Evaluation of Non-CBT Interventions for Clients Identified as At Risk Mental State (ARMS) in an Early Intervention Psychosis Service (EIP)

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1. Introduction

1.1 Literature Review

1.1.1 *Summary of Early Intervention Psychosis (EIP) service & At Risk Mental State (ARMS) pathway*

The EIP service is a multidisciplinary community mental health team focused on supporting individuals who are experiencing their first episode of psychosis or are at risk of developing a psychosis. Their aim is to reduce the duration of untreated psychosis or prevent the transition to psychosis; supporting recovery and reducing relapse rates (NICE, 2016).

Before individuals experience their first episode of psychosis, there can be a duration of time beforehand where they begin to have experiences which indicate 'At risk mental state' (ARMS) (NICE, 2016). Therefore, one of the key pathways within EIP is the ARMS pathway which focuses on support through psychological therapy and systemic work (BPS, 2017). Individuals are likely to have co-existing difficulties and to have experienced trauma, for example Adverse Childhood Experiences (Bebbington et al., 2011; Morrison, Frame & Larkin, 2003; van der Gaag, van den Berg & Ising, 2019; Varese et al., 2012). Therefore, individual priorities are important rather than a sole focus on symptom reduction (Byrne, Davies & Morrison, 2010).

1.1.2 *CBT and Psychosis*

CBT has a strong evidence base on preventing the development of first episode psychosis or reduce the symptoms associated with psychosis (Bach, Gaudiano, Hayes & Herbert, 2013; Bird et al., 2010; Hutton & Taylor, 2014; Stafford et al., 2013). A systematic review by Wood, Burke and Morrison (2013) on qualitative studies found clients were satisfied with CBT therapy for psychosis and found it supportive. However, some have contested CBTs ability to prevent relapse within some randomised control trials (Lynch et al., 2009). Despite contention within the literature, CBT is the most evidenced psychological treatment and recommended as a first-line treatment within NICE guidelines for EIP.

1.1.3 *Case for non-CBT interventions*

CBT is the most thoroughly researched therapy for psychosis, however, there is a growing evidence base for different types of therapy (Cortens, May & Longden, 2011; Oliver, Joseph, Byrne, Johns, & Morris, 2013). A recent review of psychotherapies for psychosis (Ridenour, Hamm & Czaja, 2019) concluded that a growing evidence base for other psychotherapies creates treatment options for clients and personalised care can potentially create meaningful change. Integrative approaches to psychological therapy have become more common across different services. A key component of integrative therapy is that it is individualised. Therefore, due to the heterogeneity of this type of therapy it can be difficult to create a robust evidence base which is methodologically sound (Tasca et al., 2015; Zarbo, Tasca, Cattafi, & Compare, 2016). Therapists must be aware that presentations are complex and one size does not fit all in terms of treatment, despite what approaches may have the largest evidence base. Being open to utilising different theories, techniques and models can allow further individualisation of an intervention attuned to the client's current needs and goals (Zarbo et al., 2016). Indeed, recent literature has advocated an integrative approach within psychosis (Carr, McKernan, Hillbrand & Hamlett, 2018; Lecomte & Lecomte, 2012). The British Psychological Society (BPS) guidelines (2017) state that one type of therapy may not work for all, therefore choice should be given to an individual. As stated above, individuals who are referred to ARMS pathway may have specific difficulties they want to work on which are not directly related to symptoms associated with psychosis. CBT may be useful, however, other types of therapies could be beneficial too, for example Eye Movement Rapid Desensitisation (EMDR) for trauma (van den Berg et al., 2015).

Turner, van der Gaag, Karyotaki & Cuiljpers (2014) compared CBT to other types of psychological interventions. CBT had better outcomes relating to psychotic symptoms, however, the variation of comparative treatments were low (befriending, general counselling, social skills training) and outcomes such as levels of distress or social functioning were not measured. A rhetoric article by Strauss (2014) highlighted that a person's presentation of a psychosis is unique, therefore treatment plans should be

individualised. Consequently CBT cannot be a blanket treatment for all, rather it should be based on clinical judgement and presenting difficulties.

1.2 Service Context

The ARMS pathway was commissioned within the EIP service in South West Yorkshire Partnership NHS Foundation Trust (SWYFT) and began to formally take referrals from 2016. There are four EIP services within SWYFT including Wakefield and Barnsley which both have Clinical Psychologists, CBT Therapists, Psychotherapists and other professionals within the team. The overall service aims are to improve the long-term outcomes for people at risk of developing a psychosis; in line with national guidance (NICE, 2016). This may be achieved through: symptom reduction; greater understanding of difficulties; building and maintaining social, educational and employment opportunities. As stated above, psychological interventions are a significant part of services offered to clients on the ARMS pathway. Since inception, Wakefield EIP estimated 70 individuals have been accepted onto the ARMS pathway, with around 15 receiving non-CBT psychological interventions. Barnsley EIP are currently undertaking an audit regarding accepted referrals to the ARMS pathway.

In both services, non-CBT psychological interventions were offered to clients who declined CBT due to their past experience with this type of therapy: previously finding the therapy unhelpful; or not suited to their current difficulties. Other clients were offered non-CBT psychological interventions as the clinician, using clinical judgement, had deemed the client unsuitable for CBT for any of the following reasons: the client did not have clear and focused 'goals/problem definition'; co-morbid complex difficulties which the clinician believed did not suit CBT disorder specific models; developmental/neurodiversity issues; complex trauma which the clinician believed would be better approached from different models; and/or the client unable to manage structured sessions.

Non-CBT interventions within the context of this service are therapy approaches which are not based on traditional CBT: integrative models; EMDR; Voice Dialogue; Narrative

Therapy; Compassion Focused Therapy; and Acceptance and Commitment Therapy. Similar to CBT offered within the service, sessions are usually weekly/bi-weekly and take place over six months to one year. This is in line with NICE guidelines for the ARMS pathway (NICE, 2016). No data has been made available for this report regarding specific therapy used for each participant or how many sessions of therapy they received. The above information (regarding what constitutes as non-CBT interventions and duration of therapy) has been collected anecdotally from clinicians within the service. This is the first evaluation within the service of the client's experience of non-CBT interventions.

