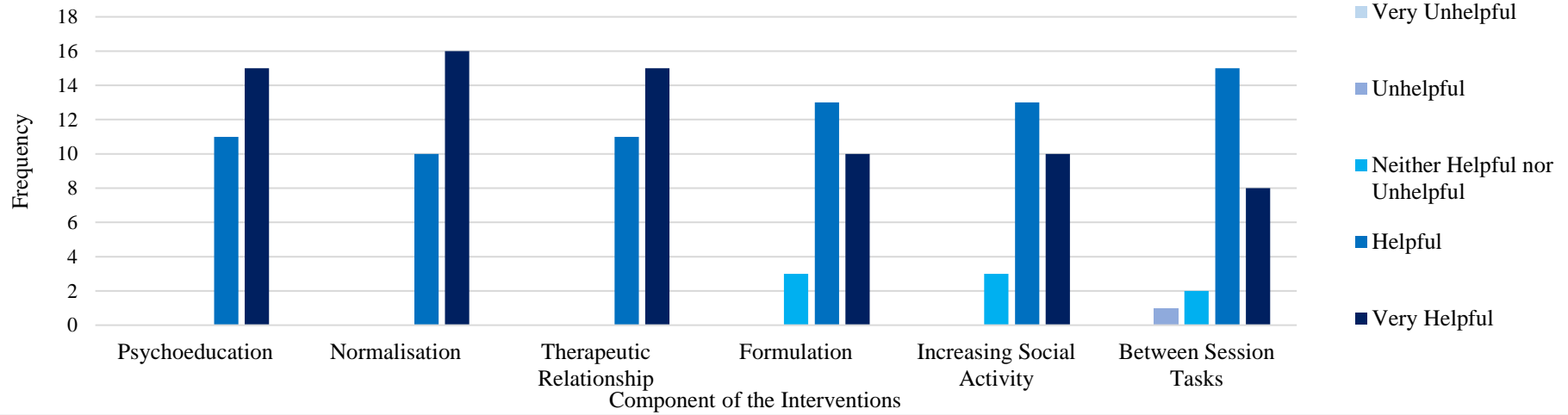

Figure 15

Helpfulness of components of the intervention: frequency of non-registered practitioners' responses