Designing and evaluating a psychological intervention for individuals with Multiple Complex Needs

Hayley Sapsford, BSc Psychology

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Portfolio Abstract

Multiple Complex Needs refers to any two of the following: homelessness, substance misuse, offending behaviour and/or mental health difficulties. Personal agency is compromised within those who experience difficulties in their mental health, impacted on further by adversity and disempowerment. The Power Threat Meaning Framework (PTMF) has been designed by its authors to take disempowerment in psychological suffering into account and provide a narrative to make sense of experiences and regain a sense of personal agency. The lack of systematic and empirical evidence for the PTMF provides further reason to conduct research within this area and explore its use. This research aimed to design a brief intervention based on the PTMF and explore the outcomes, utility and feasibility with adults experiencing Multiple Complex Needs (MCN).

A brief PTMF-based intervention was systematically designed and evaluated using a single exploratory case study. Thematic Analysis was conducted with data from process measures, session recordings and a change interview. Descriptive data was obtained from quantitative measures to explore specific outcomes on personal agency, empowerment and wellbeing.

A number of helpful therapeutic events were identified in the analysis. Qualitative data indicated shifts in empowerment and agency. There were no significant changes pre/post in the quantitative data.

It is suggested the PTMF can be translated into an acceptable intervention for those experiencing MCN. Unhelpful events and feedback were used to make changes to the workbook and enhance its feasibility. The research contributes to the field of clinical psychology in the demonstration of the utility of an intervention based on the PTMF and how it can be used within a population where engagement is challenging. Future research would benefit from replicating the current study with an increased number of participants and robust assessment of outcomes.

Statement of contribution

Hayley Sapsford was responsible for the design of this project, applying for ethical approval, reviewing the relevant literature, data collection, analysis and the writing up of the research.

Professor Thomas Schroder provided supervision on the design, ethics, analysis and write up of the research.

Dr Danielle De Boos provided supervision on the design and analysis of the research.

Dr Anna Tickle provided supervision on the conceptualisation, design and write up of the research. She was also responsible for the facilitation of the relationship with Framework and Opportunity Nottingham, recruitment of the participant and conducting the intervention.

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The effectiveness of psychological interventions for traumatic stress in the previously homeless population: A Systematic Literature Review

Hayley Sapsford, Trainee Clinical Psychologist

Dr Anna Tickle, The University of Nottingham

Dr Danielle De Boos, The University of Nottingham

Abstract

The prevalence of psychological trauma in the international homeless population is significant. Due to the high level of Multiple Complex Needs within this population, interventions require adaptation to be effective. At present, there is little evidence regarding which psychological interventions are effective in the treatment of psychological trauma for individuals experiencing homelessness. A systematic review of the effectiveness of psychological trauma interventions for the homeless population is presented, with a critical appraisal and synthesis of the available evidence. A systematic search of seven psychology, medical, health and social science electronic databases was conducted. Search terms included variations of "homeless*", "post-traumatic stress disorder" and "therapy". Six studies were identified which met the inclusion criteria. Mindfulness-orientated recovery enhancement for adults and youth specific Cognitive Behavioural Therapy for Post-Traumatic Stress Disorder were found to be promising in effective treatment of psychological trauma in homeless individuals. However, due to a paucity of high-quality empirical research, reliable conclusions could not be drawn. Recommendations for future research include further empirical research using rigorous study designs to be conducted further evaluating these interventions and using variations in the deliverance of the interventions and homeless status of the samples used.

KEYWORDS: Homelessness, PTSD, Psychological Interventions, CBT, Mindfulness

Introduction

Homelessness is a pertinent issue as it is sharply on the rise in the UK (Garrett, 2017). The economic burden on the NHS of those who experience homelessness for longer than three months is estimated to be between £2,099-£6,397 per person annually (Pleace & Culhane, 2016), and the cost of homelessness within England alone is estimated to be £1billion a year in 2012 (Department of Communities and Local Government, 2012). Psychological trauma is a significant feature in the homeless population, ranging from childhood trauma to psychological trauma incurred whilst homeless (McDonagh, 2011). Childhood trauma experiences in one homeless sample of 452 individuals included domestic violence (27%), family homelessness (16%), sexual abuse (23%) and parental drug use (24%) (Fitzpatrick et al., 2012). The Adverse Childhood Experiences (ACEs) study (Felitti et al., 1998) demonstrates the domino effect of adverse events from childhood into adulthood, with strong associations found between ACEs and subsequent homelessness (Herman et al., 2011), further demonstrated by the finding of an ACE prevalence of 60% in one sample of homeless individuals' histories (Roos et al., 2013). Whilst it cannot be said that the presence of ACEs within an individual's history will lead to the development of Post-Traumatic Stress Disorder (PTSD), there is evidence to suggest that the more ACEs an individual has, the more likely they are to experience PTSD symptoms (Carroll et al., 2017; Kalmakis et al., 2019). Furthermore, those with a high incidence of ACEs and PTSD symptoms are more likely to engage in illicit drug use (Jones et al., 2017), which makes it hard to determine the relationship between ACEs and psychological trauma, as trauma symptoms may be masked and therefore underreported, which is highly possible for the homeless where alcohol and substance misuse can be as high as 70% of a given sample (Fitzpatrick et al., 2012).

Whilst psychological trauma can lead to homelessness (Piat et al., 2014), being homeless in itself can be traumatic. Deck and Platt (2015) highlighted the process of becoming homeless, including the stress of losing your home and living in temporary shelter, combined with the subsequent vulnerabilities of substance misuse, physical and/or sexual abuse that can lead to trauma. This is further evidenced in one sample of homeless individuals where 32% of women and 27% of men had been sexually or physically abused whilst homeless (Kushel et al., 2003).

The impact of psychological trauma has a clear influence on the trajectory of an individual's pathway into homelessness, complicating their ability to access and utilise help (Cockersell, 2018). The notion of compound trauma describes the cumulative effect of a sequence of traumatic experiences which impact on the individual's development and reduces their ability to cope in a socially accepted manner (Cockersell, 2018). This leads to social exclusion and homelessness as the individual is prevented from accessing a range of services for reasons of; antisocial behaviour, difficulty adhering to routine (i.e. keeping appointments) or having Multiple Complex Needs (MCN) which services aren't designed to meet (Keats et al., 2012). The definition of MCN in this context refers to any two of the following; homelessness, substance misuse, offending behaviour and mental health difficulties. The problem of MCN within this population is key to the issue of psychological trauma, as one study found a core theme of substance misuse and mental health problems were deeply rooted in the same traumatic experience in one sample of homeless individuals (Reeve et al., 2018). The same study demonstrated the link between MCN and multiple exclusion from services as the authors found homeless individuals were unable to access the services they needed for reasons of: mental health needs going unacknowledged, falling between service thresholds, dual diagnosis, waiting lists or inappropriate referrals. Furthermore, 75% of the sample had experienced mental health issues and one in five respondents had been detained under the Mental Health Act at some point in their life. Despite this high level of need, only 59% of the respondents were receiving support for their mental health but only 27% reported that it met their needs, suggesting the current systems are not adequate to meet the complex needs of this group.

Effective interventions for psychological trauma already exist and have been well evidenced. NICE guidelines recommend a range of psychological treatments for the treatment of PTSD and complex PTSD, including cognitive processing therapy, Cognitive Behavioural Therapy (CBT), narrative exposure therapy, eye movement desensitisation and reprocessing (EMDR) or prolonged exposure therapy. The guidelines specify that for any of the treatments used, they should be based on a validated manualized approach. Guidance states that people should not be excluded from treatment if they have a co-morbid substance misuse presentation. For complex presentations, NICE recommend the following adaptations: additional time used to develop the therapeutic relationship, assistance with any issues which may prevent engagement in trauma-focused therapies and consider the safety and stability of the individuals' personal circumstances e.g. housing. Despite these recommendations, the needs of individuals experiencing homelessness and psychological trauma are going unmet. The reason for this has been identified in two key issues: differing perceptions of the service users and providers as to what the priority is for treatment, and services ability to recognise and be flexible with MCN (Bowpitt et al., 2011).

Finally, research has found that the longer a person spends homeless, the more they become accustomed and adapt to their situation, increasingly the likelihood of chronic homelessness (Scutella & Johnson, 2017). This demonstrates the high stakes nature of providing adequate and effective care within a time sensitive period. Despite the evidence of high rates of psychological trauma and MCN combined with the knowledge of economic burden, there has not been any formal review into the psychological treatment of psychological trauma in the homeless population. A systematic literature review has been conducted to synthesise information on the psychological treatments that are being used and their effectiveness.

Definitions

Homelessness within this research are defined broadly to account for differences between cultural definitions, as the review covered international research. Studies were included where they defined their sample as currently unhoused, that being without a roof over their head and sleeping rough or in a squat, individuals living unofficially and temporarily with others (i.e. sofa surfing) or individuals who were previously homeless and now accessing homeless shelters or residential/treatment facilities. The rationale for including those who were previously homeless is due to the scoping search indicating an absence of literature which used a sample of whom were literally homeless.

Psychological trauma within this research is defined in line with the Diagnostic and Statistical Manual of Mental Disorders-fifth edition (DSM-5) (American Psychiatric Association, 2013) and International Classification of Diseases and Related Health Problems-tenth edition (ICD-10) (World Health Organisation, 1992) definitions of PTSD and complex trauma. The rationale for using diagnostic definitions of psychological trauma is to ensure the inclusion of research which is exploring the outcomes in relation to a universal and recognised psychological disorder with specific symptomatology. However, participants included in the studies did not need to have a formal diagnosis of PTSD, but at least be demonstrating the potential to meet clinical thresholds i.e. on a reliable and valid symptom outcome measure.

Materials & Methods

Searching

The Cochrane Database of Abstracts of Reviews of Effects (DARE) was accessed to confirm a review of this nature was not already in existence using a combination of the terms “homeless*”, “therapy” and “PTSD”. The search did not find any reviews of this nature. An electronic systematic literature search was conducted in July 2019 using the following databases: PsycINFO, PsycARTICLES, MEDLINE, PubMed, CINAHL, PTSDpubs and ProQuest Dissertations and Theses Global. The rationale for including grey literature was the broadness of term psychological interventions, and the anticipated limited quality and volume of peer reviewed research (Benzies et al., 2006). The reference lists of key texts were hand searched to identify further relevant literature.

The following search string was used within each of the databases; (homeless*) AND (PTSD OR posttraumatic stress disorder OR post-traumatic stress disorder OR complex PTSD) AND (therapy OR intervention OR treatment). Terms were checked with each databases thesaurus and altered as needed.

Selection

Studies were included on the basis that they empirically assessed the effectiveness of a psychological trauma intervention to answer the research question. An inclusive approach was taken to study design and methodology, i.e. Randomized Controlled Trials (RCT), uncontrolled pre-post studies, quasi-experimental etc. Studies which were descriptive and did not provide some indication of change/no-change as a result of the intervention were excluded. International literature was included to synthesise all available relevant evidence. The language of literature was restricted to English due to the lack of feasibility for translation of texts. A participant age range restriction was not applied to the search, owing to the fact that there is a significant percentage of homeless adolescents and children internationally (Ringwalt et al., 1998; Haber & Toro, 2004; Kamieniecki 2001). Finally, a date range restriction was not applied to the searches in order to achieve a comprehensive review of the available literature.

Data Abstraction

Data were systematically extracted from each study. For assessment of study quality, the Centre for Review and Dissemination (CRD) recommends criteria should take into account; the validity and reliability of the outcome measures used, quality of reporting, quality of intervention, risk of bias and statistical issues. The quality criteria were further informed by a similar systematic literature review evaluating the effectiveness of a range of health and social care interventions for homeless youth, which uses a quality rating system derived from the U.S. preventive Services Task Force Work Group (Altena et al., 2010).

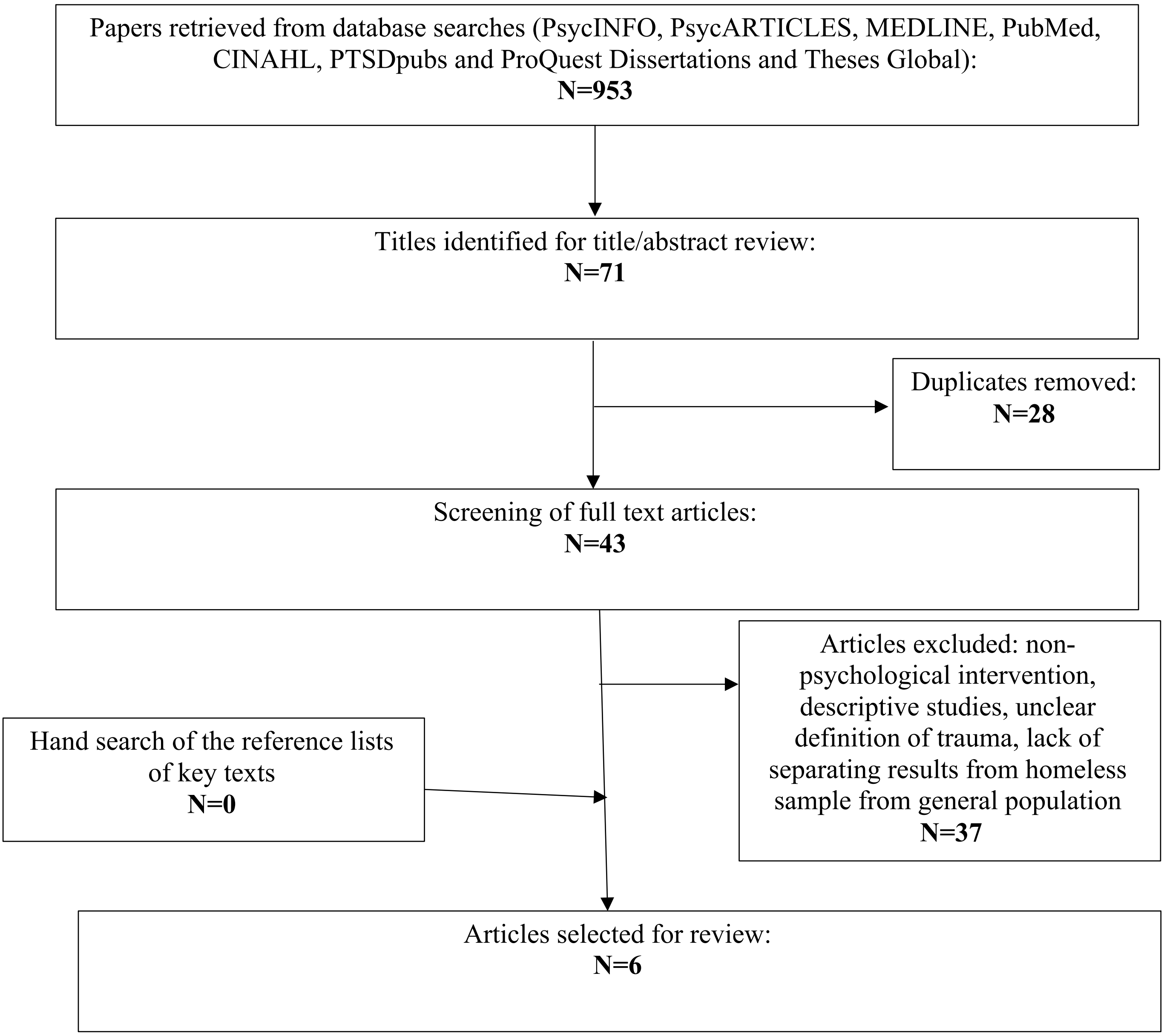
Quality Assessment

Using these examples as a guide, an *a priori* approach was taken to the assessment of quality of the studies. Based on the CRD recommendations, the sample size of a study is given a positive rating if there are 100+ participants. However, due to the transient and hard to engage nature of this group, the sample size was lowered to 50 with a retention rate of 80% at post measurement based on previous systematic reviews of this group (Hwang et al., 2005; Altena et al., 2010). Studies were rated on transparency and replicability by providing a clear rationale and definition of the intervention. Ratings were given on how primary outcomes were measured and the reliability and validity of these measurements. Consideration was given to whether studies used a follow up period and how they statistically controlled for attrition in reporting follow up measurements. Evaluation of the control of confounding variables included control, randomization and blinding along with subjective critical appraisal of the study procedure, statistical control and the authors acknowledgment of study limitations. The Treatment Fidelity Grid (Bellg et al., 2004) was consulted to evaluate the studies intervention validity, and finally, studies were scored on the presence of an intention to treat analysis.

Results

Figure 1 provides a PRISMA flow chart for the search and selection procedure. Six studies were included in total.

Figure 1
PRISMA diagram outlining the selection process



Characteristics of included studies
As seen in Table 1, five of the six included studies were from the US and conducted with adults (1,2,3,5,6), demonstrating a cultural and age bias. Samples tended to have a predominantly female representation (1,4,5,6), with two studies using an all-male sample (2,3). Study design and methodology varied but all used a pre-post measurement. The samples in all studies were all accessing some form of support for housing and no participants were literally living on the streets at the time of the studies. CBT is represented in all but one study, with most studies using the Seeking Safety (SS) CBT for comorbid substance misuse and PTSD. All studies found psychological intervention to significantly reduce PTSD symptom scores.

Table 1
Study Characteristics

Ref	**Authors**	**Study design and methodology**	**Primary outcome measure**	**Population** **-Gender** **-Mean age** **-Location**	**Intervention Conditions** **-Key components (as defined by study authors)** **-Group/individual**	**Key Findings**
1	Desai et al., (2008; 2009)	Quasi-experimental design Pre/post measures Inferential statistics	PTSD Checklist-Civilian Version (PCL) (Weathers, Litz, Herman, Huska & Keane, 1993)	Females 45 years old USA	**SS CBT** -Psychoeducation on safe behaviours and relationships, life skills and relapse prevention -Individual **Treatment as usual (TAU)**	• Women in the CBT condition showed modest significant improvement in PTSD symptoms compared to controls (p=.03) immediately post intervention. • The intervention group were more likely to have used drugs than controls during intervention. • The differences weren't significant between the two groups at 6-month follow up.
2	Kip et al., (2016)	Prospective cohort treatment study Pre/post measures Inferential statistics	Military PTSD Checklist (PCL-M) (Weathers, Litz, Herman, Huska & Keane, 1993)	91% Male 51 years old USA	**Accelerated Resolution Therapy (ART)** -Imaginal exposure & imagery rescripting -Individual	• There was a significant reduction in PTSD symptom measures (p=.001), with reliable change indicated. • Non-significant results between samples.
3	Garland et al., (2015)	Pragmatic randomized controlled trial Pre/post measures Inferential statistics	PTSD Checklist-Civilian Version (Weathers, Litz, Herman, Huska & Keane, 1993)	Men 36-38 years old USA	**SS CBT** -Psychoeducation on safety & PTSD, compassion, recovery and boundary setting -Individual **Mindfulness-orientated recovery enhancement (MORE)**	• MORE demonstrated significantly greater reduction in PTSD symptoms than CBT(p=.04) & TAU (p=.05)

					-Mindfulness training for automatic behaviour, reappraisal training and fostering positive affect -Individual **TAU**	
4	Shein-Szydlo et al., (2016)	Randomized Controlled Trial Pre/post measures Inferential statistics	The Child Post Traumatic Stress Reaction Index (CPTS-RI) (Pynoos et al, 1987) Child PTSD Symptom Scale (CPSS) (Foa, Johnson, Feeny & Treadwell, 2001)	67% Female 14 years old Mexico	**CBT for PTSD** -Learning emotion-regulation skills, cognitive restructuring, relaxation and imaginary exposure -Individual **Waiting List (WL)**	• CBT was significantly better than the WL (p=00.1, ES=1.75) • CBT significantly reduced PTSD symptom scores (p=.001, ES=1.73) • There were no significant changes in follow up scores from the endpoint scores (t=0.51)
5	Jones (2018)	Pre-post outcome doctoral thesis Pre/post measures Inferential statistics	Trauma Symptom Inventory-2 (Briere, 2011)	Females 31 years old (N.B. a large proportion of the samples age was not recorded) USA	**SS CBT** -Psychoeducation on safety and substance abuse, coping and recovery -Group	• SS CBT demonstrated a significant reduction in PTSD symptom scores (p=.001) at post measurement
6	Lange-Altman (2014)	Pre-post outcome doctoral thesis	COPE Inventory (Carver, Scheier & Weintraub, 1989)	58% female ? USA	**SS CBT** -Psychoeducation on safety and PTSD, coping and recovery -Group	• SS CBT demonstrated a significant reduction in maladaptive coping p=.001, with an effect size of 0.46 to 1.10 • SS CBT demonstrated a significant increase in adaptive coping p=.001 with effect sizes ranging from 0.41 to 0.98

Overall quality of included studies

Table 2 provides an overview of study quality. Studies generally received a rating lower than good due to small sample sizes (2) or poor retention (1, 2, 3, 4, 5), a lack of control (2, 5), randomization (1, 2, 5, 6) and blinding (1,2,5,6) and poor treatment fidelity (1,5,6). Only one study met the full criteria for sample size and retention (4), whereas others generally only partially met the criteria, with one not meeting the criteria at all (2). The reason for only partially meeting the criteria were not exclusive to either a small sample size or retention. All studies used measures which were of reasonable quality with regards to reliability and validity, with half (1,2,3) using some form of the PTSD Checklist (Weathers et al., 1993) which has high internal consistency (a=.87), high convergent & discriminant validity high correlations (a=.75) and high test-retest reliability (a=.92). All studies relied on the use of subjective rating scales as the primary measurement, which introduces the risk of bias by participants acting in a socially desirable way or conveying superficial change due to acquiring a new understanding and language of their difficulties. The grey literature studies (1,2) received the lowest ratings which is symptomatic of the absence of peer review.

Table 2

Study Quality

Ref	Authors and intervention	Sample size & Retention	Clear rationale and definition of intervention	Primary outcome measure	Follow up period	Control of confounding variables	Treatment Fidelity	Intention to treat analysis	Overall quality rating
1	Desai et al., (2008; 2009) SS CBT	+/-	+/-	+	+	+/-	+/-	-	Adequate
2	Kip et al., (2016) ART	-	+	+/-	+	-	+	+	Good
3	Garland et al., (2015) MORE & SS CBT	+/-	+	+	-	+	+	+	Good
4	Shein-Szydlo et al., (2016) CBT for PTSD	+	+	+	+	+	+	-	Good
5	Jones (2018) SS CBT	+/-	+	+/-	-	-	-	-	Poor
6	Lange-Altman (2014) SS CBT	+/-	+	+/-	-	-	-	-	Poor

Note: + = Criteria met, +/- = Criteria partially met, - = Criteria not met/not reported
Good= <3 -, Adequate= 3 -, Poor= >

Interventions

SS CBT

Results

SS CBT is a manualized treatment for comorbid substance misuse and PTSD. Sessions covered; psychoeducation on safety, PTSD and substance misuse, interpersonal coping skills, recovery and relapse prevention (Najavits, 2002). Three of the four studies which evaluated the effectiveness of SS CBT reported significant change in primary outcome scores (1,5,6). Administration of the intervention varied between studies, with the amount of sessions ranging from 8-25 and differing between an individual (1,3) and group format (5,6). One study explored the use of the intervention in a group format with previously homeless women in a substance misuse unit, reporting a large effect size of d=1.41(5). Another explored its use in a homeless shelter for individuals overcoming addiction, using the intervention in a group format, reporting medium (d=0.41) to large (d=0.98) effect sizes in increases in adaptive coping and medium (d=0.46) to large (d=1.10) effect sizes in decreases in maladaptive coping (6). Only one study, which used a quasi-experimental design in a veteran's homeless shelter, presented significant changes in PTSD symptom scores (p=.03) received a rating of adequate, owing to its sample size, extensive follow up period and treatment fidelity (1). The final study assessing the effectiveness of SS CBT in a comparison to MORE and TAU in a pragmatic randomized control design, was found to be of good quality and did not find a significant treatment effect of SS CBT (3).

Quality

The quality of the methodology of the three studies which reported significant change ranged only from poor (5,6) to adequate (1), with none of the studies reaching full criteria for sample size and retention. Two studies, both grey literature (5,6), received a rating of poor because of significant methodological flaws including having no control group, random allocation or blinding. Further to this, a combination of a lack of treatment fidelity and no control/measurement of therapeutic intervention prior to the research intervention means results of changes in the primary outcome measures could not be confidently attributed to the intervention as other factors (i.e. therapeutic alliance, individual motivation) could not be ruled out. Additionally, both studies present bias as the researcher delivered the intervention, increasing the risk of the impact of therapist factors and social desirability on the outcome measures. Within the present study, which received a rating of adequate (1), bias is presented in the intervention sample as they had significantly lower symptom scores at baseline and had spent more time in residential treatment, as acknowledged by the authors who suggest the sample may have been receiving further help from substance misuse services. The results of the study therefore cannot be confidently attributed to the SS CBT intervention due to the presence of other therapeutic factors. Further to this, the SS CBT group were significantly more likely to have used drugs and/or alcohol in the last 30 days than the TAU group, therefore making it hard to distinguish if the changes in PTSD symptoms scores were attributable to the intervention or avoidant coping. The study which did not find a significant effect for SS CBT had reduced from the amount of recommended 25 sessions down to 10 in order to match the MORE intervention (3). Some bias towards the quality in the delivery of the interventions could be speculated as the first author of the study had designed the MORE intervention and provided training and supervision to the clinicians delivering the intervention. The clinician delivering the SS CBT arm was not formally trained in CBT, and whilst the clinician was supervised by a registered CBT therapist, it is not stated that this therapist was formally trained in the SS CBT intervention. Therefore, the absence in significant effect from the SS CBT on PTSD symptoms could be attributable to biased treatment fidelity.

MORE

Results

One study reported a significant reduction in PTSD symptoms (p=.03), with an intention to treat analysis confirmed at a medium effect size (d=.50) following a specially designed mindfulness intervention for comorbid substance misuse and PTSD (3). Sessions covered mindfulness training to target automatic habit behaviour, reappraisal training and training in savouring pleasant events.

Quality

Preference towards the MORE intervention could be speculated as the primary author was the designer of the intervention but the use of a control and comparison group, random allocation and blinding provide some balance to this and ultimately led to a good quality rating. Furthermore, a similar approach was taken to treatment fidelity between interventions to reduce bias. The study lacked a follow up period, which means the success of the intervention cannot be determined to be stable over time.

ART

Results

ART is a brief intervention which uses imaginal exposure and rescripting combined with the generation of bilateral eye movements to consolidate and modify traumatic memories (Kip et al, 2012). One study evaluated the effectiveness of ART in a cohort study (2) found a significant reduction in PTSD symptoms (p=.001), which were stated to be maintained at 6-month follow up. An intention to treat analyses indicated an effect size of d=-0.15.

Quality

The authors did not report to conducting statistical analysis to assess if the change was still significant at follow up. Additionally, some of the participants were residing in the community at follow up, therefore the causality of reduced PTSD symptoms could be attributed to external study variables. The study received an overall quality rating of good but did not include a control, blinding or randomization, therefore the changes in symptom scales could be influenced by external factors. Finally, a $50 financial incentive was provided before and after treatment and could therefore have influenced the participant’s engagement and motivation in the intervention and subsequent outcome scores.

CBT for PTSD

Results

One study using an RCT evaluated the effectiveness of CBT for PTSD in children and reported to finding large effect sizes in the reduction of PTSD symptoms on both of the primary outcome measures at 1.75 and 1.73 (4). The intervention covered emotional regulation skills, cognitive restructuring, relaxation, imagery exposure and in-vivo exposure for avoidance across 12 sessions on an individual basis.

Quality

The study received a rating of good. The intervention is made more robust by the use of a pilot on 10 adolescences prior to the RCT, further increasing its validity and reliability. Potential limitations exist in the use of primary outcome measures; The CPTS-RI (Pynoos et al, 1987) and the CPSS (Foa et al., 2001). The authors state both of the scales have been used with Spanish speaking populations, however a literature search indicates the scales have not been validated for use within this subpopulation. Whilst the study had a waiting list control group, there was no treatment comparison group; therefore, the attribution of clinical change may be attributable to variables external to the intervention (e.g. therapist factors, changes in housing situation).

Discussion

This review has systematically collated, appraised and synthesised literature exploring the effectiveness of psychological interventions for psychological trauma in the homeless population and has found research efforts to be limited. The lack of research can be seen to demonstrate further the multiple exclusion of this group as has already been identified (Bowpitt et al., 2011; Keats et al., 2012; Reeve et al, 2018).

Due to differences in the type of interventions included and flawed study methodology (Cheung & Vijayakumar, 2016), a meta-analysis was not conducted. Of the identified research, only a very small percentage is of good quality and indicates PTSD specific CBT interventions for homeless youth (4) and MORE for dually diagnosed adults (3) to be effective. Both studies utilised an approach whereby the intervention was delivered on a one to one basis, which could be considered to be more in line with the NICE recommendations around complex PTSD with consideration around taking more care to develop the therapeutic relationship (NICE, 2018), which may not be possible in a group context. Despite the good quality rating of the studies, knowledge of the duration of effect is unknown owing to the limited or absence of follow up. This is of importance as an effective treatment for PTSD which has long lasting effects could have the potential to reduce the chance of chronic homelessness (Scutella & Johnson, 2017). The use of an RCT design within these studies limits ecological validity of the interventions and cannot be said to be representative of the majority of the homeless population who do not have shelter. This highlights a broader issue across all of the studies included within this review, as no sample included individuals who were literally homeless at the time of study. This skews the representativeness of the synthesised data to that of individuals who have been in a fortunate enough position to access and utilise support, as exhibited in one study which excluded children who would not be utilising the shelter for more than 3 months and would be unavailable for follow up (4), indicating a selection bias.

Whilst the representativeness of the homeless population is skewed, consideration needs to be given to the likelihood of those in a situation where they are sleeping rough to engage in research for an extended period of time, owing to the difficulty to utilise services due to the presence of a high level of MCN present in the individuals' life (Reeve et al, 2018). It could be argued that the individuals who have been recruited into the studies identified in this research are actively having their MCN addressed, as recommended (NICE, 2018), e.g. accessing research opportunities whilst residing in a substance misuse unit (5,6). This is pertinent due to the high rate of substance misuse within the population (Fitzpatrick et al., 2012). Strengths of the included studies are the use of interventions which aim to alleviate distress caused by comorbid conditions, something which is highly relevant to a population with high rates of MCN. Whilst the studies were flawed methodologically and the effectiveness of SS CBT and ART is questionable, they provide some insight into the potential of these treatments being used with this population. This is of importance as the ongoing effects of PTSD may pose a huge barrier to some people exiting chronic homelessness – particularly those using substances to cope with the symptoms - and adapted treatment might offer a stepping stone towards this. However, at present this can only be a hypothesis as there is no research evidence. Additionally, the predominant focus of each of the studies was on the substance misuse, leaving other areas of comorbid MCN understudied.

A consideration highlighted across all studies was the use of subjective self-report measures. Whilst receiving a PTSD diagnosis is dependent on self-report and therefore requires subjective accounts, the sole use of self-report measures limits what can be understood. Although this review was interested in the change/no change in PTSD symptomology, further measures would have provided more evidence as to the impact of treating PTSD symptomology for this population more broadly. Relevant measures may have included social stability/housing, employment, relapse in drug/alcohol use, further episodes of homelessness or psychological wellbeing. Qualitative reports from clinicians administering the interventions would also provide objective perspectives on the change processes within the intervention, as clinicians may be able to pick up on changes that participants may not be conscious of or be able to articulate, as well as providing insight into the impact of factors external to the intervention itself i.e. therapeutic alliance (Rodgers & Elliott, 2015). Further to this, specific elements of the interventions were not individually analysed through the use of process measures, therefore making it difficult to ascertain which parts produced positive therapeutic effects.

A potential advantage presented in some of the studies was the use clinicians of whom had never come into contact with the therapeutic modality they administered prior to the research (1,2,5,6). If interventions can be delivered by clinicians without a high level of training, this makes the intervention more accessible and economically efficacious, targeting concerns around the economic burden of homelessness (Pleace & Culhane, 2016).

The transient nature of this population makes the design and conduct of research exploring the effectiveness of psychological interventions challenging from the outset. This is reflected in the high rates of attrition throughout the literature, with only one study meeting the criteria for retention (4). This further complicates the ability to determine an intervention's effectiveness as follow up periods are difficult to implement. This could explain why many studies used samples which had previously been homeless and were now residing in treatment units. It is proposed that more research is needed firstly on how to effectively engage this population prior to intervention and secondly on using interventions which vary from traditional deliverance i.e. administration outside of conventional settings. In addition to this it could be speculated that if members of this population struggle to engage with services therapeutically, then they will also struggle to engage with research. Despite this, reimbursement to take part in the research presented within this review was only reported to be offered by one study (2), even though evidence is available to indicate that providing reimbursement is valued by participants and is unlikely to induce coercion (Radecki-Brietkopf et al, 2011). Furthermore, it is considered to be unethical to withhold or adapt reimbursement for individuals who have a history of substance misuse (NHS Health Research Authority, 2014) as may be the temptation of some researchers working with this population. It is recommended that further research is conducted to explore how best to promote engagement with research.

Limitations of this review include the exclusion of literature written in other languages, thereby potentially missing some crucial literature and engaging in a selection bias. The review is also limited in its use of the definition of psychological trauma using diagnostic terms, as a large amount of literature refers to psychological trauma within the homeless population outside of these terms and without measuring symptoms. It would be beneficial to conduct a further review taking a qualitative approach to explore these broad terms of psychological trauma within the homeless population and evaluate how these terms are taken into account in the treatment of psychological distress and the effectiveness of this. Further limitations exist in the predominance of studies from the USA, making the generalizability of the results from these studies, if they were of high enough quality, questionable.

To conclude, youth specific CBT for PTSD and MORE interventions have been found to be potentially promising in the treatment of psychological trauma in the homeless population. This population is likely to have high levels of need in relation to psychological trauma and its effects but face barriers to accessing and engaging with psychological treatments. Individuals who are homeless not only have a right to effective treatments, but also effective treatments could potentially contribute to pathways out of homelessness. However, specific recommendations for clinical care and policy cannot be made due to the following reasons; the limited amount of evidence, the quality of the available evidence and the potential restrictions on generalisability due to cultural differences/sample characteristics. Due to the small number of high-quality studies in existence, it is recommended that further empirical research using rigorous study designs is conducted further evaluating these interventions. The literature base would benefit from diversifying the deliverance of interventions with regards to the use of an actively homelessness sample and environmental context, thereby providing information on the efficacy and feasibility of using psychological interventions with a hard to engage population in unconventional contexts.

Statement of contribution

Hayley Sapsford was responsible for the design of this project, reviewing the relevant literature, data collection, analysis and the writing up of the research.

Dr Anna Tickle provided supervision on the conceptualisation, design analysis and write up of the research.

Dr Danielle De Boos provided supervision on the analysis of the research.

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Declaration of Interest
The authors report no declarations of interest. The authors alone are responsible for the content and writing of

References

Altena, A., Brilleslijper-Kater, S. & Wolf, J. (2010) Effective Interventions for Homeless Youth: A Systematic Review, *American Journal of Preventive Medicine, 38*(6), 637-645

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).* Washington, DC: Author.

Bellg, A. J., Borrelli, B., Resnick, B., Hecht, J., Minicucci, D. S., Ory, M., Ogedegbe, G., Orwig, D., Ernst, D. & Czajkowski, S. (2004) Treatment Fidelity Workgroup of the NIH Behavior Change Consortium. Enhancing Treatment Fidelity in Health Behavior Change Studies: Best Practices and Recommendations from the NIH Behavior Change Consortium. *Health Psychology, 23*(5), 443-451. http://dx.doi.org/10.1037/0278-6133.23.5.443

Benzies, K., Premji, S., Hayden, K.A. & Serrett, K. (2006) State-of-the-Evidence Reviews: Advantages and Challenges of Including Grey Literature. *Worldviews on Evidence Based Nursing, 3*(2)

Bowpitt, G., Dwyer, P., Sundin, E. and Weinstein, M. (2011), "The support priorities of multiply excluded homeless people and their compatibility with support agency agendas – new research into multiple exclusion homelessness", Housing, Care and Support, Vol. 14 No. 1, pp. 31-32.

Breitkopf, C. R., Loza, M., Vincent, K., Moench, T., Stanberry, L. R., & Rosenthal, S. L. (2011). Perceptions of reimbursement for clinical trial participation. *Journal of empirical research on human research ethics: JERHRE*, *6*(3), 31–38. doi:10.1525/jer.2011.6.3.31

Briere, J. (2011). Trauma Symptom Inventory–2 (TSI–2). Odessa, FL: Psychological Assessment Resources

Carroll, T., Currier, J. McCormick, W. & Drescher, K. (2017). Adverse childhood experiences and risk for suicidal behavior in male Iraq and Afghanistan veterans seeking PTSD treatment. *Psychological Trauma, 9*(5), 583-58

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. Journal of Personality and Social Psychology, 56, 267-283.

Cheung, M. W.-L., & Vijayakumar, R. (2016). A guide to conducting a meta-analysis. *Neuropsychology Review, 26*(2), 121-128. http://dx.doi.org/10.1007/s11065-016-9319-z

Cockersell, P. (2018) *Social Exclusion, Compound Trauma and Recovery: Applying Psychology, Psychotherapy and PIE to Homelessness and Complex Needs.* London: Jessica Kingsley Publishers.