1.3 Aims

This service evaluation aims to better understand the participants' experiences of non-CBT psychological interventions within the ARMS pathway. If non-CBT interventions have been perceived as beneficial (or not beneficial) by the participants, as well as, what they have taken from the experience and what service learnings/improvements are indicated.

2. Method

2.1 Author's input into methodology and reflexivity

The service evaluation framework was designed by the commissioner and the author analysed data that had already been collected by the service. The majority of the data collection happened whilst the author was on placement within the service, supervised by the service commissioner.

In terms of the author's own therapeutic stance, I prefer an integrative approach to therapy which can include CBT informed techniques. Being aware of my own therapeutic stance, as well as my relationship with the team whilst undertaking the service evaluation, led me to ask a DClin Trainee to peer check generated themes and subthemes so as to counter some of the potential bias.

2.2 Design

A qualitative design was chosen by the commissioner as formal feedback regarding non-CBT therapies within the ARMS pathway is limited, therefore an exploratory design is appropriate. Semi-structured interviews were conducted using an interview schedule (Appendix 1); this allowed for flexibility with questioning whilst ensuring that particular topics were covered during the interview (Gill, Stewart, Treasure & Chadwick, 2008). The interview schedule was developed by the commissioner of the evaluation, they were supported by the Trust Research & Development Team, as well as recommendations from members of staff on the DClin course. The commissioner used open and simple questions within the interview schedule to understand what participants had found useful and not useful within therapy. The commissioner confirmed the interview schedule was a guide for questioning. When I discussed interview techniques with the interviewers, I spoke about the importance of open non-bias questioning; allowing the participant to lead the conversation, as well as, trying not to ask leading questions.

Focus groups or surveys could have been used rather than semi-structured interviews, however, due to the individualised nature of therapy (structure and content of therapy

would vary between participants), it is more viable to use individual interviews as these are more likely to lead to in-depth accounts of therapy.

2.3 Participants and procedure

Participants were recruited from Wakefield and Barnsley EIP service. Due to the ARMS pathway being a relatively new service, with the majority receiving CBT intervention, the recruitment pool was small. Potential participants must have attended non-CBT interventions within EIP; they did not have to have attended CBT previously, although all participants recruited did speak about previous CBT therapy. Clients who were no longer in contact with the service or were in the early stages of therapy were not approached. All participants were recruited between February 2020 – July 2020. Due to COVID-19, the recruitment process and procedure for data collection changed between Wakefield and Barnsley, each discussed separately below.

Overall, 12 potential participants were approached for the evaluation, 6 from each service. Ten agreed to take part, one declined and one was uncontactable (both were from Barnsley EIP service). There is no recommended sample size for thematic analysis, Braun & Clarke (2006) suggested that for small projects 6-10 participants would be enough to detect patterns in data; small enough to manage the time consuming task of data analysis whilst providing enough data to allow for meaningful themes to emerge.

As agreed with the service commissioner, demographics will not be made available within this report, as they may have identifiable information. All participants were above the age of 16, a range of genders took part and had received mixed therapeutic approaches. During recruitment stage, the Assistant Psychologist (AP) who conducted the Wakefield interviews left the service, therefore a Trainee Social Worker (TSW) conducted the remaining interviews. For consistency, the author discussed semi-structured interview skills with both interviewers, providing opportunity to practice techniques. Neither of the interviewers had been trained in any therapeutic model and did not provide therapeutic interventions to clients. The author did not discuss their own stance on preferred therapeutic models with the interviewers. Although the interviewers' personal experience

may always bias responses from participants, both interviewers' lack of experience with therapy models may have lessened potential bias. The author did not discuss the interviews with the interviewers after they had taken place. All interviews were recorded on an audio recorder, recordings were uploaded to an NHS secure folder and were transcribed by a member of the EIP service. Recording therapy sessions is standard practice within the service, therefore, recording the interviews for the service evaluation was approved by the commissioner and the Research and Design department within the Trust. The transcripts were then checked by the service commissioner to remove any identifiable information (of either the client or the therapist). Participants were given a number to ensure anonymity. All transcripts were then sent to the author securely, the transcripts were then uploaded to the OneDrive.

2.3.1 Wakefield recruitment and procedure

The service evaluation commissioner wrote a list of potential participants who fitted criteria from the Wakefield service; the commissioner first mentioned the project to potential participants in therapy or during a telephone discussion. They were then contacted by the AP by telephone and asked if they would like to take part. Participants were given an information sheet regarding the project (Appendix 2), as well as given a consent form to read and sign (Appendix 3). Six potential participants were approached of whom five were currently still in therapy and one had been discharged. All six agreed to take part. The interviews were conducted face to face, five interviews took place within NHS premises and one interview took place at the participant's home.

2.3.2Barnsley recruitment and procedure

A Clinical Psychologist from Barnsley EIP service was asked to contact therapists with information on the project and ask them to send names of suitable potential participants. This list was then forwarded to the TSW who contacted each person by telephone and asked if they would like to take part. The information sheet and consent form was given to potential participants and if they agreed to take part, they were invited to the interview over the online platform Microsoft Teams (due to social distancing restrictions). Consent was

given verbally. All six potential participants were still in therapy and four agreed to take part in the service evaluation.

2.4 Data analysis

Transcripts were analysed by the author using the six steps of thematic analysis by Braun & Clarke (2006). Figure 1 below describes each stage of this process.

Themes/subthemes (with all relevant quotes) were also checked by both the commissioner and a peer on the Doctorate of Clinical Psychology training, with adjustments and revisions made in accordance to this. The peer had no previous involvement with the project or the service so offered an independent perspective on the data. Interpretive Phenomenological Analysis was considered for analysis of the data, however, this requires a strict homogenous sample, with strong guidelines on how to answer questions (Smith, Flowers & Larkin, 2009). Thematic analysis allowed more flexibility with heterogeneity.

