Staff Views on Formulations in Community Mental Health Services: A Discursive Analysis

Rebecca Bealey

Candidate number: 100225167

Supervisor: Dr Gillian Bowden

Clinical Lecturer in Clinical Psychology, University of East Anglia

Secondary Supervisor: Dr Paul Fisher

Senior Clinical Lecturer in Clinical Psychology, University of East Anglia

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Contents

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Abstract

The aim of this research was to understand staff views and experiences of using psychological formulations in mental health services. A systematic review was conducted utilising a Thematic Synthesis to combine findings from qualitative studies on staff experiences of participating in team formulations. The review also aimed to provide a quality appraisal of the included research using the Critical Appraisal Skills Programme qualitative checklist. The review examined 16 qualitative papers which were of a mixed quality and in some instances there was an insufficient amount of detail to complete an accurate assessment. The review highlighted the importance of team formulation in general practice for enhancing staff understanding of service users but also improving professional confidence and validation. The review also highlighted some barriers to staff practicing team formulation. An empirical study was conducted to further identify discourses of community mental health staff regarding psychological formulation in their everyday practice. Focus groups were completed with staff in three different multidisciplinary community mental health teams, with the discussions subsequently analysed using a critical discourse informed approach. Discourse topics were identified relating to the importance of storytelling, the role of power and hierarchy, trauma and exclusion of the individual and staff struggles, burnout and constraints. Four overlapping major discourses were found in the research, with the study highlighting the positive impacts that formulation can have on staff but emphasising the role of power in mental health settings. The findings from both studies were critically discussed and evaluated.

Chapter One: Introduction

Chapter One

Introduction

Formulation is the process of constructing a shared 'best guess' understanding of the origins of an individual's difficulties taking into account their life events, social circumstances, relationships and what sense they make of them (Johnstone, 2018). Professional practice guidelines posit that formulation can have other benefits, such as helping the service user feel understood and providing an overall map of the person (Division of Clinical Psychology, 2011). Psychological formulations are now embedded as a core competency of a psychologist's clinical practice (British Psychological Society, 2010; Health Care Professions Council, 2012). In addition to individual formulations, teams have begun to participate in formulations together (Johnstone, 2013). Research has suggested that mental health practitioners have found this process helpful, but the research field is sparse (Johnstone, 2018).

As already alluded to, there are several different approaches to formulation in practice. Traditionally formulations are facilitated within individual one-to-one therapy sessions, with the clinician bringing the research and evidence-based knowledge and the service user contributing the expertise on their own life and experiences (Johnstone, 2018) creating a 'collaborative empiricism' (Beck, 1995). Individual formulations primarily act as a way of working with a service user to make sense of what has happened to them in the past and how this may affect them going forward (Johnstone, 2018).

The process of facilitating formulations as a team or as a group of professionals, is beginning to become common practice (Johnstone, 2018). Attempts have been made to define this process but due to its fluid nature, team formulations are generally defined

through their function as being to enable team members to develop a shared psychological understanding of presenting difficulties; summarises their nature, explaining their development and maintenance, and guiding intervention planning (Geach, Moghaddam & De Boos, 2018). Team formulations should take place with the service user present, to enable their voice to be heard and to contribute their own unique expertise, however in practice staff only team formulations are frequently facilitated. Throughout this portfolio team formulations are generally defined as being meetings of professionals which are focused upon making sense of an individual service user's difficulties, these have been included with or without a service user presence. This definition does not include reflective practice groups which are focused on more broad difficulties or issues that staff may have in general when working with service users.

The current study explores staff views and opinions on the process of formulations. A systematic review (Chapter Two) was conducted collating qualitative studies concerning staff views and perspectives on team formulations. The included studies were analysed using a Thematic Synthesis (Thomas & Harden, 2008) and seven analytical themes were extracted. Chapter Three provides a bridge of understanding between the systematic review and empirical papers.

An empirical paper (Chapter Four) analysing staff views and opinions on formulations collected from focus groups was carried out. These focus groups were conducted with multidisciplinary staff members of community mental health teams with experience or knowledge of psychological formulations. The resulting discourses collected from these focus groups were analysed utilising a critical discourse informed approach. Four major discourse topics were identified and explored. Two further discourse topics are discussed in an extended results chapter (Chapter Five). The

conclusions from both papers are discussed and critically evaluated (Chapter Six). Finally, the researcher's reflections on the process are included in Chapter Seven.

Chapter Two: Systematic Review

Prepared for submission to Journal of Mental Health

(Author guidelines in Appendix A)

A systematic review of team formulations in multidisciplinary teams: staff views and opinions

R. Bealey[1], G. Bowden[1], P. Fisher[1]

[1]*School of Medicine, University of East Anglia, Norwich, Norfolk*

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A systematic review of team formulations in multidisciplinary teams: staff views and opinions

Background: Formulation and working psychologically with teams is considered a fundamental part of the role of a clinical psychologist. Quantitative studies have found positive effects on staff views and opinions regarding the usefulness of team formulation processes. **Aims:** This review aims to utilise a Thematic Synthesis to combine qualitative studies on staff experiences of participating in team formulations. The review also aims to provide a thorough quality appraisal of the included research. **Method:** A Thematic Synthesis was completed on qualitative studies which met the required inclusion criteria. The Critical Appraisal Skills Programme qualitative checklist was used to appraise the included research. **Results:** The studies included in the review were of a mixed quality, and in some instances there was an insufficient amount of detail to complete an accurate assessment. Overall, seven themes were identified across the studies. **Conclusions:** The current review highlights the importance of team formulation in general practice for both enhancing staff understanding of service users but also improving professional confidence and validation. The review also highlighted some of the barriers to staff practicing team formulations.

Keywords: team formulation; thematic synthesis; qualitative research; critical appraisal skills programme; staff views and opinions

Introduction

The use of team formulations with staff groups has become an increasingly popular practice within Clinical Psychology in the United Kingdom (UK) as a means to engage and work collaboratively with teams (Division of Clinical Psychology; DCP, 2011). Psychological formulations are a mainstream practice within the UK and are guided by the *Good Practice Guidelines* published by the British Psychological Society (DCP, 2011). Psychologically working with teams is also considered a fundamental role of practitioner psychologists by regulatory bodies (Health and Care Professions Council, 2015). The frequency of team formulations has increased in recent years reflecting the rising prominence of team-based psychological work by clinical psychologists

(Johnstone, 2018), the current pressurised NHS context in which more is expected with fewer resources (Alderwick, Robertson, Appleby, Dunn, & Maguire, 2015) and the growing demand for psychotherapeutically informed approaches to mental health (Department of Health, 2007).

Team formulations can be characterised as the "process of facilitating a group of professionals to construct a shared understanding of a service user's difficulties" (Johnstone & Dallos, 2013, p.5). These formulations are then often used to explain the development, maintenance of presenting difficulties and to guide the planning process of future interventions (Geach, Moghaddam, & De Boos, 2018). A systematic review completed by Geach et al. (2018) found that although no uniform definition was reported across studies a common focus was established as being a forum to share psychological understanding of an individual's presenting difficulties whilst guiding interventions. Team formulations have also been found to be helpful in working with complex individuals, particularly when considering the support given to staff (DCP, 2011; Royal College of Psychiatrists, 2017). In addition, team formulation was generally seen to be an umbrella term inclusive of formulation activities which reached multiple people in a short space of time and is reported to be unique to clinical psychology (DCP, 2011; Geach et al., 2018).

Quantitative studies have found that team formulations have improved staff perception of formulation as a useful practice (Geach et al., 2018; Whitton, Small, Lyon, Barker, & Akiboh, 2016). Qualitative studies collecting professional views and opinions of team formulations have mixed findings and, in some cases, it has been highlighted that the outcomes have potentially been impacted by the individual analysing the data. Research by Summers (2006) highlighted that views on team formulation differed according to the profession of the individual being interviewed;

clinical psychologists provided positive and valuing accounts of team formulation and inpatient nursing staff expressed dissatisfaction regarding the meetings with "some people wanting to be right or more powerful" (Summers, 2006, p.342). A theme of increased empathy was evident across multiple qualitative studies. Murphy, Osborne and Smith (2013) reported how one individual identified seeing service users more as 'people' and less as 'patients'.

