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### **Psychological Interventions for First-Episode Psychosis: An Exploration of Individual and Group Interventions**

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# **Psychological Interventions for First-Episode Psychosis: An Exploration of Individual and Group Interventions**

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A thesis submitted in partial fulfilment for the degree of Doctorate in Clinical Psychology

May 2019

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## **Declarations**

I hereby declare that this thesis is the result of my own work, unless otherwise stated. This work has not been previously accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed: .....

Date: .....

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## **Thesis Abstract**

This thesis explores psychological interventions for young people experiencing psychosis, with a specific focus on group interventions, across three individual papers.

The first paper presents a systematic review comparing the efficacy of individual and group psychological interventions for improving symptoms and functioning in a sample of young people experiencing first-episode psychosis (FEP). The findings of 12 studies were synthesised narratively, with comparisons of interventions and studies being made. Results were inconclusive, with mixed findings for the efficacy of individual and group interventions for improving symptoms and functioning. However, there were promising findings that both modalities may offer some benefits for functioning. Limitations, clinical implications and areas for future research are explored.

The second paper presents the findings from an empirical study exploring young peoples' experiences of engaging with an outdoor therapy group (OTG) run by an Early Intervention in Psychosis Service (EIPS). A total of six interviews were undertaken, and were analysed using Thematic Analysis. The analysis identified two main themes: "I was a bit nervous to begin with" and "Turn my life around for the better", which contained six subthemes: "We're all in the same boat", "My mental health has improved and improved", "I thought I'd have an adventure", "Makes me wanna change", "It just brought confidence/I ain't a waste of space" and "I hope it can help other young people". The findings are promising for the benefits of OTGs with EIPS populations. Limitations, clinical implications and areas for future research are explored.

The final paper considers the clinical and theoretical implications arising from both papers, and personal reflections of the process are discussed. Recommendations include better

quality EIPS group intervention studies, more research with FEP samples and feasibility studies of OTGs in EIPS to provide a basis for the development of the intervention within services.



## **Chapter 1: Literature Review**

# **A Systematic Review of the Effectiveness of Group and Individual Interventions for First-Episode Psychosis**

SHORT TITLE: A comparison of individual and group interventions for first-episode psychosis

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## **Abstract**

**Purpose.** This review sought to systematically review the evidence on the efficacy of individual interventions compared to group interventions for the treatment of first-episode psychosis (FEP), focusing on symptoms and functioning.

**Methods.** Twelve published randomised and non-randomised controlled trials, ranging from poor to good quality, were systematically identified through searches of PubMed, PsycINFO, Cinahl and Medline and through hand-searches of references of identified papers. A meta-analysis was not feasible due to heterogeneity of outcomes, measures and lack of useable data; the results were therefore synthesized narratively.

**Results.** Mixed results were found for the efficacy of group and individual interventions improving symptoms and functioning, although within-groups improvements of individual and group interventions were noted for both outcomes. Study quality varied, with individual intervention studies being rated as better quality. The content and format of individual and group interventions varied, although there was a focus on CBT or adapted CBT interventions for both.

**Conclusion.** There is promising evidence that both intervention modalities could offer improvements in functioning and symptoms; however, rigorous, good quality evidence is lacking, particularly for group interventions. Undertaking such studies would improve the ability to pool studies in meta-analyses.

### **Key Practitioner Message**

- There are promising findings that individual and group interventions may improve symptoms and functioning in young people experiencing FEP, however more evidence is needed.
- Both intervention modalities appear to focus on different aspects of functioning, with group interventions appearing to improve coping and individual interventions appearing to improve social functioning.
- Offering both individual and group interventions in EIPS may be beneficial to clients' recovery.

*Key words:* first episode; early; psychosis; psychological intervention; systematic review

The age of onset of psychosis varies, with estimates suggesting that symptoms typically develop between the ages of 14-35 (Kessler, 2007). Early, intensive input during the critical period of the onset of psychosis ( $\leq 3$  years), suggested as offering a ‘window of treatment opportunity’, can prevent prolonged duration of untreated psychosis (DUP; Birchwood, 1998), which is associated with disrupted social and interpersonal developmental processes, increased psychosis symptomatology, decreased functioning and physical health, and poorer long-term outcomes (Nordentoft et al., 2009). Early Intervention in Psychosis Services (EIPS) therefore offer biopsychosocial support in the form of individual cognitive-behaviour therapy (CBT) in conjunction with family therapy and medication (National Institute for Health and Care Excellence [NICE]; 2013) to reduce the DUP and improve symptoms and functioning.

Although individual CBT is recommended (NICE, 2013), the evidence-base of its efficacy in improving symptoms and functioning remains unclear, with an ongoing debate. Reviews and meta-analyses have found mixed results, with some finding medium effects (e.g. Zimmerman, Favrod, Trieu & Pomini, 2005) and some finding small to no effect of CBT on positive symptoms, an over-emphasis of studies on positive symptom reduction and little exploration of the impact on functioning (e.g. Jauhar et al., 2014; Lynch, Laws & Mckenna, 2010). Wykes, Steel, Everitt and Tarrier (2008) also concluded that increased study rigour leads to a weaker effect of CBT. Further, there is growing evidence that alternative therapeutic approaches and modalities can be efficacious in the treatment of FEP, such as third-wave therapies (Louise, Fitzpatrick, Strauss, Rossell & Thomas, 2018), with group interventions also identified as offering benefits such as social support, normalisation, de-stigmatisation, and improvements in social functioning (e.g. Louise et al., 2018; Wykes, Parr & Landau, 1999). Group interventions could therefore offer important benefits for functioning that individual interventions may be unable to provide.

However, little is known about whether individual or group interventions are more efficacious for the FEP population in improving symptoms and functioning, and there is a paucity of research exclusively exploring FEP populations (Lutgens, Garipey & Malla, 2017). A review comparing the efficacy of these modalities for participants with longer-term psychosis concluded that individual interventions improved mental and global functioning, and group interventions improved life skills and social interaction (Hodgkinson, Evans, O'Donnell, Nicholson & Walsh, 2000). An update to this review drew similar conclusions (Lockwood, Page & Conroy-Hiller, 2004); however, both were limited by studies of variable quality, and the inability to perform meta-analyses. Furthermore, as both reviews used participants with longer-term experiences of psychosis, these findings may not be applicable to FEP samples, given that those experiencing FEP are typically younger and are therefore at a different developmental stage. Those experiencing FEP are also more likely to have better recovery following intervention compared to those experiencing longer-term psychosis (Jager et al., 2007), further indicating differences between the groups. It may therefore be useful to explore which treatment modality works best for the FEP population in improving symptoms of psychosis and functioning, with findings being applicable to clinicians developing interventions and researchers identifying potential research gaps.

To the best of our knowledge, no reviews since Lockwood et al. (2004) have compared the effectiveness of individual and group interventions for those experiencing psychosis, and none have specifically looked at a FEP sample. The current review therefore aimed to compare the efficacy of individual and group interventions in improving functioning and reducing the symptoms of psychosis, for this population, as well as the state of the evidence and the details of the clinical approaches used by each modality.

## **Method**

### **Search Strategy**

A systematic search of four databases (PubMed, PsycINFO, Cinahl and Medline) was undertaken in October 2018. The following search terms were chosen based on terminology used in the literature: (“individual OR group”) AND (“psychosis OR psychotic OR schizo\* OR hearing voices OR paran\* OR delus\* OR halluc\*”) AND (“early OR recent OR first”) AND (“therap\* OR psychotherap\* OR intervention”). In all databases, language parameters were restricted to studies published in English; no date parameters were set. Grey literature was also considered to account for publication bias. Screening was undertaken by the lead author.

### **Selection Criteria**

Studies were included in the review if the research: (1) explored the effectiveness of face-to-face psychological interventions delivered individually or in a group; (2) was a randomised or non-randomised controlled study; (3) included participants experiencing a FEP; (4) included participants aged between 14 and 35, in line with estimated age of onset (Kessler, 2007) (4) included at least one pre- and post-intervention quantitative measure of psychosis symptoms and/or functioning.

Studies were excluded from the review if: (1) the primary mental health difficulty was not psychosis; (2) participants had received a mixture of individual and group interventions as part of the main intervention; and (3) participants were identified as being in an at-risk mental state (ARMS) rather than FEP. Other systematic reviews were not included.

### **Quality Assessment**

The Downs and Black’s (1998; Appendix A) index, rated as a good assessment tool for systematic reviews (Deeks et al., 2003), was used to assess the methodological robustness of

studies included in this review. The index was developed for healthcare interventions, and includes 27 items within five categories: reporting, external validity, internal validity, selection bias and power, with a maximum score of 31, and quality ranges of excellent (26-28); good (20-25); fair (15-19); and poor ( $\leq 14$ ).

### **Data Extraction**

Data was extracted systematically by the lead author to ensure relevant aspects of the studies were recorded (see Table 1). There were differences in the reporting of effect sizes across studies, with some researchers reporting and others not. Effect sizes have been reported where possible, with other statistics reported if they are informative.

### **Data Synthesis**

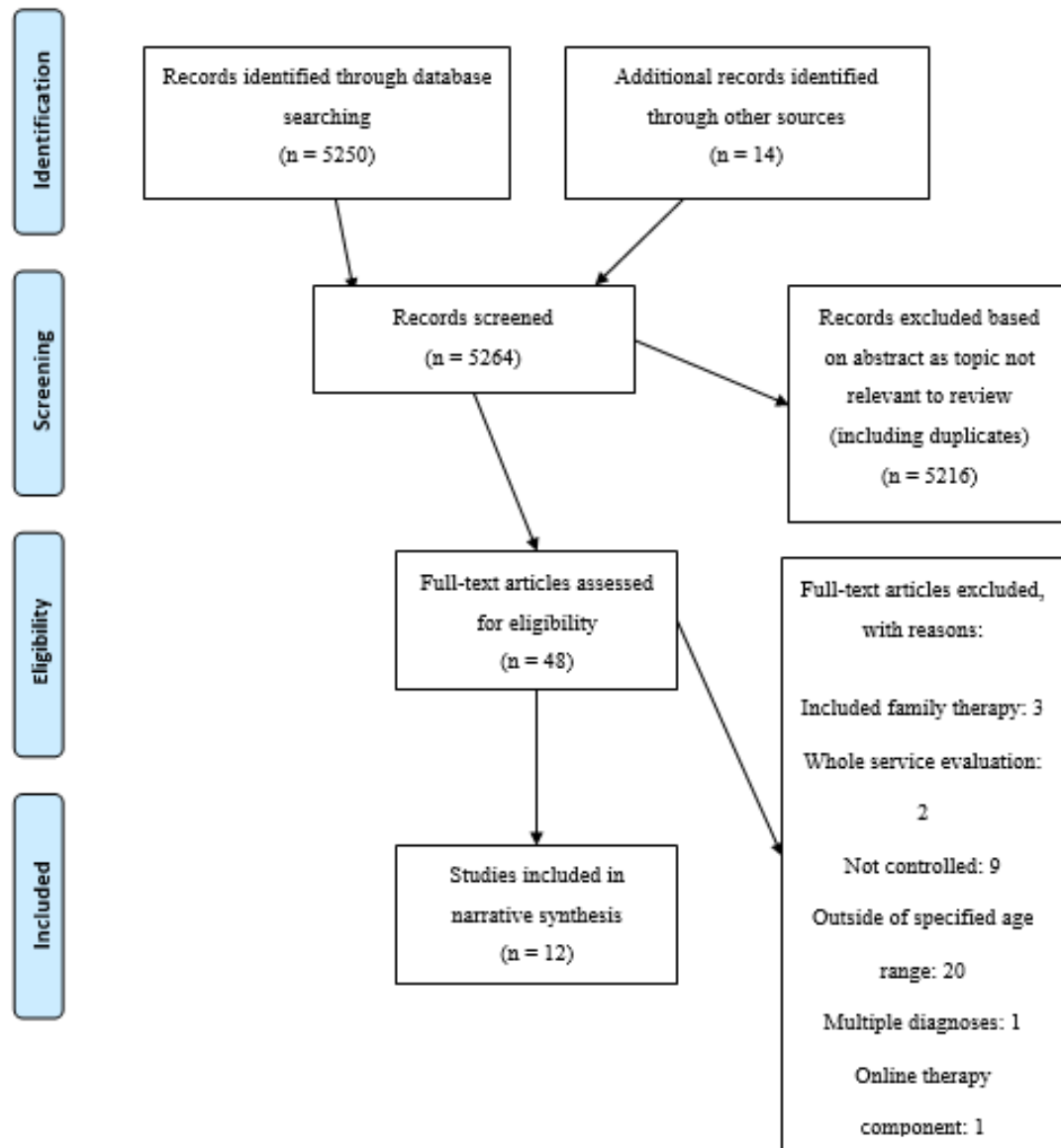
Due to the heterogeneity of the final studies including diversity of interventions and outcomes, inconsistency in reporting outcomes, lack of useable data and small number of studies, a meta-analysis was not feasible; therefore, a narrative synthesis was the most appropriate method to summarise this literature (Brown & Richardson, 2017).

## **Results**

Selection followed the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA; Moher, Liberati, Tetzlaff & Altman, 2009). The initial search returned 5264 records and an additional 14 were identified by a reference list search of the final papers. 5216 records were excluded subsequent to screening abstracts in accordance with inclusion criteria. In total, 48 articles were read in full and 12 studies met criteria. Figure 1 illustrates the selection process and reasons for exclusion, in line with the PRISMA (Moher et al., 2009). Where insufficient data were reported in the paper to calculate effect sizes, all lead



and corresponding authors were contacted three times to obtain this data. Out of nine contacted authors, three responded, which made pooling of statistics unfeasible.



**Fig. 1.** PRISMA diagram showing study selection process (Moher et al., 2009)

**Table 1**

*Overview of Included Studies*

Authors (Country)	Participants	Intervention (I)/Control (C)	Format	Contact Time (hours where reported)	Design	Drop-out rate	Outcome Measures (Symptoms/F unction)	Main Findings	Limitations	Quality Rating
<b>Fowler et al., (2018) UK</b>	N=155 outpatients of EIPS, first 12-30 months of service engagement; experiencing severe and persistent social disability. Age: Range - 16-35, total mean age NR.	I: SRT + TAU (n=76) Age: M = 24.84 (21 – 29) 25% female, 75% male.  C: TAU (n=79) Age: M = 24.15 (22 – 28) 24% female, 76% male.	I	M = 16.49 sessions (SD 8.39; range 0-37)	RCT	8%	TUS SANS PANSS BHS MLQ	Intervention group associated with large and clinically important increase in structured activity of 8.1 hours compared with TAU alone. No significant difference on any other measures.	High level of missing data for secondary outcomes, with higher levels in the control group and therefore considered missing not at random.	24
<b>Jackson et al., (2005) Australia</b>	N=91 outpatients of EIPS of unclear duration. Age: Range – 15-29; total mean age NR.	I: CBT + TAU (n=45) Gender M/F: 32/13 Age: M = 22.49  C: TAU (n=46) Gender M/F: 38/8 Age: M = 22.50	I	Weekly or bi-weekly sessions, range 1-34	Control	27%	BPRS SANS SOFAS QLS	No significant differences on any measures for either condition.	Not randomised. Treatment was not standardised for TAU, including number of sessions, duration, frequency or order of sessions. Many participants did not receive all the components of treatment and therefore authors suggested that some participants received incomplete treatment.	22
<b>Lewis et al. (2002) UK</b>	N=309, <3 years of engagement in EIPS, experiencing symptoms of psychosis.  Age: total mean age and range NR. 70% male	I: CBT + TAU (n=101, median age: 29.1 years)  Comparison: SC + TAU (n=106, median age: 27.2 years)  C: TAU (n=102, median age 27)	I	15-20	RCT	4%	PANSS (total and positive subscales) PSYRATS	No significant improvement on the measures for intervention in comparison to control or comparison groups. Trend towards CBT leading to faster remission of symptoms than other groups as measured by PANSS.	Routine care (TAU) was not standardised; non-specific control used which had a more powerful effect than expected. Brief therapy (5 weeks)	22

<b>Penn et al., (2011)</b> <b>USA</b>	<i>N</i> =46, ≤ 3 years of EIPS engagement, experiencing symptoms of psychosis. Age: <i>M</i> = 22 years (Range 18-35). 61% male	I: CBT + TAU ( <i>n</i> =23) C: TAU ( <i>n</i> =23)	I	Up to 36 weekly sessions	Pilot RCT	4%	QLS RFS MCAS PANSS	Analyses were not statistically significant between groups. Significant within-group improvement on extended social network subscale of RFS and total score, and MCAS social competence scale, for intervention group at follow-up compared to control group.	Assessors were not blind on the MCAS and RFS; unclear blinding on other outcome measures. Lack of statistical power.	21
<b>Wykes et al., (2007)</b> <b>UK</b>	<i>N</i> =40 in- and outpatients of specialist mental health services, (≤ 3 years of service contact). Age: <i>M</i> = 18 (range: 14-22) 65% male	I: CRT + TAU ( <i>n</i> =21) C: TAU ( <i>n</i> =19)	I	Minimum of 3 sessions per week for 3 months	RCT	24%	SBS BPRS QLS	No effect of CRT on any measures.	Short follow-up Small sample size and therefore potentially under-powered.	21
<b>Uzenoff, Perkins, Hamer, Wiesen &amp; Penn (2008)</b> <b>USA</b>	<i>N</i> =24 in- and outpatients of general mental health services (≤ 12 months of engagement in services), experiencing symptoms of psychosis Age: ≥16 years, range and mean NR. 60% male	I: CBT-based + TAU ( <i>n</i> =NR) C: ST + TAU ( <i>n</i> =NR)	I	14 sessions over 6 months (weekly and bi-weekly)	Pilot RCT	NR	PANSS QLS	Significant within-group improvement for intervention group from baseline to post-treatment on PANSS positive and general subscales in comparison to control group. Statistically significant within-group improvement on QLS for intervention group compared to control group.	Small sample size, unclear power. Detailed participant demographics not provided. Drop-out rates and number of participants in each condition was not reported. Intention-to-treat analyses were not completed	19
<b>Power et al., (2003)</b> <b>Australia</b>	<i>N</i> =56 outpatients experiencing FEP, <1 year in EIPS. Demographic information NR	I: CT + TAU ( <i>n</i> =31) C: TAU ( <i>n</i> =25)	I	8-10	RCT	32%	BHS QLS	Within-group improvements for intervention group on BHS and QLS in comparison to control group.	Participant demographics and statistical information not reported. Brief intervention.	9
<b>Pos et al., (2018)</b> <b>Holland</b>	<i>N</i> =50 in- and outpatients of EIPS, experiencing recent onset psychosis; unclear duration of symptoms	I: MCT + TAU ( <i>n</i> =NR, <i>M</i> = 23.59) Gender ratio M/F: 18/7 C: OT + TAU ( <i>n</i> =NR, <i>M</i> = 23.08)	G	8	RCT	20%	PANSS	No significant effect on measures.	Control group scored worse at baseline, and experienced higher attrition	23