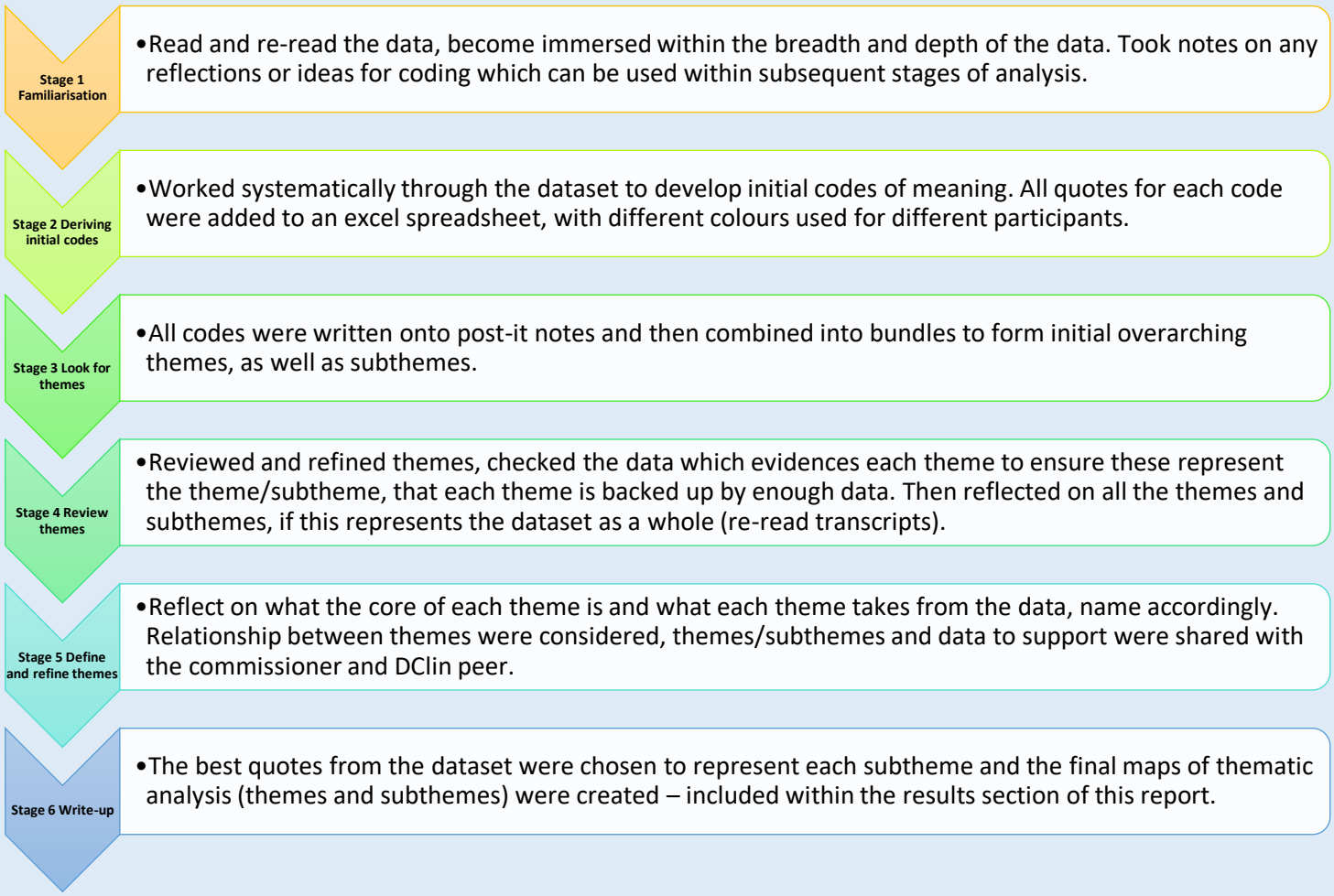

Figure 1 Stages of thematic analysis, adapted from Braun & Clarke (2006).

2.5 Ethics

Ethical approval was sought from the University of Leeds Research Ethics Committee and obtained on 16th June 2020. The commissioner also obtained approval from the Research and Development team within SWYFT in January 2020.

3. Results

This service evaluation sought to understand the experience of participants undertaking non-CBT psychological therapy approaches. During stage one of the thematic analysis process it became clear that all participants spoke highly of their current therapy;

"*the therapy is the best I've had from my experiences with the others. It is helping me and I can't see another way forward for it to be better." Participant 4.*

To further explore the participants' experience of the therapy, during the second stage of thematic analysis, the data was broken down further, into two key questions: what made therapy work and what were the barriers to previous therapy. The results are therefore broken down into two sections, with themes, subthemes (in bold) and quotes detailed below.

3.1: Section 1: What made therapy work?

As Figure 2 below demonstrates, there were four key themes which appeared to facilitate the participants' positive experience of non-CBT therapy, as well as several subthemes. All subthemes bar one represented five or more participants' experience; *systemic working* was only taken from two participants' experience. Each theme and subtheme will now be discussed in detail.