The DCP (2011) have highlighted a sparsity of evidence related to the influences of team formulations despite noting several benefits and research, such as that by Ingham (2011) and Wainwright and Bergin (2010), suggesting that professionals and other staff find team formulations useful. Staff views on formulation are important to investigate as they are the primary group using and engaging with team formulations. Although quantitative studies have found potentially positive impacts of team formulation, what the research field is currently lacking is context around 'why' team formulations are seemingly having this positive impact.

Aims and Objectives

This review aims to analyse UK-based qualitative studies on staff experiences of participating in team formulations using Thomas and Harden's (2008) method of Thematic Synthesis. The review also aims to provide a thorough quality appraisal of the research which meet inclusion criteria.

The review focused on the following questions: What are mental health staff experiences of participating in service user focused team formulations? What benefits do mental health staff perceive from participating in service user focused team formulations? What is the current quality of qualitative research examining mental health staff experiences of participating in service user focused team formulations?

Methods

Systematic search and eligibility criteria

Identification

Nine electronic bibliographic databases covering pertinent topic areas were searched on 12th November 2019: AMED, British Library ETHOS, CINAHL, Director of Open Access Journals, MEDLINE, PsychINFO, PsychARTICLES, Scopus and Social Sciences Citation Index. Reference lists of accepted articles were also screened.

Search terms were developed by searching currently published articles and assimilating keywords. Search terms were tested and refined through scoping searches within the selected databases. The search was also limited to studies that took place in the UK. The search strategy was as follows: (psychological formul* OR case conceptuali* OR case formulat* OR formulat*) AND (staff or nurs* or healthcare professional or psychiatrist or psychologist) AND (mental health or psychiatric setting). A separate hand search was conducted through the online back catalogues of the British Psychological Society's DCP Clinical Psychology Forum publication. The Clinical Psychology Forum was included as it serves as the main professional forum for issues of relevance to clinical psychologists.

Inclusion criteria required the articles to be primary research with a qualitative component gathering data on clinician views and experiences regarding the process of team psychological formulations. Within studies that focused more on case conceptualisation, the main focus of the discussions of the group had to be focused on specific clients and not the formulation of the team. Dissertations, doctoral theses, and non-peer reviewed reports, found through the search strategy, were also included to reduce potential for publication bias. Studies which focused on collecting psychologists'

views and opinions were included as it was felt they would provide a unique insight into the processes of team formulation.

Screening

Figure 1 summarises the screening process in a PRISMA Flow Diagram. A total of 2,729 titles were screened and considered against the eligibility criteria described above. Following title screening, 89 papers were screened by their abstract and 31 articles were selected for full text screening. A further 35 articles were identified for screening from the Clinical Psychology Forum hand search and of these 22 articles were retained for a full text screening. In total 53 articles were screened at the full text stage (31 from the title screening and 22 from the Clinical Psychology Forum hand search).

Eligibility

The full text of 53 articles were sought for review, of these 13 were excluded due to not being empirical papers. A further five were excluded as they did not contain a formal qualitative analytic component. A final 19 studies were excluded due to their focus being on either individual formulations, reflective groups or not encompassing staff views into their study.

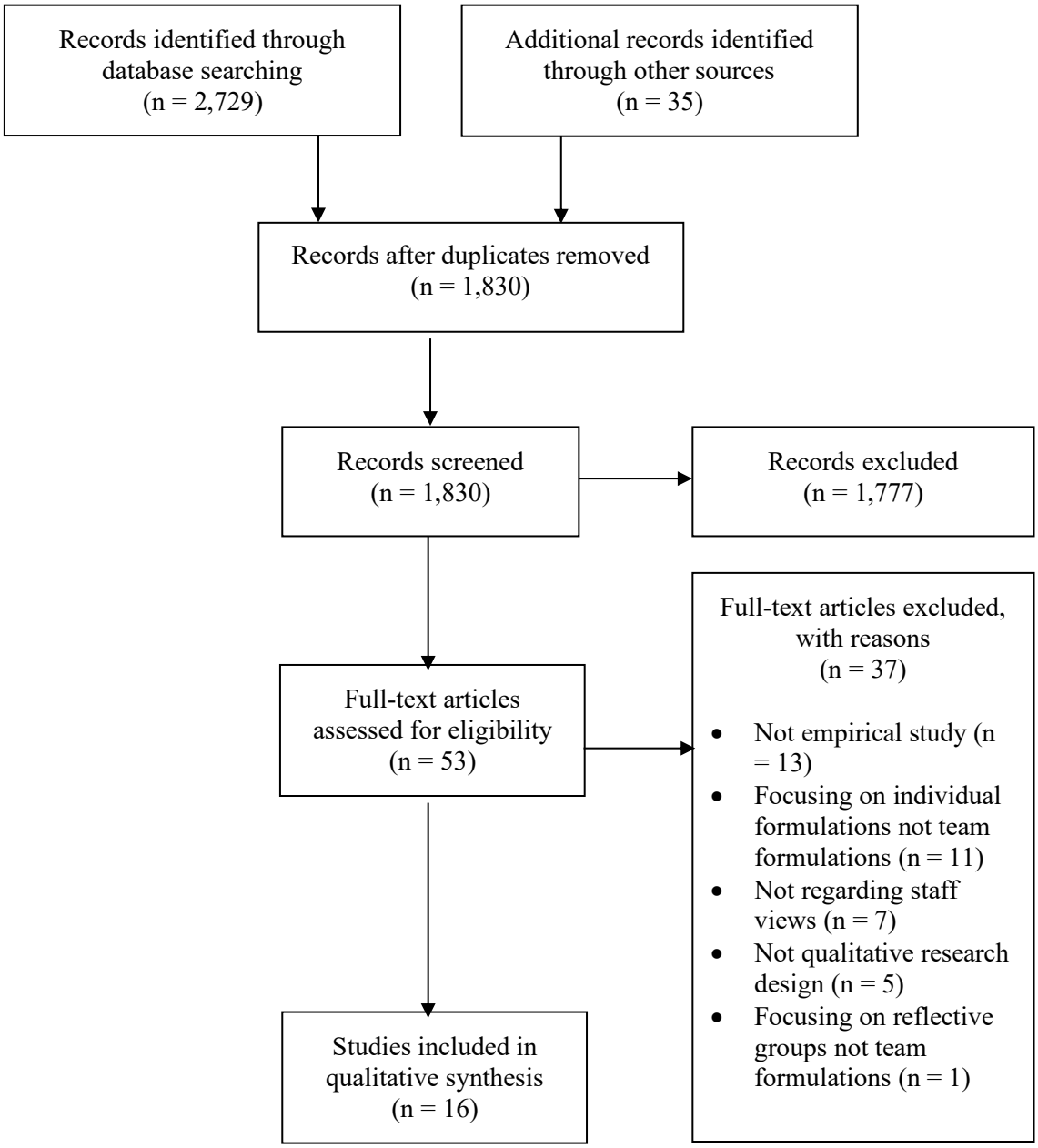

Figure 1. PRISMA Flow Diagram

Data quality assessment

The Critical Appraisal Skills Programme (CASP) checklist for qualitative research was employed (CASP, 2017). The CASP checklist covers three broad issues, across 10 questions, for appraising qualitative research; are the results of the study valid, what are the results, and will the results help locally. The CASP checklist was used as a framework to not discredit studies that, although may have scored lowly on

some items, make a valuable contribution to the field (Sandelowski & Barroso, 2002). Each item on the CASP scale was rated as either 'yes', 'partial', 'no' or 'unclear', and was graphically represented using an adapted Cochrane traffic light scheme (Voss & Rehfuess, 2012). Two of the 16 articles were double rated by a second investigator to ensure accuracy of appraisal. Uncertainties were resolved during discussion and a third investigator was available if necessary. All studies were retained for synthesis, no matter their rating, due to the inherent difficulties in accurately assessing qualitative studies (Dixon-Woods, Shaw, Agarwal, & Smith, 2004), particularly when considering publication pressures and structures (Walsh & Downe, 2006). The quality of the studies will be considered in the analysis.

