A pilot study exploring the utility of a 'therapeutic research group' intervention for people experiencing psychosis related difficulties.

DOI:

[10.1080/18387357.2019.1604070](https://doi.org/10.1080/18387357.2019.1604070)

Document Version

Accepted author manuscript

[Link to publication record in Manchester Research Explorer](#)

Citation for published version (APA):

Abram, M., Awenat, Y., Byrne, R., Fin, M., Finlayson, S., Foat-smith, G., Galarza, M., Haddock, G., Jackson, P., Lee, G., Melia, S., Mcculla, J., Messham, L., Mulligan, J., & Wardle, L. (2019). A pilot study exploring the utility of a 'therapeutic research group' intervention for people experiencing psychosis related difficulties. *Advances in Mental Health*, 1-18. <https://doi.org/10.1080/18387357.2019.1604070>

Published in:

Advances in Mental Health

Citing this paper

Please note that where the full-text provided on Manchester Research Explorer is the Author Accepted Manuscript or Proof version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version.

General rights

Copyright and moral rights for the publications made accessible in the Research Explorer are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Takedown policy

If you believe that this document breaches copyright please refer to the University of Manchester's Takedown Procedures [<http://man.ac.uk/04Y6Bo>] or contact uml.scholarlycommunications@manchester.ac.uk providing relevant details, so we can investigate your claim.

A pilot study exploring the utility of a 'Therapeutic Research Group' intervention for people experiencing psychosis related difficulties.

Journal:	<i>Advances in Mental Health</i>
Manuscript ID	RAMH-2018-0020.R4
Manuscript Type:	Original Paper
Keywords:	Auditory Hallucinations, Hearing Voices, Group Intervention, Participatory Action Research, recovery, resilience measure
Abstract:	Objectives: This pilot study explored the feasibility and acceptability of using research as the basis of a therapeutic group intervention for hearing voices/auditory hallucinations. Methods: Using a Participatory Action Research methodology, seven male current or previous residents of a low secure hospital participated in the study. Participants independently conducted research on ideas that were generated and operationalised by the group, on a weekly basis over a seven-month period. Participants focused on developing a new 'easy to complete' recovery/resilience measure. The group also themselves developed a qualitative interview schedule, and participated in interviews at the conclusion of the intervention period. In addition to the four participants who engaged throughout the intervention period and contributed towards the analysis of transcripts, three other participants (two who disengaged on moving to a new area and one who consented to participate but never attended), took part in post-intervention interviews. Results: The study demonstrated preliminary evidence supporting the utility of a 'Therapeutic Research Group' intervention for people who experience distressing voices. In addition to feedback about the positive impact participating in the group had on well-being, participants offered advice on overcoming barriers and increasing the popularity of therapeutic interventions. Participants also developed a new recovery/resilience measure (the M-PART) whose preliminary face validity appears positive. Discussion:

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

	Mental health service users/survivors can independently make important contributions to advancing knowledge and improving services. Further research examining whether 'the conducting of research' could form the basis of a therapeutic intervention is warranted. Empirical testing of the M-PART measure is also necessary.

SCHOLARONE™
Manuscripts

Running head: *Therapeutic Research Group intervention*

A pilot study exploring the utility of a ‘Therapeutic Research Group’ intervention for people experiencing psychosis related difficulties.

Abram, M.¹, Awenat, Y.², Byrne, R.³, Fin, M.¹, Finlayson, S.¹, Foat-Smith, G.¹, Galarza, M.¹, Haddock, G.², Jackson, P.¹, Lee, G.¹, Melia, S.¹, McCulla, J.¹, Messham, L.¹, Mulligan, J.³, & Wardle L.¹

¹Mersey Care NHS Trust

²University of Manchester

³Greater Manchester Mental Health Trust

Word count (exc. figures/tables): 4503

*The authorship of this research paper is alphabetical. Requests for reprints should be addressed to Dr John Mulligan, Manchester Early Intervention Service, Chorlton House, Manchester, UK, M21 9UN.

Tel: 0161 358 2500 Email: johnmulligan@nhs.net

Acknowledgements:

In memory of two of our fantastic co-researchers SM and GL who sadly passed away subsequent to the completion of this project.

The authors would like to thank the Manchester Hearing Voices and Burnley Bipolar UK groups for the support and inspiration during the initial stages of this research. Also thanks to Tony Morrison, Kate Weiner, Mike Wilson, Liz Pitt, Jason Price, Paul French and colleagues from the North West Research Design service and Mersey Care NHS Trust for their valuable contributions.

Funding

The North West research design service kindly contributed £350 to support service user/survivor consultation in the early stage of this project. Mersey Care NHS Trust funded the consultation fee paid to co-researchers during the course of this project.

ABSTRACT

Objectives

This pilot study explored the feasibility and acceptability of using research as the basis of a therapeutic group intervention for hearing voices/auditory hallucinations.

Methods

Using a Participatory Action Research methodology, seven male current or previous residents of a low secure hospital participated in the study. Participants independently conducted research on ideas that were generated and operationalised by the group, on a weekly basis over a seven-month period.

Participants focused on developing a new ‘easy to complete’ recovery/resilience measure. The group also themselves developed a qualitative interview schedule, and participated in interviews at the conclusion of the intervention period. In addition to the four participants who engaged throughout the intervention period and contributed towards the analysis of transcripts, three other participant’s (two who disengaged on moving to a new area and one who consented to participate but never attended) took part in post-intervention interviews.

Results

The study demonstrated preliminary evidence supporting the utility of a 'Therapeutic Research Group' intervention for people who experience distressing voices. In addition to feedback about the positive impact participating in the group had on well-being, participants offered advice on overcoming barriers and increasing the popularity of therapeutic interventions. Participants also developed a new recovery/resilience measure (the M-PART) whose preliminary face validity appears positive.

Discussion

Mental health service users/survivors can independently make important contributions to advancing knowledge and improving

services. Further research examining whether ‘the conducting of research’ could form the basis of a therapeutic intervention is warranted. Empirical testing of the M-PART measure is also necessary.