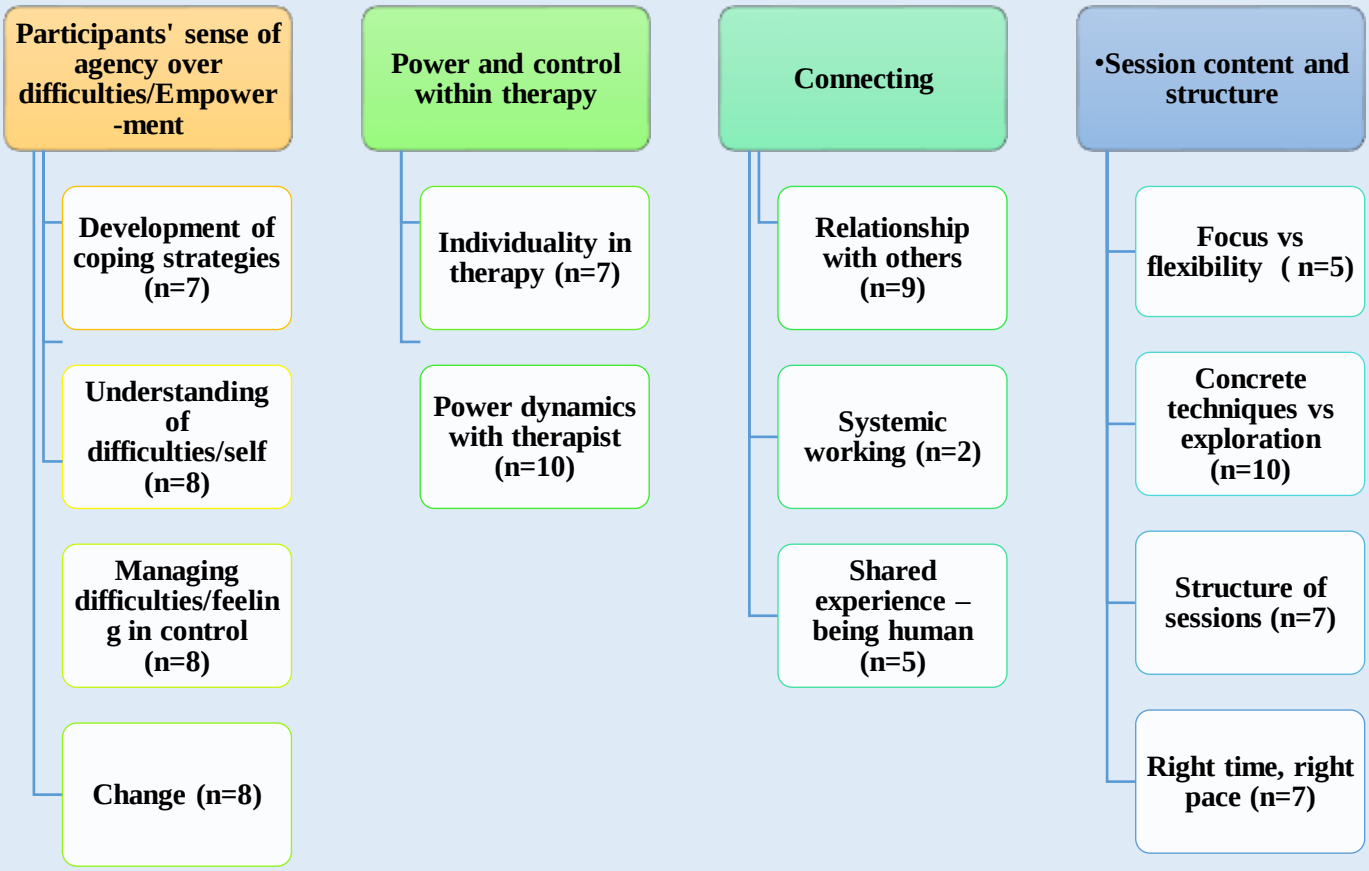

Figure 2. Themes and subthemes demonstrating positive experiences of attending therapy.

3.1.1 Participants' sense of agency over difficulties/empowerment

Participants reported an increased sense of control over any perceived difficulties, with more ability to cope day to day. For some, this meant a reduction in perceived difficulties, for others this meant difficulties feeling more manageable, or overall holistic changes in their life for the better.

Participants spoke about **developing coping strategies**, such as breathing techniques, problem solving techniques, grounding exercises and expression through the arts.

"this therapy we're getting taught how to cope….We're learning rather than obeying orders." Participant 6

Participants spoke about having a deeper understanding of their emotions, thoughts and behaviours, where these may stem from (both theory based and based on their previous life experience), how different emotions and difficulties work and what this means for them. Therefore, an overall deeper **understanding of difficulties and self**.

"[therapist] just helped me understand it all and how it all worked….the understanding it all just helped a lot with me getting better." Participant 2

Participants spoke about rather than stopping their difficulties, they have learnt how to **manage difficulties and/or feeling in control** of themselves and their difficulties.

"it made it a lot easier to manage as well. Obviously none of it's gone away, it's not gone away, but it made it a lot easier to deal with." Participant 3

"I'm learning that letting emotions out rather than locking them in helps – they've brought that out of me...I'm starting to express myself more, because all that sort of stuff, I used to block it all in. .... It's been massive. It's helped a lot." Participant 9

Participants noticed **change** in their overall wellbeing and/or reduction in their difficulties.

"I've found it brilliant to be honest, and it's helped in other areas where I wasn't receiving treatment, it's had a really positive impact overall." Participant 8

3.1.2 Power and Control within therapy

Participants spoke about feelings of control within therapy; therapy was created in a collaborative way, leading to participants feeling ownership over their therapy. There was a sense of **individuality in therapy**; the therapy was adapted to suit their needs, they felt some power and control over how therapy progressed and the issues to be discussed within the session.

"it's [therapy] more involved and allows you to understand what's wrong with you and what you need to work on. ... you have a box of lego and you can build a house however you like." Participant 5

Participants discussed **power dynamics with the therapist.** There was a feeling of being equal to their therapist, the idea of being a team and using the term 'we' frequently which allowed the participant to build trust and feel heard.

"when we need to do the EMDR we smash it out of the ballpark, it's amazing. Something I've never experienced." Participant 10

"I was made to feel equal and that definitely helps." Participant 3

"I'd probably say, one that I can remember .. is taking part in the experiment with me…. they'd do it with me, and it was sort of like, if they're doing it, then it's got to be okay" Participant 8

3.1.3 Connecting

The feeling of connection was elicited from the data. Participants spoke about positive changes in their **relationship with others** outside of therapy, as well as having a good relationship with their therapist.