	Age: Range 18-35, total mean age NR.	Gender ratio M/F: 22/3								
<b>McCay et al., (2007) Canada</b>	<p><i>N</i>=67 outpatients from EIPS, ≤ 2 years of engagement. No antipsychotic medication 8 weeks prior to engaging in the study. Age: 18-35; total mean age NR.</p> <p><i>n</i>=20 dropped out of the study and were subsequently not described in final sample.</p>	<p>I: Group intervention to promote healthy self-concepts and reduce by engulfment, + TAU (<i>n</i>=29) Age: <i>M</i> = 25.07 69% male, 31% female</p> <p>C: TAU (<i>n</i>=18) Age: <i>M</i>=26.17 77.8% male, 22.2% female</p>	G	18	RCT	27%	SES QLS MHS PANSS GAF	Significant within-group increase on MHS and QLS compared with control group. No significant improvement on other measures.	No intention to treat analyses. Significant differences between groups and sites. Small sample. Lack of power.	19
<b>Lecomte et al., (2008) Canada</b>	<p><i>N</i>=129, experiencing symptoms of psychosis, ≤ 2 years of EIPS engagement. Age: <i>M</i> = 24 years 73% male</p>	<p>I: Group CBTp (<i>n</i>=NR) Comparison: SKT (<i>n</i>=NR) C: Waitlist (<i>n</i>=NR)</p>	G	24 sessions (twice a week for 3 months)	RCT	12%	BPRES-E CCS SPS	No significant between groups scores on any measures. Significant within-group improvement for intervention group on BPRS general symptoms sub-scale in comparison to control and comparison groups. Both intervention and comparison groups showed significant within-groups improvements on positive and negative sub-scales of BPRS at follow-up.	Unclear how many participants were in each condition. Participants were excluded if they had previously received CBT; a common treatment for the sample. Participants were excluded if not receiving medication.	17
<b>Macdougall et al., (2018) Canada</b>	<p><i>N</i>=21 outpatients from an EIPS, ≤ 3 years of engagement. 76.5% male</p> <p><i>n</i>=3 dropped out, and were therefore not described in the final sample.</p>	<p>I: MAP+TAU (<i>n</i>=9) C: TAU (<i>n</i>=8)</p>	G	12	Pilot RCT	18%	POMS SAPS SANS SFS	Ancillary outcomes: participants in intervention group reported significantly lower fatigue compared to controls at follow-up based on lack of overlap of confidence intervals on POMS.	Small sample (however this was a pilot study). No intention-to-treat analyses.	14

<b>Newton et al., (2005) UK</b>	<i>N</i> =22 in- and outpatients experiencing auditory hallucinations ( $\leq 3$ years) with onset before the age of 18. Unclear service Age: <i>M</i> = 17, range: 15-21 23% male	I: Group CBT + TAU ( <i>n</i> =NR)  C: Waitlist ( <i>n</i> =NR)	G	7	Control	24%	PSYRATS PANSS CQ	Significant within-group reduction scores on the PSYRATS in comparison to control; no significant differences on any other measure.	Unclear how many participants were in each condition. Small sample and lacked power. Participants were not randomised to conditions. Unclear setting and service.	13
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*Note:* Age and gender reported where possible. *N*=number of participants, *M*=mean age, *SD* = standard deviation, NR = not reported, M/F = male/female, EIPS = Early Interventions in Psychosis Service, UK=United Kingdom, RCT = randomised controlled trial; CBT = Cognitive Behaviour Therapy, CBTp = Cognitive Behaviour Therapy for Psychosis, CRT = Cognitive Remediation Therapy, CT = Cognitive Therapy, MAP = Mindfulness Ambassador Programme, MCT = Metacognitive Training, OT = Occupational Therapy, SKT = Skills Training, SRT = Social Recovery Therapy, SC = Supportive Counselling, ST = Supportive Therapy, TAU = treatment as usual; BHS = Beck Hopelessness Scale, BPRS/E = Brief Psychiatric Rating Scale/Extended, CCS = Cybernetic Coping Scale, CQ = Coping Questionnaire, GAF = Global Assessment of Functioning Scale, MCAS = Multnomah Community Ability Scale, MHS = Miller Hope Scale, MLQ = Meaning in Life Questionnaire, PANSS = Positive and Negative Syndrome Scale, POMS = Profile of Mood States, PSYRATS = Psychotic Symptoms Rating Scale, QLS = Quality of Life Scale, RFS = Role Functioning Scale, SAPS/SANS = Scale for the assessment of positive/negative symptoms, SBS = Social Behaviour Schedule, SES = Self-Efficacy Scale, SFS = Social Functioning Scale, SOFAS = Social and Occupational Functioning Assessment Scale, SPS = Social Provisions Scale, TUS = Time Use Survey.

## **Study and Participant Characteristics**

Descriptive characteristics of each study are outlined in Table 1. In summary, ten studies used a randomised controlled trial (RCT) design and two studies were non-randomised controlled studies. Seven studies evaluated the effectiveness of an individual intervention and five studies evaluated the effectiveness of a group intervention. A total of 1,008 participants were included across all studies, ranging from sample sizes of 21 to 309 participants ( $M=84$ ;  $SD=78.9$ ). Participants had a current or recent diagnosis of non-affective psychosis, as outlined by the DSM-III and IV (APA, 1980/1994) and were taking anti-psychotic medication; however, two studies did not report medication use (Fowler et al., 2018; Macdougall et al., 2018) and medication use was an exclusion criterion in one study (McCay et al., 2007). Due to differences in the reporting of age and gender information across studies, it was not possible to calculate a mean age and gender percentage for the whole sample; this information has been included in Table 1 for each study.

## **Quality Scores**

Studies were rated as fair quality by the Downs and Black's tool (scores ranging from 9-24;  $M=19$ ,  $SD=4.5$ ), indicating that studies were generally of fair quality (see Table 1 for individual scores).

## **Outcome Measures**

Outcomes of interest were symptoms of psychosis and functioning; a wide range of measures exploring these outcomes were used across the studies as primary, secondary or ancillary outcomes. Details of the measures are included in Table 2.

**Table 2***Outline of Included Measures*

<b>Measure</b>	<b>Author/s</b>	<b>Description</b>
<b>Beck Hopelessness Scale</b>	Beck, Weissman, Lester & Trexler, 1974	A 20-item self-report inventory (true/false scale) measuring three aspects of hopelessness: feelings about the future, loss of motivation and expectations.
<b>Brief Psychiatric Rating Scale - Extended</b>	Overall & Gorham, 1962	24-item, semi-structured interview, scored on a 7-point Likert scale, measuring symptoms such as anxiety, hostility and hallucinations.
<b>Cybernetic Coping Scale</b>	Edwards & Baglioni Jr., 1993	A 20-item, self-report scale measuring coping techniques for managing stress.
<b>Coping Questionnaire</b>	Wykes et al., 1999	Described as a simple self-report measure of coping strategies, devised by Wykes et al. (1999) for their study; not described in detail and not validated.
<b>Global Assessment of Functioning Scale</b>	Endicott, Spitzer, Fleiss & Cohen, 1976	A clinician-rated scale measuring individuals' functioning in a variety of areas such as social and psychological functioning, scored from 1 – 100.
<b>Multnomah Community Ability Scale</b>	Dickerson, Origoni, Pater, Friedman & Kordonski, 2003	A 17-item clinician-rated measure of functioning assessing a variety of areas such as social competence and behavioural problems, scored on a 5-point Likert scale.

<b>Miller Hope Scale</b>	Miller & Powers, 1988	A 40-item, self-report, 6-point Likert scale, measuring different aspects of hope, including psychological wellbeing, coping and meaning in life.
<b>Meaning in Life Questionnaire</b>	Steger, Frazier, Oishi & Kaler, 2006	A 10-item, self-report measure of the presence of meaning in life and the search for meaning in life, scored on a 7-point Likert scale.
<b>Positive and Negative Syndrome Scale</b>	Kay, Fiszbein & Opler, 1987	A clinician-rated measure, scored from 1-7 for measuring psychosis symptom severity.
<b>Profile of Mood States</b>	Curran, Andrykowski, Studts, 1995	A self-report measuring aspects of mood, such as anxiety, hostility and fatigue; scored on a 5-point Likert scale.
<b>Psychotic Symptoms Rating Scale</b>	Haddock, McCarron, Tarrier & Faragher, 1999,	A 17-item clinician-rated measure of the severity of delusions and hallucinations, scored on a 4-point scale.



<b>Quality of Life Scale</b>	<b>Heinrichs, Hanlon &amp; Carpenter, 1984</b>	A 21-item, semi-structured interview scored on a 7-point Likert scale, measuring symptoms and functioning in those diagnosed with Schizophrenia.
<b>Role Functioning Scale</b>	Goodman, Sewell, Cooley & Leavitt, 1993	A semi-structured interview measuring functioning in various areas of everyday life, such as work, independent living and social networks, with scores ranging from one to seven, with seven being an optimal level of functioning.
<b>Scale for the Assessment of Positive/Negative Symptoms</b>	Andreason, 1983	Two clinician-rated measures; one of positive symptom-severity and one of negative-symptom severity. Measured on a 7-point scale.
<b>Social Behaviour Schedule</b>	Wykes & Sturt, 1986	A 20-item, clinician-rated measure assessing social behaviour in clinical populations rated from 1-4, with 0 indicating acceptable behaviour.
<b>Self-Efficacy Scale</b>	Sherer et al., 1982	A self-report, 23-item measure of general and social self-efficacy.
<b>Social Functioning Scale</b>	Birchwood, Smith, Cochrane, Wetton, Copestake, 1990	A semi-structured interview measuring areas of functioning such as interpersonal functioning and pro-social activities.
<b>Social and Occupational Functioning Assessment Scale</b>	American Psychological Association (APA), 1994	A clinician-rated scale measuring global functioning, on a scale from 0-100 with lower scores representing lower functioning.
<b>Social Provisions Scale</b>	Cultrona & Russell, 1987	A 24-item, self-report scale measuring the availability of social support, e.g. emotional

		support or attachment and social integration. Scored on a 4-point Likert scale.
<b>Time Use Survey</b>	Hodgekins et al., 2015	A semi-structured interview exploring time spent in structured activity, such as work, education and voluntary work.

## Individual Interventions

**Participant demographics.** A total of 719 participants were included in the studies at baseline ( $M=102.71$ ;  $SD=93.33$ ; range=24-309). Clinical samples recruited from EIPS and community mental health services were included, and included inpatient and/or outpatients; demographic information was not reported in one study (Power et al., 2003). All participants were experiencing ongoing symptoms of psychosis and had been engaging in services for  $\leq 3$  years. Ages ranged from 14-35; as studies varied in their reporting of age information, it was not possible to calculate a mean age for this sample; more detailed demographic information is presented in Table 1. Of the 11 studies that reported gender information, 71% (663 participants) were male.

**Study design.** Studies were RCT's ( $n=6$ ) and a non-randomised controlled study ( $n=1$ ). Control conditions were treatment as usual (TAU), described as high standard EIPS ( $n=5$ ), and supportive therapy/counselling as comparison conditions ( $n=2$ ). Studies were rated as good quality by the Downs and Black's tool ( $M=20$ ;  $SD=4.78$ , range 9-24).

**Intervention format.** Interventions varied in their content and focus, and included: cognitive therapy (CT) to enhance medication adherence (Uzenoff et al., 2008); CBT for positive symptom reduction (Lewis et al., 2002; Penn et al., 2011; Power et al., 2003), CBT for functional recovery (Jackson et al., 2005; Fowler et al., 2018) and cognitive remediation (Wykes et al., 2007). The intensity and duration of interventions varied, and studies varied on how this information was reported (e.g. some studies reported duration in hours, and some did not report this, or any, information). In terms of duration, interventions lasted from 5–37 weeks, and varied from 15-20 hours over five weeks, to 14 sessions offered over six months. Interventions were mostly delivered by experienced clinicians (e.g. clinical psychologists;

$n=6$ ). Therapist information was not reported in one study (Uzenoff et al., 2008). Of those that reported the information, drop-out rates from intervention groups ranged from 4% (Penn et al., 2011) to 32% (Power et al., 2003).

**Efficacy of individual interventions in reducing symptoms.** Six of the seven studies examined the effectiveness of individual interventions in reducing symptoms of psychosis; two reported an impact of an intervention in comparison to a control group, and four reported no impact. One study did not use a measure of symptom severity (Power et al., 2003).

Two studies used the PANSS to measure the impact of an intervention in comparison to a control (Lewis et al., 2002; Uzenoff et al., 2008). Using the PANSS positive and total subscales, Lewis et al. (2002) found that five weeks of CBT and TAU showed a trend towards faster improvement of symptoms on the PANSS than TAU alone, although TAU also eventually improved over the trial period, and this was not statistically significant. They acknowledged that the intervention was short and that not all participants had completed treatment, and that TAU was already effective at reducing symptoms. Similarly, Uzenoff et al. (2008) reported that an adapted form of CT and TAU, in comparison to TAU alone, led to significant within-group improvements from baseline to post-treatment (six months) on the PANSS positive ( $d=-1.19$ ) and general subscales ( $d=-1.02$ ) for CT, with no significant within-group changes in the comparison group of supportive therapy. This study was limited by a small sample size ( $n=24$ ), and it was unclear whether the study was sufficiently powered to detect small differences between groups as power statistics were not reported. Although both studies outlined were rated as fair-good quality, with positive findings, the findings need to be interpreted with caution, as they were not statistically significant between groups.

In contrast, four studies reported that there had been no effect of the intervention group in comparison to the control group on measures of psychosis symptoms. Using the PANSS, Fowler et al. (2018) found no significant difference between the intervention and control group when comparing social recovery therapy and TAU with TAU alone. Similarly, in a study comparing a CBT-derived intervention focused on managing symptoms of psychosis and TAU with TAU only, Penn et al. (2011) found no significant effect of the intervention over the control group on the PANSS, although they did report that the intervention group had higher effect sizes at follow-up than the control group ( $d=-0.22$ ). When using the BPRS as a measure of symptoms to compare an intervention to a control group, Jackson et al. (2005) and Wykes et al. (2007) also reported that there were no significant differences between the groups, although both acknowledged that their interventions had not been focused on reducing symptoms of psychosis but improving social recovery (Jackson et al., 2005) and cognitive functioning (Wykes et al., 2007). The studies outlined here were of good quality, suggesting robust findings.

Overall, evidence of individual interventions reducing symptoms of psychosis were unclear, which is in line with the current state of the ‘CBT for psychosis’ evidence-base (e.g. Jauhar et al., 2014), and may be explained by the limitations of the studies, as well as the use of a well-established, efficacious treatment (EIPS) as TAU, making it difficult to demonstrate the efficacy of an adjunctive treatment.

**Efficacy of individual interventions in improving functioning.** Six studies used a measure of functioning, with a wide variety of measures being used; overall, four studies reported improvements in functioning, with two studies reporting improvements in functioning in comparison to a control group, and two studies reporting within-group

improvements in the intervention group in comparison to a control group. One study did not use a measure of functioning (Lewis et al., 2002).

Using a measure of social functioning, the TUS, Fowler et al. (2018) reported that social recovery therapy in addition to TAU led to a significant increase in structured activity of 8.1 hours (95% CI 2.5–13.7;  $p=0.005$ ) compared with TAU alone. Similarly, Penn et al. (2011) reported that participants receiving an adapted form of CBT showed significantly greater within-group improvements on the extended social network subscale of the RFS in comparison to the control group at follow up ( $d=0.78$ ) and total score ( $d=0.59$ ), and on the MCAS social competence scale in comparison to TAU ( $d=0.53$ ), although these findings were not statistically significant between groups. Although this study had a low drop-out rate, indicating a well-tolerated intervention, findings were limited by the sample being underpowered ( $n=46$ ). Uzenoff et al. (2008) also reported improvements in functioning; using the QLS as a measure of functioning, they reported that CT had a medium effect ( $d=0.49$ ) on the QLS for the intervention group which was not demonstrated in the control group (TAU). Both studies discussed were of good quality, suggesting robust findings. Finally, in a study of the impact of a suicide prevention strategy in conjunction with TAU in comparison to TAU alone, Power et al. (2003) found that the intervention group improved on the BHS and QLS at 10 weeks and six months follow-up in comparison to the control group. However, these findings were not statistically significant and need to be interpreted with caution due to the study's poor quality as rated by the Downs and Black's tool (9/31), characterised by a lack of information regarding participants, participant and rater blinding, randomisation methods and statistical methods employed, making it difficult to interpret the quality of the findings.

In contrast, Jackson et al. (2005) and Wykes et al. (2007) reported that their interventions did not have an effect on measures of functioning (SANS; SOFAS), with Wykes et al. (2007) highlighting that functioning had not been directly targeted with their intervention.

Overall, the studies described provide some support for individual interventions improving functioning, with studies reporting medium effect sizes. However, the findings do need to be interpreted with caution due to the reasons outlined.

## **Group Interventions**

**Participant demographics.** A total of 289 participants were included in the studies at baseline ( $M=57.8$ ;  $SD=39.63$ ; range=21-129). Clinical samples were recruited from EIPS; recruitment location was unclear in one study (Newton et al., 2005). Participants were experiencing ongoing symptoms of psychosis and had been engaging in services for  $\leq 3$  years. Ages ranged from 15-35; as studies varied in their reporting of age information, it was not possible to calculate a mean age for the sample as a whole; Table 1 presents more detailed information. Of the papers that reported baseline gender demographics, 67% were male. Interestingly, participants in one study were 77% female (Newton et al., 2005).

**Study design.** All studies included control conditions: RCT's ( $n=4$ ) and a non-randomised controlled study (Newton et al., 2005). Control conditions were TAU ( $n=2$ ); waitlist control ( $n=1$ ); “comparable” TAU, described as a social skills training group ( $n=1$ ) and occupational therapy as an additional comparison ( $n=1$ ). Studies were of fair quality, as rated by the Downs and Black's tool ( $M=17$ ;  $SD=3.6$ , range-13-23).

**Intervention format.** Interventions varied in their content and focus and included: group CBT for positive symptom reduction (Lecomte et al., 2008; Pos et al., 2018; Newton et

al., 2005), and groups utilising group processes to improve emotional and social functioning (Macdougall et al., 2018; McCay et al., 2007). Of the two studies that reported therapist information, one involved therapists with clinical experience of working with psychosis and no experience of delivering interventions (Lecomte et al., 2008); the other reported that the group facilitators were experienced EIPS clinicians (McCay et al., 2007). Three studies did not report information about the therapists involved in the delivery of the intervention (Macdougall et al., 2018; Pos et al., 2018; Newton et al., 2005). Group interventions sessions were structured; session duration ranged from 7-12 weeks, and from one 1-hour session per week to two 1-hour sessions per week. Drop-out rates from intervention groups ranged from 12% (Lecomte et al., 2008) to 27% (McCay et al., 2007).

**Efficacy of group interventions in reducing symptoms.** Of the five studies, two reported symptom improvement in comparison to a control group, and two reported no significant difference in between-groups improvements. One study did not report symptom measure scores as they reported that the scores were significantly correlated with a measure of functioning (McCay et al., 2007).

Lecomte et al. (2008) reported that there were no significant differences between the intervention (CBT), comparison (social skills training) or control (TAU) at any of the assessment times on any of the outcome measures. However, they demonstrated that CBT resulted in a significant change in general symptoms on the BPRS from T0 and T1 ( $d=0.54$ ) in comparison to the control and comparison groups, which did not have this effect. They also reported that both intervention and comparison conditions showed significant improvements compared with the control group at six month follow-up on the negative and positive symptoms subscales of the BPRS. Finally, they reported that all calculated effect



sizes from means revealed small to medium effect sizes (from 0.25 to 0.54), with this study being rated as fair quality. Similarly, Newton et al. (2005) reported a significant reduction in scores on the PSYRATS in comparison to a waitlist control (95% CI, 3.7–13.1;  $p < 0.001$ ), although this study had a small sample size ( $n=17$ ) and was rated as poor quality as a result of a lack of randomisation and blinding, and difficulty ascertaining the details of the quality of the recruitment and statistical methods employed. The results of both studies also need to be interpreted with caution, as they were not statistically significant between groups. In contrast, Pos et al. (2018) and Macdougall et al. (2018) reported that there had been no significant differences between either intervention or control group on measures of symptoms (SAPS; SANS; PANSS) in their studies, with their quality scores ranging from poor (Macdougall et al., 2018) to good (Pos et al., 2018). However, Macdougall et al. (2018) was a pilot study assessing the acceptability of the intervention, and the authors acknowledged that the study was underpowered to detect statistically significant differences. Pos et al. (2018) was limited by a small sample size, making it more difficult to detect significant effects.