Deck, S. & Platt, P. (2015) Homelessness Is Traumatic: Abuse, Victimization, and Trauma Histories of Homeless Men, *Journal of Aggression, Maltreatment & Trauma, 24*(9), 1022-1043, DOI: 10.1080/10926771.2015.1074134

Department of Communities and Local Government (2012) *Evidence Review of the Costs of Homeslessness.* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

Desai, R. A., Harpaz-Rotem, I., Najavits, L. M., Rosenheck, R. A., Desai, R. A., Harpaz-Rotem, I., Rosenheck, R. A. (2008). Impact of the seeking safety program on clinical outcomes among homeless female veterans with psychiatric disorders. *Psychiatric Services, 59*(9), 996-1003. doi:10.1176/ps.2008.59.9.996

Desai, R. A., Harpaz-Rotem, I., Najavits, L. M., & Rosenheck, R. A. (2009). Seeking safety therapy: Clarification of results. *Psychiatric Services (Washington, D.C.), 60*(1), 125-125. doi:10.1176/appi.ps.60.1.125

Felitti, V. Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M. & Marks, J. (1998) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults, *American Journal of Preventive Medicine, 14*(4), 245 – 258

Fitzpatrick, S., Bramley, G., & Johnsen, S. (2012). *Multiple exclusion homelessness in the UK: an overview of findings: Briefing paper no. 1.* (Multiple Exclusion Homelessness in the UK: Briefing Papers). Edinburgh: Heriot-Watt University.

Foa, E., Johnson, K., Feeny, N. & Treadwell, K. (2001)The Child PTSD Symptom Scale: A Preliminary Examination of its Psychometric Properties, *Journal of Clinical Child & Adolescent Psychology, 30*(3), 376-384,DOI: 10.1207/S15374424JCCP3003_9

Garratt, E. (2017, May 30). *Homelessness in the UK: Estimating the scale of the problem.* Retrieved from http://csi.nuff.ox.ac.uk/?p=909

Garland, E. L., Roberts-Lewis, A., Tronnier, C. D., Graves, R., & Kelley, K. (2016). Mindfulness-oriented recovery enhancement versus CBT for cooccurring substance dependence, traumatic stress, and psychiatric disorders: Proximal outcomes from a pragmatic randomized trial. *Behaviour Research and Therapy, 77*, 7-16. doi:10.1016/j.brat.2015.11.012

Harber, M.G. & Toro, P.A. (2004) Homelessness among families, children, and adolescents: an ecological-developmental perspective. *Clinical, Child & Family Psychology Review, 7*(3), 123-164

Herman, D. B., Susser, E. S., Struening, E. L., & Link, B. L. (1997). Adverse childhood experiences: are they risk factors for adult homelessness? *American journal of public health*, *87*(2), 249–255. doi:10.2105/ajph.87.2.249

Hwang, S., Tolomiczenko, G. & Garner., R. (2005). Interventions to improve the health of the homeless: a systematic review. *American Journal of Preventive Medicine, 29*(4), 211-319

Jones, M., Worthen, M., Sharp, S. & McLeod, D. (2018)Bruised Inside Out: The Adverse and Abusive Life Histories of Incarcerated Women as Pathways to PTSD and Illicit Drug Use, *Justice Quarterly*, 35:6, 1004-1029, DOI: 10.1080/07418825.2017.1355009

Jones, D. (2018). *Evaluating the effectiveness of seeking safety treatment on homeless women who have substance use disorders and have experienced trauma*. (2018-40528-055). Retrieved from https://proxy.library.lincoln.ac.uk/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2018-40528-055&site=ehost-live

Kalmakis, K., Chiodo, L., Kent, N. & Meyer, J. (2019) Adverse childhood experiences, post-traumatic stress disorder symptoms, and self-reported stress among traditional and nontraditional college students, *Journal of American College Health*, DOI: 10.1080/07448481.2019.1577860

Kamieniecki G. (2001) Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: a comparative review. *Australian and New Zealand Journal of Psychiatry, 35*, 352–358

Keats, H., Maguire, N.J., Johnson, R. & Cockersell, P. (2012) *Psychologically informed services for homeless people', Good Practice Guide*, Department of Communities and

Local Government, available at: www.southampton.ac.uk/ assets/imported/transforms/peripheral- block/UsefulDownloads

Kip, K., Elk, C., Sullivan, K., Kadel, R., Lengacher, C., Long, C., Rozenzweig, L., Shuman, A., Hernandez, D., Street, J., Girling, S. & Diamond, D. (2012) Brief Treatment of Symptoms of Post-traumatic Stress Disorder (PTSD) by Use of Accelated Resolution Therapy (ART). *Behavioral Sciences, 2,* 115-134

Kip, K. E., D'Aoust, R. F., Hernandez, D. F., Girling, S. A., Cuttino, B., Long, M. K., Rosenzweig, L. (2016). Evaluation of brief treatment of symptoms of psychological trauma among veterans residing in a homeless shelter by use of accelerated resolution therapy. *Nursing Outlook, 64*(5), 411-423. doi:10.1016/j.outlook.2016.04.006 [doi]

Kushel, M.B., Evans, J.L., Perry, S., Robertson, M.J. & Moss, A.R. No Door to Lock: Victimization Among Homeless and Marginally Housed Persons. *Arch Intern Med.* 2003;163(20):2492–2499. doi:10.1001/archinte.163.20.2492

Lange-Altman, T. (2015). *Seeking safety and the social model of addictions treatment: A comparison study for the homeless, addicted, and traumatized* (Psy.D.). Available from ProQuest Dissertations & Theses Global. (1566656033). Retrieved from https://search-proquest-com.proxy.library.lincoln.ac.uk/docview/1566656033?accountid=16461

McDonagh, T. (2011) *Tackling homelessness and exclusion: Understanding complex lives.* Joseph Rowntree Foundation

Najavits, L. M. (2002). *Guilford substance abuse series. Seeking safety: A treatment manual for PTSD and substance abuse.* New York, NY, US: Guilford Press.

NHS Health Research Authority (2014) *HRA Ethics Guidance: Payments and Incentives in research.* Retrieved from:https://www.hra.nhs.uk/documents/274/hra-guidance-payments-incentives-research.pdf

NICE (2018), Post-traumatic stress disorder, Guideline [NG116], Retrieved from https://www.nice.org.uk/guidance/ng116/chapter/Recommendations#care-for-people-with-ptsd-and-complex-needs

Piat, M., Polvere, L., Kirst, M., Voronka, J., Zabkiewicz, D., Plante, M., Isaak, C., Nolin, D., Nelson, G. & Goering, P. (2014) Pathways into homelessness: Understanding how both individual and structural factors contribute to and sustain homelessness in Canada. *Urban Studies, 52*(13), DOI: 10.1177/0042098014548138

Pleace, N. & Culhane, D.P. (2016) *Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England*. London: Crisis.

Pynoos, R., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., Nunez, F. & Fairbanks, L. (1987) Life threat and posttraumatic stress in school-age children. *Archive of General Psychiatry, 44*(12), 1057-1063

Reeve, K. McCarthy, L. Pattison, B. Parr, S. Batty, E. Maye-Banbury, A. Bashir, N. & Dayson, C. (2018) *The mental health needs of Nottingham's homeless population: an exploratory research study.* Centre for Regional Economic and Social Research: Sheffield Hallam University

Ringwalt, C. L., Greene, J. M., Robertson, M., & McPheeters, M. (1998). The prevalence of homelessness among adolescents in the United States. *American journal of public health*, *88*(9), 1325–1329. doi:10.2105/ajph.88.9.1325

Rodgers, B. & Elliott, R. (2015). Qualitative Methods in Psychotherapy Outcome Research. DOI:10.1007/978-3-7091-1382-0_27.

Roos, L. E., Mota, N., Afifi, T. O., Katz, L. Y., Distasio, J., & Sareen, J. (2013). Relationship between adverse childhood experiences and homelessness and the impact of axis I and II disorders. *American journal of public health*, *103 Suppl 2*(Suppl 2), S275–S281. doi:10.2105/AJPH.2013.301323

Scutella, R. & Johnson G. (2018) Psychological distress and homeless duration, *Housing Studies, 33*(3), 433-454,

Shein-Szydlo, J., Sukhodolsky, D. G., Kon, D. S., Tejeda, M. M., Ramirez, E., & Ruchkin, V. (2016). A randomized controlled study of cognitive–behavioral therapy for posttraumatic stress in street children in mexico city. *Journal of Traumatic Stress, 29*(5), 406-414. doi:10.1002/jts.22124

Weathers, F., Litz, B., Herman, D., Huska, J. & Keane, T. (1993). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. Paper Presented at the Annual Convention of the International Society for Traumatic Stress Studies.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization.

Designing and evaluating a psychological intervention for individuals with Multiple Complex Needs

Short Title: An Intervention for Individuals with MCN

Hayley Sapsford, Trainee Clinical Psychologist

Professor Thomas Schroder, The University of Nottingham

Dr Danielle De Boos, The University of Nottingham

Dr Anna Tickle, The University of Nottingham

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Abstract

Objective: The Power Threat Meaning Framework (PTMF) has been designed by its authors to take disempowerment in psychological suffering into account and provide a narrative to make sense of experiences and regain a sense of personal agency. This research aimed to design a brief intervention based on the PTMF and explore the outcomes, utility and feasibility with adults experiencing Multiple Complex Needs (MCN).

Method: A brief PTMF-based intervention was systematically designed and evaluated using a single exploratory case study. Thematic Analysis was conducted with data from process measures, session recordings and a change interview. Descriptive data was obtained from quantitative measures. One measure was analysed using reliable change.

Results A number of helpful therapeutic events were identified in the analysis. Qualitative data indicated shifts in empowerment and agency. There were no significant changes pre/post in the quantitative data.

Conclusion: It is suggested the PTMF can be translated into an acceptable intervention for those experiencing MCN. Unhelpful events and feedback were used to make changes to the workbook and enhance its feasibility. Future research would benefit from replicating the current study with an increased number of participants and robust assessment of outcomes.

KEYWORDS: Multiple Complex Needs, Power Threat Meaning Framework, Multiple Exclusion, Personal Agency, Empowerment

Background

Multiple Complex Needs

Multiple Complex Needs (MCN) refers to any two of the following: homelessness, substance misuse, offending behaviour and mental health difficulties (Keats et al., 2012). It is estimated around 60,000 people in the UK experience MCN (Fulfilling Lives, 2020), with the societal economic burden ranging from £1.1bn to £2.1bn per year (Furness, 2018). Additionally, those experiencing MCN have a higher risk of facing aspects associated with a poor quality of life, including increased mortality and morbidity (Aldridge et al., 2018; Waugh et al., 2018).

There is increasing recognition that psychological trauma often underpins MCN (McDonagh, 2011). The Adverse Childhood Experiences (ACEs) study (Felitti et al., 1998) demonstrates the domino effect of adverse events from childhood into adulthood, with strong associations found between ACEs and subsequent MCN (Herman et al., 2011), further demonstrated by the finding of an ACE prevalence of up to 60% in some homeless individuals' histories (Roos et al., 2013). Moreover, those with a high incidence of ACEs are more likely to engage in illicit drug use (Jones, et al., 2018). ACEs in one sample of 452 individuals who had experienced homelessness included domestic violence (27%), family homelessness (16%), sexual abuse (23%) and parental drug use (24%) (Fitzpatrick, Johnsen & Bramley, 2012). One study found a core theme of substance misuse and mental health problems to be deeply rooted in the same traumatic experience in one sample of individuals facing homelessness (Reeve et al., 2018). It can be suggested that the presence of multiple disadvantages in an individual's life cluster, escalate and perpetuate one another into MCN (Sosenko, Bramley & Johnsen, 2020). *[See section 1.1 for further discussion: Gender]*

Multiple Exclusion

Multiple Exclusion (ME) is defined as an individual being unable to access the labour market, welfare or varying aspects of their community (Evans, 1998) and has been identified as exacerbating the difficulties of those facing MCNs. A suggested pathway of ME is described by the notion of compound trauma: the cumulative effect of a sequence of traumatic events, without time or support for recovery between each, which impact an individual's development and reduces their ability to cope in a socially accepted manner (Cockersell, 2018). This leads to ME as the individual is prevented from accessing a range of services for reasons of antisocial behaviour, difficulty adhering to routine (keeping appointments) or experiencing multiple needs which services are not designed to meet (Keats et al., 2012). Further examples of ME have been seen where individuals with MCN were unable to access the services they needed for reasons such as mental health needs going unacknowledged, falling between service thresholds, dual diagnosis, waiting lists or inappropriate referrals (Reeve et al, 2008; Fitzpatrick & Bramley, 2019). It has been reported that some individuals experiencing MCN will even go to the lengths of offending as a last resort to access care after being repeatedly failed by community services (Fitzpatrick & Bramley, 2019). However, this is no means to an end, as it is reported ex-offenders are often released from prison without housing provision resulting in the "hamster wheel of homelessness" (Opportunity Nottingham, n.d.). It is argued the current systems are not adequate to meet the complex needs of this group due to two key issues: differing perceptions by service users (SU) and providers as to what the priority is for treatment, and services inability to be flexible with MCN (Bowpitt et al., 2011). Despite an increasing acknowledgment of the need for trauma/psychologically informed services to meet the needs of those who are coping with the long-term effects of psychological trauma (Maguire et al, 2010), limited resources mean a provision of a "one-size-fits-all" model is used, whereby if those experiencing MCN "fail to engage" they are discharged or refused service (Fitzpatrick & Bramley, 2019).

Personal Agency

Personal Agency (PA) within this study is defined as the power or control an individual has over their own life (Vallacher & Wegner, 1989). It is proposed individuals experiencing MCN receive contradictory messages about their PA when trying to navigate services. For example, legislation around statutory homelessness places emphasis on PA, as if a person becomes homeless due to rent arrears they are classed as 'intentionally homeless' (Ministry of Housing, Communities & Local Government, 2018). Similarly, those experiencing MCN suffer inequality in accessing Universal Credit (Fitpatrick & Bramley, 2019) and are more likely to receive sanctions on their benefit claims (Watts & Fitzpatrick, 2018). In contrast, the application of a psychiatric diagnosis reduces PA as the individual receives the message that they have symptoms to be treated, shifting the control from the individual to a wider system (Kennedy, 2008). This is significant as it has been demonstrated that individuals suffering with difficulties in their mental health have a compromised PA that impairs their ability to take ownership over their thoughts and actions (Dimaggio et al., 2009). Consequently, when an individual with a reduced sense of PA struggles to navigate a system that demands a high level of PA, they are left feeling disempowered and hopeless about their situation. Parsell, Tomaszewski and Phillips (2014) conducted qualitative research with individuals who had previously been homeless and identified that an increase in PA was the catalyst for their engagement with services and changing their circumstances. However, this research was conducted in Australia, placing cultural limitations on the findings. This would suggest that an intervention is required which promotes PA whilst also recognising the challenges face by people experiencing MCN, compound trauma and multiple exclusion. *[See section 1.3 for further discussion: Personal Agency].*

Power Threat Meaning Framework

Regaining PA has been cited as essential in the process of recovery from mental health conditions (Lysaker & Leonhardt, 2012). A proposed method of doing so is through making meaning of experiences by developing a narrative that allows the individual to take ownership of thoughts, feelings and actions. This has previously been demonstrated with individuals with a diagnosis of schizophrenia (Roe & Davidson, 2005). The Power Threat Meaning Framework (PTMF) (Johnstone & Boyle et al., 2018a) is presented as an alternative to psychiatric diagnostic systems and considers psychological distress as more than a set of symptoms and biological responses. Rather biology is seen as a role of mediating experience within the context of social, psychological and cultural factors.

The PTMF enables the user to develop their narrative by considering five key constructs (Table 3). The use of the PTMF is considered to be appropriate in developing PA within this context as the authors describe a philosophy of "assigning a central role to personal agency, personal meaning, emerging out of social and cultural discourses…" (Johnstone & Boyle et al., 2018a, p.8). *[See section 1.2 for further discussion: Theories of Power]*

Table 3
A Brief Outline of the PTMF

PTMF Construct	**Power "What has happened to you?"**	**Threat "How did it affect you?"**	**Meaning "What sense did you make of it?"**	**Threat Response "What did you do to survive?"**	**Strengths "What are your strengths?"**
Definition	This area considers how adversity has played a role in psychological distress	This area explores how adverse use of power creates threatening situations	The attributions made about the threat	The behavioural, emotional and physiological responses to the threat	Privileges and positive aspects of power which have acted as coping mechanisms
Example	An individual loses their job, is unable to pay their rent and loses their home, and consequently struggles with their mental health	The individual is a low priority to be housed by the council and there are limited resources to provide shelter	"Society is unfair" "I am unequal" "I am different" "I have little control"	To manage physical and psychological distress of sleeping rough the individual begins to use illicit substances and steal to meet their needs	The individual has a motivation to seek help They have strengths in intelligence and are educated at degree level

The PTMF is still in the early stages of accruing evidence for clinical utility, but its potential is increasingly recognised with calls to incorporate the PTMF into the curriculum of mental health nursing (Grant & Gadsby, 2018). There are a number of criticisms of the PTMF, including the language used to explain distress potentially making the ideas inaccessible

(Aherne, Moloney & O'Brien, 2019) and the vagueness around the expected outcomes. It could be argued the PTMF has not introduced anything "new" as methods of psychological formulation, Narrative Therapy and Trauma Informed Care already exist. However, a pre-existing model which draws these principles together into a formal framework does not exist, and this is what the PTMF is offering.

The PTMF has been designed by its authors to take disempowerment in psychological suffering into account and provide a narrative to make sense of experiences and regain a sense of personal agency. Those experiencing MCN are amongst those who are the most disempowered in our society and are cited to have limitations placed on their ability to exercise PA. The PTMF is proposed to be a potentially suitable intervention for promoting PA whilst also recognising the challenges faced by people experiencing MCN, compound trauma and multiple exclusion.*[For further discussion See section 1.4: The PTMF, 1.5:: PTMF Literature & see section 1.6 for further discussion: Existing Psychological Approaches]*

Aim

To design a brief intervention based on the PTMF and explore the outcomes, utility and feasibility with adults experiencing MCN.

Research Questions

Phase 1

1. How can the PTMF be translated into an intervention for individuals experiencing MCN?

Phase 2

1. Do individuals demonstrate a change in their PA?
2. Do individuals demonstrate a change in their sense of power over their situations?
3. Do individuals demonstrate a change in their mental wellbeing?
4. What are the participant's views on the helpfulness of each session?
5. What are the clinician's views on the helpfulness of the intervention?
6. What changes do participants' report post-intervention? Do they attribute these changes to the intervention?

Methods

The systematic design of an intervention based on the PTMF was evaluated using an exploratory case study of the PTMF as an intervention with individuals experiencing MCN. Specific outcomes on PA, empowerment and wellbeing were explored. The research was approved by the Faculty of Medicine and Health Science University of Nottingham Ethics Committee.

Phase 1: Design of the PTMF workbook

An interventive workbook based on the PTMF (Appendix 1) was designed by the lead researcher in consultation with the field supervisor as a professional expert, using the PTMF template as a guide. The intervention was designed to be approximately 45 minutes per session and started with some brief psychoeducation based on the material presented in the PTMF, followed by exercises designed to support the participant in applying the PTMF concepts to their life experiences. All definitions of the concepts were taken verbatim from the PTMF template to ensure the concepts were not changed by the subjective interpretations of the researcher. The sessions were structured as follows:

- Session 1 What is the PTMF? & Power: What has happened to you?
- Session 2 Threat: How did it affect you?
- Session 3 Meanings: What sense did you make of it?
- Session 4 Threat Responses: What did you have to do to survive?
- Session 5 Strengths: What are your strengths?
- Session 6 Your Story: What is your story?

The first session was designed to introduce the PTMF by presenting the core questions. The participant was then asked to describe their current situation/difficulties. This is not suggested by the PTMF but was added to the workbook as a starting exercise to begin to build the rapport with the clinician in the development of a mutual understanding of the participants current experiences. This is in line with the idea that the PTMF places "emphasis on personal meaning and the importance of healing through relationships" (Johnstone et al., 2018b, p.17).

Next, the participant was asked to describe what the word "power" meant to them, followed by the introduction of PTMF definition of power. The definition was linked to the participant's language to personalise their understanding of the PTMF definition. The participant was provided with examples of the different forms of power and how they can be enacted both positively and negatively. This was further supported in the next exercise where the participant was asked to generate their own examples of how different forms of power had impacted them, encouraging the participant to begin to learn how to conceptualise their experiences using the concepts of the PTMF.

Each subsequent session started with a recap of the session from the previous week, aiming to consolidate the information previously introduced to the participant. The participant was given the opportunity to add any new understandings or insights they may have had between sessions, encouraging the use of reflection to strengthen learning (Kolb, 1984).

The second session introduced the participant to the concept of threat as a result of disempowerment. The participant was provided with examples of ways in which the misuse of the different forms of power can result in common threats e.g., losing your job results in the threat of being unable to pay for food/rent. The participant was asked to consider the threat they faced as a result of the negative use of power against them. Coherence between the different PTMF concepts was ensured by linking the participant's own examples between sessions.

The session on Meanings presented the idea of the interaction between threat and psychobiological responses. A list of common feelings, beliefs and bodily sensations presented in the original PTMF template was taken and presented verbatim in the workbook to ensure consistency to the model. The participant was asked to consider one key threat they had previously identified and label the responses they experienced in relation to this. By connecting their psychobiological responses to the threats, this would potentially help them to develop an understanding of maladaptive patterns of responding in the face of threat.

This led on to the introduction of threat responses in the fourth session, where the participant was introduced to the idea of how they have behaved or developed 'symptoms' in response to the meanings of threatening situations. In the original publication of the PTMF, a list is provided of possible behaviours/symptoms which could be considered to be threat responses.

This list was provided as an insert to the workbook but only provided to the participant if they were struggling to understand the concept. The rationale for this was due to the significant length of the list, which could be potentially overwhelming for the participant. This is of particular importance to those experiencing MCN as it is likely they had experienced or engaged in multiple aspects of the list, therefore potentially leading to an unfocused approach from the identified line of examples in previous sessions. Once the participant was reminded of their previous examples, they were encouraged to think about how they had behaved or what symptoms they had experienced and how this had helped them to manage threat in the past, including any problematic consequences. In the consideration of problematic consequences, the participant was encouraged to think about their own role in responding to threatening situations, with the aim of highlighting potential patterns of responding which are no longer adaptive and developing the participant's PA.

The final concept introduced to the participant was strengths. The rationale for introducing the concept of strengths was to encourage the participant to reflect not only on their positive attributes and skills, but also circumstances which have made threats easier to survive. The authors of the PTMF base their rationale in community psychology, with the argument that power imbalance can be addressed in the focusing on personal strengths and attributes (Bostock & Diamond, 2005). The participant was given examples of how they could build upon their strengths and asked to consider if there were any ways they could enhance their pre-existing strengths or add any new ones into their repertoire.

The final session of the PTMF encouraged the participant to pull all the information from across the sessions together into a complete narrative. The rationale for the final narrative was to encourage the participant to take their reflections from across the sessions and generate new meanings which enable them to enact change. Minimal instruction was given to the participant to avoid the imposition of a rigid structure but prompts of the PTMF core questions were given to support coherent linking between the different concepts. *[See section 2.2 for further discussion: Design of Workbook]*

Therapists Manual

A therapist's manual was created which included the rationale and instructions for each session and the materials required. The clinician was also provided with reminders for when to administer particular outcome measures and at what point. Finally, advice was given around attending to the participant's emotional state at the end of each session, as it was likely they would have been asked to reflect on potentially upsetting life events. This gave the clinician the opportunity to either support the participant in emotional regulation or signpost/acquire additional support.

Service user consultation

An Expert Citizen (EC) group with lived experience of MCN provided their expert opinion on the design and pilot of the PTMF intervention, Participant Information Sheets and Informed Consent Forms. The use of the EC group holds a strength in creating a participatory rhetoric, holding true to the idea of "nothing about us, without us" (DH, 2001). This is particularly important when working with those who have faced MCN, as to neglect consulting these individuals in the entire research process is to perpetuate the ongoing cycle of exclusion. *[See section 3.1 for further discussion: Service User Involvement]*

Phase 2: An exploratory case study

All participant processes, including obtaining informed consent, were conducted remotely (by telephone) during the lockdown period of the COVID-19 pandemic. Demographic details were collected from the participant at the start of the intervention. The study took place in affiliation with Framework and Opportunity Nottingham which are charities working with individuals experiencing MCN and provide support in attaining housing, health care, financial stability and social inclusion. The intervention was delivered by a registered Clinical Psychologist on secondment to Framework/Opportunity Nottingham. The intervention was given in addition to any clinical care as the study was conducted outside of an NHS context. *[See section 2.3 for further discussion: Recruitment and section 2.4 Design justification]*

Recruitment

The initial plan for recruitment was for participants who met the inclusion criteria to be identified by the field supervisor and the care team at Framework/Opportunity. If the individual was interested in the study, they would be provided with a PIS and given a minimum of 24 hours to make an informed decision to participate. However, one participant was recruited into the study after he provided feedback on the study design during the EC group consultation and requested to join the study. It was agreed care staff at the EC group consultation would pass his name to the field supervisor to complete the ICF.

The initial aim of the research was to recruit six participants. Further recruitment into the study was not possible due to the impact of the COVID-19 pandemic. It has been reported single participant designs are suitable in projects whereby the "unfolding behavioural repertoire of an individual organism is of primary interest" (Morgan & Morgan, 2001, p.125) and the utility of an intervention is yet to be established (Barlow & Hersen, 1973; Morley, 2017). As the aim of this research was to establish the utility of the PTMF, an exploratory case design is argued to be sufficient to explore the subject and make a valuable contribution to the field. Furthermore, this was considered to be feasible owing to the access to the target population, as the complex nature of the participants needs and potential difficulties in engagement reduced the number of available participants. *[For further discussion see section 2.1: Epistemology, 2.8: Ethical Considerations, 2.3 Recruitment, 2.10 COVID Impact Statement and 4.0 Extended Discussion]*

Participant

Alex* (*pseudonym to protect the participants confidentiality) was a 54-year-old British male with a self-reported diagnosis of depression. He disclosed a history of offending on the basis of experiencing homelessness and being unable to be compliant with housing restrictions. He reported receiving one assessment for his mental health when he was held in police custody and received a prescription for Sertraline, however he had stopped taking this. Alex reported no further historical or current support for his mental health. He was receiving housing support and in contact with Framework and Opportunity Nottingham.

Measures

Psychometric measures were completed at specific time points (pre/mid/post) by both the participant and the clinician. Due to the transient nature of the study population, the establishment of a stable baseline was unlikely to be feasible. The rationale for including psychometric measures is to facilitate triangulation, calculate reliable change and make the findings more robust (Bekhet & Zauszniewski, 2012).

The Sense of Agency Scale (SoAS) (Tapal et al., 2017) (see Appendix 2) is a 13-item self-report scale measuring an individual's general and context free beliefs about core agency and is divided into subscales of positive (SoPA) and negative agency (SoNA). It has been demonstrated to have good test-retest reliability (SoA=0.78, SoNA=0.74) and moderate construct validity when correlated with conceptually relevant tools (.35). However, there was no available data for the tool's sensitivity to change.

The Empowerment Scale (ES) (Rogers et al., 1997) (see Appendix 3) is a 28-item self-report scale which measures the following factors derived from definitions of empowerment within mental health and society: self-esteem, power, autonomy, future control and righteous anger. The ES is cited to have good internal consistency (.86) and internal reliability. However, there was no available data for the measure's sensitivity to change. The definition of empowerment within this study follows that used in the literature of the ES; "the connection between a sense of personal competence, a desire for and a willingness to take action in the public domain" (Rappaport, 1987).

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al, 2007) is a 14-item scale which measures mental wellbeing. The rationale for using this questionnaire is the scale aligns well with the proposed outcomes of the PTMF-based intervention. The authors of the scale claim it to be sensitive to change in mental wellbeing at individual and group level with a probability of change greater than 0.5 (Maheswaran et al., 2021), normally distributed, have high test-retest reliability (.83) and good content validity (.91) (Stewart-Brown et al, 2011). *[See section 2.5 for further discussion: Measures]*

Process measures

Each session was audio-recorded to capture the underlying therapeutic processes. In addition, the Helpful Aspects of Therapy Form (HAT) (Elliott, 2000) was completed by the participant. The HAT is a brief, open-ended questionnaire designed for use after every session. The participant was asked to consider helpful and hindering aspects of the session and at which points they occurred. This was used to explore the underlying process of the PTMF, as participant-identified helpful events have been cited as being effective in predicting therapeutic outcome (Martin & Stelmaczonek, 1988).

After each session, the clinician completed a brief, open-ended questionnaire which mimicked similar questions to the HAT (See Appendix 4), including additional questions around the feasibility of the intervention. The clinician was also given the opportunity to report any abnormalities or disruptions to contribute to the final considerations/limitations of the study. The rationale for including a clinician measure was to give an additional perspective on the change processes within the intervention, as clinicians have the potential to pick up changes that participants may not be conscious of or be able to articulate (Rodgers & Elliott, 2015).

After the completion of the intervention, a semi-structured change interview adhering to the schedule of Elliott & Rodgers (2008) was conducted by the lead researcher to ascertain if changes were a result of the PTMF intervention or other therapeutic/external processes. The interview was conducted within two weeks of the final intervention session to maximise recall and protect against attrition from this transient population. *[See section 2.6 for further discussion: Process Measurement]*

Analysis

Data obtained from the Empowerment Scale (ES) were analysed using the Reliable Change Index (RCI) and Clinically Significant Change (CSC) (Jacobson & Truax, 1992). The RCI specifies the amount of change an individual must show on a specific psychometric instrument between time points for that change to be reliable. If change is found to be reliable, then it can be considered to be practically or clinically significant. It was not possible to calculate the RCI or CSC for the WEMWBS or SoAS due to an absence of reference data, therefore the results from these measures were used descriptively.

Data from the session transcripts, the change interview, HAT and the Clinician Questionnaire were analysed collectively using the Braun and Clarke (2006) method of Thematic Analysis (TA). Inductive analysis was conducted first to allow for the identification of new knowledge without the imposition of preformed theoretical ideas and concepts but did not introduce anything new related to the research questions. Secondary deductive analysis was informed by the Events Paradigm (Elliott & Sharpio, 1988) and a meta-analysis of therapy events (Timulak, 2010). *[See section 2.7: Thematic Analysis for further discussion]*

Results

<u>Preliminary Outcomes</u>

To address the research questions, TA identified verbalisations which indicated changes in empowerment, PA and mental wellbeing from the session transcripts, the change interview, the change question, HAT and the Clinician Questionnaire were analysed collectively. Inductive analysis was conducted first but did not generate any new knowledge outside of the pre-determined deductive codes or relevant to the aims of the research. Therefore, the inductive and deductive analyses were merged. These themes were presented with the coinciding quantitative data collected from the psychometric measures. *[For further discussion see section 2.7: Thematic Analysis]*

Empowerment

A shift in a sense of empowerment can be seen in Alex's narrative around his living situation as the sessions progress. In the first session, Alex shared his beliefs when completing the problem statement:

> *Alex: "maybe it's time for me to or for Framework should be looking at a move on plan for my independent living, you know? and that's the only kind of problem at the moment because I don't even have a number to do anything, and I have slight rent arrears which has causes apprehension"*

Alex speaks about having limited resources in knowing who to speak to and the barrier of his financial situation causing him apprehension. It can be suggested Alex is unclear in his responsibility in enacting change or if this should be led by Framework. However, there appears to be a shift in Alex's view of his control over the situation by the end of session three:

> *Alex: "...I realise what the problems I had faced and now I'm still in a situation where I want to be able to kind of move on and almost prove [inaudible] but it's almost like I'm proving to myself...in fact it's kind of making me want to put the phone down and ring the office myself [laughing]"*

Session three focused on developing a narrative around what the meaning of significant life events has for the individual. Alex spoke about the events which led to losing his accommodation in previous years, resulting in a cycle of imprisonment and homelessness. As can be seen from the extract, Alex expresses a clear idea for enacting change for himself in "calling the office", in reference to contacting those who can support him in moving into independent living, which was previously identified as a barrier for a change. This shift is maintained in the change interview:

> *Alex: "...I've just given my example of my move can't happen yet, but I won't...you know back down until I've got a result. Simple as."*

This change in empowerment is partially supported by the results from the ES, summarised in Table 4. As can be seen in the table, whilst there was no reliable change in the total ES score from pre/post, there is positive significant reliable change in the subscales of power, optimism and anger at post measurement.

Table 4

Changes in the Empowerment Scale Scores

	ES Total score	Self-esteem	Power	Community	Optimism	Anger
Pre	3.29	2.56	2.75	3.67	3	2.5
Mid	2.5	2.89	3.37	3.83	2.5	3
Post	3.21	2.11	3.38	3.67	3.67	3
RCI & CSC	-0.08 No	-0.45 Yes	0.63 Yes	0.00 No	0.67 Yes	0.5 Yes

However, there is an indication Alex's personal attributes also contributed to the shifts in empowerment:

Alex: "Right, I'm going to have to say in a strange way I'm not too surprised because that's me anyway. I'm one of those kind of you know…yeah…determination"

Personal Agency

During the sessions there was a suggestion of a change in agency as identified by Alex in changing his behaviour:

> *Alex: "You can see the impact already, I have got a beer looking at me straight in the eye and I'm thinking coffee you see?"*

This is in reference to Alex's frequent disclosure of using alcohol as a coping mechanism due to the distress caused by the COVID-19 pandemic and subsequent lockdown restrictions. During the session, Alex had identified that he can often experience a sense of losing control whilst using alcohol and the adverse consequences of this. There is an indication of a change in agency in his acknowledgement that he is actively choosing to make a cup of coffee when he has the temptation of alcohol in front of him. This is supported by the results of the SoAS, which demonstrated a slight increase in a positive agency (SoPA) and a slight decrease in a negative agency (SoNA) from pre/post (Table 5).

Table 5

Changes in the Sense of Agency Scale Scores

	Pre	Mid	Post
SoPA score	20	15	23
SoNA score	24	29	17

Alex highlights further changes in behaviour with new insights of how past events have impacted him:

> *Alex: "I'm going to fight back what triggered me and I'm not going to act impulsively on what I feel or whatever…and taking the time to sit back and really think before I strike out at anybody else"*

Alex was reflecting on situations where he has taken offence to other people and identified that other people can inadvertently "trigger" him. However, he developed the understanding this can be related to past experiences rather than the present situation. The extract suggests a change in agency in taking control in his response to being "triggered".

There is a suggestion of Alex developing a realistic understanding of the world and the limitations of PA:

> *Alex: "…I can pretty much determine what happens in my life…it's made me take that and think you know can I really determine what goes on? I can make arrangements and whatever, but it doesn't always go to plan, you know? It's kind of made me sit back and question things about how I go about things."*

Whilst Alex acknowledges that there will inevitably be elements of life which will remain outside of his control, he re-establishes himself as an active agent by his questioning of his own approach.

Mental wellbeing

The analysis on mental wellbeing involved looking for both positive and negative changes in mental wellbeing owing to the intervention and to extraneous variables. Alex described a change in his mental attitude during the change interview:

> *Alex: "It's given me incentive and a positive towards…a bit more positive. I know I keep saying I'm lacking certain things but in a strange way I feel a bit more positive as well."*

However, there are a larger number of extracts which indicate a negative impact on Alex's mental wellbeing:

> *Alex: "I'm feeling a little bit in low spirits…you know…having realisations that certain things that have happened and whatever so yeah…hmm I dunno"*

This extract was taken from the change interview and was elicited using direct questions about the impact of the intervention. As can be seen, Alex attributes the change in his mental wellbeing to "having realisations" about past experiences which may be the indication of the impact of reflecting on difficult life events and developing new understandings. However, this was not reflected in the findings of the WEMWBS, which did not find any meaningful change in the pre/post score but did find a deterioration of four points in the mid score. Literature indicates meaningful change occurs when the post score is three to eight points different from the pre score when using the WEMWBS (Putz et al, 2012).

Table 6

Changes in the Warwick-Edinburgh Mental Wellbeing Scale Scores

	Pre	Mid	Post
WEMWBS score	45	41	46

Therapeutic Processes

Subthemes were constructed from Alex's insights which indicated outcomes specific to his experience of the intervention. The first outcome identified was enabling Alex to think about his experiences from new perspectives:

> *Alex: "So my whole life has kind of…it's changing, it's kind of made me look at things differently, totally differently"*

There was also an indication of a cognitive shift as Alex reflected on a childhood incident which he found threatening:

> ***Clinician: "so, let me just check that I have understood that right. I think what you're saying is you experienced it as a bully but now you wonder whether he was trying to encourage you and tell you could do it?***
>
> *Alex: "Absolutely correct…"*

As can be seen from this interaction between Alex and the clinician, there is a confirmation that whilst he previously perceived an experience of a teacher to be bullying, he is now able to recognise that the teacher was trying to encourage him. A change of perception is observed through the process of reflection and building a narrative around the different uses of coercive power. This fits with the second subtheme whereby a process of connecting past experiences to the present was found to be helpful:

> *Alex: "…and it took me a second to realise how powerful that feeling was it felt like it was happening again…but because I was able to connect with feelings from the past and with some people feeling that ill feeling in these present-day circumstances"*

Alex identified that whilst the discussion triggered distressing emotions, he found the process of recognising these feelings are based in past experience and how this can impact his perception of others in the present to be helpful. This was reiterated by the clinician:

> *Clinician: "Hearing [Alex] talk during the reflections and completion of the H.A.T. was surprising in terms of hearing how powerful he had found it to be reconnected with previous feelings (what I would think of as implicit, physiological memories) and the recognition that some of these feelings are unresolved seemed to be very important to him."*

There is a suggestion of the impact of developing these alternative perspectives:

> *Alex: "I don't know how to explain it…it's kind of made me feel like that I have opened up a little bit more rather than holding back myself…yeah."*

Alex makes reference to feeling as though he has "opened up", "come out of my shell" and feeling less "held back" throughout the intervention. It could be suggested the intervention has enabled Alex to process distressing life experiences in the creation of his life story narrative. However, the meaning of "opening up" is subjective and personal to Alex and it cannot be said how this may influence change in other areas of his life. *[See section 3.4: Additional Themes for further discussion]*

Workbook Acceptability and Feasibility

Following feedback from the clinician and Alex, the workbook was changed to improve its utility (Appendix 5), as summarised in Table 7 and evidenced in the qualitative information.

