Examine the effectiveness of a transdiagnostic short-term
Cognitive Behaviour Therapy group for secondary school age children
referred to Child and Adolescent Mental Health Services (CAMHS)

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Thesis submitted to the University of Limerick in fulfilment of the requirements for
the Doctoral Programme in Clinical Psychology (Ph.D.)
DECLARATION
I declare that this thesis is entirely my own work, other than the counsel of my supervisors, is an accurate reflection of work, and has not been submitted as part of another degree at the University of Limerick or any other academic institution

_________________________  August 2019
Kathleen Sexton  Date
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Firstly, I would like to humbly thank Dr. Rob Kidney, who initially employed me as an assistant psychologist and from there my career in the field of clinical psychology has progressed. Without his contribution in writing the original group intervention and trusting me to adapt content as required this project would not have been possible.

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ABSTRACT

Primary aim of research: The study aims to evaluate the effectiveness of implementing a brief Transdiagnostic Cognitive Behaviour Therapy Group intervention for young people experiencing common mental health conditions. The “Mind and Mood Group” seeks to empower young people to manage and understand their symptoms and to make changes with positive effects. It is a six-session, skills-based group, which models a stepped care approach based on the Improving Access to Psychological Therapies (IAPT) initiative devised in the United Kingdom. The Health Service Executive (HSE) has demonstrated a commitment to developing services for young people, following A Vision for Change (2006). It is hoped that by modelling a stepped care, evidence-based approach, services will be better equipped to meet the demands of this growing population.

Method: The study used a deployment focused, multi-site mixed-method approach to incorporate a pre- and post-intervention repeated measures experimental design. Seven intervention groups across individual Child and Adolescent Mental Health Services (CAMHS) were involved in the study. Data was collected from participants who gave signed informed consent to take part in the study and completed the programme, N=40.

Results: The findings were analysed for statistical significance and clinically meaningful analysis such as crossing clinical thresholds and reliable change. Participants’ experience of the intervention was elicited to provide richer in-depth data as a means to determine whether the intervention is meaningful and valuable to this population.

Discussion: This study provided a deployment focused approach to introduce an innovative transdiagnostic group intervention to adolescents to assist services meet the growing demands for this population. It succeeded in addressing the current gaps in the transdiagnostic group literature for adolescents. The findings of this study are therefore discussed with reference to relevant literature, and the implications for clinical practice, policy, and education. Finally, the limitations and strengths of the study are discussed with recommendations for future research.
# DECLARATION

# ACKNOWLEDGEMENTS

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# Glossary of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BA</td>
<td>Behavioural Activation</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
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<tr>
<td>CR</td>
<td>Cognitive Restructuring</td>
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<tr>
<td>CORC</td>
<td>Child Outcomes Research Consortium</td>
</tr>
<tr>
<td>CYP IAPT</td>
<td>Child and Young Persons Improving Access to Psychological Therapies</td>
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<tr>
<td>DBT</td>
<td>Dialectical Behaviour</td>
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<tr>
<td>ET</td>
<td>Exposure Therapy</td>
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<tr>
<td>HSE</td>
<td>Health Service Executive</td>
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<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<tr>
<td>LICBT</td>
<td>Low Intensity Cognitive Behaviour Therapy</td>
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<tr>
<td>M</td>
<td>Mean</td>
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<tr>
<td>NATS</td>
<td>Negative Automatic Thoughts</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<tr>
<td>PS</td>
<td>Problem Solving</td>
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<tr>
<td>ROI</td>
<td>Republic of Ireland</td>
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<tr>
<td>RCADS</td>
<td>Revised Child Anxiety and Depression Scale</td>
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<tr>
<td>RCT</td>
<td>Randomised Control Trial</td>
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<tr>
<td>ROMS</td>
<td>Routine Outcome Measures</td>
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<tr>
<td>SD</td>
<td>Standard Deviation</td>
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<tr>
<td>tCBT</td>
<td>Transdiagnostic Cognitive Behaviour Therapy</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UP</td>
<td>Unified Protocol</td>
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<td>UP-A</td>
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CHAPTER 1: INTRODUCTION

1.1 Importance of the Present Study
In April 2017, RTÉ, the Irish state television service, aired “The Big Picture: Young and Troubled”. Presented by RTÉ broadcast journalist, Della Kilroy, this documentary investigated the reality of Irish youth’s ongoing struggle with mental health difficulties. Most heartbreakingly, the programme related the story of an 11-year-old girl who had taken her own life in 2016. The girl’s parents described how on seeking help from professional services their General Practitioner (GP) had made an urgent referral to their local Child and Adolescent Mental Health Service (CAMHS) which underscored the young girl’s suicidal ideation and active self-harm. In spite of the urgency of her case, she was placed on a waiting list and offered an appointment one month after the original referral date. Tragically, this was too late. In short, she had been failed by the CAMHS system with devastating consequences.

The demands on services which are understaffed and under-resourced are increasing. Meantime, the reality of families and young people in crisis, who seek support from professional services and are then faced with extensive waiting lists, is difficult to comprehend. It is clear that the HSE and Irish society as a whole must find a way to respond to the increasing mental health needs of our youths.

1.1.2 The Prevalence of Mental Health Difficulties in Youths
Prevalence studies in children and adolescent literature, such as Merikangas et al., (2010) purport that mental health conditions such as anxiety, depression, substance-use disorders, and behaviour disorders occur in approximately 40 percent of the youth population. They found that the median age of onset for such disorders in youths ranged from six to 15 years old. While children from six years of age were found more likely to suffer with problematic anxiety followed by behavioural problems, teens from the age of 13 years old were more likely to suffer with depression, and older adolescents from substance-use disorders. This suggests that untreated mental health conditions escalate with the further risk of comorbid symptoms as the child ages and approaches key transition phases, such as child, early teens, late teens, and young adult.
Comorbid symptoms for our youth population are common, especially in terms of mood disorders such as anxiety and depression. Ost, Cederlund and Reuterskiold (2015) stated that there are high co-morbidity rates associated with childhood anxiety disorders. Talkovsky, Green, Osegueda and Norton (2017) also demonstrated elevated rates of comorbidity between anxiety and depression leading to more severe clinical presentations than either condition alone. The author’s personal experience of working in child and adolescent mental health settings reaffirmed that it is rare for a client to present with symptoms of anxiety or depression in isolation. This is hardly surprising when considering the maintaining factors of escape/avoidance and withdrawal/isolation. Anxious individuals may avoid leaving their house which has a knock-on effect on their mood and isolation, or conversely, an individual suffering with depression may avoid going out and meeting people, which can exacerbate anxiety levels.

Traditionally, evidence-based treatments for common mental health conditions are disorder specific, and while many manuals pertain to single disorder-specific interventions, they are not widely used in everyday clinical practice. In fact, Weisz et al., (2015) claim that single-strand interventions may not be applicable to real-world clinical problems. Given the high rates of mood disorders in youths and the further risk of comorbid symptoms if left untreated, transdiagnostic treatments are therefore receiving more attention in the current literature. Weisz et al., (2015) also suggest that although clinicians generally work with young people on a broad range of disorders, lack of time and resources impede accessing and assimilating the separate treatment manuals for each disorder.

1.2 Aim of the Current Study
The focus of this study is to introduce a deployment-focused approach for a brief transdiagnostic group intervention for common mental health conditions for adolescents. The majority of current research on transdiagnostic approaches is based on meta-analysis and reviews of current literature and current transdiagnostic interventions (mostly individual sessions). Transdiagnostic interventions for adolescents are in their infancy in the literature, with most of the research focused on adults or children (under 12 years old). To the author’s knowledge a brief transdiagnostic group intervention for common mental health conditions has not
been implemented for the adolescent (12-17 year old) population. This intervention will use a core dysfunction approach to target multiple forms of psychopathology by using common techniques used from evidence-based single strand interventions. This research will implement a brief (six session) Transdiagnostic Cognitive Behaviour Therapy Group (TGCBT) for adolescents experiencing common mental health conditions utilising a stepped care approach.

1.3 Thesis Structure

1.3.1 Chapter Two: Literature Review
This chapter will begin with a brief definition of common mental health conditions in general. It will then refine this to common mental health conditions and prevalence rates for the youth population with particular reference to anxiety and depression. It will explore current legislation and policies within the Irish system and other comparable counties. The literature review will discuss how other countries have attempted to address the increase in mental health difficulties in this population by introducing a stepped care model and evidence-based treatment. This will be followed by a discussion for the need of new transdiagnostic intervention approaches.

The chapter will conclude with an introduction to the current study which delineates the theoretical framework and the research questions and hypotheses. It will also outline the implementation of the intervention for replication purposes.

1.3.2 Chapter Three: Methodology
This chapter will discuss the rationale for the current research design as a means of properly evaluating interventions within this population. The methods used to recruit participants, procedures followed in gaining informed consent, and all modes of data collection and analysis will also be elucidated. Ethical considerations of the study will be highlighted and all measures put in place will also be outlined.

1.3.3 Chapter Four: Results
This chapter will synthesise the findings in two distinct phases and the results from each phase of the study discussed sequentially. Figures and tables will be used to support the quantitative data, while direct quotes and examples will illustrate the
qualitative data section. The chapter will conclude with a summary of all results derived from the various phases.

1.3.4 Chapter Five: Discussion

The findings in Chapter Four will be outlined and compared to previous literature and results in this field and a critical reflection of the strengths and limitations of the study will be presented. The results and literature will be combined to address the implications for clinical practice, policy, teaching, and future research. The chapter will conclude with an overall summary of the study as a whole.
CHAPTER 2: LITERATURE REVIEW

2.1 Literature Search Strategy
The literature search consisted of a wide-ranging exploration of the following databases: Psych Info, Psych Articles, Cochrane Database, Medline, and Google Scholar. The reference lists of key articles were reviewed and further papers on the research topic also identified and reviewed. Research papers were included and reviewed from published articles and peer-reviewed articles. A variety of search terms were used within these databases in order to narrow down the key articles for review. Search terms consisted of various combinations of the following:
adolescents and related modifications (youths, young person, young people, student, teens, teenagers, young adults, children), common mental health conditions and relevant variations (common mental health difficulties, disorders, problems, anxiety, depression), mental health policies and associated terminology (legislation, guidelines, policy, best practice) and treatment programmes for adolescents, (transdiagnostic interventions, transdiagnostic group interventions, and transdiagnostic approaches).

Literature citing transdiagnostic individual treatment programmes for adults were excluded from the current study due to its focus on transdiagnostic group interventions for adolescents. However, literature which cited adolescents (and variations) with transdiagnostic treatment and approaches were included in the review. A wide range of titles and abstracts were reviewed and key articles established for full review and critique on the basis of the search results.

2.2 Common Mental Health Conditions
Mental health is a state of psychological and emotional wellbeing. Good mental health enables individuals to develop resilience and coping skills to deal with adversities in life. Moreover, it constitutes sound psychological development, forming and maintaining relationships, education and attainment, employment, self-care, self-actualisation, and the ability to enjoy life, balance daily demands and contribute to society. The ability to cope with daily stressors can be impacted when an individual experiences poor mental health (The World Health Organisation
One critical phase of psychological development pertains to that of young people transitioning into early adulthood.

### 2.2.1 Youth Mental Health

According to McGorry (2005), untreated mental health disorders are common particularly in late adolescence and early adulthood that can lead to early mortality and substance-abuse. He highlighted that overall mental health difficulties result in 8.1 percent of avoidable deaths. Kessler et al., (2005) noted that mental health problems affect a large number of the youth population. Moreover, Kim-Cohen et al., (2003) in a longitudinal study examining prior juvenile diagnoses in adults with mental health conditions found that 73.9 percent of adults suffering with mental health disorders received a diagnosis prior to the age of 18 years and 50 percent of adults received their diagnosis before the age of 15 years. As such, the transition phases of child to adolescent and adolescent to adulthood are clearly crucial. Early psychoanalysts highlighted emotional turmoil as a critical phase for adolescents. Since young people (children and adolescents) constitute almost one third of the world’s population, mental health problems affect 10 to 20 percent of young people worldwide, (Kieling et al., 2011).

Patton et al., (2014) purported that mental health conditions with onset between 11 and 18-years-old are more likely to progress into adulthood. On that basis, they undertook a 14-year prospective cohort study with the aim of investigating the prevalence of common mental health difficulties in adolescents persisting into young adulthood. Between 1992 and 2008, Patton and colleagues (2014) commenced a nine-wave cohort study in Australia to capture the health status of young people aged between 14 and 15 years old. They demonstrated that common mental health difficulties across both genders (boys 29% and girls 54%) occurred at least once during adolescence. However, girls (37%) showed higher rates of recurring and persistent common mental health difficulties than boys (14%). At least one episode of common mental health difficulties persisted into young adulthood for both genders (male 31% and female 52%). Their results confirm that recurring and persistent common mental health conditions in adolescence have an increased risk for recurrence in young adults. On the basis of these findings, it is clear that evidenced-based psychological interventions targeting adolescents could prove
invaluable. However, according to Kieling et al., (2011), the development of services for the growing needs of this population remains disadvantaged by inadequate funding and a lack of trained clinicians. The adequate provision of resources, trained clinicians, and funds are therefore essential factors to consider when attempting to establish accessible services and availability of evidence-based treatment.

To date, limited research exists on mental health in youths in the context of Ireland. The *My World Survey* (2012) was therefore undertaken to redress this gap and to investigate a number of the issues and concerns affecting Irish youth. The survey had two main objectives: firstly, to extend the young adult population to the age of 25 years old, since most current research into youth mental health, particularly in Ireland, ages out at 18 years old; secondly, to evaluate protective factors in combination with risk factors. As the first of its kind then, this national Irish survey of mental health in youths encompassed an age range of between 12 and 25 years. The protective factors explored included coping skills, social support, life satisfaction, resilience, optimism, self-esteem, and help-seeking behaviours, while risk factors included stress, addictive activities, such as substance-use and gambling, depression, anxiety, peer pressure/bullying, suicidal and self-harming behaviours (Dooley & Fitzgerald, 2012).

The key findings of this national survey support evidence of the emergence of mental health difficulties in early adolescence, with a peak in late adolescence and early adulthood. During this peak in mental health difficulties, there was a notable decline in the protective factors outlined above. Gender differences were also observed in help-seeking behaviours, with females more likely to request help than males. On the other hand, levels of self-esteem and satisfaction proved higher for males. The presentation of mental health difficulties was also differentiated between genders; males engaged in more risk-taking behaviours such as substance-misuse and violence towards others, while females were more likely to present with avoidant coping strategies. A number of themes which emerged from the young people’s perspectives are crucial to understanding and addressing mental health difficulties within this population. The key themes identified in the survey are:
“One good adult is important in the mental well-being of young people”

“Excessive drinking has very negative consequences for the mental health and adjustment of young people”

“Young adults experiences of financial stress are strongly related to their mental health and well-being”.

“Rates of suicidal thoughts, self-harm and suicide attempts were found to be higher in young adults who did not seek help or talk about their problems”

“Talking about problems is associated with lower mental health distress and higher positive adjustment”

*My World Survey* (2012, p. 9)

Such themes clearly highlight the importance of early intervention. The notion that “one good adult” in life can support positive mental health can be linked to research on attachment and the importance of forming a secure attachment bond with a primary care-giver. This bond creates a sense of security and an openness to communicate about problems and build resilience. This was reflected in the data. For example, MWS (2012) found that young people who perceived low social support from a trusted adult when in need, experienced elevated levels of depression compared to peers who perceived good social support from a trusted adult.

Youths often use substances as maladaptive coping strategies. This study confirmed that common mental health conditions, such as depression and anxiety, were exacerbated in cases where a young person engaged in harmful alcohol intake. It further found that harmful alcohol intake is more significant in adolescents than young adults. Since this is a pivotal phase of biological, emotional, and social development, it is clearly of the utmost importance to introduce adolescents to adaptive coping strategies with the aim to encourage and support good mental health.

The survey found that 60 percent of young adults felt unduly stressed about finances and the demands to take external paid employment while attending college. Financial duress was found to affect individual self-esteem and life satisfaction: both key markers for good mental health. Individuals experiencing financial stress
were therefore more likely to engage with maladaptive coping strategies such as avoidance or risk-taking behaviours.

The suicide mortality rate in the 15-24 year age group in Ireland is in the top six countries for high suicides rates in the EU (NOSP, 2009). The findings in the My World Survey indicated that youths experiencing suicidal thoughts and/or engaging in self-harming behaviours were less likely to talk about their problems compared to youths who did not experience these symptoms. Such young people felt unable to acknowledge their own problems and their need for help. A clear trend which emerged from this data is that those who reported minor problems were found to have greater wellbeing and lower levels of distress than those who reported experiencing emotional problems which required professional help.

The findings of this study demonstrate that 70 percent of young people who reported good mental health are supported by “one good adult”. Older adolescents reported higher levels of difficulties than younger adolescents as is commensurate with the increasing demands of school and study. Young adults reported greater distress levels than adolescents, with 40 percent of young adults experiencing higher levels of anxiety and depression. This research supports previous evidence that mental health conditions have an early onset, increase in older adolescence, and if not treated, are likely to continue into early adulthood. Throughout this timeframe, as mental health difficulties increase, protective factors decrease. Thus, during this vulnerable period in the life span, maladaptive coping strategies and avoidance are more likely to emerge and dominate. This profile clearly supports the need for effective early treatment for the emergence of mental health difficulties for this vulnerable population.

2.2.2 The Impact of Common Mental Health Conditions for Youths

Almost everyone, including young people, occasionally experience adversities in life. But what actually constitutes a mental health condition such as depression and anxiety?

*Depression*

Depression can sometimes be confused with low mood. In fact, sadness is a natural response to loss, and at some point in life, everyone experiences sadness and low
mood. When linked to significant life events such as trauma, loss, relationship difficulties, or daily stressors, the body’s reaction to such life events is deemed a normal response. However, depression can be diagnosed when such symptoms become severe, persistent, or impact on areas of social, occupational, and educational functioning. The American Psychiatric Association (2013) classification of typical features of depression include:

- Low mood / irritability - persistent, most of the day, nearly every day
- Feeling sad or empty
- Tearfulness
- Loss of interest or pleasure in most activities
- Appetite changes - increase or decrease
- Sleep disruption - insomnia or hypersonnia
- Loss of energy - feeling lethargic or fatigued
- Feelings of guilt or worthlessness
- Inability to concentrate
- Suicidality or self-harm

While the 1984 pamphlet produced by the National Institute of Mental Health entitled, *Depression: what we know*, explicitly stated that the onset of a clinical presentation of depression cannot be prevented, their contention was directly contested by 2009 Institute of Medicine Report, *Preventing Mental, Emotional, and Behavioural Disorders Among Young People: Progress and Possibilities* (National Research Council and Institute of Medicine, 2009b), who concluded that common mental health conditions in youths are preventable and effective evidence-based interventions are crucial for this population. If, as the later report maintains, major depression can be prevented, it is imperative that interventions targeting prevention and early detection are readily accessible to populations at risk.


However, in order to reach this population, it is necessary to properly understand the symptoms and life experiences of young people living with mental health difficulties. To the authors’ knowledge, there is conspicuously little research into
living with depression from a young person’s perspective, particularly in the context of Ireland. However, an Australian qualitative study to explore the experiences of young people with depression was carried out by McCann, Lubman and Clark, (2012). This study interviewed 26 young people between the ages of 16-25 years old and used Interpretive Phenomenological Analysis (IPA). Four themes where identified on the experiences of depression in young people as follows:

1. Struggling to make sense of their situation
2. Spiralling down
3. Withdrawing
4. Contemplating self-harm or suicide

The young people surveyed expressed the feeling of being different to their peers. The fear of the stigmatisation of being and feeling different increased the likelihood of using avoidant behaviours and withdrawal to cope with their symptoms of depression. Paradoxically, in utilising these maladaptive coping strategies, social isolation and feelings of loneliness merely increased and the world grew ever-smaller as social invites begin to cease. As feelings of isolation increased, young people felt that their symptoms were spiralling downwards, their quality of life and meaningful relationships deteriorated, and they were unable to reverse this cycle. As this situation became more prominent, young people reported contemplating suicide and self-harming behaviours.

It is clear that depression in young people affects their physical, social, and psychological wellbeing (McCann et al., 2012). As young people attempt to make sense of such symptoms, they may engage in maladaptive coping strategies such as avoidance, withdrawal, self-harming behaviours, or suicidality. In fact, the leading cause of death by suicide within this young population can be attributed to mental health difficulties (McGorry, 2005; Kessler et al., 2005). This underscores the need to increase mental health literacy both in this population and the wider community and support the findings of McCann, (2012). Greater mental health communication and information would arguably enable family and friends to recognise the symptoms of depression in young people. Since stigma is a major obstacle for young people in seeking help, schools also have a crucial role to play here and could help promote positive mental health, thereby diminishing the stigmatisation of depression. As previously stated, when left
untreated, the symptoms of common mental health problems are more likely to escalate and continue or to re-present in young adulthood. It is therefore imperative that effective intervention programmes are implemented for young people.

**Anxiety**

According to Davis, May and Whiting, (2011) one of the most prevalent disorders in childhood is anxiety. As with any common mental health conditions, untreated anxiety can escalate and continue into adulthood. Everyone will experience anxiety to some degree in their lives; anxiety is a natural response to danger and designed to protect us. This is called the fight/flight/freeze response. It is innate and goes back to pre-historic times with the sole purpose of survival. In the modern world our brains no longer have the capacity to distinguish between perceived danger (psychological threats) or actual danger (physical threat); therefore, our bodies react for survival in all situations perceived as threatening. When the body is in fight/flight/freeze mode, the physical sensations that occur can be extremely unpleasant and frightening, for example palpitations, breathing difficulties, and feeling faint, to name but a few. Symptoms of anxiety can present as psychic or somatic complaints, as categorised by the American Psychiatric Association (2013) under the following classifications:

- Social phobia
- Specific phobia
- Generalised anxiety disorder
- Panic disorder
- Separation anxiety
- Obsessive compulsive disorder (OCD)
- Posttraumatic stress disorder (PTSD)

The American Psychiatric Association (2013) classify each of the disorders by a set of symptoms, including affective, physiological, cognitive, and behavioural symptoms. PTSD and OCD are classified in the DSM-V as separate anxiety-related disorders.

As anxiety is essentially an adaptive function for safety and survival, it becomes problematic only when it is severe, persistent, and/or adversely impacts normal development and daily living. If left untreated, problematic anxiety can have huge implications for quality of life, interpersonal relationships, self-actualisation, and academic attainment which are key benchmark areas for positive mental health. Pine
and Klein (2008) found a prevalence rate of anxiety disorders in young people of between five and 10 percent with a over-representation of girls. Contributing factors to the development of anxiety disorders include stress, substance-misuse, poor coping skills, and parental anxiety.