Overall, the findings offer mixed results for group interventions reducing symptoms of psychosis, with small-medium effects being reported in one study. Although the findings are similar to Lockwood (2004), who found that short-term interventions (of approximately eight weeks duration) were not effective at improving symptoms, the findings of that review and the current review are based on a small number of poor-quality studies, and so findings remain unclear.

**Efficacy of group interventions on improving functioning.** Of the five studies, two reported improvements in functioning; one study did not use a measure of functioning (Pos et al., 2018).

Using the QLS and MHS as measures of functioning, McCay et al. (2007) reported increased scores on both measures for their group aimed at reducing engulfment and improving self-concept, compared to TAU, indicating improved quality of life and feelings of hope for group participants. However, these scores were not significant between groups and findings were limited by being underpowered, with a relatively high drop-out rate from the intervention group of 27%. Similarly, using a range of measures of functioning, Lecomte et al. (2008) reported improvements in coping skills, as measured by the CCS, and the attachment subscale of the SPS, indicating improved social relationships at follow-up for the intervention group only, in comparison to the control and comparison conditions, although these findings were not significant between groups. In contrast, Newton et al. (2005) reported that there were no significant changes in functioning in comparison to the waitlist control based on the CQ. Finally, as part of a feasibility pilot, Macdougall et al. (2018) reported functioning outcomes as ancillary outcomes, and reported CI's based on their findings; they found that the intervention group had reported lower fatigue scores on the POMS fatigue subscale compared to controls at follow-up, based on a lack of overlap between confidence intervals (95% CI, 2.1 – 5.2; p value NR). However, they cautioned against this as an interpretation of a significant finding, as they suggested that lack of CI overlap cannot be used to infer a significant result (Sedgwick, 2014). Overall, the findings discussed offer mixed results for the impact of group interventions on functioning, within the context of studies of lower quality.

## **Discussion**

This review aimed to compare the efficacy of individual interventions to group interventions in reducing symptoms of psychosis and improving functioning in young people experiencing FEP. The results of the search found 12 studies meeting inclusion criteria. Due to the heterogeneity of the studies and the lack of useable data, pooling findings in a meta-analysis was not possible; a narrative synthesis of the findings was therefore undertaken. Firm conclusions cannot be drawn from this review regarding the effectiveness of individual interventions in comparison to group interventions, however it has been useful in clarifying the state of the evidence and identifying differences in characteristics of both modalities.

### **Individual versus Group Interventions: General Comparison**

Individual interventions were of varying lengths and intensities, and appeared to be more flexible in duration and intensity, with a focus on CBT, CT or CBT adaptations. Group interventions tended to be more structured in terms of weekly sessions for a set amount of time, up to 12 weeks, in line with Lockwood's (2004) findings of group duration and intensity. Group interventions also used CBT, as well as mindfulness and a specially designed intervention focused on reducing engulfment and improving self-concepts. Therapists for individual interventions tended to be more experienced; one group intervention study chose to use less experienced facilitators to reflect intervention delivery in practice (Lecomte et al., 2008). Although the authors suggested that this did not impact on results, therapists' experience levels are important to consider in clinical practice.

Interestingly, only two of the five group interventions directly referenced using group processes to enable change, which may reflect the therapeutic approach of these groups (mindfulness-based, and a more novel intervention focused on improving self-concept; Macdougall et al., 2018; McCay et al., 2007). Drop-out rates were similar across

interventions, and quality scores were higher for individual intervention studies (M=20) compared to group intervention studies (M=17), indicating the former were of better quality as rated by the Downs and Black's tool.

### **Individual versus Group Interventions: Symptoms**

Results were mixed; for studies that reported significant effects, these were mostly within-group effects, indicating a lack of clarity around whether the intervention was effective at improving symptoms in comparison to another treatment. However, it is important to note that individual interventions tended to focus on improving symptoms as a primary outcome, and group interventions tended to focus on improving functioning and symptoms. Further, group intervention studies tended to be of poorer quality than studies exploring individual interventions, and so a firm conclusion and comparison is difficult to make. These findings are in contrast with previous research, such as the meta-analyses outlined previously (Jauhar et al., 2014; Wykes et al., 2008), which found that both group and individual CBT interventions had a small effect on reducing psychosis symptoms. The difference in results could be explained by the studies in this review being of poorer quality.

### **Individual versus Group: Functioning**

Results were mixed; however, both modalities appeared to have some impact on improving participants' quality of life and feelings of hope, with individual interventions also appearing to improve engagement in structured social activities, perceptions of role functioning and extended social networks, and group interventions appearing to improve coping skills and attachment (emotional closeness to others). However, this may be a reflection of the studies included in this review.

It is also important to note that many of the results discussed were within-group rather than between-group differences, which limits their usefulness, as it is unclear whether the

improvement was related to the intervention or to natural improvement. These findings slightly contrast with previous meta-analyses, which found that both group and individual interventions did not appear to improve functioning in participants with longer-term psychosis (Jauhar et al., 2014) and those considered in an ARMS (Devoe, Farris, Townes & Addington, 2018).

Generally, the mixed results could be explained by many factors. As previously discussed, an important point of note is that many studies used a well-established intervention as TAU, potentially making it harder to establish an effect of the new intervention. Further, TAU were often complex, multi-faceted interventions, including family therapy and medication, again making comparisons between the two interventions difficult. Further, due to drop-out rates and variable use of intention-to-treat (ITT) analyses, some studies were underpowered, which can make it difficult to find an effect and makes it difficult to reach a conclusion based on significance. It should also be noted that for some individual interventions an improvement in functioning was not the aim, which was sometimes a secondary or ancillary outcome. Therefore, these studies would not have focused on improving functioning directly and may have impacted on their results.

### **Strengths and Limitations**

This is an up-to-date comparison of the efficacy of individual and group interventions for improving symptoms and functioning in young people experiencing a FEP, which is significant given the lack of research focusing on this population.

However, the review was limited by a number of factors. The small number of studies that met inclusion criteria, as well as the inability to perform a meta-analysis, makes it difficult to draw firm conclusions. Further, systematic reviews can be associated with

publication bias, as studies with positive results can be more likely to be published than studies with negative or null results (Dalton, Bolen & Mascha, 2016). However, many of the reviewed studies did report null results, suggesting this bias was reduced to some degree. Related to this is the lack of grey literature in the review; although this was not an exclusion criterion, due to the requirement of the studies being controlled, it was less likely that grey literature would be available, which may have also led to publication bias (Dalton et al., 2016). Another limitation was the inclusion of English-only papers, which limits the generalisability of the findings.

Functioning was defined and measured in multiple ways by the studies, with a range of measures of functioning being used, making it difficult to produce a useful comparison of findings. For example, the QLS is a self-report measure exploring life satisfaction and social functioning, and was used as a measure of functioning by studies, while the RFS is an informant-based measure exploring informant's perceptions of the participant's daily functioning in areas such as work, independent living and social relationships. Although both were used as measures of functioning, functioning itself has been defined and measured differently by the measures, and therefore does not offer strictly comparable information. Future studies would benefit from a consensus on which measures best reflect functioning as defined by service users of this population, which would enable a careful comparison of results and add to theoretical understanding.

Studies ranged in quality, with studies frequently not reporting effect sizes, as well as means, standard deviations and condition sizes which would enable effect sizes to be calculated, which compromises confidence in the studies. Further, some studies were underpowered due to attrition; although difficulty engaging this population is common and

expected in both research and clinical practice, not reporting power statistics is a violation of reporting standards (Moher, Schulz & Altman, 2001). Many study authors were also involved in delivering, or supervising the delivery of the intervention, as well as creating the manual for the intervention, introducing another risk of bias (researcher allegiance) of researchers potentially finding positive treatment effects of their intervention (Munder, Brutsch, Leonhart, Gerger & Barth, 2013).

Another important consideration is the well-documented limitations of using RCTs in establishing efficacy of psychotherapeutic interventions (Mulder et al., 2017; Shean, 2014). This includes issues of blinding assessors to the intervention received, with assessors often able to guess the intervention that participants have received, even when blinded (Friedberg, Lipsitz & Natarajan, 2010), limiting the effectiveness of blinding and increasing the risk of biased results; the difficulty in controlling for the non-specific elements of psychotherapy, established as the “main therapeutic ingredient” of interventions (Klein, 1997), again introducing a risk of bias and making it difficult to establish whether an intervention has been effective; and the difficulty in standardising complex, long-term, flexible interventions offered to complex clients, as used in EIPS, for RCT’s (Pawson, Greenhalgh, Harvey & Walshe, 2004). These difficulties may be more prevalent in group intervention studies due to its format, making it difficult to evaluate such studies based on a research design that was not designed for psychotherapeutic interventions.

Finally, males were disproportionately represented across all but one study (Newton et al. (2005) which affects the generalisability to females. However, this reflects the demographics of clients typically seen within EIPS, and the overrepresentation of males is a

common problem both clinically and within research (Ochoa, Usall, Cobo, Labad & Kulkarni, 2012).

### **Clinical Implications**

The findings have a number of implications and questions to be explored further. Services are increasingly focusing on improvements in functioning as an important outcome in response to service-user perspectives (Farkas, 2007). As has been discussed, functioning can be defined in various ways, and it would be useful to continue to compare which aspects of functioning individual and group interventions work best to improve, which could then be incorporated into clinical practice. It is also important to continue offering interventions focused on improving functioning, however it is defined.

### **Research Implications**

The findings of this review offer some suggestion that individual and group interventions impact different aspects of functioning, which could be explored through further better-quality studies, whilst acknowledging the limitations of RCTs. Individual and group interventions offered in conjunction may also offer benefits, which could also be explored in future research, with reporting following Consolidated Standards of Reporting Trials guidelines (CONSORT; Moher et al., 2001) to improve quality of reporting. This would ensure clear descriptions of interventions and results, enabling improved interpretations. Research could also explore potential moderators of interventions, such as impact of treatment duration, intensity, therapist, and treatment modality to establish what works best for this population, as well as the qualitative experience of engaging with group interventions for those experiencing FEP, which is currently lacking and would provide valuable insights.



## **Conclusions**

This systematic review indicates mixed findings for the efficacy of individual and group interventions improving symptoms and functioning in FEP; it was limited by poor quality studies and an inability to perform a meta-analysis. However, it was able to provide an overview of the available research for the FEP population, finding that group interventions were rated as poorer quality than individual studies. Individual interventions were offered more flexibly and for longer durations than group interventions, which tended to be shorter term and more structured. Better quality studies exploring the active therapeutic ingredients of both interventions could be undertaken; however, research design issues may limit this comparison.

## **Ethical Statement**

No ethical approval was required as this is a review of published literature.

## **Conflict of Interest**

The authors declare no conflicts of interest with respect to this publication.

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10.1016/j.schres.2005.02.018.

## **Chapter 2: Empirical Study**

**“I thought I’d have an Adventure”: Young People’s Experiences of Engaging in an Outdoor Therapy Group as an Adjunct to their Early Interventions in Psychosis Service**

SHORT TITLE: Young People’s Experiences of Engaging in an Outdoor Therapy Group Adjunctive to an Early Interventions in Psychosis Service

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## Abstract

**Objectives:** An Early Interventions in Psychosis Service (EIPS) offers talking therapy in conjunction with family therapy and medication to improve symptoms and functioning. Research with young people experiencing mental health difficulties suggests that outdoor therapy can be an effective intervention, and there is emerging evidence that it may be a useful adjunct to EIPS. In the absence of existing literature, the aim of the present study was to explore young people's experiences of engaging with a therapeutic outdoor therapy group (OTG) alongside their routine clinical care within an EIPS.

**Design:** A qualitative study was undertaken, using semi-structured interviews for data collection.

**Methods:** Six participants who had engaged with an OTG in a rural EIPS were recruited; their experiences of the group were explored using thematic analysis (TA).

**Results:** The analysis identified two main themes: "I was a bit nervous to begin with" and "Turn my life around for the better", which contained six subthemes: "We're all in the same boat", "My mental health has improved and improved", "I thought I'd have an adventure", "Makes me wanna change", "It just brought confidence/I ain't a waste of space" and "I hope it can help other young people".

**Conclusions:** Participants were initially anxious about engaging with the group, but once they overcame their anxiety, they felt that the group provided them with new experiences, a space to connect with others with shared experiences. They reported improved confidence, improved mental wellbeing, a desire for lifestyle change and a desire to help others with shared experiences.

### **Key Practitioner Points**

- Participants valued the experience of engaging in new experiences in an outdoor group environment with others with shared experiences.
- Highlights the potential benefits of this approach as an adjunct to routine care provided through EIPS.
- More research is needed to establish its feasibility and acceptability within EIPS, however the current findings are promising.

*Keywords:* first-episode; early; outdoor; adventure; group



Symptoms of psychosis typically develop between the ages of 14-35 (Kessler et al., 2007) and can have an adverse impact on psychological, cognitive, social and educational development, functioning (National Institute for Health and Care Excellence [NICE]; 2013), and confidence (Lloyd, Bassett & Samra, 2000). The stigma associated with psychosis can also significantly impact on wellbeing (Lloyd et al., 2000) and can often result in feelings of disconnection, impacting on recovery (Voruganti et al., 2006).

Early Interventions in Psychosis Services (EIPS) have therefore been developed to provide intensive biopsychosocial interventions (e.g. individual therapy, family therapy) to improve symptoms and functioning. However, engagement can be poor, with suggested rates of disengagement of around 70-80% (Turner; Smith-Hamel, & Mulder, 2007), which is often predicted by substance misuse, young age, male gender, low social functioning and adverse social environments, reflecting the demographics of many EIPS clients (Turner et al., 2007). Further, the service-user recovery movement defines recovery as social inclusion and leading a meaningful life, rather than remission of symptoms (Fowler et al., 2018); however, interventions aimed at these areas is often limited within EIPS (Voruganti et al., 2006). Therefore, adjunctive interventions that focus on improving functioning more broadly, and **supporting** clients to develop social networks, a sense of purpose, routine and hope for the future (Lloyd et al., 2000), which can improve outcomes (Fowler et al., 2018), are important.

## **Outdoor Therapy**

Under the umbrella term of adventure therapy, outdoor therapies are group-based interventions integrating challenging, experiential learning activities with structured therapeutic work (e.g. Cognitive Behavioural Therapy, CBT) in outdoor environments (Gass,

Gillis & Russell, 2012). Detailed approaches and philosophies have been described elsewhere (e.g. Gass et al., 2012; Fernee, Gabrielsen, Andersen, & Mesel, 2017); however, in brief, the theoretical underpinning is experiential learning to encourage the transference of learning experiences to other life areas (Gillis & Thomsen, 1996), with the aim of effecting “psychological and/or behavioural change” (Gass et al., 2012). Further aims include empowering individuals, social development, providing peer group membership (Bowen, Neil & Crisp, 2016), and supporting the recognition and adaptation of maladaptive life patterns (Richards & Peel, 2005). A key strength of the approach is the ability for facilitators to offer in-vivo support whenever maladaptive behaviours arise (Fernee, Gabrielson, Andersen & Mesel, 2015).

The approach is practised world-wide (Fernee et al., 2015), with increasing recognition within the mental health field (Bowen & Neill, 2013). A growing evidence-base supports its efficacy in creating short- and long-term therapeutic change with a range of populations, particularly adolescents described as experiencing psychological difficulties (e.g. Bowen et al., 2016). There is also emerging evidence of its usefulness as an adjunct to EIPS (Girard & Dube, 2017); in their small-scale quantitative study with a small qualitative element using a sample of participants aged between 19-27, Girard found that participants developed new interests, connected with others and experienced the group as fun. However, as this was a brief conference paper, detailed explanations of the study are not reported, and it is unclear on the detailed qualitative methods employed.

Group interventions can be an important part of EIPS (Lloyd, Sullivan & Williams, 2005), and outdoor therapies in particular may be useful for this client group, with recreationally-based forms of intervention often being better received by clients than

traditional forms of psychological interventions (Ferneer et al., 2015). Further, outdoor therapies target functioning in a variety of areas, a key concern for the recovery movement, and can provide a distraction from difficulties and adverse environments, and improve quality of life (Frances, 2006).

Much of the literature has centred on outcomes-based research, with few qualitative studies of participants' experiences being undertaken. An Interpretative Phenomenological Analysis study exploring the experiences of students with anxiety engaging in an OTG alongside their individual therapy, found that the group enhanced intra- and interpersonal relationships and enabled therapeutic change (Kyriakopoulos, 2010). Another qualitative study exploring the experiences of adolescent inpatients undertaking an OTG, found that the group improved participants' trust in themselves and others, led to empowerment, teamwork and enabled participants to recognise their personal values (Autry, 2001).

Despite the positive outcomes, and the experiences outlined, much of the research has not been explored with FEP samples, and evidence of how this type of intervention might be experienced by this population is scarce. Further, no such studies have been undertaken in the United Kingdom, with most research focusing on the United States and Australia. The current study therefore aims to explore the experiences of an EIPS sample of young people of engaging with an OTG in the United Kingdom; the research question is "what are young people's experiences of engaging with an OTG as an adjunct to their EIPS".

## **Method**

### **Design**

Semi-structured interviews were undertaken for data collection; the initial framework and analysis chosen was Interpretative Phenomenological Analysis (IPA), to enable an in-depth exploration of participants' lived experiences. IPA focuses on understanding people's lived experience, in great detail, requiring the ability of participants to be verbally expressive and articulate about their experiences (Willig, 2013, pg. 283).

Through the process of data collection, it was felt that participants struggled to articulate and verbalise their experiences of the group to an appropriate level for an IPA analysis. The data was therefore analysed using thematic analysis (TA), chosen for its flexibility in approach and assumptions, and in line with Braun and Clarke's (2006) assertion that analysis choice can and should change depending on the type of data available. Further, TA is able to provide a detailed account of a range of data (Braun & Clarke, 2006). The aim of the chosen analysis was to provide a rich and detailed description of the entire dataset, particularly useful in under-researched areas (Braun & Clarke, 2006), as an initial exploration of the experiences of young people in an EIPS of engaging in an OTG.

### **Intervention**

An open, rolling, OTG was set up independently of this study in a rural EIPS in Wales in March 2018, and was offered alongside routine EIPS on a fortnightly basis. In line with outdoor therapy philosophies, the aim was to integrate therapy and the outdoors to build psychological resilience through a programme of activities of increasing difficulty and exposure.

The group was underpinned by principles of CBT adapted for psychosis (CBTp), and sessions typically lasted around four hours. Facilitators were specialist EIP practitioners who provided support as needed throughout sessions. The group was ongoing at the time of this study. See Table 1 for sample activities and associated challenges.

**Table 1.**

*Sample Activities and Associated Challenges*

Activity	Challenges
<b>Paddle Boarding</b>	<ul style="list-style-type: none"> <li>Physical exertion</li> <li>Social skills</li> <li>Following instructions</li> <li>Managing emotions in a potentially frightening environment</li> <li>New activity</li> <li>Overcoming fears</li> </ul>
<b>Mountain walks</b>	<ul style="list-style-type: none"> <li>Physical exertion</li> <li>Social skills</li> <li>Following orders</li> <li>Managing emotions in a confined environment</li> <li>Overcoming fears</li> <li>New activity</li> </ul>
<b>5-day sailing trip</b>	<ul style="list-style-type: none"> <li>Physical exertion</li> <li>Social skills</li> <li>Following orders</li> <li>Managing emotions in a confined environment</li> <li>Working as a team</li> <li>New activity</li> <li>Overcoming fears</li> <li>Being away from home environment for an extended period</li> <li>Managing emotions and conflict in a confined environment, for an extended period of time</li> </ul>

## Participants

In accordance with qualitative methodology, the aim was to find a small homogenous sample (Lyons & Coyle, 2007). A purposive sample of six participants who were currently engaged in the EIPS OTG were recruited. Eligible participants were aged 16 and over, were English-speaking and could give informed consent. Group members had been screened for

appropriateness by their clinicians prior to group engagement based on their clinical presentation. Diagnoses were not specified as inclusion criteria as young people are often not given a diagnosis for some time following symptom onset (Lieberman & Fenton, 2000). Participant information is presented in Table 2. All participants were male and White British (four Welsh, two English); five were receiving benefits and one was a middle-class university student. A mean of 13 sessions of the activity group had been attended (SD=4.8, range 5-20 sessions).