Keywords: Auditory Hallucinations, Hearing Voices, Group Intervention, Participatory Action Research, recovery, resilience measure

Practitioner points:

Supporting people who experience mental health problems to conduct research could benefit both the participants themselves, and help to advance understanding and improve services.

Supporting service users to gain insights and transferable skills, whilst focusing on and conducting research for the benefit of others, has the potential to provide an alternative intervention strategy that could aid recovery.

INTRODUCTION

A significant proportion of mental health service users have current or previous experience of coping with auditory verbal hallucinations (AVH or ‘hearing voices’). While there is increasing research focus on non-problematic or positive AVH in the general and clinical populations (Jenner, Rutten, Beuckens, Boonstra & Sytema, 2008), distressing AVH's often detrimentally impact on people’s quality of life, mood, suicidality, anxiety levels, and self-esteem (Copolov, Mackinnon & Trauer, 2004; Harkavy-Friedman, Kimhy, Nelson, Venarde, Malaspina & Mann, 2003; Smith, Fowler, Freeman, Bebbington, Bashforth, Garety, et al., 2006).

Although Cognitive Behaviour Therapy for Psychosis (CBTp) has been demonstrated as efficacious and is recommended for people who experience psychosis (e.g. National Institute for Health and Care Excellence, 2014), reviews suggest that CBTp has limited impact on hearing voices (Pillings, Bebbington, Kuipers, Garety, Geddes, Orbach & Morgan, 2002; Rector & Beck, 2001; Wykes, Steel, Everitt & Tarrier, 2007). Similarly, up to 50% of people who

regularly take antipsychotic medication continue to experience voices (Carter, Mackinnon & Copolov, 1996). With adherence and efficacy problems with anti-psychotic medication (e.g. Kamali, Kelly, Clarke, Browne, Gervin, Kinsella, Lane, Larkin, & O'Callaghan, 2006; Whitaker, 2016), high drop-out rates in therapy (Bados, Balaguer & Saldaña, 2007) and limited implementation of CBTp within services (Berry & Haddock, 2008; Haddock, Eisner, Boone, Davies, Coogan, & Barrowclough, 2014), it appears that aspects of available AVH related treatments may be perceived as ineffective or unacceptable to many service users and/or mental health staff.

Group interventions

Efforts to maximise resources and support people who experience AVH, particularly those who are uninterested or unable to take part in individual therapy, have led to a significant increase in the number of group interventions for hearing voices., both via peer supported groups within the community (e.g. the Hearing Voices Network) and staff facilitated groups within mental health services (e.g. Dillon & Longden, 2011). There is increasing evidence that both peer led and mental health staff facilitated interventions are becoming increasingly important and effective (e.g. Dillon & Hornstein, 2013; Corstens, Longden & May, 2012; Newton, Larkin, Melhuish & Wykes, 2007; Thomas, Hayward, Peters, van der Gaag, Bentall, Jenner, & García-Montes, 2014). Promising as this is, further research to more accurately identify mechanisms of change and predictors of outcome for successful hearing voices interventions is necessary (Ruddle, Mason & Wykes, 2011; Thomas et al., 2014).

Participatory Action Research (PAR)

Recent years have seen a slow but progressive move towards increased involvement of mental health service users/survivors in clinical research and practice (e.g. Corstens, Longden, McCarthy-Jones, Waddingham & Thomas, 2014; Simpson & House, 2002). There is increasing emphasis on, and good examples of, ‘expert by experience’ led research (e.g. Faulkner & Layzell, 2000; Pitt, Kilbride, Nothard, Welford & Morrison, 2009; Byrne & Morrison, 2010; Rose, Sweeney, Morven, Clement, Jones, Burns & Wykes,

Therapeutic Research Group intervention

2009), as well as evidence that service user/survivor led research and clinical practice can be more effective and acceptable to research participants (Simpson & House, 2002).

This study used a PAR methodology to support people with personal experience of AVH to conduct research within a therapeutic group environment. Combining learning from social psychology (Lewin, 1946) and pedagogy (Freire, 1970), PAR places researchers and participants as co-researchers (Argyris & Schön, 1984). It involves providing the people who are directly affected by a problem, the resources and power to conduct research with a view to increasing understanding, taking action and facilitating change (Nelson Ochocka, Griffin, & Lord, 1998). The emphasis in PAR is on co-learning, shared investigation, critical reflection and action for education and change (Freire, 1982; Wallerstein, 1999). Such an emphasis could conceivably complement CBTp, with its aims to enhance critical thinking skills, address reasoning and attribution biases, etc. (Garety, Freeman, Jolley, Dunn, Bebbington, Fowler, Kuipers & Dudley, 2005; Morrison, 2001).

Stringer (1999) suggested that PAR assists people in extending their understanding of their situation, which in turn empowers them to resolve issues that confront them. PAR pairs 'experts by experience' with the means and opportunity to conduct high quality research. The means by which PAR often occurs in mental health involves service users/survivors being recruited to studies as co-researchers at an early stage, supported to enhance their knowledge of research processes (e.g. training in qualitative interviewing skills), and then involved in parts or most stage of the research from developing/refining the aims through to dissemination of findings. Whether utilised to more accurately assess the efficacy of therapeutic interventions (e.g. Rose, Wykes, Farrier, Doran, Sporle & Bogner, 2008) or to develop new knowledge (Michalak, Jones, Lobban, Algorta, Barnes, Berk, et al., 2016) or measures (Evans et al., 2012; Rogers, Chamberlin & Ellison, 1997), the use of 'expert by experience' knowledge presents much opportunity to enhance our understanding and the quality of research production.

It has been suggested that participating in PAR is 'transformative and liberating' (Stringer, 1999; Stringer & Genat, 2004), 'empowering and life enhancing' (Koch & Kralik, 2006, p28) and can support participants to increase awareness of their own resources and strengths (Balcazar, Keys et al, 2006). With increasing use of PAR within mental health research in recent years (e.g. Schneider, 2012; Hutchinson & Lovell 2013;; Koroloff, Osher, Jivanjee, Pullmann, Sofich & Guthrie, 2010; Munten, Van Den Bogaard, Cox, Garretsen & Bongers, 2010), further opportunities to use and explore the effectiveness of using PAR for the benefit of participants and the production of high quality research are necessary. While it is conceivable that supporting service users to conduct research could form the basis of a positive therapeutic intervention, claims that taking part in PAR (or indeed research more generally) is good for one's health could benefit from further investigation.