As a child is developing and exploring their environment they look to their main care-giver for support and encouragement. For this reason, unduly anxious parents may unconsciously teach a child that the world is an unsafe place through their own unintentional protective actions and thereby prevent the child from developing adaptive coping skills and self-actualisation. A population study carried out in Brazil for young people between the ages of 18-24 years old, found a 20.9 percent prevalence of anxiety disorders in young adults, the most common being Generalised Anxiety Disorder, (Mondin et al., 2013).

It is typical for young children to experience normal developmental childhood fears, such as fear of the dark, fear of strangers, fear of death, and so on. As children move through various transition phases different fears emerge. In teenagers, for example, social fears and fear of judgement, become more prevalent. Anxiety can occasionally be mistaken for these fears and become more debilitating as adolescents transition into young adulthood. Therefore it is imperative for parents, teachers, and health professionals to determine whether the anxiety symptoms are severe, persistent, and/or affecting quality of life. If anxiety impacts daily functioning and is marked by avoidant behaviours, the possibility that it is more than typical developmental fears should be addressed.

To reiterate: key benchmarks for positive mental health include psychological development, forming and maintaining relationships, education and attainment, employment, self-care, self-actualisation, the ability to enjoy life, balancing daily demands, and contributing to society.

The research to date has highlighted the prevalence of common mental health conditions for youths and demonstrated that deep-seated untreated common mental health conditions can impact such areas in development, giving rise to maladaptive coping strategies which diminish adaptive coping and resilience. The literature further emphasised the escalation and recurrence for adolescents and young adults
when mental health conditions are left unrecognised or untreated and questions the societal cost of treating common mental health conditions in a timely manner. Some commentators argue that the cost incurred through neglecting the impact of common mental health conditions in youths represents a greater burden to the State since research confirms that such conditions are likely escalate into adulthood if left untreated.

2.3 Cost of Common Mental Health Conditions

To the author’s knowledge, there has been no economic report produced in the Republic of Ireland (ROI) regarding the costs of common mental health conditions to the State. The Depression Report completed in UK by Layard et al., (2006) highlighted the significant economic burden arising from untreated depression and anxiety disorders. Depression and anxiety can have severe consequences for the sufferers, their families, and the economy. Since adults model behaviours and coping skills to their offspring, a generation of anxious or depressed youths may exhibit behaviours learned from their care-givers, such as a lack of coping skills and resilience. The Depression Report found that mental illness accounted for 40 percent of those in receipt of incapacity benefit, equating to a massive one million people across the UK (Layard et al., 2006).

Depression and anxiety can prevent individuals from gaining or sustaining employment. Moreover, it may contribute to increased absenteeism and termination of employment due to high sickness records or time-management difficulties. All of this places extra pressure on the economy in terms of loss of output and income. Layard et al., (2006) estimated the total loss of output to the economy due solely to untreated depression and anxiety disorders to be £12 billion per annum. They further emphasised that of this £12 billion, £7 billion falls to the taxpayer. As such, they maintained that the cost of providing effective evidence-based therapy services to tackle the problem and to enable patients to remain in or return to work, would ultimately be a more cost effective strategy than that of not treating common mental health conditions.

Clark (2011) supported Layard and colleagues’ (2006) estimation of the cost benefits to Government of increased access to effective psychological therapies in the reduction of other depression and anxiety-related expenditures such as
incapacity benefits and medical costs. Moreover, they purported the potential for increased revenues in terms of income tax and increased productivity.

2.3.1 Cost Effective Therapies

Evidenced-based therapies are emerging as the forefront of empirically sound therapies. Cognitive Behaviour Therapy (CBT) is the most common and effective treatment for depression and anxiety disorders (NICE 2009; 2011). Layard et al., (2006) combined hundreds of clinical trials wherein participants had been assigned therapy, medication, or waitlist conditions. Overall, they found therapy is as effective as medication in the short-term. However, they also concluded that therapy had longer lasting effects than medication in the long-term. The short-term success rate of CBT was observed at 50 percent, with individuals suffering with anxiety disorders found unlikely to relapse following therapy. Moreover, while the results demonstrated a possibility of relapse in individuals suffering from depression, they also revealed that those who had received therapy were less likely to do so than those who had been exclusively treated with medication.

If the Depression Report’s estimate of treatment costs of £750 per individual are accurate, patients’ ability to remain in or attain full employment, means the treatment cost will pay for itself. Additional savings to the State will also occur, such as for instance, in the reduced overall healthcare costs of numerous GP visits. Mental health medication costs will also decrease along with hospital referral rates. For instance, mental health conditions, such as panic disorder, can present as a physical illness. This report highlighted three key supporting arguments to psychological therapy access for all, as follows:

1. The money which the government spends will be fully offset by the money which the government saves.

2. The financial benefits to society as a whole are at least double the benefits to the government (while the costs of the treatment are the same).

3. On top of these financial benefits, there is the reduced suffering. Life becomes more worth living.

Layard et al., (2006, p. 7)
2.3.2 Improving Access to Psychological Therapies (IAPT)

The depression report estimated that a further 10,000 trained therapists will be required to implement effective evidence-based psychological therapy services (Layard et al., 2006). On the basis of the reported financial benefits of implementing effective psychological therapies for mild-moderate anxiety and depression disorders the UK government funded the Improving Access to Psychological Therapies (IAPT) programme. IAPT is a large-scale initiative which aims to increase availability of recommended psychological treatment for depression and anxiety in the adult population in the UK (Clark, 2011). The programme began as a pilot study in which the two demonstration sites of Doncaster and Newham were allocated additional funding to employ CBT-focused therapists trained under this initiative and following a national curriculum and National Institute of Health and Clinical Excellence (NICE) guidelines for the treatment of anxiety and depression. Accessibility of services was extended by accepting both practitioner and self-referrals.

Layard et al., (2007) measured the outcomes of both services. The expected improvement for employment status was initially observed at four percent and at five percent at the nine month follow-up. Recovery rates were in line with predictions. In the Newham demonstration site, which focused mainly on low intensive CBT interventions, 55 percent of patients recovered, while the Doncaster demonstration site, which also incorporated high intensity CBT interventions, saw a 56 percent patient recovery (Clark, 2011). One criticism of the IAPT demonstration sites is that although these outcomes match the predictions, data was collected from everyone who accessed the services. Since the data was not based on randomised controlled trials (RCTs) then, it is impossible to rule out other variables which could account for recovery, such as natural or spontaneous recovery. To counter this critique, Clark (2009) subsequently isolated the data and computed recovery rates separately for patients who had presented with symptoms of depression and anxiety for more than six months. His results confirmed that treatment had provided more benefits to this group than natural recovery. It is therefore not possible to ascertain whether patients with a recent onset of depression and anxiety benefited more from treatment than natural recovery. Clark and Borglin’s (2011) two-year prospective cohort study concluded that 55 percent of patients with anxiety and depression
attained reliable change and/or reliable significant change in six sessions or less. Furthermore, they found no significant difference in recent onset or longer duration of symptoms, with the exception of long-term depression.

Following the success of the pilot studies, the IAPT programme was rolled out nationwide across the UK. Over 900,000 people currently access IAPT annually. They are treated by a group of para-professionals called Psychological Wellbeing Practitioners (PWP’s), thousands of whom are now trained and employed by the health service to deliver evidence-based low intensity CBT interventions following NICE guidelines. Services are also expanding and include other therapies recommended by NICE. By 2020/2021 IAPT aims to care for 1.5 million people annually.

2.3.3 Child and Young Persons IAPT

The IAPT recent expansion and creation of a division to transform existing children’s services is known as the Child and Young Persons Improving Access to Psychological Therapies (CYP IAPT).

The increase in mental health problems for the child and adolescent population is of concern in both the ROI and the UK. While it is estimated that mental health difficulties during childhood cost £11,030 to £59,130 annually per child in the UK, to the author’s knowledge, no such financial reports are currently available in the ROI context. Both Little and Edovald (2012) and Suhrcke, Puillas and Selai (2008), concur that evidence-based practice has substantial clinical and cost benefits. However, Kennedy (2010) noted that only six percent of current mental health expenditure goes to services aimed at children and young people. The expansion of the IAPT programme to the CYP IAPT programme focused on the collaboration with young people in developing existing services. For the adult model of IAPT new services and clinicians were trained in line with the national curriculum and NICE guidelines. In the CYP IAPT programme however, the aim was to transform existing children’s services by training current CAHMS clinicians with a national curriculum to deliver evidence-based psychological therapies in a stepped care model. Thus in the first year, clinicians were trained to deliver CBT for anxiety and
depression, parenting for 3-10-year olds with conduct disorder, and transformational leadership (IAPT Three Year Report, Department of Health, 2012).

The programme was introduced in 2011 with the aim that CAMHS work would cover 60 percent of the child and adolescent population by March 2015. In fact, the programmes exceeded expectations and achieved 68 percent coverage, and the target for 2018 set at 100 percent coverage.

2.4 Relevant Policies and Legislation

This section will present an overview of the current policies and relevant legislation of the United Nations (Children’s Rights), the ROI Health Service Executive (HSE) and the UK National Health Service (NHS). The author has included UK legislation and policy since the NICE guidelines are commonly referred to in the context of clinical practice within the Republic of Ireland. Furthermore, the Irish Psychological Society and the British Psychological Society offer reciprocal recognition of the other’s doctoral qualifications in Clinical Psychology and adhere to the same principles and best practice guidance.

2.4.1 The National Institute for Health and Clinical Excellence (NICE)

The National Institute for Health and Clinical Excellence (NICE) guidelines were devised in the UK on the basis of a comprehensive review of evidence on treatment effects for symptoms of illness. NICE supports the findings of the depression report which holds CBT to be as effective as medication for symptoms of depression and anxiety.

NICE Guidelines for Depression (2009) recommend that prior to drug treatment, psychological therapies should be offered for individuals suffering with persistent depressive symptoms or mild to moderate depression. Drug treatment should only be offered in cases of severe, persistent, or long-term symptoms of depression. Therapies offered can consist of guided self-help based on CBT principles, computerised CBT, or group programmes.

NICE Guidelines for Anxiety (2011) recommend therapies based on CBT principles such as non-facilitated self-help, guided self-help, and group programmes. The various interventions which were systematically reviewed by NICE for evidence of
efficacy for a range of mental health conditions led to a series of publications (NICE, 2004a, 2004b, 2005a, 2005b, 2006, 2009a, 2009b, 2011). CBT was the main recommendation for mild to moderate symptoms of depression and anxiety. Alternative therapies, such as interpersonal psychotherapy, behavioural couples’ therapy, and counselling, were also recommended for depression.

2.4.2 The Green Paper
The UK Department of Health has begun to implement increased access to evidence-based psychological therapies to young people and their families. The Green Paper (2017) delineates the programme aims to increase awareness and support for this population in a timely manner. As such, it stresses the importance of providing interventions at the right time and within the right setting. The three objectives for targeting mental health difficulties set out by the Green Paper (2017) are as follows:

1. Mental health support teams will be trained in evidence-based psychological therapies and based in an education setting
2. They will be supervised by a designated Senior Lead
3. They will aim to reduce waiting times for young people seeking professional help by the end of 2022/2023

CYP IAPT are involved in training and implementing this workforce and plan to be operational from 2019. The specific interventions included are:

- CBT in a school/college setting for adolescents at risk of depression
- CBT in a school/college setting for young children and adolescents showing signs of anxiety
- Family-based behaviour change, which can be successfully delivered by teachers and other non-clinical staff to help reduce child conduct problems
- Group-based interventions

This is an extremely positive step in terms of awareness, early intervention, and prevention of mental health difficulties for this population. Moreover, the provision of professional support in educational settings will arguably help to reduce stigma and lengthy waiting-lists for specialist services such as CAMHS.

2.4.3 The Rights of the Child
The United Nations Convention on the Rights of the Child is an internationally binding agreement. All countries who sign this agreement must promote, protect, and fulfil the rights of children in all areas of their lives. Under this convention a child is defined as any person under the age of 18 years old. To date, the only UN
members who have not signed this agreement are the United States of America and Somalia. Ireland did so in 1990. Since then, a UN committee has examined Ireland’s adherence to this convention on two occasions; firstly, in 1998, and again in 2006. Based on their performance Ireland was subsequently issued with a number of recommendations (UN Convention on the Rights of the Child, 2010), in light of which the State has made notable progress in upholding the fundamental rights of Irish children. These include:

- The National Children’s Strategy (2000)
- The National Children’s Advisory Council (2001)
- The appointment of Ireland’s first Ombudsman for Children (2004)
- Children First (2015).

The main principles in the UN Convention of the Rights of the Child stipulate that no child should be discriminated against, that the best interest of the child must be foremost, that survival and development are fundamental rights of the child, and that the child’s views must be considered in all decisions pertaining to the child, (UN Conventions on the Rights of the Child, 2010). Article 24 of this convention on the Rights of the Child further states that:

“The State shall recognise the rights of a child to the enjoyment of the highest attainable standard of health and the facilities for the treatment and rehabilitation of health, shall strive to ensure that no child is deprived of his or her right of access to such health care services”.

(cited in A Vison for Change, 2006, p.86)

It is evident that while Ireland has recently devised and implemented a number of successful policies for children’s services, the many supports needed to fully adhere to the rights of children require more consideration. In fact, current services are failing to meet the mental health needs of children and young people.

2.4.4 Health Service Executive: “A Vision for Change”

“Each citizen should have access to local, specialised and comprehensive mental health service provisions that is of the highest standard”.


A Vision for Change, (2006) is a strategy put forward by the Irish Government in 2006 as a framework for building positive mental health throughout the country and
was derived through an action point from The National Health Strategy Quality and Fairness: *A Health System for You, (2001)*. This document highlighted the need for an overhaul of mental health policy. The *A Vision for Change, (2006)* strategy covers mental health for all types of people and encompasses all age ranges. As such, it aims to promote mental health in a range of services at all levels within the country, including community, primary, secondary, and crisis care services. To this end, it incorporates a number of specific recommendations for child and adolescent mental health services as follows:

- Mental health promotion and primary early prevention should be targeted towards children at risk. “Children at risk” can include but is not limited to: children with physical illness or disability; a family with a history of psychiatric problems; children with low self-esteem; children whose basic needs are not being met; separation or loss; children who are or have been exposed to violence, abuse, or use of substances; this can include the children themselves or their care-givers and childhood neglect.

- Evidence-based mental health promotion programmes to be implemented in primary and secondary schools.

- CAMHS teams need to be expanded to include young people up to the age of 18 years old.

### 2.4.5 Ongoing Challenges for Irish Services

To reiterate: “The Big Picture: Young and Troubled” (RTÉ, 2017) drew widespread attention to the extensive mental health services waiting-lists for child and adolescents throughout Ireland. Alarmingly, the average waiting time to see a Child Psychologist in Primary Care was reported as 18 months. During the intervening time, mental health conditions which are left untreated may escalate and reach a crisis point. CAMHS services are daily inundated with referrals from young people in crisis, many of whom may not have been referred to CAMHS if timely support had been available at an early intervention stage.

During the broadcast one young boy related his difficulties with mental health; about reaching out for support but feeling “alone and abandoned”. This boy subsequently attempted suicide. As previously stated: in Ireland the rate of suicide death in young males is a major concern. Although the HSE protocol stipulates that
all urgent referrals to CAMHS should be seen within 72 hours, this boy waited two weeks after his hospital discharge following a suicide attempt for an assessment with his local CAMHS team. His parents’ anxiety and stress levels were high, and they provided 24/7 suicide watch to keep their son safe. Seven months on the young boy discussed his recovery and his satisfaction with the level of support he received once he was seen by the team. There seems little doubt that while such services provide good care and support to young people, they remain largely understaffed and under-resourced. It is also clear that location has a huge impact on the level of care received and waiting times for services.

Questions are therefore raised concerning how and why certain CAMHS teams respond within this 72-hour response protocol and others do not, as in this case and that of the 11 year old young girl who sadly completed suicide. The HSE currently have no statistics monitoring this protocol despite the fact that the Government allocated six percent of the overall 2017 budget to mental health. In addressing the issue, Jim Daly TD, Minister of State for Mental Health, who participated in a live debate following the broadcast of the documentary, conceded that he could not know specifically how much of this budget allocation went into child and adolescent mental health services.

The Governments mental health strategy, *A Vision for Change*, (2006) has not been fully implemented: only 69 out of proposed 95 CAMHS teams have been established. Moreover, while the policy stipulated that each CAMHS team should comprise 11 clinicians, only three CAMHS teams in the country currently have the full complement of staff. In reality, there is a 44 percent shortfall in national staffing levels. At time of writing, 2,603 children and adolescents across Ireland are waiting for a first appointment with CAMHS. 1,322 of these have been waiting more than three months (*A Vision for Change*, 2006).

On a positive note, mental health awareness is increasing and stigma is being reduced. Nonetheless, services must be equipped to offer the right support at the right time; namely, when young people and their families seek support. While the Minister of State for Mental Health has acknowledged the need to tackle mental health difficulties with early interventions, research suggests a national growth in
youth mental health conditions. The following section examines how other countries have attempted to address the current youth crisis.

2.5 What Have Other Countries Done to Address This Need?

2.5.1 Stepped Care Model in Mental Health Services

Targeting a population with specific evidence-based psychological therapies requires resources and time. Thus, a stepped care model has been utilised in the UK and Australia to enhance the accessibility of evidence-based psychological therapies. A stepped care model ensures that the least restrictive and most effective treatments are first offered to individuals (i.e. minimum therapist input, and brief interventions, such as guided self-help, group interventions). Using a stepped care model, individuals can either be “discharged” upon completion of a brief psychological evidence-based intervention or “stepped up” for more intensive treatment as required. The rationale for this approach is that not everyone experiencing mental health difficulties requires the same intensity of intervention. As previously discussed, with the increase of referrals to CAMHS, some young people may have benefited from brief earlier intervention prior to reaching a crisis point. Table 2.1 demonstrates care offered in each step of this model.

Table 2.1

<table>
<thead>
<tr>
<th>Example of a Stepped Care Model</th>
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<tbody>
<tr>
<td>1. Identification, assessment and watchful waiting</td>
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<tr>
<td>2. Low Intensity Psychological Interventions</td>
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<tr>
<td>3. High Intensity Psychological Interventions /Pharmaceutical</td>
</tr>
<tr>
<td>4. Highly Specialist Treatment, such as Crisis Team, inpatient care, and/or complex care</td>
</tr>
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NICE guidelines stress that low intensity psychological therapies are not recommended for severe, persistent, or long-standing symptoms of depression and this should start at Step 3. A number of anxiety disorders such as PTSD and OCD should also be treated at Step 3 (Clark, 2011). In support of a stepped care model, Newman (2000) found that people suffering with anxiety disorders can benefit from low intensity interventions.
Many anxious children do not receive treatment because of barriers such as limited availability of trained practitioners, costs of treatment, and time. A stepped care approach that “steps up” care as needed from less intensive therapies with minimal therapist assistance to therapist directed treatment may address these barriers and provide more accessibility to treatment within Irish services.

2.6 Transdiagnostic Approach

There has been extensive research establishing empirically supported evidence-based psychological therapies in the current literature for both adults and youths (children and adolescents). While CBT has emerged as the most effective treatment for common mental health difficulties, the use of manualised disorder specific interventions are not widely used in services (Weisz et al., 2015). Although empirically supported interventions have been established for common mental health difficulties in youths, such as anxiety and depression, Weisz et al., (2018) found that a large number of youths do not recover following empirically supported treatments.

They also argued that the most comprehensive meta-analyses for randomised controlled trials (RCT) for youth psychotherapies fall within the medium effect range. Given the huge impact on mental health difficulties in the youth population, more research is clearly needed on the effects of treatment and particularly transdiagnostic interventions.

Transdiagnostic interventions focus on common mechanisms within and across disorders as opposed to disorder specific treatment. Meier and Meier (2018) suggest that a common psychopathology factor underlies all mental disorders. These can be broken down into two higher order factors: 1) internalising; and 2) externalising. This implies that disorders which share internalising factors such as depression and anxiety, or disorders which share externalising factors such as substance abuse, self-harm, and anti-social behaviours, could potentially be treated simultaneously by targeting the core shared mechanisms of the higher factors. Within the youth population such an approach may be more valuable given the high co-morbidity rates, escalation rates, and systemic factors affecting youths today, (Ehrenreich-May
and Chu, 2014). By targeting core common mechanisms within and across disorders, multiple clinical problems could be addressed with a single intervention.

2.6.1 Current Transdiagnostic Interventions

Current transdiagnostic interventions are largely based on individual sessions within children or adult populations. The Newby et al., (2015) meta-analysis of transdiagnostic treatment for depression and anxiety disorders suggests more favourable results than wait-list controls or treatment as usual control groups. Current and up-to-date transdiagnostic interventions include:

- Coping Cat which is a 16 session individual CBT manual-based and comprehensive treatment program for children from seven to 13 years old for separation anxiety disorder, social anxiety disorder, generalized anxiety disorder, and/or related anxiety disorders, (Kendall et al., 1997). This programme was also adapted for adolescents. The C.A.T. Project is a version of Coping Cat for adolescents aged 14 to 17 years old.
- Transdiagnostic treatment for a range of eating disorders in adults, (Fairburn and colleagues, 2003).
- The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP), (Barlow and colleagues, 2004). More recently this approach has been adapted and evaluated for treatment with adolescents (UP-A) and a group based programme for children (UP-C).
- Dialectical Behaviour Therapy (DBT) is an evidence-based psychotherapy designed to help people suffering from borderline personality disorder. It is largely a treatment programme targeting the higher factor of externalising behaviours (Linehan, 1993).
- Transdiagnostic Group Behavioural Activation and Exposure Therapy for youths, is a 10 week group for ages 12-14 years old in a school-based setting, (Chu et al., 2016).
- Underway is the Community Study of Outcome Monitoring for Emotional Disorders in Teens (COMET), (Jensen- Doss et al., 2018).

2.6.2 Transdiagnostic CBT Treatment:

There is also strong emergent evidence for the effectiveness of psychological therapies (Hofmann and Smits; Stewart and Chambless). Cuijpers, Sijbrandij,
Koole, Andersson, Beekman and Reynolds’ (2013) meta-analysis of the effectiveness of psychological therapies for the treatment of depressive and anxiety disorders found favourable results when compared with pharmacotherapy. The field of psychological therapies is moving away from manualised programmes and beginning to acknowledge the need for a treatment focus on transdiagnostic symptoms. Norton, (2012b) found that a CBT transdiagnostic group intervention for anxiety was as effective as a relaxation training group. Treatment manuals do not usually allow for flexibility with issues of comorbidity. As most clients will present with comorbid symptoms this can limit their clinical use (Kessler, Chiu, Demler and Walter, 2005). Therefore, a need for flexible adaptations of programmes for successful implementation across services is required.