Change No.1

There is evidence of Alex experiencing emotional and physiological arousal during the sessions when discussing his life experiences:

> *Alex: "…I can almost sense it very strongly how I would have felt back then, including the anger which is 'ahhhh' and I'm only ever so slightly feeling it…so yeah…"*

As can be seen, Alex is skilled in identifying and attending to his emotional state and reflecting this back to the clinician. The clinician also highlighted concerns regarding the workbook's potential to evoke the participant to potentially experience psychological distress:

> *Clinician: "As [Alex] reconnected with a difficult childhood episode, he clearly experienced very strong emotional reactions, to the extent that he needed to stop. He was able to ask for this break so as to regulate himself, but as in previous sessions I wonder if there should be some more setting up of exercises and explicit preparation."*

As a result of Alex's expression of physiological and emotional arousal in direct relation to the discussions elicited in session, a disclaimer was added to the first session informing the participant that they are likely to think and discuss upsetting life events. A space was provided for the clinician and participant to note down contracted ways in which the participant could be supported should they feel overwhelmed. A reminder of the potential to cover distressing information and to utilise the agreement was added at the start of each subsequent session. Session 1 was divided into two separate sessions to allow for greater discussion of the participant's self-care needs at the start of the intervention.

Change No.2

Alex and the clinician explicitly identified the recap of the previous session as a helpful aspect of the workbook:

> *Alex: "yeah, the recap of the threat and how I perceived the threat of my teacher and how that has continued with me into my latter years…which result in me becoming isolated or very almost alone or lonely in order to be in full control and almost feeling as though I have lost the battle before even having begun one."*
>
> *Clinician: "The recap sections have been really helpful each week…I think it has helped to reconnect back to what we were talking about the week before and build on it."*

Alex attributed the process of the recap to supporting him in connecting a past experience to present day behaviour. Acceptability of the PTMF can be suggested in Alex's use of the concepts (threat) to understand his experiences. The clinician highlights the importance of creating coherence between the sessions, which is key to the PTMF as it aims to create a narrative throughout each session. A space for the participant to make notes was added to the bottom of each session. This was in response to Alex adding new pieces of information during the session recap and aimed to encourage conceptualisation of the model outside of sessions.

Change No.3

Changes were made to the layout of the workbook in the examples of power, replacing the speech bubbles with a table. Within the table, comprehensive descriptions of power were added to support the participants understanding of each power definition. Additional examples of power were added to provide a wider range of ideas. This change was in direct relation to the clinician observation that Alex took a concrete view of the examples used in the first workbook:

> *Clinician: "I wonder if some of the examples of power might limit some people's thinking about types of power? E.g., he read the examples and maybe did not generalise."*

Change No.4

Similar changes were made to the layout of the session for threat, with the examples of threat in speech bubbles replaced with a table. Columns connected the different types of power, how the power can be used negatively and how this results in threat. This was to create more coherence between the sessions and was followed by a table in the same format with blank spaces, intended to be filled with the examples the participant would have provided in the previous session.

Table 7

A Summary of Workbook Changes

Workbook Feature	**Feedback**	**No.**	**Change**
PTMF concepts and reflection on adverse life events	HAT, session recordings, clinician questionnaire	1	Disclaimer added to the start of each session Contract of support added in the first session Introduction to the PTMF and Power separated.
Session recap	HAT, session recordings, clinician questionnaire	2	Notes space added at the bottom of each section
Power	Clinician Questionnaire	3	Changes to the presentation of concepts and examples
Threat	n/a	4	Changes to the presentation of concepts and examples in line with changes to power
Meaning	Clinician Questionnaire	5	Thoughts, feelings and bodily sensations merged into one table
Threat responses	Clinician Questionnaire	6	List of threat responses removed and replaced with a table of definitions and examples
Final narrative	Clinician Questionnaire	7	"Your Story" provided with more structure and prompts

Change No.5

In the session covering meanings, the separate boxes providing examples of feelings, beliefs and bodily reactions were merged and placed into a single box labelled "Meanings". The rationale for this was due to the clinician feedback:

> *Clinician: "…I realised it was quite a long list of difficult emotions and was hesitant about whether to continue as it might be a bit overwhelming."*

The clinician also observed Alex to use words directly from the list and reflected these may not be within his usual vocabulary and may not be an accurate reflection of his experience. The exercise to reflect on meanings was largely kept the same, although an additional column labelled "threats" was added to the table to encourage coherence in the participant's understanding of meanings in relation to threat.

Change No.6

In the threat responses session, the clinician reflected the layout was incoherent with the previous sessions. An extensive list of examples was provided as an insert for the clinician to use if the participant struggled with the concept. This was changed to a table with headings of the different threat responses, followed by examples of what these might be (for example, self-harm could be a threat response of regulating overwhelming feelings). The exercise was modified to include the threats and meanings referenced in previous sessions. This was in response to the clinician's observation that Alex began to talk about things associated with the list of threat responses rather than examples from previous sessions.

Change No.7

The final session focused on pulling the participant's narrative together in the "Your Story" exercise, and was identified as a helpful aspect of the intervention:

> *Alex: "…I don't think I've really ever sat there and thought about it up until now when I've seen it in black and white, and had it written down and they've got the power and they have the authority"*

One of the predominant aims of the PTMF workbook is to encourage the development of a new understanding of power and authority. However, Alex does not elaborate on why this is helpful, apart from the acknowledgement of other parties holding power. Further to this, the clinician identified the layout of the final narrative as problematic:

> *Clinician: "I think it needs more structure and either explicit, guided connection to previous sessions, and / or previous sessions need to have more specific reference to specific points in a 'life story'"*

The final session of "Your Story" was provided with a greater amount of structure, and the exercise was broken up, using prompts to encourage the participant to reflect back on the previous examples used across the sessions to create a coherent narrative. *[See section 3.2: Workbook Design & section 3.3: Feasibility for further discussion]*

Discussion

This research has made an original contribution to the field of clinical psychology in the design and evaluation of a PTMF based intervention for individuals experiencing MCN. Acceptability of the intervention was evaluated in the retention and engagement of Alex, and in the qualitative reports of helpful and hindering aspects (Orsmond & Cohn, 2015). In line with literature on the Events Paradigm (Elliot and Shapiro, 1988; Timulak, 2010), a number of helpful therapeutic events were identified in the analysis, therefore signifying the PTMF can be translated into an acceptable intervention for those experiencing MCN. Helpful events were identified in the development of awareness of insight of self and past experiences, exploring feelings, empowerment and behavioural change. The repeated presence of these events throughout the sessions demonstrates the potential of the workbook for future use. Unhelpful events and feedback from Alex and the clinician were used to make changes to the workbook and enhance its feasibility.

The research has established qualitative changes in PA and empowerment. Alex's initial narrative regarding feeling restricted from moving on from supported accommodation confirms the notion of individuals experiencing MCN receiving contradictory messages of agency and empowerment in their ability and responsibility in navigating services. The change in Alex's narrative in changing his housing situation demonstrated a sense of empowerment, and is consistent with the literature presented by Parsell, et. al (2014). However, whilst these findings of empowerment were presented in the qualitative evidence, this research did not conduct any further investigation to confirm any behavioural change as a result of this shift in narrative, therefore, suggesting contemplative change at best.

It can be suggested the PTMF's aim of "assigning a central role to PA… personal meaning, emerging out of social and cultural discourses…" (Johnstone & Boyle et al, 2018a, p.8) can be observed when Alex discloses his attempts to control his alcohol use and reactions to other people who have "triggered" him. In developing an understanding of how past experiences have impacted him, it can be suggested Alex built up his PA in reflecting on how he can change his behaviour in relation to this new understanding. Conversely, it is wondered if an adverse impact of developing a narrative whilst attending to social and cultural discourses, brings an unwelcome perspective on the responsibility and limitations of personal power. Certainly, in the qualitative evidence for change in Alex's PA, he acknowledged the limitations of agency and the responsibility to consider his approach in enacting change, which could be considered to be a daunting task to those who are amongst the most disempowered in society. This could explain why Alex did not experience a change in his sense of confidence as he had hoped.

The PTMF intervention has potential clinical implications in the engagement of individuals experiencing MCN with services. In providing individuals with the space to conceptualise their experiences and difficulties, a relationship can be built in the understanding and validation of the individual. There is also an advantage in care staff having a detailed understanding of the individual which enables them to avoid perpetuating the cycle of exclusion/disempowerment, as seen in models of Trauma Informed Care and Psychologically Informed Environments. Further to this, an intervention which has a beneficial impact on PA and empowerment is likely to improve a range of relevant outcomes for this population (e.g., reduced drug/alcohol use, engagement in education/training, accessing stable accommodation etc.). However, due to the lack of impact on mental wellbeing it may be a relevant psychological intervention for the individual is used in addition to the PTMF, much like the psychological model of Cognitive Analytic Therapy (CAT) (Ryle, 1995).

Strengths of the research exist in the mixed methods design with repeated measurement from multiple sources, producing a rich and detailed single case analysis of the applicability of the PTMF intervention. Limitations are present in the lack of change in the quantitative results and an improvement to this research would include using measures which are sensitive to change. The research would be further strengthened in presenting the revised workbook to the EC group for feedback, however this was not possible due to the pandemic. Longitudinal follow up of the participant would have provided insight into the longer-term impacts (or lack thereof) of the intervention, although the feasibility of this is dubious due to the transient nature of the population. However, an alternative to this could have been achieved via external validation through reports or measurement of participant change from care staff.

Of interest is the lack of significant effect in the quantitative results from pre/post, despite the reports of change qualitatively. The lack of significant change could be speculated to be related to the significant decrease/deterioration in scores at the mid-point across all three measures, before improving back to baseline. There are a number of possible explanations for the mid-point deterioration as established from the narrative of Alex. These included extraneous variables of the pandemic and lockdown restrictions, altercations with other residents in his accommodation, and the impact of alcohol and substance misuse. In addition to these variables, the mid-point measures were administered after Alex had spent three sessions engaging in the conceptualisation of the meaning of adverse life events, which has been explicitly identified as triggering strong adverse physiological and emotional responses. This may also explain why Alex experienced a clinically reliable and significant deterioration on the self-esteem subscale on the ES. Unpleasant as it may be to revisit difficult memories and emotions, a meta-analysis of literature indicates engagement with emotions is a crucial element in the development of self-understanding and enacting change (Peluso & Freund, 2018). Changes in the workbook and clinician guidance were made in line with literature (Markowitz & Milrod, 2011) to ensure the clinician responds to negative affect and contracts emotional support, thereby improving the interventions feasibility.

Whilst this research made a contribution to the field of clinical psychology in the design of a PTMF-based intervention which is both acceptable and feasible to use with those experiencing MCN, it faces limitations in demonstrating tangible results. Whilst the research can demonstrate shifts in vocalisations which suggest changes in enhanced agency and empowerment, there is little to indicate sustained behavioural change as a result of these shifts. Future research would benefit from replicating the current study with an increased number of participants and robust assessment of outcomes to test the hypotheses on change in agency and empowerment. *[See section 4.0: Discussion for further discussion]*

References

Aherne, C. Moloney, O'brien, G. (2019) Youth mental health and the power threat meaning framework: Jigsaw's systems perspective. *Clinical Psychology Forum Special Issue: The power threat meaning framework, 313,* 3-7

Aldridge, R. W., Story, A., Hwang, S. W., Nordentoft, M., Luchenski, S. A., Hartwell, G., Hayward, A. C. (2018). Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: A systematic review and meta-analysis. *The Lancet, 391*, 241-250. doi:https://doi.org/10.1016/S0140-6736(17)31869-X

Barlow, D. H., & Hersen, M. (1973). Single-case experimental designs: Uses in applied clinical research. *Archives of General Psychiatry*, *29*(3), 319-325.

Bekhet, A. & Zauszniewski, J. (2012) Methodological Triangulation: An approach to understanding data, *Nurse Researcher, 20*(2), 40-43

Bostock, J. & Diamond, B. (2005). The value of community psychology: Critical reflections from the NHS. *Clinical Psychology*, 153, 22-25.

Bowpitt, G., Dwyer, P., Sundin, E. & Weinstein, M. (2011). The support priorities of multiply excluded homeless people and their compatibility with support agency agendas – new research into multiple exclusion homelessness. *Housing, Care and Support,* 14(*1*), 31-32

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology, *Qualitative Research in Psychology, 3(*2), 77-101

Cockersell, P. (2018). *Social exclusion, compound trauma and recovery: Applying psychology, psychotherapy and PIE to homelessness and complex needs*. Jessica Kingsley Publishers

Department of Health (2001). *Valuing people*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/250877/5086.pdf

Dimaggio,G., Vanheule, S., Lysaker, P., Carcione, A., Nicolò, G. (2009) Impaired self-reflection in psychiatric disorders among adults: A proposal for the existence of a network of semi-independent functions, *Consciousness and Cognition,18*(3), 653-664, Retrieved from: https://doi.org/10.1016/j.concog.2009.06.003.

Elliott, R. (2000) Helpful Aspects of Therapy form [measurement scale]. retrieved from http://experiential-researchers.org/instruments/elliott/hat.html.

Elliott, R., & Rodgers, B. (2008). Client change interview schedule (v5). [unpublished research instrument], University of Strathclyde, Glasgow.

Elliott, R., & Shapiro, D. A. (1988). Brief structured recall: A more efficient method for studying significant therapy events. *British journal of medical psychology*, *61*(2), 141-153.

Evans, M. (1998). Behind the rhetoric: The institutional basis of social exclusion and poverty. *Ids Bulletin*, *29*(1), 42-49.

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M. & Marks, J. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults, *American journal of preventive medicine, 14*(4), 245 – 258.

Fitzpatrick, S. & Bramley, G. (2019). *Hard edges Scotland.* [White paper] Lankelly Chase.

Fitzpatrick, S., Bramley, G., & Johnsen, S. (2012). *Multiple exclusion homelessness in the UK: An overview of findings: Briefing paper no. 1* [White paper] Heriot-watt university.

Fulfilling lives. (2020). *What is "Multiple and complex needs"?* http://www.fulfillinglives-ng.org.uk/direct-client-work/multiple-complex-needs/

Furness, L. (2018, June 26). *Complex commissioning for complex needs.* [PowerPoint Slides]. GOV.UKhttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/754455/Complex_commissioning_BLF_seminar_slide_pack.pdf

Grant, A., & Gadsby, J. (2018). The power threat meaning framework and international mental health nurse education: A welcome revolution in human rights. *Nurse Education Today*, *68*, 1-3.

Herman, D. B., Susser, E. S., Struening, E. L., & Link, B. L. (1997). Adverse childhood experiences: Are they risk factors for adult homelessness? *American journal of public health*, *87*(2), 249–255. doi:10.2105/ajph.87.2.249.

Jacobson, N. S., & Truax, P. (1992). Clinical Significance: A statistical approach to defining meaningful change in psychotherapy research. In A. E. Kazdin (Ed.), *Methodological issues & strategies in clinical research* (pp. 631–648). American Psychological Association. https://doi.org/10.1037/10109-042

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018a). *The power threat meaning framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British psychological society.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018b). *The power threat meaning framework: Overview.* Leicester: British psychological society.

Jones, M., Worthen, M., Sharp, S. & McLeod, D. (2018) Bruised inside out: The adverse and abusive life histories of incarcerated women as pathways to PTSD and illicit drug use, *Justice Quarterly*, 35(*6*), 1004-1029, DOI: 10.1080/07418825.2017.1355009.

Keats, H., Maguire, N.J., Johnson, R. & Cockersell, P. (2012). *Psychologically informed services for homeless people: Good practice guide*, Department of communities and local government. https://www.pathway.org.uk/wp-content/uploads/2013/05/Psychologically-informed-services-for-Homeless-People.pdf

Kennedy, F. (2008). The use of formulation in inpatient settings. in I. Clarke & H. Wilson (eds.) *Cognitive behaviour therapy for acute inpatient units: Working with clients, staff and the milieu* (pp.39–63). Routledge.

Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs.

Lysaker, P. H., & Leonhardt, B. L. (2012). Agency: Its nature and role in recovery from severe mental illness. *World Psychiatry: Official journal of the world psychiatric association (WPA)*, *11*(3), 165–166.

Maguire, N., Johnson, R., Vostanis, P., & Keats, H. (2010). *Meeting the psychological and emotional needs of homeless people*. National Mental Health Development Unit, https://eprints.soton.ac.uk/187695/1/meeting-the-psychological-and-emotional-needs-of-people-who-are-homeless.pdf

Maheswaran, H., Weich, S., Powell, J. (2012) Evaluating the responsiveness of the Warwick Edinburgh Mental Well-Being Scale (WEMWBS): Group and individual level analysis. *Health Quality Life Outcomes*. https://doi.org/10.1186/1477-7525-10-156.

Markowitz, J. C., & Milrod, B. L. (2011). The importance of responding to negative affect in psychotherapies. *The American journal of psychiatry*, *168*(2), 124-128 https://doi.org/10.1176/appi.ajp.2010.10040636.

Martin, J., & Stelmaczonek, K. (1988) Participants' identification and recall of important events in counselling. *Journal of counselling psychology, 35*(4), 385- 390.

McDonagh, T. (2011). *Tackling homelessness and exclusion: Understanding complex lives*, Joseph Rowntree Foundation https://www.jrf.org.uk/report/tackling-homelessness-and-exclusion-understanding-complex-lives

Ministry of Housing, Communities & Local Government. (2018) *Chapter 9: Intentional homelessness*. (Homelessness code of guidance for local authorities.) https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/chapter-9-intentional-homelessness

Morgan, D. L., & Morgan, R. K. (2001). Single-participant research design: Bringing science to managed care. *American psychologist*, *56*(2), 119.

Morley, S. (2017). *Single Case Methods in Clinical Psychology: A Practical Guide.* Routledge

Opportunity Nottingham. (N.D). *The 'hamster wheel' of homelessness*. http://www.opportunitynottingham.co.uk/latest-news/news/the-hamster-wheel-of-homelessness/

Orsmond, G. I., & Cohn, E. S. (2015). The distinctive features of a feasibility study: Objectives and guiding questions. *OTJR: Occupation, Participation and health*, *35*(3), 169-177.

Parsell, C., Tomaszewski, W. & Phillip, R. (2014) Exiting unsheltered homelessness and sustaining housing: A human agency perspective, *Social Service Review, 88*(2), 295-321.

Peluso, P. R., & Freund, R. R. (2018). Therapist and client emotional expression and psychotherapy outcomes: A meta-analysis. *Psychotherapy*, *55*(4), 461.

Putz, R., O'Hara, K., Taggart, F., & Stewart-Brown, S. (2012) Using WEMWBS to measure the impact of your work on mental wellbeing: A practice-based user guide. *Feeling Good and Doing Well in Coventry Wellbeing Project,*

Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. *American journal of community psychology*, *15*(2), 121-148.

Reeve, K. McCarthy, L. Pattison, B. Parr, S. Batty, E. Maye-Banbury, A. Bashir, N. & Dayson, C. (2018) *The mental health needs of Nottingham's homeless population: An exploratory research study.* Centre for regional economic and social research: Sheffield-Hallam University http://shura.shu.ac.uk/21958/1/mental-health-nottinghams-homeless-population.pdf

Rodgers, B. & Elliott, R. (2015). Qualitative methods in psychotherapy outcome research. *Psychotherapy research*, 559-578, DOI:10.1007/978-3-7091-1382-0_27.

Rodgers, S., Chamberlin, J., Langer-Ellison, M. & Crean, T. (1997) A consumer-constructed scale to measure empowerment among users of mental health services, *Psychiatric Services, 48*(8).

Roe, D. & Davidson, L. (2005) Self and narrative in schizophrenia: Time to author a new story, *Medical Humanities 31*(2),89-94.

Roos, L. E., Mota, N., Afifi, T. O., Katz, L. Y., Distasio, J., & Sareen, J. (2013). Relationship between adverse childhood experiences and homelessness and the impact of axis I and II disorders. *American journal of public health*, *103*(2), S275–S281. doi:10.2105/AJPH.2013.301323.

Ryle, A. E. (1995). *Cognitive Analytic Therapy: Developments in theory and practice*. John Wiley & Sons.

Sosenko, F., Bramley, G., & Johnsen, S. (2020). *Gender matters: Gendered patterns of severe and multiple disadvantage in England.* Lankelly Chase. https://lankellychase.org.uk/publication/gender-matters/

Stewart-brown, S., Platt, S., Tennant, A., Maheswaran, H., Parkinson, J., Weich,S., Tennant, R., Taggar, F. & Clarke, A. (2011) the Warwick-Edinburgh mental well-being scale (WEMWBS): A valid and reliable tool for measuring mental well-being in diverse populations and projects, *Journal of Epidemiololgy & community health*, 65.

Tapal, A., Oren, E., Dar, R., Eitam, B. (2017) The sense of agency scale: A measure of consciously perceived control over one's mind, body, and the immediate environment, *Frontiers in psychology,8*.

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J. & Stewart-brown, S. (2007). The Warwick-Edinburgh mental well-being scale (WEMWBS): Development and UK validation. *Health and quality of life outcomes*, *5*(63). doi:10.1186/1477-7525-5-63.

Timulak, L. (2010), Significant events in psychotherapy: An update of research findings. psychology and psychotherapy: Theory, research and practice, 83: 421-447. https://doi.org/10.1348/147608310X499404.

Vallacher, R. & Wegner, D. (1989) Levels of personal agency: Individual variation in action identification. *Journal of personality and social psychology, 57*(4), 660-67.

Watts, B., & Fitzpatrick, S. (2018). welfare conditionality. Routledge.

Waugh, A., Clarke, A., Knowles, J. & Rowley, D. (2018). health and homelessness in Scotland. Edinburgh: Scottish government

1.0 Extended Background

1.1 Gender

The term MCN is used interchangeably with Severe and Multiple Disadvantage (SMD), which further considers the experience of domestic violence/abuse (DVA) and the prevalence of this in the female population (Fitzpatrick & Bramley, 2019). Previous definitions of MCN and SMD have generated a skewed picture of gender representation towards men. When SMD was originally defined to include only homelessness, substance misuse and offending, white single men under the age of 40 were found to be the most affected (Bramley et al., 2015); however this was felt to be due to the high incidence of male offenders (Sosenko, Bramley & Johnsen, 2020). Whilst this group is still the most at risk of experiencing multiple disadvantage, the inclusion of DVA and mental health into the definition increased the representation of women in the single domain experience of disadvantage (Bramley et al., 2019), providing a more comprehensive picture of SMD and ensuring resources are not directed away from women. When offending is removed from consideration, 17,000 people in England were found to be experiencing multiple disadvantage of mental health difficulties, homelessness, substance misuse and DVA, with 70% of these being women. Women who are in contact with the criminal justice system are also more likely to be experiencing multiple forms of disadvantage than men (Sosenko, Bramley & Johnsen, 2020). The same report identified commonalities between men and women who experience SMD, including ACEs, living in a deprived area, experiencing poverty, social isolation and high rates of disability.

A further consideration is mothers who experience SMD, as the majority of a sample of women experiencing SMD had had children removed from their care (Sharpen, 2018). The idea of these women experiencing compound trauma perpetuated by exclusion can be seen, as after having their child removed, the women reported to have no further contact from social care and were left without support to cope with the trauma and loss of their child, along with the other adverse conditions they were facing, thereby exacerbating mental health difficulties and substance misuse. A further gap in service response has been identified in relation to DVA, with one report finding women experiencing SMD were refused support from specialist DVA services due to reasons of active substance misuse or having a "chaotic lifestyle" (Bramley et al., 2019).

The variations of the SMD definition and its impact on the data demonstrates the problematic nature of systematically categorising human behaviour, through increasing the risk of neglecting an entire group of people. Further demonstrating this point is the lack of data on ethnic minorities, despite the acknowledgement that Asian/Asian British and Black/Black British women are over-represented as a group facing mental health difficulties alongside socioeconomic deprivation (Sosenko, Bramley & Johnsen, 2020). Literature on the development of the PTMF offers some commentary on the differing natures of psychological distress of men and women, suggesting the gender power imbalance and social construction of masculinity/femininity created when growing up in a patriarchal society influences gender differences in the expression of emotional and behavioral difficulties (Johnson et al., 2018). As these difficulties have been constructed in a gendered way, it can often be seen as necessary to acknowledge them as experienced by a gendered individual.

1.2 Theories of power

The PTMF uses Smail's (2005) broad definition of power; "the means of obtaining security and advantage" (Johnson et al., 2018, p.94). From this broad definition, there is greater consideration of different forms of power based on, but not limited to, Foucault's (1980) theorisation of the "power by subtraction" (Johnson et al., 2018, p.95). This is the idea that a significant proportion of power is held by particular groups and located into a centralized source. This impacts on those outside of these groups through oppression and punishment via the implementation of laws, strict systems, prohibitions and sanctions. Further to this, Foucault considered language to be a key tool in creating norms, standards and identities. Therefore, the abuse of language creates threat to disempowered groups by invalidation of experience and imposing shame through devaluation of identity. This is reflected in the literature on those experiencing MCN/SMD, whereby those who cannot conform to the standards of public systems are often shamed, stereotyped and excluded (Oravecz, Hárdi, & Lajtai, 2004).

These ideas are echoed in the Social Dominance Theory (Sidanius & Pratto, 1999), which considers group-based social hierarchies. The authors of this theory propose dominant groups command a disproportionate number of valuable resources (wealth, health, material possessions) and subordinate groups are left with negative social values (poverty, poor health, lack of control). The hierarchy is maintained by the creation of conflict and oppression between groups including sexism, homophobia, classism and racism, fitting with the ideological category of power within the PTMF, whereby language is used to create beliefs and stereotypes about particular groups which are disempowering.

The Approach Inhibition Theory of Power (Keltner, Gruenfeld & Anderson, 2003) theorises the individual processes of power, with those who have repeated experience of positive power developing an approach orientated cognitive style. This means they are assumed to be more likely to experience positive affect and mental states, be more receptive to social rewards and view others in the same manner as they satisfy their own goals/needs. Those who have repeated experiences of disempowerment are more likely to develop an inhibited cognitive style whereby they are more likely to experience negative affect, be more receptive to punishment and threat, and view themselves as a means to others ends, therefore acting in a more inhibited manner. This may explain why those who have repeatedly experienced disempowerment may have a reduced sense of agency, as they view themselves as subjected to the will of those who are more powerful, and the threat of the social environment inhibits their ability to behave in a way which will induce change or give them a greater sense of power.

French and Raven (1959) take the ideas of rewarding and coercive power even further and consider their role in psychological change. Reward power determines the extent to which an individual may conform to the demands of the system e.g., committing to sobriety in order to obtain stable accommodation or access a mental health service. The "reward" of stable accommodation leads to psychological change via the alteration of behaviour to conform. Coercive power is the threat of punishment should the individual fail to conform to the demands of the system e.g., a relapse into substance misuse resulting in being evicted from stable accommodation. It is theorised that psychological change within an individual is enacted via the use of coercive power, when the threat of punishment is enough to induce conformity but not enough to cause the individual to reject conforming to the system completely, e.g., leaving stable accommodation with sanctions to sleep rough. The use of reward power is argued to be more effective in establishing conformity, as it increases the likelihood of the development of an independent system, whereas coercive power maintains a dependency between the individual and the system (French & Raven, 1959). An example of this is seen in the creation of the Housing First Programme which recognized the need to provide individuals experiencing MCN with housing and a range of support without the continuous threat of harsh sanctions (Pleace, 2016). The effectiveness of Housing First using reward power instead of coercive power has been demonstrated in a comparison of up to 60% of individuals experiencing MCN being ejected or leaving traditional housing services, in comparison to 80% of individuals remaining in stable accommodation with Housing First for at least one year (Pleace, 2008).

1.3 Personal Agency

One thing the theories of power all have in common is the influence of the power of the system on the individual. A strong ideological power is seen in the capitalist nature of Western society, whereby exercising personal agency is the mark of an autonomous individual. One study explored the narratives of individuals facing MCN who framed experiencing homelessness as their own choice (Parsell & Parsell, 2012). In rationalising sleeping rough as a choice, the individuals constructed a narrative whereby they were autonomous and still aligned with society. This can be linked back to French and Raven's explanation of coercive power, whereby the individual conforms to the constructs of the system to minimise rejection (French & Raven, 1959).

Conversely, young people experiencing MCN who hold a narrative whereby they recognise and critique the systems holding power, have been reported to have an enhanced sense of agency and psychological resilience in a series of cases studies of homeless youth in the US (Toolis & Hammack, 2015). The differences between the studies can only be speculated but may be down to a variety of factors (length of time rough sleeping, age, gender, culture etc).

1.4 The PTMF

The PTMF was created in response to the acknowledgment by the DCP (2013) of current psychiatric diagnostic classification systems, i.e., the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013) and the International Statistical Classification of Diseases (ICD) (World Health Organization, 2004), holding significant conceptual and empirical limitations. An argument is presented in a lack of reliability and validity in functional psychiatric diagnoses which result in flawed guidelines for treatment and research (Boyle, 2002; Aboraya, 2007).

Problems exist in the overlap between different presentations of psychological distress, making categorisation of such difficult and unreliable between clinicians (Nagar et al., 2018). Additionally, the evidence for a biological basis for psychological suffering is limited. An example of this is seen in the chemical imbalance theory of mood disorders and proposed the treatment of anti-depressant medications. There is empirical evidence for this theory from a Cochrane review of anti-depressant medication in primary care (Arroll et al, 2009). However, this does not take into account the selection bias of academic journals to publish studies which prove theories rather than disprove, especially when they are funded by the medical industry (Bhandari et al, 2004). This is reiterated by Goldacre (2011) who explored publications bias around the effectiveness of the anti-depressant Reboxetine in the treatment of depression. He found one published study with findings that Reboxetine was more effective than a placebo, but a further six studies with insignificant findings which were all left unpublished.

Benefits of psychiatric diagnosis are acknowledged as providing individuals with comfort and understanding, as their distress is recognised as a documented condition which can potentially protects them from negative connotations around their identity (Boyle, 2007). Additionally, diagnosis provides a common language between professionals and lay people. However, diagnosis can also incite harm through discrimination (Read et al., 2006), stigmatisation (Barham & Hayward, 1995), negative impacts on identity (Estroff, 1993) and disempowerment (Deegan, 1993). The DCP report to holding the position of conceptualising psychological distress within the context of multifactorial psychosocial causal factors, including acknowledging the complexity of interactions involved using psychological formulation (The British Psychological Society, 2011).

The authors of the PTMF have designed the framework to consider psychological distress as more than a set of symptoms and biological responses. Rather biology as a role of mediating experience within the context of social, psychological and cultural factors. Further to this, the PTMF holds the view of psychological distress cannot be "global" and will always be influenced by dominant social and cultural discourses. However, the transition from a disease-based model is complex due to the significant contributions current diagnostic models have made to research and theory. In addition, a range of systems are based on diagnostics including administrative, insurance and benefits (DCP, 2013). Changing the meaning of psychological distress will require a shift in narrative and understanding amongst professionals, service users and the general public.

The authors of the PTMF have received critique in their approach, in particular to their use of contentious statements such as "…it can no longer be considered to be professionally, scientifically or ethically justifiable to present diagnoses…" (Johnstone & Boyle, 2018, p.85). Whilst the authors defend this statement by arguing it is necessary to spark debate, there is less consideration of the impact this may have on service users and their sense of trust and safety in the fields of psychology and psychiatry. Indeed, it cannot be claimed the field of psychology is free from unreliability with researcher allegiance to certain therapeutic models reportedly creating an optimism bias with larger effect sizes in RCT's (Dragioti et al., 2015). However, the acknowledgement of allegiance bias brings an awareness to a positivist process which can improve the quality of psychological research, as demonstrated in the guidelines of Leykin and DeRubeis (2009). Whilst the authors of the PTMF have received critique of using polemical arguments, a challenge is presented to the holding of positivism as a set of rules in the discovery of knowledge as opposed to a philosophy (Johnstone et al., 2019). Polemical arguments aside, it is cited that the PTMF is proposed as merely an alternative to diagnostic classification, with a broadening of narratives around psychological distress and the use of alternative philosophies in the gathering of evidence.

Further critique of the PTMF exists in the same criticism the authors present for diagnostic classification, a lack of evidence for its reliability. An initial study is presented in the full document (Johnstone & Boyle, 2018) whereby eight service users who have extensive experience of the psychiatric system provided consultation on the experience of the PTMF, reporting it to provide validation, reassurance, normalization of distressing experiences and making them feel less alone. However, it's felt the sample used in this consultation are likely to be biased towards an alternative for psychiatric diagnosis as some had pre-established relationships with the authors and one participant was even a campaigner for change in psychiatry. This therefore gives the impression of an element of hypocrisy in the authors arguments of psychiatric diagnostic systems being based on flawed and unreliable science.

1.5 PTMF Literature

Professionals have suggested the PTMF may be potentially useful in providing a structure when a young person has a particularly complex narrative (Aherne, Moloney & O'Brien, 2019). Furthermore, there have been promising insights in the use of the PTMF from two group interventions. In the exploration of the impact of long-term imprisonment on male individuals, the PTMF was found useful in encouraging prisoners to take ownership of their own challenging behaviour by placing it in a wider societal context, suggesting the prisoners reclaimed a sense of PA (Reis, Dinelli & Elias 2019). A peer led group provided first-hand accounts of the impact of completing the PTMF and sharing their personal stories with others. They reported the process enabled the development of a new perspective for their psychological suffering, shifting from a narrative of symptoms and biological blame to understandable reactions to abnormal and threatening experiences (SHIFT Recovery Community, 2020). However, it is difficult to ascertain whether the outcomes from each of the group interventions are attributable to the PTMF or the group process. Particularly for the group of prisoners, where the authors reported inmates found the group process was a particularly important factor in their outcomes. Additionally, both group studies are limited in terms of not having systematically or empirically tested outcomes of the PTMF.

There have also been claims that the PTMF has been perceived as stigmatising towards individuals who have received a diagnosis of Attention Deficit Hyperactivity Disorder, due to the PTMF argument of the diagnosis lacking reliability and therefore "invalid" (AADD-UK, 2018).

1.6 Existing Psychological Approaches

There is debate around categorising psychological formulation as an intervention due to little empirical evidence for its use (Aston, 2009). The rationale of sharing formulations with clients is thought to provide benefit through understanding and validation, which is seen as interventive in its own right (Bergner, 1998). The idea of formulation as intervention is supported by the Division of Clinical Psychology (DCP) who propose the benefits of formulation are; explaining the development and maintenance of difficulties, identifying the best way forward, helping the client to feel understood, increasing a sense of agency, meaning and hope (British Psychological Society, 2011). This definition is highly akin to the proposed outcomes of the PTMF; however, this is unsurprising given the affiliation between the authors of the PTMF and the DCP. Conversely, it is unclear how the process of formulation has an impact on outcomes other than providing context and building the therapeutic relationship (Aston, 2009). The authors of the PTMF argue that whilst formulation does form part of the framework, it also promotes the development of a narrative which is based on individual experience rooted in relational and social contexts (Johnstone et al., 2018). Narrative approaches aim to enact change by exploring how language is used to construct and maintain problems within a personal, social, cultural and political context (Etchison & Kleist, 2000). Through this process, it is hoped the individual develops the ability to externalize the problem from themselves and create an opportunity for change (White & Epston, 1990).

2.0 Extended Method

2.1 Epistemology

Epistemology is defined as the theory of knowledge and is concerned with how knowledge is generated (Zagzebski, 2009). The rationale for employing a mixture of quantitative and qualitative approaches is to provide scope in understanding and interpreting the findings of the research. It is acknowledged that quantitative and qualitative methods are born from differing philosophical assumptions, and there is argument that to employ both methods extinguishes the philosophical foundations of each, resulting in incoherence in the data (Guba and Lincoln, 1989). Conversely, others argue the two methods can be integrated for complementary purposes despite their ontological and epistemological differences (Sale, Lohfeld & Brazil, 2002), and that is best done in smaller single studies (Slevitch, 2011).

The stance of this research is pragmatism, which argues methodology is free from the epistemology it has been developed from (Patton, 1990). Pragmatism holds a philosophical stance of "the meaning of an event cannot be given in advance of experience. The focus is on the consequences and meanings of an action or event in a social situation" (Denzin, 2012, p.81). This is of particular importance within this research as whilst there is an interest in the procedure of solving a problem, there is also an interest in the meaning making of the procedure, which is dependent on the context in which it is enacted and the discourses surrounding this. The mixed methodology of this research aligns itself well with Dewey's systematic pragmatic approach to inquiry, as defined by Morgan (2014). The method implies the use of systematic and rigorous methods in the acquisition of knowledge, which coincide with the efforts of mixed methods to increase the quality and validity of knowledge by combining the perspectives of quantitative and qualitative methodologies (Fishman, 2017). Benefits of the pragmatic exploratory case method are argued in the ability to conduct conceptual synthesis, theoretical mediation, democratic decision making, providing a middle ground to generalization and holding the researcher to account by placing the needs of the participant before theory (Fishman, 2005).

2.2 Design of Workbook

To inform the design of the workbook based on the PTMF, literature on the adaptation of established therapeutic approaches was consulted in line with the design of a manual for a feasibility trial as demonstrated in Table 8 (Carroll & Nuro, 2002). The procedure was adapted to fit the needs of the research, as the PTMF cannot be said to be an "established" approach, therefore, some considerations of Carroll & Nuro's procedure could not be addressed. Criticism of manualized approaches exist in the limited ability to consider the nuances, complexity and diversity of the individual on the receiving end of the approach (Addis & Krasnow, 2000) and can potentially reduce the flexibility of the clinician in using their expertise (Goldstein et al., 2012). Indeed, to create a fully manualized version of the PTMF would go against the philosophy underpinning its creation. However, it is argued that this research does not seek to engage in a process of generating a manualized intervention in preparation for a large randomized controlled trial (RCT), but rather translate it into a framework to explore its use with individuals of whom RCT evidenced approaches often fail to reach.