Study aims:

1. The first aim of this study was to support 'experts by experience' who have in the past struggled to engage or benefit from interventions for hearing voices to themselves conduct research and generate output in relation to an aspect of mental health of their choosing.
2. The study's second aim was to explore the feasibility and acceptability of utilising 'the conducting of research' within a 'Therapeutic Research Group' (TRG) environment as a therapeutic intervention for people experiencing distressing voices.

METHOD

Participants

Ten current and ex-service users of a regional low-secure hospital were identified by hospital staff (based on presence of AVH and current risk), and provided with verbal and written information about the research. Seven participants (or 'co-researchers') consented to participate in the study (5 current and 2 ex-service users). Subsequent

Therapeutic Research Group intervention

to consenting and prior to the group commencing, funding was secured to provide co-researchers with a £12 voucher for each session attended (this was in keeping with the 'Service User consultation fee' offered by the local NHS Trust at the time) In addition to experiencing distressing AVHs, all seven participants were male, aged 27 – 65 (mean age of 42) and were detained or subject to provisions under the UK Mental Health Act (UK Department of Health, 1983). Co-researchers had been involved with mental health service for between four and 29 years (mean 13.57), having spent an average of 5.42 years in hospital (range 3-10 years).

Two of the seven co-researchers (P4 & P5) lived in the community, whilst the other five (P1, P2, P3, P6 & P7) resided within the low-secure hospital where the intervention took place. Of the five hospital based participants, two 'dropped out' (P6 & P7), when they were progressed to community accommodation during the intervention period (attendance rates of 36% and 42%). These two individuals, along with one person (P5) - who initially consented to participate in the intervention but did not attend any sessions, all participated in the post-intervention qualitative interviews. The four individuals who participated in the full seven-month group intervention (P1, P2, P3 & P4) attended most weekly groups over the seven-month timeframe (average attendance was 89%, range between 80-100%).

Measures

The primary assessment of outcome involved the use of qualitative interviews using an interview schedule developed by the co-researchers during the intervention period. This schedule was informed by discussions that took place during the course of the intervention. In addition to exploring the interventions utility, this interview schedule also contained questions co-researchers included to generate information about enhancing the uptake and positive impact of therapeutic interventions within this field of research and service provision. Several quantitative measures were originally identified with the intention of using these at the first and last group session to assess the project's efficacy as a potential intervention. The challenges participants experienced whilst completing these

measures within the group setting (e.g. missing or misinterpreting items, discussing items and influencing each other’s scoring) resulted in the abandoning of efforts to gather valid quantitative data.

M-PART

The Mersey Participatory Action Research Team measure (M-PART) is a 20 item questionnaire developed by co-researchers within the current study (see procedure and results sections for further details).

Design

A qualitative design using a PAR methodology was used in this study. Service user/survivor consultation was provided at each stage of the research from the project's inception (e.g. author JM visited local Hearing Voices Network and Bipolar UK meetings before the development of a research idea) through to the point of data analysis and publication.

In addition to their role as ‘expert by experience’, co-researchers developed a new measure of their own design and a qualitative interview schedule alongside participating in their own qualitative interviews. The transcribed qualitative interviews with co-researchers (including the co-researcher who ‘dropped out’ early and the individual who who consented to participate but did not engage. as the group wanted their perspectives included) were analysed at the conclusion of the intervention period.

Ethical Approval

The process of gaining ethical approval was not straightforward. Permission was being sought to support a group of participants to have flexibility to identify and research as yet unspecified topics that were of the group’s own choosing. A detailed discussion with the Ethics panel about PAR and the importance of the group controlling their own research, contributed towards their decision to provide formal ethical approval through the UK NHS-IRAS ethics process.

Procedure

Intervention

Therapeutic Research Group intervention

Co-researchers attended weekly one-hour groups over a seven-month period (22 sessions, with a break at the midpoint and in the last month of the intervention). At the outset of this group, participants were supported to develop their understanding of research (e.g. discussions about evidence based practice, how research and service user/survivor involvement can improve services, critical thinking skills, qualitative and quantitative research etc.). They were also introduced to PAR.

During group sessions, co-researchers were supported by a staff member (assistant psychologists LM and G F-S or psychologist JM) to conduct research (e.g. discuss research papers and findings, review or complete measures, develop items for a new measure, discuss/record topics or questions for future discussion, or for addition to the qualitative interview schedule to be used at the intervention's conclusion). Consistent with the PAR methodology, the aim was to facilitate the development of a supportive and democratic environment within which co-researchers explored and conducted research based on the agreed priorities or preferences of the group. Although staff contributed more actively in the earlier sessions (e.g. providing a selection of relevant measures and research papers for review, supporting group members to engage etc.), co-researchers themselves decided to develop a new measure and were supported to take increasing responsibility for the content and focus of sessions as the weeks progressed.

Co-researchers were aware of the two aims of the group from the outset (i.e. to engage in research and to assess the utility of such a Therapeutic Research Group as an intervention). In the first two group sessions co-researchers examined, discussed and partially completed a collection of quantitative measures commonly used in AVH related research. With emphasis placed on focusing on agreed tasks and producing research related 'output', co-researchers initially discussed developing 'information leaflets' or self-help material. Subsequent to completing the quantitative questionnaires (with two co-researchers in particular struggling to complete any measures), the group decided to focus on developing a new measure of their own. The group agreed that this measure would contain no more than 20

Therapeutic Research Group intervention

'easy to complete' questions, aimed at supporting people who struggle to complete questionnaires, and focusing on areas that group members felt were most relevant to a person's quality of life or resilience.

During the following months, co-researchers discussed and made notes on a variety of topics that were agreed as worthy of consideration by the group. The group progressed from more general conversations to formulating questions for consideration, refinement and eventual inclusion in the final measure. The group developed four examples or scenarios for each question. This was done so that people who normally struggle to complete measures or provide accurate estimate scores might have a 'frame of reference' or 'scaffolding' to aid them in their completion of the M-PART.