Transdiagnostic Cognitive Behavioural Therapy (tCBT) has been evaluated in randomised control trials, and compared to treatment specific approaches. The therapy has demonstrated favourable results for relapse prevention (Barlow, Bullis, Comer and Ametje 2013). Moreover, tCBT addresses shared mechanisms of comorbid symptoms across disorders (Harvey, 2004). As such, running group-based treatment using a tCBT model could save therapist time and treatment costs, and increase accessibility and treatment options for clients, (Bullis et al., 2015).

A Randomised Control Trial of 23 participants on Norton and Barrera’s (2012), 12 week tCBT group for anxiety in adults found positive results for severity of symptoms compared to a wait-list control, (Norton and Hope, 2005). Allen, Tsao, Seidman, Ehrenreich-May and Zeltzer, (2012) also found transdiagnostic treatment effective for depression and anxiety in adolescents with chronic pain.

It is widely agreed that therapeutic alliance is important for promoting change. This raises questions as to what actually happens within a group process and whether group cohesion has an impact on mechanism for change. Gullo et al., (2014), investigated the perception of group alliance and found a positive relationship between perceptions of alliance from the group as a whole when symptomatic change is noticed in other group members.
Talkovsky et al., (2017) carried out a tCBT group intervention for adults with an anxiety disorder with comorbid symptoms of depression. In comparing groups with depressive symptoms and no depressive symptoms, they found that individuals with depressive symptoms generally scored higher on self-report pre-intervention, but that both groups improved similarly. However, there was some evidence of greater levels of improvement for the individuals with co-morbid depressive symptoms. Such results are promising and demonstrate that treating co-morbid symptoms of anxiety and depression with a transdiagnostic group intervention can be effective.

2.7 Gap in Literature

Current research in transdiagnostic treatment is mainly focused on the adult population and lacks a deployment focused approach. The majority of studies entail meta-analysis and an evaluation of treatments in non-clinical settings. Current transdiagnostic treatments examined in the literature mainly employ an individual face-to-face format of approximately eight to 21 sessions. Meier and Meier (2018) propose future research into this area and suggest treatment should be implemented in mental health settings in order to observe the effects of such interventions in real world conditions.

Ewing et al., (2015) undertook a meta-analysis of transdiagnostic CBT in the treatment of child and young person anxiety disorders which concluded that transdiagnostic CBT in any format is effective for treating anxiety disorders in youths. They also reported that transdiagnostic CBT group interventions for adolescents between the ages of 15-18 years is scarce and requires more attention in future research. Transdiagnostic interventions in group formats as outlined above are between eight and 16 sessions and mostly focused on the younger age group of seven to 14 years old. As the majority of the literature in this field is based within an adult population, youths between the ages of 14-17 years old are largely under-represented in the field of transdiagnostic CBT group interventions.

To the author’s knowledge, a brief (six session) transdiagnostic CBT group intervention for adolescents in the age range of 12 to 17 years old which targets common mental health conditions such as anxiety and depression has not been implemented and evaluated within a CAMHS setting.
2.8 Rationale for the Current Study

In consideration of the increase in mental health conditions and the escalation of untreated mental health conditions in the youth population, along with the gaps in the current literature as identified above, this study implemented a multi-site, deployment focused approach. This method was utilised as a means to examine the effectiveness of a transdiagnostic short-term CBT group for secondary-school aged children referred to CAMHS.

Building on the UK success of IAPT for adults, many of whom would not have accessed and benefited from evidence-based psychological therapies without this service, a stepped care initiative is currently being rolled out across UK children’s services which focuses on evidence-based treatment for anxiety and depression. During the initial phase existing CAMHS workers and colleagues, such as social workers and school nurses, were trained to deliver brief interventions within these settings. Currently a new workforce is being trained by CYP IAPT to implement brief early CBT based interventions to children and young persons.

NICE guidelines recommend low intensity interventions such as psycho-educational groups, behavioural activation, guided self-help, and computerised CBT as treatment options for common mental health conditions. The development of the current intervention had been influenced by my previous work undertaken in the UK as part of a CAMHS team and a University team. As I am passionate about improving wellbeing for young people I feel this a crucial time for developing mental health awareness and resilience. To that end, I have chosen to investigate whether this brief intervention could be successfully implemented in Irish services.

2.8.1 Theoretical Underpinnings for the Current Study

Transdiagnostic approaches target underlying common mechanisms both across and between disorders. Meier and Meier (2018) identified higher factors of internalising and externalising symptoms across different disorders, thereby suggesting that disorders with internalising symptoms could share similar maintaining factors and vice versa. This intervention targeted disorders with internalising symptoms such as anxiety and depression. It is hoped that by learning how to manage the maintaining factors of common disorders, young people would be equipped to apply these skills
to other difficulties they may face in life such as stress, awareness of emotional reactions, and general well-being.

Seagar et al., (2014) found common underlying factors common across anxiety disorders and depression included three areas: 1) cognitive biases, which include interpretation biases, attention bias, memory bias and judgement bias; 2) behavioural deficits mainly escape and avoidance as maladaptive coping strategies; and 3) poor emotion regulation skills and the inability to tolerate negative emotions.

Chu et al., (2016) highlighted that a beneficial transdiagnostic approach must address common cognitive, emotional, physiological, and behavioural processes. One of the first unifying theoretical models to incorporate these areas was Barlow et al., (2014) unified protocol approach. This approach targets poor emotional regulation skills, awareness of various emotions, behavioural and emotional avoidance, maladaptive cognitive appraisals, and cognitive flexibility. The Unified Protocol for the treatment of emotional disorders (UP) is a transdiagnostic CBT protocol for the treatment of adults with various emotional disorders. An adaptation of this programme led to the UP-A treatment for adolescents and the UP-C group treatment for children. All except the child version are individual face-to-face based programmes comprising eight to 21 sessions and incorporating five core modules as follows:

1. Increasing awareness of emotional experiences
2. Using cognitive reappraisal to rethink rigid emotional thoughts and attributions
3. Recognising and prevention of emotion-driven avoidance and maladaptive behaviours
4. Enhancing emotional awareness, mindfulness, and the role of physical sensations in emotion experiences
5. Exposing the client to both interoceptive and situations cues

(Barlow et al., 2010).

2.8.2 Current study

Barlow’s theoretical model was applied in developing the current intervention under examination. The core common mechanisms targeted in the current intervention are:
1) physiological symptoms; 2) emotion regulation; 3) behavioural deficits; 4) problem solving deficits; and 5) cognitive biases. This intervention concentrates on internalising disorders marked by avoidance, withdrawal, and maladaptive cognitions. It was intentionally devised to be as open as possible so as to represent a stepped care model. However, young people experiencing higher levels of distress and externalising disorders such as self-harm or suicidality would be offered alternative treatment options such as DBT.

**Content of group**

The content of the group is based on NICE guidance for recommended therapies and transdiagnostic maintaining factors in CBT models, such as Behavioural Activation, Problem Solving, Exposure, Habituation, Cognitive Restructuring and Goal Setting, and other third-wave therapies such as mindfulness. It differs from traditional group interventions by offering a unique individuated experience within the group. As such, personalisation of the skills is key and is particularly important since the broad age range involved encompasses variations in cognitive ability which requires the individualisation of skills.

Emotion regulation was addressed through psycho-education regarding the physical, behavioural, and cognitive components of an emotion. This was followed by normalising natural emotional responses to certain situations: for example, understanding that sadness is a normal and helpful response to loss. Mindfulness-based strategies were also used to enhance emotion regulation skills and participants were asked to practice various activities such as mindful breathing, mindful blowing of bubbles (which also helps to regulate breathing), mindful colouring, and mindful listening to music.

Physiological symptoms were also addressed through psycho-education, and used to highlight the biological basis of both anxiety and low mood response. Cognitive biases were targeted in session, wherein participants were taught to become more aware of their negative automatic thoughts (NATS), to label their NATS with unhelpful thinking patterns (thinking traps), and learning to challenge NATS with a cognitive restructuring technique (CR). This process also incorporated the interpretation and memory biases common across disorders. For example, memory biases for social anxiety arise in cases in which a client evaluating their performance will only remember the negative aspects, while interpretation biases for anxiety
occur in cases where clients notice physical sensations and attribute this to real danger.

Behavioural deficits were targeted by utilising behavioural activation (BA) and graded exposure therapy (ET). The role of avoidance and escape were taught through psycho-education and understanding responses linked to their cognitive, physical, emotional, and behavioural components (CBT model). Participants were encouraged to work towards their goals and values by using goal-directed behaviours as opposed to mood-directed behaviours. Problem solving (PS) abilities can be diminished when individuals feel overwhelmed with emotions. This technique was introduced as a tool to aid in the treatment process. Garcia-Escalera et al., (2016) found that studies utilising this technique were associated with greater reductions in symptoms of depression.

In view of the above, this intervention is utilising the theoretical model of the UP programme, whilst also incorporating evidence-based techniques that have been found effective. In this way, this transdiagnostic group intervention is targeting how youths respond emotionally to a set of different disorders.

The disorders evaluated for this study comprised separation anxiety, social anxiety, generalised anxiety disorder, panic disorder, and major depression.

### 2.8.3 Overview of the Current Intervention

The aim of the “Mind and Mood Group” intervention is to target adolescents experiencing common mental health conditions and overall wellbeing through a six-session psycho-educational and skills-based transdiagnostic CBT-based group, which incorporates an individual component within the group setting.

**Group outline:**

- Orientation session: conducted in pairs - try to match participant pairs by similar age
- Formulation: what keeps me stuck and starting to make a change (goal setting), awareness of emotions, and physiological symptoms
- The role of avoidance in maintaining low mood and introduction to BA
- Review of BA and introduce PS.
- Exposure, habituation, and recognising safety behaviours, and introduce ET
- Catching NATS, awareness of thinking traps, and CR
- Coping, Resilience, and Relapse Prevention.

Each session will conclude with facilitators modelling making a change and selecting a goal to work towards over the coming week. Participants will also be encouraged to choose a goal they personally value to work towards. At the beginning of each session, this will be reviewed and modelled by the facilitators. Refer to Appendix A for full group session content.

2.8.4 Research Questions and Hypothesis

Table 2.2 displays null and alternative hypothesis I, Table 2.3 displays null and alternative hypothesis II and Table 2.4 displays the null and alternative hypothesis III under examination in this study.

Table 2. 2

Hypothesis I

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Alternative Hypothesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants will not cross clinical thresholds for overall symptoms of common mental health conditions and individual specific disorders measured.</td>
<td>Participants will cross clinical thresholds for overall symptoms of common mental health conditions, and individual specific disorders measured.</td>
</tr>
</tbody>
</table>

Table 2. 3

Hypothesis II

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Alternative Hypothesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>There will be no statistically significant decrease in mean scores for overall symptoms of common mental health conditions and individual specific disorders measured.</td>
<td>There will be a statistically significant decrease in mean scores for overall symptoms of common mental health conditions and individual specific disorders measured.</td>
</tr>
</tbody>
</table>

Hypothesis I will be tested using the RCADS pre and post intervention data points. RCADS symptoms specific disorder subscales (mini trackers), while pre- and post group intervention scores will be used to test hypothesis II.
Table 2. 4

**Hypothesis III**

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Alternative Hypothesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants will not achieve reliable change for social anxiety, panic disorder, GAD, separation anxiety, and major depression post intervention.</td>
<td>Participants will achieve reliable change, for social anxiety, panic disorder, GAD, separation anxiety, and major depression post intervention.</td>
</tr>
</tbody>
</table>

This hypothesis will be measured by pre-and-post group intervention scores following the guidelines for reliable change calculations on the RCADS, (Chorpita, Moffitt and Gray 2005).

These following questions will be measured by participants qualitative feedback upon completion of the group intervention.

**Question 1:**

*Will young people find this intervention meaningful?*

**Question 2:**

*Will the skills component of the group help young people to manage their symptoms more effectively?*

Additional information that the project intends to examine include:

- Does attendance (number of sessions) influence outcome?
- Does gender affect outcomes?
- Acceptability and dropout rates.

Symptoms of common mental health conditions in young people are rising and services with limited resources are under pressure to effectively manage this increase. Parents are increasingly frustrated by long waiting lists and access to services when their young people are in need of support, (“The Big Picture”, 2017).

In summary, this study will therefore evaluate the usefulness of implementing an adolescent transdiagnostic CBT group intervention for common mental health conditions within an ROI CAMHS setting. If found to be effective, the goal of this research is to roll out this intervention on an ongoing and nationwide scale. This would initially enable services to implement low level input with minimal therapist
support, following a stepped care model. It would also add to the growing evidence-base in this field of treating transdiagnostic symptoms as opposed to individual manualised programmes for separate mental health conditions.
CHAPTER 3: METHODOLOGY

3.1 Chapter Introduction
This chapter will provide a framework supporting the use of a mixed methods research design approach. It will outline the rationale underpinning the quantitative and qualitative project design and data collection. An outline of the rationale for sampling procedures and participants who took part in the research component of the intervention will also be formulated. It will demonstrate the procedures used during data collection and a summary of the data analysis processes from both quantitative and qualitative perspectives. In conclusion the chapter will reflect upon the ethical considerations of the current study.

3.2 Rationale for Research Methodology
The aim of this research is twofold: firstly, to evaluate the effectiveness of the group intervention; and secondly, to explore the experiences of those who took part in the group intervention from the young people’s perspective. During the implementation of the pilot study, qualitative data was gathered by face-to-face interviews both with the young people who attended the group intervention and with their parents. The perspectives of those receiving the intervention is of utmost importance when evaluating outcomes of a new intervention.

As this study aims to evaluate the effectiveness of a group intervention for transdiagnostic symptoms of common mental health conditions, a quantitative design was devised in the first instance, and a secondary qualitative design applied thereafter.

3.2.1 Quantitative Design
A quantitative design was selected to test the hypotheses as outlined in the previous chapter. The aim of testing the hypotheses is an attempt to reject the null hypotheses and accept the alternative hypotheses. Determining absolute truths regarding hypotheses is the central principle of scientific research. This can be achieved in two ways: by incorporating observed natural occurrences in natural settings (correlational or observational research methods); or by manipulating variables to observe the effects (experimental research methods) (Field and Hope, 2003).
An experiment was therefore devised to test the causal relationship between the dependent variable (outcome) and the independent variable (anything the experimenter proposes as a cause to the outcome). The dependent variable being measured in this study is outcome (effect - reduction in symptoms of common mental health conditions), and the independent variable is the group intervention (cause). A repeated measures design (pre- and post-intervention measures) will establish whether the independent variable had an effect on the dependent variable.

True experiments in scientific research incorporate a control condition in cases where the experimenter has full control over the manipulation for cause and effect. For example if a true experiment was implemented in this current study, it would compare treatment effects with a control comparison group. Figure 3.1 below demonstrates what this design may look like:

Random Allocation - Group A:

Random Allocation – Group B:

*Figure 3.1. Example of a True Experimental Design*

With this design it is more likely that any effect measured can be reliability attributed to experimenter manipulation. However, in clinical practice it is not always feasible to conduct true experimental designs.

While this design was considered for the current study, the services involved in the recruitment and implementation of the intervention meant it was not feasible. Moreover, the clinical team held it would be unethical for clinical practice. As many studies implement this design, this led to considerations in terms of changing the “no treatment condition” to a “treatment as usual” condition. However, due to time and clinical practice constraints, this design was not deemed applicable at this time. Rather, a quasi-experimental design was deemed the best fit for services, participants, and the researcher. The quasi-experimental design chosen was a one group pre/post repeated measures design as illustrated in Figure 3.2:
Repeated measure designs are economical to run in terms of time and effort and are sensitive to differences between conditions since the same participants are used. When properly controlled, this design is more likely to reveal any existing effects of intervention as opposed to independent measure designs (Field and Hope, 2003). The aim of any experimental research design is to ensure that validity (produce valid results), reliability (results can be replicated), and generalisability (findings have a wider applicability) are present. The current study attempted to address all three elements as will be discussed in the discussion chapter.

### 3.2.2 Qualitative Design

In order to gather richer data from the participants’ perspective, qualitative methods were also incorporated in the study. According to Grix (2010), qualitative research discovers sense-making and meaning ascribed to experiences from individual perspectives. Qualitative research is an exploratory approach, which is open-ended to provide detailed data and can be interpreted in a number of different ways. When planning a new intervention, it is essential to involve a representative sample of the targeted population. In its simplest form qualitative data is derived from spoken or written words as opposed to statistical information. As such, it seeks to identify meanings within context by establishing patterns in data and applying relevant interpretations. While qualitative research is arguably more subjective than quantitative research, it nonetheless offers research instruments which enable questions such as those outlined in Chapter Two to be answered. In their research evaluating outcomes following intervention for young people, Edbrooke-Childs et al., (2018) highlighted the importance of gathering the perspectives from the individuals receiving intervention, combined with quantitative data. Quantitative research cannot tell us whether young people find this intervention meaningful or whether the group outline (i.e. the skills component within the group setting) actually helps the young people to feel more involved and utilise the skills for better adherence.

**Experiential versus Critical Qualitative Research**
Experiential qualitative research rests on the perspectives, views, and meanings elicited in the data. Thus, the interpretations expressed from participant perspectives are prioritised and accepted and the researcher does not analyse the data in any other way. Critical qualitative research, on the other hand, builds on the experiences revealed in the data to explore other phenomenon. As such, it attempts to understand factors which may influence the experiences expressed in the data, (Braun and Clarke, 2013). For the purposes of this study experiential qualitative research was chosen since the primary aim is to elicit the perspectives of the young people who participated in the intervention. In order to fully answer the research questions, it was deemed imperative that their perspectives be heard and prioritised. Thematic analysis (Braun and Clarke, 2006) was thus held to be the most suitable approach using a data driven inductive approach it allows patterns and themes to be identified within the collected data.

3.3 Section A: Quantitative Analysis

This study aims to implement a pre-post intervention and repeated measures quasi-experimental design. The mixed methods research design is devised to evaluate the effectiveness of this brief transdiagnostic group intervention for adolescents.

3.3.1 Descriptive Statistics

Descriptive statistics will be used to summarise the data from the sample population.

3.3.2 Parametric Versus Non-parametric Tests

Parametric tests are predicated on the assumption that data is normally distributed. Non-parametric tests have fewer assumptions about the data and do not require data to be normally distributed as they assign each raw data with a single number; for example, the lowest raw data would be assigned number one, the next highest number would be assigned number two, and so on. Parametric tests have more statistical power than non-parametric tests. Therefore, a parametric test is more likely to detect a significant effect in the data when one truly exists. If the data in a non-parametric test is dispersed this test may not provide valid results (Field and Hope, 2003).

For the purposes of this study the parametric test, paired sample t test, was chosen as the best fit to analyse the current data.
3.3.3 Paired Sample *t* Test

This test was chosen as it compares two means using the same participants, (repeated measures). As such, it can test the continuous dependant variable of symptom severity against the categorical independent variable of time (pre- and post-group intervention).

3.3.4 Statistical Power

Statistical power is a calculation to determine the effect sizes observed in data. If the value of an effect seen in the data is $r = .5$ or more, the researcher can be confident that sufficient statistical power was achieved. However, if the value is less the experiment may need to be replicated using a greater number of participants, (Field and Hope, 2003). “Based on Cohen’s (1992) guidelines with a standard alpha level of .05 and recommended power of .8 then 783 participants would be needed to detect a medium effect size and 28 participants would be required to detect a large effect size” (Field, 2009, p58). This current study aimed to use a sample of 84 participants.

3.3.5 Reliable Change

Research from CORC suggests that reliable change is a more meaningful analysis of data for this targeted population. Reliable change is calculated on an individual level which analyses scores using the internal consistency of the subscale with the standard deviation of the final included sample at the first point in time (Edbrooke-Childs et al., 2018). For the current study a reliable change criterion was calculated for each subscale of the RCADS following the guidelines and scores from Chorpita *et al.*, (2005) as demonstrated in Table 3.1:

Table 3. 1

*Reliable Change Criteria for Males and Females Specific to Age*

<table>
<thead>
<tr>
<th>Separation Anxiety</th>
<th>Social Anxiety</th>
<th>GAD</th>
<th>Panic Disorder</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-14yrs =</td>
<td>13-14yrs = 4.97</td>
<td>13-14yrs =</td>
<td>13-14yrs =</td>
<td>13-14yrs =</td>
</tr>
<tr>
<td>3.72</td>
<td>3.54</td>
<td>4.57</td>
<td>6.26</td>
<td></td>
</tr>
<tr>
<td>15-16yrs =</td>
<td>15-16yrs = 6.81</td>
<td>15-16yrs =</td>
<td>15-16yrs =</td>
<td>15-16yrs =</td>
</tr>
</tbody>
</table>
Reliable change measures symptom improvement using the figures above which are unlikely to occur due to measurement error. Participants who scored equal to or greater than the reliable change criterion at this point were deemed as reaching “reliable change” and participants not crossing the reliable change criterion were deemed as “no reliable change”. Various research into the use of outcome measures for children and young people, such as Edbrooke-Childs et al., (2018), Wolpert et al., (2016), Chorpita et al., (2005), suggest that reliable change may be more clinically and individually meaningful compared to statistical measures that yoke group scores together. Thus, while the use of group means is a powerful tool to establish efficiency of interventions and effect sizes, it is possible for individual improvement or no improvement to be exaggerated or dismissed within this data.

Upon examining a systematic review carried out by Edbrooke-Childs et al., (2018) on the use of reliable change as a means of evaluating treatment effects, it became clear that this analysis is currently in its infancy. The author identified six studies in the adolescent literature that used this approach (Edlund et al., 2016; Jónsson et al., 2015; Biegel et al., 2009; Hayes et al., 2011; Queen et al., 2014; and Nilsen et al., 2015) and one study in the adult literature (Talkovsky, et al., 2017), thereby confirming a significant gap in the literature in terms of the evaluation of treatment effectiveness for children and young people.

3.3.6 Summary of Statistical Analysis

Descriptive statistics will be used to summarize the data and explore trends in the data such as gender and attendance. Parametric paired sample t tests will be used to compare means using a repeated measures design (pre and post intervention) to test
for statistical significance and effect sizes for phase two which has a larger sample size than phase one.

Scores from the Revised Child Anxiety and Depression Scale (RCADS) will be converted to T scores. T scores will establish whether participants scores Cross Clinical Thresholds (CCT). RCADS disorder specific subscales (symptom trackers; mini RCADS) will track symptoms of major depression, panic, GAD, social anxiety, and separation anxiety disorders. T scores will establish whether participants CCT for disorder specific conditions. Using the scoring programme for the RCADS, Reliable Change (RC) will be measured to assess individual level improvement (Chorpita, Moffitt and Gray (2005)).

3.4 Section B: Qualitative Analysis

A range of qualitative approaches were considered for this study. Many approaches under the umbrella of qualitative research are suitable to accomplish its aims including thematic analysis, interpretative phenomenological analysis, and grounded theory.