Procedure of Thematic Synthesis

Thomas and Harden's (2008) Thematic Synthesis method was used to combine the findings. A Thematic Synthesis approach is deemed appropriate when bringing together a large set of qualitative studies (Tong, Flemming, McInnes, Oliver, & Craig, 2012; van Leeuwen et al., 2019). The identification of important and recurring themes between studies is the main aim of Thematic Synthesis, whilst not negating the importance of subjectivity in the nature of participants experience (Barnett-Page & Thomas, 2009; Centre for Reviews and Dissemination, 2008).

Data was extracted from the studies through transfer of the results sections of the papers into QSR's NVivo v12 software (2018). The results sections were then reviewed and data that was not explicitly related to staff views was excluded.

The Thematic Synthesis took a three-step approach. Initially, each line was coded individually according to its context and meaning. These codes were then grouped together to form higher order codes and developed into descriptive themes through looking at similarities and differences between the codes. These themes were

named taking into consideration the meaning of the groups of codes. Finally, an inductive thematic analysis was carried out to create analytic themes using the descriptive themes to answer the review question. To ensure context and rigour was maintained throughout the synthesis, detailed records were maintained through the use of NVivo software. These detailed electronic records enabled researchers to clearly see the process by which themes were developed and how the themes were represented across the papers (Soilemezi & Linceviciute, 2018; Thomas & Harden, 2008). To ensure clarity, the steps described above were closely followed and the focus remained on the review questions and context of the research (Soilemezi & Linceviciute, 2018).

Results

Quality Appraisal

From the quality appraisal nine of the studies were rated highly, four rated moderately and three rated poorly. Table 1 outlines the study authors, title, data analysis approach and quality appraisal. In total across the studies approximately 178 staff participants were included, whilst a further 89 responses were taken from reports on formulation meetings (Walton, 2011). This number is an approximate as Beardmore (2016) did not include the total number of their participants. The professions included in these studies were: mental health nurses, psychologists, occupational therapists, recovery workers, support workers, social workers, team leaders, specialist registrars, residential staff members and an activities co-ordinator.

Table 1. Summary of quality appraisal for studies

Author(s)	Title	Analysis	Quality Appraisal
Beardmore (2016)	Psychological formulation in a community learning disability team	Thematic Analysis	Aims of the qualitative section of the research unclear and unclear as to whether a qualitative approach is appropriate. Clear design and clear what data were collected and how. Ethical issues not considered and no evidence of researcher reflexivity.
Bensa & Aitchson (2016)	An evaluation of inpatient staff perceptions of psychological formulation meetings	Thematic Analysis	Aims of the study unclear but clearly laid out design. Little discussion regarding recruitment of participants or questionnaire distribution. Detailed description of data analysis approach. Ethical issues not considered but research reflexivity evident.
Blee (2015)	Community mental health team members' perceptions of team formulation in practice	Thematic Analysis	High-quality design, method and analysis. Findings of high relevance. Ethical issues considered and high degree of reflexivity displayed by researcher regarding their view stance and potential impacts.
Christofides et al. (2012)	‘Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working	Thematic Analysis	High-quality design, method and analysis. Findings of high relevance. Ethical issues not considered in detail. High degree of reflexivity displayed by researcher regarding their view stance and potential impacts.

Eyres & McKay (2011)	Qualitative evaluation of a case consultation group within a multidisciplinary home treatment team	Thematic Analysis	High-quality design and methodology. Limited description re. data analysis, limited discussion of findings and the clinical application of the research not clear. Clear researcher reflexivity but limited consideration of other ethical issues.
Harris-Waller & Jacyna (2014)	Using a solution-focused model for case discussion with non-psychology colleagues	Content Analysis	High-quality design, method and analysis. Findings of high relevance Ethical issues not considered and no evidence of researcher reflexivity.
Harrison et al. (2018)	Team psychological formulations in assertive outreach teams: Evaluating staff experiences.	Thematic Analysis	High-quality design and method. Data analysis approach not described in detail. Findings of high relevance but not discussed in detail. Ethical issues considered and high degree of reflexivity displayed by researcher regarding their view stance and potential impacts.
Kellet et al. (2014)	Team consultancy using cognitive analytic therapy: a controlled study in assertive outreach.	Content Analysis	Clear description of data analysis approach, findings and valuability of the research. Aims of the study, aspects of study design and recruitment are unclear. Ethical issues considered briefly but not in detail and a lack of researcher reflexivity.

King (2016)	Psychological formulation in residential teams working with people with dementia: an exploration of multidisciplinary views using Q-methodology	Q-methodology	High-quality design, method and analysis. Findings of high relevance. Ethical issues considered and high degree of reflexivity displayed by researcher regarding their view stance and potential impacts.
Lewis-Morton et al. (2017)	Co-producing formulation within a secure setting: A co-authorship with a service user and the clinical team	Thematic Analysis	Good quality method and design, however some elements unclear (such as recruitment). Some consideration of ethical issues but lacking researcher reflexivity
Manuel (2016)	A grounded theory study of multidisciplinary staff views on participating in team formulation	Grounded Theory	High-quality design, method and analysis. Findings of high relevance. Ethical issues considered and high degree of reflexivity displayed by researcher regarding their view stance and potential impacts.
Stratton & Tan (2019)	Cognitive analytic team formulation: learning and challenges for multidisciplinary inpatient staff	Thematic Analysis	High-quality design, method and analysis. Findings of high relevance. Consideration of ethical issues clear but lacking detailed discussion. No evidence of researcher reflexivity consideration

Turner et al. (2018)	Team formulation in an assessment and treatment unit for individuals with learning disabilities: An evaluation through staff views.	Thematic Analysis	High quality design and method. Difficult to gauge whether data analysis was rigorous as it was unclear what data analysis had been carried out. Ethical issues considered but no evidence of researcher reflexivity.
Walton (2011)	Complex case consultation forums: A thematic analysis	Thematic Analysis	High quality design and method but data analysis only named and no detail regarding how it was employed. Ethical issues not considered and no evidence of researcher reflexivity.
Weedon (2017)	Multidisciplinary team members' experiences of team formulation: A thematic analysis	Thematic Analysis	High-quality design, method and analysis. Findings of high relevance. Ethical issues considered and small mention of researcher reflexivity but lacking detail.
Wood (2016)	Clinical psychologists' experiences of moving towards using team formulation in multidisciplinary settings	Thematic Analysis	High-quality design, method and analysis. Findings of high relevance. Ethical issues considered but lacking researcher reflexivity.

The criteria most frequently not met was evidence of consideration of the relationship between the researcher and the participants. At times it was unclear who conducted the data collection or the researcher's epistemological stance was referenced but without clarity as to how this may have affected the findings. Within three studies it was clear that the researchers were actively known to the participants and the impact of this was not considered. The absence of researcher reflexivity feels particularly important in research of this kind as the collection of staff views has the potential to be selective in terms of how open and honest participants feel they can be. Studies were typically good at communicating the value and contribution of their research to clinical practice and the research field.

Three of the four studies taken from the British Psychological Society's DCP Clinical Psychology Forum were rated poorly. However, this publication also has the lowest word count limits potentially meaning relevant quality indicators could not be sufficiently described within this limit.

The quality of all papers was considered during the development of themes in the Thematic Synthesis.

Thematic Synthesis

Seven analytical themes were identified in the data: understanding the framework of team formulations, opening up communication, changing ways of thinking, service user as central, validating the sense of professional self, improvements to practice and perceived barriers to team formulation. See Table 2 for outline of all the themes and how they developed from the data. Ten papers contributed to all seven themes; Table 3 provides the details for which papers contributed to each individual theme.