**Table 2.**

*Clinical and Demographic Information*

<b>Participant ID and pseudonym</b>	<b>Age</b>	<b>At-Risk Mental State (ARMS) or First-Episode Psychosis (FEP)</b>	<b>Sessions attended</b>	<b>Length of time in EIPS (years)</b>	<b>Boat trip</b>
<b>P1 Dafydd</b>	16	ARMS	10	3	Yes
<b>P2 Aled</b>	23	FEP	5	2	Yes
<b>P3 Gethin</b>	21	FEP	15	4	Yes
<b>P4 Dylan</b>	23	ARMS	10	2	No
<b>P5 Osian</b>	23	FEP	15	2	Yes
<b>P6 Rhys</b>	23	ARMS	20	1	Yes

## Procedure

Ethical approval was granted (appendices B-F). Potential participants were identified by group facilitators and provided with participant packs, which included participant information sheets (appendix G). Interested participants were contacted by the first author. Braun & Clarke (2006) suggest that sample size guidance is non-specific and based on study needs, with 6-10 participants being recommended for smaller projects. From the small number

of OTG attendees, seven people expressed an interest and six were recruited, with one participant eventually declining due to life circumstances.

### **Author Reflexivity Statement**

The first author (CB) is a female final-year Trainee Clinical Psychologist with a keen interest in the outdoors and its integration with therapy; participants were informed of this during recruitment. CB completed the interviews; she had little experience of undertaking qualitative research interviews and researched and practised completing interviews beforehand. The second and third authors are both male qualified Clinical Psychologists of over 10 years. All authors worked in the EIPS; the first author did not meet the participants until the interviews began, whilst the other authors had worked clinically with all participants. Reflexivity was enhanced with a reflective diary (Braun & Clarke, 2013), particularly useful in developing ideas for the analysis, charting the learning process and staying close to participants' experiences.

### **Data Collection**

Semi-structured interviews were undertaken by the first author in January 2019 in locations convenient for the participants (i.e. community centre or home). A flexible interview guide was developed by the first author in consultation with the second author (Appendix I) and piloted on the third author. Questions included "what was going on in your life around the time you became involved in the group" and "how does the group fit in with your life". Confidentiality, anonymity and permission for interviews to be recorded was discussed, and written informed consent was obtained (Appendix H). Interviews lasted between 34 and 118 minutes and were audio-recorded; five interviews were undertaken in one session and one interview was undertaken across two sessions. Participants had a variable level of articulacy

about their experiences; some were able to speak at length and reflect on their experiences, whilst others required more prompting, which was managed using interview prompts. Participants spoke about their experiences of the group generally, and some also spoke at length about their experiences on a five-day sailing trip.

## **Data Analysis**

An inductive approach to analysis was taken from a contextualist epistemological position, chosen as it **would enable the exploration of** the reality of participants' experiences of the group, alongside an acknowledgement of the impact of the wider context in shaping their meaning making and understandings (Willig, 2008). Coding and theme development were primarily at the semantic level, with these choices reflecting the research aim of identifying patterns in young people's experiences and to stay close to these experiences (Braun, Clarke & Rance, 2014). This approach also helps to avoid assumptions and biases in the literature being perpetuated and limits the influence of researchers' pre-existing beliefs (Braun & Clarke, 2006).

Analysis was undertaken by the first author. Interviews were transcribed verbatim and the transcripts read multiple times for data immersion. Braun and Clarke's (2006) six-step approach to TA was chosen to ensure methodological rigour; diverse coding by hand following their approach produced 227 initial codes, which were then collapsed into 62 codes throughout the analysis process. This included checking for repetition, changing related smaller codes into larger 'key' codes, and discarding codes and themes which were not directly related to the research question (see appendix J and K for example transcript and list of codes). Coding and themes were shared throughout with the co-authors and disagreements were resolved through



discussion. The analysis process also adhered to the 15-point checklist outlined by Braun, Clarke and Rance (2014; Appendix L) which outlines criteria for a good TA process.

## Results

Two main themes and six subthemes were elicited by the analysis (see Table 2). This paper focuses on the main theme of “turn my life around for the better”, due to its relevance to functioning and recovery, key concerns of the recovery movement and EIPS (Farkas, 2007). A description of the patterns in the dataset, followed by interpretations and theorising around their broader meaning and implications in the discussion section, as outlined for an inductive TA (Braun & Clarke, 2006), is presented.

**Table 3.**

*Themes and Subthemes*

Themes	Subthemes
<b>1. “To begin with I was a bit nervous”</b>	
Participants’ experiences of initial anxieties of engaging in the group (see appendix M for an exploration of this theme)	
<b>2. “Turn my life around for the better”</b>	(a) “We’re all in the same boat”
Participants’ experiences of their journey from negative to positive experiences	(b) “My mental health has improved and improved”
	(c) “I thought I’d have an adventure”
	(d) “Makes me wanna change”
	(e) “It just brought confidence”
	(f) “I hope it can help other young people”

## **“Turn My Life Around for the Better”**

Participants spoke at length about the positive impact the group had in different areas of their lives, reflected in the six subthemes that this main theme was broken down into. All themes were inter-linked and contributed to participants' sense of their lives changing positively.

**2 (a): “We’re all in the same boat”.** This subtheme highlighted the experience of disconnection from society prior to the group, to the experience of developing connections with other group members. Participants spoke about feeling disconnected from society prior to the group because of their unusual experiences; Aled said: “one of the things that I experienced with the whole experience of psychosis was like being different and strange”.

This was contrasted with participants' experiences of connecting with other group members who had similar experiences, with the group enabling them to build friendships and connections with others, whilst recognising that they were not alone in their difficulties.

These experiences are summed up by the following quote from Rhys:

*It's made me like I'm not lonely, you know what I mean? There's other people out there suffering the same kind of stuff. And when we were doing the activity group it was like we all had our own problems but we all had things in common. And err that basically, well, that's obviously helped me a lot as well*

Dylan also said: “it was really good making friends with all of them people because they went through the same stuff as what I went through and I could really relate to them”, with

Gethin also highlighting the strong friendships that had been built through the group. When talking about his relationship with another group member, Gethin said: “turns out I’m better mates with him (now) than my old mates”.

Participants also spoke about their new experience of being cared for within the group and being valued as a person, rather than being judged in relation to their difficulties; Dylan said: “it felt like people like actually cared about me yeah and not see me for, not see what’s wrong with me, see me as a person”. Dafydd also noted: “none of them judged me for my problems because they’ve got problems (too) innit?”.

**2 (b): “My mental health has improved and improved”.** This subtheme was related to the positive impact the group had on participants’ mental wellbeing, which was contrasted with their wellbeing prior to engaging with the group. Participants spoke about their difficulties before the group:

*Erm I was going through like a rough time. Really like mentally and I hit like quite a bad phase at that time and erm I was experiencing like imaginary friends and stuff, so I needed help. It was a bit scary at times (Rhys)*

In contrast, participants described that overall, the group had been a joyful experience; when talking about mental wellbeing and how the group had played a positive part in this, Aled said: “building experiences that are positive, having fun is actually probably the best thing you can do”, with some participants noticing changes within the group itself, and for others, this was sustained. In relation to the experiences, participants also valued that the group allowed them to create positive memories; when talking about the group and mental

wellbeing, Aled said: “I think gaining good memories is really important, especially if you’ve had something that’s largely negative (psychosis)”.

Participants also spoke about ways the group had reduced their stress; Gethin said: “yeah it was proper nice just being there, not like fucking stressing. Everything stresses me really but this was different”, and participants also described the impact the group had on their unusual experiences, which had provided an opportunity for participants to leave difficult environments and experience feeling calmer and more relaxed. When talking about his experiences on the sailing trip, Osian said:

*ahh it was nice...I don't have any other words for it...it was just really good...it was just peaceful and chilled out...and having no worries...there's like nothing going on...like no worries...don't hear voices and stuff...just nice*

**2 (c): “I thought I’d have an adventure”.** This **subtheme** was defined by the new experiences that participants had as a result of their group engagement. Participants described their sense of life being bleak prior to engaging with the group; when describing his life before, Osian said: “I didn’t have anything to look forward to, just like the next week is just, just what comes, just the next day and it just goes on and drags a bit, and it just feels like one big day”.

In contrast, the group was seen as offering a new experience: “I didn’t have anything to look forward to but next week (with the group) I’ve got something to do and something to look back on” (Osian). Dylan also said of the group: “it made my life more exciting”.

Participants also spoke about the experience of engaging with different things; Dylan said: “I was getting out and seeing things and experiencing things and learning about different things, like nature and stuff”.

Participants also valued experiencing different environments, which they found helped them gain perspective on their lives:

*we were in the sea and it was just so sunny and....so calm and I was just...looking out, and I was just...open my mind up yeah...like the problems I have at home, they're not that big. The things I worry about I shouldn't worry as much about (Rhys)*

**2 (d): “Makes me wanna change”.** This subtheme was defined by participants’ motivation to make lifestyle changes as a result of their group experiences, which they contrasted with their lifestyles prior to the group. When talking about his life before the group, Gethin said that he was “smoking loads, doing nothing” and participants generally conveyed a sense that they felt their lifestyles were unhealthy before the group. When talking about his mental health, Aled said: “too much time spent doing nothing was actually very damaging”, as he felt it encouraged him to dwell on difficult thoughts.

In contrast, by engaging in the group, particularly the sailing trip, the participants found that routine and structure had been missing from their lives but was an important experience: “because it was like getting up every morning, like, we had routine, we were doing something” (Dafydd).

The group experience, and particularly having routine and structure, lead to a desire for participants to make lifestyle changes: “it made me wanna stop smoking yeah” (Gethin). Participants had then attempted to make changes in their everyday lives; Osian said: “like I’m not gonna have a job soon yeah...but trying to build up to getting a job like trying to wake up early and stuff, so just getting into a routine if you know what I mean”. Rhys added: “but after

that sailing trip I started erm ... boxing, I started running. I started eating well every single day”.

Many participants were aiming for employment, with some already having found work, which they attributed to their group experiences: “like going on the boat, actually working to do something...if I could do the same outside of the boat then sorted innit? And then I ended up getting a job” (Dafydd).

Participants also spoke about the ways that the group had made them want to change. Rhys said: “what that did was open my mind up and make me want to do things with my life”.

**2 (e): “It just brought confidence/I ain’t a waste of space”.** This subtheme was defined by participants’ experiences of how the group had positively impacted on their self-esteem and confidence over time, which was contrasted with a perceived lack of confidence prior to the group. When discussing their lives prior to the group, participants described themselves in negative terms, such as “a waste of space” (Dafydd) and “a bum” (Gethin). They described the experience of psychosis as having a profound impact on their self-esteem and confidence: “a lot of people had similar experiences in terms of their confidence was knocked considerably by what they’d experienced [psychosis]” (Aled).

Participants also spoke about seeing themselves as unworthy due to their unusual experiences. When describing his experiences of hearing voices and his self-perception prior to the group, Dylan said: “at first I just thought I was going insane, I thought I was not worthy of anything”.

Further, participants alluded to their understanding of the stigma attached to mental health difficulties. Gethin was keen not to be labelled and hadn’t shared his difficulties with

his friends for fear of being ridiculed: “I just don’t wanna get labelled, none of my mates know I go through shit yeah, hell no they’d take the piss out of me if they knew”.

This was contrasted by the way participants described themselves after engaging in the group, with participants describing feeling more confident and able to do things they had previously been unable to do: “like being able to speak to people in the street, being able to go to the shop to buy milk, being able to leave the house” (Rhys).

Participants also acknowledged the process of building confidence as incremental, and the transference of building confidence in the group to other areas of life: “not just in the group but confidence in like other places and stuff. And it was like over time, obviously it hasn’t happened overnight but over time its builded up” (Rhys).

Often, participants’ self-esteem and confidence improved as a result of feeling capable and achieving within the group, which often involved completing new activities and tasks:

*I felt good to be honest. Because they’re all like, I think the youngest next to me was 18 and that’s still two years difference. But like they’re older than me and I’m still doing the same as them [boat activities] (Dafydd)*

Dafydd further illustrated the impact the group had on the way he viewed himself: “it was like I changed as a person, I ain’t a waste of space innit”.

Finally, in line with participants’ experiences of their confidence being affected as a result of their experiences, rebuilding confidence was seen as an important part of recovery: “I think in terms of elements of recovering from psychosis, because it affects confidence largely” (Aled).

**2 (f): “I hope it can help other young people”.** This theme was defined by participants’ desire to return the perceived benefits they had received from attending the group, to others who shared similar experiences. Participants saw the group as valuable and as an important part of their recovery process, and were keen to share the benefits of this with others:

*The way I’ve used the experiences, like the sailing trips and the groups, to turn my life around for the better and I just hope that it can help other young people with the same problems, or with difficult problems, to encourage them to do the same with their lives. I just hope they can gain from that, even just a little of what I’ve gained, it’s helped me so much so I just hope other young people will gain as much as I have from it (Rhys).*

## **Discussion**

This is a preliminary qualitative study exploring the experiences of a sample of EIPS participants in engaging with an OTG, which aims to support the development of this novel approach within EIPS. It is the first detailed exploration with this client group engaging with an OTG, and findings indicate that participants were able to overcome their anxieties and engage with the group, which lead to positive change and growth. These findings are in line with both outcomes and qualitative research into the benefits of outdoor therapy with other samples (e.g. Bowen et al., 2016) and EIPS participants (Girard & Dube, 2017), and demonstrates that individuals experiencing psychosis can engage and benefit from this form of intervention. The OTG was ongoing at the time of this study, and therefore, the experiences discussed represent an ongoing process for participants.

### **“Turn My Life Around for the Better”**

Change and growth was facilitated by the group in a variety of ways, which were all inter-linked: by developing connections and having their experiences normalised by their peers,



and engaging with and overcoming challenges, participants were able to develop their confidence and self-esteem. They developed a new perspective on themselves and their lives through engaging with new activities and environments, and led to a desire for lifestyle change and a desire to help others with similar experiences. These findings are in line with research, indicating that service-users value interventions that improve functioning in a range of areas and see improvements in these areas as integral to their recovery (Byrne, Davies & Morrison, 2010).

Participants' experiences of connecting with others, developing friendships and having their difficulties normalised is in line with similar research of OTGs (Girard & Dube, 2017; Kyriakopoulos, 2010; Bowen et al., 2016). Their experiences also suggest that they had been able to develop social skills as part of the group, which are often negatively impacted in young people experiencing psychosis (Lloyd et al., 2000). Further, as psychosis can often be lonely and isolating, experiences of belonging and connectedness to a group can be important protective factors against declining functioning and other mental health difficulties, with research suggesting that social isolation can be a barrier to recovery (Fowler et al., 2018). The OTG also appeared to be experienced as safe by participants, as evidenced by their continued engagement and ability to develop friendships, an interesting finding given that the group was open to new members, and that many people experiencing psychosis often feel unsafe (Freeman et al., 2015). Again, this indicates that an important process had taken place within the group context, which appears to have been facilitated by shared adversity. These findings of connection as part of the OTG are also in line with those from Kyriakopoulos (2010) and Girard and Dube (2017), who found that participants felt connected with fellow group members in their OTGs.

Participants also valued engaging with the new experiences the OTG provided, which was in contrast to their everyday lives. Most participants were from lower socioeconomic status (SES) backgrounds, with limited abilities to engage with the activities provided by the group; research indicates that those from lower SES backgrounds are less physically active than those from higher SES backgrounds (Stalsberg & Pedersen, 2010), with high costs of activities a barrier to engagement (Hoff & Mitchell, 2007). Therefore, for this sample, engaging with these activities may have been more impactful given their low SES. The intervention offered participants a different perspective from being in new environments and engaging in new activities. As discussed, adverse social environments are a known maintenance factor of psychosis, and therefore leaving such environments, even for short periods of time, can be useful interventions (Fowler et al., 2018), which normal life and mental health services cannot typically provide. Whilst leaving adverse environments is not always possible or feasible, providing participants with the opportunity to leave these environments at least once a week seemed to provide a positive benefit for this sample, in line with other research on outdoor therapies that highlighted that a core component of the approach is its use of new environments and experiences to effect change (Gass et al., 2012).

Participants also described making changes to their daily lives by changing their behaviour, particularly referring to routine as a positive and important change; research has indicated that unstructured time increases risky behaviours and poor outcomes in young people (Fredricks and Simpkins, 2012). Participants associated having a routine with positive attributes that could potentially lead to finding employment, indicating an awareness of society and the impact that not having a routine could have on their lives, in line with service-user research that increased structure had a positive impact (Byrne et al., 2010), and similar findings from Fowler et al. (2018) on the importance of structured activity for EIPS clients. These

experiences also indicate that participants were able to use experiences from the group and apply these to other life areas, in line with research that indicates that such changes can occur through OTGs (Gass et al., 2012).

Participants built their confidence through engaging in the group and seeing themselves as capable of completing activities. This increased confidence was reflected in other areas, such as the desire to make lifestyle changes, become healthier, find employment, and help other people with their difficulties. As iterated by participants, building confidence is an important part of recovering from psychosis; again, this is reflected in the literature which indicates that OTG's can improve confidence and self-esteem (Gass et al., 2012). Although this sample did not directly talk about overcoming difficult tasks, they alluded to their experience of feelings of achievement, suggesting this had taken place as part of the group, which is again consistent with the outdoor therapy literature.

Participants were also keen to share the positive aspects of the group with others with similar experiences; similar findings were reported by Kyriakopoulos (2010), who found that participants reported enhanced feelings of mutual caretaking whilst engaged in their OTG. Fowler et al. (2018) outlines this as an important aspect of social functioning.

Although participants' group engagement wasn't directly explored in this study, the current sample were currently engaging with the group, had been doing so for some time, and frequently commented on their enjoyment of it. This supports research that suggests that recreationally-based forms of interventions may be better received by some clients, particularly younger clients (Ferneer et al., 2015). Further, this type of intervention could potentially be more suitable and beneficial for their developmental stage than more traditional "talking therapies", which require the ability to articulate and reflect on experiences and

tolerate close proximity to others. Further, this intervention also links in with clients' perspectives about recovery; social inclusion and functioning improvement, rather than symptom reduction (Fowler et al., 2018).

### **Strengths and Limitations**

This is the first detailed exploration of EIPS participants and their experiences of engaging with an OTG as part of their EIPS. It is a timely piece of research given the growing consideration of incorporating the outdoors in mental health interventions, and it was felt that TA offered a useful and appropriate method of analysis which matched the aims of the research question.

The authors also acknowledge several limitations with the current study. Although the purpose of qualitative studies is not to make generalisations to other populations, the sample is skewed towards young White British men, and whilst this reflects the study's local population and EIPS clients, black and minority ethnic (BME) and female clients also engage with EIPS and were not represented in this sample. A broader range of diversity when exploring OTGs would therefore be beneficial.