Co-researchers also developed a schedule of questions for the post-intervention qualitative interviews, which were completed in the month subsequent to the intervention's conclusion. The group reconvened at one-month post intervention for a focus group, debrief and celebration. The focus group discussion involved co-researchers reaffirming statements made during individual qualitative interviews. The group also reviewed data, helped to identify and label themes. In this latter session, co-researchers also made decisions about the content of the final research paper (e.g. involvement in authorship, example quotations to include, statements about the need to emphasise the groups eagerness for other researchers to use and refine the M-PART so it can be used more regularly in research or services etc.).

Qualitative interviews were analysed using thematic analysis (Braun and Clarke, 2006). This analysis involved co-authors (i.e. JM and PJ) initially independently identifying themes and subthemes with relevant examples. A collection of identified themes and preferred example quotations was discussed and agreed with Therapeutic Research Group members at the final 'focus group session'. During this session and subsequent discussions amongst authors, themes, categories and relevant example quotations were then examined and agreed for inclusion in the final publication.

Chronological summary

The corresponding author visited local self-help groups to develop initial research idea (month one). Ethical approval gained (month eight). Consent process completed with participants (month 10-12). Funding received to offer participants payment as per Health Trust consultation police (month 13) Commencement of the group (month 14). Group identified research objectives and in 7-month period developed M-PART and qualitative interview schedule (month 14-21). At the conclusion of the group, participants engaged in data analysis and preparation of results section of the research paper (month 21). Paper prepared and submitted for publication (21-36).

RESULTS

Qualitative Analysis and Results.

The themes and sub-themes, with example quotations identified from the seven qualitative interviews, are presented in the table below.

Table 1. The themes, sub-themes and example quotations identified in relation to the seven qualitative interviews that were conducted.
(Insert table 1 here)

Qualitative interviews – Summary

All co-researchers who participated in the qualitative interviews made positive comments about the personal benefits that conducting research within the group had on their own wellbeing. Co-researchers enjoyed and felt valued during the process. There was consensus that focusing on research tasks that had the potential to benefit others, with the option but not an emphasis on personal disclosure, gave people a sense of purpose and focus, which made the group a more comfortable experience. Aware of the importance of objectivity, co-researchers also provided constructive criticism of the group and using research as an intervention. It was suggested that participation was occasionally boring, and hosting the group within a hospital setting was challenging. One co-researcher suggested that the primary focus on research during group sessions could, on occasion, impede or limit people's ability to talk about their own experiences in

more detail. Alongside detailing positives and challenges, all co-researchers confirmed that the research group was beneficial and that such an intervention opportunities should be made available to people in future.

Co-researchers also discussed barriers and facilitators to engaging in group interventions for people who experience mental health difficulties. In addition to discussing why people struggle to engage, co-researchers offered suggestions on how to increase the popularity of and support retention of participants in such therapeutic interventions. Co-researchers concluded their participation in qualitative interviews with advice to mental health service users and staff about the importance of active engagement, tolerance and compassion.

The M-PART measure

Co-researchers developed a 20-item questionnaire that examines individual's level of distress or functioning in a variety of areas such as relationships, positivity, coping, use of humour, understanding, goal achievement, impact of negative events, safety etc. (copy available in appendix or from corresponding author). Each questionnaire item contains four statements to act as 'scaffolding' or 'reference points' aimed at supporting individuals to make estimates more comfortably. Each of the 20 items score between one and four, with total scores ranging between 20 and 80. Lower scores are anticipated to correlate with increased resilience/improved recovery. The measure's face validity appears positive. In addition, preliminary investigation of test/re-test reliability carried out by four co-researchers who completed the new measure on two occasions within a two week period also appeared promising, although further testing of validity and reliability is necessary.

Reflectivity

While every effort was made to limit the influence and involvement of staff members each week, some structure and guidance was provided by facilitators during the course of the intervention. Supporting staff (JM, LM & G F-S) each have a strong interest in

promoting service user/survivor involvement and employment in research and clinical practice. Acknowledging that staff perspectives and experience can impact on the research process (e.g. Bury, Raval & Lyon, 2007), staff debriefs and supervision were utilised to ensure that the facilitator 'footprint' was minimised and a democratic co-researcher led approach was supported throughout.

DISCUSSION

This research explored the feasibility of supporting people who experience mental health difficulties and AVHs to benefit themselves and others by conducting research within a therapeutic group environment.

Aim 1 - To support 'experts by experience' to conduct research and produce output in relation to an aspect of hearing voices or mental health of their choosing.

Although the individuals involved had complex difficulties and lived in a challenging environment, co-researchers were able to conduct research collaboratively with limited involvement from staff. The group identified that completing questionnaires and accurately estimating appropriate scores can be difficult for people with more complex difficulties. Attempting to address this challenge, the group developed the M-PART. This new measure explores the aspects of recovery, resilience or quality of life that co-researchers believed were most important (e.g. relationships, positivity, humour, safety, happiness, coping etc.). The measures face validity appears positive and the measure is now available within the appendix or from the corresponding author for use and further testing.

Through developing the qualitative interview schedule and participation in subsequent interviews, co-researchers also offered valuable advice from the perspective of individuals who in the past have frequently avoided engaging in interventions. This feedback included practical tips about selection, preparation for, the conducting of and retention of participants within therapeutic interventions.

When discussing overcoming challenges related to interventions with people who experience voices, co-researchers identified several reasons why people might drop out or struggle to engage (e.g. insufficient preparation prior to first session, stigma, uncertainty about what is on offer, concentration challenges or disinterest, concerns about the intervention aims/relevance/utility etc.). Participants offered a number of suggestions in relation to improving uptake and reducing intervention drop-out rates. These included investing more effort in support of potential participants before interventions begin, providing refreshments or incentives to participate (e.g. tea & biscuits, reimbursement of travel costs, emphasising personally meaningful goals etc.), involving people with personal experience of voices as facilitators, supporting the potential participant to feel positive, valued and as though they are helping others and/or able to receive help for themselves etc. This information and the newly developed measure have been produced by individuals who might normally be counted amongst the many who avoid, struggle to engage with or dropout of therapeutic interventions. If service users coping with long-term difficulties and multiple stressful life events can, with limited staff involvement, produce results such as these, it is likely that many more groups could be similarly supported to focus on and benefit other important areas of research in future.