"It's helped in the relationship with my wife, as well, because it's helped me understand when she gets emotional, well you understand their emotions more. It's helped in a lot of ways." Participant 9

"I got to a point where I was still comfortable, even when [therapist] would tell me off, or contradict me, or be really blunt towards me and say that some of the things I was saying were irrational… I'd still take it because I felt comfortable…" Participant 7.

Two participants spoke about a holistic approach to care, **systemic working**, with therapist speaking to the other professionals or directing to other support outside therapy to support the participant.

"[therapist] been in contact with my college, or my university now, to explain that and give me some mitigation on my coursework … and work out a care plan." Participant 4

Participants shared experiences of having a deeper understanding that others go through similar difficulties to them, creating a sense of not being alone; **a shared experience of being a human**.

"it's not a taboo subject for me is what's changed. My view of mental health...Probably to find out how many people experience similar things...It's not something to be ashamed of, it's not something you need to go and get treatment for, it's just something you might need a bit of extra help on." Participant 6

3.1.4 Session Content and Structure

Focus vs Flexibility - Although some participants spoke about particular difficulties being worked on in therapy, participants spoke about flexibility in sessions, a sense that they can bring what was important to them at the time and the focus could be changed to their needs.

"I just explain about the problem I'm having, I explain about how the week was, stuff like that...It's, like, you can talk about any problems, literally anything….we talk about really everything." Participant 1

"We just go with the flow most of the time...We've followed the right sort of program but none of it has been in a set pattern...We have kind of a structure of discussions and how they lead, but it's all very freeform." Participant 5

Concrete techniques vs exploratory - Participants described a mix of techniques from specific therapies, or having more of an exploratory approach to understand their difficulties.

"she puts it [EMDR light] on and we go through all the memories, and then she'll stop it after a couple of minutes, ask me how it's affecting me, and stuff like that." Participant 10

"it's been everything from really not normal methods like the music thing, general conversation stuff of me opening up on my own behalf, we've written stuff down, we've done mind maps, we've collated documents about how my head works regarding different people and different things that I value." Participant 4

Participants described similar **structure of sessions** although content of sessions may differ; general chat at the beginning of sessions, some practicing relaxation exercises, discussion of the week and then either exploratory work or specific therapeutic techniques.

"[therapist] calmed you down, that meet and greet, ten minutes to see everything that was going on before we'd start… it relaxed me...a lot of preparation before it, getting into a happy, quiet, calm place." Participant 9

Participants spoke about the importance of time, **the right time/right pace**, with regards to feeling ready for therapy, the pace being appropriate to allow participants to open up and a sense of therapy not being rushed.

"I don't think they wanted to jump straight into everything without actually knowing anything about me or how I would react." Participant 7

"It's about gradually getting to that place instead of forcing it and we've talked about other things...time to get to know the person, feel comfortable enough to open up to the person." Participant 4

3.2: Section 2: What were the barriers to previous therapy?

During the interviews, participants spoke about barriers to therapy, in particular, the barriers to fully engaging in or benefiting from previous therapy. Four themes were derived from the data regarding barriers to engaging with previous therapy and are displayed below in Figure 3. Although the data below primarily focused on previous therapy, some interesting points were made from participants regarding barriers to their current therapy and are added to the overall count detailed in Figure 3. One participant spoke about clinical rooms being too formal in their current therapy and this has been added to the subtheme *formality- 'clinical' environment*. Participants also spoke about difficulty initially opening up about their feelings in both their current and previous therapy; this has been added to the subtheme *difficulty opening up*. All other themes and subthemes relate to previous therapy and are discussed in more detail below. All subthemes bar one represented four or more participants' experience; *systemic influences* was only taken from the experience of two participants.

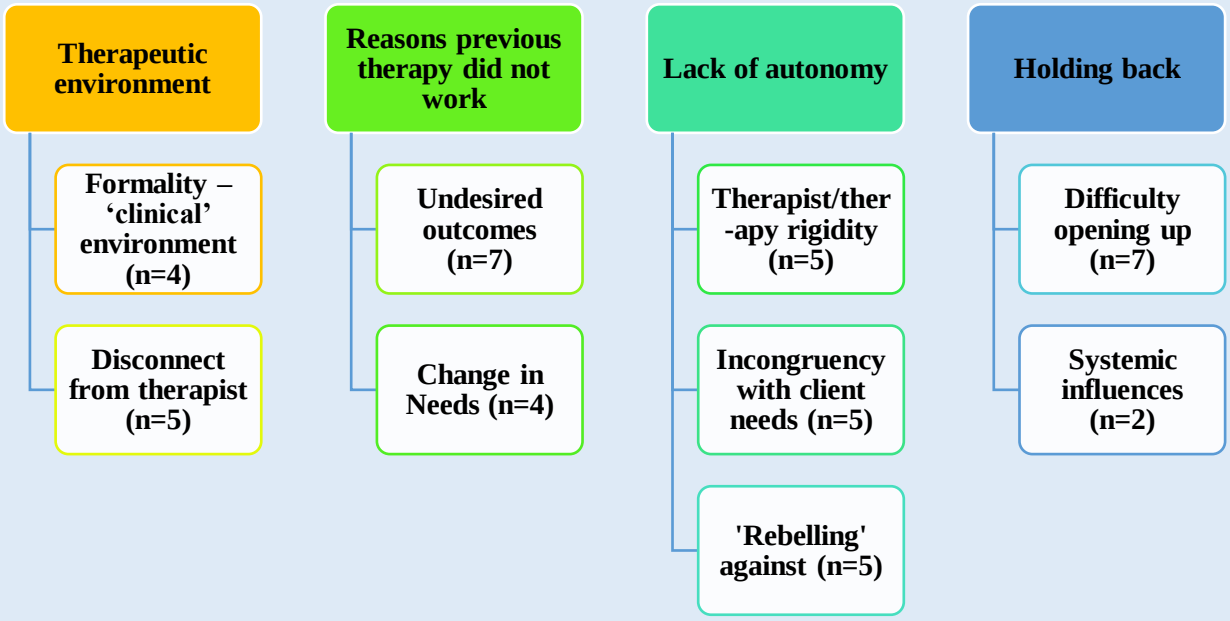

Figure 3. Themes and subthemes of barriers to attending therapy

3.2.1 Therapeutic Environment

Participants spoke about the setting of therapy not being a welcoming environment and it feeling like a **clinical and formal environment**. Some spoke specifically about the physical environment, while others spoke about the overall feeling of the environment being clinical rather than friendly, likening it to parents evening or a job interview.