Table 8

General Outline for a Stage 1 Manual Adapted (Carroll & Nuro, 2002)

Section	Issue to be addressed	Evidence
Overview, description and rationale	A. Overview of intervention B. Theoretical rationale, empirical underpinnings of treatment and rationale for treatment to this population C. Brief summary of hypothesised mechanisms of action, critical "active ingredients"	A. See *Phase 1: Design of PTMF Workbook,* **Method**, Journal Paper B. See *Multiple Complex Needs & Multiple Exclusion,* **Background,** Journal Paper C. See *Personal Agency* & *Power Threat Meaning Framework,* **Background,** Journal Paper
Conception of the problem	A. Summary of factors which lead to the development of the problem B. Factors/processes which are thought to be associated with or improvement in the problem C. Hypothesized agent of change D. Assessment of suitability	A. See *Multiple Complex Needs & Multiple Exclusion,* **Background,** Journal Paper B. See *Personal Agency* & *Power Threat Meaning Framework,* **Background,** Journal Paper C. Patient and therapist D. See *Inclusion criteria,* **Method,** Extended Paper
Contrast to other approaches	A. Similar approaches	A. See *Existing Psychological Approaches,* **Background**, Extended Paper
Session content/specification of interventions	A. Unique and essential elements B. Essential but not unique elements	A. See *Power Threat Meaning Framework,* **Background,** Journal Paper B. See *Phase 1: Design of PTMF Workbook,* **Method**, Journal Paper
General format	A. Format for Delivery, frequency and intensity of sessions, flexibility in content, session format, level of structure, extra session tasks	A. See *Phase 1: Design of PTMF Workbook,* **Method**, Journal Paper

2.3 Recruitment

The study took place in affiliation with Framework and Opportunity Nottingham. The services were deemed to be appropriate for the study as they were in touch with the target population. Opportunity sampling was used to recruit participants and utilised the knowledge of the researchers to identify suitable participants (Jupp, 2006). This method of sampling is argued to be the most appropriate due to the transient nature of the population which would make applying a traditional sampling formula difficult. Whilst limitations exist in the representativeness of an opportunity sample, it is argued the sampling technique best fits the aims of this research and the pragmatic epistemological position.

The purpose of collecting the demographic details was to ensure the participant met the inclusion criteria. The rationale for collecting information about previous interventions the participant had received is to have an awareness of the potential influence it may have on the participant's conceptualisation of their situation.

Inclusion Criteria

- Individuals open to Framework/Opportunity who were experiencing at least two of the following: homelessness, substance misuse, mental health difficulties or offending behaviour
- Age 18+
- Capacity to provide informed consent
- A sufficient level of English to engage in the intervention and interview process

Exclusion Criteria

- Individuals suffering from any condition which prevents them from being able to engage with the study process, e.g., florid psychosis/neurological conditions, as this may impact on the participant's ability to engage in the intervention including recalling and reflecting on their psychological state during interviews

2.4 Design justification: Exploratory case study

The PTMF is being conceptualised as a meaning making intervention that is yet to accrue evidence. A single exploratory case design is argued to be a good fit due to the potential high volume of repeated measurement, giving better inference to the process and outcome of change, due to the smaller requirement of participants (McLeod, 2010; Morley, 2017). This is also important to the feasibility of the study, as the population being recruited from is transient, so a smaller number of participants with high quality information is preferable to a large number with a high rate of attrition. Furthermore, exploratory case studies present the opportunity to accrue bottom-up knowledge of a new phenomenon (Fishman, 2005). The lack of empirical evidence around the outcomes of the PTMF makes the use of any other methodology questionable as it is challenging to assess evidence from a higher number of cases or gain ethical approval to run trials when there is no existing evidence.

The use of exploratory case studies fits the pragmatic epistemological position, as the research seeks to investigate the phenomena within the situations of which they holistically present themselves (Fishman, 2005). Furthermore, it is argued that "actual cases -- in all their multisystemic complexity and contextual embeddedness – should be one of the crucial units of study in applied and professional psychology" (Fishman, 1999).

A criticism of case studies is subjectivity and bias within the interpretation of findings. The accuracy and trustworthiness of analysis was protected by keeping an audit trail of audio recordings, transcripts and researcher notes and was monitored by research supervisors through the process of interim reports. A reflexive diary was kept supporting the rigor of interpretation and manage potential bias. Supervision was utilised to ensure the plausibility of interpretations.

2.5 Measures

Table 9 demonstrates the time point at which each measure was administered and were either delivered by the clinician or researcher depending on the time point.

Table 9

Timeline of measures

Measure	**Pre (Baseline)**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Post interview**
SoAS	X				X					X
ES	X				X					X
WEMWBS	X				X					X
HAT		X	X	X	X	X	X	X	X	
Clinician questionnaire		X	X	X	X	X	X	X	X	
Open ended change question			X	X	X	X	X	X	X	

The Sense of Agency Scale: The rationale for choosing this measurement is to answer the first research question. Literature evaluating a number of agency measures was consulted and highlighted various limitations of existing measures of agency (Alkire, 2008), therefore the SoAS was chosen based on its face validity and context-free items.

Empowerment scale: A systematic literature review was consulted to consider other measurements of empowerment (Cyril, Smith & Renzaho, 2015). Whilst there were measures which had stronger ratings in terms of reliability and validity, the response items were less specific or unrelated to the requirements of this research. The rationale for choosing this measurement is to answer the second research question. A limitation of both the SoAS and ES is the lack of data indicating their sensitivity to change. Sensitivity to change is defined as the ability of an instrument to measure a change in state (Liang, 2000). Therefore, a risk is presented in these measures being insensitive to change and failing to detect the true effects of the intervention.

WEMWBS: Consultation was taken from the field supervisor working in the services, who provided expert knowledge of the population, including conducting research. The field supervisor had previous experience in using the WEMWBS in research with the target population and identified it to be of good face validity and feasible to use with individuals experiencing MCN. Further rationale for using the WEMWBS was due to the holistic focus on mental wellbeing, as opposed to the absence of disease, which fits with the ethos of the PTMF of evaluating and understanding beyond the categorisation of mental illness. The authors of the WEMWBS argue the scale takes into account physical, social and spiritual contexts in the assessment of wellbeing. There is a 7-item version, however the decision was taken to use the full version as the majority of validation and assessment of psychometric properties has been conducted using the full scale.

2.6 Process Measurement

Change process research is defined as the study of processes which bring about therapeutic change, including exploring how and why change happens in therapy (Elliott, Slatick & Urman, 2001). The rationale for conducting change process research was to support the discovery of how and why an individual may change over the course of an intervention. There is an argument that to rely on outcome driven research could result in the use of simplistic assumptions that can come with process-outcome findings and obscure the complex and nuanced process of change. The Events Paradigm considers changes in therapy, the therapeutic alliance and the linking of in-therapy processes with overall therapeutic outcome (Elliott & Sharpio, 1988), and was used to inform the identification of change processes. However, a critique of the Events Paradigm is the limited available evidence the identification of significant events has on the overall treatment outcome. This was accounted for by a triangulation of methods in the evaluation of the intervention.

The HAT is a crucial element of the Events paradigm as it holds the assumption of the participant as uniquely capable of identifying helpful and hindering events within the therapeutic process (Elliott et al., 1985). Significant events in the therapeutic process are identified by the participant and deemed to be either helpful or hindering. This method of enquiry is highly relevant to the exploration of a new intervention, as it promotes the intense analysis of smaller episodes of therapeutic process (Greenberg, 2007). Limitations of the HAT are identified in the potential for participants to provide vague answers which limit the researcher's ability to pinpoint change process.

The rationale for introducing the Clinician Questionnaire was to acquire an additional perspective on the acceptability and feasibility of the PTMF workbook, as literature indicates clinician perceptions regarding new innovations can impact on their adoption into regular practice (Greenhalgh et al., 2004). Furthermore, a difference has been cited in the clinician and participant perspectives in the helpful or hindering aspects of a therapeutic intervention (Llewelyn, 1988), warranting the collection of alternative data sources to conduct a thorough investigation of the intervention's feasibility.

The Change Interview (Elliott & Rodgers, 2008) is a semi-structured interview which uses open-ended questions to obtain information on changes perceived by the participant over the course of the intervention, what they attribute those changes to and if those changes were helpful or hindering. The author of the Change Interview states the interview schedule should be used with an attitude of curiosity and encourages empathic understanding of responses to ensure the participant is able to fully elaborate on their responses. To support the narrative of change generated by the participant, they are asked to rate how likely they believe the change to have occurred in the absence of therapy, thereby pinpointing their attribution of change. The author cites this as an alternative to randomized clinical trial and behavioural single case designs which attempt to control and eliminate casual factors.

Whilst the lead researcher had experience of conducting interviews for the purpose of research which increased the validity of data collected, it was a first using Elliot's Change Interview protocol. Therefore, knowledge and experience of senior research supervisors was utilised to ensure the quality of the data. It was deemed appropriate to use a different researcher to conduct the interviews to reduce the chance of participants giving socially desirable answers, as they will inevitably build some form of therapeutic relationship with the clinician delivering the intervention. As recommended in literature of conducting the Change Interview, an open and curious attitude was used to avoid the participant responding to the questions in a way which indicated their beliefs about the motives of the researcher (Cameron, 2001).

2.7 Thematic Analysis

Braun and Clarke's six step method of TA (2006) was used to qualitatively analyse the data gathered from the numerous process measures. TA aims to identify repetitive patterns within a data set to generate themes of interpretation. TA is cited to be appropriate to use with a range of epistemological perspectives and fits with the pragmatic position as TA is flexible as an analytic method and acknowledges the researcher's subjectivity (Clarke, Braun & Hayfield, 2015). It is considered to be appropriate to use because the flexibility of the indicative nature of the TA process allows new information to be discovered and inferred, which maps onto the aims of this project.

First the lead researcher became familiar with the data by transcribing the audio recordings which included data from all of the sessions, HAT and change interview. The Clinician Questionnaire was recorded on electronically and kept with the corresponding session recording. All data was subject to the same analytic process. Transcripts were read and re-read before the start of coding. Initial codes were generated session by session, inductively then deductively. Coding was done by a line-by-line basis and the units of analysis were the session and interview transcripts, HAT and Clinician Questionnaire (See Appendix 6 & 7 for example codes). The research used both inductive and deductive analysis approaches. Inductive coding is a bottom-up process which allows the generation of themes directly from the data set. Conducting inductive analysis first helped to manage researcher bias and stay close to the words and meaning of the data set. However, the inductive coding did not generate anything new related to the research questions and was therefore merged into the deductive themes.

Deductive coding template which was informed by the research questions and Events Paradigm (see Table 10 for coding examples). Deductive coding is a top-down approach, whereby the analysis is informed by pre-defined concepts and ideas. Braun and Clarke (2012) acknowledge the acceptability of using both approaches and argue that it is impossible to be purely inductive as the researcher will always bring their own subjective views to the analysis. Likewise, it is impossible to be purely deductive and ignore the semantics presented within the data. Semantic level analysis is defined as a direct representation of the explicit meanings within the data (Boyatzis, 1998). Latent level analysis explores the underlying meaning of vocalisations and requires a level of interpretation informed by the researcher's theoretical assumptions (Braun and Clarke, 2012). Coding took a mixed semantic and latent approach in order to be as responsive to what was presented in the data whilst keeping the research questions in mind.

The secondary research supervisor was consulted throughout the initial coding process to provide a second level of analysis. Once the initial codes had been agreed, they were sorted into groups. After it was established that the inductive coding was unlikely to yield any new knowledge, the research questions and Events Paradigm were reviewed to establish deductive themes and agreed with the secondary research supervisor. The data sources were revisited to identify quotes which corresponded with the overarching themes. Finally, the themes were reviewed before the names were confirmed.

TA has often been critiqued by fellow researchers as a jumble of theories, methods and techniques (Morse, 1989). Indeed, the authors too have outlined methodological inaccuracies which compromise the quality of a reflexive TA (Braun & Clarke, 2020a). To ensure the quality of the data and adherence to the reflexive method of TA, a reflexive diary was kept documenting the process of analysis, including the subjective views of the researcher. In addition, supervision from the research supervisors experienced in the use of TA was sought to ensure the generation of themes adhered to the reflexive method, including identifying the presence of confirmation bias in the deductive analysis. Further to this, the lead researcher undertook the transcription of all data sources personally. The rational for this was to make use of the opportunity to become fully familiarised with the data set, as it has been indicated that the way in which information is transcribed can impact on the way in which participants are understood (Poland, 2002). A naturalistic transcriptive process was taken to ensure the nuance of the data could be fully comprehended (Oliver, Serovich & Mason, 2005).

Table 10
Deductive analysis examples

Category	Possible vocalisation
Personal agency	"I can do something about it" "It's out of my control"
Empowerment	"I'm going to fight and make a change" "It's unlikely that if I do anything about it that it will make a difference"
Wellbeing	"I'm feeling a lot better" "I'm feeling really down"
Events Paradigm therapeutic relationship	
Helpful- evidence of feeling understood, feeling reassured/supported/safe, participant involvement and personal contact	"I feel that you understand me"
Hindering- misperception, negative clinician reaction, unwanted responsibility, repetition, misdirection, unwanted thoughts	"You aren't listening to me"
Events Paradigm in-session outcomes	
Helpful- new insights/awareness/self-understanding, behavioural change, relief, exploring feelings/emotional experiencing, empowerment	"I've never thought about it like that before"
Hindering- difficulty understanding the language/concepts of the therapeutic	"I don't understand"

model, adverse emotional/physiological responses	
Extraneous factors	"I can't do X because I don't have the money" "My friend has been really supportive"

In the consideration of alternative processes of analysis, content analysis was considered due to its suitability in the analysis of novel phenomena and multiple overlaps with TA (Vaismoradi, Turunen & Bondas, 2013). The rationale for circumventing the use of content analysis was due to the suggestion of quantitative elements minimising researcher subjectivity and maximising accuracy through the use of calculation in inter-coder agreement, thereby giving an indication of a post positivist or realist epistemological position (Braun & Clarke, 2020b). Furthermore, it can be suggested the focus on counting the frequencies of codes simplifies the complexity of the communication (Allen, 2017).

During the initial design of the research, consideration was also given to the suitability of Interpretive Phenomenological Analysis (IPA) due to its focus on personal experience and meaning making within a specific context (Smith, Flower & Larksin, 2009). However, this was quickly ruled out due to the requirement of the research to analyse data from multiple sources rather than from interviews only (Braun & Clarke, 2020b). Further to this, IPA would not have met the aims of the research in considering the wider context from which an individual's narrative was based within and would have been unable to meet the needs of generating actional outcomes in changing the PTMF workbook (Sandelowski & Leeman, 2012).

2.8 Ethical considerations

Ethical approval was granted by the University of Nottingham's Ethics Committee (see Appendix 8). This included submitting the study protocol, Informed Consent Form (ICF) (Appendix 9) and Participant Information Sheet (Appendix 10). An amendment was made to request approval to conduct all study procedures over the phone (including obtaining informed consent verbally) in response to the COVID-19 pandemic. The study was conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, 1996; the principles of Good Clinical Practice and the UK Department of Health Policy Framework for Health and Social Care, 2017.

Informed consent was obtained verbally rather than in written form due to the remote nature of the research. To ensure this was done in line with ethics, a copy of the ICF was posted to the participant. The field supervisor then read through each point of the ICF with the participant and confirmed their consent whilst audio recording. This was checked and confirmed by the lead researcher and the audio recording securely stored. Consent and capacity were checked at each study visit and the participant's capacity to provide ongoing consent was assessed in response to any observation that suggests capacity may be impaired. The participant was continuously reminded of their right to withdraw from the study and this was confirmed at each session. The following guidance for withdrawal was adhered to:

- Temporary discontinuation: If the participant is found to have impaired capacity during a study visit, the visit will be rescheduled. If a participant fails to attend an appointment they will be contacted to reschedule. In the event that the person is unable to be contacted their personal development coordinator will be informed.

- Permanent discontinuation: If the participant is unable to provide informed consent and capacity is continuously found to be impaired, the participant will be withdrawn from the study. They will also be withdrawn if they request to or if they fail to comply with the protocol of the study e.g., refusing to follow the full schedule of sessions and interview.
- Participants may withdraw from the study at their own request. They will be made aware that this will not affect their future care. Participants will be made aware (via the CIF and PIS) that should they withdraw the data collected to date cannot be erased and may still be used in the final analysis.

Ethics guidance from the Health Research Authority (HRA, 2014) was sought in consideration of the reimbursement of participants, as in the recruitment of the target population there was a possibility of current substance/alcohol misuse. It was therefore felt to be prudent to ensure reimbursement avoided discriminatory practices and was free of potential coercion. The HRA holds the position that individuals are autonomous and can make their own decisions, unless evidence is present to suggest otherwise. Further to this, there is wealth of evidence to suggest the payment of participants does not promote the purchase of illegal substances or relapse (Festinger et al., 2005; Slomka et al., 2008; Dempsey, et al., 2008). However, these studies were all conducted in the USA, therefore cultural limitations are placed on the findings. The participant was reimbursed for their time in the form of a £5 gift voucher per session attended, at a total possible reimbursement of £50. Whilst literature indicated that it could be considered to be discriminatory to pay the participants in vouchers (Australian Injecting & Illicit Drug User League, 2003), it was deemed appropriate to pay the participants in supermarket vouchers due to the COVID-19 lockdown resulting in the closure of numerous shops and a preference to avoid handling cash. It was considered that it may be possible that participants would be willing to engage in the study due to the reimbursement received, and this may in turn make them more suggestable/amenable to the researchers which may unintentionally bias their opinions during the interview portion of the research. It was therefore made explicit that the participant was expected to give their full, honest opinion and would be reimbursed for their time regardless.

An information sheet of useful contacts within the local area was provided for the participants in recognition of the requirement to reflect on adverse life experiences for the workbook. Literature indicates that whilst participants interviewed about distressing events experienced a temporary increase in negative affect and stress, their moods returned to baseline between interviews (Labott et al., 2013). However, this research was conducted on “non-vulnerable” participants therefore the provision of a contacts sheet and the clinical judgement of the clinician for signposting for further support were built into ethics.

The researcher endeavoured to protect the rights of the participants to privacy and informed consent, and adhered to the Data Protection Act, 2018. Access to the information was limited to the researcher and supervisors but was limited by the remits of confidentiality. Identifiable data was stored on a password protected UoN electronic database including:

- Signed ICF’s
- Participant database, holding information on names, ID numbers, contact details (name, address and phone number)
- Audio recordings were transferred to a secure laptop and deleted from the Dictaphone

Anonymised data was separated from identifiable data, including the interview transcripts. All research data will be stored for seven years after completion of the study and then destroyed securely.

2.9 Remote deliverance

Due to the COVID-19 pandemic and subsequent lockdown, all study procedures were conducted remotely. This included the informed consent process, deliverance of the intervention and change interview. The field supervisor contacted the participant by telephone to obtain informed consent and used a telephone pick-up microphone to record process. Following consent, the intervention and change interview was delivered over the phone. To aid the process the participant was sent study materials (measures and each section of the workbook) by post in advance of the arranged research appointment. Each session was again recorded by telephone pick-up microphone and stored securely on the University of Nottingham systems to be accessed remotely by the research team for analysis. After each session the field supervisor sent the participant payment in the form of a voucher via post and confirmed he had received it at the start of each session.

2.10 COVID Impact Statement (based on the UoN form)

Due to the country going into a national lockdown in March 2020, the recruitment efforts for the study were severely impacted. Luckily one participant had already been recruited prior to the start of the lockdown but no further recruitment was possible. This is due to the partner organisation of the research (Opportunity/Framework Nottingham) having to run only essential services. This meant that usual methods of identifying potential participants was not possible.

Consideration also needs to be given to the participant population. Due to the lockdown, the study had to be delivered remotely over the phone or video consultation. The study population is that of individuals who are homeless or in severe poverty and therefore did not have access to these resources, adding a further barrier to recruitment.

There was regular contact with the field supervisor to discuss the issues with recruitment. Repeated attempts had been made to make contact with care staff at Framework/Opportunity Nottingham to encourage recruitment, however no suitable candidates have been identified due to the limitations previously mentioned caused by the pandemic.

An ethics amendment was made back in March 2020 to ensure the study could be conducted remotely. The thesis has been adapted and written as a single participant design.

3.0 Extended Results

3.1 Service user involvement

The feedback from the consultation with the EC group resulted in changes to the Participant Information Sheet. Members expressed a strong reaction to the name "Power Threat Meaning Framework" in the title of the sheet, stating they found the name "scary", "threatening" and immediately put them off the research. They also stated that they associated the name with Framework as an organisation, which they found confusing. Members asked if the term could be removed completely, and if not the explanation of the intervention be given before the name. Apart from this, the members had no issues with the PIS and felt it explained the study in clear terms. As a result of this, an ethics amendment was made to remove the term from the title and introduce it in the text below.

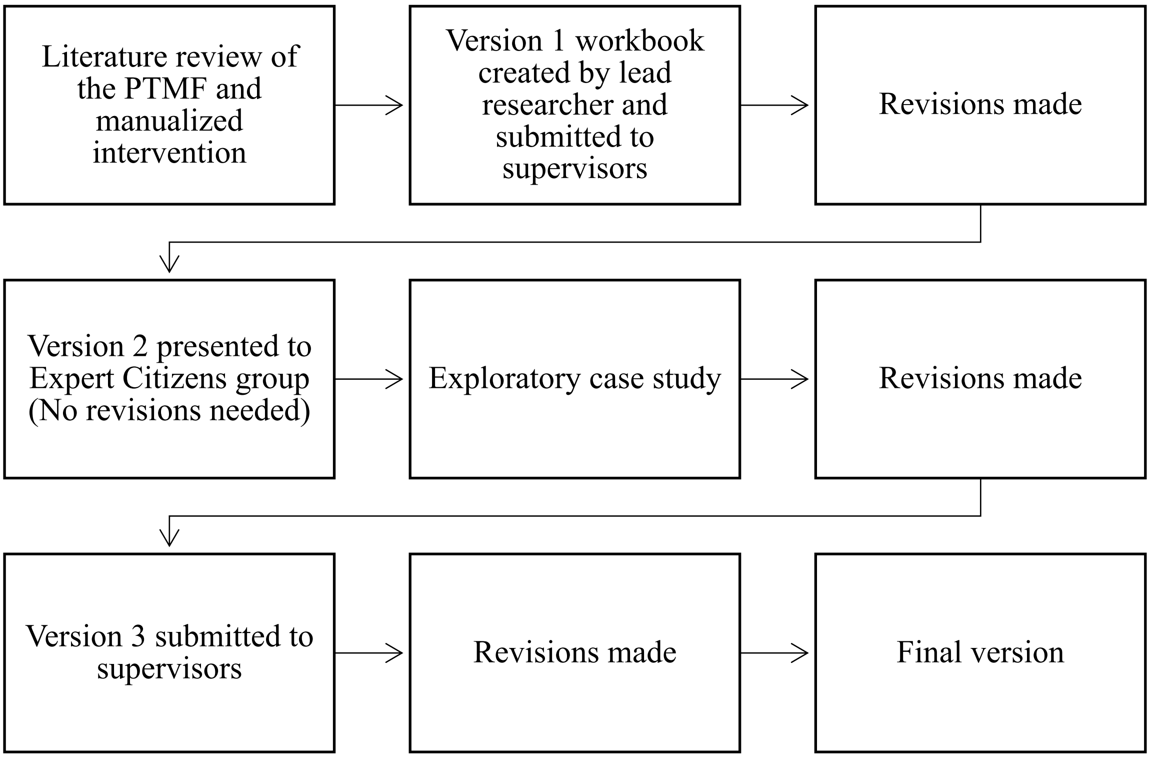
The feedback for the intervention workbook was positive and no changes were required. Two members (and even one staff member) requested to be part of the research as a result of looking through it.

3.2 Workbook Design

Figure 2 demonstrates the final process of the design of the workbook.

Figure 2

The Process of Designing the PTMF-based workbook



3.3 Feasibility

The initial intention of the research intended the single case to be used as a pilot phase to test the feasibility of the study procedure, intervention and evaluate the appropriateness of the measurement materials following the design phase of the intervention. Piloting the design has a number of advantages including contributing to the assurance of high-quality research, increasing the validity of the intervention, giving an indication of the acceptability of the intervention and providing an insight into the appropriateness of the measures used (In, 2017). The success of the pilot was based on:

- Feedback from the clinician delivering the pilot intervention on: ease of delivery, coherence of materials and identification of any process issues, along with analysis of the clinician feedback questionnaires
- Feedback from the participant using the HAT. The participant will also be invited to comment on the procedure of the study, including their perception of the intervention material and outcome measures
- Analysis of quantitative measures
- Analysis of the change interview using inductive and deductive TA

The following criteria was applied to the outcome of the pilot (Thabane et al, 2010):

(i) *Stop* - main study not feasible

(ii) *Continue, but modify protocol* - feasible with modifications

(iii) *Continue without modifications, but monitor closely* - feasible with close monitoring

(iv) *Continue without modifications* - feasible as is.

The exploratory case received the rating of "*Continue but modify protocol",* as demonstrated in the workbook changes. However, due to complications in recruitment due to the COVID-19 pandemic combined with the hard to engage nature of the study population, there was no further recruitment beyond the pilot phase.

The clinician questionnaire provided direct feedback regarding the feasibility of each session (Table 11).

Table 11

Clinician Rating of Workbook Session Feasibility

Session	Feasibility rating
Introduction to the PTMF and Power	Feasible with some changes
Threats	Feasible and recommended for future use
Meanings	Feasible with some changes
Threat responses	Feasible and recommended for future use
Strengths	Feasible and recommended for future use
Final narrative	Feasible with some changes

3.4 Additional Themes

Extra Therapeutic Processes

The TA identified some additional subthemes in helpful aspects which were explicitly linked to the therapeutic relationship. The final elements Alex identified as helpful for him was having the opportunity to talk through his experiences:

> *Alex: "why I'm saying a big thank you because today has really helped I don't think you realise...and these are just a few examples because talking to you this is a difficult thing and I'm kind of offloading, and you might be able to sense it in my voice…you don't have to say anything but it's all coming out"*

However, what Alex is identifying as helpful here is the opportunity to speak about extraneous variables and incidents which had occurred outside of the sessions which had been distressing. As can be seen from the extract, the clinician did not necessarily have the opportunity to frame the participant's difficulties in a way which was related to the PTMF, but rather Alex finds the opportunity to "offload" and be listened to helpful.

Further to this, the clinician identified some insight on the unique strengths which Alex holds which are likely to have enabled him to find use in the intervention:

> *Clinician: "[Alex] is very able to talk openly about experiences he has had and clearly makes connections that fit with a 'PTMF' way of thinking. He has begun describing experiences in terms of 'power' and 'threat' – I think it is important to give thought to whether this is a new way of thinking or just newer language to describe things he already knows."*

Alongside the participant bringing positive attributes which supported the deliverance of the intervention, the clinician and therapeutic relationship were also a clear factor:

> *Alex: "I am going to say thank you to you for being so brilliant. You have done it in such a way that I haven't felt under pressure and I have never felt uneasy at any given time when I have been doing it with you. Maybe I have felt a little bit uneasy myself because of you know…but with yourself as a person thank you because wow brilliant."*

Throughout the transcripts, Alex makes frequent reference to the clinician's patience and providing him with the time and space to develop his narrative. This is also identified by the clinician, who ensured they blocked out plenty of time to conduct the sessions:

> *Clinician: "[Alex] was able to ask me as soon as I called to call back in 15 minutes so that he could be comfortable, and I had allowed the time after the call to be able to do this and have flexibility. When I offered him a break part way through, he also extended this to be longer. Having the flexibility of time to enable this allowed the session and breaks to be at his pace."*

Strengths

The contents of the session on strengths remained unchanged due to the positive feedback received from both Alex and the clinician:

> *Alex: "I kinda, I knew I had some strengths there, but it was the lack of confidence but kinda doing this intervention brought it out that A) it's there and people are already saying it to you, you know? You need to stop doubting yourself a little bit and look at this part… you know?"*

Whilst the clinician agreed with the session on strengths acting as a helpful aspect of the intervention, there was greater consideration as to how this might be interweaved throughout the intervention to balance the evoking of distressing experiences. The clinician also provided insight into the unique attributes of Alex and the limitations of discussing strengths with other members of the population experiencing MCN:

> *Clinician: "Great to focus on strengths and [Alex] was able to identify these and did not have difficulty doing so – I wonder if some individuals might struggle to do this. [Alex] did at one point temper with 'I don't want to sound boastful' and I think that some individuals would either know their strengths but wonder about sounding boastful or would just struggle to identify any strengths at all when in very difficult circumstances."*

Extraneous variables

The clinician reported a number of times there was a disruption to the intervention due to conducting it over the phone. Practical difficulties were noted caused by signal problems or distractions in the surrounding environment:

> *Clinician: "Some interruptions on the phone line but he just asked me to repeat myself when I cut out and it did not seem to interrupt the flow of the session too much."*

> *Clinician: "In part two my cat also interrupted by loudly scratching at a wooden door – I had to interrupt the session to get rid of him and apologised to [Alex], but he seemed to find it amusing."*

Some concerns were noted regarding the suitability of the environment Alex was in whilst engaging with the intervention:

> *Clinician: It was also clear that there were other people around him. I checked out with him whether he could find a private space and was okay to do the session. He did not sound too intoxicated and was able to go to a private space, so we continued. In part two of the session, he told me that he was not in his own accommodation, but in somebody else's. However, he was borrowing somebody's room and did have privacy.*

Within the transcript of the session, the clinician supports Alex in making a decision in continuing with the session by helping him to consider the limitations of speaking about personal life events around other people, including how this may prevent him from going into full detail or the impact this may have on other people if they overheard the full details. Alex made the decision to continue the session and compromised by finding a private space to continue.

Alex initially identified some difficulties in engaging over the telephone during the fourth session:

> *Alex: "...speaking on a mobile I don't know...with face-to-face contact...I think you get better reactions with face-to-face contact that's what I'm trying to say"*

It can be suggested that Alex is missing the additional factors (e.g., non-verbal communications) which support engagement when meeting face to face. However, in later sessions, Alex identified some positives of remote engagement:

> *Alex: "...like I say without actually seeing it, I sense it and I've been able to kind of express myself knowing that you don't have to see me walking up and down"*

> *Clinician: "[Alex] also made a comment when completing the HAT about the potential benefits of having sessions over the phone rather than in person, e.g., that he might feel more on the spot if in the room together"*

Alex identified that he was able to process and regulate his emotions a lot more effectively than if he had been with the clinician in person. This is because he was able to pace around his room which provided him with a physical release and enabled him to continue to engage with the session. He identified that if he had been with the clinician face to face, it would have been unlikely that he would have been able to regulate his emotions through movement due to feeling self-conscious. The clinician also identified some advantages of conducting the intervention remotely:

> *Clinician: "As a therapist, I perhaps feel less on show and I am also able to write detailed notes as we go without that being evident/distracting for the client, whereas I would not do this in the room with him"*

Alex was recruited into the research just as the COVID-19 pandemic began to impact the UK, subsequently resulting in the national lockdown in March 2020. Alex disclosed the impact the lockdown restrictions were having on his mental wellbeing throughout the study sessions:

> *Alex: "I am just a little bit frustrated with how it is staying inside in the worst sense, that is probably the worst scenario for me… it's now starting to have an impact on my life…I don't know if I should say this Anna but I'm going to have to say it, I'm actually starting to have to turn to the drink."*
>
> *Clinician: "He said that he has been struggling with the current Covid-19 restrictions and said that he has been drinking, including having had a drink today."*

Alex continued to disclose using alcohol as the sessions progressed, including when he was under the influence during a session:

> ***Clinician: "So, you were saying you've had a bit of a drink today, but do you still feel okay to do the session?"***
>
> *Alex: "yeah, I do, I do. In fact, probably more because I've had a drink…"*

The clinician reported each instance when Alex had attended the session under the influence of alcohol, a total of two sessions:

> *Clinician: "…he had subsequently been drinking. He was coherent and I gave him the option of doing the sessions – he said "it might be the perfect thing" and so I chose to continue with him."*

4.0 Extended Discussion

Of particular importance to the feasibility and acceptability of this intervention is the stance of the clinician, as Alex repeatedly identified the clinician's therapeutic style as a helpful factor. Indeed, the clinician herself highlighted the importance of being flexible and adaptable to the participant's needs to protect engagement and can be considered as being beyond standard therapeutic engagement skills. This is in line with literature regarding the nature of working with individuals facing MCN, as it has already been identified that this population that are a high risk of being excluded from services due to difficulties adhering to strict appointment times (Cockersell, 2018; Keats et al., 2012). Whilst there have been no changes made to the structure of the sessions in relation to this, consideration has been given to the idea that the sessions were estimated to be around 45 minutes in length and the therapist's manual was updated to include considerations around the MCN population and the conditions for each individual to engage.

Some of the helpful aspects of the intervention may not be strictly related to the PTMF content of the workbook, as demonstrated by Alex's expression of finding the opportunity to "offload" as helpful. Pre-existing literature identifies the process of talking helpful for a number of reasons, for example emotional processing (Murray & Segal, 1994), feeling understood and developing an understanding of self (Timulak, 2010). Whilst these helpful aspects are not exclusive to the workbook, the workbook can be argued to provide a framework to elicit important talking points which are highly relevant to this population.

The identification of the Strengths session as valuable and feasible by both the participant and the clinician is promising to the future application of this model. However, there is a disparity between the qualitative admissions of the helpfulness of this session and the ES and WEMWBS post scores, particularly the significant deterioration of the Self-Esteem subscale on the ES. The construct of self-esteem in the ES scale is based on that used in the Rosenberg Self-Esteem scale (1965). Within the scale, self-esteem is defined as the attitude towards oneself. It would be logical to consider that the identification of personal strengths would have a positive impact on self-esteem, however this is not demonstrated in the case of Alex. It can be theorised the strengths session did not hold enough impact to influence the final post scores significantly, and the deterioration in the score may be explained by the confrontation of adverse life events, including one's role within them, alongside a deterioration in mental wellbeing in response to the COVID-19 lockdown.

However, it is possible the ES was unable to detect a change in Alex's self-esteem score due to having a lack of sensitivity to change. As previously stated, there was a lack of reference data for the ES's and the SoAS scales sensitivity to change. Further critique of the ES and the SoAS is the absence of scoring template, resulting in the measure being scored by hand. Scoring by hand has been cited to result in significant error rates which undermine the measure's reliability (Simons et al., 2002). To protect the reliability of the ES and the SoAS in this research it was double scored and checked with supervisors. Whilst the WEMWBS has demonstrated its sensitivity to change in literature (Maheswaran et al, 2012), it is not without its flaws. One study found the measure to be less suitable to those who are of a lower cognitive ability and a significant difference in scores depending on gender (Deary et al., 2013). However, a critique of this literature is the lack of definition of lower cognitive ability and a lack of information on how gender impacts scores. To the authors knowledge, Alex did not have a lower cognitive ability (as could be identified by the demographic form) therefore protecting the reliability and validity in the use of the WEMWBS.

Specific points in which the intervention encouraged the development of personal agency are pinpointed when Alex was asked to consider ways in which he has been influenced by power, both positively and negatively. In considering both influences of power, the participant is positioned as an active agent in the processes of power. Further to this, the Strengths session encouraged Alex to engage in personal agency when he was asked to think of ways he could improve upon his strengths. The clinical implications of an intervention which enhances personal agency can only be speculated but can be suggested to be highly relevant for those facing MCN. Individuals who hold a high sense of personal agency are cited to be better equipped to handle stress and difficult life events, as they are more able to make use of psychosocial resources (Thoits, 2006). One study found individuals experiencing homelessness but who had a strong sense of personal agency, engaged in positive meaning-making and were more likely to demonstrate resilience despite receiving negative messages about their identity from society (Shelton, et al., 2018). However, this study was conducted on a homogenous sample of transgender individuals therefore the application of findings is limited. It can be argued that as Alex developed a narrative which addressed the power held by him as an individual vs the system, he was able to develop an enhanced sense of agency, as seen in the young people in Toolis & Hammack's study (2015). Previous research on ex-substance users has indicated recovery from addiction involved the enhancement of personal agency (Rowlands, Youngs & Canter, 2019), as demonstrated in Alex's narrative regarding choosing coffee instead of beer. It would be of benefit for future research to further investigate the ability of the PTMF workbook to influence the development of personal agency within this population using robust, repeated measurement and tangible outcomes.

The underlying mechanisms of empowerment are suggested to be attributed to the process of formulation and narrative development. It is argued that through building an understanding of his current problems within a societal context, Alex was able to externalise the problem from himself and consider opportunities for change (White & Epston, 1990). This was demonstrated in his change in narrative around moving on to independent living. Empowerment is observed in his challenging tone of his narrative around "not giving up", which can be said to be acknowledging the power held by the system but enacting personal power and change through determination. This could be theoretically understood as Alex beginning to initiate an approach orientated cognitive style to power (Keltner, Gruenfeld & Anderson, 2003). However, this approach needs to be supported by tangible reward, such as Alex is supported to move into independent accommodation. This means the systems around Alex need to be responsive to the empowerment of individuals experiencing MCN by enacting reward power (French & Raven, 1959), as suggested by Tanekenov, Fitzpatrick & Johnsen (2017) or as demonstrated by the Housing First Programme.

A way in which this could be done is through the implementation of the PTMF workbook within models of Psychologically Informed Environments (PIEs) or Trauma Informed Care (TIC). PIEs are services designed to take into account the psychological and emotional needs of the individuals using them (Homeless Link, 2017). The aim of designing services in this way is to empower SUs to make changes which increase their wellbeing and quality of life. With the recognition that engaging individuals with MCN requires an acknowledgement of the impact a history of trauma can have on their ability to trust and engage with services (Keats et al., 2012), a core principle of PIEs is the development of a relationship between staff and SUs, using psychological models, as a tool for instigating change (Johnson, 2018). This overlaps with the principles of Trauma Informed Care (TIC). TIC is a philosophical service approach whereby the impact of trauma is recognised, and services provide a response which promote a sense of safety for the survivor, helps to find empowerment using a strengths-based approach and enables them to rebuild a sense of control (Hopper, Bassuk & Olivet, 2010). It is suggested the PTMF could be used as a complimentary tool within these models, particularly by other allied health professionals. The use of the PTMF in the training of social workers is beginning to be explored (Fyson, Morley & Murphy, 2019), however there is a lack of research evaluating the acceptability and feasibility of its use by these professions. It would therefore be of benefit for future research to explore the use of the PTMF by other allied health professional groups, such as mental health nurses and social workers.