Aim 2 - Assessing whether the conducting of research within a ‘Therapeutic Research Group’ environment could form the basis of a therapeutic intervention for people experiencing distressing voices.

Although caution is warranted, preliminary evidence appears supportive of the acceptability and beneficial effects of utilising therapeutic research groups as an intervention for people with mental health difficulties. Qualitative feedback was positive in relation to each individual’s overall experience of taking part in the TRG. Participants appeared to value the altruistic component of the intervention in terms of the development of a new measure for the benefit of others. They also valued meeting and learning alongside others who had similar experiences within an environment where

self-disclosure and utilising personal experience was valued but not emphasised or a prerequisite of participation. Individuals identified that participation contributed towards improved coping and confidence as well as enhanced social skills and increased self-esteem.

Whilst the comments made by those who participated were predominantly very positive, participants also made comments about aspects of the intervention that they disliked or found challenging (e.g. finding group sessions boring on occasion or experiencing the focus on research related tasks as an occasional limitation for someone who wanted to focus on discussing his own personal experiences more frequently). Detailed analysis of the particulars of what worked for whom is not easy to understand from the research that took place, and hence future research to examine potential 'active ingredients' is necessary.

Methodological challenges

In addition to low participant numbers, the intervention was located within a secure hospital setting and involved a convenience sample of participants who were all coping with complex longer-term difficulties. Although this is a weakness in terms of generalisability of findings, it is also a strength as the insights provided by such 'under-researched' individuals is essential in supporting efforts to improve the quality of available interventions in mental health.

Consistent with the PAR approach, decisions and research activities were democratically decided by co-researchers. This posed a challenge in terms of accurately assessing the intervention's utility. Co-researchers designed the post-intervention interview schedule based on topics and priorities that emerged during the course of the intervention. This contributed towards valuable discussions about a variety of important topics, but possibly at the expense of more robustly exploring the interventions utility. Detailed information about possible 'mechanisms of change', impact on AVHs and other aspects of life and recovery (including delusions, critical thinking skills, etc.) were insufficiently explored. Also, the flexible nature of this PAR approach, which has resulted in interesting but limited data

and the development of a new recovery measure, has made the writing up of results into a coherent research paper challenging.

Administering quantitative measures within the TRG environment was reported by co-researchers as helpful in terms of support in completion and getting the idea to develop the M-PART. Despite this however, the associated challenges of completing these measures (e.g. group members discussing items during completion, concentration and estimation challenges, large quantities of missing data etc.), resulted in the authors abandoning attempts to accurately assess the intervention’s efficacy through these quantitative measures. Co-researchers received a ‘consultation payment’ for each hour of their involvement, in keeping with the local NHS trust policy. With feedback from co-researchers indicating that the payment contributed towards them feeling appreciated and valued, it is possible that such a payment positively influenced the high levels of engagement and retention as well as the reported positive impact that participation had on group members. Although this is a possibility, each of the participants consented to participate prior to the funding to provide vouchers was secured, and each said that they would have happily contributed regardless of whether the contribution was made or not.

Future research more effectively exploring the challenges, limitations and biases associated with participants with more complex difficulties engaging in research and completing measures would be welcomed. Similarly, further testing of therapeutic research group interventions and separately, the M-PART measure, with a larger sample and using more methodologically robust research methods is necessary. In addition, efforts to support service user/survivor involvement from the earliest stages of research, delaying the development and operationalisation of research ideas until participant recruitment is completed or having a degree of flexibility within projects to support creativity, raise both challenges as well as opportunities. Further consideration of such challenges and how ethical approval is granted to PAR projects such as this would be welcome.

Conclusion

The idea of using research as the basis of an intervention will likely make sense to many who have personal experience of the rewards and challenges associated with conducting research. It is clear that further research is required to investigate the utility of using Therapeutic Research Groups as the basis of an intervention for people experiencing distressing voices.

With the dual purpose of being both an intervention and a way of eliciting 'expert by experience' led knowledge, it is possible that any such further investigation of Therapeutic Research Groups will facilitate increased understanding that will positively impact on clinical research and practice in future.

REFERENCES:

- Argyris, C., & Schön, D. (1984). Theories of action, double loop learning and organizational learning. *Infed* [http://www. infed. org/thinkers/argyris.htm](http://www.infed.org/thinkers/argyris.htm) (Accessed Sep 23, 2015).
- Bados, A., Balaguer, G., & Saldaña, C. (2007). The efficacy of cognitive-behavioural therapy and the problem of drop-out. *Journal of clinical psychology*, 63(6), 585-592.
- Berry, K., & Haddock, G. (2008). The implementation of the NICE guidelines for schizophrenia: Barriers to the implementation of psychological interventions and recommendations for the future. *Psychology and Psychotherapy: Theory, Research and Practice*, 81(4), 419-436.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.
- Byrne, R. & Morrison, A.P. (2010). Young people at risk of psychosis: A user-led exploration of interpersonal relationships and communication of psychological difficulties. *Early intervention in psychiatry*, 4, 162-168. eScholarID: 114215

Therapeutic Research Group intervention

Carter, D. M., Mackinnon, A., & Copolov, D. L. (1996). Patients' strategies for coping with auditory hallucinations. *The Journal of nervous and mental disease*, 184(3), 159-164.

Copolov, D. L., Mackinnon, A. & Trauer, T. (2004). Correlates of the affective impact of auditory hallucinations in psychotic disorders. *Schizophr Bull* . 30: 163–171.

Corstens, D., Longden, E., & May, R. (2012). Talking with voices: exploring what is expressed by the voices people hear. *Psychosis*, 4(2), 95-104.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the Hearing Voices Movement: implications for research and practice. *Schizophrenia bulletin*, 40(Suppl_4), S285-S294.

Dillon, J., & Hornstein, G. A. (2013). Hearing voices peer support groups: a powerful alternative for people in distress. *Psychosis*, 5(3), 286-295.

Dillon, J., & Longden, E. (2011). Hearing voices groups: Creating safe spaces to share taboo experiences. *Psychosis as a Personal Crisis: An Experience Based Approach*. London, UK: Routledge, 129-139.