"a very alien environment that I was forced into instead of being willing….everything that was being said or worked through never felt natural, it kind of felt forced… like I was in trouble basically. It's the same sort of feeling that I got when I got put into the principal's office." Participant 4

Some participants discussed a difficult relationship with their previous therapist, feeling not heard or understood by the therapist; **a disconnect from therapist.**

"he seemed bored by the entire experience… Basically he's going 'this guy is a patient to treat, not a person to see'." Participant 5

3.2.2 Reasons previous therapy did not work

Some participants disclosed their previous experience of therapy had led to **undesired outcomes**; a deterioration in their wellbeing.

"CBT wasn't focussing on that [voice hearing/'multiple personalities'] at all and obviously when I was getting annoyed by it and getting angry the switching [between voices/personalities] and things were worse and I was more stressed." Participant 2

Other participants discussed a **change in needs** over time which led to their previous therapy (mainly CBT) not being perceived as suitable anymore for them.

"They just no longer were as effective or just no longer applied properly." Participant 5

3.2.3 Lack of Autonomy

Participants discussed their previous experience of therapy, speaking about the **rigidity of the therapy/therapist**, feeling that it was forced and the therapist not being flexible to the client's needs.

"What we'd do in the next session would remain the same regardless…I just find it completely futile. They also could have rephrased questions, because it's like they were reading out of a book and sometimes if I don't understand what they are talking about… they just keep saying it the same and it makes it very uncomfortable." Participant 6

Participants commented on previous therapy not focusing on what was important to them, therefore an **incongruency with client needs.**

"There were things I was telling her and she wasn't focussing on that….my problem was hallucinations and things and the CBT just doesn't really focus on that, it focusses on anxiety.. that wasn't the problem at the point..so it didn't really help at all." Participant 2

Due to frustration, feeling therapy was not working or that there was a lack of power within therapy, participants spoke about disengaging and **rebelling against** therapy work to take back some control.

"I'd either ignore them and try and get out that way, which oftentimes I can't really remember how I'd just see it from a third person perspective, or I would get really aggressive…. it was like a flight or fight response." Participant 4

3.2.4 Holding back

Difficulty opening up

Participants spoke about **difficulty opening up** within therapy or speaking about emotions and that this process takes time.

"I started off a little bit wary about opening up and letting my guard down." Participant 8

Two participants spoke about **systemic influences** outside of therapy having an impact on their ability to engage with therapy.

"A lot of it was to do with being in a bad relationship, so when I got out of that I saw the light a lot more." Participant 2

4. Discussion

4.1 Summary of results

Participants were overwhelmingly positive regarding their experience of non-CBT psychological therapies; participants struggled to think of how it could be improved. One of the key trends voiced within the data was the importance of the therapeutic alliance, with strong feelings related to collaboration, flexibility and being heard. The positives derived from the data present as directly opposite to the barriers to previous therapy; feeling disconnected in the therapeutic relationship, the therapy being perceived as rigid and not aligning with clients' needs. These key findings will be discussed below and compared to relevant research.

Therapeutic alliance has been highlighted as one of the most essential influences on therapy, which mirrors the results from this service evaluation (Ardito & Rabellino, 2011). Qualitative studies investigating the experience of CBT for psychosis have found similar results regarding the importance of therapeutic alliance and collaboration in creating change and the importance of using technique flexibly (Miles, Peters & Kuipers, 2007; Wittorf et al., 2013). CBT should also be a collaborative experience for clients, in a welcoming non-formal environment with communication used that suits the client (Morrison & Barratt, 2010; Wood et al., 2013). This reflects the analysis of the data, with formal environments and rigidity to the model being barriers to therapy. Therefore, barriers to therapy highlighted within this evaluation are not due to the CBT model per se, rather how a therapy is conducted and the importance of basic therapeutic skills which transcends particular models and schools of psychotherapy.

Another key learning point from the results was the importance of clients feeling empowered over their perceived difficulties and their overall wellbeing. Some participants reported reduction in symptoms, however, feeling able to cope and manage difficulties, understanding their difficulties, normalising their difficulties and building on relationships, appeared a more significant change to participants. This reflects previous research regarding what outcomes may be important for clients, the difference between objective outcomes (symptom reduction/social functioning) and subjective outcomes (self-esteem,

agency and empowerment over self and difficulties) (Lysaker, Glynn, Wilkniss & Silverstein, 2010). Ridenour et al. (2019) in their review of psychotherapies for psychosis spoke about the importance for clients in seeking validation, having a space to be heard, collaborating with therapists to build resilience in their recovery, learning new strategies and seeing themselves as active agents within their recovery – rather than being told what to do to reduce symptoms. A qualitative study by Kilbride et al. (2012) highlighted clients value power balance within therapy, improving their understanding of psychosis and ways of coping, as well as social and functional recovery. The findings of this evaluation concur with previous research, indicating that the outcomes that are important to clients may not be fully represented within RCTs which tend to focus on evidence of symptom reduction in psychosis (Turner et al., 2014). Therefore continued evaluation of varied outcomes of therapy could be important to understanding how to best support clients with psychosis/ARMS, creating user-defined recovery.