3.4.1 Thematic Analysis

For the purposes of this current study, thematic analysis was chosen as the most suitable approach to answer the research questions outlined in Chapter 2. This analysis is a method that identifies themes and patterns within the data, prioritises these themes and patterns, and does not attempt to interpret beyond this, as is the case with other approaches such as interpretative phenomenological analysis. The primary researcher for this study therefore transcribes the data; a lengthy process which enables the researcher to become familiar with the data and generate initial codes. Utilising an inductive data-driven approach, these codes, themes or patterns in the data can then be identified and reviewed.

3.5 Sampling

Participants in the current study were recruited from CAMHS and targeted young people aged between the 12 to 17 years old who were experiencing common mental health conditions. The intervention was open to young people both currently in service and new referrals. Young people were offered the intervention on the condition that they had symptoms of common mental health condition(s) and met
the inclusion criteria. While ideally participants would score above the clinical threshold on the RCADS, young people were also invited to the intervention group based on the clinician’s judgement of symptom severity. Adolescents who expressed an interest to attend the group intervention were also invited. The inclusion and exclusion criteria are outlined below.

3.5.1 Inclusion and Exclusion Criteria

Bearing in mind that persons not suitable for CBT and being offered this intervention may risk potential negative effects after treatment, and may delay an appropriate intervention being offered, (Myhr et al., 2007), the following inclusion and exclusion criteria were established for the group intervention:

**Participants who meet the suitability criteria for Cognitive Behavioural Intervention:**

- CBT is a recommended intervention for anxiety and depression (NICE, 2009; 2011)
- Participants can identify their thoughts in relation to their difficulties
- Participants can generate alternative thoughts
- Participants can identify and distinguish between different emotions
- Participants are willing to engage in out-of-session tasks
- Participants feel that the CBT model would be helpful (informed consent)
- Participants are experiencing co-morbid symptoms of anxiety and depression
- Participants can describe how they would like things to be different (‘SMART’ goal setting)

**Participants will meet the specific group suitability criteria:**

- Participants meet level of clinical significance on the RCADS and/or the clinical judgment of the assessing clinician indicates significant difficulty with common mental health conditions
- Participants can commit to attending a pre-group orientation session and six group sessions

**Exclusion criteria:**

- Difficulties are better explained by neuro-developmental conditions alone
- Difficulty is not recommended for CBT
• Participant presents with high suicidal risk

3.5.2 Sample Size
A total of seven intervention groups were facilitated across four CAMHS teams in the Southern Region of the ROI. Each group offered a maximum of 12 places, equating to offering a possible 84 young people an intervention. A total of N=51 participants provided consent for their data to be used for research purposes, of which (N=40) completed the intervention.

3.5.3 Sample Characteristics
Across phases one and two participants comprised 19 (47.5%) males and 21 (52.5%) females between the ages of 12 and 17 years of age. All participants were attending secondary school and experiencing symptoms of common mental health conditions such as depression and anxiety.

3.6 Recruitment
Clinicians working in CAMHS were furnished with group information leaflets, while each service created their own referral sheet requesting information such as name, date of birth, main clinician, presenting problem and maintaining factors (Appendix C). Clinician’s offered the intervention to young people they deemed suitable for the group in adherence to inclusion and exclusion criteria. Each young person was invited to attend an orientation session following their expression of interest in the group.

3.6.1 Orientation
This session introduced the group outline and what to expect from the intervention. As such, it enabled the young person to make an informed choice about attendance. Orientation sessions were conducted in pairs, with young people matched by age on the referral information and offered a joint appointment. The session was carried out by two of the group facilitators in the same location and room as the intervention venue. The intervention was initially described in this setting to both the young people present and their parents, thereby allowing the participants to greet each other and ask questions. Once this element of the orientation was completed, the young people were separated and engaged in a one-to-one discussion with one of the group facilitators. This discussion established the presenting problem, maintaining
factors, and goals for treatment from the young person’s perspective. The potential participants were then given verbal information regarding the research component of the intervention. They were also supplied with written information and given sufficient time (one to two weeks) to make an informed decision about this element (Appendix D).

3.7 Procedure
Upon referral to the group all potential participants attended an orientation session, as outlined above. The young people then received six group sessions of psycho-education and CBT-based skills for the management of common mental health conditions. In each group session, the attendees were introduced to a new skill and asked to practice these skills in their everyday lives. Interim out-of-session tasks were also modelled by the group facilitators and reviewed at the beginning of each subsequent session.

3.7.1 Instruments used for Data Collection
The RCADS were the Routine Outcome Measures (ROMS) used in this study (Appendix E) as recommended by both the Child Outcomes Research Consortium (CORC) and Law and Wolpert (2014). They were deemed most appropriate since they are designed to give a broad perspective of difficulties and measure transdiagnostic anxiety disorders alongside symptoms of depression. Previous studies such as Barlow, (2010) and Queen et al., (2014) have successfully used these measures in their evaluations.

The RCADS is a 47-item self-report exploratory test for anxiety and depression in children and adolescents; which can be administered either to parents or the young person (8-18 years old). They yield a total score for anxiety and depression independently (mini RCADS), and a combined score for anxiety and depression (full RCADS), using a four-point scale as follows:

0 = never
1 = sometimes
2 = often
3 = always

Subscales of the RCADS allow for the symptoms of each disorder to be tracked individually using symptom trackers known as the mini RCADS.
Deemed reliable and valid (Chorpita et al., 2005), the RCADS are widely used measures for young people experiencing symptoms of anxiety and/or depression, with evidence of validity and reliability (Cronbach’s α=0.78–0.88 across the subscales) (Chorpita et al., 2000).

CORC highlight data is categorised as Flawed, Uncertain, Proximate, and Sparse (FUPS). Wolpert et al., (2016) took this into account but maintained that they still are the best available. Although ROMS are by no means perfect they can nonetheless assist in providing a baseline and monitoring treatment outcomes. Since this intervention seeks to target transdiagnostic symptoms of anxiety and depression and place less pressure on attendees to complete one inclusive measure, these were therefore deemed the most appropriate measure for the purposes of this study.

3.7.2 Section A: Quantitative Procedure
All groups completed pre-and-post measures (RCADS). Pre- measures were administered at the beginning of session one and post- measures at the end of session six. Symptom trackers of the individual disorders depression, panic, GAD, social anxiety, and separation anxiety, were analysed to assess symptoms for CCT and RC. The subscale for OCD was excluded from this analysis as the literature suggests that the aetiology and treatment for this disorder may be different to the other anxiety disorders measured by the RCADS, (Stein et al., 2010). In support of this, the DSM-V has removed OCD and PTSD from the original anxiety disorder chapter (American Psychological Association, 2013). In the stepped care model as outlined previously in Chapter Two, OCD is not recommended for low intensity treatment, (Clarke, 2011).

3.7.3 Section B: Qualitative Procedure
Participants’ experiences of the group intervention using qualitative methods was sought. Invitations for a short interview with the young person and a separate interview with their parent(s) were offered on completion of the pilot intervention groups. Participants were invited to provide written feedback for the rollout groups. The thematic analysis approach was adopted to analyse this data (Braun and Clarke, 2006). ROMS are useful but do not always capture a full picture as ROMS data can be flawed (Wolpert, 2016).
3.8 Data Summary
A total of 84 places were offered across the seven group interventions. A total of 51 young people consented to be research participants of which (N=40) completed the programme. Seven participants (13.7%) dropped out of the group intervention midway and four participants (7.8%) missed either session one or session six data collection points and therefore their data was incomplete and could not be used. Out of these 40 participants, 21 participants (52.5%) attended all 6 group sessions, 17 participants (42.5%) attended five out of six group sessions and two participants (5%) attended four out of six sessions.

3.8.1 Section A: Quantitative Data Summary
The data was analysed in two phases displayed in Table 3.3 below.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Stage</th>
<th>Groups</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Pilot study</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Two</td>
<td>Roll out following data-driven content changes</td>
<td>5</td>
<td>32</td>
</tr>
</tbody>
</table>

**Phase One** of the data utilised descriptive statistics, CCT and RC.

**Phase Two** of the data analysis included the paired sample $t$-test to test for statistical significance and effect size. CCT and RC were also examined.

For both phases of the study, the scores on the RCADS were converted to T scores to establish mean scores for participants. This was then converted to a graph using Excel in order to assess if participants CCT and/or reached RC pre- and post-group intervention, which provide a clearer indication of outcome from individual levels and may be more meaningful for the representation population and services.

3.8.2 Section B: Qualitative Data Summary
**Phase One** concerned the pilot study where eight participants, completed the intervention and provided consent for research purposes. Six young people who attended the group intervention and six parent(s) of the young people who attended the group intervention attended the post-group interviews, totalling 12 interviews (see Appendix F for an example of the interview schedule). The interviews were
scheduled for one week after the group ended and held on the same day and time of the group sessions for convenience. Participants were notified of their time slot via an appointment letter as per service policy.

**Phase Two** of the study involved five further group interventions where (N=32) participants completed the intervention and provided consent for the research component. Due to larger numbers and a restricted timeframe it was not possible to interview participants or parents separately. Upon group completion participants were asked to provide anonymous written feedback of their experiences of the intervention based on the questions asked in the original interviews (see Appendix G for an example feedback form). The researcher left the room during this phase in the hope of mitigating any potential bias, and the participants placed their completed feedback forms together in an anonymous pile.

The primary researcher duly transcribed this data which helped familiarisation with the data and the generation of initial codes. Using these codes, themes or patterns in the data were identified and reviewed. Thematic Analysis identified five core themes from the data set of the young people who attended the group. The core themes highlighted a variety of topics related to the experience of the group intervention which are fully presented in the results chapter. Thematic analysis for the parent(s) data set followed the same procedure of familiarisation with the data, generating initial codes, searching for themes/patterns within the data, and defining overall themes and sub-themes from the data. This data set identified three core themes which are also broken down into sub-themes and further elucidated in the results chapter.

**3.9 Ethical Considerations**

**3.9.1 Informed Consent**

Each participant was given a written consent form which required a signature from both the young person and their parent(s) (Appendix A), and an information leaflet (Appendix D). Younger participants were given an assent form alongside a separate parental consent form (Appendix I) and an information leaflet (Appendix D). During the pre-group orientation meeting the study was orally explained to the young person and parent(s). In addition, they received information about the group in written format. Each participant was given sufficient time to consider whether they wished for their data to be used in the study (approximately one to two weeks
prior to the group commencing). All participants were assured that consent for the use of their data would not impact on their place in the intervention.

In adherence to service protocols, participants were made aware that all personal information would be kept in their file and all identifiable information removed during analysis. Participants were also reassured that withdrawing from or declining to take part in the study would not affect future interventions which would ordinarily be offered to them by services.

3.9.2 Data Confidentiality

A Dictaphone was used to audio record individual interviews. All quantitative and qualitative data collected was encrypted and stored on a password protected computer.

During the transcription process participants were assigned a number and all identifiable information removed. Audio recordings would be destroyed on completion of the study and only research team members have access to the data collected. Consent forms and measures will be stored in the participants’ file in their service location as per service policy.

3.10 Conclusion

This chapter provides an outline of the procedures used and the methodological design chosen to best address the research questions and test the hypotheses. It discussed a number of issues relevant to data analysis and provided a rationale for the decisions made by the researcher. It also highlighted gaps in the current literature, such as reliable change. This chapter clearly elucidated each phase of data collection and analysis and concluded with ethical considerations and management of confidential materials for this vulnerable population.
CHAPTER FOUR: RESULTS

4.1 Introduction
This chapter highlights the findings for both the quantitative and qualitative components of the current study and has been broken into two phases accordingly.

Phase One captures the findings from the pilot study which included two intervention groups. During this phase the data was analysed for Crossing Clinical Thresholds (CCT) and Reliable Change (RC). Adaptations to the content of the group sessions were highlighted following the quantitative and qualitative findings from this phase. As the primary focus on this group intervention, these adaptations were made in an attempt to target transdiagnostic symptoms of common mental health conditions.

Phase Two of the study incorporated five further intervention groups into the adapted materials. Within this phase data was analysed for statistical significance, effect sizes, CCT, and RC.

4.2 Phase One: Pilot Study
Figure 4.1 provides a breakdown of participant retention rates for the pilot study. Data was analysed from the participants who gave consent and completed the intervention. A total of N=11 participants across two group interventions provided consent for data use for research purposes and eight participants completed the programme. Of these eight participants four attended all six group sessions and four attended five group sessions. Due to the small numbers involved, both groups’ data were ultimately collated and analysed together.

Data analysed N=8.

The final data analysed N=8 was deemed appropriate since both groups had the same lead facilitator, structure, timing, location, and layout.

Figure 4.1. Summary of participant retention rates
4.3 Section A: Quantitative Analysis

This data analysis was designed to test hypotheses I and III as follows:

**Hypothesis I:** To investigate whether a CCT in mean scores occurred post-group intervention for overall symptoms of common mental health difficulties and disorder specific difficulties.

**Hypothesis III:** To investigate whether participants reached RC criteria for symptoms of common mental health conditions upon completion of the group intervention.

Due to the modest sample size statistical analysis was not deemed appropriate for this phase of the study. Therefore CCT and RC were investigated. Descriptive statistics were used to summarise the data from the sample population and the data analysed using the Statistical Package for Social Sciences (SPSS, version 22).

**Descriptive statistics**

The participant ages were negatively skewed given the small sample size. In light of this, it was deemed more appropriate to display the frequency of ages within the current phase. Figure 4.2 below shows the numbers of participants in the pilot study as categorised by age.

The largest group comprised those aged 16 (N=3, 37.5%), while two were in the 15 year old category. All remaining categories comprised a single participant:

![Age categories](image)

*Figure 4.2. Number of pilot study participants in each age category*
The pilot study participants consisted of males and females. Figure 4.3 illustrates that the majority of participants were female (N=6, 75%) and the remaining two participants were males.

![Gender distribution](image)

*Figure 4.3. Breakdown of total numbers of males and females in the Pilot Study*

**Crossing Clinical Thresholds**

*Full RCADS*

In order to assess whether participant scores CCT, the group mean scores from the full RCADS and symptom trackers for disorder specific conditions were converted to T scores. Clinical thresholds for symptom severity were defined in three categories: 1) normal range; 2) borderline range; and 3) clinical significant range. Table 4.1 illustrates the levels of each of these ranges:

<table>
<thead>
<tr>
<th>Normal range</th>
<th>Borderline range</th>
<th>Clinical significant range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 65</td>
<td>65 - 70</td>
<td>70 +</td>
</tr>
</tbody>
</table>

Table 4.1

*Clinical Ranges for Symptom Severity Measured by the RCADS*

Figure 4.4 below shows that upon completion of the pre-group RCADS, participants scored in the borderline range (T=68.5), while upon completion of the group intervention participants scored in the normal range on the RCADS (T=63.8) for symptom severity. This confirms that the group participant mean scores (N=8) reveal that their symptoms reduced to the normal range of symptom severity:
Figure 4.4. Pre-and-post group mean scores for the full RCADS, Phase One

**Depression**

Figure 4.5 demonstrates that group mean scores for symptoms of depression pre-group intervention were in the borderline range ($T=67.87$) and post-group intervention scores reduced to the normal range ($T=63.12$).

This indicates that, as a group, the severity of depression symptoms decreased to normal levels following participant completion of the group intervention:

Figure 4.5. Pre-and-post group mean scores for depression, Phase One
Panic

The mean group score pre-group for symptoms of panic fell above the range for clinical significance (T=80) and with post-group (T=64.75). Participants (N=8) scored in the clinical significant range pre-group intervention, and upon completion of the group intervention, scores fell to within the upper level of the normal range for symptom severity, displayed in Figure 4.6.

![Figure 4.6](image)

Figure 4.6. Pre-and-post group mean scores for panic, Phase One

Overall findings for crossing clinical thresholds

The greatest effect was observed for symptoms of panic, with a large mean difference of (M=15.37). Symptoms of depression showed a lesser effect at (M=4.75) and for the full measure (M=4.7).

Reliable change

Participants who met the criteria as previously outlined in Chapter Three were deemed as reaching “reliable change”, while those who did not reach the criteria were deemed as “no reliable change”. Figure 4.7 illustrates the breakdown of RC achieved for each disorder specific category measured post group intervention.

The greatest effect noted for reaching RC was for symptoms of panic (N=6, 75%). This was closely followed by (N=5, 62.5%) for separation anxiety. Social anxiety demonstrated a RC index of (N=3, 37.5%), and the remaining disorders of GAD and depression each had (N=2, 25%) RC:
Overall Findings for Quantitative Data in Phase One

The group participants showed a general reduction in clinical scores, which was measured by CCT and RC. The most significant effect related to symptoms of panic and depression using CCT. This was followed by panic and separation anxiety using RC.

4.4 Section B: Qualitative: Thematic Analysis

Participants’ experience of the group intervention was analysed using thematic analysis (Braun and Clarke, 2006). Author transcription of the interview data enabled the researcher to become familiar with the content. Data was then coded across the complete dataset using a data-driven inductive approach (Boyatzis 1998). Using the computer programme NVivo the researcher examined the codes, coded the data, and began to identify patterns. A review of the codes and patterns drove the search for dominant themes in the data. These were then reviewed and subthemes identified. All themes and subthemes were then defined and named in an attempt to answer the research questions:

1. Will young people find this intervention meaningful?
2. Will the skills component of the group help young people to manage their symptoms more effectively?
**Attendance**

Participants (N=6) and six parent(s) of the group participants attended the post-group interviews, totalling (N=12) interviews. Figure 4.8 displays the themes identified in the data:

![Diagram](image)

*Figure 4. 8. Main themes identified in the data from the participant’s perspective*

These themes were further explored using thematic analysis and related sub-themes identified.

**Reactions to a Group Intervention:**

Reactions to group interventions capture peoples’ initial emotional response to the intervention at time of invitation along with how exposure can change such responses over time. In terms of this study, reactions to group interventions demonstrate how people gradually found their skills developing and how exposure to the intervention made this meaningful.

**Initial Perceptions of Attending a Group Intervention:**

The initial perception of attending a group intervention was found to be greater anxiety based on their own expectations. For example:

“I was nervous and thought, ‘oh, my god, what is really going on here?’”

*(Participant 6)*

However many of the participants who chose to attend the intervention shared a motivation to get better:
“When I was first asked a few months ago, I said no. Then I came around to the idea so I was open to it and interested. I need to accept that I have anxiety.”

(Participant 2)

Exposure:
Exposure to a pre-group orientation session which included meeting another young person helped to alleviate this initial anxiety:

“Meeting one other person before the group started helped to see a familiar face in the group.”

(Participant 1)

A number of participants then realised that confronting their fear head-on would gradually improve their anxiety levels:

“I was scared of being in a group with people I don’t know; but after a while it got better.”

(Participant 4)

“Being exposed to the group, it wasn’t as bad as I thought it was going to be.”

(Participant 6)

Altered Perceptions:
On completion of the group intervention, participants confirmed that they felt more confident:

“I’m a little bit more confident about it. Before really anxious, but now I can recognise that, yes, I am anxious, but not alone on that. Now I can go into group work and be my normal self.”

(Participant 6)

Participants also expressed a sense of mastery and personal achievement, and felt more positive about themselves and seeking help:

“I feel much better about group work than I used to. And if I know, and try my best in a group, then I will get a lot out of it.”

(Participant 3)

The Group Environment
After participants initial reactions to the group interventions had settled, the set-up of the group and the environment, the attendees and the space to share experiences were considered important aspects for the successful completion of the intervention.

“…so I tried it out and the first session was really good. So I was definitely, like, ‘yeah, right’, so I’ll go back again.”

(Participant 5)
A Relaxed Atmosphere:
Participants emphasised that the relaxed atmosphere of the group helped to foster a sense of ease which opened up their learning opportunities:

“Atmosphere was good and relaxed. The group was casual. If formal, I would have been extra nervous.”

(Participant 1)

The participants placed considerable emphasis on feeling relaxed and being able to engage in this environment:

“No pressure and relaxed; this was good.”

(Participant 4)

This was highlighted as an essential feature for modelling and learning to take place:

“I found it helpful that there were good vibes from everyone.”

(Participant 4)

“It’s nice that you kept calm. You are a very calm person so you are good with dealing with people, and you know what to say.”

(Participant 2)

Group Presentation:
The manner in which the group was presented and the materials used also had a positive impact for the young people attending the group:

“I liked the way the room was spaced out.”

(Participant 1)

The informal approach which used incentives to encourage engagement was also welcomed by the participants:

“I thought the idea of the buzzers were good, and the rewards for buzzing.”

(Participant 4)

It is imperative that young people can relate to the materials and ideas being presented to them:

“I thought the PowerPoints and videos were good.”

(Participant 5)

As in the ability to relate to the group facilitators:

“...facilitators were nice too.”

(Participant 1)

Shared Experiences and New Friendships:
Once participants were at ease in the physical environment of the group setting they felt more comfortable to relate their experience within the social environment of the group setting. Sharing experiences with others similar to themselves reinforced that they are not atypical in their symptoms:

“People getting to know each other and maybe their problems and same sort of things and emotions, helps to create a sense of security, others can relate to you.”

(Participant 3)

“It was nice meeting other people and having something in common with them.”

(Participant 1)

Attending a group intervention also reduced a sense of isolation for participants:

“I wouldn’t have improved as much without the other people in the group. I am in touch with two people from the group still, and this helps.”

(Participant 3)

**Key Learning from the Group**

After participants settled into the group environment they developed a sense of unity with the other participants based on an acknowledgement of common difficulties. As the initial anxieties observed in the emotional reactions to the group intervention began to ease, focus turned to what the participants had learned from the experience.

*Helpful Skills:*

The group delivered a variety of CBT based skills devised to help manage symptoms of common mental health conditions. Participants found the pace of learning beneficial:

“Learning a different skill each week, and not doing loads of things in one day, was really good.”

(Participant 5)

A number of common helpful skills emerged from this analysis. For instance, learning the fundamentals of responses from a CBT perspective and the interactions between cognitions, behaviours, affect, and physical sensations, equipped participants to look at these aspects of themselves in more detail. This link was identified by participants as particularly valuable:

“The behaviour experiment and breaking down the situation; even if I thought of this before - it was not to this detail.”
As participants felt better able to relate to the content and materials of the group, so their motivation to use the techniques increased:

“Behavioural experiments; I did that.”

(Participant 2)

Participant reports resonated with key skills that they could use in their daily lives:

“I found the behaviours helpful...helped to reduce unhelpful behaviours and thinking traps. The tunnel vision and jumping to conclusions were helpful.”

(Participant 3)

Awareness of Self:

As the group progressed, participants attained a deeper sense of themselves and an awareness of the difficulties they face which empowered them to use their new skills set:

“The different thinking traps that we fall into, and explaining how we get out of that... and the hot cross bun: they really stood out because I do them a lot, and it helped to recognise them.”

(Participant 6)

Such responses are crucial to being able to implement changes to manage symptoms of distress:

“We have tried a lot of things to try and help me that hasn’t worked, so I’m glad that this group has started to help.”

(Participant 3)

Participants reported increased recognition of their own patterns of unhelpful behaviours and/or unhelpful thinking patterns:

“I can identify that I’m falling into a thinking trap and do something different like to out and go for a walk to pull myself out of isolation.”