There has been critique of the PTMF having an air of ambivalence with regards to its position as an alternative rather than a replacement for current diagnostic classification systems (Recovery In The Bin, 2018). This ambivalence extended to this research, whereby the use of the suggested patterns proposed by the PTMF was avoided and could be seen as a potential limitation of the study. The rationale for this was due to the feeling that presenting a pattern to the participant after the creation of their narrative from their own personal meanings felt counter-intuitive, and very similar to presenting a diagnostic category. The authors report the patterns within the PTMF function to provide a basis for research and creating connections between "survivors" (Johnstone & Boyle, 2018a). They further argue the patterns are not designed to represent discrete clusters or offer universal explanations for threat responses. However, due to the complexity and highly academic nature of the PTMF, it is argued the function of the patterns are open to misinterpretation making the PTMF a no better alternative to diagnostic classification in terms of reducing stigma. The author of this research has deliberately avoided the debate regarding the use of the PTMF as an alternative, and instead focused on the utility of PTMF as a meaning making formulation.

A critique of this research exists in the unusual single case design. Whilst the research does hold a repeated measure design, it was not possible to use a multiple baseline design (Morley, 2017). Advantages of multiple baseline methodology include the participants acting as their own control and the use of repeated measurement provide individual patterns in change data. However, due to the transient nature of this population, the application of a multiple baseline design was not feasible.

A potential limitation of this study is the use of a participant who engaged in the consultation on the design and pilot of the PTMF intervention and study materials. The ECs were provided with draft copies of the workbook and study materials and asked to comment openly on how understandable the language was and the appearance and format of the workbook. It is acknowledged the use of the participant introduces self-selection bias as he had previously seen a draft version of the workbook and potentially, albeit briefly, had begun to apply the principles to his own experiences resulting in a desire to participate. The use of a participant who was recruited in this manner is defended in the nature of this research in understanding the utility of a new framework as opposed to attempting to generate results which are generalisable to other members of this population. Furthermore, to refuse Alex's request to participate in the research when he is a perfectly suitable candidate is against the philosophy of the PTMF and is engaging in the ongoing cycle of disempowerment and exclusion faced by this population.

A further limitation of this research is the conducting of the intervention remotely. Alex specified missing the responsiveness from face-to-face interaction. It is cited that verbal and non-verbal communication are fundamental indicators of underlying psychological processes (Weick, 1968), and co-construct the meaning of the communication (Westland, 2015). This could therefore suggest the clinician is at a disadvantage in exercising their clinical judgement when visual cues are absent, resulting in a compromised therapeutic relationship and a mismatch of understanding between the clinician and participant (Bee et al., 2016). Indeed, it could be speculated that this is what Alex was conveying in his reflection. However, a systematic review found there was little difference in therapeutic alliance, disclosure, empathy, attentiveness or engagement when conducting psychological interventions over the phone or face to face (Irvine et al., 2020). Further to this, literature has found advantages of telephone interventions to be helpful to some participants due to the greater anonymity provided (Goss &Anthony, 2003), which can be said to be in line with Alex's admissions of telephone helpfulness. Overall, whilst there were some limitations and disruption caused by conducting the intervention remotely, it was not of great detriment to the research as Alex continued to attend all research sessions and reported to experiencing benefits from doing so.

Another potential limitation of the research exists in the conducting of sessions with Alex whilst he was under the influence of alcohol. Specific guidance regarding the ethics of conducting research with an individual under the influence of alcohol is often vague (Anderson & DuBois, 2007). Therefore, the British Psychological Society's guidance on capacity was consulted and indicated that if the participant is able to demonstrate they are able to understand, retain and weigh up information to communicate a decision, they are able to consent to research (Dobson, 2008). This is demonstrated in the transcript extracts where Alex explicitly states he feels able to continue despite having had a drink. The clinician's judgement in Alex's coherence was confirmed by the lead researcher in the reviewing of the audio recordings. There is also an argument that the exclusion of individuals who engage in alcohol and substance misuse inhibits the diversity and realness of research (Fisher, 2004). Additionally, individuals who experience drug and alcohol addiction themselves argue for their inclusion in research, stating they perceive research exclusion as harmful and discriminatory (Bell & Salmon, 2011). This links to literature on Multiple Exclusion, as those experiencing MCN are likely to struggle to adhere to strict rules around abstinence. Therefore, to refuse engaging Alex in the research session after he had demonstrated his ability to consent, would continue to perpetuate the cycle of exclusion.

5.0 Reflection

Pragmatism holds the position that the researcher will not only be guided by their own beliefs, but also by the shared beliefs of the others involved. The researcher will ultimately be guided by their own personal experiences but will also learn from the experiences of others (Morgan, 2014). A pragmatist researcher will continuously undergo a dynamic system of problem solving, resulting in constant reflection and revision of the research. A reflexive diary was kept throughout the process of research to document the changes in the research, including changes in the lead researcher's perspective. Supervision logs detailing the challenges and changes was also drawn upon to ensure transparency where the lead researcher has learnt or been influenced by the beliefs and perspectives of senior researchers.

During the design phase of the first version of the workbook, I drew on a range of literature to inform the translation of the PTMF into a usable intervention. This included reading lots of different therapy manuals to consider ways in which concepts could be adapted into experiential exercises. However, I noted some concerns in reading manuals which held a different philosophical position from the PTMF:

> *Diary: I'm worried I'm turning this workbook into a copy-cat CBT type intervention???...but I'm not sure how else to make this as easy to understand as possible when the PTMF language is so clunky and unnatural!*

Two CBT manuals of inspiration included "Cognitive Behavioural Therapy: Basics and Beyond" (Beck & Beck, 2011) and "Mind over Mood" (Greenberger & Padesky, 2016). Concepts such as problem statements and noting down examples in the style of thought diaries were inspired by the manuals due to the practical and step by step way in which they are presented. These mechanisms supported the process of slowly building up the participant's understanding and personal application of the PTMF in a step-by-step manner. I overcame my philosophical anxiety when I received feedback from senior supervisors and the EC group.

I wanted to ensure the workbook was as relatable as possible for participants, so I decided to include a running case example called Dave throughout the workbook. However, feedback from the field supervisor resulted in Dave's removal:

> *Supervision log: Hayley to make the following changes to the workbook: remove the example of Dave due to the potential to prime, and make alterations to examples of power and threat*

In discussion with the field supervisor, there was concern the presence of a case example could be perceived to be stereotyped and could potentially offend the participant. Furthermore, there was a worry the example of Dave may bias the participants perspective and limit their ability to understand the PTMF concepts in the way which was central to their own experience.

I found attending the EC group to receive feedback on the workbook and study materials really valuable:

> *Diary: That was such an amazing experience. I cannot believe how friendly and welcoming everyone was. One group member had a really strong reaction to the title "Power Threat Meaning Framework" on the PIS. He said he actually felt threatened by the words.*

In response to the EC feedback, the PIS was changed to remove the "Power Threat Meaning Framework" from the title and instead include it in the explanation of the study. Usually, psychological models and therapies hold titles which are highly academic and emotionally detached, and this made me reflect on a key criticism of the language used in the PTMF being difficult to conceptualise. Whilst I was already aware of this, I had not considered the impact the words could have on those who have experienced trauma and/or are disempowered within society.

The COVID-19 pandemic meant some alterations had to be made to the study:

> *Supervision log: Ethics amended to include doing the intervention and interview over the phone to adapt to the COVID19 crisis*
>
> *Diary: I cannot believe I have to change ethics again. What if we can't recruit or retain anyone because they won't engage over the phone? What if the participant doesn't understand the workbook at all because we can't be physically there to go through it with them?*

I was concerned about the ability to recruit and retain participant's to the study when all activity had to be conducted remotely. This was partially to do with my beliefs around the ability to build up engagement over the phone, as I have always preferred to build a relationship with the individuals, I work with face to face. I believe that a lot of information can be missed or misconstrued when visual cues are missing. Further to this, I felt that a large proportion of the target population had now become unreachable as they may not have the methods to engage e.g., a mobile phone or a fixed address to receive study materials and payment. Despite my concerns, the field supervisor successfully engaged Alex and completed all sessions with him remotely. However, COVID continued to cause disruptions to the project, as further recruitment became more and more unlikely:

> *Supervision log: Recruitment completed for thesis. One participant recruited in total- discussion around how COVID has impacted on recruitment. Discussion around using the data from session audio recordings to demonstrate research to be of a doctoral*

> *standard. Agreed to conduct an evaluation of the processes (e.g., change events) to contribute the evaluation of the PTMF as an intervention. Consideration needs to be given to the development of a framework for this analysis, Thomas recommended researching the "Event's Paradigm"*

Whilst it was hoped some more participants could be recruited to trial the latest version of the workbook, the data gathered from Alex was so rich in detail it was universally agreed that an exploratory case would be sufficient to demonstrate a doctoral standard of research.

As I read through transcripts, I observed some very clear subjective interpretations I had made during the change interview:

> *Alex: "[sigh]…ummm…I think toleration…I've tolerated so much and put up with so much, I think I've kind of...[sigh]…yeah…ummm…I've put up with more than I should've and whatever, and I've just like…yeah…I've just got into that scenario"*
>
> ***Researcher: "Okay, so if I may…ummm…it sounds to me like you were someone before who put on a happy face?"***
>
> *Alex: "Yeah!"*

I reflected on this imposition in supervision and acknowledged my limitations as a novice researcher. This was valuable in reinforcing the need to remain neutral and curious when conducting interviews. Whilst Alex appears to agree with my interpretation, it was not constructed from his own discourse and was therefore omitted from the final analysis. Instead, Alex's words were adhered to e.g. "I've tolerated and put up with so much".

During TA, I came across a few challenges as I made the mistake of alternating between analysing each transcript inductively first, followed by deductively. This meant that once I moved on to the next transcript, I was still within the mindset of deductive analysis:

> *Supervision log: The inductive codes are similar to the deductive codes and aren't true to the participants language but rather interpretive. Hayley to complete the deductive coding process and then revisit the inductive codes and review them in line with the inductive questions (ensuring to stay close to the participants words and meaning)*
>
> *Diary: supervision and peer supervision have helped me to understand merging inductive and deductive themes. I have also overcome the problem of being too deductive led (pushing inductive codes under deductive themes) e.g., taking connecting past to present as its own subtheme/theme instead of branding it as just a session outcome.*

I found TA to be an exhausting and all-consuming process, to the point that I woke in the middle of the night to think about whether "perception" or "perspective" would be the more appropriate word to use as a code. I became so involved in the process that when I came to present my project to my peers and supervisors, I had lost all sight of what my project had initially aimed to do. This resulted in the misrepresentation of the project and concerning comments about my success at Viva. However, supervision helped me to re-adjust my perspective on the project:

> *Supervision log: Reflection on a loss of focus on the aim of the project after the analysis stage and getting caught up in presenting a single case, losing sight that the focus of the thesis is the design of the PTMF intervention. Reflection of presenting the results from the TA e.g., the amalgamation of the data from all sources and how this is presented.*

Upon starting the doctorate, I labelled myself as someone who was "good at research" due to my prior experience of conducting research in NHS settings and acting as an advocate for service user involvement in all aspects of the research process/service design. Whilst these experiences provided me with a good base, they did not prepare me for the rigor required in designing and implementing a research project of my own design. I can safely say that true to the pragmatist position, I have been moulded by the experiences I have had whilst conducting this research and I have been influenced by my supervisors and the teaching provided by the Trent course. I have been particularly influenced by the field supervisor in understanding the depth of social injustice that exists in the society that I grew up in and believed to be fair. I had always been taught that if I did what I was told and followed the rules, everything would be okay. However, this is not always the case for people who are born or forced into disempowerment, often labelled as deserving of what they got or not working hard enough to overcome the challenges of life. I now recognised my responsibility as a clinical psychologist to challenge these misconceptions and use my privilege to support those of whom are the most disempowered in our society.

References

AADD-UK. (2018, January 23). *British psychological society endorses stigmatisation of ADHD*. https://aadduk.org/2018/01/23/letter-to-british-psychological-society-re-adhd-stigmatisation/#comments

Aboraya A. (2007). The reliability of psychiatric diagnoses: Point-our psychiatric diagnoses are still unreliable. *Psychiatry, 4*(1), 22–25.

Addis ME, Krasnow AD. (2000) A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of consulting and clinical psychology*, 68*(2*), 331–339. doi: 10.1037/0022-006X.68.2.331.

Aherne, C. Moloney, O. O'Brien, G. (2019) Youth mental health and the power threat meaning framework: Jigsaw's systems perspective. *Clinical psychology forum special issue: The power threat meaning framework, 313,* 3-7

Alkire, D. S. (2008). *Concepts and measures of agency*. Oxford Poverty & Human Development Initiative (OPHI).

Allen, M. (2017). *The sage encyclopedia of communication research methods* (vols. 1-4). Thousand Oaks, SAGE publications, doi: 10.4135/9781483381411.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). doi:10.1176/appi.books.9780890425596.744053

Anderson, E. E., & DuBois, J. M. (2007). The need for evidence-based research ethics: A review of the substance abuse literature. *Drug and alcohol dependence*, *86*(2-3), 95-105.

Arroll, B., Elley, C.R., Fishman, T., Goodyear-Smith, F.A., Kenealy, T., Blashki, G., Kerse, N., MacGillivray, S. (2009) Antidepressants versus placebo for depression in primary care. *Cochrane database of systematic reviews*, 3, DOI: 10.1002/14651858.CD007954.

Aston, R. (2009) A literature review exploring the efficacy of case formulations in clinical practice. what are the themes and pertinent issues? *The cognitive behaviour therapist,* 2*,* 63 - 74.

Australian Injecting & Illicit Drug Users League. (2003). *National statement on ethical issues for research involving Injection/Illicit drug users.* Canberra

Barham, P. & Hayward, R. (1995). *Re-locating madness: From the mental patient to the person*. Free association books.

Beck, J. S., & beck, A. T. (2011). *Cognitive Behavior Therapy. Basics and beyond.* New York: Guilford Publication.

Bee, P., Lovell, K., Airnes, Z., Pruszynska, A. (2016) Embedding telephone therapy in statutory mental health services: A qualitative, theory-driven analysis, *BMC psych*, 1656 doi: 10.1186%2Fs12888-016-0761-5.

Bell, K., & Salmon, A. (2011). What women who use drugs have to say about ethical research: Findings of an exploratory qualitative study. *Journal of empirical research on human research ethics*, 6(*4*), 84-98.

Bergner, R. M. (1998) Characteristics of optimal clinical case formulations: The linchpin concept. *American journal of psychotherapy, 52*(3), 287-300.

Bhandari, M., Busse, J.W., Jackowski, D., Montori V.M., Schunemann, M., Sprague, S., Mears, D., Schemitsch, E.H., Heels-Ansdell, D. & Devereaux P.J. (2004) Association between industry funding and statistically significant pro-industry findings in medical and surgical randomized trials. *The Canadian medical association journal, 170 (4)* 477-480.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage.

Boyle, M. (2002). *Schizophrenia: A scientific delusion?* (2nd ed.) Routledge.

Boyle, M. (2007) The problem with diagnosis. *The Psychologist, 20(5),* 290-292.

Bramley, G., Fitzpartick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F. & Watkins, D. (2015). *Hard edges: Mapping sever and multiple disadvantage*, Lankelly Chase Foundation. https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

Bramley, G., Fitzpatrick, S., Wood, J., Sosenko, F., Blenkinsopp, J., Littlewood, M., Frew, C., Bashar, T., McIntyre, J. & Johnsen, S. (2019). *Hard edges Scotland: New conversations about severe & multiple disadvantage.* Lankelly Chase. https://lankellychase.org.uk/wp-content/uploads/2019/06/Hard-Edges-Scotland-full-report-June-2019.pdf

Braun, V. & Clarke, V. (2020a) Can I use TA? should I use TA? should I *not* use TA? comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Couns Psychotherapy res*.; 00: 1– 11. https://doi.org/10.1002/capr.12360.

Braun, V. & Clarke, V. (2020b) One size fits all? what counts as quality practice in (reflexive) thematic analysis? *Qualitative research in psychology*, DOI: 10.1080/14780887.2020.1769238.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2012). *Thematic analysis.* In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (eds.), *APA handbooks in psychology®. APA handbook of research methods in psychology, vol. 2. research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American psychological association. https://doi.org/10.1037/13620-004.

The British Psychological Society (2011) *Good practice guidelines on the use of psychological formulation.* The British psychological society, Division of Clinical Psychology. http://www.sisdca.it/public/pdf/DCP-Guidelines-for-Formulation-2011.pdf

Cameron, D. (2001). *Working with spoken discourse.* Sage.

Carroll, K. M., & Nuro, K. F. (2002). One size cannot fit all: A stage model for psychotherapy manual development. *Clinical psychology: Science and practice*, *9*(4), 396-406.

Clarke, V., Braun, V., & Hayfield, N. (2015). Thematic Analysis. *qualitative psychology: A practical guide to research methods*, 222-248.

Cockersell, P. (2018). *Social exclusion, compound trauma and recovery: Applying psychology, psychotherapy and PIE to homelessness and complex needs*. Jessica Kingsley Publishers

Cyril, S., Smith, B. & Renzaho, A. (2015) Systematic review of empowerment measures in health promotion, *Health promotion international, 31*(4), 809-826

Deary, I. J., Watson, R., Booth, T., & Gale, C. R. (2013). Does cognitive ability influence responses to the Warwick Edinburgh mental well-being scale? *Psychological Assessment, 25*(2), 313–318. https://doi.org/10.1037/a0030834.

Deegan, P.E. (1993). Recovering our sense of value after being labelled mentally ill. *Journal of psychosocial nursing and mental health services, 31*, 7–11.

Dempsey, J. P., Back, S. E., Waldrop, A. E., Jenkins, L., & Brady, K. T. (2008). The influence of monetary compensation on relapse among addicted participants: Empirical vs. anecdotal evidence. *American journal on addictions*, *17*(6), 488-490.

Denzin, N. (2012) Triangulation 2.0, *Journal of mixed methods research, 6*(2), 80–88

Division of Clinical Psychology. (2013). *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift. DCP position statement.* The British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Classification%20of%20behaviour%20and%20experience%20in%20relation%20to%20functional%20psychiatric%20diagnoses.pdf

Dobson, C. (2008). *Conducting research with people not having the capacity to consent their participant: A practical guide for researchers*. Leicester: The British Psychological Society.https://www.ed.ac.uk/files/atoms/files/bps_guidelines_for_conducting_research_with_people_not_having_capacity_to_consent.pdf

Dragioti, E., Dimoliatis, I., Fountoulakis, K.N. (2015) A systematic appraisal of allegiance effect in randomized controlled trials of psychotherapy. *Annals of general psychiatry* 14, 25 . https://doi.org/10.1186/s12991-015-0063-1.

Elliott, R., & Rodgers, B. (2008). *Client change interview schedule (v5).* [unpublished research instrument], University of Strathclyde

Elliott, R., & Shapiro, D. A. (1988). Brief structured recall: A more efficient method for studying significant therapy events. *British journal of medical psychology*, *61*(2), 141-153.

Elliott, R., James, E., Reimschuessel, C., Cislo, D., & Sack, N. (1985). Significant events and the analysis of immediate therapeutic impacts. *Psychotherapy: Theory, research, practice, training, 22*(3), 620–630. https://doi.org/10.1037/h0085548.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychological test and assessment modeling*, *43*(3), 69.

Estroff, S. (1993). Identity, disability and schizophrenia: The problem of chronicity. in S. Lindenbaum & M. lock (eds.), *Knowledge, power, and practice: The anthropology of medicine and everyday life*. Berkeley: University of California.

Etchison, M., & Kleist, D. M. (2000). Review of narrative therapy: Research and utility. *The family journal*, *8*(1), 61-66.

Festinger, D. S., Rarlowe, D. B., Croft, J. R., Dugosh, K. L., Mastro, N. K., Lee, P. A. & Patapis, N. S. (2005). Do research payments precipitate drug use or coerce participation? *Drug and alcohol dependence*, *78*(3), 275-281.

Fisher, C. B. (2004). Ethics in drug abuse and related HIV risk research. *Applied developmental science*, *8*(2), 91-103.

Fishman, D.B. (1999). *The case for pragmatic psychology*. NYU press.

Fishman, D. B. (2005). Editor's introduction to PCSP--from single case to database: A new method for enhancing psychotherapy practice. *Pragmatic case studies in psychotherapy*. 1*(1),* 1-50

Fishman, D. B. (2017). The pragmatic case study in psychotherapy: A mixed methods approach informed by psychology’s striving for methodological quality. *Clinical social work journal, 45*(3), 238–252. https://doi.org/10.1007/s10615-016-0612-3.

Fitzpatrick, S. & Bramley, G. (2019). *Hard edges Scotland.* Lankelly Chase. https://lankellychase.org.uk/wp-content/uploads/2019/06/Hard-Edges-Scotland-full-report-June-2019.pdf

Foucault, M. (1980). In C.Gordan (Ed.), *Power/knowledge: Selected interviews and other writings 1972–1977,* Harvester Wheatsheaf.

French, J. R. & Raven, B. (1959) The bases of social power. *Classics of organization theory*, *7*, 311-320

Fyson, R., Morley, K., & Murphy, A. (2019). Using the power threat meaning framework in social work education. *Clinical Psychology Forum 313,* 33-36

Goldacre, B. (2011, September 30) *Battling bad science* [video] retrieved from https://www.ted.com/talks/ben_goldacre_battling_bad_science/transcript.

Goldstein, N. E., Kemp, K. A., Leff, S. S., & Lochman, J. E. (2012). Guidelines for adapting manualized interventions for new target populations: A stepwise approach using anger management as a model. *Clinical Psychology: A publication of the division of clinical psychology of the American psychological association*, *19*(4), 385–401. https://doi.org/10.1111/cpsp.12011.

Goss S.K. & Anthony, S. (2003) Conclusion, eds. K. Anthony (ed.), *Technology in counselling and psychotherapy: A practitioner's guide*, Palgrave

Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy research*, 17, 15–30. doi:10.1080/10503300600720390

Greenberger, D., & Padesky, C. A. (2016). *Mind over mood: Change how you feel by changing the way you think* (2nd ed.). Guilford Press.

Greenhalgh, T., Robert, G., MacFarlane, F., Bate, P. & Kyriakidou, O. (2004), Diffusion of innovations in service organizations: Systematic review and recommendations. *The Milbank Quarterly*, 82, 581-629. https://doi.org/10.1111/j.0887-378X.2004.00325.x.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Sage.

Health Research Authority. (2014). *HRA guidance: Payments and incentives in research.* https://s3.eu-west-2.amazonaws.com/www.hra.nhs.uk/media/documents/hra-guidance-payments-incentives-research.pdf

Homeless Link. (2017). *Support for single homeless people in England: Annual Review 2017*, Ministry of Housing, Communities and Local Government, https://www.homeless.org.uk/sites/default/files/site-attachments/Annual%20Review%202017_0.pdf

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The open health services and policy journal*, 2, 131-151.

In J. (2017). Introduction of a pilot study. *Korean journal of Anaesthesiology*, *70*(6), 601–605. doi:10.4097/kjae.2017.70.6.601.

Irvine, A., Drew, P., Bower, P., Brooks, H., Gellatly, J., Armitage, C.J., Barkham, M., McMillan, D. & Bee, P., (2020). Are there interactional differences between telephone and face-to-face psychological therapy? A systematic review of comparative studies. *Journal of affective disorders*, *265*, 120-131.

Johnson, R. (2018). Principles and practice in psychology and homelessness: Pre-treatment, trauma informed care & psychologically informed environments. In, J. S. levy. *Cross-*

cultural dialogues on homelessness: From pre-treatment strategies to psychologically informed environments (pp. 13-34). Loving healing press.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The power threat meaning framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British psychological society

Johnstone, L., Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., & Read, J. (2019). Reflections on responses to the Power Threat Meaning Framework one year on. In *Clinical Psychology Forum,* 313, 47-54

Jupp, V. (2006). *The SAGE dictionary of social research methods* (vols. 1-0) SAGE publications, ltd doi: 10.4135/9780857020116.

Keats, H., Maguire, N.J., Johnson, R. & Cockersell, P. (2012). *Psychologically informed services for homeless people: Good practice guide*, Department of communities and local government. https://www.pathway.org.uk/wp-content/uploads/2013/05/Psychologically-informed-services-for-Homeless-People.pdf

Keltner, D., Gruenfeld, D. H., & Anderson, C. (2003). Power, approach, and inhibition. *Psychological review*, 110, 265–284.

Labott, S. M., Johnson, T. P., Fendrich, M., & Feeny, N. C. (2013). Emotional risks to respondents in survey research. *Journal of empirical research on human research ethics: JERHRE*, *8*(4), 53–66. https://doi.org/10.1525/jer.2013.8.4.53.

Leykin Y& DeRubeis RJ. (2009) Allegiance in psychotherapy outcome research: Separating association from bias. *Clinical psychology: Science and practice.*16, 54–65.

Liang, M. H. (2000). Longitudinal construct validity: Establishment of clinical meaning in patient evaluative instruments. *medical care*, *38*(9), II-84.

Llewelyn, S. P. (1988). Psychological therapy as viewed by clients and therapists. *British journal of clinical psychology*, *27*(3), 223-237.

McLeod, J. (2010) *Case study research in counselling and psychotherapy*. Sage.

Morgan, D. (2014) Pragmatism as a paradigm for Social Research, *Qualitative inquiry, 20*(8), 1045-1053.

Morse, J. M. (1989) Qualitative nursing research: A free-for-all? In Morse, J. M. (Eds) *Qualitative nursing research*, (pp. 3–14). Aspen publishers.

Murray, E. J., & Segal, D. L. (1994). Emotional processing in vocal and written expression of feelings about traumatic experiences. *Journal of traumatic stress*, *7*(3), 391-405.

Nagar, M., Westen, D., Nakash, O., (2018) Reliability of DSM and empirically derived prototype diagnosis for mood, anxiety and personality disorders, *Comprehensive Psychiatry*, 85, 8-14.

Oliver, D. G., Serovich, J. M., & Mason, T. L. (2005). Constraints and opportunities with interview transcription: Towards reflection in qualitative research. *Social forces; a scientific medium of social study and interpretation*, *84*(2), 1273–1289. https://doi.org/10.1353/sof.2006.0023.

Oravecz, R., Hárdi, L., & Lajtai, L. (2004). Social transition, exclusion, shame and humiliation. *Torture*, *14*(1), 3-15.

Parsell, C. & Parsell, M. (2012) Homelessness as a choice, *Housing, theory and society*, *29*(4),420-434, DOI: 10.1080/14036096.2012.667834.

Patton, M. (1990). *Qualitative evaluation and research methods.* Sage.

Pleace, N. (2008). *Effective services for substance misuse and homelessness in Scotland: Evidence from an international review.* Scottish Government Social Research. https://www.york.ac.uk/media/chp/documents/2008/substancemisuse.pdf

Pleace, N. (2016). *Housing first guide: Europe.* White Rose. https://eprints.whiterose.ac.uk/100794/1/HFG_full_Digital.pdf

Poland, B. (2002). Transcription quality. In Gubrium, J. & Holstein, J. (Ed.), *Handbook of interview research* (pp. 629-650) Sage.

Read, J., Haslam, N., Sayce, L. & Davies E. (2006). Prejudice and Schizophrenia: A review of the 'mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavica, 114*, 303–318.

Recovery in the Bin (2018, January 22). #PTMframework: Power Threat Meaning Framework – an evaluation By Avon [Online forum post] https://recoveryinthebin.org/2018/01/22/power-threat-meaning-framework-an-evaluation-by-avon/

Reis, M. Dinelli, S. Elisa, L. (2019) Surviving prison: Using the power threat meaning framework to explore the impact of long-term imprisonment. *Clinical psychology forum special issue: The power threat meaning framework,* 313, 25-32 .

Rosenberg, M. (1965). Rosenberg self-esteem scale (RSE). *Acceptance and commitment therapy. measures package*, *61*(52), 18.

Rowlands, D., Youngs, D., & Canter, D. (2019). Exploring an agency-communion model of identity transformation in recovery from substance misuse. *Journal of substance use*, *24*(3), 265-272.

Sale, J. E. M., Lohfeld, L. H., & Brazil, K. (2002). Revisiting the quantitative-qualitative debate: Implications for mixed-method research. *Quality and quantity*, *36*, 43–53.

Sandelowski, M., & Leeman, J. (2012). Writing usable qualitative health research findings. *Qualitative health research*, *22*(10), 1404-1413.

Sharpen, J. (2018). *Jumping through hoops: How are coordinated responses to multiple disadvantage meeting the needs of women?* AVA, MEAM, Agenda and St Mungo's. https://www.basw.co.uk/resources/jumping-through-hoops-how-are-coordinated-responses-multiple-disadvantage-meeting-needs

Shelton, J., Wagaman, M. A., Small, L., & Abramovich, A. (2018). I'm more driven now: Resilience and resistance among transgender and gender expansive youth and young adults experiencing homelessness. *International journal of transgenderism*, *19*(2), 144-157.

SHIFT Recovery Community (2020) Using the power threat meaning framework in a self-help group of people with experience of mental and emotional distress, J*ournal of constructivist psychology*, DOI: 10.1080/10720537.2020.1773361

Sidanius, J., & Pratto, F. (1999). *Social dominance: An intergroup theory of social hierarchy and oppression.* Cambridge university press.

Simons, R., Goddard, R., & Patton, W. (2002). Hand-scoring error rates in psychological testing. *Assessment*, *9*(3), 292–300.

Slevitch, L. (2011) Qualitative and quantitative methodologies compared: Ontological and epistemological perspectives, *Journal of quality assurance in hospitality & tourism*, 12:1, 73-81, DOI: 10.1080/1528008X.2011.541810

Slomka, J., Ratliff, E. A., McCurdy, S., Timpson, S., & Williams, M. L. (2008). Perceptions of risk in research participation among underserved minority drug users. *Substance use & misuse, 43*(11), 1640–1652. https://doi.org/10.1080/10826080802241243

Smail, D. (2005). *Power, interest and psychology*. PCCS Books.

Smith, J.A., Flower, P., & Larkin, M. *Interpretative phenomenological analysis: Theory, method and research*. Sage.

Sosenko, F., Bramley, G., & Johnsen, S. (2020). *Gender matters: Gendered patterns of severe and multiple disadvantage in England.* Lankelly Chase. https://lankellychase.org.uk/publication/gender-matters/

Tanekenov, A., Fitzpatrick, S. & Johnsen, S. (2018) Empowerment, capabilities and homelessness: The limitations of employment-focused social enterprises in addressing complex needs, *Housing, theory and society, 35*(1), 137-155, DOI: 10.1080/14036096.2017.1290676.

Thabane, L., Ma, J., Chu, R., Cheng, J., Ismaila, A., Rios, L. P., & Goldsmith, C. H. (2010). A tutorial on pilot studies: What, why and how. *BMC medical research methodology*, *10*(1), 1-10.

Thoits, P. A. (2006). Personal agency in the stress process. *Journal of health and social behavior, 47*(4), 309–323. https://doi.org/10.1177/002214650604700401 .

Timulak, L. (2010), Significant events in psychotherapy: An update of research findings. psychology and psychotherapy. *Theory, research and practice, 8*3, 421-447. https://doi.org/10.1348/147608310X499404.

Toolis, E. E., & Hammack, P. L. (2015). The lived experience of homeless youth: A narrative approach. *Qualitative psychology*, *2*(1), 50.

Vaismoradi, M., Turunen, H. and Bondas, T. (2013), Qualitative descriptive study. *Nurse health sci, 15*, 398-405. https://doi.org/10.1111/nhs.12048.

Weick, H. (1968). Systematic observational methods, in Lindzey and E. Aronson (Eds.), *The handbook of social psychology*, (2nd ed. 357–451.) Addison-Wesley

Westland, G. (2015). *Verbal and non-verbal communication in psychotherapy.* W. W. norton & co.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* W. W. Norton & Company.

World Health Organization. (2004). *ICD-10: International statistical classification of diseases and related health problems: Tenth revision* (2nd ed.) https://apps.who.int/iris/handle/10665/42980.

Zagzebski, L. (2009) *On epistemology.* Wadsworth: Cengage learning

Appendix 1: PTMF-based workbook delivered in exploratory case

Session 1: What is the Power Threat Meaning Framework?

The Power Threat Meaning Framework is a tool to understand and tell your life story in a bigger picture, using the following questions;

- ‘What has happened to you?’ (How is Power operating in your life?)
- ‘How did it affect you?’ (What kind of Threats does this pose?)
- ‘What sense did you make of it?’ (What is the Meaning of these situations and experiences to you?)
- ‘What did you have to do to survive?’ (What kinds of Threat Response are you using?)
- ‘What are your strengths?’ (What access to Power resources do you have?)
- ‘What is your story?’ (How does all this fit together?)

Exercise 1: Problem statement

Describe your current situation/difficulties

Power: ‘What has happened to you?’

Defining Power

What does the word “power” mean to you?

‘Power’ can have several meanings. Generally, it means being able to gain advantages or privileges, to arrange things to meet your own interests; or being able to gain advantages or privileges for others, to arrange things to meet their interests.

Power can operate through our partners, families, friends, communities, schools, work, health services, the police, government and the media.

Power can be used negatively; for example, when people are hurt, excluded or silenced by others. It can also be used positively, such as when others protect and care for us.

There is a great deal of evidence that the negative use of power, both in the past and in the present, can lead to mental health problems. There is also evidence that we can be helped and protected by positive and supportive power. Examples of the various kinds of power and the difficult events and circumstances that they can lead to, are given below. Some of them may apply to you.

Examples of power

Power by force
Physically defending or protecting yourself
Bullying

Legal power
Access and support to the police
Getting arrested

Biological power
Physical strength
Physical illness

Social
Being part of a community
Being unable to access education

Economic power
Benefits
Losing your job/benefits

Interpersonal
Good friendships
Domestic violence

Ideological
Religious or spiritual freedom
Rejection of beliefs by others

How is power affecting you?

	Positive	Negative
Biological		
Legal		
Social		
Economic		
Force		
Interpersonal		
Ideological		

Thank you for sharing this information. How you see power affecting you is an important part of your story. We will use the information we have talked about today in future sessions and in the final story we write together.

Session 2: Threat

Recap

Last session we identified the positive and negative influence of power in your life. Is there anything you would like to add?

Threat: "How did it affect you?"

When power is used in negative ways it often brings about very difficult and threatening situations or challenges. Some additional examples to help you think about threats in your own past or present life are given below.

Examples of Threat

Power by force
Disempowerment:
Bullying
Threat: Physical and
emotional harm

Legal
Disempowerment:
Getting arrested
Threat: Loss of freedom

Economic
Disempowerment: Losing
your job/benefits
Threat: Being unable to
pay for rent or food

Biological
Disempowerment:
Physical illness
Threat: Being unable to
work

nt: Being
to access
education
Threat: Having restricted
access in employment

Interpersonal
Disempowerment: Death
of family members
Threat: loss of love,
support and care

Ideological
Disempowerment: Rejection
of beliefs by others.
Threat: Persecution for
beliefs

What threats have you faced in life?

	Disempowerment	Threat
Biological		
Legal		
Social		
Economic		
Force		
Interpersonal		
Ideological		

Session 3: Meanings

Recap

Last session we identified the threats you face in life. Is there anything you would like to add?

Meanings: “How did you make sense of the things that happened”?

We make sense of a situation through our beliefs, feelings and bodily reactions. Making sense of threats usually leaves us feeling bad.

Box 1: Feelings

Unsafe, afraid, attacked	Trapped
Helpless, powerless	Failed, inferior
Invaded	Betrayed
Emotionally overwhelmed	Injustice/unfairness
Contaminated, evil	Isolated, lonely
Different, abnormal	Excluded, alienated
Shamed, humiliated	Bad, unworthy
Alien, dangerous	Empty
Controlled	Hopeless
Abandoned, rejected	Defeated
Guilty, blamed, responsible	Sense of meaninglessness

Box 2: Beliefs

I am unlovable	No one can be trusted
What’s the point	Something bad is going to happen
I’m pathetic	People are awful
The world is unfair	Life is cruel
Nobody cares	It’s all my fault
Everyone is against me	Nothing helps

Box 3: Bodily reactions

Rapid breathing	Racing heart
Upset stomach/butterflies	Panic attacks
Headaches	Feeling very hot
Blurry vision	Feeling tense

Exercise: Describe below what feelings, beliefs and bodily sensations you experienced in response to a threat

Feelings	**Beliefs**	**Bodily reactions**

Session 4: Threat Responses

Recap

Last session we identified the feelings, beliefs and bodily sensations you might experience in response to threat. Is there anything you would like to add?

Threat Responses

“What did you have to do to survive?”