The common factors model states that different approaches to psychotherapy can produce similar outcomes, however, replicated psychotherapy will not have the same outcome on two separate individuals; all psychotherapies have common factors which influence change in an individual (Wampold, 2015). This common factors approach includes variables such as therapeutic alliance and goal consensus, and argues that these common factors are more meaningful contributors to clinical change compared to specific therapy approaches (Nahum, Alfonso & Sönmez, 2019). The common factors model does not contest any specific therapy, rather it encourages evidence based practice to be derived from the principles of a therapy, instead of ridgidly adhering to specific techniques (Brown, 2015; Swan & Heesacker (2013). Although specific techniques (for example techniques within the EMDR therapy model, breathing techniques and exploration techniques) were mentioned by participants, overall the themes and subthemes from the analysis suggest the importance of common factors.

Overall, the service evaluation is in favour of offering non-CBT interventions to some individuals when deemed appropriate. The evaluation also highlights the wider importance of general therapy skills for clients to gain the most from the service. Participants voiced

becoming disengaged from their previous therapy, or having undesired outcomes, when they did not feel alligned with their therapist, did not feel heard and had no sense of control within therapy. This is in line with recent guidance from BPS (2017) that people are individuals and one therapeutic model will not suit all, therefore, their preferences should be considered, as well as what their own goals and perceived idea of 'getting better' are. Collaboration and shared power are also key recommendations within BPS guidance. Therefore, continuing to offer both CBT and other therapeutic models provides choice to individuals could be beneficial for engagement and inclusivity within the service.

4.2 Limitations

The clients who took part were self-selecting, with limited clients approached for the study and those who were approached were chosen by their therapists. Those who took part may have agreed to take part due to their own positive experience, or due to the positive relationship they had with their therapist which may have skewed their response. Some participants were directly approached by their therapist which may have impacted on what they felt comfortable sharing, although participants were assured that participating would not impact their care. This limits findings being generalised, however, as noted above, the findings are in line with previous research. Efforts were taken to limit bias, for example inviting clients from different parts of the service to take part who had received different types of psychotherapy from various therapists. The interviewees were not part of the participants' care (or aligned to particular therapeutic models) in an attempt to create a safe space to share honest feedback. A limitation of the evaluation was that the author did not conduct the interviews. This may have impacted the analysis as non-verbal cues or communication through tone of voice may have been lost. This report encourages future service evaluations to be conducted by the person undertaking the analysis.

The therapy received by clients varied, with some more structured than others (for example EMDR vs Voice Dialogue), therefore all findings do not directly link to any particular therapeutic model or stance, rather general feedback on non-CBT interventions. Access to specific details regarding the model of therapy each participant

received and the duration of their therapy, may have allowed further comparisons between different models of therapy. Despite this gap in information, the author was able to draw similarities in experience between participants; with at least half of the participants' experiences drawn upon for the majority of the subthemes on why they believed therapy worked.

Due to COVID-19, the methodology changed between Wakefield and Barnsley services, which may have impacted data.– despite this, the author was able to derive common themes between the two services data sets. Most participants were still under the care of the service when the interviews were conducted therefore this evaluation does not reflect any potential long-term impacts on participants; this could be further explored in future service evaluations.

4.3 Recommendations

Please see Figure 4 below for key recommendations for the service.