Evans, J., Rose, D., Flach, C., Csipke, E., Glossop, H., Mccrone, P., ... & Wykes, T. (2012). VOICE: developing a new measure of service users' perceptions of inpatient care, using a participatory methodology. *Journal of Mental Health*, 21(1), 57-71.

Faulkner, A., & Layzell, S. (2000). *Strategies for living: A report of user-led research into people's strategies for living with mental distress*. London, UK: Mental Health Foundation.

Freire, P. (1970). Cultural action for freedom (pp. 476-521). Harvard educational review.

Freire, P. (1982). Creating alternative research methods: Learning to do it by doing it. *Creating knowledge: A monopoly*, 29-37.

Therapeutic Research Group intervention

- Garety, P. A., Freeman, D., Jolley, S., Dunn, G., Bebbington, P. E., Fowler, D. G., Kuipers, E. & Dudley, R. (2005). Reasoning, emotions, and delusional conviction in psychosis. *Journal of abnormal psychology*, 114(3), 373.
- Haddock, G., Eisner, E., Boone, C., Davies, G., Coogan, C., & Barrowclough, C. (2014). An investigation of the implementation of NICE-recommended CBT interventions for people with schizophrenia. *Journal of Mental Health*, 23(4), 162–165.
- Harkavy-Friedman, J. M., Kimhy, D., Nelson, E. A., Venarde, D. F., Malaspina, D., & Mann, J. J. (2003). Suicide attempts in schizophrenia: the role of command auditory hallucinations for suicide. *J Clin Psychiatry*, 64(8), 871-874.
- Hernandez, B., Balcazar, F., Keys, C., Hidalgo, M. A., & Rosen, J. (2006). Taking it to the streets: Ethnic minorities with disabilities seek community inclusion. *Community Development*, 37(3), 13-25.
- Hutchinson A, Lovell A. Participatory action research: moving beyond the mental health 'service user' identity. *J Psychiatr Ment Health Nurs*. 2013;20:641–9.
- Jenner, J. A., Rutten, S., Beuckens, J., Boonstra, N., & Sytema, S. (2008). Positive and useful auditory vocal hallucinations: prevalence, characteristics, attributions, and implications for treatment. *Acta Psychiatrica Scandinavica*, 118(3), 238-245.
- Kamali, M., Kelly, B. D., Clarke, M., Browne, S., Gervin, M., Kinsella, A., A. Lane, C. Larkin, & O'Callaghan, E. (2006). A prospective evaluation of adherence to medication in first episode schizophrenia. *European Psychiatry*, 21(1), 29-33.
- Koch, T., & Kralik, D. (2009). Participatory action research in health care. John Wiley & Sons.
- Koroloff, N. M., Osher, T., Jivanjee, P. R., Pullmann, M., Sofich, K., & Guthrie, L. (2010). Under new management: Research collaboration with family members and youth. In K. E. Hoagwood, P. S. Jensen, M. McKay, & S. Olin (Eds.), *Children's mental health*

Therapeutic Research Group intervention

research: The power of partnerships. Oxford: Oxford University Press.

Lewin, K. (1946). Action research and minority problems. *Journal of social issues*, 2(4), 34-46.

Michalak, E. E., Jones, S., Lobban, F., Algorta, G. P., Barnes, S. J., Berk, L., ... & Milev, R. (2016). Harnessing the potential of community-based participatory research approaches in bipolar disorder. *International journal of bipolar disorders*, 4(1), 4.

Morrison, A. P. (2001). The interpretation of intrusions in psychosis: an integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy*, 29(03), 257-276.

Munten, G., Van Den Bogaard, J., Cox, K., Garretsen, H., & Bongers, I. (2010). Implementation of evidence-based practice in nursing using action research: a review. *Worldviews on Evidence-Based Nursing*, 7(3), 135-157.

National Institute for Health and Care Excellence. Psychosis and Schizophrenia in adults. (2014). The NICE guideline on treatment and management. CG178. London: National Institute for Health and Care Excellence.

Nelson, G., Ochocka, J., Griffin, K., & Lord, J. (1998). "Nothing About Me, Without Me": Participatory Action Research with Self-Help/Mutual Aid Organizations for Psychiatric Consumer/Survivors. *American journal of community psychology*, 26(6), 881-912.

Newton, E., Larkin, M., Melhuish, R., & Wykes, T. (2007). More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations. *Psychology and Psychotherapy: Theory, Research and Practice*, 80(1), 127-149.

Pilling, S., Bebbington, P., Kuipers, E., Garety, P., Geddes, J., Orbach, G. and Morgan, C. (2002) 'Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive

Therapeutic Research Group intervention

behaviour therapy', *Psychological Medicine*, 32(5), pp. 763–782.
doi: 10.1017/S0033291702005895.

Pitt, L., Kilbride, M., Welford, M., Nothard, S. & Morrison, A.P. (2009). Impact of a diagnosis of psychosis: user-led qualitative study. *Psychiatric Bulletin*, 33, 419-423.

Rogers, E., Chamberlin, J., & Ellison, M. (1999). A Consumer-constructed Scale to Measure Empowerment Among Users of Mental Health Services. *Year Book of Psychiatry and Applied Mental Health*, 1999 (5), 192-193.

Rogers, E. S., Chamberlin, J., & Ellison, M. L. (1997). Measure Empowerment Among Users of Mental Health Services. *Psychiatric services*, 48(8).

Rector, N. A., & Beck, A. T. (2012). Cognitive Behavioral Therapy for Schizophrenia: An Empirical Review Neil A. Rector, PhD and Aaron T. Beck, MD (2001). Reprinted from the *J Nerv Ment Dis* 189: 278–287. *The Journal of nervous and mental disease*, 200(10), 832-839.

Rose, D., Sweeney, A., Morven, L., Clement, S., Jones, I., Burns, T. & Wykes, T. (2009). Developing a user-generated measure of continuity of care. *Acta Psychiatrica Scandinavica*, 119, 320–324.
Ruddle A, Mason O, Wykes T. (2011). A review of hearing voices groups: Evidence and mechanisms of change. *Clinical Psychology Review*; 31(5), 757-766.