Table 2. Theme Development

Analytical Theme	Descriptive Theme	Higher Order codes
Understanding the framework of team formulation	Definitions of team Formulation	A space for reflection About the person Undefinable Unique Safe environment A discussion
	Framework of formulations	Initiation of team formulation Need for structure Creative and flexible
Opening up communication	Collaboration	Diversity of the group Idea collecting Working as a collective
	Communication	Open communication Presence of conflict
	Improving team functioning	Improving empathy towards each other Improving team working Increasing team belonging
Changing ways of thinking	Attributes of the facilitator	Facilitator as fundamental Facilitators ability to manage Facilitators characteristics Facilitators relationship to the team Psychologists as experts Psychologists as non-experts
	Challenging thinking	Broadening perspectives Challenging the medical model Questioning personal beliefs
	Medical model	Diagnosis as helpful Dominance of the medical model Medical model as containing
	Psychological awareness	Becoming more psychologically aware Formulation becoming more informal

Service user as central	Importance of client information	Challenging therapeutic relationships Putting the service user at the centre Service users understanding of oneself Understanding complexity of the individual
Validating the sense of professional self	Emotional experiences	Evoking negative emotions Risk as all consuming Staff felt responsibility
	Equality	Facilitators promotion of equality Respectful of views
	Staff validation	Feeling listened to Feeling of professional validation Feeling valued
	Valued about team formulation	A sense of sharing Evoking positive emotions Positive effects Positivity of team formulation Protected time Removal of hierarchy Team formulation as a way of managing distress Team formulation as important Team formulation as sense making
Improvements to practice	Team formulation outcomes	Highlighting knowledge gaps Importance of tangible action Improvements in practice Promoting critical thinking
Perceived barriers to team formulation	Challenges to team formulation	Changing of roles Impact of formalities Narrow Perspectives Rigidity in working Formulations as insufficient Transient impacts
	Practical constraints	Not enough time Obligation to attend Too many commitments
	Team formulation criticisms	Lack of meaning to service user Lack of team engagement No standardised outcomes Lacking structure

Table 3. Theme contribution across studies

Study	Theme						
	Understanding the framework of team formulations	Opening up communication	Changing ways of thinking	Service user as central	Validating the sense of professional self	Improvements to practice	Perceived barriers to team formulation
Beardmore (2016)	✓	✓	✓	✓	✓	✓	X
Bensa & Aitchson (2016)	X	✓	✓	✓	X	X	✓
Blee (2015)	✓	✓	✓	✓	✓	✓	✓
Christofides et al. (2012)	✓	✓	✓	✓	✓	✓	✓
Eyres & McKay (2011)	✓	✓	✓	✓	✓	✓	✓
Harris-Waller & Jacyna (2011)	✓	✓	✓	✓	✓	X	X
Harrison et al. (2018)	✓	✓	✓	✓	✓	✓	✓
Kellet et al. (2014)	✓	✓	✓	✓	✓	✓	✓
King (2016)	✓	✓	✓	✓	✓	✓	✓
Lewis-Morton et al. (2017)	✓	✓	✓	✓	✓	✓	X
Manuel (2016)	✓	✓	✓	✓	✓	✓	✓
Stratton & Tan (2019)	✓	X	✓	✓	✓	✓	✓

Turner et al. (2018)	✓	✓	✓	✓	✓	✓	✓
Walton (2011)	X	✓	✓	✓	✓	✓	✓
Weedon (2017)	✓	✓	✓	✓	✓	✓	✓
Wood (2016)	✓	✓	✓	✓	✓	✓	✓

Understanding the framework of team formulations

Staff members defined and described the framework of team formulations in multiple different ways and seemed to struggle to find a common understanding, however most participants seemed clear that a team formulation was different to other meetings. Many participants cited having a space in which to reflect on cases as a main function of a team formulation, whilst others felt the purpose of team formulation was to promote an environment of safety in which "staff felt safe to float ideas" (Manuel, 2016, p. 77).

Many participants described the formulations as a "space to think" (Christofides, Johnstone, & Musa, 2012, p. 429) or an "informal discussion" (Manuel, 2016, p. 82). However, some participants were left struggling to define exactly how a team formulation was different from other meetings, defining a team formulation as an "experience" (Manuel, 2016, p. 91) and as being "distinctly separate from other multi-professional meetings" (Manuel, 2016, p. 86). Participants communicated about an environment in which formulations are viewed as enabling a "sense of safety" (Weedon, 2017, p. 172). Within Kellet, Wilbram, Davis and Hardy's (2014) study many of the staff felt that it had "provided a time to reflect on practice and so helped the team to share experiences" (p. 694).

Opening up communication

Staff highlighted the importance of a whole team presence in contributing and generating ideas within formulation meetings. The diversity of the group appeared to be a significant factor in the success of a team formulation and the widening of the discussion. The theme of diversity and perspective sharing was widely present across the included papers, being in a total of eight of the studies. The sense of working as a collective also appeared to improve team communication and team working in general.

There was a sense across the research that participation in team formulations seemed to increase professionals' empathy towards each other, as well as increasing their sense of belonging.

One member of staff highlighted the usefulness of having a wide variety of professionals "who actually know the person" citing that this results in "good discussions when you feel like everyone is contributing" (Harrison, Sellers, & Blakeman, 2018, p. 78). Another staff member commented on how the groups have widened their understanding of other professions: "helped me to realise that each profession brings their own expertise to the table" (Beardmore, 2016, p. 31). Several other professionals also commented on how team formulations had led them to understand the importance of learning from others, staff likening it to seeing "different angles", "different strands" of service users (Weedon, 2017, p. 169) and the "widening instead of sort of narrowing in your discipline" (Weedon, 2017, p. 169).

Participants cited having a developed understanding of "what's going off with each other" (Kellet et al., 2014, p. 695) and being able to share the emotional impact of the work as important outcomes. Staff generally felt that there was an improvement in team cohesion reducing a sense of isolation. One member of staff felt that it had helped to humanise other professionals in the team more: "we look at each other more I think, whereas before people just had their caseload and someone was just a name on the list" (Kellet et al., 2014, p. 695).

Changing ways of thinking

As a result of team formulations, professionals often cited a change in their usual way of thinking about service users. Staff views were that they had a broader understanding of clients and their difficulties as a result of team formulations. Team formulations also appeared to increase psychological awareness amongst staff with individuals actively

advocating for more psychologically informed approaches. Within three of the included papers, psychological formulations were highlighted as being a direct challenge to the typical medical model of some mental health teams. Staff also attributed success of the team formulation to the role of the facilitator, believing that they should be a psychologist due to the ability to ask the right questions, be non-judgemental, be skilled in problem solving, and creating the right environment for discussion.

Some members of staff attributed a shift in their thinking to an "understanding of the service user better" (Blee, 2015, p. 104) or having a broader understanding of the clients' difficulties (Christofides et al., 2012). At times professionals described an increase in their psychological awareness, with one member of staff describing it as "like everyone's a psychologist in the team now" (Eyres & McKay, 2011, p. 28). One member of staff in particular highlighted the difference between formulations and the "very definite" medical model as potentially being the "fly in the ointment" of the use of team formulations (Manuel, 2016, p. 88).

At times the staff members' views on the role of the facilitator were divergent with some believing the facilitator to be there to "teach clear-cut strategies" (Eyres & McKay, 2011, p. 28) whilst others believed the facilitator should have a more indirect role. Despite the difference in opinion of directedness, most members of staff felt that the facilitator had to be skilful and explicitly trained to hold the meetings. A large number of staff also felt that the facilitator needed to be a psychologist: "makes me feel more comfortable knowing that a psychologist is in charge of it" (Manuel, 2016, p. 74).

Service user as central

Team formulations were seen as a way of providing focused attention on individual service users and staff commented that it enabled them to retain focus on what is best for the client. Staff highlighted this as being particularly unique to team formulations as

they often lacked the space to dedicate isolated time to an individual service user. Developing an understanding of the complexity of an individual and providing consideration of an individual's past history were deemed important within a team formulation meeting. Five of the studies focused on staff preferences for discussing challenging service users in team formulations whom they struggled to form strong therapeutic relationships with.

Staff commented that "gaining a greater understanding of a client's background" (Bensa & Aitchson, 2016, p. 36) often helped to consider possible past traumatic events or childhood events rather than overlooking them in favour of information supporting the diagnosis (Manuel, 2016). One staff member commented on the importance of "remembering as well where they come from, what are their triggers erm how much they have suffered" (Stratton & Tan, 2019, p. 91).