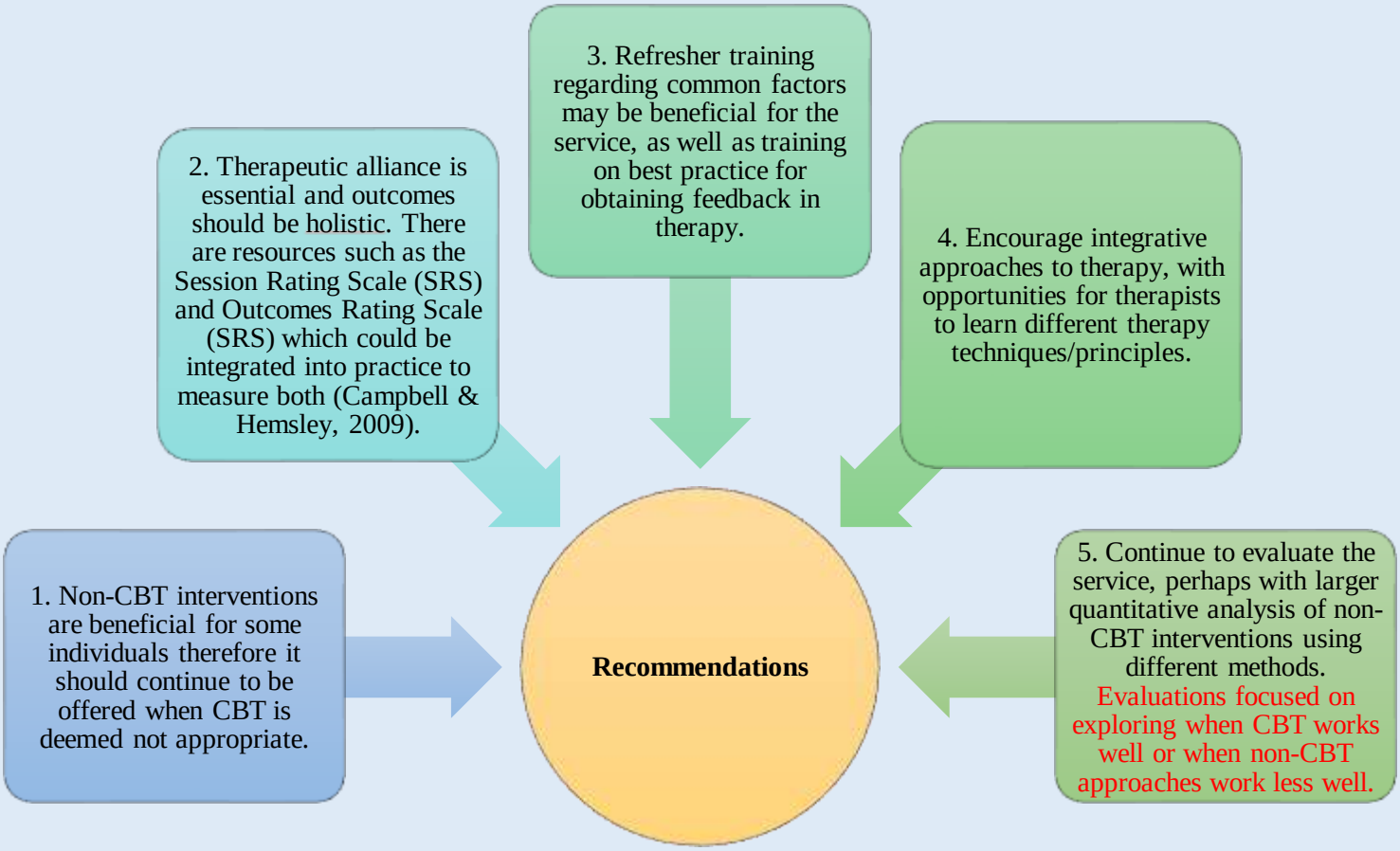

Figure 4 – Recommendations for service

4.4 Dissemination

A summary of this evaluation was presented to DClin trainees and staff on 23/10/20. This presentation has also been shared with the commissioner. An extended version of this will be presented to the Wakefield EIP service on 17/12/2020 and the author has offered to

present to the Barnsley team. The commissioner has requested a poster presentation which will be created before 17th December (based on feedback from this report) and a one page summary will also be created with the commissioner to send to participants. The commissioner has also offered to present the findings to Yorkshire and the Humber EIP Network.

5. References

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6. Appendices

Appendix 1 Interview Schedule

Proposed Interview Schedule for SEP

- Please outline your previous experiences of therapy (not including the most recent/current one)

- Can you explain a little bit about the therapy you have at the moment/have recently completed? Prompts – is this type of therapy called anything? What kind of things have you focussed on/worked on? (in general terms)

- How is this therapy different from your previous therapy?

- What has been beneficial about your work with the therapist?

- What could be improved about your work with the therapist?

- What has changed for you and what have you learned from the therapy work?

- Any other comments about the therapy

Appendix 2 Participant information sheet

Insight Service Evaluation Project
Information Sheet

What is this project about?
We are trying to find out more about the experience of our clients who have had therapy with a psychologist or a therapist in models other than Cognitive Behavioural Therapy (CBT). This is because most of the people we work with have CBT therapy, and it is proven to be a helpful intervention for many. However, for some people CBT may not have worked for them in the past or might not be the best approach, and they have received other kinds of therapy work with the Early Intervention team. We want to learn what has been helpful about their therapy experience and what could be improved, to try and make our service the best it can be for our clients.

Why am I being asked to take part?
We are asking clients to take part who have had therapy interventions as the main aspect of their treatment with Early Intervention, and who have received therapy in a model other than CBT. We are asking people who have completed or are near the end of their therapy. We expect that most of the people who will take part will have experienced therapy before their most current contact with the team, in many cases this might be CBT, but this is not essential to take part.

What does taking part involve?
We will ask you to complete an interview with a member of the Early Intervention Team who you have not worked with directly, they will ask you some questions about your current and previous experiences of therapy. This will be recorded and what you say will be transcribed (written word for word) and then made anonymous, removing any identifiable information. These transcripts are then analysed for themes, and put into a report, which helps us to understand more about the experience of therapy and how we may improve our service. What you say in the interview will not be made available to your therapist in any identifiable way, and taking part or not will not affect the treatment you receive. The interview should take less than 30 minutes and can be completed face to face or over the phone.

Are there any risks of taking part?
There are unlikely to be any risks of taking part for most people. You will be asked to discuss your experiences of therapy in general terms and will not be asked about specific topics that could be upsetting (e.g. details of the nature of trauma you may have experienced). However, if you do find that the interview raises difficult feelings and you find it to be distressing, you can terminate the interview at any time. You can also seek support via your worker in Early Intervention or GP if you feel that you are struggling with your mental health.

What are the benefits of taking part?

We hope that people find that participating in this process is rewarding as it is an opportunity to provide meaningful feedback to the service which helps us to improve

What next
If you are happy to participate please complete the consent form and return it to your Insight worker. A member of the team will be in contact with you to arrange the interview. If you would like to see the completed report when it is finished, please let the interviewer know and you will receive a copy.

If you have any further questions please contact Kate (study supervisor), or Emily (interviewer and assistant psychologist) on 01924 316936

Appendix 3 Consent form

INSIGHT EARLY INTEVENTION IN PSYCHOSIS SERVICE
Consent form for Audio Recording and Participation in Service Evaluation Project

The Client

Name:……

I give my consent to participate in the Early Intervention Team Service Evaluation project about non-CBT work, having read and understood the information sheet

I give consent for my interview to be audio recorded and transcribed (typed up word for word) by a member of the Early Intervention Team or the Trust's Research & Development department or audit department.

I understand that these transcripts will be anonymized (so will not contain any identifiable information) and then the original recording will be securely destroyed

I understand that the audio/video recording does not constitute part of any clinical record and will only be used for the purpose of the service evaluation

I consent for the information I give in the interview to be used as part of the service evaluation report, including anonymous quotes from the transcript.

I understand that the interview and transcript will be completed by someone who is not involved in my care, and that comments I make will remain non-identifiable to the clinician I have worked with. Confidentiality will be maintained unless the interviewer is concerned that I, or someone else may be at risk of harm, in which case this may be disclosed to my care team.

I give my consent on the understanding that the recording will be stored safely for a period of up to 2 years, after which time if not before it will be destroyed.

I understand that I may withdraw my consent during the interview or in the immediate aftermath. However, once the transcript has been anonymized it will be non-identifiable, so I will be unable to withdraw this after this time.

Signed: …… Date:

The Interviewer
Name:……

The audio/video recording is for the purposes of service evaluation. I undertake to protect the confidentiality of the client above. The recording will be stored properly in a secure place and will only be used for the purposes indicated above and deleted once the recording is no longer required for that purpose.

Signed: ……
Date:…….....