The ways we react to threats are the ways in which we behave, or they could be recognised as symptoms. These responses are necessary and understandable survival strategies in response to the threat. These responses may include;

- Helping to manage overwhelming feelings
- Protection from physical danger
- Keeping a sense of control
- Protecting yourself from loss, hurt, rejection or abandonment
- Seeking or holding onto safe relationship
- Holding on to a sense of yourself and your identity
- Finding a place for yourself in social groups
- Meeting your emotional needs
- Communicating a need for care and help
- Finding meaning and purpose in your life

However, some of these threat responses may no longer be needed or useful. In fact, they may be causing you problems in their own right. Examples of threat responses include;

- Preparing to ‘fight’ or attack
- Preparing to ‘flee’, escape, seek safety
- Freeze response
- Hypervigilance, startle responses, insomnia
- Panic, phobias
- Fragmented memory encoding
- Memory suppression (amnesia)
- Hearing voices
- Dissociating (losing track of time/place; various degrees of splitting of awareness)
- Depersonalisation, derealisation
- Flashbacks Nightmares

- NEAD (‘non-epileptic attack disorder’)
- Emotional numbing, flattening, indifference
- Bodily numbing Submitting, appeasing
- Giving up, ‘learned helplessness’, low mood
- Protesting, weeping, clinging
- Suspicious thoughts
- Emotional regression, withdrawal
- ‘High’ or extreme moods; rapid mood changes (‘emotional dysregulation’)
- Holding unusual beliefs
- Having unusual visual, olfactory, tactile sensations
- Physical sensations – tension, dizziness, physical pain, tinnitus, sensations of heat or cold, exhaustion, skin irritation, gastrointestinal problems and many other bodily reactions
- Emotional defences: denying what has happened, idealising people, and so on.
- Intellectualisation (avoiding feelings and bodily sensations)
- Attention/concentration problems
- Confused/unstable self- image/sense of self
- Confused/confusing speech and communication
- Self-injury of various types Self-neglect
- Dieting, self-starvation Bingeing, over-eating Self-silencing
- Mourning, grieving
- Self-blame and self- punishment
- Body hatred Compulsive thoughts
- Carrying out rituals and other ‘safety behaviours’
- Collecting, hoarding
- Avoidance of/compulsive use of sexuality
- Impulsivity
- Anger, rage
- Aggression and violence
- Suicidal thinking and actions
- Distrust of others Feeling entitled Reduced empathy Distrust
- Avoiding threat triggers
- Striving, perfectionism, ‘drive’ response
- Using drugs, alcohol, smoking
- Overworking, over- exercising, etc.
- Giving up hope/loss of faith in the world
- Relational strategies: rejection and maintaining emotional distance; seeking care and attachments; taking on caring roles; isolation/ avoidance of others; dominance, seeking control over others; and so on
- Ruminating, reflecting, anticipating, imagining, interpreting, meaning- making

Exercise 2: Can you identify how you behave or what symptoms you have? How do they manage the threat in your life?

Behaviour/Symptom	How does it manage threat?	Does is cause any problems?

Session 5: Strengths

Recap

Last session we identified how you behave or what symptoms you have which help you to manage the threats you face in life. Is there anything you would like to add?

Strengths

“What are your strengths? What power do you hold?”

This may include people who care for you, aspects of your identity that you feel good about, skills and beliefs, and so on. Other possible strengths in your life, past and present, are:

- Loving and secure early relationships.
- Supportive partners, family and friends
- Social support and a sense of belonging.
- Having the chance to enjoy material, leisure and educational opportunities.
- Having access to information/knowledge/alternative views (e.g. on mental health).
- Positive/socially valued aspects of your identity.
- Skills/abilities – such as intelligence, resourcefulness, determination, talents.
- Bodily resources – appearance, strength, health.
- Belief systems – faiths, community values and so on.
- Community practices and rituals.
- Connections to nature and the natural world.

What are your strengths?

You might want to think about some of these ways of building on your resources and strengths:

- Managing your emotions by releasing/expressing/processing feelings (e.g. writing, exercise, talking therapies, body therapies, creativity and the arts, compassion-focused approaches, mindfulness, meditation).

- Self-care – e.g. nutrition, exercise, rest, alternative therapies.
- Using or finding relationships for emotional support, protection, validation.
- Finding meaningful social roles and activities.
- Other cultural rituals, ceremonies and interventions.
- Getting involved in campaigning, activism.
- Creating/finding new narratives/meanings/beliefs/values.

Do you have any ideas on how you could build your strengths?

Session 6: Your story

Recap

Last session we identified how your strengths and ideas for building on these. Is there anything you would like to add?

Now that we have considered the influence of power and threat in your life it may be helpful to pull all this information together in the form of a narrative or story about your life.
Here are some prompts to help you:

The threats I have faced…
What it made me feel and believe…
The symptoms I have experienced or the ways I have behaved to cope…
The strengths I have which have helped me to survive...

Appendix 2: The SoA (sense of agency) scale – English version*

*Note that psychometrics and other data in the Tapal et al., 2017 paper refer to the Hebrew version

Instructions for participants:

Welcome to our research questionnaire in which you will be presented with a number of statements. Please think thoroughly about each and every statement and determine the degree to which you agree or disagree with it. Judge the statements in reference to your general feeling and/or beliefs – we understand that sometimes it will be difficult to choose a single answer, as most of the statements are context dependent. Notwithstanding, please pick the response that best fits your feelings and beliefs. Many thanks for your participation.

Scale:

1) Totally disagree
2) Moderately disagree
3) Somewhat disagree
4) Neither agree nor disagree 5) Somewhat agree
6) Modestly agree
7) Fully agree

If using a single score then Items 2,3,5,6,7,10,11 should be reverse coded (8-x) before all items are summed.

If scoring for the two subscales SoPA*, SoNA just sum participants' raw ratings.**

*** SoPA, Sense of Positive Agency ** SoNA, Sense of Negative Agency**

Item SoPA SoNA

1. I am in full control of what I do **+** 0

2. I am just an instrument in the hands of somebody or something 0 **+** else

3. My actions just happen without my intention 0 **+**

4. I am the author of my actions **+** 0

5. The consequences of my actions feel like they don't logically follow 0 **+** my actions

6. My movements are automatic—my body simply makes them 0 **+**

7. The outcomes of my actions generally surprise me 0 **+**

8. Things I do are subject only to my free will **+** 0

9. The decision whether and when to act is within my hands **+** 0

Item SoPA SoNA

10. Nothing I do is actually voluntary 0 **+**

11. While I am in action, I feel like I am a remote controlled robot 0 **+**

12. My behavior is planned by me from the very beginning to the very **+** 0 end

13. I am completely responsible for everything that results from my **+** 0 actions

Appendix 3: The Empowerment Scale

MAKING DECISIONS

Instructions: Below are several statements relating to one's perspective on life and with having to make decisions. Please circle the number above the response that is closest to how you feel about the statement. Indicate how you feel now. First impressions are usually best. Do not spend a lot of time on any one question. Please be honest with yourself so that your answers reflect your true feelings.

PLEASE ANSWER ALL QUESTIONS
BY CIRCLING THE NUMBER THAT BEST DESCRIBES HOW YOU FEEL.
PLEASE CHECK ONLY ONE.

1. I can pretty much determine what will happen in my life.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

2. People are only limited by what they think is possible.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

3. People have more power if they join together as a group.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

4. Getting angry about something never helps.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

5. I have a positive attitude toward myself.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

6. I am usually confident about the decisions I make.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

7. People have no right to get angry just because they don’t like something.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

8. Most of the misfortunes in my life were due to bad luck.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

9. I see myself as a capable person.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

10. Making waves never gets you anywhere.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

11. People working together can have an effect on their community.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

12. I am often able to overcome barriers.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

13. I am generally optimistic about the future.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

14. When I make plans, I am almost certain to make them work.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

15. Getting angry about something is often the first step toward changing it.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

16. Usually I feel alone.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

17. Experts are in the best position to decide what people should do or learn.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

18. I am able to do things as well as most other people.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

19. I generally accomplish what I set out to do.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

20. People should try to live their lives the way they want to.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

21. You can’t fight city hall.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

22. I feel powerless most of the time.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

23. When I am unsure about something, I usually go along with the rest of the group.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

24. I feel I am a person of worth, at least on an equal basis with others.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

25. People have the right to make their own decisions, even if they are bad ones.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

26. I feel I have a number of good qualities.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

27. Very often a problem can be solved by taking action.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

28. Working with others in my community can help to change things for the better.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

Appendix 4: Clinician Questionnaire

Therapist:

Participant initials:

Session:

1. Brief summary of what was covered in the session:

2. Any noteworthy events? (e.g., late, interruptions, challenges)

3. Was there anything about the session which you felt was particularly helpful or important? Please consider both the content of the workbook AND extra therapy factors (e.g. your relationship with the participant)

4. Did anything happen during the session which might have been unhelpful or hindering? Please consider both the content of the workbook AND extra therapy factors (e.g. your relationship with the participant)

5. Please rate the feasibility of this session for this population (Please circle)

1. Feasible-I think would use it again and recommend it to other clinicians
2. It could be feasible with some changes- Some parts work, others don't
3. Irrelevant- I don't think this will make a difference to the participant/there are better interventions already out there
4. Unfeasible- This has been detrimental to the participant

Appendix 5: PTMF-based workbook based on exploratory case feedback

Session 1: What is the Power Threat Meaning Framework?

The Power Threat Meaning Framework is a tool to understand and tell your story, using the following questions:

- ‘What has happened to you?’ (How is Power operating in your life?)
- ‘How did it affect you?’ (What kind of Threats does this pose?)
- ‘What sense did you make of it?’ (What is the Meaning of these situations and experiences to you?)
- ‘What did you have to do to survive?’ (What kinds of Threat Response are you using?)
- ‘What are your strengths?’ (What access to Power resources do you have?)
- ‘What is your story?’ (How does all this fit together?)

During these sessions you will be required to think about difficult and possibly upsetting things which have happened in your life. Please take the time to talk with your clinician and agree what you would like to do if talking about these things becomes upsetting for you. Your clinician can support you in a variety of ways, from taking a break to using calming techniques. Use the space below to note down what you agree:

Exercise 1: Problem statement

Describe your current situation/difficulties

Are there any notes you would like to make about today’s session?

Session 2: Power: ‘What has happened to you?’

Reminder: During these sessions you will be required to think about difficult and possibly upsetting things which have happened in your life. Please remember to use the agreement you set up with your clinician if you feel that talking about these things is becoming too much for you.

Last session we introduced the PTMF and thought about your current situation/difficulties. Is there anything you would like to add?

Exercise 2: What does the word “power” mean to you?

‘Power’ can have several meanings. Generally, it means being able to gain advantages or privileges, to arrange things to meet your own interests; or being able to gain advantages or privileges for others, to arrange things to meet their interests.

Power can operate through our partners, families, friends, communities, schools, work, health services, the police, government and the media.

Power can be used negatively; for example, when people are hurt, excluded or silenced by others.

It can also be used positively, such as when others protect and care for us.

There is a great deal of evidence that the negative use of power, both in the past and in the present, can lead to mental health problems. There is also evidence that we can be helped and protected by positive and supportive power. Examples of the various kinds of power and the difficult events and circumstances that they can lead to, are given below. Some of them may apply to you.

In this box is descriptions and examples of different types of power. Remember these are just examples. You might be able to think about different ways a type of power has had an impact on you.

Types of power	Power Advantage	Power Disadvantage
Power by force Anything which makes another person do things that they don't want to by using violence, aggression or intimidation.	• Physically defending or protecting yourself	• Being bullied in school • Being abused as a child • Suffering domestic abuse
Biological power Our bodies and physical attributes.	• Having good physical health and strength • Being attractive • Having average to high intelligence	• Having a physical or mental illness/disability • Having a learning needs or a learning disability • Physical dependence on alcohol or substances • Undernourishment due to lack of access to healthy food
Legal power The law can be used to protect us or prosecute us.	• Being protected by the police • Having Legal entitlement to the health and welfare system	• Getting arrested by the police • Being restrained or isolated by police or mental health staff on an inpatient unit
Economic power Having enough money to live on and meet our needs.	• Having access to benefits • Having the opportunity to work and earn money	• Being restricted by benefit allowances • Losing your job • Being in debt • Engaging in criminal activity to survive
Social/cultural power Having access to education, job opportunities and leisure opportunities.	• Having access to free education • Having access to community resources; libraries, theatre projects, parks etc.	• Being unable to access education due to a lack of social support • Living in a deprived area with little opportunity or resources • Being discriminated against for being a certain race/gender/age

Interpersonal power All forms of relationships; family, friends, partners, professionals etc.	• Having good relationships with family, friends and neighbours • Having good relationships with healthcare and social care staff	• Being subject to domestic violence • Being forced into being in a gang or criminal activity • Not having your needs met by healthcare or social care staff
Ideological power Having power over your own beliefs	• Having freedom to have your own religious, spiritual or political beliefs • Engaging in equality movements and peaceful protests and petitions • Having the freedom to have a peaceful differing opinion or belief to others • Having the power to interpret information from your own view	• Suffering rejection and discrimination due to your religious, • Being discriminated against for being a certain race/gender/age • Being discriminated against for holding certain religious, spiritual or political beliefs • Being told that you are wrong or bad because of your beliefs • Being subject to biased information presented in the media, social media, advertising etc

Exercise 3: How is power affecting you?
It might be helpful to think about different stages of your life such as your past along with what is happening for you right now. It may be that a particular type of power had a big impact on you in the past but is no longer present in your life.

	Positive	**Negative**
Force		
Biological		
Legal		
Economic		
Social/Cultural		
Interpersonal		
Ideological		

Thank you for sharing this information. How you see power affecting you is an important part of your story. We will use the information we have talked about today in future sessions and in the final story we write together.

Are there any notes you would like to make about today’s session?

Session 3: Threat

Reminder: During these sessions you will be required to think about difficult and possibly upsetting things which have happened in your life. Please remember to use the agreement you set up with your clinician if you feel that talking about these things is becoming too much for you.

Recap

Last session we identified the positive and negative influence of power in your life. Is there anything you would like to add?

Threat: “How did it affect you?”

When power is used in negative ways it often brings about very difficult and threatening situations or challenges. Some additional examples to help you think about threats in your own past or present life are given below.

Examples of Threat

Types of power	**Power disadvantage**	**Threat**
Power by force	Bullying	Physical and emotional harm
Biological power	Physical illness	Being unable to work
Legal power	Getting arrested	Loss of freedom
Economic power	Losing your job/benefits	Being unable to pay for rent or food
Social/Cultural power	Being unable to access education	Having restricted access to jobs
Interpersonal power	The ending of a good relationship	Loss of love, support and care
Ideological power	Rejection of religious beliefs by others	Persecution for those religious beliefs

Exercise 4: What threats have you faced in life?
You might want to look at what you wrote for Exercise 3 to help you link the impacts of power you have faced to the threats in your life. Remember it might be helpful to think about what has happened in the past too.

	Power	**Threat**
Force		
Biological		
Legal		
Economic		
Social/cultural		
Interpersonal		
Ideological		

Thank you for sharing this information. How you the threats in your life is an important part of your story. We will use the information we have talked about today in future sessions and in the final story we write together.

Are there any notes you would like to make about today’s session?

Session 4: Meanings

Reminder: During these sessions you will be required to think about difficult and possibly upsetting things which have happened in your life. Please remember to use the agreement you set up with your clinician if you feel that talking about these things is becoming too much for you.

Recap

Last session we identified the threats you face in life. Is there anything you would like to add?

Meanings: “How did you make sense of the things that happened”?

We make sense of a situation through our beliefs, feelings and bodily reactions. Making sense of threats usually leaves us feeling bad.

Box 1: Meanings

Unsafe, afraid, attacked	Trapped
Helpless, powerless, defeated	Failed, inferior
Invaded	Betrayed
Emotionally overwhelmed	Injustice/unfairness
Abandoned, rejected	Excluded, alienated
Different, abnormal	Bad, unworthy
Shamed, humiliated	Empty
Alien, dangerous	Hopeless
Controlled	Isolated, lonely
Contaminated, evil	Sense of meaninglessness
Guilty, blamed, responsible	Defeated

Exercise 5: Describe below what meanings (including feelings, beliefs and bodily sensations) you experienced in response to a threat. You may want to look back on Exercise 4 to remind yourself of the key threats you have faced and reflect on how they made you feel emotionally and physically, and the beliefs you have to understand the threat.

Threat	Feelings	Beliefs	Bodily reactions

Thank you for sharing this information. Understanding how you make meanings of threats is an important part of your story. We will use the information we have talked about today in future sessions and in the final story we write together.
Are there any notes you would like to make about today's session?

Session 5: Threat Responses
Reminder: During these sessions you will be required to think about difficult and possibly upsetting things which have happened in your life. Please remember to use the agreement you set up with your clinician if you feel that talking about these things is becoming too much for you.

Recap

Last session we identified the meanings you have made in response to threat. Is there anything you would like to add?

Threat Responses

"What did you have to do to survive?"

The ways we react to threats are the ways in which we behave. These responses are necessary and understandable survival strategies in response to the threat. These responses may include;

Regulating overwhelming feelings	• Self-harm • Memory loss • Bingeing/over eating • Using rituals, repeating actions or double-checking things • Using alcohol and drugs • Doing things without thinking • Denial • Disconnecting from reality, losing track of time/place, separating from yourself or the environment around you • Avoiding feelings and bodily sensations
Protection from physical danger	• Feeling very alert or jumpy • Looking out for threat or danger • Feeling on edge, as if ready to fight or run at any moment • Difficulties sleeping • Memory flashbacks • Nightmares • Suspicious thoughts • Aggression
Maintaining a sense of control	• Self-starvation • Rituals, repeating actions or double checking • Violence or aggression • Dominance in relationships

Seeking a bond with other people	• Believing other people are better than they really are • Seeking care and emotional reactions from other people • Giving in to other people, giving them what they want • Self-blame • Use of sexuality
Protecting yourself from loss, hurt and abandonment	• Rejecting other people • Distrusting other people • Violence • Hoarding • Self-silencing • Self-punishment
Holding on to a sense of yourself and your identity	• High or inflated self-esteem • Unusual beliefs • Feeling entitled • Perfectionism • Striving • Dominance • Hostility • Aggression
Finding a place for yourself in society or a social group	• Striving • Competitiveness • Trying to be perfect • Self-silencing/keeping your opinions to yourself • Self-blame/letting others “get away with it” • Overworking
Meeting your emotional needs	• Rocking • Self-harm • Bingeing/over-eating • Alcohol/drug use • Use of sexuality
Communicating a need for care and help	• Giving up, ‘learned helplessness’, low mood • Protesting, weeping, clinging • ‘High’ or extreme moods; rapid mood changes (‘emotional dysregulation’) • Self-harm • Self-neglect • Suicidal thinking and actions

These are just examples. You might think of other ways that you act in response to threats which aren’t included here. Or you might recognise a way you act in response to a threat but not for the reason given here

Exercise 6: Can you identify how you behave to manage the threats in your life, both past and present? These behaviours might not be within your control, e.g. when faced with the threat of losing their job or benefits, a person might have a panic attack.

Threat	Beliefs and feelings (physical and emotional) about the threat	Behaviour	How does it manage threat?	Does is cause any problems?
	Belief: **Emotions:** **Physical feelings:**			
	Belief: **Emotions:** **Physical feelings:**			
	Belief: **Emotions:** **Physical feelings:**			

Thank you for sharing this information. Understanding your threat responses is an important part of your story. We will use the information we have talked about today in future sessions and in the final story we write together.

Are there any notes you would like to make about today's session?

Session 6: Strengths

Reminder: During these sessions you will be required to think about difficult and possibly upsetting things which have happened to you in your life. Please remember to use the agreement you set up with your clinician if you feel that talking about these things is becoming too much for you.

Recap

Last session we identified how you behave or what symptoms you might have which help you to manage the threats you face in life. Is there anything you would like to add?

Strengths

"What are your strengths? What power do you hold?"

This may include people who care for you, aspects of your identity that you feel good about, skills and beliefs, and so on. Other possible strengths in your life, past and present, are:

- Loving and secure early relationships.
- Supportive partners, family and friends
- Social support and a sense of belonging.
- Having the chance to enjoy material, leisure and educational opportunities.
- Having access to information/knowledge/alternative views (e.g. on mental health).
- Positive/socially valued aspects of your identity.
- Skills/abilities – such as intelligence, resourcefulness, determination, talents.
- Bodily resources – appearance, strength, health.
- Belief systems – faiths, community values and so on.
- Community practices and rituals.
- Connections to nature and the natural world.

Exercise 7: What are your strengths and what power do they give you?

You might want to think about some of these ways of building on your resources and strengths:

- Managing your emotions by releasing/expressing/processing feelings (e.g. writing, exercise, talking therapies, body therapies, creativity and the arts, compassion-focused approaches, mindfulness, meditation).
- Self-care – e.g. nutrition, exercise, rest, alternative therapies.
- Using or finding relationships for emotional support, protection, validation.
- Finding meaningful social roles and activities.
- Other cultural rituals, ceremonies and interventions.
- Getting involved in campaigning, activism.
- Creating/finding new narratives/meanings/beliefs/values.

Exercise 8: Do you have any ideas on how you could build your strengths?

Thank you for sharing this information. Identifying your strengths is an important part of your story and in helping you move forward. We will use the information we have talked about today in future sessions and in the final story we write together.

Are there any notes you would like to make about today's session?

Session 7: Your story

Reminder: During these sessions you will be required to think about difficult and possibly upsetting things which have happened in your life. Please remember to use the agreement you set up with your clinician if you feel that talking about these things is becoming too much for you.

Recap

Last session we identified how your strengths and ideas for building on these. Is there anything you would like to add?

Exercise 9: Now that we have considered the influence of power and threat in your life it may be helpful to pull all this information together in the form of a narrative or story about your life. Please do look back over the workbook to help you piece together your story. It might be more meaningful for you to create your story in a different way such as drawing or painting it but jotting it down using the prompts below with your clinician might help you get started.

Here are some prompts to help you:

Looking back at the exercises, how has power impacted you? What are the key threats from this power which have had a significant impact on your life?

What meaning have you made of these threats? How have they made you think or feel?

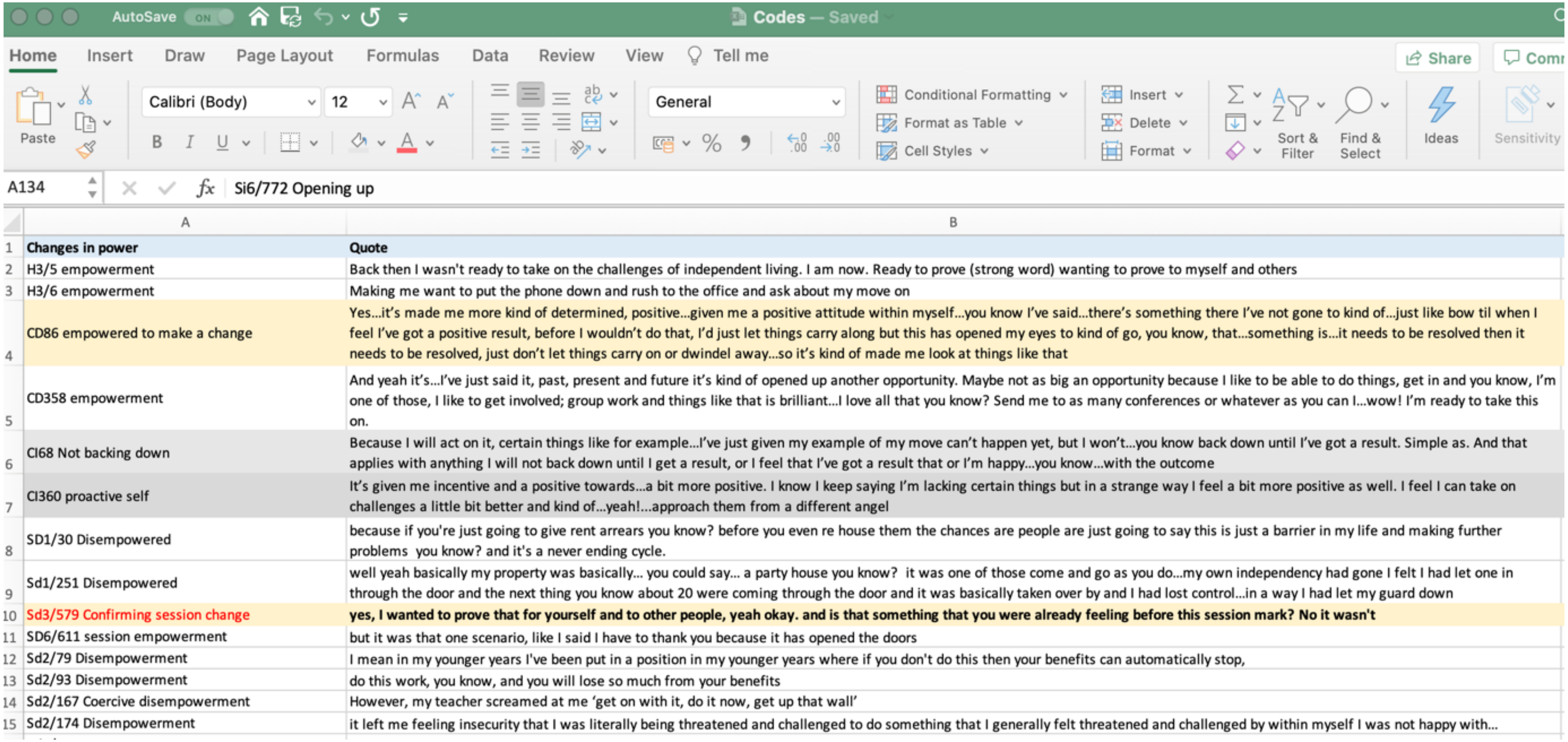
How have you behaved or responded to these threats?

What strengths have you identified which have helped you to survive these threats? How could they help you in the future?

Thank you for sharing your story. Your story is an important part of pulling all the work you have done together. However, you can always come back and rewrite it as your story continues. This is the end of the workbook.

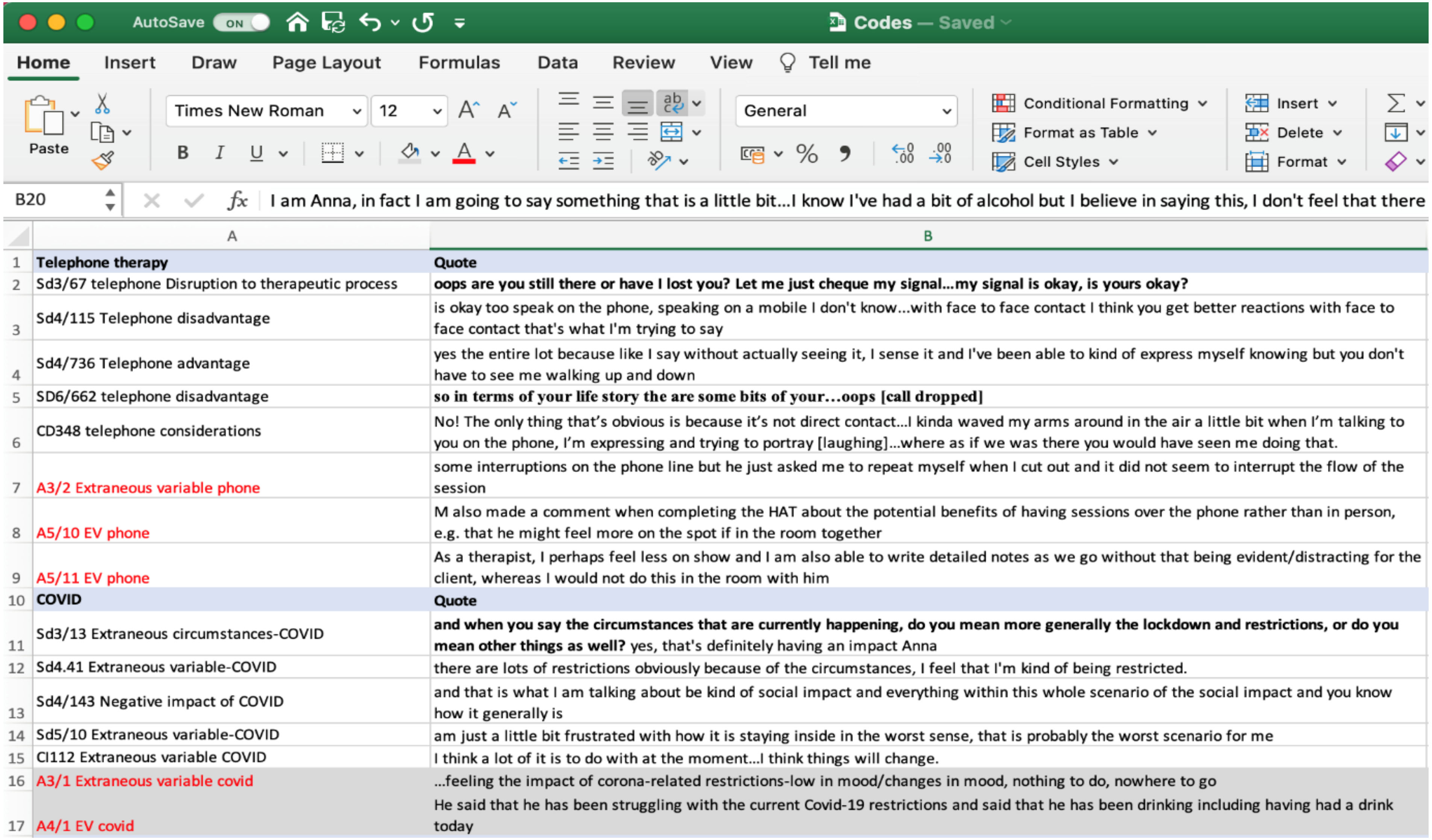
Are there any notes you would like to make about today's session?

Appendix 6: Examples of TA codes



A134 *fx* Si6/772 Opening up

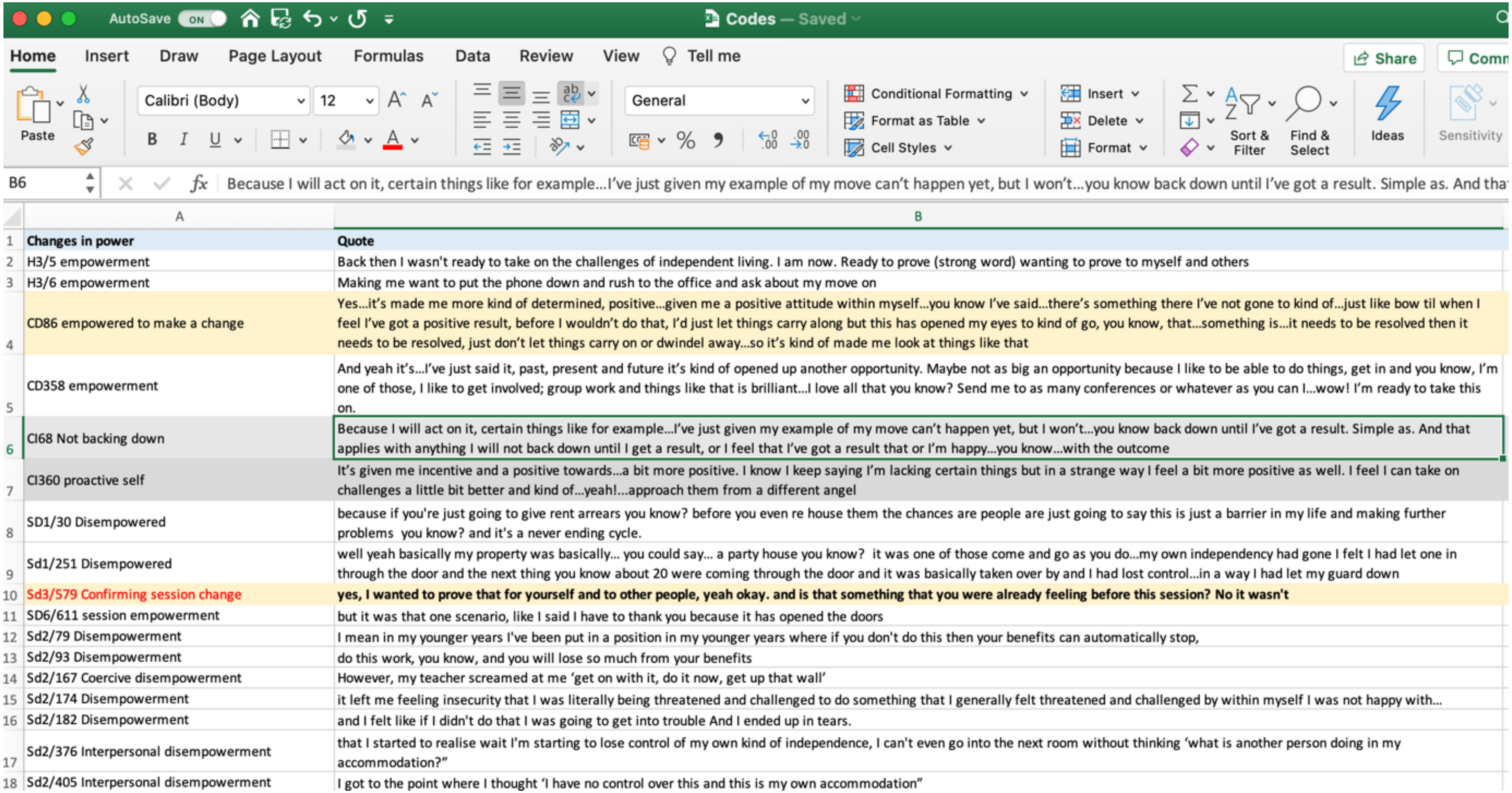
	A	B
1	**Changes in power**	**Quote**
2	H3/5 empowerment	Back then I wasn't ready to take on the challenges of independent living. I am now. Ready to prove (strong word) wanting to prove to myself and others
3	H3/6 empowerment	Making me want to put the phone down and rush to the office and ask about my move on
4	CD86 empowered to make a change	Yes…it's made me more kind of determined, positive…given me a positive attitude within myself…you know I've said…there's something there I've not gone to kind of…just like bow til when I feel I've got a positive result, before I wouldn't do that, I'd just let things carry along but this has opened my eyes to kind of go, you know, that…something is…it needs to be resolved then it needs to be resolved, just don't let things carry on or dwindel away…so it's kind of made me look at things like that
5	CD358 empowerment	And yeah it's…I've just said it, past, present and future it's kind of opened up another opportunity. Maybe not as big an opportunity because I like to be able to do things, get in and you know, I'm one of those, I like to get involved; group work and things like that is brilliant…I love all that you know? Send me to as many conferences or whatever as you can I…wow! I'm ready to take this on.
6	CI68 Not backing down	Because I will act on it, certain things like for example…I've just given my example of my move can't happen yet, but I won't…you know back down until I've got a result. Simple as. And that applies with anything I will not back down until I get a result, or I feel that I've got a result that or I'm happy…you know…with the outcome
7	CI360 proactive self	It's given me incentive and a positive towards…a bit more positive. I know I keep saying I'm lacking certain things but in a strange way I feel a bit more positive as well. I feel I can take on challenges a little bit better and kind of…yeah!…approach them from a different angel
8	SD1/30 Disempowered	because if you're just going to give rent arrears you know? before you even re house them the chances are people are just going to say this is just a barrier in my life and making further problems you know? and it's a never ending cycle.
9	Sd1/251 Disempowered	well yeah basically my property was basically… you could say… a party house you know? it was one of those come and go as you do…my own independency had gone I felt I had let one in through the door and the next thing you know about 20 were coming through the door and it was basically taken over by and I had lost control…in a way I had let my guard down
10	Sd3/579 Confirming session change	**yes, I wanted to prove that for yourself and to other people, yeah okay. and is that something that you were already feeling before this session mark? No it wasn't**
11	SD6/611 session empowerment	but it was that one scenario, like I said I have to thank you because it has opened the doors
12	Sd2/79 Disempowerment	I mean in my younger years I've been put in a position in my younger years where if you don't do this then your benefits can automatically stop,
13	Sd2/93 Disempowerment	do this work, you know, and you will lose so much from your benefits
14	Sd2/167 Coercive disempowerment	However, my teacher screamed at me 'get on with it, do it now, get up that wall'
15	Sd2/174 Disempowerment	it left me feeling insecurity that I was literally being threatened and challenged to do something that I generally felt threatened and challenged by within myself I was not happy with…



B20

I am Anna, in fact I am going to say something that is a little bit...I know I've had a bit of alcohol but I believe in saying this, I don't feel that there

	A	B
1	**Telephone therapy**	**Quote**
2	Sd3/67 telephone Disruption to therapeutic process	**oops are you still there or have I lost you? Let me just cheque my signal...my signal is okay, is yours okay?**
3	Sd4/115 Telephone disadvantage	is okay too speak on the phone, speaking on a mobile I don't know...with face to face contact I think you get better reactions with face to face contact that's what I'm trying to say
4	Sd4/736 Telephone advantage	yes the entire lot because like I say without actually seeing it, I sense it and I've been able to kind of express myself knowing but you don't have to see me walking up and down
5	SD6/662 telephone disadvantage	**so in terms of your life story the are some bits of your…oops [call dropped]**
6	CD348 telephone considerations	No! The only thing that’s obvious is because it’s not direct contact…I kinda waved my arms around in the air a little bit when I’m talking to you on the phone, I’m expressing and trying to portray [laughing]…where as if we was there you would have seen me doing that.
7	A3/2 Extraneous variable phone	some interruptions on the phone line but he just asked me to repeat myself when I cut out and it did not seem to interrupt the flow of the session
8	A5/10 EV phone	M also made a comment when completing the HAT about the potential benefits of having sessions over the phone rather than in person, e.g. that he might feel more on the spot if in the room together
9	A5/11 EV phone	As a therapist, I perhaps feel less on show and I am also able to write detailed notes as we go without that being evident/distracting for the client, whereas I would not do this in the room with him
10	**COVID**	**Quote**
11	Sd3/13 Extraneous circumstances-COVID	**and when you say the circumstances that are currently happening, do you mean more generally the lockdown and restrictions, or do you mean other things as well?** yes, that's definitely having an impact Anna
12	Sd4.41 Extraneous variable-COVID	there are lots of restrictions obviously because of the circumstances, I feel that I'm kind of being restricted.
13	Sd4/143 Negative impact of COVID	and that is what I am talking about be kind of social impact and everything within this whole scenario of the social impact and you know how it generally is
14	Sd5/10 Extraneous variable-COVID	am just a little bit frustrated with how it is staying inside in the worst sense, that is probably the worst scenario for me
15	CI112 Extraneous variable COVID	I think a lot of it is to do with at the moment…I think things will change.
16	A3/1 Extraneous variable covid	...feeling the impact of corona-related restrictions-low in mood/changes in mood, nothing to do, nowhere to go
17	A4/1 EV covid	He said that he has been struggling with the current Covid-19 restrictions and said that he has been drinking including having had a drink today