(Participant 4)

Moreover, this has a positive knock-on effect on mood and physical symptoms:

“The more I did, the more I realised it does work.”

(Participant 2)

Putting Outcome Measures into Context

During the individual interviews participants were provided with a copy of their pre- and post-group intervention scores in a line graph. Their initial thoughts and
emotions were then captured. Participants had the capacity to put their learning into context of their daily lives and ongoing stressors.

**Reflection on Increased Scores:**
Participants reflected on their outcomes of increased scores and provided additional context of their understanding of this as they began to notice different situations and induce different emotional states:

“I’m always extremely panicky, but looked forward to coming to the group. Overall stressful time...also had pre-exams and waiting for results from the pre-exams.”

(Participant 1)

External factors were found to play a role in the scores captured on the outcome measures:

“…not because of the group - I was happy with the group. But sad that I have to go back to people that I don’t really like in school.”

(Participant 5)

**Reflection of Decreased Scores:**
The remaining participants reflected on scores which had started to decrease post-group. This consolidated their efforts in using the techniques they had learned to help manage their symptoms:

“The decrease looks lovely. Surprised with the increase in Week 2, but happy that it is levelling out now.”

(Participant 3)

They could also contextualise what helped:

“…the past few weeks [I’ve] definitely able to think things through more clearly and notice unhelpful thoughts and feelings. I feel more in control of myself. The last few weeks I have been more logical. In Week 3 I started to practice the skills and this is reflected on scores.”

(Participant 2)

And what still needs to improve or change:

“It has helped my mood at home, but I need a balance with friends and socialising. It is not good. I haven’t gone out for ages”

(Participant 5)

This engendered a sense of self-empowerment within the young people:

“Before I would get panic and anxious, and then depression. This experience has helped me to step back from it all and identify the good things, and go out and do something different. It’s really good to see the improvements on the graph.”
Challenges
The group environment gave voice to meaningful change and positive experiences. However, as with any new intervention, attendant challenges must be considered.

**Difficulties with Content:**
A number of participants found certain aspects of the group content challenging and hard to resonate with. The thought-challenging session proved especially problematic:

> “Thought challenging not very helpful; and the timetable of mood tracking. I didn’t understand how this would help in general.”

*(Participant 1)*

The behavioural tracking diary was very detailed and proved hard to complete. Clearly, it is imperative that participants fully understand the materials provided so as to be able to transfer the skills and ideas to their daily lives. Participants also reported that some of the terminology used was hard for them to identify with:

> “…you could have explained some things better...more clarity needed with thought challenging; ‘balanced thought’ did not make sense”

*(Participant 6)*

**External/Internal Factors:**
Participants referred to ongoing outside stressors in their lives at the time of the group intervention:

> “Exams are getting closer. Panic is increasing. The year I am in is stressful.”

*(Participant 6)*

Additional pressures make it more difficult to use the skills in the uncontrolled environments that young people negotiate every day:

> “I have difficulties in school. I was happy with the group, but sad that I have to go back to people that I don’t really like in school.”

*(Participant 4)*

> “It has helped my mood at home, but I need a balance with friends and socialising. It is not good. I haven’t gone out for ages”

*(Participant 5)*

One participant revealed the internal stresses of partaking in the group:
“I felt angry with myself sometimes during the group. I felt at a loss for words, or not making a big enough contribution to the group.” (Participant 3)

Overall Findings for Participant Qualitative Data in Phase One

This data highlights the many challenges and rewards of partaking in this group intervention from the participants’ perspective. Participants found the intervention meaningful and felt it was a positive experience which had boosted their confidence levels. They were able to identify with the social aspect of the group and thus feel less isolated in their own experiences of common mental health difficulties. Skill usage outside of the group environment appeared to be dependent on immediate external factors, such as stressful examination times, during which participants felt less able to practice skill usage. Since it was held that parent(s) or main carer(s) would have a vital role in skill adherence, parental/carer data was also elicited through individual interviews.

Parents Perspective

The parent/carer(s) (N=6) of the young people who attended the group intervention were also interviewed to elicit their perspective of their charges’ experience of attending this intervention. The main themes identified are shown in Figure 4.9 below:

![Figure 4.9. Main data themes from parent/carer(s) perspective](image)

Attitude toward Group Intervention for Young People

Attitudes of the group intervention were captured from the parent participants. The parents highlighted support for group interventions encouraging an environment for
young people to address their mental health difficulties in unity. The type of group intervention offered also seemed of importance.

When faced with young people in need of support and services with waiting lists, the group intervention was welcomed by parents:

“I was very happy about it.”

(Parent 3)

On balance, parents felt that group interventions may be more meaningful for adolescents than individual therapies.

_Type of Group:_
A number of the parent(s) had prior knowledge of CBT and were delighted that this type of group was being offered to young people:

“I thought it was a good idea, especially that is was cognitive behavioural therapy.”

(Parent 6)

Many maintained that young people would learn valuable skills that they could use throughout their lives:

“I was delighted that is was a cognitive behaviour therapy group because I have done some myself. So I thought it would really help her.”

(Parent 2)

_Group Benefits:_
Parent(s) also welcomed the benefits of a group intervention:

“I was delighted. It would be good for her to see that other young people are in a similar position to her, you know?”

(Parent 4)

Parent(s) felt that it would illustrate to young people that they are not alone in how they are feeling,

“Part of the problem is socialisation and feeling isolated. So I thought it would help him to realise that he is not alone in how he is feeling and there are a lot of other kids that kind of feel the same way, and that would be beneficial for him.”

(Parent 3)

As the group would help to normalise issues for young people it was held they would feel less isolated:
“Just being in contact with others; experiencing the same things; knowing that, there’s less isolation.”

(Parent 6)

It was also felt that the group could target social avoidance:

“I think the experience of the group you can learn from other people and I think socially this is good for her because she wouldn’t really put herself into a situation so it was good for her to mix with others.”

(Parent 5)

**Noticeable Changes in the Young Person since Completing the Group**

Parent(s) reported their happiness with and support of the intervention offered to their adolescents and the changes they had started to observe in their son/daughters. A number of positive changes were discussed between parents, mostly individual to their young person. Areas discussed were better mood management:

“Her mood is better and she is more able to study.”

(Parent 1)

An awareness of becoming overwhelmed with emotions and what to do was also evident:

“If he is feeling overwhelmed with emotions he will take some time out.”

(Parent 3)

A build-up of confidence and forging new friendships was also observed:

“It has helped her confidence.”

(Parent 5)

“She has made a friend from the group, so that is good also”

(Parent 4)

There was a general sense that the young people felt more empowered to use their new skills to improve difficult situations and manage change:

“She missed school one day out of the whole time, which is amazing. That’s a huge improvement!”

(Parent 2)

“What she has learnt will stay with her and be able to use the equipment all the time. She has learnt how to manage changes.”

(Parent 6)

**Future Direction**

Parents were motivated to help and eager to become more involved in the group. They felt that, once group finished, their role would be important in helping their
young people to maintain and use the new skills.

**Communication:**

Parents maintained that it would be helpful to be informed of the skills their young person was learning week to week as this would better equip them to support the use of the skill at home:

“It would help if we know more about what happens in the group so we can help with what they are learning.”

(Parent 1)

“[A] feedback session would be helpful to support skills at home.”

(Parent 4)

**Parental Support:**

A number of parent(s) identified the need for more parental support during the intervention. This was suggested as a separate parent session:

“Maybe link in with parents one night during the group; that would help. Good to listen to other parents and help each other see what’s going on for other kids as well, and a bit of support. The conversation would be different without the kids in the room.”

(Parent 2)

There was some uncertainty about how the young people could continue to practice their new skills once the group had ended:

“She needs to practice the skills; a continuation group might be helpful.”

(Parent 5)

**Overall Findings for Parent Qualitative Data in Phase One**

Parents were satisfied with the intervention which was provided to their son/daughter. They noticed positive changes in mood and confidence, and the ability to deal with emotions and difficult situations more effectively on completion of the intervention. One concern raised by parents was the continued skill use once the group had ended. Parents were eager to get involved with the intervention to help with ongoing management of common mental health difficulties. Figure 4.10 highlights a summary of key words used to describe the group intervention:
4.5 Changes Made to Group Content Following Results
As outlined below, a number of adaptations to the content of group sessions were made following the quantitative and qualitative results of the pilot study:

1. The addition of exposure and habituation instead of behavioural experiments.
2. Behavioural Activation (BA) was simplified, i.e. a less detailed diary and clearer rationale of BA was provided and linked to young peoples’ lives.
3. As the terminology of BA was too adult-focused and participants could not identify with the classifications of routine, pleasurable, and necessary activities, in collaboration with the participants in the group session these classifications were rephrased as essential activities and mood-lifting activities. Such areas included stress-control elements, sleep hygiene, study, social, use of technology, parental demands, and so on.
4. The addition of “one thing different task” to complete each week based on the content from that session.
5. Following feedback on the difficulties of cognitive challenging, more emphasis was put on the think/feel connection and how situations and events are interpreted.

6. The addition of video clips, such as a clip from the film “Inside Out” to illustrate emotionality and a video clip about how events can be interpreted differently. This was implemented to target different learning styles within this setting.

7. Written handouts for each session were additionally provided to the young people attending the group and to their parents.

4.6 Phase Two: Roll-out to Additional Teams
The group was subsequently implemented across 4 CAMHS teams in the southern region of Ireland. Group material was modified in accordance with the above following participant feedback from the pilot groups. The group content was also adapted in order to target a wider range of symptoms and to incorporate a transdiagnostic group intervention.

4.6.1 Section A: Quantitative Analysis Phase Two
Descriptive Statistics
Data was tested for normal distribution, estimates of skewness and kurtosis were within expected limits, and scatter plots, QQ plots, and histograms demonstrated reasonable normality.

Data was analysed from the participants who gave consent and completed the intervention. Figure 4.11 provides a breakdown of participant retention rates for Phase Two of the study. A total of (N=40) participants across five groups gave consent for data use, four participants (10%) missed data points by being absent on either session one or session six and consequently their data could not be used and a further four participants dropped out of the intervention. Therefore, a total (N=32) participants completed the intervention and provided consent for data use.
The participants consisted of males and females. Figure 4.12 demonstrates that Phase Two of the study had a more even spread of male and female compared to Phase One. Thus, of the 32 participants, females were (N=15, 46.9%) and males (N=17, 53.1%).

Figure 4.13 below presents the number of participants in Phase Two of the study as categorised by age. The largest groups were those aged 16 (N=11, 34.4%), followed by 17 and 15 year olds each comprising of (N=7, 21.9%). There were four participants in the 14 year old category (N=4, 12.5%), the 13 year old category comprised two participants, and the 12 year old category comprised a single participant:
Figure 4.13. Number of participants in each age category in Phase Two

Across five group settings (N=16, 50%) of participants attended all six sessions, (N=13, 40.6%) attended five sessions, and (N=3, 9.4%) attended four sessions as illustrated in Figure 4.14:

Figure 4.14. Number of sessions attended by participants in Phase Two

**Trends**

Means, standard deviations, and confidence intervals were calculated on an excel programme in order to establish differences in mean reduction scores between gender and number of sessions attended. Overall reductions of symptoms of common mental health conditions were calculated using pre- and post- group intervention scores on the RCADS.
Outcome Variations between Genders

Table 4.2 below demonstrates that males were found to have a decrease in scores on the RCADS from pre-group intervention (M=66.82) to post-group intervention (M=57.59) with a mean decrease of (M=9.24). Females were found to also have a decrease in scores on the RCADS from pre-group intervention (M=79.80) to post-group intervention (M=64.87) highlighting a mean decrease of (M=14.93).

Table 4.2

Pre-and-post Group Variations between Gender, Phase Two

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Pre M</th>
<th>Post M</th>
<th>SD Diff</th>
<th>M Diff</th>
<th>CI (95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>17</td>
<td>66.82</td>
<td>57.59</td>
<td>0.23</td>
<td>9.24</td>
<td>9.13 – 9.35</td>
</tr>
<tr>
<td>Females</td>
<td>15</td>
<td>79.80</td>
<td>64.87</td>
<td>4.35</td>
<td>14.93</td>
<td>12.73 – 17.13</td>
</tr>
</tbody>
</table>

Note. N = number of participants, pre = pre-group intervention, post = post-group intervention, M = mean, SD = standard deviation, Diff = difference from pre-and-post group, CI = confidence interval range.

Outcome Variation for Number of Sessions Attended

To establish whether the number of session attended affected outcome, the group mean differences and standard deviations were calculated for participants who attended six, five, or four group sessions. Participants who attended four out of six sessions, displayed a mean decrease (M=27), from pre-group intervention (M=85.67) to post-group intervention (M=58.67). Participants who attended five group sessions demonstrated a mean reduction of (M=10.38) from pre-group intervention (M=72.54) to post-group (M=62.15). Participants who attended all group sessions displayed a mean reduction of (M=10.13) from pre-group intervention (M=70.81) to post-group intervention (M=60.69). Table 4.3 below summarises these results:

Table 4.3

Pre-and-Post Group Variations for Attendance, Phase Two

<table>
<thead>
<tr>
<th>Sessions attended</th>
<th>N</th>
<th>Pre M</th>
<th>Post M</th>
<th>SD diff</th>
<th>M Diff</th>
<th>CI (95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>16</td>
<td>70.81</td>
<td>60.69</td>
<td>2.56</td>
<td>10.13</td>
<td>8.88 – 11.38</td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>72.54</td>
<td>62.15</td>
<td>3.66</td>
<td>10.38</td>
<td>8.39 – 12.37</td>
</tr>
</tbody>
</table>
Statistical Significance

The current data was tested for normality, skewness, kurtosis, and differences between means. A Kolmogorov-Smirnov test was conducted and the ensuing data confirmed either a normal distribution or a reasonably normal distribution (see Appendix J for normal distribution analysis).

Paired-sample t-test for Common Mental Health Conditions

A parametric test (t-test) was used to examine the effectiveness of the group intervention and investigate whether statistical significance occurred (Hypothesis II). A paired-sample t-test was used to compare the means between subjects (repeated measures) over time. Table 4.4 presents the results of the t-test on symptoms of common mental health conditions as measured using the full RCADS pre- and post- scores:

<table>
<thead>
<tr>
<th>Disorder</th>
<th>M diff</th>
<th>SD</th>
<th>CI 95%</th>
<th>t</th>
<th>Sig *</th>
<th>Cohen’s d</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full RCADS</td>
<td>11.91</td>
<td>11.86</td>
<td>7.62 – 16.18</td>
<td>5.7</td>
<td>P = .000</td>
<td>1.00</td>
<td>Large</td>
</tr>
</tbody>
</table>

Note. M diff = mean difference from pre-and-post group intervention scores, SD = standard deviation CI = confidence interval range, sig * = significance two-tailed, Cohen’s d was calculated using the formula d = mean/standard deviation

A paired samples t-test was conducted to evaluate the impact of the intervention on participant scores on the full RCADS. This revealed a statistically significant decrease in full RCADS from pre-group intervention (M=72.91, SD=15.42) to post-group intervention (M=61.00, SD=15.54), t(31)=5.7, p=.000 (two-tailed). The mean decrease in full RCADS was 11.91 with a 95% CI (7.62 to 16.18). Cohen’s d statistic (1.00) indicated a large effect size.
Paired-sample t Test for Disorder Specific Conditions

Table 4.5 presents the results for paired samples t-tests conducted for the disorder specific mental health conditions of separation anxiety, GAD, panic disorder, social anxiety, and major depression. Each of these continuous dependent variables was compared with the effects of the categorical independent variable of time with two levels, (pre-and post-group intervention scores).

Table 4.5
Paired Samples T-test for Disorder Specific Conditions in Phase Two

<table>
<thead>
<tr>
<th>Disorder</th>
<th>M diff</th>
<th>SD</th>
<th>CI 95%</th>
<th>t</th>
<th>Sig *</th>
<th>Cohen’s d</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separation Anxiety</td>
<td>7.1</td>
<td>12.28</td>
<td>2.66–11.52</td>
<td>3.3</td>
<td>P=.003</td>
<td>0.58</td>
<td>Medium</td>
</tr>
<tr>
<td>GAD</td>
<td>7.25</td>
<td>9.8</td>
<td>3.72–10.78</td>
<td>4.2</td>
<td>P=.000</td>
<td>0.74</td>
<td>Medium</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>11.8</td>
<td>11.99</td>
<td>7.45–16.1</td>
<td>5.5</td>
<td>P=.000</td>
<td>0.98</td>
<td>Large</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>8.4</td>
<td>11.67</td>
<td>4.2–12.62</td>
<td>4</td>
<td>P=.000</td>
<td>0.72</td>
<td>Large</td>
</tr>
<tr>
<td>Major Depression</td>
<td>9.16</td>
<td>10.17</td>
<td>5.49–12.82</td>
<td>5.1</td>
<td>P=.000</td>
<td>0.9</td>
<td>Large</td>
</tr>
</tbody>
</table>

Note. M diff = mean difference from pre-and-post group intervention scores, SD = standard deviation, CI = confidence interval range, sig * = significance two-tailed, Cohen’s d was calculated using the formula d = mean/standard deviation

Paired samples t-tests conducted to evaluate the impact of the intervention on disorder specific mental health conditions, measured by participant scores on the RCADS as outlined below.

Separation Anxiety
Symptoms of separation anxiety showed a significant decrease from pre-group intervention (M=71.63, SD=11.86) to post-group intervention (M=64.53, SD=11.93), t(31)=3.3, p=.003 (two-tailed). The mean decrease from pre-group to post-group intervention was 7.1 with a 95% CI (2.66 to 11.52). Cohen’s d statistic (0.58) indicated a medium effect size.
GAD
Symptoms of GAD showed a significant decrease from pre-group intervention (M=58.72, SD=11.93) to post-group intervention (M=51.47, SD=13.4), t(31)=4.2, P=.000 (two-tailed). The mean decrease from pre-group to post-group intervention was 7.25 with a 95% CI (3.72 to 10.78). Cohen’s d statistic (0.74) indicated a medium effect size.

Panic Disorder
Symptoms of panic showed a significant decrease from pre-group intervention (M=77.47, SD=18.2) to post-group intervention (M=65.69, SD=17.6), t(31)=5.5, P=.000 (two-tailed). The mean decrease from pre-group to post-group intervention was 11.8 with a 95% CI (7.45 to 16.1). Cohen’s d statistic (0.98) indicated a large effect size.

Social Anxiety
Symptoms of social anxiety showed a significant decrease from pre-group intervention (M=62.53, SD=14.43) to post-group intervention (M=54.13, SD=14.2), t(31)=4, P=.000 (two-tailed). The mean decrease from pre-group to post-group intervention was 8.4 with a 95% CI (4.2 to 12.62). Cohen’s d statistic (0.72) indicated a large effect size.

Depression
Symptoms of depression showed a significant decrease from pre-group intervention (M=73.22, SD=13.75) to post-group intervention (M=64.06, SD=13.93), t(31)=5.1, P=.000 (two-tailed). The mean decrease from pre-group to post-group intervention was 9.16 with a 95% CI (5.49 to 12.82). Cohen’s d statistic (0.9) indicated a large effect size.

*Overall Statistical Findings for Phase Two*
Overall, there were statistically significant decreases for all disorder specific symptoms measured and overall symptoms of common mental health conditions with medium to large effect sizes noted. The findings therefore reject the null Hypothesis II and accept the alternative Hypothesis II.
Crossing Clinical Thresholds

Full RCADS

In order to assess whether participant scores CCT, the group mean scores from the full RCADS and mini RCADS for disorder specific conditions were converted to T scores. Clinical thresholds for symptom severity were defined into three categories: 1) normal range; 2) borderline range; and 3) clinical significant range, as outlined in Table 4.1 (Phase One). Participant (N=32) scores for the full RCADS were converted to group mean T scores to determine whether participants CCT (Hypothesis I).

Figure 4.15 demonstrates group mean scores for overall symptoms of common mental health conditions (full RCADS). Pre-group intervention scores were in the clinical significant range (T=72.9) and post-group intervention scores reduced to the normal range (T=61). This indicates that, as a group, the severity of mental health conditions decreased to normal levels after participants had completed the group intervention. This allows for a rejection of the null Hypothesis I and acceptance of the alternative Hypothesis I.

Disorder Specific Conditions

A breakdown of disorder specific symptoms measured by the mini RCADS pre-and-post group intervention were also investigated for CCT as illustrated in Figure 4.16 below:
Figure 4.17 demonstrates group mean scores for symptoms of separation anxiety, GAD, panic disorder, social anxiety, and major depression as measured by participants’ pre- and post-group intervention scores (mini RCADS). Pre-group intervention scores for separation anxiety were in the clinical significant range ($T=71.6$) and normal range post-group intervention ($T=63.9$). GAD scores were in the normal range pre-group intervention ($T=58.7$) and remained in the normal range post-group intervention with a decrease of 7.3 points ($T=51.4$). Pre-group intervention scores for panic disorder were in the clinical significant range ($T=77.5$) and post-group intervention scores decreased to the borderline range ($T=65$). Social anxiety scores pre-group intervention ($T=62.5$) and post-group intervention ($T=54$) began and remained in the normal range. Pre-group intervention scores for major depression began in the clinical range ($T=73.2$) and reduced to the normal range post-group intervention ($T=64.1$).

As such, a reduction in all disorder specific symptoms measured post-group intervention was established with CCT.

**Reliable Change**

The RC criteria was analysed (Hypothesis III) for (N=32) participants for disorder specific symptoms of GAD, panic, depression, separation anxiety, and social anxiety. Participants who met the criteria as previously outlined in Chapter Three
were deemed as reaching “reliable change”, while participants who did not reach the criteria were deemed as “no reliable change”.

The greatest rate of RC was noted for symptoms of social anxiety (N=22, 68.8%). This was followed by symptoms of major depression and panic disorder each displaying RC rates of (N=20, 62.5%). RC for symptoms of GAD displayed (N=19, 59.4%) and (N=17, 53.1%) for symptoms of separation anxiety. Thus the null Hypothesis III was rejected leading to the acceptance of alternative Hypothesis III. Table 4.6 summarises the rate of reliable change achieved for Phases One and Two of the study:

Table 4.6

<table>
<thead>
<tr>
<th>Summary of Reliable Change for Phases One and Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>One</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Panic disorder</td>
</tr>
<tr>
<td>Social anxiety</td>
</tr>
<tr>
<td>Separation anxiety</td>
</tr>
<tr>
<td>GAD</td>
</tr>
</tbody>
</table>

As can be seen from Table 4.6 the reliable change achieved per disorder is more consistent within Phase Two of the study in comparison to Phase One where the rates of RC vary across disorders.