Although challenges were discussed by participants about their initial anxieties of engaging with the group, and questions were asked about difficult experiences, most reported that they had not encountered any difficulties during the group. Whilst this represents the experiences of this particular sample, it contrasts with general research and theory about outdoor therapy of its challenging nature and challenging activities, which are of core importance. For example, Kyriakopoulos (2010) found that participants valued the challenging nature of the outdoor group they engaged with and reflected on this as a core component of their growth, and the finding in the current sample may be related to several factors. The level

of challenge in the activities may not have been sufficient for participants to experience them as challenging; participants may have had difficulty verbalising and discussing their difficult experiences; participants may have felt unable to discuss more challenging aspects of the group as the research team were also part of the EIPS and one author was particularly involved in the group. It is also acknowledged that the interviews were undertaken by a member of the EIPS; whilst she had not engaged with the participants prior to the interviews, their responses about their group experiences may have been positively biased. Further, all participants were engaged in the group to some degree, representing a bias towards those who had benefitted from the intervention and therefore continued to engage. It may have been helpful to include participants who were no longer engaged in the group to provide a broader range of experiences, and potentially use interviewers who were not part of the EIPS to provide more space for participants to discuss difficult or challenging experiences. Nevertheless, the findings represent an interesting and valuable insight into group experiences in this setting.

The degree to which participants were able to articulate their experiences varied greatly. Participants contributed to all themes, and although efforts were made to ensure a wide range of quotes were included from each participant, with an even spread between participants, some participants were slightly overrepresented in the included quotes. However, according to Braun and Clarke (2006), this is common when writing up qualitative research with participants of varying levels of articulation. This may also be reflective of the fact that participants are still in the midst of their growth and change, and may have had different opportunities to reflect on their experiences prior to interview.

Due to the first author's interests and knowledge of outdoor interventions, there was a constant tension between maintaining an inductive analysis and bracketing existing knowledge

of the evidence-base and theories to steer away from a deductive, theory-driven analysis. However, as outlined by Braun and Clarke (2006), the authors acknowledge that researchers cannot completely free themselves from pre-existing knowledge and beliefs, and the impact of this on the study, particularly the analysis, was frequently reflected upon in supervision.

Finally, an important point of note is the focus of participants on talking about their experiences of the five-day sailing trip. Whilst the interview explored their experiences of the group in general, participants spoke at length about their sailing trip experience, and it was often difficult to ascertain which part of the intervention had contributed to their experiences. Again, whilst this represents this particular sample's experiences of their OTG, a core part of outdoor therapy is engaging in accessible activities that clients can frequently engage in. Whilst the current findings are interesting, specific findings, such as the experience of extended routine and structure whilst on a boat, will be difficult to replicate in routine clinical practice. However, activities that provide an element of these experiences may be replicable, such as a short-term wild camping trip, and could be considered as an adjunct to routine EIPS.

### **Clinical and Research Implications**

The experiences of participants in this study adds to the developing evidence-base that outdoor therapy can be a beneficial adjunct to EIPS, with it also being well-received by the current sample. The experiences outlined, such as improvement in wellbeing and confidence based on new experiences and meeting others, could provide the basis for developing new interventions in EIPS, whether developing OTGs or incorporating the outdoors into existing therapies.

Future research could begin to explore its feasibility and acceptability in other EIPS teams, to determine whether this type of intervention would be possible elsewhere in the UK.

The current study took place in a rural location, and the traditional outdoor therapy activities of hiking and camping may be difficult to arrange, particularly in urban areas; however, creativity could make this possible, and it appears that the benefits are worthwhile.

Theories regarding outdoor therapy have been detailed elsewhere (e.g. Fernee et al., 2017); however as discussed, these theories may not be applicable to EIPS samples as much of the literature has been completed with non-clinical samples. Therefore, future research, such as ethnographic studies, based on live observations, could begin to explore the core components of the outdoor therapy experience for such a sample and provide a further basis for theory developments.

Future research could also begin to quantitatively explore the outcomes of OTG's in EIPS, using the themes outlined in this study, such as increased confidence and desire for lifestyle change, as guidance for outcome measures, to determine its efficacy. Specific questions may include questions of whether increased engagement leads to better outcomes within the group and whether those who have individual therapy alongside the group are more able to incorporate OTG education and skills into their everyday life. Longer-term evaluation is also important to track its usefulness over time, and practical difficulties of developing a realistic control condition would also need to be considered.

Samples should, where possible, reflect EIPS populations as much as possible to ensure findings are applicable to a range of clients; therefore, including more females, more BME clients and those who have struggled or disengaged from the group, would provide important insights.

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### **Ethical Statements**

The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the APA. Ethical approval was granted by The School of Psychology Bangor University, (2018-16276), and the Betsi Cadwaladr University Health Board Research Ethics Committee and HRA and Health and Care Research Wales (REC reference: 18/WS/0227).

### **Conflict of Interest**

The authors have no conflicts of interest with respect to this publication.

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### **Chapter 3: Discussion Paper**

## **Contributions to Theory and Practice**

This thesis explored psychological treatments for young people experiencing first-episode psychosis (FEP), with a focus on group interventions. The systematic review compared the effectiveness of individual and group psychological interventions for improving functioning and symptoms of psychosis in young people experiencing a FEP. The empirical paper explored young people's experiences of engaging with an outdoor therapy group as an adjunct to their routine care in Early Interventions in Psychosis Service (EIPS). The final paper integrates the findings from both papers to consider the implications for theory development, future research and clinical practice. Finally, personal reflections on conducting the research are included.

## **Theoretical Implications and Future Research**

Whilst the findings of the literature review were inconclusive, it broadened our understanding of group and individual interventions with a comparison being made between the two modalities. The comparison raised the question of whether both interventions are effective in improving different aspects of functioning; with individual interventions appearing to work well at improving engagement in structured social activities, perceptions of role functioning and extended social networks, whilst group interventions appear to improve coping skills and attachment (emotional closeness to others). Whilst this may be the result of the studies included in the review, it may also represent specific outcomes targeted by each intervention; for example, the individual therapy recommended for EIPS, Cognitive Behavioural Therapy, often focuses on reducing symptoms as a primary outcome and functioning as a secondary outcome (Fowler et al., 2018). However, as outlined by the user-recovery movement, improvements in functioning, rather than reductions in symptoms, are a

main concern (Fowler et al., 2018), and interventions in line with these outcomes should also be offered. It is recommended that large-scale studies with larger sample sizes, suitably powered to detect effect sizes, as well as smaller-scale research, such as service evaluations, are used to explore interventions focusing on improving functioning, which could result in beneficial interventions being developed.

The literature review also highlighted the differences in quality and availability of studies for each modality, with individual studies being more common, and tending to be larger and better reported. A lack of research related to FEP samples was also noted as part of the literature search, with many studies focused on older samples of participants experiencing longer-term psychosis and/or diagnosed with Schizophrenia, meaning a small number of studies were included in the review. This is an interesting finding, given the development of EIPS which focuses on FEP in clinical practice, and the mixed availability of targeted, biopsychosocial interventions for those with longer-term psychosis, or diagnoses of Schizophrenia, in community mental health teams. These findings highlight the need for more studies focused on outcomes of group interventions for EIPS and their clients. The findings also highlight the need for more studies focused on samples of FEP individuals, to develop a better understanding of the interventions that are most useful for this client group.

There was a difference in the quality of papers, with individual intervention studies generally receiving higher scores based on a quality assessment tool, than group intervention studies, generally based on the ways in which information was reported. Future studies should be of a good quality; RCTs are the golden standard, however there are limitations of this approach for evaluating complex psychotherapeutic interventions with complex samples, which should be acknowledged. Studies should ensure they follow reporting guidelines at the

least, to improve study quality (Consolidated Standards of Reporting Trials guidelines (CONSORT; Moher, Schulz & Altman, 2001)).

Many studies included in the first paper specified substance misuse as an exclusion criterion; however, in clinical practice, co-morbid mental health and substance misuse difficulties are common. Further, studies used strict diagnostic criteria (diagnoses of non-affective psychosis) as inclusion criteria (with the exception of Newton et al., 2005, who acknowledged the difficulty in giving young people diagnoses due to the complexity of the development of psychosis). Whilst this is a pragmatic approach, it does not accurately reflect clinical practice, with younger people often not receiving diagnoses for some time following symptom onset (Lieberman & Fenton, 2000). Further, there is a shift towards conceptualising psychosis as a spectrum (Kuipers et al., 2006) and this should be reflected more accurately in the research. It is therefore important that research includes samples that match clinical practice in EIPS as much as possible, to ensure validity and reliability of findings.

The empirical paper presents findings from an exploration of a novel intervention, an outdoor therapy group, as an adjunct to routine EIPS. Whilst there is a growing evidence-base for its application with a range of client groups, samples of young people experiencing psychosis are scarce. One study, reported as a conference paper, demonstrated benefits of an outdoor therapy group (OTG) as an adjunct to an EIPS in Canada (Girard & Dube, 2017). Whilst the findings were promising, the study was not peer-reviewed, and details of important aspects of the project, such as participant demographics, details of the EIPS within which the study was undertaken, and the OTG itself, were not included, making it difficult to assess the findings. The current empirical paper therefore adds to this emerging evidence-base, and provides further insights into the experiences of young people of engaging with an



OTG as an adjunct to their EIPS. The findings indicate that participants were able to experience many benefits, such as improved confidence and wellbeing, and a desire for lifestyle change, in contrast with negative experiences they described as having before their group engagement.

On a broad level, the participants' descriptions of negative experiences before their group engagement are in line with evidence regarding young people in general, which suggests increasing mental health difficulties and reduced wellbeing as a result of increased societal pressures and the current socioeconomic climate. A recent report by the Prince's Trust (Prince's Trust, 2019), which measures young people's happiness and confidence levels, found that young people are experiencing their lowest levels of wellbeing since their reports began in 2009. Contributing factors included poor working conditions and employment availability, perceived lack of opportunities for career development and worry about finances. For young people with psychosis, these societal pressures are compounded by psychosis and its associated stigma and perceptions of abnormality (Lloyd et al., 2000). Further, the symptoms of psychosis and its associated difficulties typically develop at a young age, during a critical period of development for young people (Birchwood, Todd & Jackson, 1998), further compounding young peoples' wellbeing and development.

The negative experiences that participants outlined of their lives before their group engagement can be understood within the context of theories of psychosis. Participants described living within poor social circumstances, experiencing symptoms of psychosis, poor wellbeing and low confidence and self-esteem; in their cognitive model of psychosis, Garety, Kuipers, Fowler, Freeman & Bebbington (2001) suggested that adverse social environments are important triggers and maintaining factors of symptoms of psychosis. In further support

of this theory, participants in the current study outlined their experiences of reduced symptoms during their engagement with the group, which involved leaving these environments. Participants also valued experiencing brief periods of change in their social environments whilst engaging in the activities, particularly the sailing boat, and experienced positive change as a result, further suggesting that they were able to break a maintenance factor of their difficulties. In further support, research has suggested that supportive social environments are related to reduced positive symptoms of psychosis (Norman et al., 2005), with participants in the current study describing such experiences.

The findings of the empirical paper of participants experiencing positive outcomes as a result of their group engagement, also link with the outdoor therapy theories of change, with one theory suggesting that the positive outcomes often evidenced by OTGs is the result of engaging with unfamiliar physical environments (Nadler, 1993). Further, the theory suggests that the unfamiliar environment creates a state of dissonance through the creation of anxiety and perceptions of risk, and that by overcoming the dissonance through engaging with, and overcoming the challenges produced by the environments, individuals experience positive benefits, such as improved confidence (Nadler, 1993). Participants in the current study were able to experience positive benefits such as improved confidence and wellbeing and a desire for lifestyle change, and as suggested by the theory, the change of environment may have been an important factor in these improvements.

Table 1 outlines the conceptual framework of the wilderness, or outdoor therapy, treatment milieu, as outlined by Russell and Farnum (2004). The theory outlines the potential therapeutic factors leading to change for participants; as previously stated, much of outdoor therapy literature has not been completed with young people experiencing psychosis,

however, the framework outlines potential aspects of change which could be applicable to the sample in the empirical paper as it is based on studies of ‘at-risk’ adolescents. The model specifically focuses on wilderness therapy, a form of outdoor therapy that also incorporates elements of outdoor living, such as wild camping. Fernee, Gabrielsen, Andersen and Mesel (2017) suggest this as being applicable to outdoor therapies more broadly due to their similarities. The model suggests a dynamic process between the three therapeutic categories, which are each able to facilitate change and are present at all times of the intervention to varying degrees, which are: (1) the wilderness, (i.e. nature, the outdoors) (2) the physical-self, which includes interactions with nature and activities as part of the therapy which facilitate learning or personal growth; and (3) the social-self, related to the social interactions which take place as part of the group, and the specific learning environment facilitated by the OTG. It was hypothesised that each category had peak intensities, as participants moved through their OTG experience, with the ‘wilderness’ category being the highest at the start of a new activity, where the environment may be perceived as new, exciting and/or overwhelming. Once participants had familiarised with the environment, Russell and Farnum (2004) hypothesised that the physical-self became most important, with participants able to challenge themselves and engage with physical activities. Finally, once participants had developed a level of perceived mastery over the environment and tasks, Russell and Farnum (2004) suggested that social interaction could occur, with developments in the ‘social-self’ category.

This model corresponds to some degree with the findings of the empirical paper; for the category of ‘wilderness’, participants experienced the **new environments as positive**, and a “break” from stressful social situations; for ‘physical-self’, participants also outlined the desire to be physically healthy, and had attempted to make changes to their everyday lives to

make this possible, whilst also speaking about increased confidence and self-esteem; and for ‘social-self’, participants described being able to develop friendships and connections, suggesting they had been able to engage in cooperative behaviours as part of the group. Although participants in the empirical study did not directly mention feelings of success and mastery from engaging in the group activities, they did mention feelings of achievement, and were able to engage with the group to some degree; it could therefore be hypothesised that this aspect of change did take place for the participants.

**Table 1**

*Conceptual Framework of the Wilderness Therapy Treatment Milieu*

Category	Time of Peak Intensity	Proposition
<b>Therapeutic Factors of the Wilderness Experience</b>		
<b>Wilderness</b>	Beginning	The wilderness environment, acting alone, can be seen as a restorative environment for at-risk youth who have high levels of anxiety and are stressed from mental fatigue caused by too much direct attention.
<b>Physical-self</b>	Late	By combining the effects of feeling and looking better physically through consistent physical activity and wilderness activities that are designed to challenge while allowing opportunities for immediate feedback and success, the wilderness works as a therapeutic medium to foster an enhanced image of the self.
<b>Social-self</b>	Middle	Research has shown that wilderness experience programs, through a variety of day-to-day activities while on the program, <b>help</b> at-risk youth learn more cooperative behaviours. Breaking down barriers of stereotypes and preconceived notions allows participants get to know each

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other better, meeting the needs of youth at risk who have  
limited capacities to form close interpersonal relationships.

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*Source.* Adapted from Russell and Farnum (2004, p. 41).

This model was further developed by Fernée et al. (2017) in their realist synthesis of literature on adolescents experiencing psychological and behavioural problems. The authors incorporated a new category, the ‘psychosocial-self’ based on integrating conceptions of the ‘psychological-self’ from the literature, and the existing ‘social-self category’, and this new category included the challenges of engaging in the group environment and relational difficulties that may arise. The authors suggested that OTGs present the opportunity for cooperative activities and social support, and suggested that this could facilitate pro-social processes, acceptance of others and closer relationships. The authors also suggested that key change factors of the intervention are peer dynamics and a strong alliance with the group facilitators. This developed model also provides insights into the change processes potentially involved with OTGs, and links with the findings of the empirical paper, with participants describing social support from peers, acceptance of others and closer relationships.

A further area of consideration is the social aspect of the OTG. As discussed previously, due to the disruptions in development which can be caused by developing psychosis, psychosocial outcomes can be affected (Lloyd, Bassett & Samra, 2000). Disruptions in these developments can lead to poor social functioning, with the recovery movement suggesting that recovery from psychosis includes improved social and functional outcomes (Law & Morrison, 2004), with a lack of improvement in these areas suggested as being a barrier to recovery and improved long-term outcomes (Fowler et al., 2018). Fowler et al. (2018) also outlined the importance of structured activity in facilitating improvements in social functioning, an important part of the recovery process (Law & Morrison, 2004).

Therefore, interventions that target these areas, such as OTGs, are important; OTGs, for example, are theoretically aligned with young people's developmental stage, with its emphasis on peer group membership and positive risk-taking, key developmental stages for this age group (Ferneer et al., 2017). In line with the findings of the empirical study, participants did appear to experience improvements in their social and functional outcomes, as evidenced by their ability to develop friendships and make lifestyle changes, which included finding work for some participants. Participants also valued the experiences of routine and structure as part of the group, which appeared to be an important part of their improvements in functioning, in line with Fowler et al.'s (2018) assertions. An interesting point of note is that participants in the empirical paper did not discuss their experiences of positive risk-taking, suggested as a key aspect of the outdoor therapy experience (Ferneer et al., 2017), which could be related to a number of factors, such as participants potentially finding it difficult to discuss uncomfortable situations.

McCormack (1999) highlighted that sailing trips can be part of OTGs, as the aims and environments are often aligned with the aims and environments of land-based OTGs (McCormack, 1999). The author outlined the specific benefits that arise from engaging in such an environment, highlighting that sailing trips for young people can facilitate personal and social development due to its intense environment, learning and natural discipline imposed by the environments. An important aspect of some participants' group experience was their experience of going sailing as part of the OTG, and discussed similar experiences and benefits following the sailing component of the OTG.

As the study in the second paper is a preliminary study, an important next step for research would be feasibility research, to assess the feasibility and acceptability within EIPS

in the NHS, given the potential practical difficulties of incorporating this type of intervention into services. It is also recommended that future quantitative research includes well-powered studies with large sample sizes where possible, bearing in mind the potential difficulties of setting up such an intervention with a traditionally difficult-to-engage client group within EIPS (Fowler et al., 2018). Longitudinal studies are also required, to establish whether outcomes exist over time, or whether benefits change following engagement. Themes outlined in this study could also be used as potential outcome measures in quantitative research, such as exploring whether areas such as confidence and wellbeing objectively improve as a result of group engagement. Services could also trial such interventions and complete service evaluations to explore their efficacy on a local level.

An interesting area of exploration may be exploring whether participants are able to continue applying their learning experiences in their lives following their group engagement, or whether booster sessions or continued engagement are required. The findings suggest that improving in these areas counteracted the negative experiences of feeling isolated, disconnected and different, which would need further exploration.

It is also recommended that research continues to explore participants' experiences of engaging with OTGs to understand the process of change in more detail, which would contribute to theory development. A range of qualitative methods, including ethnographic studies, could be used for this aim.

### **Implications for Clinical Practice**

The findings from the literature review were inconclusive, however highlighted the unclear evidence-base for recommending individual CBT as the treatment of choice for EIPS clients, and mixed findings regarding the efficacy of both individual and group interventions

for improving symptoms and functioning. However, this may have been related to many of the control conditions being routine EIPS care, which is regarded as the treatment of choice for the client group (Craig et al., 2004) and would therefore be difficult to show improvements. There were promising findings that both modalities could lead to improvements in functioning and symptoms, with within-groups improvements being noted. In clinical practice, it may be useful to consider the mixed efficacy of both approaches, and tailor interventions to suit individuals, as well as acknowledging the potential differences in the targets of each intervention modality.

The findings from the second paper indicate that the OTG was experienced positively by the participants, and highlighted the positive impact the group had on a range of domains, including increased confidence and connections with others, desire for lifestyle change, new experiences, improved wellbeing and a desire to help others with similar experiences. Improvements in these domains of functioning are an important part of the recovery process according to the recovery movement (Fowler et al., 2018), and the findings suggest that OTGs could tie in with this process. The findings of this study, as well as other studies such as Fowler et al. (2018), suggest that improving social functioning can be an important area of focus of interventions for this population. Clinically, EIPS could therefore consider developing OTGs within their services and attempting to incorporate elements of the group, such as the ability to connect with others and engage in new activities, into routine practice if feasible. However, as this is a new intervention within EIPS, services will need to acknowledge the novelty of the intervention when deciding on its delivery in practice. It is also important to consider the practical difficulties of implementing such a group within NHS services, such as providing staff with the time to facilitate the intervention and the potential difficulties of getting into the outdoor environment for more urban services; however, the



empirical study demonstrates that this can be possible, and specific activities could be tailored to reduce the level of unacceptable risk.