B6 *fx* Because I will act on it, certain things like for example...I've just given my example of my move can't happen yet, but I won't...you know back down until I've got a result. Simple as. And tha

	A	B
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3	H3/6 empowerment	Making me want to put the phone down and rush to the office and ask about my move on
4	CD86 empowered to make a change	Yes…it's made me more kind of determined, positive…given me a positive attitude within myself…you know I've said…there's something there I've not gone to kind of…just like bow til when I feel I've got a positive result, before I wouldn't do that, I'd just let things carry along but this has opened my eyes to kind of go, you know, that…something is…it needs to be resolved then it needs to be resolved, just don't let things carry on or dwindel away…so it's kind of made me look at things like that
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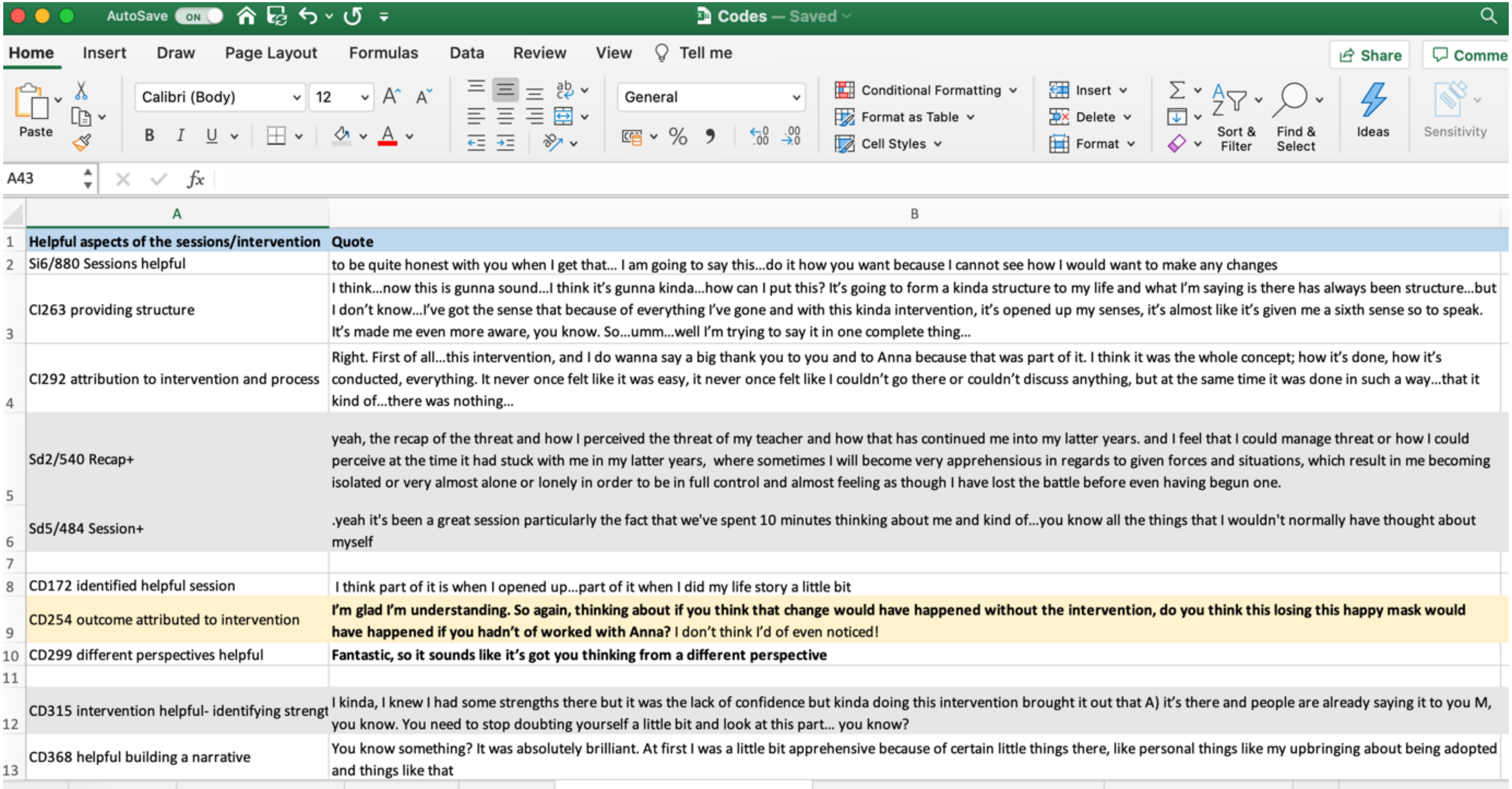
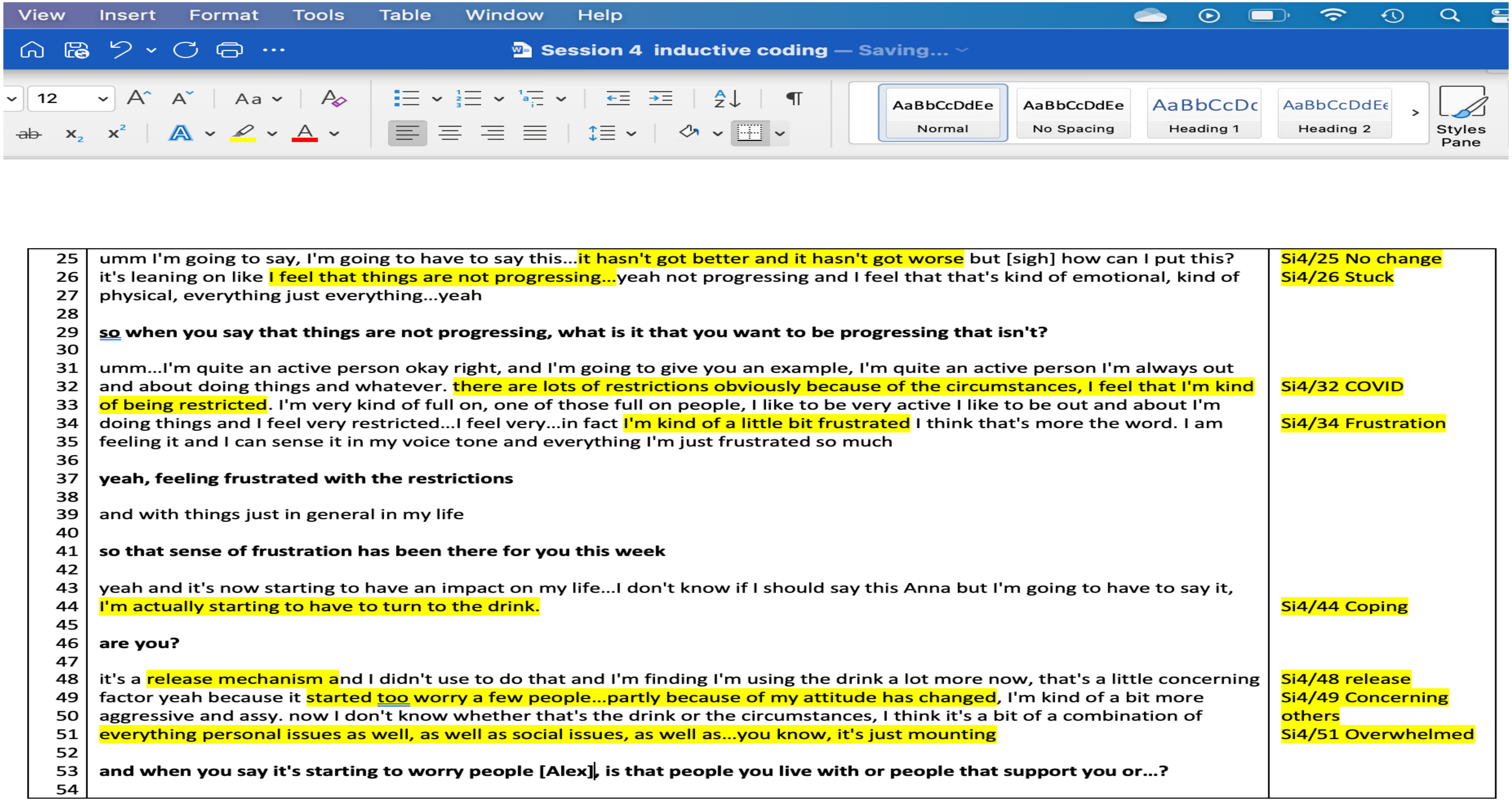
14	Sd2/167 Coercive disempowerment	However, my teacher screamed at me 'get on with it, do it now, get up that wall'
15	Sd2/174 Disempowerment	it left me feeling insecurity that I was literally being threatened and challenged to do something that I generally felt threatened and challenged by within myself I was not happy with…
16	Sd2/182 Disempowerment	and I felt like if I didn't do that I was going to get into trouble And I ended up in tears.
17	Sd2/376 Interpersonal disempowerment	that I started to realise wait I'm starting to lose control of my own kind of independence, I can't even go into the next room without thinking 'what is another person doing in my accommodation?"
18	Sd2/405 Interpersonal disempowerment	I got to the point where I thought 'I have no control over this and this is my own accommodation"

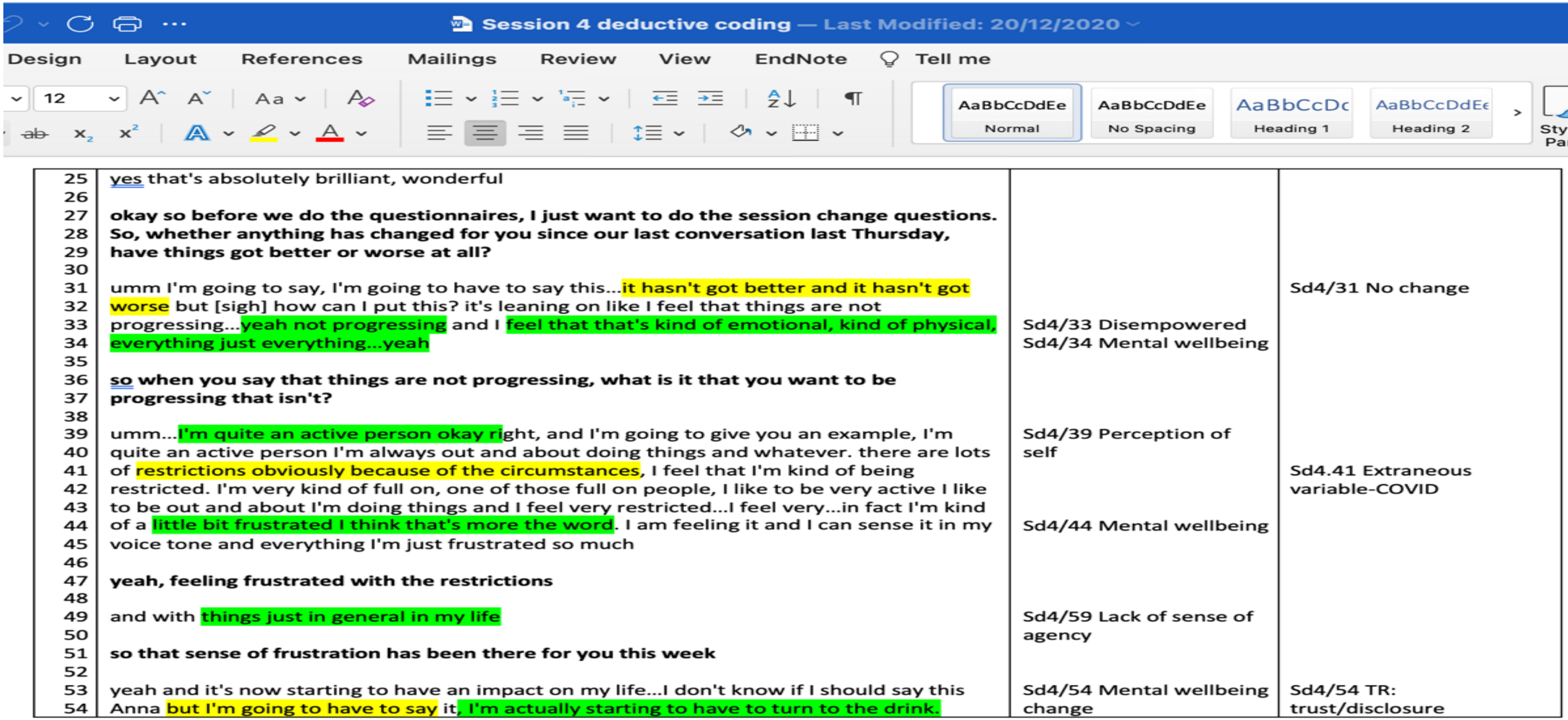


	A	B
1	**Helpful aspects of the sessions/intervention**	**Quote**
2	Si6/880 Sessions helpful	to be quite honest with you when I get that... I am going to say this...do it how you want because I cannot see how I would want to make any changes
3	CI263 providing structure	I think...now this is gunna sound...I think it's gunna kinda...how can I put this? It's going to form a kinda structure to my life and what I'm saying is there has always been structure...but I don't know...I've got the sense that because of everything I've gone and with this kinda intervention, it's opened up my senses, it's almost like it's given me a sixth sense so to speak. It's made me even more aware, you know. So...umm...well I'm trying to say it in one complete thing...
4	CI292 attribution to intervention and process	Right. First of all...this intervention, and I do wanna say a big thank you to you and to Anna because that was part of it. I think it was the whole concept; how it's done, how it's conducted, everything. It never once felt like it was easy, it never once felt like I couldn't go there or couldn't discuss anything, but at the same time it was done in such a way...that it kind of...there was nothing...
5	Sd2/540 Recap+	yeah, the recap of the threat and how I perceived the threat of my teacher and how that has continued me into my latter years. and I feel that I could manage threat or how I could perceive at the time it had stuck with me in my latter years, where sometimes I will become very apprehensious in regards to given forces and situations, which result in me becoming isolated or very almost alone or lonely in order to be in full control and almost feeling as though I have lost the battle before even having begun one.
6	Sd5/484 Session+	.yeah it's been a great session particularly the fact that we've spent 10 minutes thinking about me and kind of...you know all the things that I wouldn't normally have thought about myself
7		
8	CD172 identified helpful session	I think part of it is when I opened up...part of it when I did my life story a little bit
9	CD254 outcome attributed to intervention	**I'm glad I'm understanding. So again, thinking about if you think that change would have happened without the intervention, do you think this losing this happy mask would have happened if you hadn't of worked with Anna?** I don't think I'd of even noticed!
10	CD299 different perspectives helpful	**Fantastic, so it sounds like it's got you thinking from a different perspective**
11		
12	CD315 intervention helpful- identifying strengt	I kinda, I knew I had some strengths there but it was the lack of confidence but kinda doing this intervention brought it out that A) it's there and people are already saying it to you M, you know. You need to stop doubting yourself a little bit and look at this part... you know?
13	CD368 helpful building a narrative	You know something? It was absolutely brilliant. At first I was a little bit apprehensive because of certain little things there, like personal things like my upbringing about being adopted and things like that

Appendix 7: TA Transcripts with codes



25	umm I'm going to say, I'm going to have to say this...it hasn't got better and it hasn't got worse but [sigh] how can I put this?	Si4/25 No change
26	it's leaning on like I feel that things are not progressing...yeah not progressing and I feel that that's kind of emotional, kind of	Si4/26 Stuck
27	physical, everything just everything...yeah	
28		
29	**so when you say that things are not progressing, what is it that you want to be progressing that isn't?**	
30		
31	umm...I'm quite an active person okay right, and I'm going to give you an example, I'm quite an active person I'm always out	
32	and about doing things and whatever. there are lots of restrictions obviously because of the circumstances, I feel that I'm kind	Si4/32 COVID
33	of being restricted. I'm very kind of full on, one of those full on people, I like to be very active I like to be out and about I'm	
34	doing things and I feel very restricted...I feel very...in fact I'm kind of a little bit frustrated I think that's more the word. I am	Si4/34 Frustration
35	feeling it and I can sense it in my voice tone and everything I'm just frustrated so much	
36		
37	**yeah, feeling frustrated with the restrictions**	
38		
39	and with things just in general in my life	
40		
41	**so that sense of frustration has been there for you this week**	
42		
43	yeah and it's now starting to have an impact on my life...I don't know if I should say this Anna but I'm going to have to say it,	
44	I'm actually starting to have to turn to the drink.	Si4/44 Coping
45		
46	**are you?**	
47		
48	it's a release mechanism and I didn't use to do that and I'm finding I'm using the drink a lot more now, that's a little concerning	Si4/48 release
49	factor yeah because it started too worry a few people...partly because of my attitude has changed, I'm kind of a bit more	Si4/49 Concerning
50	aggressive and assy. now I don't know whether that's the drink or the circumstances, I think it's a bit of a combination of	others
51	everything personal issues as well, as well as social issues, as well as...you know, it's just mounting	Si4/51 Overwhelmed
52		
53	**and when you say it's starting to worry people [Alex], is that people you live with or people that support you or...?**	
54		



25	yes that's absolutely brilliant, wonderful		
26			
27	**okay so before we do the questionnaires, I just want to do the session change questions.**		
28	**So, whether anything has changed for you since our last conversation last Thursday,**		
29	**have things got better or worse at all?**		
30			
31	umm I'm going to say, I'm going to have to say this...it hasn't got better and it hasn't got		Sd4/31 No change
32	worse but [sigh] how can I put this? it's leaning on like I feel that things are not		
33	progressing...yeah not progressing and I feel that that's kind of emotional, kind of physical,	Sd4/33 Disempowered	
34	everything just everything...yeah	Sd4/34 Mental wellbeing	
35			
36	**so when you say that things are not progressing, what is it that you want to be**		
37	**progressing that isn't?**		
38			
39	umm...I'm quite an active person okay right, and I'm going to give you an example, I'm	Sd4/39 Perception of	
40	quite an active person I'm always out and about doing things and whatever. there are lots	self	
41	of restrictions obviously because of the circumstances, I feel that I'm kind of being		Sd4.41 Extraneous
42	restricted. I'm very kind of full on, one of those full on people, I like to be very active I like		variable-COVID
43	to be out and about I'm doing things and I feel very restricted...I feel very...in fact I'm kind		
44	of a little bit frustrated I think that's more the word. I am feeling it and I can sense it in my	Sd4/44 Mental wellbeing	
45	voice tone and everything I'm just frustrated so much		
46			
47	**yeah, feeling frustrated with the restrictions**		
48			
49	and with things just in general in my life	Sd4/59 Lack of sense of	
50		agency	
51	**so that sense of frustration has been there for you this week**		
52			
53	yeah and it's now starting to have an impact on my life...I don't know if I should say this	Sd4/54 Mental wellbeing	Sd4/54 TR:
54	Anna but I'm going to have to say it, I'm actually starting to have to turn to the drink.	change	trust/disclosure

Appendix 8: UoN ethics approval

DPAP Committee : 21/05/2020 Supervisor: Professor Thomas Schroder Applicant: Hayley Sapsford

Project ID 437 – project : Designing and evaluating a PTMF based intervention for homeless adults with MCN

Dear Hayley,

A favourable opinion is given to the above named study on the understanding that the applicants conduct their research as described in the above numbered application. Applicants need to adhere to all conditions under which the ethical approval has been granted and use only materials and documentation that have been approved.

If you need to make any any changes (for example to the date or place of data collection, or measures used), an Amendment Form should be submitted. This can be done by the Supervisor in 'Create Sub Form' in the Actions Menu on the left hand side of the page on the on-line system: Select 'Amendment Form'

Yours

Professor David Daley

Co-Chair DPAP Ethics Subcommittee

David Daley

Amanda Griffiths

Professor Amanda Griffiths
Co-Chair DPAP Ethics Subcommitte

Appendix 9: Informed Consent Form

CONSENT FORM
(Version 2: 03/20)

Title of Study: Designing and evaluating a psychological intervention for individuals with multiple complex needs.

Name of Researcher:

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1 dated 03/20 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of my data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

5. Consent for storage and use in possible future research (Optional)
   I agree that the information gathered about me can be stored by the University of Nottingham, for possible use in future studies. I understand that some of these studies may be carried out by researchers other than the current team who ran the first study, including researchers working for commercial companies. Any data used will be anonymised, and I will not be identified in anyway. ☐

7. I agree to my GP being informed of my participation in this study. ☐

8. I agree to take part in the above study. ☐

IF INFORMED CONSENT IS CONDUCTED ON THE TELEPHONE:

9. I understand I am providing consent to participant in the study verbally and an audio recording will be kept as a record of my consent ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix 10: Participant Information Sheet

Participant Information Sheet
(Version 7: 02/20)

Title of Study: Designing and evaluating a psychological intervention for individuals with multiple complex needs.

Lead Researcher: Hayley Sapsford
Research Supervisors: Thomas Schroder and Danielle De Boos
Local Researcher: Anna Tickle

You are invited to take part in our research. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The study aims to explore if a new psychological intervention for people experiencing multiple complex needs. The intervention is 6-8 sessions and is based on a new document which aims to support people to understand their experience of psychological distress. We want to see if using it with a psychologist leads to any changes in your wellbeing. The intervention is based on a document called 'The Power Threat Meaning Framework (PTMF)'. If you are interested, you can read more about it at https://www.bps.org.uk/power-threat-meaning-framework/introduction-ptmf. The PTMF is very long and we have put key ideas from it into a workbook. The study is to find out if the workbook is useful.

Why have I been invited?

You are being invited to take part because you are engaged with Framework or Opportunity Nottingham. We are interested in working with people who have experience of at least three of the following: homelessness, substance misuse, mental health problems or offending. We are inviting up to 6 people to take part.

Do I have to take part?

It is up to you whether you take part. You can keep this information sheet. If you decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

You will meet with a Clinical Psychologist or Trainee Clinical Psychologist for up to 8 sessions. Due to the recent outbreak of COVID-19, these sessions may take place face to face or over the telephone. You will be asked to complete a form to give us some information about yourself including; any mental health diagnoses, substance misuse, past offences, current and past treatment. This is to ensure you meet the criteria of the study.

In the sessions, you and the psychologist will talk about your life experiences using questions from the PTMF as a guide. You will think together about relationships and power to help understand your experiences. Each session should last no more than an hour. Sessions will usually be weekly. You would be involved in the study for 9 hours over a maximum of three months.

The study aims to find out if these sessions can be useful and whether you find it ‘acceptable’. To find this out, you will be asked to complete some questionnaires each session. The questionnaires will focus on your thoughts and beliefs. You will also be asked what you think went well and what could have been better. Each session will be audio recorded.

At the end of the intervention you will be interviewed by the lead researcher about the sessions and whether it led to any changes for you. Even if you decide to stop the sessions, you will still be invited to the interview to discuss your opinions. The interviews will last for around an hour and will be audio recorded and typed out by the lead researcher. Again, due to the recent outbreak of COVID-19, these interviews may be face to face or over the telephone, whatever is safest for you and the researcher at the time.

All information collected will be kept in the strictest confidence and be protected in line with the data protection policies of the university.

Expenses and payments

You will be reimbursed for your time participating in the study through a £5 gift voucher per session and interview that you attend.

What are the possible risks of taking part?

We do not anticipate any risks of taking part in the study. However, there is always a risk with any psychology sessions may lead to some distress due to the nature of reflecting on life experiences. If you do feel distressed, please speak with a member of the research team or your usual support team. We will also give you a list of organisations who can provide you with support.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help other people in your situation in the future. It might be helpful to spend time reflecting on your life in a structured way.

What happens when the research study stops?

All of the information collected from you will be analysed and written into a report. Your views will be anonymous, and nobody will be able to identify you. If you want, the researcher can talk to you about the results of the research after the study ends. You will need to provide consent details to be contacted for this.

What if there is a problem?

If you have any concerns about this study, you should ask to speak to the researchers. Their contact details are at the end of this sheet.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice. If you join the study, we will use information collected from you. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible. You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. The data may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow checks by other researcher's re-use (and therefore avoiding duplication of research). Data sharing in this way will be anonymised (so that you could not be identified).

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, or relates to a criminal offence, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Taking part is voluntary, and you are free to stop at any time, without giving any reason, and without your legal rights being affected. If you withdraw, we will no longer collect any information about you or from you but we will keep the information about you that we have already collected and it may be used in the final reports.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham.

Who has reviewed the study?

An independent group of people, called a Research Ethics Committee, has reviewed the study to protect your interests. Nottingham Research Ethics Committee has said this research can take place.

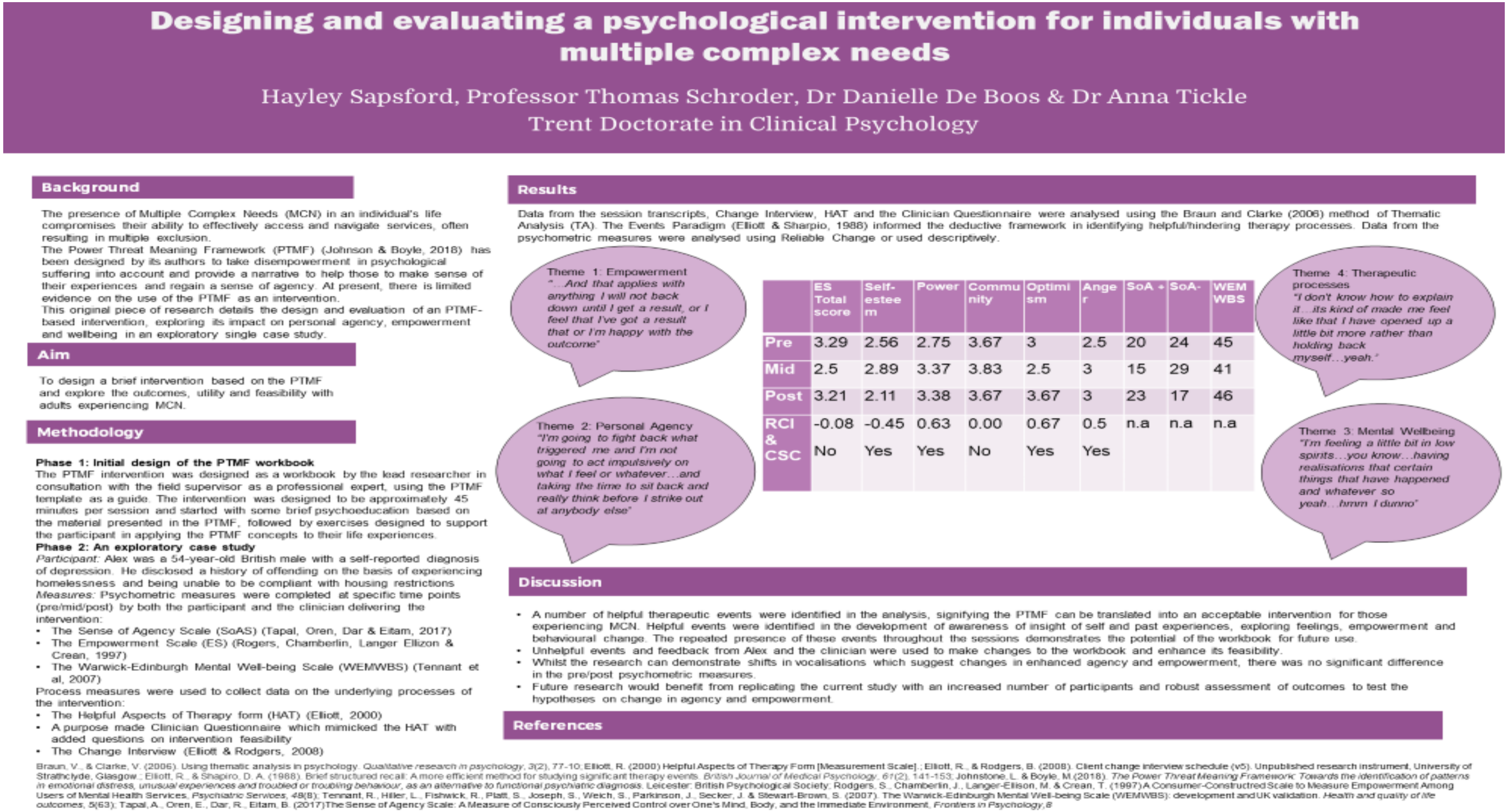
Further information and contact details

Lead Researcher: Hayley Sapsford
Email: msxhs13@nottingham.ac.uk

Research Supervisor: Dr Danielle De Boos
Email: mczdcd@exmail.nottingham.ac.uk

Chief Investigator: Professor Thomas Schroder
Email: lwzts@exmail.nottingham.ac.uk
Field Supervisor/researcher: Dr Anna Tickle
Email: lwaat@exmail.nottingham.ac.uk

Appendix 11: Poster



Designing and evaluating a psychological intervention for individuals with multiple complex needs

Hayley Sapsford, Professor Thomas Schroder, Dr Danielle De Boos & Dr Anna Tickle
Trent Doctorate in Clinical Psychology

Background

The presence of Multiple Complex Needs (MCN) in an individual's life compromises their ability to effectively access and navigate services, often resulting in multiple exclusion.
The Power Threat Meaning Framework (PTMF) (Johnson & Boyle, 2018) has been designed by its authors to take disempowerment in psychological suffering into account and provide a narrative to help those to make sense of their experiences and regain a sense of agency. At present, there is limited evidence on the use of the PTMF as an intervention.
This original piece of research details the design and evaluation of an PTMF-based intervention, exploring its impact on personal agency, empowerment and wellbeing in an exploratory single case study.

Aim

To design a brief intervention based on the PTMF and explore the outcomes, utility and feasibility with adults experiencing MCN.

Methodology

Phase 1: Initial design of the PTMF workbook
The PTMF intervention was designed as a workbook by the lead researcher in consultation with the field supervisor as a professional expert, using the PTMF template as a guide. The intervention was designed to be approximately 45 minutes per session and started with some brief psychoeducation based on the material presented in the PTMF, followed by exercises designed to support the participant in applying the PTMF concepts to their life experiences.
Phase 2: An exploratory case study
Participant: Alex was a 54-year-old British male with a self-reported diagnosis of depression. He disclosed a history of offending on the basis of experiencing homelessness and being unable to be compliant with housing restrictions
Measures: Psychometric measures were completed at specific time points (pre/mid/post) by both the participant and the clinician delivering the intervention:

- The Sense of Agency Scale (SoAS) (Tapal, Oren, Dar & Eitam, 2017)
- The Empowerment Scale (ES) (Rogers, Chamberlin, Langer Ellizon & Crean, 1997)
- The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al, 2007)

Process measures were used to collect data on the underlying processes of the intervention:

- The Helpful Aspects of Therapy form (HAT) (Elliott, 2000)
- A purpose made Clinician Questionnaire which mimicked the HAT with added questions on intervention feasibility
- The Change Interview (Elliott & Rodgers, 2008)

Results

Data from the session transcripts, Change Interview, HAT and the Clinician Questionnaire were analysed using the Braun and Clarke (2006) method of Thematic Analysis (TA). The Events Paradigm (Elliott & Sharpio, 1988) informed the deductive framework in identifying helpful/hindering therapy processes. Data from the psychometric measures were analysed using Reliable Change or used descriptively.

Theme 1: Empowerment
"…And that applies with anything I will not back down until I get a result, or I feel that I've got a result that or I'm happy with the outcome"

Theme 2: Personal Agency
"I'm going to fight back what triggered me and I'm not going to act impulsively on what I feel or whatever…and taking the time to sit back and really think before I strike out at anybody else"

	ES Total score	Self-esteem	Power	Community	Optimism	Anger	SoA +	SoA-	WEMWBS
Pre	3.29	2.56	2.75	3.67	3	2.5	20	24	45
Mid	2.5	2.89	3.37	3.83	2.5	3	15	29	41
Post	3.21	2.11	3.38	3.67	3.67	3	23	17	46
RCI & CSC	-0.08 No	-0.45 Yes	0.63 Yes	0.00 No	0.67 Yes	0.5 Yes	n.a	n.a	n.a

Theme 4: Therapeutic processes
"I don't know how to explain it…its kind of made me feel like that I have opened up a little bit more rather than holding back myself…yeah."

Theme 3: Mental Wellbeing
"I'm feeling a little bit in low spirits…you know…having realisations that certain things that have happened and whatever so yeah…hmm I dunno"

Discussion

- A number of helpful therapeutic events were identified in the analysis, signifying the PTMF can be translated into an acceptable intervention for those experiencing MCN. Helpful events were identified in the development of awareness of insight of self and past experiences, exploring feelings, empowerment and behavioural change. The repeated presence of these events throughout the sessions demonstrates the potential of the workbook for future use.
- Unhelpful events and feedback from Alex and the clinician were used to make changes to the workbook and enhance its feasibility.
- Whilst the research can demonstrate shifts in vocalisations which suggest changes in enhanced agency and empowerment, there was no significant difference in the pre/post psychometric measures.
- Future research would benefit from replicating the current study with an increased number of participants and robust assessment of outcomes to test the hypotheses on change in agency and empowerment.

References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-10; Elliott, R. (2000) Helpful Aspects of Therapy Form [Measurement Scale].; Elliott, R., & Rodgers, B. (2008). Client change interview schedule (v5). Unpublished research instrument, University of Strathclyde, Glasgow.; Elliott, R., & Shapiro, D. A. (1988). Brief structured recall: A more efficient method for studying significant therapy events. *British Journal of Medical Psychology, 61*(2), 141-153; Johnstone, L. & Boyle, M.(2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society; Rodgers, S., Chamberlin, J., Langer-Ellison, M. & Crean, T. (1997) A Consumer-Constructed Scale to Measure Empowerment Among Users of Mental Health Services, *Psychiatric Services, 48*(8); Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J. & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health and quality of life outcomes, 5*(63); Tapal, A., Oren, E., Dar, R., Eitam, B. (2017)The Sense of Agency Scale: A Measure of Consciously Perceived Control over One's Mind, Body, and the Immediate Environment, *Frontiers in Psychology,8*

“Thank you for being here”
An Evaluation of a wellbeing hub based on domains of Psychologically Informed Environments

Abstract

The presence of Multiple Complex Needs (MCN) in an individual's life compromises their ability to effectively access and navigate services which address single issues, often resulting in multiple exclusion. Services striving to be Psychologically Informed Environments (PIE) acknowledge the difficulties faced by individuals experiencing MCN and actively adjust service provision to best meet these needs and empower these individuals to overcome multiple exclusion. At present, there are few examples of empirical evaluations of PIEs. The PIEs Assessment and Self-development for Services (PIZAZZ) is a newly developed self-assessment and service specification for PIEs. A service evaluation was conducted using data taken from three teams and SU questionnaires evaluating a Wellbeing Hub (WBH) against PIE domains and found the WBH as a whole is progressing into a PIE. Recommendations are made for future development and considerations are given regarding the use of a new tool in an area with a limited evidence base.

KEYWORDS: Multiple Complex Needs, Psychologically Informed Environments, PIZAZZ, Multiple Exclusion, Inclusion Health

Introduction

Multiple Complex Needs

MCN refers to any two of the following; homelessness, substance misuse, offending behaviour and mental health difficulties (Keats et al., 2012). It is estimated around 60,000 people in the UK experience MCN (Fulfilling Lives, 2020), with the economic ranging from £1.1bn to £2.1bn per year (Furness, 2018). MCN is used interchangeably with Severe and Multiple Disadvantage, which further considers how the reductionist stance of systems can often lead to the multiple exclusion of these individuals (Fisher, 2015).

There is increasing recognition psychological trauma underpins MCN (McDonagh, 2011). The notion of compound trauma describes the cumulative effect of a sequence of traumatic experiences which impact on the individual's development and reduces their ability to cope in a socially accepted manner (Cockersell, 2018). This leads to social exclusion as the individual is prevented from accessing a range of services for reasons of antisocial behaviour, difficulty adhering to routine (i.e. keeping appointments) or experiencing multiple needs which services are not designed to meet (Keats et al., 2012). One study found a core theme of substance misuse and mental health problems to be deeply rooted in the same traumatic experience in one sample of homeless individuals (Reeve et al., 2018). The same study demonstrated the link between MCN and multiple exclusion from services as individuals were unable to access the services they needed for reasons of; mental health needs going unacknowledged, falling between service thresholds, dual diagnosis, waiting lists or inappropriate referrals. This suggests the current systems are not adequate to meet the complex needs of this group and are due to two key issues:

1. differing perceptions by service users (SU) and providers as to what the priority is for treatment
2. The services' inability be flexible with MCN (Bowpitt et al., 2011).

With increasing evidence connecting MCN and poor service provision (Keene, 2001; Melrose, 2004; Rosengard et al.,2007), a multifaceted approach of Inclusion Health (IH) has been constructed whereby those experiencing MCN are able to access a fully integrated primary and secondary healthcare service (Hewett, 2011). These services aim to address substance abuse, mental health difficulties, physical health needs and homelessness. There is limited evidence available for the effectiveness of IH, however a synthesis of typical interventions used within an IH environment found a range of effective interventions for physical and mental health but limited evidence for structural interventions (housing, employment etc.) (Luchenski et al., 2018). The WBH in this evaluation has a number of services under one roof with a single point of access providing support for mental health, substance misuse, housing and employment.

Psychologically Informed Environments

PIEs are services designed to take into account the psychological and emotional needs of the individuals using them (Homeless Link, 2017). The aim of designing services in this way is to empower SUs to make changes which increase their wellbeing and quality of life. With the recognition that engaging individuals with MCN requires an acknowledgement of the impact a history of trauma can have on their ability to trust and engage with services (Keats et al., 2012), a core principle of PIEs is the development of a relationship between staff and SUs, using psychological models, as a tool for instigating change (Johnson, 2018). This overlaps with the principles of Trauma Informed Care (TIC), and indeed TIC can be included as a specific psychological approach within a PIE. TIC is a philosophical service approach whereby the impact of trauma is recognised and services provide a response which promote a sense of safety for the survivor, enables them to rebuild a sense of control and helps to find empowerment using a strengths based approach (Hopper et al., 2010).