One professional believed that through developing a deeper understanding of a service user they could establish a stronger relationship: "one step deeper, which is what's needed to be able to get to know people a little bit better and develop that relationship with them." (Weedon, 2017, p. 166). Discussions appeared to often centre on helping the staff member feel less "stuck" (Blee, 2015, p.102) and developing ways in which to connect to the service user.

Validating the sense of professional self

Team formulations appeared to help validate staff professionalism, in addition to aiding staff to feel listened to. Staff referenced feeling equal to other professionals in the team within team formulations, regardless of their specific role. Across nine of the studies participants expressed positive feelings of being professionally validated during the team formulation meetings and staff empowerment was recorded by participants across four of the studies. Despite the feelings of being validated and heard, in 12 of the

studies negative emotions were frequently referred to by staff in association with team formulations, particularly when related to risk or risk management.

Some of the participants believed that previous unsuccessful attempts at working with service users had led to professionals feeling "disenfranchised" resulting in the need for staff to be "empowered" to take part in the revised interventions (King, 2016, p. 76). One participant stated: "it's given people more confidence that what they're doing is right" (Manuel, 2016, p. 98). The importance of feeling equal in the meetings despite their role in the team also came across: "the equalness of everybody in that's in the situation regardless of your role or whatever. You go in there as equals, that sense of equalness" (Manuel, 2016, p. 79). However, for some participants, this was a negative experience of team formulations and led to them feeling "frustrated" when individuals were voicing opinions as if in a "talk shop" without the aim to make direct changes to a service users care (Weedon, 2017, p. 171).

Individuals across the papers referenced feeling that the process was "intensive" (Wood, 2016, p. 24) and "frustrating" (Eyres & Mckay, 2011, 28). Some staff believed that other professionals lacked the confidence to openly voice their opinions during team formulations: "I think a lot of people probably hold back and that could possibly…. lessen the effectiveness I suppose" (Stratton & Tan, 2019, p. 91). However, some staff felt that formulations had been positive in stopping staff feeling "governed by the seriousness and nature of the risks and behaviours" (Lewis-Morton, Harding, Lloyd, Macleod, Burton, & James, 2017, p. 233).

Improvements to practice

The importance of team formulations generating tangible outcomes was referenced across 13 of the studies. Some of the perceived outcomes from team formulations were care plans, improvements in clinical practice and a written formulation report.

In one study team formulations were intrinsically linked to the production of individual service user care plans. Within Blee (2015), all 12 participant transcripts reported care plans to be integral to a team formulation by providing a clear direction for the therapeutic work and aiding staff to feel less stuck. In other studies team formulation was utilised as a method to "provide more accurate care plans" (Beardmore, 2016, p. 31) or "collectively decid[ing] a way forward" (Eyres & McKay, 2011, p. 27). Team formulations appeared to be viewed more positively when associated with clear cut goals and outcomes: "it has made visits more purposeful as I am achieving quite a few objectives" (Kellet et al., 2014, p. 694).

Staff also generally spoke about team formulations improving their clinical practice overall. For example, one participant explains "it has influenced my practice, not only for my clients but for the other clients in the team that I didn't even know about" (Kellet et al., 2014, p. 695). Some participants believed that participating in team formulations had developed their compassion towards others or created a 'consistent approach' (Turner, Cleaves, & Green, 2018). Professionals believed that some of this change in practice came from adopting a more critical stance to their work: "when she asks you something about your work so far you are thinking, 'well am I missing something? Is this very subjective? How objective am I being here?' And that all helps" (Manuel, 2016, p. 75).

Perceived barriers to team formulations

Throughout this review staff highlighted several barriers to the utilisation of team formulations. Across six of the studies time was referenced as a significant barrier to professionals attending team formulation meetings. Other potential barriers to team formulations appeared to be more related to staff personal views and opinions.

Staff members discussed how it was difficult to ensure "protect[ed] time" (Bensa & Aitchson, 2016, p. 36) which resulted in the "timing of meetings" (Turner et al., 2018, p. 280) being unhelpful and staff feeling that there was "too much to discuss" (Turner et al., 2018, p. 281). Some staff cited the barrier to ensuring there was protected time for meetings as being trying to "negotiate" (Wood, 2016, p. 24) a time when the whole team was available with many seeing it as a major "drawback" (Harrison et al., 2018, p. 79). Other staff felt that the competing demands of working in mental health services left them with little time or space to participate in team formulations: "some of the people that really need to go to case formulation… who are working with the women face to face don't often get the opportunity" (Stratton & Tan, 2019, p. 91).

Many staff cited team formulations as potentially "vague" or "wishy-washy" (Christofides et al., 2012, p. 430) leaving staff feeling that the meetings were pointless or lacked action-orientated outcomes. Staff felt that teams were at times "set in their ways" (Christofides et al., 2012, p. 431) or that certain staff held quite "fixed beliefs" (Wood, 2016, p. 28). The fixed viewpoint of some members of staff left others unwilling to contribute for fears that they were the minority viewpoint.

Discussion

The review found that nine of the studies rated highly, four rated moderately, and three rated poorly on quality appraisal. The three papers that were considered to be poor in quality (Bensa & Aitchson, 2016; Eyres & McKay, 2011; Walton, 2011), were still included in the development of themes but only when corroborated with other studies as they still make a valuable contribution to the field (Sandelowski & Barroso, 2002). The criteria that was least frequently met was the inclusion of researcher reflexivity. Reflexivity was particularly important in the current review due to the presence of inherent 'power' dynamics and hierarchy in community mental health teams requiring

the researcher to reflect on how they may be contributing or affecting these dynamics (Currie, Lockett, Finn, Martin, & Waring, 2012; Singh, 2000).

The variety of types of papers that have been included in the current review should also be considered. Nine of the included studies were taken from grey literature and five of these were doctoral theses. Although themes were balanced across all of the included papers the length of the doctoral theses in comparison to a generic published study may have resulted in certain themes containing a larger collection of data than other themes. The other four studies were taken from DCP publications and were therefore shorter in length than other publications. Grey literature is an important contribution to systematic reviews and helps to provide balanced viewpoints without publication bias (Paez, 2017). However, the reasons why the vast majority of the studies included in the current review are located within grey literature should be considered. Six of the seven published papers were evaluations of service developments related to team formulations whereas the five doctoral theses related to the collection of general staff views and opinions. It may be that grey literature reflects the gap between science and practice that has previously been highlighted in clinical psychology (Grol & Grimshaw, 2003), meaning the more directly practical service evaluation findings have been published as opposed to the generalisable overall picture of staff viewpoints.

The present review demonstrated how participating in formulations could potentially aid staff to humanise, develop their compassion towards service users and place the service user at the centre. Previous research, such as that by Murphy et al. (2013), has also found that formulation helps individuals to see service users as ‘people’ and less as ‘patients’. The idea of seeing an individual as a whole and as a person rather than just their difficulties has its roots in person-centred care (Naldemirci et al., 2018). Research has begun to highlight the importance of and the positive impact that this can

have to individuals with mental health difficulties (Lindström, Sturesson, & Carlborg, 2019; Staniszewska et al., 2019). Changes seen in participants' thinking is also reflective of the DCP's assertion that team formulations are an effective way of achieving cultural change and promoting psychosocial perspectives (DCP, 2011; Kennedy, Smalley, & Harris, 2003; Onyett, 2007). Team formulations should be utilised as a method of achieving cultural change and promoting person-centred care.