4.6.2 Section B: Qualitative data for Phase Two

Participant’s experience of the group intervention was analysed using thematic analysis (Braun and Clarke, 2006). Author transcription of the feedback questionnaire data allowed the researcher to become familiar with the data. Data was then coded across the complete dataset using a data-driven inductive approach of Boyatzis (1998). Using the computer programme NVivo the researcher examined the codes, the coded data, and began to identify the dominant patterns. A review of
the codes and patterns led to a search for themes in the data. Themes were then reviewed and subthemes identified. These themes and subthemes were then defined and named in an attempt to answer the research questions:

1. Will young people find this intervention meaningful?
2. Will the skills component of the group help young people to manage their symptoms more effectively?

Upon completion of session six of the group intervention, participants were invited to provide written feedback of their experiences through a seven-question questionnaire. These questions were devised to maximise the capture data for all stages of the intervention from beginning to end. As it imperative to detect all factors contributing to young people attending a group intervention, as follows:

1. How did you feel about the idea of coming to the group before you came?
2. Did anything from the group stand out to you?
3. What was helpful about the group?
4. What was not helpful about the group?
5. Now you have completed the group how do you feel about having done this?
6. Would you recommend this group to a friend?
7. Anything else you would like to let us know?

Completion
Participants (N=31) provided written feedback for this phase of the study and four themes were identified in the data and explored further using sub-themes.

Perceptions of Group Intervention:
Perceptions of a group intervention captures the initial emotional response at being invited to a group intervention. These were found to mainly consist of anxiety and social fears, but also included annoyance and inconvenience of this type of intervention. While these initial reactions then progressed to a sense of motivation to get support, participants drew attention to many initial concerns in reference to being invited to a group intervention.

Apprehension:
There was a sense of participant anxiety and nervousness prior to attending the group intervention:
“I was nervous at the thought of being in a group of people. I thought I wouldn’t be able to go.”  
(Participant 24)

Being invited to a group intervention raised initial social concerns for participants:

“I was really nervous and scared about meeting strangers.”  
(Participant 30)

“No-one will talk and it will be awkward.”  
(Participant 29)

While there was clearly some uncertainty around expectations of the group, there was also some optimism that it may help:

“...really nervous because I didn’t know what we would be doing, I was hoping it would be useful.”  
(Participant 13)

Inconvenience:

Several participants stressed concerns about external commitments and the level of input required to attend a group programme:

“…anxious that I didn’t know anybody, and that I’d be missing some school.”  
(Participant 4)

There was a sense of annoyance and of participants feeling dismissed:

“Why bother?”  
(Participant 20)

“Hassle.”  
(Participant 12)

Pessimistic and Unsure:

Participants expressed misgivings that a group intervention is what they needed or whether it could actually help:

“Oh, dear god, what is this?”  
(Participant 19)

“This will be pointless.”  
(Participant 11)

Participants underscored concerns of not feeling heard or understood, and doubted that a group intervention would help them:
“It’s not going to work. It is pointless. There is no point. They don’t understand.”

(Participant 28)

**Determined and Motivated:**

Coupled with pessimistic feelings, there was also a sense of self-determination and motivation to make changes to assist in the management of symptoms of common mental health difficulties:

“This nervous, but determined to go, as I knew it would help my anxiety and low mood.”

(Participant 2)

There was a developing sense that facing their fears would lead to a reduction in their anxiety levels over time and the hope that the intervention would provide something useful:

“I was very anxious at first; but there was a part of me that said, if it would help with anxiety and learn about it then why not?”

(Participant 18)

“It may be effective.”

(Participant 26)

**Supportive**

After participants initial anxieties about the group intervention had been replaced by a determination and motivation to get guidance, the supportive nature of the intervention became a crucial aspect in successfully completing the intervention:

“Without this group I honestly don’t feel I would have made my first step to realising I need to change.”

(Participant 28)

**Caring:**

Participants emphasised that a supportive and warm group environment is essential to successful completion of the intervention:

“It was welcoming and easy to get used to.”

(Participant 9)

“It is a warm environment”

(Participant 19)

Such an environment helped to alleviate initial social fears:

“The people are really friendly.”
(Participant 13)

“Not everyone is an asshole. Some people are actually okay.”

(Participant 8)

Shared Experiences

Once participants felt at ease in the environment and social fears began to diminish, participants were better able to connect with others in the group:

“I found it helpful to know other people have the same thoughts.”

(Participant 30)

Participants came to realise that their symptoms were experienced by many different people:

“That everyone has the same problems as me.”

(Participant 7)

“[The] most random people all have same problem.”

(Participant 10)

Participants found this realisation helpful, and the sense of isolation was somewhat mitigated by understanding that mental health difficulties are common and the symptoms shared by many:

“It made me realise I am not alone.”

(Participant 9)

“I’m not alone.”

(Participant 10)

Advice to a Friend

Upon completion of the group intervention, participants were asked to reflect on their experiences of being in the group. They were asked to think about this in an external way by considering what they would say to a friend who was nervous about attending the group intervention. The majority of participants identified that their own thoughts and apprehensions about attending were worse than the group itself:

“That it is honestly not as bad as you think.”

(Participant 7)

There was also a recognition that anxiety will gradually reduce:

“I would say that it’s okay to be anxious and nervous, but it gets better and you learn so many useful skills.”
“...that after the first week he/she will feel more comfortable.”

(Participant 2)

There was also a sense of self-empowerment from the participants at this point:

“Give it a chance. Be yourself.”

(Participant 10)

“...just try your best”

(Participant 18)

One participant drew attention to the importance of being non-judgemental:

“Have an open mind, and don’t be quick to assume. Be open to the techniques.”

(Participant 5)

Moreover, participants were equipped to weigh up the pros and cons of attending:

“It’s good to go to it; you might get some skills so you kind of have to get over the nerves.”

(Participant 15)

“It’s only six weeks and has helpful information.”

(Participant 14)

What was Learned

Learning occurred throughout this environment, as participants noted anxiety reduces overtime and their initial perceptions and fears about the intervention had been heightened above the reality of the group. Once this experiential learning took place participants were better able to focus on learning the skills taught in the intervention. Thus, once initial anxieties were dispelled the capacity for new learning was extended.

Skills:

Many new skills were taught as part of the group intervention, and participants were able to take this on board:

“I found it was very helpful and I learnt a lot of different skills during the group”

(Participant 13)

Participants reflected on the skills which resonated most with them:
“I found the mood-lifters helpful, and problem-solving techniques.”
(Participant 2)

“Goal-setting and just changing one thing can make a big difference.”
(Participant 3)

“I learned to take a step back before reacting to a situation.”
(Participant 9)

Participant 6 found that:

“The activity diary it helped me being on track.

While Participant 14 highlighted utility of:

“...figuring out what from my usual week made me feel better and trying new things.”

Each participant was provided with session handouts and worksheets to assist in their skill usage outside of the sessions:

“The flow chart looks useful; sheets and handouts”
(Participant 22)

Structure:
Participants reported that they found the structure and layout of the group sessions useful:

“I think it has helped me learn how to break things/problems down so it’s easier to manage them.”
(Participant 26)

Setting weekly goals to achieve was also perceived to be of help:

“Goal-setting and just changing one thing can make a big difference”
(Participant 3)

Participants found it helpful to have a safe space were they could reflect on their own circumstances and let the external world fade away for a short period of time:

“It was nice to sit down for an hour and a half and just think about myself and ways I could help myself out”
(Participant 24)

Cognitive Processes:
This group underscored the “think/feel” connection and common thinking biases. Participants highlighted that these areas were helpful to learn:
“I thought it helped that I could relate to the thinking traps.”

(Participant 1)

“The thinking traps. I identified unhelpful thinking traps, and I can stop them in the future.”

(Participant 4)

Exposure:

It is clear that participants in the group learned a lot about anxiety and habituation in both theory and in practice. They reflected on their ability to manage their symptoms of anxiety:

“Feel the fear, and do it anyways.”

(Participant 28)

There is also an appreciation that knowledge and theory was helpful:

“Learning about the fight or flight response, and why it happens, and learning skills on how to deal with it, was helpful.”

(Participant 26)

“After the first week, it’s all uphill from there.”

(Participant 3)

Meaningful

The next important phase of the group for participants was the feeling of being able to manage their symptoms and effectively use their new skill set.

Beneficial:

As participants reflected on the group overall, what emerged from the data was a sense of empowerment and control:

“It has helped me take the first step to change; it has made things add up. Change is possible. We have choices.”

(Participant 28)

Participants were able to reflect on various areas that improved for them:

“The group has made me be able to feel less worried and identify my thoughts and how it effects my behaviours, sensations and emotions”

(Participant 2)

Management strategies were identified and put into context. As Participant 5 stated:

“It was very helpful. I learned quite a few strategies and effective ways of thinking that have proved to be extremely beneficial to me mentally”.

83
Participants 6 and 17 agreed:

“It was very interesting and it worked really well. For example, I don’t get angry as much now.”

“I am more calm and confident.”

There was also a sense that participants felt empowered when equipped with knowledge about their symptoms:

“I feel that is has actually helped me and I have a better understanding of my anxiety.” 

(Participant 21)

Valuable:

The majority of participants found the group intervention worthwhile. For example, several participants’ feedback was extremely positive:

“It was really helpful and useful; people just like you.”

(Participant 30)

“I think you were all really helpful and kind, and I would like to say that it’s worth it.”

(Participant 1)

“Keep doing what you’re doing😊”

(Participant 5)

“Thanks for making a group like this”

(Participant 8)

Participants became so comfortable and at ease in the setting that they began to express themselves socially:

“I wished the group lasted longer because it was fun and it was really interesting talking to new people.”

(Participant 13)

“Thanks - it has helped me a lot”

(Participant 18)

“It was worth doing it.”

(Participant 11)

Negative

It is also important to consider three participants provided negative feedback and did not find the group useful. These participants found the group boring and awkward:

“Bring your phone so it’s not awkward.”
Overall Qualitative Findings from the Participants' Perspective in Phase Two

Overall the adolescents were positive about the intervention. They felt empowered to make changes in their daily routines. Participants noted an increase in confidence levels, a decrease in feeling anxious in social settings, and the knowledge that anxiety will reduce over time. They reported using the skills taught in the group. They all stated that they would feel less nervous about group work in future. Only three of the 31 participants stated that they found the group boring and unhelpful.

4.7 Conclusion

This chapter has clearly defined the phases of the study. It provided quantitative analysis at each phase. The statistical tests incorporated were reliant upon the number of participants within each phase. It included statistical analysis, paired sample t tests with a larger sample size (Phase Two). For both phases, CCT and RC were analysed. Findings from Phase One led to group session content adaptations in order to target a more inclusive transdiagnostic approach. Phase Two highlighted the statistically significant finding in the reduction of common mental health conditions post-group intervention, and also for the disorder specific conditions of panic, social anxiety, GAD, depression, and separation anxiety. Clinically meaningful change was also found for rates of reliable change and the crossing of clinical thresholds.

The qualitative data was analysed by applying thematic analysis for phase one and two. The overall findings of this study conclude that young people value this intervention and felt empowered to use the skills learned therein to manage their symptoms more effectively.
CHAPTER FIVE: DISCUSSION

5.1 Introduction
A six-week transdiagnostic group intervention for adolescents demonstrated success for implementation in child and adolescent mental health services. The Mind and Mood group (M&M) is an intervention that places an emphasis on internalising disorders such as: anxiety and depression) and targets the common higher factors within and across separate disorders. The deployment focused approach to the current study alongside incorporating a stepped-care model with co-delivery by clinical psychologists bodes well for the potential dissemination of the intervention. Results from the three hypotheses examined show a reduction in symptom severity within and across disorders. Statistical analysis portrays that a post-group reduction in mean scores reached statistical significance for all disorders investigated with medium to large effect sizes. Clinical and statistical analysis both reveal a reduction in symptom severity from pre-to-post group intervention, measured by Crossing Clinical Thresholds (CCT), Reliable Change (RC) and the paired sample $t$-test.

Participants’ found the intervention meaningful. This was noted by their responses and their sense of achievement post-group intervention. The majority of participants stated that they would recommend this intervention to a friend and were pleased that this intervention was on offer. Within this data, participants’ depicted that they were able to reflect on their difficulties and use their skills to intervene and manage their symptoms more effectively upon completion of the intervention. The intervention retained good adherence, males and females were represented similarly within the sample, with a somewhat larger positive outcome effect size observed for female participants.

5.2 Summary of Quantitative Findings

5.2.1 Pilot Study:
The main results for this phase of the intervention showed a large reduction in symptom severity for panic disorder and a small reduction in symptom severity for major depression. Clinical analysis for group mean scores demonstrated a crossing of clinical thresholds from borderline to normal ranges post intervention.
The group intervention demonstrated reductions in participants scores from the borderline range to the normal range of symptom severity, with the largest reduction in symptoms of panic disorder. The IAPT initiative and evaluations by Clarke (2011) provide evidence for this finding. Under this initiative evidence-based low intensity CBT interventions targeted mild to moderate symptoms of anxiety and depression in adults with positive outcomes. As mentioned previously services in the UK and Australia have implemented a stepped-care model to provide the right level of support in a timely manner. Therefore, common mental health conditions, such as those tested in this study have been proven to respond to low intensity interventions. This probability was explored further in the subsequent phase of the intervention rollout. It is imperative when creating a new intervention programme that it is used effectively and for the right population and level of severity.

The results of phase one did not meet the overall aim of treating common mental health conditions in one brief transdiagnostic group intervention. Although there was a marked reduction in symptom severity observed in panic disorder, contributing factors such as natural or spontaneous recovery were not examined. However, the qualitative breakdown of participants’ experience of the intervention provided positive support for ongoing exploration. Thus, in order to target a transdiagnostic intervention, data driven adaptations of group materials were made (as outlined in chapter four).

5.2.2 Intervention Rollout with Adapted Materials:
Results from the three hypotheses examined demonstrated a reduction in symptom severity within and across disorders, thus, supporting a rejection of null hypotheses I (CCT), II (statistical significance) and III (RC).
Clinical analysis reveals a reduction in symptom severity by participants CCT post-treatment. Overall, crossing clinical thresholds group analysis demonstrate that participants’ symptom severity reduced from clinical significant levels to normal levels post-treatment. This replicated the findings from Queen et al., (2014) who demonstrated a symptom severity reduction to normal levels post-treatment. Although Queen and colleagues (2014) evaluated an individual adolescent treatment programme (UP-A), the same outcome measures (RCADS) were used as the current study and hence the clinical analysis cut off levels were identical. The current study
also replicates and further enhances the findings from Talkovsky et al., (2017) who calculated a clinical significant effect of 67.7 percent for their transdiagnostic (12 week) group programme with adults. As opposed to previous studies conducted in non-clinical settings this study was deployed in a mental health service and supports Weisz et al., (2015) inspiration to implement treatment programmes in the contexts for which they are intended. Therefore, the results to the current study demonstrate positive outcomes for this brief group intervention relative to real world clinical practices.

The importance of RC as a clinical measurement of change was introduced by Jacobson and Truax (1991).  RC for this study, validates a large number of participants who demonstrated symptom improvement over no improvement, beyond chance. Upon completion of the intervention, (n = 22, 68.8%) participants satisfied RC criteria for social anxiety, (N=20, 62.5%) participants satisfied RC criteria for both major depression and panic disorder. This was followed by (N=19, 59.4%) participants reaching RC criteria for GAD and RC for separation anxiety was noted at (N=17, 53.1%). This coinides with Talkovsky and colleagues, (2017) results of RC for symptoms of depression reaching 64.4 percent in their transdiagnostic 12-week group intervention for adults. Edbroke-Childs et al., (2018) evaluated reliable improvement rates for adolescents following treatment for anxiety and depression. They collected data from 75 child and adolescent services, where practitioners were trained by the CYP IAPT initiate to deliver evidence-based interventions and outcome monitoring (RCADS) between 2011 and 2015. With a sample size of (N=4465) they concluded a RC rate for depression of (44%), anxiety (53%) and comorbid anxiety and depression at (35%). Previous studies such as (Edlund et al., 2016; Jónsson et al., 2015; Biegel et al., 2009, Hayes et al., 2011 and Nilsen et al., 2015) report RC rates between 5-67 percent for youths post-treatment. All of these studies investigated reliable change for symptoms of emotional disorders, anxiety or depression in youths but used different therapeutic approaches, however they incorporated the RC index from Jacobson and Truax (1991) and therefore is comparable to this study. The findings of the current study both support and enhance the previous findings with a higher rate of RC for depression (62.5%) and anxiety disorders such as panic, social anxiety, GAD and separation anxiety had a RC rate ranging from 53 to 68.8 percent with this brief group intervention with a
smaller sample size to other studies for example Nilsen et al., (2015) had a sample of 113 participants. Clinically meaningful analyses such as CCT and RC enables service providers to be more transparent with expected outcomes when offering interventions. Young people will be more empowered to make informed decisions about their treatment options and parent(s)/carer(s) will be better equipped with realistic expectations.

Statistical significant effects were found for overall reductions in symptoms of common mental health conditions and each disorder specific condition tested. The results are consistent with Chu et al., (2016) who found statistical significant results in favour of their 10 week group intervention compared to a wait-list control group. Post-treatment effect sizes for the current study ranging between medium to large were observed. Large effect sizes were observed for overall symptoms (full RCADS) and symptoms of panic disorder, social anxiety and depression; medium effect sizes were detected for symptoms of separation anxiety, and GAD. These findings are consistent with the clinical significant findings outlined above and together support and augment Weisz and colleagues (2018) suggestion that the most comprehensive meta-analyses for randomised controlled trials (RCTs) for youth psychotherapies fall within the medium effect range. Collimore and Rector, (2014) found upon interviewing CBT clinicians that mood disorders such as anxiety and depression co-occur frequently and can have implications for treatment effectiveness. Due to this many clinicians would treat severe depression with a disorder specific intervention initially. The current intervention takes this into account and targets mild to moderate levels of common mental health difficulties; therefore, coinciding with the inclusion and exclusion criteria highlighted in chapter three individuals displaying severe levels of externalising symptoms such as self-harm or suicidal ideation were excluded from this intervention. The results of this study add to the literature supporting transdiagnostic approaches and fill the gap identified in the literature in reference to the scarcity of brief transdiagnostic group interventions for the adolescent population.

5.2.3 Rationale for Data Analysis
Statistical significance does not always equate to clinically meaningful change. While using group means is a powerful tool to establish effectiveness of
interventions and effect sizes, individual improvement or no improvement could be exaggerated or dismissed within this data. Evans et al., (1998) believe that individual level change should be conveyed as an addition to standard statistical group method analysis. Therefore, CCT and RC were deemed important for examining the hypothesis under investigation for this study. Wolpert et al., (2015) suggest that CCT and RC analysis could potentially be used concurrently to establish clinically meaningful change at an individual and service level, and statistical analysis could be conducted to inform policy level decisions. The results demonstrate that participants’ scores reduced and fell closer to the mean of the functional population for symptom severity post-group intervention.

5.2.4 Other Contributing Factors to Outcome

Many factors were not examined in the current study such as: spontaneous recovery, natural recovery over time, external circumstances, previous treatment, onset and duration of symptoms, and ongoing life stressors. However, the study was conducted over different timescales and the results have shown consistency over time. Therefore, greater confidence has been established for the reliability and validity of the intervention that changes observed have a causal relationship with the intervention. Other contributary factors to outcome such as: group dynamics, gender, number of sessions attended and symptom severity were explored in the current analysis.

*Group dynamics*

Group dynamics did not appear to have an effect on the outcomes observed in the current study. Norton and Kazantzis (2016) found that drop-out rates in groups were related to group cohesion. Prior to this finding, Oei and Browne (2006) assessed group cohesion and found no correlation between outcome and cohesion, supporting the findings of this study. All groups were similar in reductions in scores post-treatment. One explanation put forward for this finding is that the groups were run by the same lead facilitator who was also the researcher of this study. This indicates that fidelity to the intervention was a controlled and important variable among the groups.
**Age range**

Many treatment programmes target a particular age group subset within the population such as (Chu *et al.*, 2016) their transdiagnostic 10 session group intervention for BA and ET targeted 12-14 year olds leading to a disadvantage for other age groups within the population. (Ewing *et al.*, 2015) suggested that transdiagnostic CBT group interventions for adolescents between the ages of 15-18 years is scarce and needs more attention in future research. The average age over the interventions for the current study was (15.44 years old), the largest subgroup were between the ages of 15 and 17 year olds. The individualised skill component within the group aimed to facilitate the diversity of age and support participants to translate the skills on a personal level. This group was intentionally set up to include a wide age range and within the data analysis all participants benefited from the intervention.

**Gender**

The impact of gender was explored. The representation of the sample was reasonably spread consisting of (n = 21, 52.5%) females and (n = 19, 47.5%) males, these figures contradict previous research by Dooley and Fitzgerald, (2012) who purported that males were less likely to seek support in comparison to female adolescents. The data established an emerging trend that females exhibit a larger effect size post-treatment than males. Research has suggested that females are more likely than males to experience internalising disorders, and the findings of this study provide preliminary support for this phenomenon. Therefore, it is possible that this larger effect was observed in the female participants because they resonated with the content of the group at a higher level than males. Fink *et al.*, (2015) carried out a comparison of two cross sectional studies in England from 2009–2014. They highlighted more emotional problems (internalising symptoms) within the adolescent female population. Further explorations of this trend will need to be investigated with a larger sample size to establish if this trend has statistical significance.

**Attendance**

The number of sessions attended and outcome effects were investigated to establish the optimum number of group sessions. No clear trends emerged. Therefore,
optimum number of group sessions has not been established in this current study. Although treatment effects were established overall for the brief six session group intervention, more research will be needed with larger sample size to test for statistical significance and to establish the optimum number of sessions required. Norton & Barrera (2012), 12 week tCBT group for anxiety in adults; found positive results for severity of symptoms compared to a wait list control, Chu et al., (2016) found statistical significant results in favour of their 10 week group intervention compared to a wait-list control group. The current study has demonstrated both statistical and clinical significant results through quantitative data analysis alongside clinically meaningful results established through qualitative data analysis for the six week programme.

**Symptom severity**

The findings from phase one (CCT) suggested that the participants who benefited from the intervention where rated in the borderline range. These results were not replicated with in phase two of the study. The results from the rollout phase two found that participants rated in the significant range pre-treatment had a higher decline to the normal range than participants who scored in the borderline range and reduced to the normal range post-treatment. This supports the intention of the intervention to be open to all levels of symptom severity (with the exception of externalising symptoms as previously discussed) within and across common mental health conditions.

**5.3 Summary of Qualitative Findings**

Qualitative analysis of participants experience of the intervention, highlighted value for its implementation in child and adolescent services. The themes and sub-themes from the participants’ perspective highlighted their journey, from their initial emotional reaction of being invited to a group intervention, the challenges faced within the intervention, the outcome of the intervention, what they learned in the intervention and the importance of the group environment. The conclusion of these themes and sub-themes acknowledged that participants’ find the intervention meaningful. This was noted by their responses and their sense of achievement post-group intervention. Participants experience of the intervention was not caught by the RCADS, therefore, capturing qualitative data provides an extra depth to the
usefulness of the intervention from the young peoples’ perspective. Participants reported feeling more confident in their abilities to manage their symptoms post-treatment, this brought a sense of empowerment and fulfilment. One of the guiding principles for the CYP IAPT initiative places importance on young people being involved in the transformation of child and adolescent mental health services; and this study successfully incorporates this value. The majority of participants stated that they would recommend this intervention to a friend and were pleased that this intervention was fashioned.