The second paper also outlined the important role of group facilitators in supporting young people to be able to engage in the OTG (theme 1; appendix M). This will be an important factor in developing such interventions in clinical practice, and the development of a safe environment to ensure young people feel comfortable with engaging will be key.

### **Personal Reflections**

The following reflections are based on my thoughts and experiences that I noted in my reflective diary, throughout the research process, as recommended for qualitative researchers (Braun & Clarke, 2006). Keeping this reflective diary enabled me to reflect on my context and lived experience as a researcher and helped me to focus on each participant's story.

I was able to combine one of my third-year placements, the local EIPS, with my research project, which was an interesting and useful experience, enabling me to learn more about EIPS and FEP, which I had limited knowledge of and was valuable in understanding more about the service and the clients. There had initially been plans for me to be involved in the OTG early on in my placement; however, as I learnt more about qualitative research and reflected on my dual roles as researcher and clinician, and after reflecting with my supervisors, I decided that I would be involved in the group once the interviews had been completed. Reflecting on this decision, I acknowledged that there were some benefits to being involved in the group, such as helping the young people feel more comfortable with me in the interviews and developing more knowledge about their experiences outside of the interview. However, I was keen to enable the young people to feel as open as possible in

sharing their experiences with me, and I felt that being involved in the OTG as both clinician and researcher would potentially be confusing for participants and potentially limit their abilities to be open and honest with me during interviews. One participant made reference to my role as a clinician during the interviews, and I wondered whether this had impacted on his interview responses and whether he had viewed the interview as a therapy session.

To attempt to make participants more comfortable about my dual roles, I explicitly outlined both of my roles before each interview, and was keen to stress the confidentiality agreement to enable the participants to feel comfortable in sharing their experiences with me. I was constantly aware of my two roles throughout the research process, particularly during interviews, and acknowledged the tension I felt between being a researcher and being a Trainee Clinical Psychologist, which involved tensions between being a therapist, and feeling an urge to respond in a certain way to answers, to being a researcher, and attempting to leave space for participants to make sense of their experiences without my interpretations. This was difficult, however keeping a reflective diary throughout the process and reflecting on this with my supervisors was invaluable. I felt this tension most in my first interview, and the more I read about the interview process, the more comfortable I felt to integrate these identities. Supervision also helped with this. There were parts of “trainee psychologist Carla” that I became aware of and which I attempted to moderate throughout the interviews; for example, my skills in active listening, that I have developed as a trainee, were used as an attempt to make the participants feel as comfortable as possible. I was also aware of the interpretive stance I take as a therapist and the attempts I make to make sense of things with my clients, and the need to allow the participants to make sense of their own experiences without my influence. This was particularly important as many of the participants required lots of prompting, with participants often struggling to reflect on and articulate their

experiences. I reflected that a more holistic approach, such as in-vivo observations, may have enabled participants to share their experiences in a variety of ways.

Undertaking qualitative research was a new, and often challenging experience for me. I have always been more interested in the findings of qualitative research, and appreciate its ability to ensure participants' voices are heard. However, my research background is in quantitative methodology, and I decided to take on this project as a way of developing my skills as a researcher.

The initial framework and analysis chosen for the project was Interpretative Phenomenological Analysis (IPA), to enable an in-depth exploration of participants' lived experiences. However, after completing the interviews, it became clear that participants struggled to articulate and verbalise their experiences, and prompts were required throughout each interview to enable the participants to reflect on their experiences. I reflected on this with my supervisors, as well as an experienced qualitative researcher with recent experience of completing both IPA studies and thematic analysis (TA) studies. I also read extensively into IPA and TA approaches. Following this, and after reflecting on my interview data with my supervisors, it was agreed that IPA may not be best suited to my sample and interview data, given IPA's focus on understanding people's lived experience, in great detail, requiring the ability of participants to be verbally expressive and articulate their experiences (Willig, 2013, pg. 283). TA was instead chosen, due to its flexibility in approach and assumptions, and in line with Braun and Clarke's (2006) assertion that analysis choice can and should change depending on the type of data available.

I also reflected frequently on my own interests and hopes for the study. I am a keen hillwalker and love the outdoors; I am very biased to believing in the benefits of this form of

group activity, and also have an interest in the ways in which therapy and the outdoors can be combined. It was important for me to acknowledge this, particularly during the analysis of the empirical paper, to ensure I stayed close to participants' experiences. Throughout the process, I have also been aware of a sense of privilege to be able to share the stories of the young people within the empirical paper, as their voices are not frequently heard. I hope I have done them justice.

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## **Appendices**



## Appendix A: Downs and Black's Assessment Tool

Downs, Black

### Appendix

#### Checklist for measuring study quality

##### Reporting

1. Is the hypothesis/aim/objective of the study clearly described?

yes	1
no	0

2. Are the main outcomes to be measured clearly described in the Introduction or Methods section?

If the main outcomes are first mentioned in the Results section, the question should be answered no.

yes	1
no	0

3. Are the characteristics of the patients included in the study clearly described?

In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given.

yes	1
no	0

4. Are the interventions of interest clearly described?

Treatments and placebo (where relevant) that are to be compared should be clearly described.

yes	1
no	0

5. Are the distributions of principal confounders in each group of subjects to be compared clearly described?

A list of principal confounders is provided.

yes	2
partially	1
no	0

6. Are the main findings of the study clearly described?

Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below).

yes	1
no	0

7. Does the study provide estimates of the random variability in the data for the main outcomes?

In non normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.

yes	1
no	0

8. Have all important adverse events that may be a consequence of the intervention been reported?

This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events. (A list of possible adverse events is provided).

yes	1
no	0

9. Have the characteristics of patients lost to follow-up been described?

This should be answered yes where there were no losses to follow-up or where losses to follow-up were so small that findings would be unaffected by their inclusion. This should be answered no where a study does not report the number of patients lost to follow-up.

yes	1
no	0

10. Have actual probability values been reported (e.g. 0.035 rather than  $<0.05$ ) for the main outcomes except where the probability value is less than 0.001?

yes	1
no	0

##### External validity

All the following criteria attempt to address the representativeness of the findings of the study and whether they may be generalised to the population from which the study subjects were derived.

11. Were the subjects asked to participate in the study representative of the entire population from which they were recruited?

The study must identify the source population for patients and describe how the patients were selected. Patients would be representative if they comprised the entire source population, an unselected sample of consecutive patients, or a random sample. Random sampling is only feasible where a list of all members of the relevant

population exists. Where a study does not report the proportion of the source population from which the patients are derived, the question should be answered as unable to determine.

yes	1
no	0
unable to determine	0

12. Were those subjects who were prepared to participate representative of the entire population from which they were recruited?

The proportion of those asked who agreed should be stated. Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population.

yes	1
no	0
unable to determine	0

13. Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive?

For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. The question should be answered no if, for example, the intervention was undertaken in a specialist centre unrepresentative of the hospitals most of the source population would attend.

yes	1
no	0
unable to determine	0

#### Internal validity - bias

14. Was an attempt made to blind study subjects to the intervention they have received?

For studies where the patients would have no way of knowing which intervention they received, this should be answered yes.

yes	1
no	0
unable to determine	0

15. Was an attempt made to blind those measuring the main outcomes of the intervention?

yes	1
no	0
unable to determine	0

16. If any of the results of the study were based on "data dredging", was this made clear?

Any analyses that had not been planned at the outset of the study should be clearly indicated. If no retrospective unplanned subgroup analyses were reported, then answer yes.

yes	1
no	0
unable to determine	0

17. In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls?

Where follow-up was the same for all study patients the answer should be yes. If different lengths of follow-up were adjusted for by, for example, survival analysis the answer should be yes. Studies where differences in follow-up are ignored should be answered no.

yes	1
no	0
unable to determine	0

18. Were the statistical tests used to assess the main outcomes appropriate?

The statistical techniques used must be appropriate to the data. For example non-parametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken but where there is no evidence of bias, the question should be answered yes. If the distribution of the data (normal or not) is not described it must be assumed that the estimates used were appropriate and the question should be answered yes.

yes	1
no	0
unable to determine	0

19. Was compliance with the intervention's reliable?

Where there was non compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. For studies where the effect of any misclassification was likely to bias any association to the null, the question should be answered yes.

yes	1
no	0
unable to determine	0

20. Were the main outcome measures used accurate (valid and reliable)?

For studies where the outcome measures are clearly described, the question should be answered yes. For studies which refer to other work or that demonstrates the outcome measures are accurate, the question should be answered as yes.

yes	1
no	0
unable to determine	0

#### Internal validity - confounding (selection bias)

21. Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population?

For example, patients for all comparison groups should be selected from the same hospital. The question should be answered unable to determine for cohort and case-control studies where there is no information concerning the source of patients included in the study.

yes	1
no	0
unable to determine	0

22. Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same period of time?

For a study which does not specify the time period over which patients were recruited, the question should be answered as unable to determine.

yes	1
no	0
unable to determine	0

23. Were study subjects randomised to intervention groups?

Studies which state that subjects were randomised should be answered yes except where method of randomisation would not ensure random allocation. For example alternate allocation would score no because it is predictable.

yes	1
no	0
unable to determine	0

24. Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable?

All non-randomised studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no.

yes	1
no	0
unable to determine	0

25. Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?

This question should be answered no for trials if: the main conclusions of the study were based on analyses of treatment rather than intention to treat; the distribution of known confounders in the different treatment groups was not described; or the distribution of known confounders differed between the treatment groups but was not taken into account in the analyses. In non-randomised studies if the effect of the main confounders was not investigated or confounding was demonstrated but no adjustment was made in the final analyses the question should be answered as no.

yes	1
no	0
unable to determine	0

26. Were losses of patients to follow-up taken into account?

If the numbers of patients lost to follow-up are not reported, the question should be answered as unable to determine. If the proportion lost to follow-up was too small to affect the main findings, the question should be answered yes.

yes	1
no	0
unable to determine	0

#### Power

27. Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%?

Sample sizes have been calculated to detect a difference of x% and y%.

	Size of smallest intervention group	
A	$<n_1$	0
B	$n_1 - n_2$	1
C	$n_1 - n_3$	2
D	$n_1 - n_4$	3
E	$n_1 - n_5$	4
F	$n_5 +$	5

## Appendix B: West of Scotland Research Ethics Committee Provisional Approval Letter

**WoSRES**  
*West of Scotland Research Ethics Service*



Miss Carla Benton  
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### **West of Scotland REC 1**

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Date 10 December 2018  
Direct line 0141-232-1806  
e-mail [WosRec1@ggc.scot.nhs.uk](mailto:WosRec1@ggc.scot.nhs.uk)

Dear Miss Benton

**Study Title:** Experiences of Engaging with an Outdoor Therapy Group in an Early Intervention Psychosis Service  
**REC reference:** 18/WS/0227  
**IRAS project ID:** 244178

The Research Ethics Committee reviewed the above application at the meeting held on 04 December 2018. Thank you for attending to discuss the application.

### **Provisional opinion**

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to a meeting of the Sub committee of the REC.

### **Further information or clarification required**

- 1) Please provide reference or rationale for using IPA analysis.
- 2) Please make it clear at the beginning of the interview and PIS that participants can stop at any time and do the interview over several timepoints if they prefer.
- 3) As stated in the meeting, please update the PIS to make it clear that data is kept for 10 years and not 5 years.
- 4) Please make the boxes on the consent form larger so there is space to initial them.
- 5) It was agreed that Dr Mike Jackson would act as Chief Investigator for the study. Please update the IRAS form accordingly and have the form re-signed. There is no requirement to update any other sections of the IRAS form.

- 6) Please review the interview guide order. Currently the close part states "Before we end the interview, is there anything else that you would like to add?", however there are then several questions after this.

The Committee suggested that A6-1 was changed as this section is published. It thought that the part "the study is expected to last as long as it takes" was slightly strange wording and could be changed to give a rough estimate. This is a suggestion and not a condition of approval. Any new wording should be provided in a cover letter.

**If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact Kirsty Burt on 0141 232 1806.**

When submitting a response to the Committee, the requested information should be electronically submitted from IRAS. Please refer to the guidance in IRAS for instructions on [how to submit a response to provisional opinion electronically](#).

Please submit revised documentation where appropriate underlining or otherwise highlighting the changes which have been made and giving revised version numbers and dates. You do not have to make any changes to the REC application form unless you have been specifically requested to do so by the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 09 January 2019.

#### **Extract of the meeting minutes**

##### **Social or scientific value; scientific design and conduct of the study**

Overall the Committee thought this was a useful study with little research having been done on this, however it wanted some more information on the outdoor therapy.

Miss Benton stated that the therapy involved the surrounding in Wales so the mountains and the sea. There was low level mountain walks, sailing and beach cleans. The therapy group was set up in February and everyone receiving early intervention is asked if they want to join. The service is aimed to be as flexible and accessible as possible with users being able to attend as little or much as they want. There are currently 10-15 regular attendees.

The Committee asked if Miss Benton was involved in running the therapy group.

*Miss Benton stated that she was doing placement so had assisted with the group but was not involved in running it.*

The Committee was content.

The Committee asked about the number of participants that would be required given there was no formal sample size calculation.

*Miss Benton stated that there were 10-15 regular attendees in the therapy group of which 10 were currently well at the moment and would be eligible for the study. She hoped they would all be interested but regarded a minimum of 6 for success as 6 was needed for the IPA analysis.*

The Committee was satisfied with this.

The Committee asked about the IPA analysis.

*Miss Benton stated that this was regarded the appropriate analysis for this type of study. It is interest in people's experiences and what it meant to them. This is a double hermeneutic with making sense of the participants making sense of their experiences.*

The Committee asked if this analysis was affected by the participants having psychosis.

*Miss Benton state that she didn't think so as the participants have a valid view point even if it is a different experience and no commonly shared.*

The Committee accepted this, however wanted some written reference or rational for using IPA.

The Committee thought that A13 of the IRAS form could have been clearer but understood the study design and was content.

The Committee asked how long the interview would last as there were discrepancies throughout the application and there was a large number and breadth of questions

*Miss Benton stated that this was something they had realised and discussed. She was aware that participants may not have much patience and stamina for interviews but could speak for as long as they wanted. If it got too much they could stop. There was the option for the interview in short bursts so over several timepoints if the preferred.*

The Committee was content with this but wanted it made clear at the beginning of the interview and PIS. It also noted that the amount of data collected may affect analysis.

The Committee was pleased there had been some public involvement with the North Wales Clinical Psychology Programme People's Panel.

#### **Recruitment arrangements and access to health information, and fair participant selection**

The Committee wanted clarification on the recruitment process.

*Miss Benton stated that the clinical team which is made up of psychologists and specialist nurse who could decide who may be appropriate for the study. This is based on the patient having capacity and where they are at with their illness. They would approach the patient and make them aware of the research, if they were interested then their details would be passed on to her.*

The Committee was content with this.

**Favourable risk benefit ratio; anticipated benefit/risks for research participants (present and future)**

The Committee asked about the location of the interviews.

*Miss Benton stated that they would be done at the NHS centre or arrangements made for them to be done in the community or at home.*

The Committee asked about the safety arrangements and privacy.

*Miss Benton stated that lone working policies would be followed. This was the university's policy with being a doctorate and NHS policy as was employed by the NHS. When interviews were in the community these would be in a private space with adequate privacy.*

The Committee was pleased with this.

The Committee was content with the participants receiving a £20 gift voucher.

The Committee was content with the favourable risk benefit ratio.

**Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity**

The Committee agreed that if a participant lost capacity during the study there was no need to withdraw data that had already been collected.

*Miss Benton was satisfied with this.*

*Miss Benton stated that there had been an error within the applicant and data would be kept for 10 years and not 5 and that the PIS will be updated accordingly.*

The Committee had no issues.

The Committee was satisfied with the care and protection and data protection. It was also content with the insurance arrangements.

**Informed consent process and the adequacy and completeness of participant information**

Overall the Committee was content with the PIS and consent. It is brief but clear and suitable for the patient population. The Committee noted the boxes on the consent form were not large enough to initial.

The Committee was content that the GP was not informed.

**Suitability of the applicant and supporting staff**

The Committee noted that with current guidelines, the student would not usually act as CI except if they are suitability qualified.

Miss Benton stated that they were already aware of this and that academic supervisor Dr Mike Jackson would act as CI.

The Committee was content with this.

#### **Suitability of supporting information**

With regard to the interview guide, the Committee noted that the close part stated "Before we end the interview, is there anything else that you would like to add?", however there are then several questions after this.

#### **Other general comments**

Miss Benton stated there had been an error in the IRAS form and that the study would run until 2021 so would be 3 years.

The Committee was satisfied with this.

#### **Suitability of the summary of the research**

The Committee was content with A6-1 however thought the part "the study is expected to last as long as it takes" was slightly strange wording and could be changed to give a rough estimate. It suggested this was changed.

**Other ethical issues were raised and resolved in preliminary discussion before your attendance at the meeting.**

Please contact the REC Manager if you feel that the above summary is not an accurate reflection of the discussion at the meeting.

#### **Documents reviewed**

The documents reviewed at the meeting were:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity Certificate]		16 July 2018
Interview schedules or topic guides for participants [Draft Interview Guide]	1	24 October 2018
IRAS Application Form [IRAS_Form_20112018]		20 November 2018
Other [Employers liability and public and products liability certificate]		02 July 2018
Other [E-mail confirming sponsor is non-commercial]		20 November 2018
Participant consent form [Consent Form]	1	17 September 2018
Participant information sheet (PIS) [Information Sheet]	1	18 September 2018
Research protocol or project proposal [Research Proposal]	2	28 September 2018
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		19 November 2018
Summary CV for supervisor (student research) [Dr Mike Jackson CV]		17 November 2017
Summary CV for supervisor (student research) [Dr Robin Owen CV]		05 June 2018



### Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet

### 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.

18/WS/0227

Please quote this number on all correspondence

Yours sincerely



On behalf of  
**Dr Malcolm Booth**  
Chair

*Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.*

*Copy to: Mr Huw Ellis  
Dr Rossela Roberts, Betsi Cadwaladr University Health Board*

**West of Scotland REC 1**

**Attendance at Committee meeting on 04 December 2018**

**Committee Members:**

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Malcolm Booth	Consultant in Anaesthesia and Intensive Care (Chair)	Yes	Chair of Meeting
Dr Katriona Brooksbank	Clinical Trial Manager	Yes	
Dr Anne Marie Coleman	Psychotherapist	Yes	
Dr Ross Fairgrieve	Consultant in Paediatric Anaesthesia and Pain Management	Yes	
Dr Natasha Fullerton	Consultant Neuroradiologist	Yes	
Mrs Elspeth Fulton	Retired Senior Clinical Research Associate (CRA)	Yes	
Miss Linda Galbraith	Former Management Consultant	Yes	
Dr Jane Gow	Researcher (Retired)	No	
Mrs Lynda Hamilton	Retired Manager	Yes	
Dr Peter Hutchison	GP (Vice Chair)	Yes	
Dr Derek Manson-Smith	Information Research Consultant (Retired)	Yes	
Dr John D McClure	Statistician	Yes	
Mr Steve McGlynn	Specialist Principal Pharmacist (Cardiology)	No	
Dr Colin Petrie	Physician and Cardiologist	No	
Mr Elliot Porter	General Teaching Assistant-Philosophy	Yes	
Mrs Laura Rooney	CRUK Lead Research Nurse	Yes	

**Also in attendance:**

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Kirsty Burt	Senior Co-ordinator
Mr Gerald Douglas	Observer
Dr Judith Godden	Scientific Officer

**Written comments received from:**

<i>Name</i>	<i>Position</i>
Mr Steve McGlynn	Specialist Principal Pharmacist (Cardiology)

## Appendix C: Researcher response to Ethics Committee

Dr Malcolm Booth  
Chair  
West of Scotland Research Ethics Service  
Clinical Research and Development  
West Glasgow Ambulatory Care Hospital  
Dalnair Street  
Glasgow  
G3 8SJ

13.12.2018

Dear Dr Booth,

**Study Title:** Experiences of Engaging with an Outdoor Therapy Group in an Early Intervention Psychosis Service

**REC Reference:** 18/WS/0227

**IRAS Project ID:** 244178

Thank you for your letter dated 10.12.2018 which outlined the outcome of the Research Ethics Committee Review. As detailed in the letter the Committee were unable to give an ethical opinion based on the information and documentation provided so far. Each point raised in your letter will now be addressed in turn:

1. Please provide reference or rationale for using IPA Analysis

“Participants will be interviewed about their experiences of engaging with a newly developed outdoor therapy group being run by the early intervention psychosis service. Participants will be interviewed once, which may take around one hour to complete, depending on the participants. The data will be analysed using Interpretative Phenomenological Analysis. This has been chosen to allow participants to reflect on their experiences, and for the researcher to interpret the participants' perspective in context, creating a double hermeneutic, as there do not appear to be any experiential studies into ways people with first-episode psychosis engage in outdoor activities; therefore, an in-depth understanding of how they experience this is lacking. IPA (Smith et al., 2009) is a qualitative method, focusing on people's lived experiences, and is concerned with the ways they make sense of this. This approach could therefore provide rich, in-depth information on their experiences of engaging with outdoor therapy, from their perspective. IPA has been chosen as the focus is on in-depth analyses of an individual, or small, homogeneous groups of individuals who have similar experiences (Smith & Osborn, 2003).”