In addition to the positive impacts on service users, the review found that staff felt listened to and that formulation provided a time for reflection and being heard, findings echoed in previous studies (Undakat, Irving Quinn, Jones, & Casares, 2015). A previous review completed by Geach et al. (2018) highlighted the need for further research into the positives of team formulation as only weak evidence existed for the perceived benefits of team formulations. The current review adds additional insight into the potential beneficial effects team formulation may have on staff and adds additional richness to previous quantitative findings that have found team formulation to increase staff perceptions of formulations as a useful practice (Geach et al., 2018; Whitton et al., 2016). Qualitative studies, such as McMullan, Gupta and Collins (2019), have also found that providing staff with protected time and space in which to reflect help to reduce feelings of burnout and helplessness. Additional research has also found that teaching and widening staff repertoires of intervention and working techniques has also helped to reduce staff burnout, (Ewers, Bradshaw, McGovern, & Ewers, 2002; Posner, Janssen, & Roddam, 2017) findings that are corroborated by the current study. Ensuring staff have a protected time and space in which to reflect is pertinent for future practice.

Perceived barriers to team formulation, especially time, were also highlighted within the present review. Considering the current pressurised context of the NHS and the culture of expecting more with fewer resources (Alderwick et al., 2015), it is

important that team formulations are as efficient and impactful as possible. Mental health nurses have cited large workloads, as a result of excessive administrative duties, as a principle concern in the perception of their roles (Dallender & Nolan, 2002). Within this review staff cited the difficulties of team formulation as being negotiating the time together and competing demands. In future practice these difficulties should be considered and more creative solutions, such as remote technology assisted meetings, need to be employed.

Limitations

Although the quality appraisal was considered in a clear and thorough way, some researcher influence still remains. The researcher considered their standpoint and enlisted another appraiser to appraise two of the include pieces of research to ensure a continuity of practice and allow for a space of reflection on the appraisal process.

Through the exclusion of papers outside of the UK important data related to staff experiences of team formulations may have been missed. The rationale of excluding studies outside of the UK was rooted in the notion that within the UK there were frameworks and a certain consistency put in place by professional bodies towards what was deemed to be a team formulation. However, it may be that studies from outside of the UK utilise a similar formulation framework and has therefore resulted in important data not being considered in the current review.

In addition, including data from psychologist participants is also a limitation to the current study. Although the aim of including psychologists was to allow more of an insight into the process and limitations of formulation, there are obvious limitations. In comparison to other members of the mental health team, psychologists may provide an alternative viewpoint of team formulations, usually from the role of facilitator rather

than participator. The inclusion of data from the facilitator's perspective means that some themes may not have been representative of those participating in the formulation.

Furthermore, a Thematic Synthesis can be influenced by the reviewer and their own opinions and this is something that should be considered (Noyes et al., 2018). Thematic Synthesis allows the participants experiences to be at the forefront of the research, however the reviewer's own experiences and opinions may have influenced what themes were found or discussed. The structured process of Thomas and Harden's (2008) Thematic Synthesis approach allowed the reviewer to refer back to a framework and enabled multiple reiterations of coding to take place to give the researcher time to reflect on any potential impact they may have had. The addition of a reflective log would have also been beneficial to allow for a subjective space within which the reviewer may have reflected on the process.

Conclusions and Implications

The current review highlights the importance of team formulation in general practice for both enhancing staff understanding of service users and improving professional confidence and validation. The review also highlights the barriers to team formulation, namely time and staff juggling multiple commitments. The included research placed a lack of emphasis on the researcher's role in the collection of data resulting in the potential to overlook the more negative facets of team formulations and this should be taken into account when considering the results of this review. Future research should consider the researcher's impact on the data collected and ensure that staff feel they can be as open and honest as they need to be. Although not the focus of this review, it should be acknowledged that other perspectives, namely those of service users, are missing and should be considered when contextualising the findings.

All of the research included in the current review took place within the UK, so future reviews may benefit from examining those studies that took place outside of the UK and consider different methods and forms of team formulations. Half of the research included in this review was taken from grey literature, which is an interesting point to note, and researchers should consider why more published data does not relate to experiences of team formulations.

Implications for practice

This review demonstrates that staff place a strong importance on the process of team formulations and the impact on their clinical work and their professional values. Mental health teams should ensure that staff participating in team formulations feel that they are equally valued as well as feeling safe to contribute without being marginalised by more dominant members. It is clear that the benefit of team formulations is also felt on a personal level by staff, and these benefits are an important consideration for the wellbeing of the team.

Staff highlighted the barriers to engaging in team formulation, including the lack of time and juggling multiple commitments, whilst highlighting the need for team formulations to be a safe and protected space. Future practice should ensure that team formulations are prioritised and that staff members have a dedicated time to participate. Team formulations should either be scheduled for appropriate times to ensure that all staff, including those working on the front line, are included, or use more creative strategies utilising technology assisted meetings. Overall, the current review demonstrates the potential benefits of team formulation in mental health settings, highlighting the impact of an increased use of psychotherapeutically informed approaches and the role of the clinical psychologist in the modern NHS.

Future Research Recommendations

The current review focuses on staff members' views and opinions on team formulation; however, more research is needed to help define what a team formulation is and how it is often used. Once team formulations have been clearly defined and frameworked as a concept then the field would benefit from further research focusing on the effectiveness of these team formulation approaches in practice. An improvement in the evidence base of team formulations is important if it is a practice that is being frequently employed in clinically focused work.

The present thematic synthesis also highlights the need for future research into team formulations, and indeed formulations themselves, to be published in peer-reviewed journals rather than remaining in the grey literature. The publication of team formulation focused research in peer-reviewed journals would increase awareness of research into this field by increasing the accessibility of the research whilst also subjecting the research to more stringent reviewing procedures.

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Chapter Three: Bridging Chapter

Chapter Three

Bridging Chapter

The systematic review documented in the previous chapter completed a Thematic Synthesis of staff views and opinions on team formulations. The review concluded that staff views on team formulations are generally positive, with staff placing importance on the enhanced understanding of clients they work with. The review also found that staff communicated a felt sense of improvement in the confidence of their professional practice as well as a felt sense of professional validation. The review highlighted barriers to the usage of team formulations, such as a lack of time and having multiple commitments to juggle. An important highlighted limitation of this research was the absent consideration of the impact of the research on the qualitative data collected and subsequent analysis.

Currently there are methodological limitations to the field of research investigating staff views and opinions on formulation. One of which is that many studies on team formulations ask staff to reflect on specific examples of team formulation, or to evaluate pilot groups (Blee, 2015; Eyres & McKay, 2011; Harrison, Sellers & Blakeman, 2018; Harris-Waller & Jacyna, 2014; Kellet, Wilbram, Davis, & Hardy, 2014; Walton, 2011). Although completing structured qualitative data collection that is rooted in specific examples and researcher led is useful, it can also result in participants feeling stifled creatively and lead to conformity amongst participants to the researcher's position (Nyumba, Wilson, Derrick, & Mukherjee, 2017). Currently the majority of qualitative studies have utilised an individual interview method by which to collect data. Interview methods are useful to gain in-depth perspectives from individuals (Peters & Halcomb, 2015), and have evidently expanded the research field, but they do

not accurately represent the multidisciplinary setting that staff within mental health services generally conduct themselves in and which can contribute to shared understandings.

In addition to methodological limitations there is also a significant lack of the consideration of how power and hierarchy may affect staff and subsequently formulation. Throughout research into community mental health teams there is a clear theme of hierarchy and the role of influence, assigning some professionals more 'power' than others (Singh, 2000; Currie, Lockett, Finn, Martin, & Waring, 2012) with some members of staff being assigned an expert position (Smart & Auburn, 2018).

A limitation of studies which have a psychologist as the main researcher is the potential for this to impede participants' honesty, as well as participants feeling the need to conform to the influential views of the psychologist (Adams, 2015; Blee, 2015). The facilitator's current relationship to the team has been found to be an enabler but also a barrier to the implementation of team formulations (Geach, De Boos & Moghaddam, 2019). The role of power in relation to staff views and opinions on team formulations has not been significantly investigated and would benefit from focused research.

Given the potential methodological limitations of utilising interviews to collect data on team processes and the lack of consideration of the impact of the researcher, an empirical study was devised using focus groups that took place within a community mental health setting. Through the use of focus groups, it was hoped that the natural team dynamics, and potential power imbalances, that could occur in a multidisciplinary meeting would arise. There appears to be a gap in the literature in which the complex interprofessional context, in which formulation meetings are often held, have not been considered. The use of a critical discourse informed approach, whilst holding a social constructionist standpoint, was utilised with the intention that the researcher would be

able to critically analyse the role of power in the groups and how language may be used to perpetuate these group dynamics (Breeze, 2011). The role of context is also considered important in discourse analysis as, due to adopting a social constructionist epistemological stance, ‘truth’ is believed to be created through discourses used and participant interaction.