Within this data, participants’ depicted that they were able to reflect on their difficulties and use their skills to intervene and manage their symptoms more effectively upon completion of the intervention. Thus, participants identified symptom improvement when practicing their skills outside of the group setting. Therefore, young people find the M&M group meaningful and welcome the skills component of the intervention. The participants reflected learning different skills and setting goals each week to work towards, which was modelled by the facilitators supported adherence to skill usage.

**Key findings from the themes identified**

Firstly, the emotional journey of being invited to a group intervention should not be overlooked. Initial perceptions of being invited to a group intervention raised a number of emotional responses for the participants, such as: anxiety, fear of social judgement, apprehension, uncertainty, annoyance, anger, feeling dismissed and misunderstood. It is imperative that mechanisms are put in place to help participants along this journey. However, once participants had time to think about their options, and provided with an orientation session where they met another young person of a similar age to them and the group facilitator, there appeared to be a shift in their perceptions. This shift included a motivation and determination to seek help and an optimism that it may be helpful. This process in the initial recruitment for the intervention supports the finding form MWS (2012) which identified lower mental health distress levels for adolescents who have the ability to open up about their difficulties. Inviting young people to an orientation session prior to the group commencing, allowed them to openly discuss their difficulties, acknowledge personalised treatment goals and provided young people with autonomy in decision making.
A second key finding among these themes was a sense of empowerment and an increase in confidence levels. McCann et al., (2012) found that young people who struggle to make sense of their situation can spiral down and use maladaptive coping strategies. This intervention approves this finding, and further supports and encourages the concept that young people equipped with knowledge and understanding can become more self-aware and utilise adaptive coping strategies. This was evident in both the findings for the qualitative data and quantitative data.

Another key factor that participants place value upon is the group environment. This environment provided a unity were participants felt comfortable and safe to share their experiences with other group members, MWS (2012) found higher rates of externalising behaviours in adolescent who do not seek help or talk about their difficulties. This environment helped to reduce the participants feelings of isolation and stigma. Through experiential learning participants learned to regulate their emotions and notice that anxiety naturally reduces over time. This furthermore increased a sense of hope and motivation to engage.

Finally, the participants highlighted difficulties with some aspects in the group content. Terminology of some CBT terms were adult focused and young people could not resonate with them. For example, the classification of routine, pleasurable and necessary activities identified in behavioural activation (BA). In collaboration with the young people during the group, terminology was adapted, such as the classifications in BA were changed to mood lifting activities and essential activities. For young people essential activities included a combination of routine and necessary activities such as: sleep hygiene, stress control, balancing social and academic demands, healthy eating and exercise among other areas. Mood lifting activities were any activities that provided a sense of enjoyment and/or mastery. Once the terminology of these phrases were changed the participants actively engaged in implementing BA. McCann (2012) highlighted that mental health literacy for the adolescent population needs to improve. The current study demonstrated one way to help improve mental health literacy for adolescents is to focus on terminology that young people can resonate with.

In summary, the qualitative findings in this study, provide an added aspect of effectiveness for the implementation of this brief group intervention. The findings support previous literature identifying young peoples’ perspectives of common
mental health difficulties. Given the right information and sense of autonomy young people welcome support and intervention. The group environment provides support and reduces feelings of isolation. This aspect was reflected in the data gathered and some young people stayed in touch once the group had ended. Future parental involvement would be a positive step towards supporting the findings from MWS (2012) that one adult can be helpful from well-being for young people.

5.4 Implications for Clinical Practice
Farrand, Perry, Lee and Parker (2006) report that the accessibility of evidence-based therapeutic self-help interventions such as CBT is limited for the adolescent population. The current study identified a necessity to modify terminology for young people from materials which are mainly adult focused. Young people will engage in help-seeking behaviour if they can resonate and find personal meaning in interventions. McCann, (2012) previously suggested that for the adolescent population, mental health literacy needs to improve. The current study adds to this concept further by eliciting adaptations of terminology from the young peoples’ perspective. Services need to take this onboard and adapt mental health terminology to suit its recipients.

Clinically meaningful analyses enables service providers to be more transparent with expected outcomes when offering interventions. For example, for adolescent’s attending this brief transdiagnostic group intervention, results predict approximately a 53-68 percent improvement rate for symptoms of common mental health conditions for adolescents. This proposes that this brief intervention has the potential of improving common mental health difficulties for at least half of the participants. Weisz et al., (2015; 2018) found that disorder specific treatment manuals are rarely used in everyday clinical practice. This may be attributed to lack of resources, extra demands on clinician’s and limited availability. Implementing this transdiagnostic group intervention, would save clinician time, cost and reduce the burden of learning different treatment programmes. It will aid waiting lists and is an intervention that both young people and their parents support and welcome.

5.5 Implication for Policy
Services are struggling to meet the growing mental health needs of the adolescent population. A Vision for Change, (2006) highlights this area as a priority, however
with a lack of resources the struggle continues. Policies need to broaden their scope and introduce the concept of transdiagnostic group treatment approaches for adolescents. The M&M group enables the common higher factors within and across disorders to be targeted, allowing for a generalisation of CBT skills. Findings from this study are in line with Barlow’s (2012) theoretical model the Unified Protocol (UP) for emotional disorders. The current study also adds to the literature by filling the gap for effective brief transdiagnostic group intervention for adolescents with statistical and clinical significant results in addition to clinically meaningful results. Transdiagnostic approaches like this hold great potential for the concurrent treatment of common mental health conditions in youths. Future research with the UP-A programme is underway, Jenson-Doss and Colleagues (2018) plan to implement a community study of outcome monitoring for emotional disorders in teens (COMET). The current intervention was written taking into account the theoretical underpinnings of the UP and was the first programme (to the authors knowledge) to be implemented in mental health services. Following a stepped-care model as outlined in chapter two and by implementing the M&M group routinely services would save valuable resources by facilitating this intervention with one lead qualified clinical psychologist/CBT therapist, supported by assistant psychologists.

5.6 Implications for Teaching

There is a key role here for the researcher to deliver training to clinician’s who wish to implement the M&M group in their service. As mentioned previously the researcher insured consistency in delivering the intervention across services with support from psychologists from each team, leading to treatment fidelity as a key factor in similar outcomes across group settings. Clinicians will be able to meet the comorbid needs of their clients and provide an inclusive and effective brief transdiagnostic intervention which combines evidence-based single strand interventions into one programme.

5.7 Strengths and Limitations

5.7.1 Limitations

As with any research, this current study has strengths and limitations. A small data set meant that the study was underpowered to detect anything but large effect sizes, however, in a trial such as this large effect sizes are what clinicians need. However,
medium effect sized were established within this data. Future research should attempt to replicate the current findings with a larger population sample size. This intervention was an experimental design without a control group condition. Therefore, it is difficult to establish if the changes in participants’ outcomes were due solely to the intervention or if other variables contributed to the outcomes observed. However, the qualitative analysis clearly shows that participants internalised the key skills developed through the intervention. This would indicate that the treatment would be effective for others in similar situations. Future research should include a control group to further evidence this by examining other variables that may contribute to the treatment outcomes such as previous treatment, systemic factors, social support, personal characteristics, external stressors, motivation to complete home practice tasks, alongside onset and duration of symptoms.

This intervention used one quantitative outcome measurement the RCADS. Although the RCADS are a widely used measure in the child and adolescent population research, with good reliability and validity, it would be useful to incorporate other measures to assess overall wellbeing. Participants qualitative data suggested an increase in confidence levels and self-awareness. The RCADS detect changes in participants symptomology of common mental health conditions, not overall functioning. Future research should consider incorporating other measures which are commonly used in this population alongside the RCADS such as the Outcome Rating Scale (ORS).

The current study investigated parental perspectives in relation to the intervention. Parents expressed an eagerness to be more involved. Unfortunately, due to restricted timelines in this study it was not possible to incorporate parental involvement. Therefore, future research should consider the addition of separate parental sessions, midway and upon completion of the group intervention.

Finally, the quantitative and qualitative data in the study cannot be linked. If these sets of data could be matched then the depth of the results would be richer. This was an oversight by the researcher. As the researcher was facilitating the group interventions, to reduce bias on the feedback questionnaires, the measures were anonymised and the researcher left the room during administration. Participants then folded their response and placed them in a circle pile in the middle of the room. Therefore, they cannot be identified which provides a safety for participants’
is more likely that honest feedback will be achieved. Though, the qualitative data has given valuable insights into the uptake of skills by participants, future research should enable both qualitative and quantitative data to be paired within the analysis. This would give a more in-depth understanding of the outcomes.

5.7.2 Strengths

Despite its limitations this study does provide positive results to add to the growing literature in this field. This study listened to and actioned the needs of young people in a CBT intervention. This was achieved by introducing a pilot study and adapting group session content succeeding the results. The intervention was implemented across a number of CAMHS in various locations in the ROI with a reliable pattern of outcomes.

Adolescents and their parents were very positive about engaging in this intervention, both noted positive changes in mood and confidence upon completion of the group. The orientation sessions were conducted in pairs, and this arrangement was welcomed by the participants and aided in reducing anxieties and fears about attending the intervention.

Retention rates proved to be in favour of adherence to the intervention. In phases one and two combined, a total of N=51 participants signed up to the study, (N=40, 78.4%) completed the program and (N=7, 13.7%) dropped out of the programme; three from phase one and four participants from phase two. A recent meta-analysis conducted over 115 studies for dropout rates in CBT established a 26.2 percent dropout rate during treatment (Fernandez, Salem, Swift and Ramtahal, 2015). Salmoiraghi and Sambhi, (2010) found a dropout rate ranging between 19-50 percent in a review of 14 CBT studies. Fernandez and colleagues, (2015) found the participants with the highest dropout rates during treatment consisted of those suffering from depression, anxiety and co-morbid symptoms of depression and anxiety. This current study demonstrates positive retention rates with common mental health conditions with a transdiagnostic focus.

Finally, the intervention is inclusive for a diversity of ages and common mental health conditions. Thus, enabling services to potentially run this intervention as regularly as needed and less burdensome on clinicians as they will not need to learn a variety of different treatment methods for disorder specific or age specific interventions.
5.8 Implications for Future Research
Further research will be needed with a bigger sample size to replicate these findings. A comparison condition would strengthen the results. Other variables that could potentially affect outcomes were not investigated in the current study, such as: previous treatment, onset and duration of mental health condition, and systemic factors.
Trends in the data seemed greater for treatment effects for female participants. A larger sample size will establish if this trend is statistically significant. This is important for the ongoing development of the programme for widespread dissemination in services. It may be appropriate to adapt the group content for male and females of certain ages, however, presently the data does not support further adaptations between these variables.
The current study demonstrated large to medium effect sizes and a randomised control trial (RCT) would provide valuable information on the validity of outcome effects observed currently. Therefore, future research should consider the use of a RCT, which are sparse in this area.
Parents are keen to be more involved and future research should consider the addition of a parental group session to facilitate young people to continue to utilise the skills post-treatment.
Previous research has highlighted minimum treatment gains upon completion of an intervention, for example: Weisz et al., (2018) found that a large number of youths do not recover following empirically supported treatments. A follow-up review group session should be considered to collect data post-treatment in future research.

5.9 Conclusion
This study demonstrated that the M&M intervention conducted with adolescents was successful in testing the feasibility and effectiveness of implementing a new brief transdiagnostic group intervention for adolescents, targeting common mental health conditions. Findings provide support for this intervention. The data collected show statistical and clinical significance with medium to large effect sizes in favour of the intervention. Rates of RC reached 53 – 68.8 percent. Given the small sample size results should be interpreted with caution. Nevertheless, this intervention proved viable and meaningful for the targeted population. Participants spoke
positively about the intervention and gained an awareness and insight into themselves, they were provided with a language and commonality for mental health conditions and their feelings of isolation reduced. Participants were empowered and motivated to manage their symptoms more effectively. A barrier for young people accessing services is stigma, routine group interventions will aid to reduce stigma and help to encourage a society of openness and support. Future research would benefit from implementing a comparison control condition and consider the use of other outcome measures alongside the RCADS and post-group intervention follow-up. It is anticipated that the M&M group could be implemented across adolescent services nationwide. To achieve this a larger sample population will be needed to generalise the results and inspire services to implement this new intervention. Overall these types of interventions will help reduce waiting lists and improve the psycho-social skills of adolescents.
REFERENCES:


## APPENDICES:

### Appendix A: Full Group Session Content

### Session 1

<table>
<thead>
<tr>
<th>Topic</th>
<th>Preparation</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaires whilst waiting (Full RCADS, consent forms)</td>
<td>Flip chart, flip chart pad, pens, projector, biro pens, sticky labels for badges</td>
<td></td>
</tr>
<tr>
<td>Welcome and Facilitators introduce themselves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain break / timings agenda for today</td>
<td>Flip chart overview sheet</td>
<td></td>
</tr>
<tr>
<td>Group guidelines</td>
<td>Slide and handout with guidelines, opportunity to add.</td>
<td></td>
</tr>
<tr>
<td>Ice breaker quiz</td>
<td>Powerpoint, buzzers, treat – in small teams buzz in if you recognise the celebrity</td>
<td></td>
</tr>
<tr>
<td>Overview of course</td>
<td>Slides and handout</td>
<td></td>
</tr>
<tr>
<td>This is not your fault – but it is yours to deal with (our tricky brains, evolution)</td>
<td>Finger puppet show! Rabbits and fox</td>
<td></td>
</tr>
<tr>
<td>Fight/Flight</td>
<td>Video clip demonstrating this response followed by group discussion, rate anxiety on scale for coming to the group (facilitators note ratings as will be referred to in a subsequent session).</td>
<td></td>
</tr>
<tr>
<td>Formulation — friend passing in the street</td>
<td>Flipchart passing in the street example.</td>
<td></td>
</tr>
<tr>
<td>Break 10 mins (here or after next task)</td>
<td>Drinks, biscuits.</td>
<td></td>
</tr>
<tr>
<td>Emotions and physical sensations</td>
<td>Use formulation to identify different emotions and physical sensations (video clip from inside out, understanding emotions) – followed by group discussion</td>
<td></td>
</tr>
<tr>
<td>Topic</td>
<td>Preparation</td>
<td>Lead</td>
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<tr>
<td>------------------------------------------------------------</td>
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</tr>
<tr>
<td>Welcome back and explain break / timings agenda for today</td>
<td>Flip chart, pens</td>
<td></td>
</tr>
<tr>
<td>Ice breaker - Quiz</td>
<td>Powerpoint, buzzers, treat, music quiz</td>
<td></td>
</tr>
<tr>
<td>Review of home practice rationale and facilitator examples</td>
<td>Flip chart, pens</td>
<td></td>
</tr>
</tbody>
</table>

**Session 2**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Preparation</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal Setting</td>
<td>Goal setting sheet – This week, this course (6 weeks), in 3 months, in 6 months (3 &amp; 6 can be completed as homework)</td>
<td></td>
</tr>
<tr>
<td>Mindful breathing space</td>
<td>Headspace – play video intro and a practice</td>
<td></td>
</tr>
<tr>
<td>Handouts</td>
<td>Homework folder, (should now contain for this session: Rules, Course overview, template formulation sheet, goals sheet, practice point sheet, session 1 information handout). Also parent information sheet on the session.</td>
<td></td>
</tr>
<tr>
<td>Home practice discussion in small groups and then feedback to main group</td>
<td>Role of behaviour in low mood, highlighting avoidance</td>
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</tr>
<tr>
<td>Introduction to low mood</td>
<td>Drinks, biscuits</td>
<td></td>
</tr>
<tr>
<td>Break</td>
<td>Brainstorm essential and mood lifting activities – introduce BA baseline diary</td>
<td></td>
</tr>
<tr>
<td>Introduce BA</td>
<td>Mindful blowing of bubbles</td>
<td></td>
</tr>
<tr>
<td>Mindfulness activity</td>
<td>Hand out therapy folders, homework sheets and feedback questionnaires</td>
<td>Homework folder, (problem solving worksheet, activity diary, practice point worksheet, session information handout). Also parent information sheet on the session</td>
</tr>
</tbody>
</table>

**Mind and Mood - Session 3**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Preparation</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome back and explain break / timings agenda for today</td>
<td>Flip chart, pens, powerpoint</td>
<td></td>
</tr>
<tr>
<td>Ice breaker quiz</td>
<td>Quiz questions and buzzers (film quiz)</td>
<td></td>
</tr>
<tr>
<td>Review of practice point problem solving and facilitator examples</td>
<td>Facilitators completed BA diary model of participants</td>
<td></td>
</tr>
<tr>
<td>Practice point review of activity diary worksheet</td>
<td>Facilitators to guide individually</td>
<td></td>
</tr>
<tr>
<td>What was happening sheet</td>
<td>What was happening sheet</td>
<td></td>
</tr>
<tr>
<td>Break</td>
<td>Water, drinks, biscuits</td>
<td></td>
</tr>
<tr>
<td>Activity list</td>
<td>Worksheet for essential and mood lifting activities</td>
<td></td>
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<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Hierarchy</td>
<td>Hierarchy worksheet</td>
<td></td>
</tr>
<tr>
<td>plan BA diary</td>
<td>BA diary</td>
<td></td>
</tr>
<tr>
<td>Introduce Problem solving</td>
<td>Introduce problem solving providing examples from the group</td>
<td></td>
</tr>
<tr>
<td>Mindfulness activity</td>
<td>Mindful colouring</td>
<td></td>
</tr>
<tr>
<td>Ask clients to add sheets to therapy folder</td>
<td>Homework folder, (should now contain for this session: what was happening sheet, activity sheet, activity hierarchy worksheet, and new BA diary, session information handout) Also parent information sheet on the session</td>
<td></td>
</tr>
</tbody>
</table>

**Mind and Mood - Session 4**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Preparation</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome back and explain break / timings agenda for today</td>
<td>Flip chart, pens, projector, laptop</td>
<td></td>
</tr>
<tr>
<td>Ice breaker quiz</td>
<td>Quiz questions and buzzers (famous people/groups)</td>
<td></td>
</tr>
<tr>
<td>Review of practice point rationale and BA diary and facilitator examples</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction to anxiety</td>
<td>Introduce anxiety – recap the fight/flight response,</td>
<td></td>
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<tr>
<td>Break</td>
<td>Water, drinks, biscuits</td>
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<td></td>
</tr>
<tr>
<td>Safety behaviours</td>
<td>Facilitate a group discussion of anxious actions, discuss long-term vs short-term consequences of behaviours</td>
<td></td>
</tr>
<tr>
<td>Introduce exposure and habitation</td>
<td>Refer to initial anxiety rating provided by participants in session 1 – any changes? Discuss as a group.</td>
<td></td>
</tr>
<tr>
<td>Plan exposure</td>
<td>Exposure hierarchy worksheet</td>
<td></td>
</tr>
<tr>
<td>Implement exposure</td>
<td>Plan home practice (one thing I can do different this week)</td>
<td></td>
</tr>
<tr>
<td>Mindful drawing</td>
<td>Mindful listening to music</td>
<td></td>
</tr>
<tr>
<td>Ask clients to add sheets to therapy folder</td>
<td>Initial thoughts on session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Homework folder, (should now contain for this session – exposure hierarchy worksheet, one thing different worksheet, session information handout).</td>
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<tr>
<td></td>
<td>Also parent information sheet on the session</td>
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</table>

**Mind and Mood - Session 5**

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<tr>
<th>Topic</th>
<th>Preparation</th>
<th>Lead</th>
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<tbody>
<tr>
<td>Welcome back and explain break / timings agenda for today</td>
<td>Flip chart, pens, laptop, projector, speakers, internet.</td>
<td></td>
</tr>
<tr>
<td>Ice breaker</td>
<td>Quiz questions and buzzers</td>
<td></td>
</tr>
<tr>
<td>Review of home practice task rationale and exposure task - one thing different task.</td>
<td>Facilitate group discussion and facilitators to give their examples also.</td>
<td></td>
</tr>
<tr>
<td>Introduction to the think/feel connection</td>
<td>Interpretation video clip</td>
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<tr>
<td>Introduce negative automatic thoughts</td>
<td>Group discussion</td>
<td></td>
</tr>
<tr>
<td>Common thinking traps –</td>
<td>Thinking traps guide - we all have them, which ones trap you?</td>
<td></td>
</tr>
<tr>
<td>Break</td>
<td>Water, drinks, biscuits</td>
<td></td>
</tr>
<tr>
<td>Thought challenging – the 5 steps – leading to home practice</td>
<td>Thought challenging booklet to go alongside PowerPoint example</td>
<td></td>
</tr>
<tr>
<td>Mindful activity</td>
<td>Choice of previous</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Homework folder, (should now contain for this session: extended thought record, session 5 handout, and thinking traps guide booklet and thought challenging booklet). Also parent information sheet on the session</td>
<td></td>
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</tbody>
</table>

## Mind and Mood - Session 6

<table>
<thead>
<tr>
<th>Topic</th>
<th>Preparation</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome back and explain break / timings agenda for today</td>
<td>Flip chart, pens, laptop, projector, speakers, internet.</td>
<td></td>
</tr>
<tr>
<td>Ice breaker</td>
<td>Quiz questions and buzzers (mixed quiz)</td>
<td></td>
</tr>
<tr>
<td>Review of home practice task rationale catching thoughts, labelling unhelpful thoughts and or</td>
<td>Facilitate group discussion and facilitators to give their examples also.</td>
<td></td>
</tr>
<tr>
<td>Session</td>
<td>Content</td>
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</tr>
<tr>
<td>Challenging thoughts one thing different task.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Break</td>
<td>Water, drinks, biscuits</td>
<td></td>
</tr>
<tr>
<td>Relapse prevention</td>
<td>Self-management plan worksheet</td>
<td></td>
</tr>
<tr>
<td>Group closing</td>
<td>Group discussion – reflections</td>
<td></td>
</tr>
<tr>
<td>Measures</td>
<td>RCADS and feedback questionnaire</td>
<td></td>
</tr>
<tr>
<td>Mindful activity</td>
<td>Mindful listening to poem.</td>
<td></td>
</tr>
<tr>
<td>Homework folder, (should now contain for this session: session 6 information handout, self-management plan worksheet, ). Also parent information sheet on the session</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Ethics Approval

20th January 2017

Dr Barry Coughlan
Assistant Director of Clinical Psychology
Faculty of Education and Social Sciences
University of Limerick

Re: Testing the efficacy of implementing a combined CBT-based group intervention for the treatment of anxiety and depression, within a child and adolescent mental health service (CAMHS).