Rose, D., Wykes, T. I. L., Farrier, D., Doran, A. M., Sporle, T. I. M., & Bogner, D. (2008). What do clients think of cognitive remediation therapy?: a consumer-led investigation of satisfaction and side effects. *American Journal of Psychiatric Rehabilitation*, 11(2), 181-204.

Schneider, 2012 Participatory action research, mental health service user research, and the hearing (our) voices projects. *International Journal of Qualitative Methods*, 11(2), 152-165.

Therapeutic Research Group intervention

Simpson, E. L., & House, A. O. (2002). Involving users in the delivery and evaluation of mental health services: systematic review. *Bmj*, 325(7375), 1265.

Smith, B., Fowler, D. G., Freeman, D., Bebbington, P., Bashforth, H., Garety, P., Dunn, G. & Kuipers, E. (2006). Emotion and psychosis: links between depression, self-esteem, negative schematic beliefs and delusions and hallucinations. *Schizophrenia research*, 86(1), 181-188.

Stringer, E. T. (2004). *Action research in education*. Upper Saddle River, NJ: Pearson/Merrill/Prentice Hall.

Stringer, E. T. (1999). *Action research second edition*.

Simpson, E. L., & House, A. O. (2002). Involving users in the delivery and evaluation of mental health services: systematic review. *Bmj*, 325(7375), 1265.

Thomas, N., Hayward, M., Peters, E., van der Gaag, M., Bentall, R.P., Jenner, J. & García-Montes, J. M. (2014). Psychological therapies for auditory hallucinations (voices): current status and key directions for future research. *Schizophrenia bulletin*, 40(Suppl_4), S202-S212.

Villeneuve, K., Potvin, S., Lesage, A., & Nicole, L. (2010). Meta-analysis of rates of drop-out from psychosocial treatment among persons with schizophrenia spectrum disorder. *Schizophrenia research*, 121 (1), 266-270.

Wallerstein, N. (1999). Power between evaluator and community: research relationships within New Mexico's healthier communities. *Social Science & Medicine*, 49 (1), 39-53.

Whitaker, R. (2016). The case against psychiatric drugs. *Cadernos Brasileiros de Saúde Mental/Brazilian Journal of Mental Health*, 8(17), 1-16.

Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive behavior therapy for schizophrenia: effect sizes, clinical models, and methodological rigor. *Schizophrenia bulletin*, 34(3), 523-537.

Therapeutic Research Group intervention

For Peer Review Only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Appendix 1: The M-PART questionnaire.
M-PART (named after the Mersey Care Participatory Action Research Team) is a group of people with personal experience of hearing voices who developed this measure.

Thank you for taking the time to complete this form.

Please circle either 1, 2, 3 or 4 for each of the 20 areas below depending on how you believe you are doing in each area.

A score of 1 signifies that someone is doing really well through to 4 which indicates that someone is experiencing significant difficulties in this area.

We have included statements to try and help you to decide which score (1, 2, 3 or 4) you pick in each area. We do not expect the statements used here to match exactly with you....Please select the number/statement in each section that comes closest to representing 'where you are at' today.

Motivation

- 1 I get fully involved and I'm motivated to keep going**
- 2 I am starting to do things but it's challenging**
- 3 I think about or would like to do things but it's a struggle**
- 4 I am not in a place where I feel I can do things at the moment**

Quality of life

- 1 I enjoy what I am doing most of the time**
- 2 I do things and get some enjoyment sometimes**
- 3 I do things but they don't make me feel happy usually**
- 4 I rarely do things and even when I do they don't make me feel very happy**

Actively trying to be happy

- 1 I often do things or keep up a routine that makes me feel happy**
- 2 I sometimes do things that make me feel happy**
- 3 Only on rare occasions do I do things that make me feel happy**
- 4 I almost never do things that make me feel happy**

Supportive Relationships

- 1 I have people who I am close to who support me or accept me**
- 2 I have people who I can turn to if I need support**
- 3 It feels like my options are limited when I need the support of others**
- 4 When I am unwell, I am alone**

Positivity

- 1 I try to think positive and do positive things often in order to help myself
- 2 I try to think positive and do positive things but struggle from time to time
- 3 I can't 'think positive' nearly as often as I would like
- 4 'Thinking positive' is very rare for me

Coping Strategies

- 1 I can use positive coping strategies with what life throws at me
- 2 I have some positive coping strategies that help
- 3 I do not have many positive coping strategies that help
- 4 I don't have positive coping strategies or rely more on less positive strategies to cope

Understanding

- 1 I have a good understanding of my mental health
- 2 I have some understanding of my mental health
- 3 I struggle to understand what's happening with me much of the time
- 4 I often do not understand anything about mental health or what's happening to me

Connection and Relationships

- 1 I have people I am close to and people I can turn to if I need them
- 2 I feel like when I am well I have people around me, when I am unwell I am alone
- 3 I don't have any close relationships
- 4 I don't have any close relationships and feel like no one can be bothered

Laughter/use of humour

- 1 I often find things funny and humour helps me a lot
- 2 I do try to have a laugh and regularly find things funny
- 3 Sometimes I find things funny, often I don't
- 4 I don't laugh often and things I used to find funny don't make me laugh anymore

Loneliness

- 1 I never really feel alone
- 2 I rarely feel alone but I am spending less time with people I would normally spend time with
- 3 I occasionally feel alone and feel there are not many people I can connect with
- 4 I feel completely alone

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Happiness

- 1 I feel happy most of the time**
- 2 I feel happy sometimes**
- 3 Recently I do not experience much happiness**
- 4 I am not happy at all these days**

Active/Passive participant

- 1 I am actively involved in creating the future I am hoping for**
- 2 I am involved in choices about my future with support from other people.**
- 3 Sometimes I feel I have a future but other people make the decisions for me**
- 4 I feel my future is mostly in the hands of other people.**

Enjoyment

- 1 I enjoy life most of the time**
- 2 I regularly enjoy life**
- 3 I struggle to get enjoyment from the things I do sometimes**
- 4 I get little or no enjoyment from the things I do**