The five key areas for redesigning services as a PIE are specified as follows (Johnson, 2015);

1. **Psychological Awareness**: Utilising existing psychological theory to generate a shared understanding amongst staff of their SUs.
2. **Staff training and support:** Creating a staff team which support SUs in a therapeutic and planned approach, including reflective practice. Furthermore, staff are supported in recognition of the challenges of working with MCN.
3. **Learning and Enquiry:** Engaging in a culture of evidence generation through continuous evaluation of effectiveness and disseminating good practice to the wider network.
4. **Spaces of Opportunity:** Creating a space where SUs feel comfortable and secure enough to engage with the service using evidence-based design. Creating coherent pathways between services to ensure the opportunity to meet multiple needs.
5. **The Three R's; rules, roles and responsiveness:** This holds the consideration of building relationships as central with consideration of the impact of; the service rules, the roles of staff and SUs and the service's response to events.

"Psychologically Informed Environment" is a broad term and purposefully reflects the need for the creative and flexible work homelessness services often engage in (Johnson & Haigh, 2010). This presents limitations in the development of a consistent quantitative evidence base, but it is argued the study of whole multi-faceted environments is challenging for research methodologies to achieve on a large scale in a controlled, routine fashion. Therefore, qualitative and small-scale approaches lend themselves to exploring the underlying processes which make these environments therapeutically effective (Johnson, 2018a). Literature indicates the implementation of PIEs can have positive outcomes in reduced repeat homelessness, reduced substance misuse, increased independent living, increased training and education, reduced staff sickness and a reduction in serious incidents (Cockersell, 2011;

Quinney & Richardson, 2014; Ritchie, 2015). However, these studies are limited by vague outcomes without baseline or follow up data to indicate a sustained change.

Aims

The initial intention of this evaluation was to conduct baseline and follow up measurement of the team's perceptions of their service as a PIE after the delivery of specific PIE training. However, due to the COVID-19 pandemic it was not possible to complete some of the final training sessions or gather follow up measurements. The driver for the training was an acknowledgement that whilst services in the WBH are experienced in working with MCN, there had been no specific work done to assess or further develop the services into what could be considered psychologically informed. The revised aim is to evaluate the WHB against the elements of the PIE framework, from the perspective of staff and SUs.

Method

A service evaluation was conducted using data taken from three teams and SU questionnaires evaluating the WBH against PIE domains. A service evaluation is defined as an assessment of how well a service is achieving it's intended aims and is designed to define and judge current service provision (Twycross & Shorten, 2014).

Measures

The PIZAZZ (Johnson, 2018b) is a self-assessment for PIEs completed through team discussion. The teams rate themselves on a categorical scale (Poor, Early, Progressing, Advanced) against each of five PIE areas. Comprehensive operationalisation of the categorical scale for each category can be found in the guidance within the PIZAZZ. They are asked to provide evidence for each rating and consider what is helping/hindering their development, before developing an action plan.

There is an absence of published PIZAZZ literature, despite it being the first of its kind towards the assessment of PIEs. The rationale for using the PIZAZZ was to provide a highly specific framework and actively engage staff in the process of service evaluation, which is core to the development of a PIE. However, anecdotal evidence of suggests the quality of the data generated from the PIZAZZ is dependent on the level of knowledge/training the team already has regarding PIEs, with less knowledgeable teams providing less detail in helpful/hindering factors and limited action plans (Middleton, 2019). The PIZAZZ includes a prompt sheet with questions to assist staff in thinking about their service as a PIE, however this does leave the service evaluation open to the possibility of generating data subject to circular logic (Rips, 2002). A further limitation to using the PIZAZZ is the absence of evidence supporting its psychometric properties (i.e., confirmatory factor analyses). Therefore, data generated from its use is restricted to the subjective interpretation of the respondents.

A SU questionnaire (Appendix 12) was designed specifically for the service evaluation as there is no existing SU measure of PIEs. The questionnaire mapped onto the PIE domains (excluding staff training and support) and was co-produced by a Clinical Psychologist, Trainee Clinical Psychologist and Beneficiary Ambassador team (employees with lived experience of MCN). A Likert scale was used combined with an open-ended question to give the respondent an opportunity to expand on their answer. The limitations of using a purpose made questionnaire is an absence of confirmation of psychometric properties. Furthermore, as the questionnaire was designed by staff and SUs of the service, it cannot be argued to be completely free of bias (Choi & Pak, 2005).

Procedure

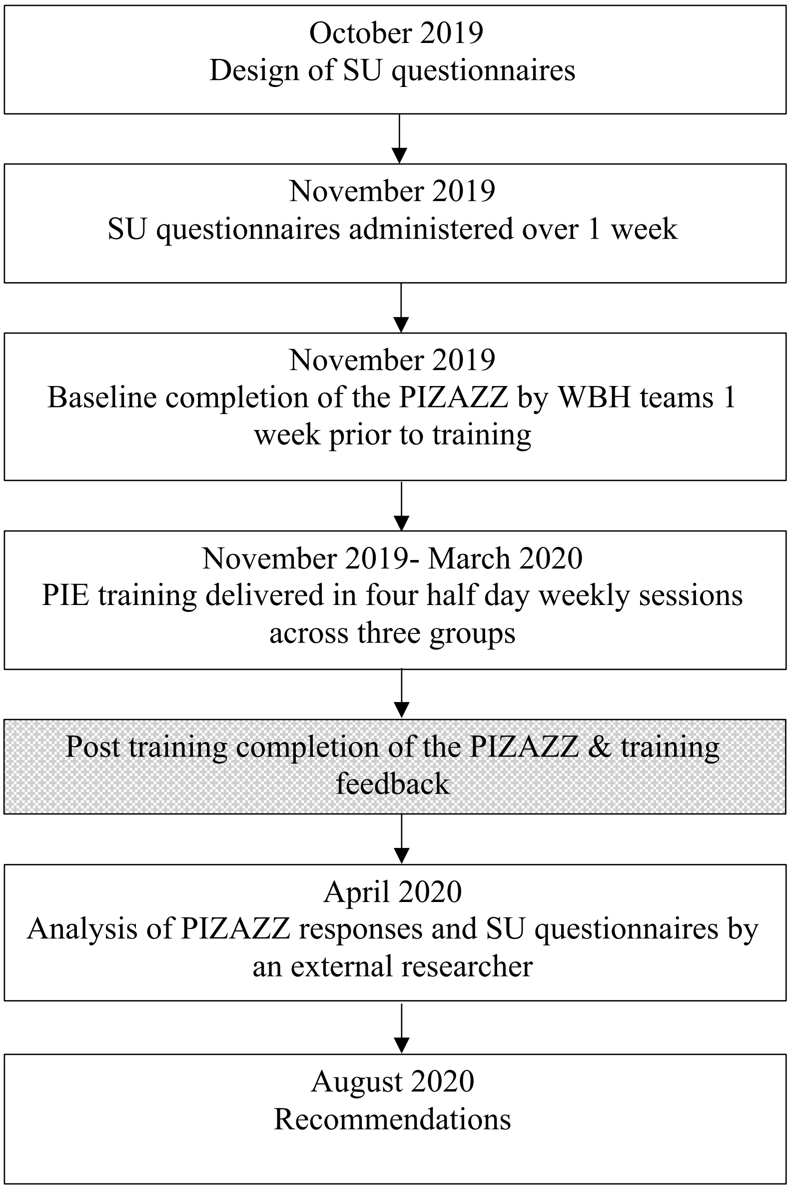
The study procedure is represented in Figure 3, including further parts of the study which were unable to be completed (shaded). Teams of the WBH were asked to complete the PIZAZZ by management prior to PIE training.

The Beneficiary Ambassador team and volunteers handed out the questionnaires to SUs in the reception area for one week, providing support with literacy where needed. The rationale for making the data collection peer led was to keep in line with the PIE principles of the development of inclusive roles for SUs. This holds a strength in creating a participatory rhetoric, holding true to the idea of "nothing about us, without us" (DH, 2001). However, there is limited evidence available on the reliability and validity of using peer led research (Harding et al., 2010).

The analysis was undertaken by an independent researcher external to the service. This is a strength of the evaluation as the researcher can provide an objective assessment and recommendations which are free of bias and awareness of internal politics (DJS Research Ltd, 2006).

Figure 3

Study Procedure



Analysis

Descriptive statistics

A descriptive analysis was conducted for the Likert data generated from the SU questionnaire. Percentages were used in place of measures of central tendency to overcome the risk of outliers and a skewed distribution impacting on the average scores of each response (Fields, 2013).

Framework Analysis

Framework analysis (FA) is a systematic and flexible qualitative research method based in the broad category of themed analysis (Gale et al., 2013). A systematic five step process is used (Ritchie & Spencer,1994);

1. Familiarization
2. Identifying a thematic framework
3. Indexing
4. Charting
5. Mapping/interpretation

The rationale for choosing FA is due to its suitability to analyse applied social policies, whereby specific information is gathered and actional outcomes are created (Ritchie and Spencer, 1994). FA is also argued to be suited to research with specific questions, conducted with a pre-designed sample within a limited time frame (Srivastava & Thomson, 2009). The PIZAZZ and SU questionnaire data were mapped on to the PIE domains using deductive FA analysis.

Results

Twenty-eight SUs completed the questionnaire. The majority of respondents were male (61%) and the majority of the sample (68%) had visited the WBH more than 20 times, with a small minority (7%) on their first visit.

Nine services were asked to complete the PIZAZZ as a mandatory part of training, however only three services did so. Teams who completed the service evaluation included an employment support service for people who had achieved abstinence, a substance misuse team and an employment and education service. Table 12 presents the anonymised service self-ratings.

Table 12

Services PIZAZZ Ratings

	Psychological Awareness	Staff Training and Support	Learning and Enquiry	Spaces of Opportunity	The Three R's: Rules, Roles, Responsiveness
Service 1	Progressing	Progressing	Early	Progressing	Progressing
Service 2	Progressing	Progressing	Early/ Progressing	Early	Progressing
Service 3	Progressing	Advanced	Progressing/ Advanced	Progressing	Advanced

Psychological Awareness

For a service to be a PIE there must be evidence of significant understanding of the SU group in the application of psychological models used, including experimentation with a range of psychological approaches:

Service 1: "Maslow's Hierarchy of Needs-people need a foundation (basic needs, housing) before having self-actualisation"

Service 2: "CBT, person-cantered, attachment theory, Trauma Informed approach, Stop & Think group… problem solving approach, Motivational Interviewing…Solution Focused…Formulation meetings-psychologist led,"

As can be seen, a range of psychological approaches are reported to be used, however there is limited detail provided for the rationale for the use of these specific approaches, instead it is assumed through the list of models applied. Responses from the SU questionnaire indicate staff emotional awareness, with the majority of respondents reporting to finding staff to be understanding (68%) and over half (57%) of respondents reported to feeling comfortable talking to staff:

Respondent 17: "Polite, helpful, good at giving support"

This comment demonstrates the building of a good relationship between staff and SUs. However, it could be considered to be superficial due to the lack of specific examples of how the support provided is meeting the needs of the SU. Furthermore, one of the respondents highlighted a gap in psychological skills:

Respondent 11: "Everyone tries and has best interests in mind, but active listening needs to be key to get full appreciation of needs."

Additionally, a small percentage (4%) reported to not feeling comfortable talking to staff at all:

Respondent 11: "Occasional brusque character - sharp / not friendly. Keyworker and reception. Could put people off coming back."

This demonstrates an approach which is not consistent with a PIE, as a key facet is building a good relationship between staff and SUs. This is further demonstrated in one services response, which gives a sense of persuading the SU into the services way of working:

Service 3: "We build participant trust from the initial meeting; this ensures a buy in from the participant and the participant owns their journey…Different techniques are adopted by delivery staff and expectations are discussed with all participants so that they are aware of what support is on offer"

The absence of identified psychological models in this quote demonstrates a limited understanding of SU needs and instead a focus on the practical issues of assistance.

Staff Training and Support

To demonstrate a psychologically informed approach to staff training and support, a service has to demonstrate a good recognition of the needs of the SUs as reflected in the training provided to staff:

Service 2: "PD course, emotional resilience, stress tolerance, RCGP, Nursing degrees… protected learning time"

The administration of a “PD” course is highly relevant to the SU demographic, as there is a recognition of a high association between diagnoses of personality disorders and complex needs (Conolly, 2018). However, there is limited indication of an understanding training provides of emotional issues for staff as well as SUs. This is lack of detail is also seen another service’s evidence:

Service 3: “Staff are happy with the training offered”

Aside from this quote, no further evidence is provided regarding what training is received or how it is designed to meet the needs of the SUs or staff wellbeing. Therefore, the data cannot demonstrate an understanding or commitment to the complex needs of the demographic they are likely working with. In other services training appeared to be limited to mandatory elements:

Service 1: “Training is generally approved…have also had relevant courses approved. However, the training tends to be standard practice and nothing forward thinking”

It is specified within this service’s action plan that specific training on psychological models would be beneficial for the staff team, demonstrating contemplation to progress as a PIE.

Another important element of a PIE is the provision of staff support. Services clearly value the range of support provided:

Service 2: “Supervision, recognising individual skills, developing areas of expertise”

Service 3: “Staff are very happy with the level of support that is offered from colleagues and line management”

Whilst it is a strength of the service that staff are satisfied with the support provided, the absence of detail and critical evaluation suggests a lack of awareness rather than a PIE. There are some clear limitations to staff support in other services:

Service 1: “There is no protected time for regular support and supervision to see how we are and how we feel about our jobs. It feels like staff wellbeing is not prioritised as much as it should be.”

One important element of a PIE is the acknowledgement of staff working in a challenging environment. Without formal structures in place for reflection or learning, staff are denied the opportunity to explore their own experience and have their work valued.

Learning and Enquiry

Within a PIE, learning is approached in a number of ways, including reflective practice, evidence generation to consciously learning from mistakes. A culture of reflective practice is evident in some services:

Service 1: “Our volunteers do reflective logs, but we feel we should utilise/focus on these reflections more. As staff we probably don’t do enough reflective logs ourselves.”

Service 2: "Reflective practice is encouraged: both with participants and with staff members during team meetings and one to ones."

There appears to be an inconsistent culture of learning across the WBH, with one service demonstrating a range of methods of the involvement and contribution to generating evidence and disseminating this to the wider sector, but clear limitations in another service:

Service 2: "Audit, journal club…restricted conference attendance, developmental aspects e.g. new drugs online training"

Service 3: "As a service… [we] gather evidence as part of service delivery so this area is pretty key"

Service 1: "No opportunities to participate in wider learning/inquiry for needs mapping or system development. No opportunities to do wider communities of practice. No opportunities to participate in wider learning/inquiry in working to produce publishable research"

Whilst it is a strength of services where a pre-established culture of evidence generation exists, it is not clear if this goes beyond contract compliance and reporting back to commissioners. In services where wider learning is not as well developed, there is an indication this is due to constraints of either system organisation or knowledge/access to different ways of learning.

Inconsistencies in the WBH are also seen in culture of enquiry, with one service reporting to the use of formal structures indicating a protection from a culture of blame and further evidenced by the recognition of needing to provide psychological support to staff after an untoward incident in the action plan:

Service 2: "Clinical enquiry…SUI, coroners, contemporaneous notes"

However, there is a suggestion of division in another service, with staff remaining uninvolved in the culture of enquiry and decision making:

Service 1: "Management only tell us about widespread problems on a need to know basis. Decisions are from management- can approach with suggestions but not always heard"

This is further reflected in the SU responses with only a small majority (36%) expressing they felt staff tried to recognise and learn from mistakes. Qualitative responses indicate a lack of understanding and awareness of the needs of the SUs:

Respondent 11: "Many people struggling to deal with emotional and mental issues get left behind if they can't get along with the systems in place."

Respondent 13: "Management need to be more mindful of issues on ground floor to get a better understanding of what people need..."

These comments suggest limitations to the extent staff are able to convey the service as psychologically informed and might be an indication of existing limitations of the systems in operation.

Space of Opportunity

Within a PIE the physical environment will ensure SUs feel comfortable and secure enough to engage with the service. Further to this, pathways between services are designed as such that SUs will be able to access and engage meaningfully. There are some clear strengths in the holistic nature of the WBH and surrounding facilities, as acknowledged by both the services and SUs:

Service 1: "We do have links with other services who provide opportunities for users to engage constructively with our service"

Respondent 9: "I go to the job club downstairs and they have told me about different support services to help me get back into work."

Respondent 11: "I love the holistic idea of services under one roof."

Service 2: "Model has some benefits. Easy access to housing, health shop, Hep C Nurse."

SUs clearly value having access to a range of services under one roof, with half (50%) of respondents reported to being provided with support to access other relevant services, contributing to the PIE attribute of pathway coherence. However, almost a quarter (21%) reported this to not be the case at all, giving a perception of limited access to certain aspects of services, demonstrating the complexities of providing holistic care. This is acknowledged in one service's action plan:

Service 1: "Better communication with reception (i.e. when a group isn't on, they should be informed of this- this can be easily missed/difficult when people are busy)"

Further strengths were identified in one service's existing effort in to make creative use of the surrounding network:

Service 1: "Discount cards for Sobar provided by the service"

This service demonstrates PIE attributes in its active encouragement of SUs in a café designed specifically for those who are tackling drug and alcohol abuse. However, a range of limitations were identified in the physical environment by both services and SUs:

Service 1: "Frosted windows, stained carpets, bare white walls"

Respondent 10: "I feel reception is not very private and some matters are very personal"

Service 3: "The pods behind reception are quite close together so sensitive conversations would not be able to take place in this environment"

These responses give an insight into the ineffective use of the physical environment. There is an indication of the impact the physical environment has on the SUs, as whilst the majority (57%) of respondents reporting to feel "very" safe when visiting the WBH, some of the qualitative responses suggest a sense of unease:

Respondent 9: "Small feeling of anxiety"

Respondent 13: "Prefer when quieter"

This is of importance as PIE guidance specifies the use of evidence-based design of the physical environment can have an effect of psychological change on SUs (Keats, et al. 2012). Additionally, there is an indication of an adverse impact of the physical environment on staff:

Service 2: "Increasing sickness in open plan office"

Service 2: "IVDU (intravenous drug use) in toilets and in surrounding WBH environment"

In establishing a PIE, services have to take active consideration of the physical environment and pathways between services, including acknowledgment of the gaps/barriers. Within each service's action plan there is a mixed picture in ideas for improvement, despite recognition of the impact on pathway coherence and wellbeing for both SUs and staff.

The Three R's: Rules, Roles, Responsiveness

For a service to be considered as a PIE it needs to have a wide repertoire of ways to engage staff and SUs in its policies and procedures. There is a clear sense of SUs being made aware of rules of the WBH, with the majority (85%) reporting to understand the rules of the service and what to expect from staff:

Respondent 26: "No aggression or violence. Staff treated similar."

Respondent 13: "Respect, dignity and most of all privacy".

Clear service expectations are also reflected in the responses of services, with clearly defined policies and procedures:

Service 2: "Policies and procedures available protecting SUs and staff"

Service 3: "Necessary written information is displayed in the building and can be viewed and accessed with ease."

The idea of the use of rules just for protection suggests an atmosphere of practicality, with an underlying narrative of "us/them". These responses do not give an indication of flexibility or adaptation. In order to work in a psychologically informed manner with those experiencing MCN an adaptive approach is recommended within a PIE, as recognised by one service:

Service 1: "…we have guidelines on the duration/frequency of one to one work, but this isn't always possible as we work with real people with complex needs"

This team demonstrate insight in their recognition that their rules are process heavy and are mindful of ways in which this could be improved:

Service 1: "Operational procedures are paperwork heavy and process driven-could be more psychologically aware"

Moreover, flexibility is seen in staff responsiveness to SU needs in a variety of other ways:

Service 1: "We don't view rule floating as transgressions, we view them as opportunities"

Service 2: "…individualised patient care, seen outside of appts"

These quotes demonstrate the pre-existing aim of balancing resilience with tolerance and consistency with person-centredness. This is echoed in the SU ratings of staff responsiveness, with just over half (53%) of the respondents reporting they felt staff responded well to their needs, however limitations are highlighted:

Respondent 11: "Sometimes overstretched? Sometimes part time. But otherwise really helpful. Sometimes need to ask several times for things."

The sense of services being "overstretched" is also echoed in services' evidence:

Service 2: "Less staff than before…"

Service 2: "Disadvantage: Fewer home visits/lack of funding"

The service provides an indication that changes to resources have led them to be less responsiveness than is ideal. This may explain ratings given by SUs for staff responsiveness to gender-specific needs, as whilst a small majority (32%) reported a gender-specific response was not required and a quarter (25%) felt staff were responsive to this need, some (15%) found staff to be neglecting it completely:

Respondent 16: "Don't have a choice"

The final key area of the Three R's is roles, whereby SUs are encouraged to be active agents in their own care and engage in the service in a way of which is meaningful for them. In the SU questionnaire, half (50%) of responses indicate staff ask their opinion and involve them:

Respondents 24: "This questionnaire is a prime example."

However, over a quarter (36%) expressed they were only involved slightly or not at all:

Respondent 13: "Never been asked but feel we need to be more included."

There is further indication of a lack of opportunities to take an active role in the service, with just under half (47%) reporting their awareness of options. A quarter (25%) expressed not being made aware of chances to be involved:

Respondent 12: "Service user forums BUT need to be advertised more."

Respondent 13: "Not aware of them."

Evidence presented from the services supports this mixed picture:

Service 1: "…peer mentors, recovery support volunteers and connectors…academy speak…No service user consultation or committee."

Service 2: "Consultation, SU groups, mentors…"

Whilst there is recognition of the missing roles for SUs, services gave limited indication in their action plans to address this.

Overall, whilst there are some clear examples of improvements, there is a sense of appreciation expressed from the SUs to the services in their current form, with staff being the main asset:

Respondent 2: "All staff are great ☺"

Respondent 24: "Thank you for being here"

Discussion

In considering the information gathered from the SU questionnaire and from the three services, the WBH as a whole is progressing into a PIE. There is a mixed picture regarding the psychological awareness of each of the services, with some demonstrating a better understanding than others. This is understandable given some services have a clinical focus with professionally trained staff, whereas others may have very little related training (e.g., reception staff, career support staff). It is therefore advised all staff continue to receive some form of PIE training in order to understand the importance of developing a tolerant and empowering relationship with SUs, and in turn improving service outcomes. It may be beneficial for the services which are currently well resourced to provide other developing services with an insight into their use of psychological frameworks and the rationales for the chosen models.

There are some clear discrepancies in the type of support staff receive between the different services. Again, this may be linked to different levels of understanding, training and commissioning. Recommendations are made for appropriate staff support to be in place with formal and protected supervision time, with acknowledgment of challenges staff face and how they are supported to manage these challenges. It has been reported that frontline workers in MCN services suffer from significantly elevated levels of anxiety and depression in comparison to population norms (Lemieux-Cumberlege & Taylor, 2018). It would be beneficial for this to be addressed using an interservice approach, whereby services pool resources to create a regular space for reflection and peer support. This has the added advantage of creating connections between services, enhancing the holistic nature of the WBH as an IH.

The evidence presented by services lacked detail regarding why and how staff training addressed the needs of the SUs and staff wellbeing, therefore it is recommended for services to demonstrate the rationale in future. Additionally, services would benefit from management engaging with both staff and SUs to establish what type of training might be beneficial in future. It is also important to note this service evaluation only gives a narrow picture of the WBH, as all nine services were asked to complete the PIZAZZ as a mandatory part of training, however only three services did so. The reasoning for this can only be postulated but it is possible teams may not have completed the PIZAZZ due to restrictions on time or resources, or it may be an indication of a lack of a pre-established culture of reflective practice. Reflective practice has advantages in identification of learning needs and recognition of professional skills, thereby improving staff confidence (Mankiewicz, 2014). It also indicates a possible design flaw in the service evaluation, as it may have been more effective to build the completion of the PIZAZZ into the delivery of the PIE training. This would have also provided the advantage of support from the psychologists delivering the training in the completion of the tool, which can be described as lengthy and complex without a pre-existing understanding of PIE's. This may also explain the poor reporting of evidence on some of the completed PIZAZZ forms, as reflected previously by Middleton (2019).

There is a clear culture of Learning and Enquiry in all of the services which provided evidence. Whilst the evidence in some cases may have lacked detail, it is clearly routine practice to evaluate service outcomes. For a service to develop as a PIE, staff should have opportunities to connect and contribute to the wider local and national network of understanding what works via attending forums or disseminating best practice research. One of the key features of a well-established PIE is a consistent culture of learning and enquiry, including repeated reflection using the PIZAZZ. It is recommended the original plan of this service evaluation is continued, with post PIE training completion of the PIZAZZ, including evaluation of the PIE training itself. A culture of enquiry was highlighted in all three of the services to need improvement. This responsibility would sit with higher management, however, to progress as a PIE these procedures would be disseminated down through all staffing levels and a duty of candour would be commonplace. Furthermore, staff of all levels and SUs should be encouraged to make suggestions regarding the development and improvement of the service.

There are some clear limitations of the physical environment within the WBH as identified by all three teams and the SU questionnaire. It is advised spaces which prevent full privacy and confidentiality for SUs are addressed immediately. The rationale for this is to ensure the SUs using the WBH feel comfortable and safe in attending, and there is a clear communication of dignity and respect for any confidential information shared. It is often the case whereby people experiencing MCN have been systemically denied the opportunity to feel proud and powerful in their identity (Brighter Futures, 2012). Therefore, communication and interaction need to be carefully considered to overcome a "us and them" dynamic, including providing basic rights like privacy during sensitive conversation. This can be achieved via evidence-based design, whereby informed design and decoration of a building can influence health outcomes (Codinhoto et al., 2008).

The WBH currently holds its strength in providing a range of services under one roof, providing system and pathway coherence for its SUs, and demonstrates an effort to overcome the multiple exclusion which those with MCN often face (McDonagh, 2011). However, improvements could be made in improving relationships between services within the WBH as indicated in some of the PIZAZZ comments. Better relationships between services would result in better communication and awareness of which service has to offer, increasing accessibility and creating a smoother pathway for SUs.

A key component of PIE is in the day to day running of services as reflected in rules, roles and responsiveness. It is advised services consider ways in which they already adapt beyond policies and procedures to meet the needs of a client group with complex needs and reflect these written policies and procedures. It should then consider how to adapt and engage SUs when they are unable to adhere to set rules. Collaboration appears to be key in the facilitation of inclusion (Repper & Perkins, 2003), with careful consideration needing to be given to the pre-existing power imbalance between services and those experiencing MCN. With such power imbalances, there is always a risk of services becoming coercive or excluding by the way of denying access when an individual is unable to conform to criteria or rules (Dunn, 1999). There will always be practical limitations to how responsive a service can be to SUs, however constant review should be taken of what works in balancing power and autonomy. For example, literature indicates women who use services designed for MCN are more likely to have experienced sexual abuse and/or domestic violence, therefore good practice indicates a preference on the gender of their worker should be offered where possible (Hutchinson et al., 2014).

The presence of multiple services under one roof presented some complexities in conducting this service evaluation, including a lack of methodological consistency in the completion of the PIZAZZ. Some services clearly used the PIZAZZ prompt sheet to assist in providing evidence, whereas there is an indication others neglected to use this resource. A further difficulty of conducting a multi-service evaluation is the administration of the SU questionnaire in reception, as the feedback cannot be attributed to any of the specific services and thereby losing the opportunity to provide insight to services about helpful/hindering aspects. This can be easily rectified in future by adapting the questionnaire to include service specific questions.

A final drawback of this research is the limitation of the data generated to the information produced from the PIZAZZ and SU questionnaire. Whilst the PIZAZZ is the most relevant and suitable tool available, its usefulness is dependent on a pre-existing knowledge of PIE's. Whilst there is an attempt to overcome a gap in knowledge in the provision of a prompt sheet, this creates a risk of circular logic, as reflected in the answers of one service, who at times used the exact language and provided direct answers to the prompts. This can be overcome in future evaluation by asking staff to provide a variety of evidence including; quantitative outcome data, evidence of resolved complaints and feedback from staff and SUs.

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Declaration of Interest
The authors report no declarations of interest. The authors alone are responsible for the content and writing of

Statement of contribution

Hayley Sapsford was responsible for the conceptualisation of the project, reviewing of relevant literature, analysis and the writing up of the research.

Dr Anna Tickle was responsible for the design and data collection of the research. She provided supervision on the write up and analysis of the data. She was also responsible for the facilitation of the relationship with Framework and Opportunity Nottingham.

References

Bowpitt, G., Dwyer, P., Sundin, E. and Weinstein, M. (2011). "The support priorities of multiply excluded homeless people and their compatibility with support agency agendas – new research into multiple exclusion homelessness." Housing, Care and Support Vol. 14(No. 1): pp. 31-3

Brighter Futures. (2012). Simple solutions for complex needs– an analytical social care approach Psychologically informed services for homeless people: Good Practice Guide. H. Keats, Maguire, N.J., Johnson, R. & Cockersell, P. Southhampton, University of Southhampton

Cockersell, P. (2018). Social Exclusion, Compound Trauma and Recovery: Applying Psychology, Psychotherapy and PIE to Homelessness and Complex Needs. London, Jessica Kingsley Publishers

Cockersell, P. (2011). "Homelessness and mental health: adding clinical mental health interventions to existing social ones can greatly enhance positive outcomes." Journal of Public Mental Health & Social Care in the Community 10 (2): 88-98.

Choi, B. C. K. and Pak, A. W. P. (2005). "A catalogue of biases in questionnaires." Preventing chronic disease 2(1): A13-A13.

Codinhoto, R., Tzortzopoulos, P., Kagioglou, M., Aouad, G. & Cooper, R. (2008). The effects of the built environment on health outcomes, University of Salford.

Conolly, J. (2018). Pre-treatment Therapy: A central London Counselling Services' Enhanced Response to Complex Needs Homelessness. Cross-Cultural Dialogues on Homelessness: From Pretreatment strategies to Psychologically Informed Environments J. S. Levy. Milton Keynes, Loving Healing Press 49-70.

DH (Department of Health) (2001). "Valuing people." London: The Stationary Office.

DJS Research Ltd (2006, 17 July 2012). "What Are the Advantages of Using Independent Consultants to Carry Out Research Within a Company?". Retrieved 25/09/2020, 2020.

Dunn, S. (1999). Creating Accepting Communities. Report of the Mind Inquiry into Social Exclusion and Mental Health Problems. London, Mind Publications.

Field, A. (2013). Discovering statistics using IBM SPSS statistics, Sage.

Fisher, G. (2015). The Complexity of Severe and Multiple Disadvantage. Synthesis, LankellyChase Foundation.

Fulfilling Lives. (2020). "What is "Multiple and Complex Needs"?". Retrieved 24th July, 2020.

Furness, L. (2018). Complex Commissioning for Complex Needs. Bristol Evening Seminar, Bristol.

Gale, N. K., Heath, G., Cameron, E., Rashid, S. & Redwood, S. (2013). "Using the framework method for the analysis of qualitative data in multi-disciplinary health research." BMC Medical Research Methodology 13(1): 117.

Harding, R., Whitfield, G. & Stillwell, N. (2010). "Service users as peer research interviewers: why bother." Social policy review 22: 317-335.

Hewett, N. (2011). The Faculty of Homeless Health: Standards for commissioners and service providers, College of Medicine.

Homeless Link. (2017). Support for single homeless people in England: Annual Review 2017, Ministry of Housing, Communities and Local Government

Hopper, E., Bassuk, L. & Olivet, J. (2010). "Shelter from the storm: Trauma-informed care in homelessness services settings." The Open Health Services and Policy Journal 3(1).

Johnson, R. (2015) "PIEs 1 & 2.0-the revised account." Retrieved 03 August 2020

Hutchinson, S., Page, A., & Sample, E. (2014). Rebuilding Shattered Lives: The Final Report. London.

Johnson, R. (2018a). Principles and Practice in Psychology and Homelessness: Pre-treatment Trauma Informed Care & Psychologically Informed Environments. Cross-Cultural Dialogues on Homelessness: From Pretreatment Strategies to Psychologically Informed Environments J. S. Levy. Milton-Keynes Loving Healing Press 13-34.

Johnson, R. (2018b). "The Pizazz ". Retrieved 03 August, 2020.

Johnson, R. & Haigh, R. (2010). "Social psychiatry and social policy for the 21st century - new concepts for new needs: the ‘psychologically-informed environment’." Mental Health and Social Inclusion 14(4): 30-35.

Keats, H., Maguire, N.J., Johnson, R. & Cockersell, P. (2012). ‘Psychologically informed services for homeless people’, Good Practice Guide. Department of Communities and Local Government. University of Southampton.

Keene, J. (2001). Clients with complex needs, Interprofessional Practice. London.

Lemieux-Cumberlege, A. and E. P. Taylor (2019). "An exploratory study on the factors affecting the mental health and well-being of frontline workers in homeless services." Health & Social Care in the Community.

Luchenski, S., Maguire, N., Aldridge R., Hayward, A., Story, A., Perri, P., Withers, J., Clint, S., Fitzpatrick, S. & Hewett, N. (2018). "What works in inclusion health: overview of effective interventions for marginalised and excluded populations." The Lancet 391(10117): 266-280.

Mankiewicz, P. D. (2014). "Reflective practice on inpatient mental health wards (1/2): integrating cognitive-behavioural framework with reflective learning process." British Journal of Healthcare Assistants 8(6): 291-296.

McDonagh, T. (2011). Tackling homelessness and exclusion: Understanding complex lives, Joseph Rowntree Foundation

Melrose, M. (2004). "Fractured transitions: Disadvantaged young people, drug taking and risk." Probation Journal 51(4): 327-341.

Middleton, R. (2019). "Psychologically Informed Environments (PIE) – Our early learning points." Fulfilling Lives: Supporting People Experiencing Multiple Disadvantage https://www.fulfillinglivesevaluation.org/psychologically-informed-environments-pie-our-early-learning-points/ 2020.

Quinney, S. &. Richardson, L. (2014). "Organisational development, appreciative inquiry and the development of Psychologically Informed Environments (PIEs). Part I: a positive psychology approach." Housing, Care and Support 17(2): 95-102.

Repper, J. & Perkins, R. (2003). Social Inclusion and Recovery London, Bailliere Tindall.

Reeve, K., McCarthy, L., Pattison, B., Parr, S., Batty, E., Maye-Banbury, A., Bashir, N. & Dayson, C. (2018). The mental health needs of Nottingham's homeless population: an exploratory research study, Sheffield Hallam University

Rips, L. J. (2002). "Circular reasoning." Cognitive Science 26(6): 767-795.

Ritchie, C. (2015). "Prevent rough sleeping; create a psychologically informed environment." Therapeutic Communities 36(1): 36-42.

Ritchie, J. & Spencer, L. 1994. Qualitative data analysis for applied policy research by Jane Ritchie and Liz Spencer in A. Bryman and R. G. Burgess [eds.] ‘Analysing qualitative data’, (pp.173-194). London: Routledge.

Rosengard, A., Laing, I., Ridley, J. & Hunter, S. (2007). A Literature Review on Multiple and Complex Needs. Edinburgh Scottish Executive Social Research.

Srivastava, A. and S. B. Thomson (2009). "Framework analysis: a qualitative methodology for applied policy research."

Twycross, A. and A. Shorten (2014). "Service evaluation, audit and research: what is the difference?" Evidence-based nursing 17(3): 65-66.

Appendix 12

Wellbeing Hub Questionnaire

We are asking everybody who accesses services at the Hub this week to complete this questionnaire. It is an opportunity to give your feedback to inform services at the Hub.

It is confidential – we are not asking for your name. All of the answers will be gathered together. The results will be put up in reception.

Completing this questionnaire will in no way affect the services you receive. They will not know you have done this.

Please circle the answer that best fits for you. There is also a space to add comments.

It will take about 5 – 10 minutes. We appreciate your time. Thank you.

1. How many times have you been to the Wellbeing Hub?

First time   2-5 times   5-10   10-20   20+

2. Are you:

Male   Female   Other (specify if you wish)____________

3. How understanding do you find the staff at the Wellbeing Hub?

Not at all (0)   A bit (1)   Mostly (2)   Very (3)

Do you want to say any more about this?

4. Do you find the staff at the Wellbeing Hub respond to you and your needs, e.g. answer questions, help you if you're in a crisis etc.?

Not at all (0)   A bit (1)   Mostly (2)   Very much (3)

Do you want to say any more about this?

5. How comfortable do the staff make you feel when talking to them?

Not at all (0) A bit (1) Mostly (2) Very (3)
Do you want to say any more about this?

6. How much does the service ask your opinion and involve you?

Not at all (0) A bit (1) Mostly (2) Very much (3)
Do you want to say any more about this?

7. If something goes wrong, how much do you think the service recognise this and try to learn from it?

Not at all (0) A bit (1) Mostly (2) Very much (3) Not applicable (4)
Do you want to say any more about this?

8. How safe do you feel at the Hub?

Not at all (0) A bit (1) Mostly (2) Very (3)
Do you want to say any more about this?

9. Has the service supported you to access other relevant services / groups at the Hub / support / organizations?

Not at all (0) A bit (1) Mostly (2) Very (3) Not applicable (4)
Do you want to say any more about this?

10. Are there opportunities for you to take an active role in the service if you want to?

Not at all (0) A bit (1) Mostly (2) Very (3) Not applicable (4)
Do you want to say any more about this?

11. Do you know what is expected from you and do you know what to expect from staff and other users of the service?

Not at all (0) A bit (1) Mostly (2) Very (3)

Do you want to say any more about this?

12. Do you think the staff and services at the Hub meet any gender-specific needs you may have, e.g. offering you a choice of worker, single-gender space, asking gender related questions etc.?

Not at all (0) **A bit (1)** **Mostly (2)** **Very much (3)** **I do not have gender-specific**

Do you want to say any more about this?

Is there any other feedback you would like to give us about the Hub?