Dear Dr Coughlan

The Chairman approved the following:

- Revised participant information sheet
- Parent Consent Form
- Revised assent form for young persons under 18 years old
- Revised consent form for young persons over 15 years old.

Full approval is now granted to carry out this study.

Yours sincerely

[Signature]

Professor Michael G Molloy
Chairman
Clinical Research Ethics Committee
of the Cork Teaching Hospitals

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The Clinical Research Ethics Committee of the Cork Teaching Hospitals, UCC, is a recognised Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004, and is authorised by the Department of Health and Children to carry out the ethical review of clinical trials of investigational medicinal products. The Committee is fully compliant with the Regulations as they relate to Ethics Committees and the conditions and principles of Good Clinical Practice.

[Signature]

Ollscoil na hEireann, Corcaigh - National University of Ireland, Cork.
4th October 2017

Dr Barry Coughlan
Assistant Director of Clinical Psychology
Faculty of Education and Social Sciences
University of Limerick

Re: Testing the efficacy of implementing a combined CBT-based group intervention for the treatment of anxiety and depression, within a child and adolescent mental health service (CAMHS).

Dear Dr Coughlan

The Chairman approved the following:

- Amendment Application Form dated 13th September 2017
- Study protocol dated 13th September 2017
- Participant Information Leaflet dated 13th September 2017
- Parental Consent Form dated 13th September 2017
- Assent Form for Children 15 years old and under dated 13th September 2017
- Consent Form for Young Person’s 16 years old and over dated 13th September 2017
- End of Group Questionnaire dated 13th September 2017

Full approval is granted to implement this amendment.

Yours sincerely

[Signature]

Professor Michael G Molloy
Chairman
Clinical Research Ethics Committee
of the Cork Teaching Hospitals

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The Clinical Research Ethics Committee of the Cork Teaching Hospitals, UCC, is a recognised Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004, and is authorised by the Department of Health and Children to carry out the ethical review of clinical trials of investigational medicinal products. The Committee is fully compliant with the Regulations as they relate to Ethics Committees and the conditions and principles of Good Clinical Practice.
12th December 2017

Dr Barry Coughlan
Assistant Director of Clinical Psychology
Faculty of Education and Social Sciences
University of Limerick

Re: Examine the efficacy of a transdiagnostic short-term CBT group for secondary school age children referred to Child and Adolescent Mental Health Services (CAMHS).

Dear Dr Coughlan

The Chairman approved the following:

- Change in study title to title above
- Addition of North Lee West and North Cork Child and Adolescent Mental Health Services and Child and Adolescent Mental Health Services, Western Road, Cork as study sites
- Addition of Dr Joanne Rolfe and Dr Karen Murphy, Clinical Psychologists as co-investigators in this study
- Study protocol dated 21st November 2017
- Assent Form for Children 15 years old and under dated 21st November 2017
- Parental Consent Form dated 21st November 2017
- Consent Form for Young Person’s 16 years old and under dated 21st September 2017

Full approval to implement this amendment will be granted subject to receipt of the following:

- Original signed amendment form.

Yours sincerely

[Signature]

Professor Michael G Molloy
Chairman
Clinical Research Ethics Committee
of the Cork Teaching Hospitals

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The Clinical Research Ethics Committee of the Cork Teaching Hospitals, UCC, is a recognised Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004, and is authorised by the Department of Health and Children to carry out the ethical review of clinical trials of investigational medicinal products. The Committee is fully compliant with the Regulations as they relate to Ethics Committees and the conditions and principles of Good Clinical Practice.
16th November 2016

Dr Barry Coughlan
Assistant Director of Clinical Psychology
Faculty of Education and Social Sciences
University of Limerick

Re: Examine the efficacy of a transdiagnostic short-term CBT group for secondary school age children referred to Child and Adolescent Mental Health Services (CAMHS).

Dear Dr Coughlan

The Chairman approved the following:

➢ Cover Email dated 1st October 2018
➢ Signed Amendment Application Form.

Full approval is now granted to implement amendment dated 12th December 2017.

Yours sincerely

[Signature]

Professor Michael G O'Molloy
Chairman
Clinical Research Ethics Committee
of the Cork Teaching Hospitals

The Clinical Research Ethics Committee of the Cork Teaching Hospitals, UCC, is a recognized Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004, and is authorised by the Department of Health and Children to carry out the ethical review of clinical trials of investigational medicinal products. The Committee is fully compliant with the Regulations on they relate to Ethics Committees and the conditions and principles of Good Clinical Practice.
Appendix C: Referral Sheet

Mind and Mood Group Referral Form:

Current Clinician:  
Child's name:

Age:  
DOB:

Description of presenting problem:

Maintaining factors:

No young person’s place will be confirmed until they have attended the pre-group orientation session. Suitability for the group will be assessed at this meeting also.
Appendix D: Information Leaflets

Participant information leaflet:

Study title:
Testing the efficacy of implementing a combined CBT based group intervention for the treatment of anxiety and depression, within a Child and Adolescent Mental Health Service (CAMHS).

Section A — about the group:
We would like to introduce the new Mind and Mood Group being ran in this service. We are running a six-week group with the aim to see if this is helpful for young people suffering with anxiety and/or depression.

Are you feeling worried, stressed or down? Is it affecting your daily life? Is life becoming harder? If your answer is yes to any of these questions then this group could help you.

What does this involve?
You will be asked to attend a pre-group meeting, this is a chance for you to meet the group leaders, see the group room and location, and ask any questions before deciding if you would like to attend the group. If you would like to give the group a go you will be asked to attend six group sessions. Once the group has ended you will be asked to complete a short questionnaire about your experiences of the group, good or bad feedback is welcomed. Group sessions will be one and a half hours long with a comfort break halfway. Squash and biscuits will be provided.

Who will be in the group?
The group is aimed at young people in secondary school aged between 12 and 17 years old. The group will have no more than 12 participants and 3 members of staff. All group participants will have similar difficulties to you, anxiety and/or depression.

Will I be expected to tell everyone in the group about my problems?
No. You will not be expected to talk about your personal problems. This is not a therapy group it is skills based. Skills based means we will introduce you to some ideas that have been shown to be helpful and you will practice these new skills at home. The group leaders
will speak to everyone in the group individually about how to do this at home. Everyone will be given the opportunity to speak in the group if they wish but you do not have to.

**I am really nervous about attending a group:**

Remember that everyone coming along to the group will be feeling the same as you. Before the group starts you will be invited to come and meet us, to ask any questions. We try to have fun in the group and we do not ask you to do anything that you are uncomfortable with. Each group session will start with a friendly quiz with the opportunity to win a prize.

**What will I learn?**

The group is based on Cognitive Behaviour Therapy (CBT). CBT looks at the links between how we think, feel and behave. You will learn how to recognise how thoughts and feelings can affect behaviours in certain situations and use skills to make changes in these areas that have been proven to work. You will learn all about CBT in session one of the group so don’t worry too much about that now.

**Section B – about the study:**

The study is looking at the effects of this group, we piloted this group previously in this service and achieved good results. This study is being run by the psychology team in the service. This group was also delivered by one of our Psychology team members in the UK and was found to be helpful.

**Why have I been invited to participate?**

Everyone in the service with symptoms of low mood and/or anxiety will be offered a place on the group programme.

**What will happen if I decide to take part?**

If you would like to come along to the group you will be asked to attend six group sessions. Once the group has ended you will be asked to complete a short questionnaire about your experience of attending the group. You will be asked to complete an outcome measure (questionnaire) at the beginning and end of the group. This will help us to track the outcome of the group programme.

**Can I say No?**
Yes. You do not have to be part of this study and if you decide not to take part, this will not affect your right to have any other treatment options that would be ordinarily offered to you in the service.

**Has permission been given for this study?**

This study has hospital Research Ethics Committee approval.

**Further information**

You can get more information or answers to any questions you may have about the study, your participation in the study, and your rights from Kathleen Sexton who can be telephoned at 021 4927821. If you have further queries concerning your rights about the research, you can contact the Clinical Research Ethics Committee of the Cork Teaching Hospitals, Lancaster Hall, 6 Little Hanover Street, Cork (021) 4901901.
Practitioner information leaflet

Mind and Mood Group

The young person will have a case worker and should any difficulties or distress arise in group the young person can be seen by their case worker also. The young person will have a short pre-group orientation and a short post-group interview also.

About the group:

The Mind and Mood Group is a CBT skill based group aimed at teenagers between the ages of 12 and 17 years old; suffering with anxiety and/or depression. To enter the group they will need to have a clinical significant level on the RCADS.

➢ 6 weekly sessions 1.5 hours
➢ 8 -10 places per group (depending on room available) for secondary school age children (12-17 yrs)
➢ Every young person in the group will have had an initial assessment with a CAMHS worker who continues to act as case holder.
➢ Case holder reviews client post group and picks up any additional clinical issues arising over the course of the group
➢ Content based on transdiagnostic maintaining factors in CBT models e.g.
➢ Behavioural activation, problem solving, avoidance, cognitive restructuring
➢ Each week ends with a short mindfulness practice
➢ Group psycho education with exercises to individualise skills use

Participants will meet the suitability criteria for Cognitive Behavioural Intervention:

➢ CBT is a recommended intervention for anxiety and depression
➢ Participant can identify their thoughts in relation to difficulties
➢ Can generate alternative thoughts
➢ Can identify their emotions and distinguish between different ones
➢ Motivated to make changes, so things are different from how they are now
➢ Will work on tasks outside of sessions
➢ Feels that the CBT model would be helpful (informed consent)
➢ The person has the ability to describe how they would like things to be different
(‘SMART’ positive goal setting)
Participants will meet the specific group suitability criteria:

- Participant meets level of clinical significance on the Revised Children’s Anxiety and Depression Scale (RCADS) or the clinical judgment of the assessing Mental Health Practitioner indicates significant difficulty with anxiety or depression.
- Participant can commit to attending 6 sessions, a pre-group orientation session and a post-group interview.

Exclusion criteria:

- Difficulties are explained by Neuro-developmental condition alone
- Difficulty is not recommended for CBT
- Person is not motivated to change (or other suitability criteria not met)
# Appendix E: RCADS

**RCADS**

**Child/Young Person’s NAME:**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
</table>

**NHS ID:**

---

*Please put a circle around the word that shows how often each of these things happens to you. There are no right or wrong answers.*

<table>
<thead>
<tr>
<th>1</th>
<th>I worry about things</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>I feel sad or empty</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>3</td>
<td>When I have a problem, I get a funny feeling in my stomach</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>4</td>
<td>I worry when I think I have done poorly at something</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>5</td>
<td>I would feel afraid of being on my own at home</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>6</td>
<td>Nothing is much fun anymore</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>7</td>
<td>I feel scared when I have to take a test</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>8</td>
<td>I feel worried when I think someone is angry with me</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>9</td>
<td>I worry about being away from my parent</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>10</td>
<td>I am bothered by bad or silly thoughts or pictures in my mind</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>11</td>
<td>I have trouble sleeping</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>12</td>
<td>I worry that I will do badly at my school work</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>13</td>
<td>I worry that something awful will happen to someone in my family</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>14</td>
<td>I suddenly feel as if I can't breathe when there is no reason for this</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>15</td>
<td>I have problems with my appetite</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>16</td>
<td>I have to keep checking that I have done things right (like the switch is off, or the door is locked)</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>17</td>
<td>I feel scared if I have to sleep on my own</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>18</td>
<td>I have trouble going to school in the mornings because I feel nervous or afraid</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>19</td>
<td>I have no energy for things</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>20</td>
<td>I worry I might look foolish</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>No.</td>
<td>Statement</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
<td>-------</td>
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</tr>
<tr>
<td>21</td>
<td>I am tired a lot</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>I worry that bad things will happen to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>I can't seem to get bad or silly thoughts out of my head</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>When I have a problem, my heart beats really fast</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>I cannot think clearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>I suddenly start to tremble or shake when there is no reason for this</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>I worry that something bad will happen to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>When I have a problem, I feel shaky</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>I feel worthless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>I worry about making mistakes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>I have to think of special thoughts (like numbers or words) to stop bad</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>things from happening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>I worry what other people think of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>I am afraid of being in crowded places (like shopping centers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>(the movies, buses, busy playgrounds)</td>
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<td></td>
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</tr>
<tr>
<td>34</td>
<td>All of a sudden I feel really scared for no reason at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>I worry about what is going to happen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>I suddenly become dizzy or faint when there is no reason for this</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>I think about death</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>I feel afraid if I have to talk in front of my class</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>My heart suddenly starts to beat too quickly for no reason</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>I feel like I don't want to move</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>I worry that I will suddenly get a scared feeling when</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>there is nothing to be afraid of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>I have to do some things over and over again (like washing my hands,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>cleaning or putting things in a certain order)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>I feel afraid that I will make a fool of myself in front of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>people</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>I have to do some things in just the right way to stop</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>bad things from happening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>I worry when I go to bed at night</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>I would feel scared if I had to stay away from home overnight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>I feel restless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix F: Post-group Interview Sheet

Post-group Interview – Young person

This list is here to guide the researcher. It does not have to be adhered to completely. The person’s response should also guide the questions.

1. How did you feel about the idea of coming to the group before you came?
2. Did anything from the group stand out to you?
3. What was helpful about the group?
4. What was not helpful about the group?
5. Now you have completed the group how do you feel about having done this?
6. Would you recommend this group to a friend?
7. Anything else you would like to let us know?

Post-group Interview – Parent

This list is here to guide the researcher. It does not have to be adhered to completely. The person’s response should also guide the questions.

1. How did you feel about the idea of your young person (insert YP name) coming to the group?
2. Have you noticed any changes in your young person (insert YP name) whilst they were in the group?
3. If yes ..... what changes have you observed? And have these changes been sustained since the group has ended?
4. If no ..... facilitate a discussion to elicit where things are at now and normalise skills need practice and take some time to master, remind parent that their case is still open and you will notify their case worker to get in touch to discuss next steps.
5. Anything else you would like to let us know?
Appendix G: Post-group Feedback Questionnaire

End of group questionnaire:

We are really interested in any feedback that you have for us about the group. Please help us to make the group better by writing a note on the questions below and by telling us what you liked and what you did not like.

What were your first thoughts about coming to the group?

Now you have completed the group, what are your thoughts about it?

Did anything from the group stand out to you, was anything helpful?

Was anything from the group unhelpful?

Would you recommend this group to a friend?

If your friend was nervous about coming to the group what advice would you give to him or her?

Is there anything else you would like to let us know?
Appendix H: Consent Form

Consent form for young person’s 16 years old and over.

Section A

Patient Name:

Title: Examine the efficacy of a transdiagnostic short-term CBT group for secondary school age children referred to Child and Adolescent Mental Health Services (CAMHS).

You are being asked to participate in a research study. In order to decide whether or not you want to be a part of this research study, you should understand enough about its risks and benefits to make an informed judgment. This process is known as informed consent. This consent form gives detailed information about the research study, which will be discussed with you. Once you understand the study, you will be asked to sign this form if you wish to participate.

Section B

I. NATURE AND DURATION OF PROCEDURE(S):

The Psychology team will be running a group programme for the treatment of anxiety and depression for young people aged between 12 and 17 years old. The maximum number of young people in the group will be 12 with two group facilitators.

The group is based on Cognitive Behaviour Therapy (CBT). CBT looks at the links between how we feel, think and behave. You will learn about anxiety and depression, and you will have the opportunity to learn some skills that can be helpful in managing these symptoms.

The duration of the whole intervention will be 7 sessions, broken down into one initial pre-group meeting (today) up to 30 minutes, and 6 group sessions which will run once a week with each session lasting 90 minutes. You will be notified of the exact day and time once group numbers are confirmed and finalized. On completion of the group intervention you will be asked to complete a short questionnaire about your experiences of the group. All sessions will be held at [insert location].

We will ask you to complete an outcome measure at the beginning and the end of the group intervention, this will tell us if the group intervention is making a difference for you. You may also be asked to complete an outcome measure six months after the group has ended, this could be by post or in person. All information collected for analysis will have all identifiable information removed.

II. POTENTIAL RISKS AND BENEFITS:

By taking part in this study you could help set up a new intervention within the service, which would lead to better outcomes for young people and families in need of support. You will be taught new skills to cope with symptoms of anxiety and depression that can be used across your whole life. Being in a group setting and realizing that you are not alone in how you are feeling can be a powerful tool.
There is a risk of initial increased anxiety levels upon attending a group; but research has shown that exposure to feared objects in a controlled and graded way is helpful for anxiety.

III. POSSIBLE ALTERNATIVES:

Participation is voluntary and you can withdraw from the study at any point if you wish to do so. This will not affect any further interventions offered by the service that would ordinarily be offered to you.

Section C

AGREEMENT TO CONSENT

The research project and the treatment procedures associated with it have been fully explained to me. I have had the opportunity to ask questions concerning any and all aspects of the study. I am aware that participation is voluntary and that I may withdraw my consent at any time. I am aware that my decision not to participate or to withdraw will not restrict my access to health care services normally available to me. Confidentiality of records concerning my involvement in this project will be maintained in an appropriate manner. When required by law, the records of this research may be reviewed by government agencies and sponsors of the research.

I, the undersigned, hereby consent to participate as a subject in the above described study. I have received a copy of this consent form for my records.

After reading the entire consent form, if you have no further questions about giving consent, please sign where indicated.

Team member signature: ___________________________ Signature of, Parent or Guardian: ___________________________

Date: ________________ Young person signature: ___________________________

Time: AM (Circle) PM

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Appendix I: Assent Form and Parental Consent Form

Assent form for Children 15 years old and under

Title: Examine the efficacy of a transdiagnostic short-term CBT group for secondary school age children referred to Child and Adolescent Mental Health Services (CAMHS).

What is this?

You are being asked to participate in a research study. A research study is a way to find out if new ideas will be helpful. To do this the psychology team will be running a group programme to help young people aged between 12 and 17 years old to understand feelings of anxiety (worries) and depression (feeling low in mood or sad).

About the group:

The group is based on Cognitive Behaviour Therapy (CBT). CBT looks at how we think, feel and behave and will give you the opportunity to learn some new ideas that can help you to feel better. The group will not be bigger than 12 young people and the other young people will have the same type of difficulties as you do. They will all be in secondary school.

If you decide that you want to be part of this group, you will be invited to 7 sessions. These sessions are broken down into one meeting before the group (today) up to 30 minutes, and 6 group sessions which will run once a week with each session lasting 90 minutes. You will be told the exact day and time once final numbers for the group have been collected. You will be asked to complete a short questionnaire at the end of the group about your experience of the group. All the sessions will be held at [insert location].

You will be asked to complete an outcome measure at the beginning and the end of the group. This will tell us if the group intervention is making a difference for you. You may also be asked to complete an outcome measure six months after the group has ended, this could be by post or in person. All information collected will have your name taken off so no one will know that it is you.

Should I take part?

By taking part you could help set up a new intervention within this service which would help more young people just like you. You will learn about anxiety (worries) and depression (feeling low in mood) and ways you can make small changes to improve your mood. Being in a group with other young people can help to recognise that you are not alone in how you are feeling and this can be very helpful.

At the beginning of the group, you may feel anxious, however this anxiety will get better the more you do it. This has been proven by research.

Attending the group is voluntary (your choice) and you can withdraw (pull out) of the study at any time. If you decide to stop after the group has begun this is okay too. Your parents know about this study and they know it will not affect any other choices that the service could offer you.
If you decide you want to be in this study, please sign your name.

I, ____________________________, want to be in this research study.
(Sign your name here)

Date:
Consent form for parents to go alongside assent form:

Section A

Patient Name:

Title: Examine the efficacy of a transdiagnostic short-term CBT group for secondary school age children referred to Child and Adolescent Mental Health Services (CAMHS).

Your young person is being asked to participate in a research study. In order to decide whether or not you want your young person to be a part of this research study, you should understand enough about its risks and benefits to make an informed judgment. This process is known as informed consent. This consent form gives detailed information about the research study, which will be discussed with you. Once you understand the study, you will be asked to sign this form if you wish for your young person to participate.

Section B

I. NATURE AND DURATION OF PROCEDURE(S):

The Psychology team will be running a group programme for the treatment of anxiety and depression for young people aged between 12 and 17 years old. The maximum number of young people in the group will be 12 with two group facilitators.

The group is based on Cognitive Behaviour Therapy (CBT). CBT looks at the links between how we feel, think and behave. Your young person will be taught about anxiety and skills that can be helpful in managing their symptoms of anxiety and/or depression. The duration of the whole intervention will be 7 sessions, broken down into one initial pre-group meeting (today) up to 30 minutes and 6 group sessions which will run once a week with each session lasting 90 minutes. You will be notified of the exact day and time once group numbers are confirmed and finalized. At the end of the group your young person will be asked to complete a short questionnaire about their experiences of the group. All sessions will be held at [insert location].

We will ask that your young person completes an outcome measure at the beginning and end of the group intervention, this will tell us if the group intervention is making a difference for your young person. Your young person may also be asked to complete an outcome measure six months after the group has ended, this could be by post or in person. All information collected for analysis will have all identifiable information removed.

II. POTENTIAL RISKS AND BENEFITS:

Taking part in this study could help set up a new intervention within the service, which would lead to better outcomes for families in need of support. Your young person will be taught new skills to cope with symptoms of anxiety and/or depression that can be used across their whole life. Being in a group setting and realizing that you are not alone in how you feel can be powerful for a young person. There is a risk of initial increased anxiety levels upon attending a group; but research has shown that exposure to feared objects in a controlled and graded way is helpful for anxiety.
III. POSSIBLE ALTERNATIVES:

Participation is voluntary and your young person can withdraw from the study at any point if they wish to do so. This will not affect any further interventions offered by the service that would ordinarily be offered to your young person.

Section C

AGREEMENT TO CONSENT

The research project and the treatment procedures associated with it have been fully explained to me. I have had the opportunity to ask questions concerning any and all aspects of the study. I am aware that participation is voluntary and that I may withdraw my consent at any time. I am aware that my decision not to participate or to withdraw will not restrict my access to health care services normally available to my young person. Confidentiality of records concerning my involvement in this project will be maintained in an appropriate manner. When required by law, the records of this research may be reviewed by government agencies and sponsors of the research.

I, the undersigned, hereby consent for my young person to participate as a subject in the above described Study. I have received a copy of this consent form for my records.

After reading the entire consent form, if you have no further questions about giving consent, please sign where indicated.

Team member signature: Signature of, Parent or Guardian:

Date: Time: AM (Circle) PM
Appendix J: SPSS Output - Normative Tests

Case Processing Summary

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Descriptives

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### Tests of Normality

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![Normal Q-Q Plot of Pre group RCADS](image1.png)

![Boxplot of Pre group RCADS](image2.png)
Histogram

- Mean = 61
- SD = 15.548
- N = 32

Frequency vs. Post group RCADS

0 1 2 3 4 5

50 40 50 60 70 80 60

Normal