Chapter Four: Empirical Paper

Prepared for submission to Psychology and Psychotherapy: Theory, Research and Practice

(Author guidelines included in Appendix B)

Staff Views on Formulation in Community Mental Health Services: A Discursive Analysis

R. Bealey[1], G. Bowden[1], P. Fisher[1]

[1]*School of Medicine, University of East Anglia, Norwich, Norfolk*

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Staff Views on Formulation in Community Mental Health Services: A Discursive Analysis

Background: Team formulations are the process by which we can construct an understanding of an individual's difficulties and strengths within a team of professionals. Formulation is a key component of a psychologist's job role, and team formulations can have many benefits for staff and service users. **Aim:** To identify topics in discourse on the use of psychological formulations in multi professional team meetings. **Method:** Focus groups were completed with staff in three different multidisciplinary community mental health teams. Focus group discussions were then analysed using a critical discourse informed approach. **Results:** Discourse topics were identified relating to the importance of storytelling, the role of power and hierarchy, trauma and exclusion of the individual and staff struggles, burnout and constraints. **Conclusions:** Four overlapping major discourses were found in the research, with the study highlighting the positive impacts that formulation can have on staff but emphasising the role of power in mental health settings.

Keywords: team formulations; critical discourse analysis; community mental health services; staff viewpoints; focus groups; qualitative

Introduction

Team formulations can be seen as the process by which a group or team of professionals are facilitated to "construct a shared understanding of a service user's difficulties" (Johnstone, 2013, p. 216). Research has found team formulations can aid team cohesion and have positive implications for service users (Summers, 2006). Preliminary findings on staff views have found the impact of team formulations to be positive (Berry, Barrowclough, & Wearden, 2009; Murphy, Osborne, & Smith, 2013); a particular study by Berry et al. (2009) found a large reduction in the depersonalisation of service users and the presence of cynical attitudes in staff members. There is also the potential for team formulations to decrease the power imbalance often observed in mental health settings, particularly in regard to psychiatric knowledge (Terkelsen, 2009). Team

formulations could promote a ‘shared’ responsibility and decrease the level of power that professionals potentially have over their service users (Smart & Auburn, 2018).

Formulations and working psychologically with teams, is a fundamental role of the modern clinical psychologist (Division of Clinical Psychology; DCP, 2011; Health and Care Professions Council; HCPC, 2015). Yet clinical psychologists themselves have described their own use of formulation in a multidisciplinary team (MDT) setting as ‘chipping in’ and ‘informal’ (Christofides, Johnstone, & Musa, 2012), demonstrating that perhaps formulation and team formulation is not clearly defined within services. Reviews focused on team formulations have found it poorly defined and inconsistently utilised citing difficulties with busy services and psychologists need to “demonstrate the value of their profession” (Geach, Moghaddam, & De Boos, 2018).

There is a sparsity of research focused on staff experiences of formulation and the potential barriers and enablers to implementing formulations within mental health teams. A little research has been conducted in the forensic field specifically focusing on service users diagnosed with personality disorder (Brown & Völlm, 2013; Davies, Black, Bentley, & Nagi, 2013; Moore & Drennan, 2013; Whitton, Small, Lyon, Barker, & Akiboh, 2016). One of the main themes arising from this research was a lack of training, leaving staff doubting that they are adequately qualified to develop formulations (Brown & Völlm, 2013). It has also been suggested that individuals would not benefit from divulging historical events to aid formulations, especially those with multiple traumas, as there was nothing that could be done about the past events (Brown & Völlm, 2013). Although Brown and Völlm’s (2013) study is interesting, this research was conducted to explore views around a particular government strategy and therefore may be difficult to generalise.

Studies that have attempted to implement a team formulation approach have struggled with high attrition rates and doubts regarding the actual process itself, such as its effectiveness and whether the formulations were based on "excessive… speculative suggestions" (Summers, 2006). Research focused on the application of case formulation processes have found similar issues, and also struggled with individuals not feeling qualified to either facilitate or engage in the formulation. As highlighted by Davies et al. (2013) there is a need for research areas beyond 'how to' formulation and more of a focus on the barriers and the implementation of such a process. An important barrier to the prioritisation of a service user's story in mental health services is the staff themselves, though the reasons for this are unclear. Staff struggled to utilise or even reference formulations in a consistent manner. By uncovering identifying topics in discourses that staff hold surrounding formulations a clearer picture can be developed which could inform service developments in this area.

Aims of the Study

This study aimed to identify discourse topics on the everyday use of psychological formulations in staff meetings. The study employed a discursive analytical informed approach, so it was possible to examine the ways in which power and team dynamics are discursively constructed by members of the mental health teams.

Participants and Procedures

The participants were clinical staff working within adult community mental health teams (CMHTs). An important consideration was that members of staff should be currently working in a MDT setting (with some experience or knowledge of formulations), this was due to previous research suggesting that "drawing on collective wisdom" is important to team formulation (Geach et al., 2019) as well ensuring the

focus groups could reflect existing team dynamics. Members of staff not actively involved with an MDT were excluded along with those who did not interact with service users. The clinical team leaders and lead psychologists of CMHTs within the NHS were approached as gatekeepers to recruit staff members. Due to their professional associations with psychological formulations individuals acting as gatekeepers were not invited to contribute to the focus groups as their attendance may have inhibited negative discourses. In addition to this, utilising psychologist gatekeepers may have resulted in the focus groups containing more psychological members of staff than one would normally encounter in an MDT setting.

In total three semi-structured focus groups were completed in different CMHTs comprising of between three and 10 members of staff and lasting between 60-90 minutes. Traditionally discourse analysis can be carried out with just one (or more) group discussion(s), or indeed with any material where there is discourse. As social constructivism, and by virtue discourse analysis, believes that truth is socially and contextually dependent, there may be multiple truths present within one discussion. As a consequence, there is no optimum or recommended amount of data to be collected. However, comparable studies in similar areas of research have analysed a similar amount of data (Haugen, Envy, Borg, Ekeland, & Anderssen, 2016; Klevan, Karlsson, Ness, Grant, & Rudd, 2018). The focus groups were mainly comprised of community mental health nurses (CMHN), but other team members, including a carer's assessor, a peer support worker, occupational therapist, a support worker and a psychological therapist attended. These groups were audio recorded and subsequently transcribed by the researcher.

All participants provided written and verbal informed consent to take part in the study and were informed of their right to withdraw. Ethical approval was obtained from

the Faculty of Medicine and Health Sciences Research Ethics Committee (Reference: 201819 – 006) and the Health Research Authority and Health and Care Research Wales (Reference: 248351).

Analytical Technique

The study drew on a critical discourse approach (CDA), which has its roots in social constructivism. Social constructivism argues that attitudes, social groups and identities are socially constructed, so the changes that occur to us as social beings also change the nature of what is 'true'. Context is considered important in discourse analysis as it believes 'truth' is created through participant interaction. It was theorised that by ensuring that each focus group consisted of staff from the same MDTs, the natural team dynamics and potential power imbalances would enrich the data and contribute to its validity within a relevant context.

Within CDA it is important to acknowledge that many scholars do not refer to CDA as one homogenous entity but rather a collection of varying approaches or "schools" within this umbrella (Breeze, 2011). However, at the base of the ideology of CDA there is a focus on critically analysing the role of power in society and how language is used to perpetuate, contribute or illuminate these dynamics (Breeze, 2011). A framework for analysis was developed by drawing on the six-staged analysis outlined by van Dijk (2001), which was adapted for use in the current study and can be seen in Table 1.