2. Please make it clear at the beginning of the interview and PIS that participants can stop at any time and do the interview over several timepoints if they prefer.

The PIS (Participant Information Sheet v2 10.12.2018) and Interview Schedule (Interview Schedule v2 10.12.2018) to include details about multiple, and shorter sessions if needed. The PIS now includes the following information:

“You will meet with the researcher at a convenient time and place to talk about your experiences, which will usually be the Abbey Road Centre. However, arrangements can be made to meet in a more convenient location if you wish. The time taken will depend on how long you want to talk about your experiences; you may wish to meet with the researcher once, or you may wish to meet the researcher a few times for shorter sessions if you feel this would be better.

The Interview Schedule has also been amended to say:

“We can also do this interview over a few, shorter sessions if this works best for you. I have also included a copy of the amended documents, with the changes highlighted.”

3. As stated in the meeting, please update the PIS to make it clear that data is kept for 10 years and not 5 years.

The PIS (Participant Information Sheet v2 10.12.2018) has been amended to state that the data is kept for 10 years.

4. Please make the boxes on the consent form larger so there is space to initial them.

The boxes on the consent form (Consent Form v2 10.12.2018) have now been made larger to allow room for initials to be added.

5. It was agreed that Dr Mike Jackson would act as Chief Investigator for the study. Please update the IRAS form accordingly and have the form re-signed. There is no requirement to update any other sections of the IRAS form.

Mike Jackson has now been added as the Chief Investigator as requested on the IRAS form, and the form has been resigned.

6. Please review the interview guide order. Currently the close part states “Before we end the interview, is there anything else that you would like to add?”, however there are then several questions after this.

The Interview Schedule (Interview Schedule v2 10.12.2018) has now been amended to change the order of the closing statement:

“Thanks again for taking the time to talk with me. That’s the end of the interview. Is there anything else you would like to add?”

As I mentioned earlier, I will transcribe this interview and remove any information that could identify you, so the transcripts will be completely anonymised. We will then analyse the information to explore peoples' experiences of engaging with the outdoor group.

Would you be interested in receiving a summary of our research findings at the end of the study? Are you happy for us to contact you about this project in future?

If you have any questions about this study, please feel free to contact me."

7. The Committee suggested that A6-1 was changed as this section is published. It thought that the part "the study is expected to last as long as it takes" was slightly strange wording and could be changed to give a rough estimate. This is a suggestion and not a condition of approval. Any new wording should be provided in a cover letter.

The wording on the IRAS form for Section A6-1 has now been changed, and states:

"Participants will be interviewed, and the study is expected to last approximately seven months, to allow for interviews to be undertaken, transcribed, and analysed."

If you require any further clarification on any of the points raised, please do not hesitate to contact me.

Yours sincerely,

Carla Benton  
Trainee Clinical Psychologist

## Appendix D: West of Scotland Research Ethics Committee Approval Letter

**WoSRES**  
*West of Scotland Research Ethics Service*



Dr Mike Jackson  
Lead Clinical Psychologist  
Betsi Cadwaladr University Health Board  
North Wales Clinical Psychology Programme  
Brigantia Building  
Bangor  
LL57 2DG

**West of Scotland REC 1**  
West of Scotland Research Ethics Service  
Clinical Research and Development  
West Glasgow Ambulatory Care Hospital  
Dalnair Street  
Glasgow G3 8SJ  
[www.nhs.gov.uk](http://www.nhs.gov.uk)  
Date 19 December 2018  
Direct line 0141-232-1806  
e-mail [WosRec1@ggc.scot.nhs.uk](mailto:WosRec1@ggc.scot.nhs.uk)

**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

Dear Dr Jackson

**Study title:** Experiences of Engaging with an Outdoor Therapy Group in an Early Intervention Psychosis Service  
**REC reference:** 18/WS/0227  
**IRAS project ID:** 244178

Thank you for your letter of 13 December 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC at a meeting held on 19 December 2018. A list of the Sub-Committee members is attached.

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](mailto: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 HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at [www.hra.nhs.uk](http://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](mailto: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).

### Approved documents

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

Document	Version	Date
Covering letter on headed paper [Covering Letter]	1	14 December 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity Certificate]		16 July 2018
Interview schedules or topic guides for participants [Draft Interview Guide (changes highlighted)]	2	10 December 2018
IRAS Application Form [IRAS_Form_14122018]		14 December 2018
Other [Employers liability and public and products liability certificate]		02 July 2018
Other [E-mail confirming sponsor is non-commercial]		20 November 2018
Participant consent form [Consent Form]	2	10 December 2018
Participant information sheet (PIS) [Information Sheet (changes highlighted)]	2	10 December 2018
Research protocol or project proposal [Research Protocol (changes highlighted)]	3	11 December 2018
Response to Request for Further Information [Covering Letter]		13 December 2018
Summary CV for Chief Investigator (CI) [Chief Investigator CV - Mike Jackson]		17 November 2017
Summary CV for student [Student CV - Carla Benton]		19 November 2018
Summary CV for supervisor (student research) [Dr Robin Owen CV]		05 June 2018

### 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.



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### 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/>

18/WS/0227
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Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project.

Yours sincerely



On behalf of  
**Dr Malcolm Booth**  
Chair

*Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments  
"After ethical review – guidance for researchers"*

*Copy to: Mr Huw Ellis  
Dr Rossela Roberts, Betsi Cadwaladr University Health Board*

**West of Scotland REC 1**

**Attendance at Sub-Committee of the REC meeting on 19 December 2018**

**Committee Members:**

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Malcolm Booth	Consultant in Anaesthesia and Intensive Care (Chair)	Yes	Chair of Meeting
Dr Peter Hutchison	GP (Vice Chair)	Yes	

**Also in attendance:**

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Kirsty Burt	Senior Co-ordinator

## Appendix E: Bangor University School of Psychology Ethics Committee Email Approval

Reply all | Delete Junk |

Ethical approval granted for 2018-16276 Experiences of Engaging with an Outdoor Therapy Group in an Early Intervention Psychosis Service



ethics@bangor.ac.uk

Wed 31/10/2018, 13:36

Carla Benton

Reply all |

Inbox

Dear Carla,

2018-16276 Experiences of Engaging with an Outdoor Therapy Group in an Early Intervention Psychosis Service

Your research proposal number 2018-16276

has been reviewed by the School of Psychology Ethics and Research Committee

and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

## Appendix F: Health Research Authority Research and Development Committee Approval



Dr Mike Jackson  
Lead Clinical Psychologist  
Betsi Cadwaladr University Health Board  
North Wales Clinical Psychology Programme  
Brigantia Building  
Bangor  
LL57 2DG

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)  
[Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk)

20 December 2018

Dear Dr Jackson

**HRA and Health and Care  
Research Wales (HCRW)  
Approval Letter**

Study title:	Experiences of Engaging with an Outdoor Therapy Group in an Early Intervention Psychosis Service
IRAS project ID:	244178
REC reference:	18/WS/0227
Sponsor	School of Psychology, Bangor University

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

**How should I continue to work with participating NHS organisations in England and Wales?**

You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

Page 1 of 7

It is important 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 of the research management function for each organisation can be accessed [here](#).

#### **How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?**

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

#### **How should I work with participating non-NHS organisations?**

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

#### **What are my notification responsibilities during the study?**

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.

#### **I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?**

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Dr Mike Jackson

Tel: 01248382205

Email: [mike.jackson@bangor.ac.uk](mailto:mike.jackson@bangor.ac.uk)

IRAS project ID	244178
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**Who should I contact for further information?**

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **244178**. Please quote this on all correspondence.

Yours sincerely

Gurmel Bhachu

Permissions Service Manager (acting)

Email: [Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk)

Copy to: *Mr Huw Ellis*  
*Dr Rossela Roberts, Betsi Cadwaladr University Health Board*

## List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Covering letter on headed paper [Covering Letter]	1	14 December 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity Certificate]		16 July 2018
HRA Schedule of Events	1.0	11 December 2018
HRA Statement of Activities	1.0	11 December 2018
Interview schedules or topic guides for participants	2	10 December 2018
Interview schedules or topic guides for participants [Draft Interview Guide (changes highlighted)]	2	10 December 2018
IRAS Application Form [IRAS_Form_14122018]		14 December 2018
Other [Employers liability and public and products liability certificate]		02 July 2018
Other [E-mail confirming sponsor is non-commercial]		20 November 2018
Participant consent form [Consent Form]	2	10 December 2018
Participant information sheet (PIS) [Information Sheet (changes highlighted)]	2	10 December 2018
Research protocol or project proposal [Research Protocol (changes highlighted)]	3	11 December 2018
Response to Request for Further Information [Covering Letter]		13 December 2018
Summary CV for Chief Investigator (CI) [Chief Investigator CV - Mike Jackson]		17 November 2017
Summary CV for student [Student CV - Carla Benton]		19 November 2018
Summary CV for supervisor (student research) [Dr Robin Owen CV]		05 June 2018

### Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

### Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	PIS mentions reimbursement Audio recording captured in PIS Quotes captured in the PIS
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
4.2	Insurance/indemnity arrangements assessed	Yes	The study is sponsored by Bangor University. IRAS Form A76 states insurance is provided for the design and management of the research. A copy of the insurance certificate issued by [name of insurance company] is in the document store. At time of this governance report, the insurance expires on 31Jul2019. NHS Indemnity will apply for the conduct of the study.
4.3	Financial arrangements assessed	Yes	R&D form A65 confirms no application for external funding will be made - Project that is part of a fellowship/ personal award/ research training award



Section	Assessment Criteria	Compliant with Standards	Comments
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	Provisional opinion letter dated 10 Dec 2018 Favourable opinion letter dated 19 Dec 2018
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

### Participating NHS Organisations in England and Wales

*This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.*

There is one site type – All site activities

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at [hra.approval@nhs.net](mailto:hra.approval@nhs.net) or HCRW at [Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk). We will work with these organisations to achieve a consistent approach to information provision.

## Principal Investigator Suitability

*This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).*

PI required

GCP training is not a generic training expectation, in line with the [HRA/HCRW/MHRA statement on training expectations](#).

## HR Good Practice Resource Pack Expectations

*This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken*

Use of identifiable patient records held by an NHS organisation to identify potential participants without their prior consent should be undertaken by a member of the direct care team for the patient, so it would not normally be acceptable for this to be done by staff not employed by that organisation.

The activities at the participating NHS organisation will be undertaken by local staff therefore it is expected that adequate contractual relationship with the host organisation are already in place.



Where contractual arrangements are not already in place, network/external staff (or similar) undertaking research activities would be expected to obtain Honorary Research Contracts on the basis of a Research Passport (if university employed) or a Letter of Access on the basis of an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). Enhanced DBS checks (incl. appropriate barred list checks) and occupational health clearance would be appropriate.

## Other Information to Aid Study Set-up

*This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.*

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

## Appendix G: Participant Information Sheet

 	<p>Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board</p> <p>North Wales Clinical Psychology Programme / <del>Ysgol Seicoleg</del> <del>Clinical Psychology</del> / <del>Ysgol Seicoleg</del> School of Psychology / <del>Ysgol Seicoleg</del> Bangor University / <del>Ysgol Seicoleg</del> Bangor Gwynedd LL57 2DG Telephone: 01248 388059</p>
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### Participant Information Sheet

**Study Title:** Experiences of Engaging with an Outdoor Therapy Group in an Early Intervention Service

**Research Team:**  
Carla Benton: Trainee Clinical Psychologist, North Wales Clinical Psychology Programme  
~~Dr~~ Mike Jackson: Consultant Clinical Psychologist, Early Intervention Service  
Dr Robin Owen: Clinical Psychologist, Early Intervention Service

We would like to invite you to take part in a research study to explore the experiences of Early Intervention service users engaging in outdoor therapy. This information sheet gives you more information about the study; please read it carefully before deciding whether you would like to take part. One of the researchers will be happy to go through this sheet with you and answer any questions you may have.

**The project has been approved by the Psychology Research Ethics Committee and the NHS Research Ethics Committee.**

**What is the purpose of the study?**  
The Early Intervention Service is running a new activity programme which aims to support people in getting involved with group-based activities in the outdoors. The purpose of this study is to learn from the participants in this programme, and find out whether and how it was useful, how it can be improved and developed in the future.

**Who is carrying out the research?**  
Carla Benton is a Trainee Clinical Psychologist on the North Wales Clinical Psychology Programme and is undertaking this research study as part of her training at Bangor University. Dr Mike Jackson, Consultant Clinical Psychologist and the Lead for the Early Intervention Service, is supervising this research alongside Dr Robin Owen, Clinical Psychologist in the Early Intervention Service.

**Why have I been invited?**  
You have been invited because you have participated in the activity group.

**Do I have to take part?**  
**No.** Taking part is completely voluntary. We ask that you read this leaflet carefully before you decide. Please ask a member of the research team about anything that you are unsure of. If you

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Clinical Psychology / Ysgol Gwyddoniaeth Cymru

School of Psychology / Ysgol Sioedol

Bangor University / Prifysgol Bangor

Bangor

Gwynedd

LL57 2DG

Telephone: 01248 388099



decide not to take part, you do not need to give a reason; you will continue to receive a service, and choosing not to take part wouldn't affect the service you receive in any way.

#### **What will happen if I do take part?**

You will be asked to meet with a researcher after you have taken part in the programme. You will have the opportunity to talk in detail about your experiences and thoughts on taking part in the outdoor activity group.

If you decide to take part, you will be asked to come and meet the researcher at the Abbey Road Centre. You are welcome to bring along a family member/friend/support worker. We will ask you to complete a Consent Form which records your agreement to take part. This is for administrative purposes only and your personal information will not be used in the study. You will be given a copy of the Consent Form to keep for your records. If you do decide to take part, the interview will be recorded on an audio device.

If you attend Abbey Road for the research, your travel expenses will be reimbursed. If you are unable to come to Abbey Road, the researcher will arrange to meet you at a more convenient location of your choice.

#### **What is the time commitment?**

You will meet with the researcher at a convenient time and place to talk about your experiences, which will usually be the Abbey Road Centre. However, arrangements can be made to meet in a more convenient location if you wish. The time taken will depend on how long you want to talk about your experiences; you may wish to meet with the researcher once, or you may wish to meet the researcher a few times for shorter sessions if you feel this would be better. You can also decide to stop whenever you would like to, and this will not have any impact on the service you receive.

#### **Will my treatment with EIS be affected?**

No, you will continue receiving the same service.

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

You will be helping the service to develop a new type of therapy which you, and many others, may benefit from. You will also receive a gift voucher of £20 at the end of the study for contributing your time in taking part. If you receive income-based benefits, you may need to tell the benefits agency that you have received this; however, you can receive £20 per week without it affecting your benefits. If in doubt, speak to your benefits advisor.

#### **What are possible disadvantages of taking part?**

This study does not involve any direct risks. You will have to take some time to answer some questions.

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#### **Will my information be kept confidential?**

**Yes – all information will be kept confidential.** The interview will be recorded on an audio device, which will always be kept in a locked cabinet. What you say will then be typed up into a Word document, with all identifying information removed; the recording will then be deleted. The Word Document will be kept on a password-protected computer. We will identify any information about you by giving it a "study number", known only to the research team.

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

The data will be used to help the Early Intervention Service develop and improve the activity group. The data may also be used for academic research publications, and anonymous quotes may be used (for instance, articles in Clinical Psychology magazines, or conference presentations); you will not be identifiable. If you want to know more about the results of the research, your Early Intervention Service clinician can explain the results to you individually, or you can speak to the research team.

#### **Who will have access to information about me?**

**Your details are confidential.** Your name is only recorded for consent purposes, and at the beginning of the study you will be assigned a random study number. Additional safeguards will be in place, including keeping any data you have supplied, including your consent form, in a locked filing cabinet. Any computer data will be stored safely on a password-protected NHS computer based at Abbey Road. All data will be retained by the research team for a minimum of 10 years, after which they will be safely and securely disposed of, in line with NHS policies.

#### **What if I want to withdraw from the study?**

You can withdraw from the study at any time, and you do not need to give an explanation. You also have the right to ask that any data you have supplied to that point be withdrawn/destroyed. You also do not have to answer questions that you do not want to answer.

#### **What if something goes wrong?**

If you have any concerns, you can contact any member of the research team, using the contact details at the bottom of the information sheet. If the researcher becomes concerned about your mental wellbeing during the course of the study, she will seek permission to contact your therapist. In the unlikely event that there is a serious concern about an issue of risk, she would have a duty to inform your therapist or care co-ordinator. If you remain unhappy about the research, the response to any concerns you may have raised, and/or wish to raise a complaint about any aspect of the research, please contact **Huw Ellis, Psychology Manager on 01248 38 3229.**

#### **How do I volunteer to take part in the research study?**

If you would like to take part in the study, your clinician will contact the research team to let them know. One of the researchers will then arrange a convenient time to come and meet with you, so

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that you can participate. If you would like to take part, you will need to sign and date two copies of the 'Consent Form', one of which will be given to you to keep for your records.

For further information, please contact:

Name	Address	Phone	Email
Carla Benton, Trainee Clinical Psychologist	North Wales Clinical Psychology Programme (NWCPP) School of Psychology, Brigantia Building, Bangor University, Bangor, Gwynedd, North Wales LL57 2DG	01248 354888	<a href="mailto:sep83d@bangor.ac.uk">sep83d@bangor.ac.uk</a>
Dr Mike Jackson, Consultant Clinical Psychologist	Abbey Road Centre 5-9 Abbey Road Bangor Gwynedd North Wales LL57 2EA	01248 354888	<a href="mailto:mike.jackson@bangor.ac.uk">mike.jackson@bangor.ac.uk</a> ; <a href="mailto:mike.jackson@wales.nhs.uk">mike.jackson@wales.nhs.uk</a>
Dr Robin Owen, Clinical Psychologist	Abbey Road Centre 5-9 Abbey Road Bangor Gwynedd North Wales LL57 2EA	01248 354888	<a href="mailto:robin.owen2@wales.nhs.uk">robin.owen2@wales.nhs.uk</a>

Bangor University is the sponsor for this study based in Wales. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that

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Bangor University / Prifysgol Bangor  
Bangor  
Gwynedd  
LL57 2DG  
Telephone: 01248 388059



we are responsible for looking after your information and using it properly. Bangor will keep identifiable information about you until the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

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

<https://www.bangor.ac.uk/governance-and-compliance/dataprotection/documents/Data%20Protection%20Policy%20final%20July%202018%20v6.pdf>

or by contacting: Governance and Compliance, Bangor University, Bangor, Gwynedd, LL57 2DG.  
Phone: (01248) 382043

Bangor University will collect information from you for this research study in accordance with our instructions.