Self opinion

- 1 I feel good about myself most of the time**
- 2 I can feel good about myself from time to time**
- 3 I struggle to feel good about myself from time to time**
- 4 I rarely or never feel good about myself**

Goal achievement

- 1 I feel strong and confident in relation to achieving my goals**
- 2 I sometimes feel strong and confident about my goals**
- 3 I do not tend to feel very strong or confident about achieving my goals**
- 4 I do not have the strength or confidence to achieve my goals**

Impact of negative events

- 1 When something negative happens, I often do a good job 'dealing with it' and move on**
- 2 When something negative happens, I sometimes do a good job 'dealing with it' and moving on**
- 3 When something negative happens, it can affect me for a while**
- 4 When something negative happens, it can have a big impact on me for some time**

Others as Trustworthy

- 1 I almost always experience people as trustworthy and helpful**
- 2 Other people are often trustworthy and helpful**
- 3 I can struggle to trust or find other people helpful**
- 4 I tend to not trust other people or find them helpful**

Distressing thoughts or voices

- 1 When I experience distressing thoughts or voices, they are challenges that I can support myself to get through comfortably**
- 2 When I experience distressing thoughts or voices, I find them challenging and have to work hard to become more comfortable**
- 3 When I experience distressing thoughts or voices, I struggle to get past them**
- 4 When I experience distressing thoughts or voices, they often feel like too big a challenge to overcome.**

Safety

- 1 I feel safe all of the time**
- 2 I feel safe most of the time**
- 3 I struggle to feel safe from time to time**
- 4 I do not feel safe very often**

Hope

- 1 I am very optimistic and hopeful about my future**
- 2 I am sometimes optimistic and hopeful about my future**
- 3 I spend time wondering if things will ever get better**
- 4 I am rarely or never optimistic or hopeful about my future**

Thank you for taking the time to complete this questionnaire. By completing this, your efforts will support people to learn more about mental health. We hope that you can take some pride in the fact that your effort today will help others to learn and likely help to improve lives and services for people experiencing distress.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46

Table 1. The themes, sub-themes and example quotations identified in relation to the seven qualitative interviews.

Theme:	
1. The benefits and challenge of the current intervention	
Sub-themes:	<i>We started off as a research group to produce a measure and say how we cope. The groups said and produced a lot of good stuff. We never came to talk about ourselves but it just evolved and the good thing was that we all learned from each other, everyone contributed. All of a sudden everyone opened up and gave tips and hints of ways to deal with voices.(P4)</i>
A. The benefits of participation	<i>Coming made me happier, took weight off my shoulders and gave me relief. I started to feel more aware and good about myself. Taking part was good for morale. Great talking to like-minded people struggling with the same stuff. Other people don't understand, they think you are gone in the head and tell you your opinion instead of asking.(P1)</i>

B. The value of incentives and overcoming disincentives.	<i>Getting paid was a good gesture, showed our time was valued, though I would have been there without the voucher and the vouchers were only offered after we agreed to take part. I didn't stick around for the vouchers; I came for the group.(P7)</i>
C. The utility of having an altruistic task to focus on.	<i>I preferred focusing on the topics that we focused on and not me. It all came together and I did focus on me at points but having the topics to focus on made it all come together. (P7)</i> <i>Sometimes you're saying things that are very personal, maybe in this groups you stopped saying what was on your mind .(P4)</i>
D. The challenges of participation in the current intervention.	<i>It's just stress, listening to a load of bullshit. It can be tough sitting for so long, listening and answering hard questions. It was no fun at times, just boring. Though I got something out of it.(P2)</i>
E. Facilitating the intervention within a hospital setting:	<i>Me taking part in the group was helpful, it got me more leave from the unit. It was good because it helped me to start doing as many things as possible, attending the group and things like that has helped me get closer to discharge.(P2)</i>

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46

Theme:

**2. Barriers and overcoming barriers to
involvement in therapeutic
interventions**

Sub-themes:	<i>Reason so many drop out or avoid groups at the start is because coming to the group makes them think more</i>
A. Barriers to engaging or maintaining involvement in interventions more generally.	<i>and make the voices worse. Coming to a group will mean acknowledging the reality, either knowing that the voices are not really there or the reality of the voices being real. (pause) People maybe can't be arsed. Maybe they don't want to be helped or think you can't help. Maybe they like hearing voices and don't want to be cured, and don't understand what the cure on offer is.(P1)</i>
B. Overcoming these barriers.	<i>Before starting a group it would be good to have a meeting, maybe even bring everyone interesting in joining the group all in with no obligation to start. This would give them insight into the group. There the tutor could explain that they hear voices too if they have which would help. Offer tea coffee and biscuits and maybe offer some support with transport, even if it's paying the bus fare.(P5)</i>

You should spend more time and effort on encouraging people to come to the groups. Offer people an incentive to come. If not vouchers, then at least a cup of tea or coffee and a chocolate digestive biscuit.(P6)

Seeing people suffering in groups could be hard so it's important to get the right mix, including some people doing a bit better. If people are new to things like this, then it's a whole new ball game. Meeting up with people beforehand will help, giving them a taste of the ball game beforehand.(P7)

Tell and remind people of how important their contribution is. Tell them the positives and the good things. Knowing other people suffering is half the problem, but knowing others are not suffering is the solution.(P4)

Theme:

3. Message to Service Users and staff

Sub-themes:

A. Service Users/Survivors

You're not alone, there are lots of people out there with the same problem. Come to the group and share a little bit, as little as you like. Sharing might make your problems go away. People would like to listen to your story. Putting it in words will help.(P2)

Keep going MAD as in 'Make A Difference'.....Keep going to groups, stick it out. Have a meeting with yourself every day, talk about your symptoms out loud. Talking about things out loud can help to change the meaning.(P4)

Come to groups, they are friendly, educational and it does help. The more you put in, the more you get out. Explain to people that you are not alone, come to the group and talk to other people. Share coping strategies that help with the voices. Find out the voices are not real or not as powerful as you think.(P5)

B. Message to staff.

Staff, you need a lot of patience and compassion. Some people find groups easy going and some find it the opposite so consider both when running groups. When staff are laid back and show they care then this is important, and doesn't cost anything.(P5)