*Bangor University will keep your name and contact details and any other identifiers such as job role confidential and will not pass this information to the NHS. Bangor University will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from Bangor University and regulatory organisations may look at your research records to check the accuracy of the research study. Bangor University will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.*

*Bangor University will keep identifiable information about you from this study until the study has finished.*

**Thank you for taking the time to read this information sheet.**

## Appendix H: Participant Consent Form



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Clyniol Gogledd Cymru  
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Gwynedd  
LL57 2DG  
Telephone: 01248 388059

### PARTICIPANT CONSENT FORM

**Study Title:** Experiences of Engaging with an Outdoor Therapy Group in an Early Intervention Service

Please initial each box if you agree with the statement

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions, and have had these answered to my satisfaction.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my medical care or legal rights being affected.
3. I understand that my Early Interventions Service clinician will be informed if the research team become concerned about my mental and/or emotional wellbeing.
4. I understand that data collected about me during this study will be collected on an audio recording device, and all interview information will be made anonymous before it is submitted for publication. Direct quotes about things I have said may be used in publication, and this will also be anonymised.
5. I agree to take part in this study.

☐☐☐☐☐

.....  
**Name of participant**

.....  
**Date**

.....  
**Signature**

.....  
**Researcher**

.....  
**Date**

.....  
**Signature**



## **Appendix I: Flexible Interview Guide**

### **Interview introduction**

I would like to thank you for taking the time to be interviewed today. I am interested in hearing about your thoughts and opinions about your experiences of the outdoor activity group so that we can understand a bit more about it. We can do the interview today in one go if you like, and we'll see how we get on with our timing. (talk about average length of other interviews). It depends on what you'd like to tell me. We can also do the interview over different days if that's better for you.

Everything we talk about today is private so you can be as honest as possible. The only reason I would need to share anything we discuss beyond the research team is if I have any concerns about you or someone you know. I'd also like to remind you that you do not have to answer any questions that you do not feel comfortable answering, and you can ask me to stop the interview at any point if you would like to take a break or stop for any reason.

Do you have any questions before we get started?

Are you still happy to take part?

### **Background**

- Briefly tell me about themselves
- General information
- What sorts of things do you enjoy?

### **Previous Experience of outdoor activities**

- Have you ever done anything in the outdoors before
- What kind of experience was this for you (positive, negative)
- If you have not done this before, what had stopped you?

### **Group**

- Why did you want to become involved?
- How did you come to be involved in the group (what did you expect it to be like, does it match those expectations, where did those expectations come from)
- Did anything get in the way of you becoming involved? (how did you overcome that?)
- What was going on in your life around the time you got involved (related to mental health)
- What have your experiences been of the group (what activities have you been involved in, best/worst things, have you done anything like that before)
- What was it like being in the group (has anything been difficult, how did you cope)
- How does the group fit in with your life (has it changed, what is your life like now)
- What did you learn in the group (challenges, goals, skills, how have you used those skills)
- What did you like the most/least

Thank you, anything to add, any questions, end

## Appendix J: Excerpt from Interview Transcript

I: is that the first time you've done anything like that

R: kind of yeah...I don't do things like I stay inside yeah...so doing something like that outside yeah...and stuff and did stuff...because I've been camping a couple of times and just walked...yeah I done that and then just like didn't do much yeah...

I: mmm

R: it was nice...it was good...

I: and I'm just thinking you've already told me a little bit about what was going on in your life before the group...so you said you weren't really doing a lot...was anything else in particular,

going on for you...if you remember...around the time you were getting involved in the group

R: I didn't have a job or anything yeah...I didn't have anything to look forward to...just like the next week is just...

I: yeah

R: just what comes...just the next day and it just goes on and drags a bit...and it just feels like one big day...you know what I mean

I: mmm

R: and then when you've got something to look forward to yeah (long pause)

I: is that about the group

R: yeah...like next week I've got something to do so its something to look forward to and something to look back on yeah... (long pause)

I: and what's that been like for you to be able to look forward to something

R: it's quite nice yeah...its good... (long pause)...mmm...

I: great...and yeah...I'm just interested to know a little bit more about the things you've been up to with the group

R: so we did the beach BBQ thing that was amazing yeah and then we did the group thing with the boat yeah...

I: yeah...do you want to tell me a little bit more about what that was like

R: yeah...they started telling us about it while we were having a BBQ and they showed us a photo and it was like wow...that's a proper boat it was like a pirate ship yeah...it's a trading ship

like all made out of wood yeah...I was like ah I wanna go on that

I: yeah

A

**Author**

Usually spends time inside  
New, different experience

A

**Author**

Sense of everything being the same  
Dragging on  
Groundhog day:  
Bringing positive memories and positive events to  
look forward to  
Previously nothing to look forward to

A

**Author**

Group as something to look forward to and  
something to look back

A

**Author**

Good impression of first group  
Process of finding out about the boat  
Process of becoming interested  
Excitement about the boat  
Pirate ship – adventure, excitement, another world?

A

**Author**

 Reply  Resolve

R: and we all ended up going for like 5 days for a week...and that was so relaxing yeah...like the boat just rocks you and you just go to sleep...it's the best sleep I've ever had yeah...it really was yeah...I remember going to sleep on the boat yeah cos you've been working all day...and the boat still moving when I went for a nap and then when I woke up the world was completely still yeah...and I walked back up to the topside and the deck yeah...and it was just that view like the sun hitting you and open water and cliffs and just like wow...its unbelievable yeah its really good yeah...and night time it was just calm and nice...very peaceful...it was just really good...(long pause)

I: mmm...and was it photos they'd showed you before you went on the boat

R: yeah it was like a picture of the boat and a picture of the group and what you'd need and I was just like it sounded really good yeah and [NAME 2] was telling us some stuff he was like ahh I've been on it before and [NAME 3] was there and he recommended it and then...like he's been on it before yeah...and he was like ahh it's the best thing I've ever done yeah you're gonna regret not doing it...and just like the week leading up to going is proper like all nervous yeah just go and live on a boat for 5 days with people you've never met...

I: yeah...so what sort of things were you sort of worried out

R: I dunno just sort of who's gonna be there is someone gonna piss me off...just like I dunno just gonna be stuck on a boat for 5 days...its quite...I was debating whether or not I should go on and like [NAME 2] was just like we all feel the same...and if you feel the same and I feel the same then we might as well just do it and that's how I ended up doing it...and it was the best 5 days I've ever had yeah...it was like a holiday yeah...and just so peaceful yeah...that's the best bit about it...just like the peacefulness and like...and you...you got up and had something to do and you had to get the sails up and...it was quite good yeah...everyone had like a role to play and we were all getting along yeah...it was nuts yeah...and we cooked food and breakfast and stuff...and just sleeping yeah...that like...that sleep was just...and you got a weird like...kinda like dreams...and I remember I fell off and stuff.

I: oh my gosh!

R: yeah I was on the top bunk and like fell off...you had this sheet and like 2 ropes like that and it was like sagging a bit yeah and then I ended up rolling off...I didn't even wake up yeah...someone told me I'd fell off and I woke up with like bruises and stuff and I was like how did that happen...I was like what...I didn't even notice yeah...and the captain the skipper as well like he was like proper cool yeah

I: what was cool about him

R: erm...I dunno he was Irish yeah...and erm...well...I dunno he just tells cool stories and you could relate to what he said and he was just chilled out and relaxed yeah like...yeah...nah he was cool...and then when we came off the boat as well...like cos you've been on the boat like rocking side to side your muscles sort of...get used to that yeah...and then when you go back on land...have you ever been on a boat before

A

#### Author

Relaxing  
Working as part of the boat  
Peaceful  
Reminiscing  
Idyllic  
Contrast between day and night

A

#### Author

Inspired by others  
Recommendation from others  
Important experience  
Feeling nervous about decision week beforehand  
Ways of managing anxiety

A

#### Author

Unsure if he would cope  
Reassurance from others through shared experience  
Implied normal life isn't peaceful  
Routine, having something to do  
Part of a team  
Everyone had a role and each role is important  
Getting along feels different suggesting that he was expecting it to not be like that?  
Cooking together – new experience?  
Having a purpose

A

#### Author

Positive attributes of captain  
Connecting and relating  
Process of being on a boat  
Struggling to articulate what it was like

I: wow...years ago when I was little erm...but I spent the entire boat trip sat on the floor being sick (shared laughter) so I don't...

R: yeah there were loads of times people were being sick yeah

I: so yeah...I don't know much about being on a boat...could you tell me a bit more about it

R: well you like come off and you're in a room and the room is like going from one side...like a boat rocking its like what...like going to the services...you know like the gas station...when you do long distances...we were like walking to the shop for food and like the whole room was like going like that we were all just like what...it was nuts yeah (shared laughter) and everyone else was looking at us like...

I: so you were actually moving as well

R: well kind of yeah...your brain just sort of gets used to it...like everything's just still like...like I remember like a week after it was like that

I: really

R: like land legs or something...like a joke like having land tablets...like having land tablets......(shared laughter) yeah it was funny yeah...it was a very good time yeah

I: and you said it was really peaceful and stuff and I'm just wondering what that was like for you to experience that

R: ahh it was nice...I don't have any other words for it...it was just really good...it was just peaceful and chilled out...and having no worries

I: mmm...and what made it peaceful do you think

R: there's like nothing going on...like no worries...don't hear voices and stuff...just nice...just nice to be...like a little break yeah

I: yeah

R: yeah it was good

I: mmm...and what was it a break from

R: I don't know just every day life...taking me away from like...this place is like boringish yeah...I don't like being here...its just nice to go away and leave all of this behind yeah...I dunno...

I: and when you say leave it all behind what do you mean

R: just like leave everything like no worries around here any more no problems nothing like that yeah

I: is that something you experience at the moment

A **Author**  
Experience of being on a boat

A **Author**  
Becoming used to and familiar with living on a boat

A **Author**  
Time away from usual every day experiences which is worrying and hearing voices  
Didn't hear voices on the boat

A **Author**  
Not happy where he currently is  
Escaping from usual life

R: erm kind of...but I'm trying to keep active like going for walks and going for runs...so not playing games all day...because I used to do like 10 hours night ~~til~~ day yeah and then

somewhere...now I just go to bed at like 12, 1 o'clock and then sleep, and ill go for a jog before I go to bed...just keep myself a bit healthier

I: mmm

R: trying to anyway

I: yeah

R: so that's...just having something to look forward to...its gonna be...like I'm not gonna have a job soon yeah...but trying to build up to getting a job like trying to wake up early and stuff...so just getting into a routine yeah if you know what I mean...

I: and you mentioned that on the boat as well you all had different roles and that sort of thing...I'm wondering what that was like for you

R: yeah you're working...same here like...I'm making fires and ill like wash the dishes and stuff...but out there its like you sort of do stuff that counts like making fires counts and stuff but out there it was like...it felt nice to be part of the team sort of thing yeah...just like you woke up...you didn't have to worry about anything else just like peaceful and happy...everyone was doing a bit yeah...sort of like...you did feel like part of a team...

I: and is that the first time...or...I'm just wondering if you've ever felt like part of a team before

R: ah no...I've felt like part of a team before yeah...it was nice to go back into it though if you know what I mean

I: what was nice about it

R: just the feeling of being part of something...

I: mmm...and when have felt like part of a team before

R: I ~~duuna~~ when I play games and stuff sometimes...when I've done those achievements and ~~stuff~~ when I do something difficult on a game its like overcoming a challenge you do feel a bit like woah...and if you do it as part of a team it's the same sort of feeling...but...mmm...

I: mmm...and I'm just wondering about all of those things that you did on the boat...I'm just wondering what it was like to do different things

R: it was alright yeah...just learning different things...it was quite a good experience yeah...we like learnt to read maps and how to tie a boat down...and about like different names of boats and what you call like place names and stuff...mmm...like getting the sails...it was like hard work yeah but you felt like you've achieved something after you've done it...that's nice...and we had a

BBQ and stuff...a trip to the shore in a little boat...that was good yeah...just lowered into the boat...and you get a speed boat down to the beach and have a BBQ go for a walk or

A

#### Author

Introducing a routine  
Changing what he usually does  
Changing behaviour  
Putting structure into life  
Wanting to be healthier  
Suggesting he wasn't healthy before  
Trying to – suggesting this is a journey, and that would be his goal, his aim

A

#### Author

Preparing himself for work  
Routine is prep for work  
Routine gives him structure and something to look forward to  
Not feeling confident that he will have a job soon  
Self-improvement

A

#### Author

Working as a positive  
Drawing parallels with work at home  
Being part of a team  
Life on the boat as relaxing and peaceful

A

#### Author

Learning new skills  
Hard but rewarding  
Sense of achievement  
New experiences  
Wanting to save the experience through photos  
Reminiscing by looking at photos

something...and you're like...land sickness...nah it was a good trip...but yeah...it was good...it was really good, good time yeah...I didn't have a phone at the time so I couldn't take any

pictures...but other people I knew have taken photos and stuff so I can go on Facebook and look at the pictures...so I haven't missed out on the pictures yeah...so...

I: yeah

R: memories of being there...

I: yeah...so erm...is it something that you think about...like do you look back to it

R: yeah...yeah...sometimes...like now...just like going back and reminiscing about the whole thing...its good yeah

I: and what are you feeling at the moment as you sort of look back

R: ~~duuuu~~ I'm just a bit happier...I'm just a little bit...yeah...

I: mmm...and I'm just wondering how you felt on the boat...is it similar

R: it just felt easier...relaxed eyes...just chilled out...like...you didn't have time to think really...you're always doing something...cos you're always moving yeah your bodies always

like...your brain your body is all...its all constantly working yeah...and like...in a house you'd just sit down for ages and its just boring yeah...but on a boat you've always go something to

look at or something to do or...its different things...like...to look forward to...

A  
Author  
Memories, reminiscing

A  
Author  
Talking about it is reminiscing  
Feels good  
Good to be reminded

A  
Author  
Feeling happier to look back  
Positive impact on mood

A  
Author  
Being busy as a good thing  
Easier and more relaxed  
Too busy to spend time thinking about things  
Distraction from thoughts?  
Physical activity as positive  
Physical and mental activity as a positive  
Inactivity is boring and bad  
Being at home forces inactivity  
Looking forward when on a boat

## **Appendix K: Code List**

### **“At first I was a bit nervous”**

1. Feeling anxious around new people
2. Needing reassurance to attend (facilitators and peers)
3. Worried about what to expect
4. Uncertainty about being involved in the group

### **“Turn my life around for the better”**

#### **“My mental health has improved and improved”**

1. Unhappiness
2. Feeling more relaxed around people
3. Increase in physical and mental activity as wellness
4. Boat as a release from difficulties
5. Mental health feels more manageable
6. Improvement in wellbeing
7. Clearer mind
8. Memories as sustaining
9. Feeling less tense
10. Experiencing joy and happiness in the group

### **“I hope it can help others”**

1. Self as helping others with similar experiences
2. Wanting to extend group to help others

### **“I thought I’d have an adventure”**

1. Negative external influences from environment
2. Change of environment important for change
3. Positive experience of the outdoors
4. Experiencing new and different things
5. Learning new skills
6. Achieving tasks
7. Adventure
8. Distance/perspective on problems
9. Different things are possible
10. Inspired by others’ achievements and experiences
11. Hard but rewarding activities
12. Escape from problems
13. Reason to leave the house

### **“makes me wanna change”**

1. Inactivity
2. Nothing to look forward to
3. Monotony

4. Re-engaging with life
5. Thinking about future
6. Routine as part of feeling normal
7. Change as a result of group
8. Putting structure in after group
9. Working as a positive outcome
10. Putting skills into practice at home
11. Keeping busy meaning less time thinking and worrying
12. Routine as preparation for work
13. Having plans as a way of preventing relapse
14. Desire to be healthier

**“it just brought confidence/I aint a waste of space”**

**Focuses on impact of group on self-perception**

1. Critical self-reflections
2. Lack of confidence
3. Feeling worthless
4. Building self confidence
5. Improving social skills
6. Self-belief
7. Building confidence through being capable
8. Feeling worthy
9. Confidence in self as important in recovery
10. Having a purpose

**“we’re all in the same boat”**

1. Rejected/judged by society
2. Feeling different
3. Getting to know others with shared experiences
4. Building connections
5. Friendship
6. Being seen as a person
7. Empathy for others with shared experiences
8. Feeling understood
9. Process of getting to know others



## Appendix L: Braun and Clarke's 15-point Checklist



Transcription	1.	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2.	Each data item has been given equal attention in the coding process.
	3.	Themes have not been generated from a few vivid examples (an anecdotal approach) but, instead, the coding process has been thorough, inclusive and comprehensive.
	4.	All relevant extracts for all each theme have been collated.
	5.	Themes have been checked against each other and back to the original data set.
	6.	Themes are internally coherent, consistent, and distinctive.
Analysis	7.	Data have been analysed rather than just paraphrased or described.
	8.	Analysis and data match each other – the extracts illustrate the analytic claims.
	9.	Analysis tells a convincing and well-organised story about the data and topic.
	10.	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11.	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12.	The assumptions about TA are clearly explicated.
	13.	There is a good fit between what you claim you do, and what you show you have done – ie, described method and reported analysis are consistent.
	14.	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15.	The researcher is positioned as <i>active</i> in the research process; themes do not just 'emerge'.

(Braun and Clark, 2006, p37)

## **Appendix M: Discussion of Theme One**

### **Theme 1. “To Begin with I Was A Bit Nervous”**

This theme was defined by the group initially being experienced as anxiety-provoking, and the process of overcoming these anxieties to be able to engage in the group. Participants were initially unsure about engaging in the group as they were anxious about meeting new people; Rhys said: “I didn’t know anyone...I was proper nervous”. Participants also spoke about their struggles with social anxiety in particular before engaging in the group, and spoke about their need for reassurance from group facilitators before making their decision about engaging. Input from facilitators beforehand was seen as an important part of enabling them to engage. When talking about his anxieties of going on the boat trip, Osian said:

*I was debating whether or not I should go on and [facilitator] was like we all feel the same...and if you feel the same and I feel the same then we might as well just do it and that’s how I ended up doing it*

Alongside input from facilitators, participants spoke about other ways they had coped with their anxieties, often “just getting on with it” (Osian) and attempting to not dwell on their anxieties. When deciding whether to join the boat trip, participants spoke about valuing getting to know other group members beforehand during the general group, which helped with their decision; Dafydd said: “if I didn’t know anyone I wouldn’t have done it because...if I don’t like any of them I’ve got to put up with them for five days...but because I liked them it was alright”.

### **Discussion of Theme “To Begin with I Was A Bit Nervous”**

Experiences of social anxiety are commonly reported in those experiencing psychosis, with a range of factors, such as delusions, hallucinations and paranoia potentially playing a role (Freeman et al., 2015), and can therefore make group engagement difficult. However, participants were able to overcome these challenges and engage with the group to varying degrees. A key aspect of OTGs is its challenging nature, provide attendees with the experience of overcoming challenges and engage in activities that are outside of their comfort zone. For participants in this sample, engaging in this group was their first challenge. Although participants did not directly speak about their sense of achievement of being able to engage with the group, the outdoor therapy literature suggests that overcoming challenges as part of the group can lead to feelings of achievement, and can lead to increased confidence (Ferneer et al., 2017).

An important part of enabling participants to engage with the group was normalising of uncomfortable emotions, evidenced by group facilitators sharing their own anxieties which participants may not have previous experience of, and meeting other group members. Overcoming this initial challenge, along with increasing their confidence, may have enabled them to continue their engagement and derive the benefits they went on to discuss, highlighting the inter-linked nature of their experiences.