Table 1. Adapted version of van Dijk's (2001) six stages of analysis as used in the current study

	Analytic Steps	Application
1	Analysis of semantic macrostructures: topics and macropropostions	Major discourses and what the discourse data is about in a global sense were summarised. This was completed by identifying topics and uniting these topics under topic headings.
2	Study of local meanings	Once topics are identified, the meaning of words used by participants are studied. Including the examination of the use of propositions and coherence.
3	The relevance of subtle 'formal' structures	Structures of speech that are less consciously controllable were examined. This may include for example: intonation, hesitations, repairs or turn taking.
4	Analysis of global and local discourse forms or formats	The focus groups were analysed for 'global' forms (or superstructures) which can be seen as the general arguments that individuals build up throughout the group. Local forms focus upon the relations between sequences, such as primacy and ordering.
5	Analysis of specific linguistic realisations	Linguistic realisation is the process in which a surface level understanding of language is derived from its underlying representation. In this section of the analysis, figures of speech were explored.
6	Analysis of wider context	Wider context was understood at two levels: **General Context**: The wider context of the service, trainings and professional bodies (such as the British Psychological Society) were considered **Context of the team:** Current and historical contexts of the teams in which the focus groups took place were also considered

Van Dijk (2001) argues CDA should be multidisciplinary in its approach and diverse in its amalgamation of approaches. As the purpose of this study was to focus on formulation which can be considered a social problem with a semiotic aspect, it was also considered appropriate to adopt elements of Chouliaraki and Fairclough's (1999) analytical framework for CDA. This analytical framework, modelled upon Bhaskar's

(1986) work, enabled the researchers to reflexively critique their own analysis and its impact upon the field of psychological formulation.

Specific Stages of Analysis

As can be seen in Table 1 the transcripts were initially summarised into topics, the global meanings of a text, allowing the researcher to gauge an idea of the key points of the transcripts. This process was completed by uploading the transcripts into QSR's NVivo v12 software (2018) and highlighting emerging key topics throughout the transcripts. These topics were then collected together into major topics, of similar meanings, and ultimately formed the major discourses discussed within the results section.

Stage two of the analysis consisted of examining individual quotes from these topics for the local meanings, for example examining the use of specific words or propositions.

Stage three of the analysis required the researcher to examine more subtle structures in the speech such as intonation, hesitations or turn taking. This was completed by repeatedly listening to the audio recordings of the transcript and highlighting key areas for further investigation.

Stage four was completed by examining how certain topics or arguments were built up throughout the transcripts, this was completed by examining the previously highlighted topics and considering their order and prominence within the transcripts.

Stage five consisted of examining linguistic realisations within the text, for example the use of hyperboles (i.e. forms of speech using exaggeration) or litotes (i.e. form of speech using understatement), and how these had been used throughout in relation to specific topics.

The sixth stage required the researcher to consider the topics as a whole and the context within which they took place. This stage required consideration of the context of the focus groups themselves but also the wider context such as certain institutions or social aims.

Finally, a reflexive critique of the research, taken from elements of Chouliaraki and Fairclough's (1999) analytical framework for CDA, was undertaken. Within this critique the effectiveness of the research and my own position as researcher was considered.

Results and Analysis

Researchers such as Buus (2005) and Traynor (2006) have levelled criticism at discourse analytical studies, believing them to be difficult to distinguish from thematic analysis due to the researchers not presenting the analysis thoroughly; therefore throughout this section key quotes will be analysed in detail, in line with stages two to five of the analysis. A key denoting the symbols used in transcription can be seen in Table 2.

Table 2. Key symbols used in transcription based on the Jefferson transcription system

Symbol	Meaning
(.)	A micro pause, notable, but of no significant length
(0.2)	Indicates a pause long enough to time and therefore show in transcription
[ ]	Denotes occurrence of overlapping speech
↑	Indicates a rise in speech intonation
(( ))	Description inside brackets refers to contextual information where no symbol

	of representation was available e.g. ((laughs))
::	Represent elongated speech, a stretched sound
°	Indicates quieter speech
underline	Underline words indicates a raise in volume or emphasis

Four major discourse topics were identified and will be analysed; the importance of storytelling, the role of power and hierarchy, trauma and exclusion of the individual and finally staff struggles, burnouts (and constraints).

"Nobody's ever spent that time listening to me" - The importance of storytelling discourse topic

Research has identified the highly meaningful nature and importance of service users being able to tell their story as part of their recovery journeys (Nurser, Rushworth, Shakespeare, & Williams, 2018), in which there has been a focus on individuals finding personal meaning in their life, beyond their mental health difficulties (Anthony, 1993). The importance of storytelling and of service users developing their own personal narrative was echoed throughout the current study's emerging discourses.

Throughout the groups there was a recurrent discourse related to the importance of a service user's "history" when developing a formulation. One CMHN explained: "Well whatever it is, the history's important because its shaped who they are at the minute and you need (.) to have that". Through the use of lexical cohesion i.e. "importance" later echoed with the word "need", the proposition that history is an important component of creating a formulation is strengthened. Another CMHN went

on to describe the goal of history taking is to "extract the headlines". The depersonalisation of the individual is interesting in the use of the word "headlines" and seemingly emphasises the background importance of the process in formulations.

When considering positive discourse analysis (Martin, 2004; Martin & Rose, 2003) many of the participants expressed an optimistic belief that giving service users the chance to tell their "narrative" was the main power of formulations. Staff focused on the worry that service users became "fragmented" and that formulation could help address that. An assistant psychologist (AP) in one group stated:

> "[]Well that well that I would I would argue that that's a problem with ↑diagnosis and not a problem with formulation (.)[yeah] because [] a formulation would (0.2) pro::vide a narrative for that individual to understand the problem and then you could look at how you could address that rather than (0.1) the limitations of a diagnosis [ ]"

Within this excerpt, the AP draws upon the discourse of storytelling to frame a positive belief regarding formulation. The upward inflection placed upon diagnosis adds extra emphasis and is perhaps used to stress the conflict between the process of diagnosis and formulation. The speaker's use of the past tense "would" could indicate a subjective attitude, highlighting that the importance of past associations with diagnosis were more relevant than the present discussion (Riddle, 1986). The significant pause before the AP says "limitations of a diagnosis" could potentially emphasise that this is a marginalised discourse and goes against the prevalent narratives within the team or perhaps society.

Earlier in the transcript a psychological therapist explains that they believe the importance of formulations to be giving someone the time to "hear" their story, "well nobody's ever spent that time listening to me". The therapist explains that for certain service users it is not the content of formulation that is deemed to be important but that service users seemed to be "overwhelmed by the principle of it". The idea of a service

user gaining benefit from the process of being able to tell their story is an important discourse not just for them but also for the professionals themselves. It appears that through hearing the profound effects that formulation may have on a service user, benefits the professionals themselves by giving them a sense of validation and reinforcing their compassion for those they work with.

"I think there's times especially with a formulation that they do need to be put to one side" – The role of power and hierarchy discourse topic

Throughout the literature the medical model approach to mental health has been critiqued for being; too ready to label distress as a "disorder" (Thyer, 2015), inadequately encompassing the complexities of mental health (Cuthbert & Insel, 2013) and for creating unnecessary diagnostic categories (Stein et al., 2010). Therefore, it is unsurprising that a discourse emerged in the focus groups on the applicability of the medical model and, more generally, the role of power and hierarchy in mental health.

An uneasiness that was peppered throughout all the groups was the role of the consultant psychiatrist and their impact on the contribution of formulation. Although a prominent discourse throughout, the groups never converged and built a single narrative regarding this. Participants insights into the power dynamics and hierarchy were usually one-off inputs that were not followed up, see quote from a CMHN below:

> "As to whether or not someone is suitable for o:ur service or not an::d that's made even worse when they go for a 45 minute appointment with a consultant and have a ↑diagnosis slapped on them a:nd especially when there's times when I've sat there and I've thought well I've met this person three times now and this is the first time you're meeting them and ↑I don't agree with your diagnosis but you kind of just (.) have to go with it"

The use of the onomatopoeic "slapped", alongside the rise in intonation on the word "diagnosis", emphasises the nurse's cynicism towards the process. The classification of

the professional as a "consultant" highlights the hierarchical nature of the service and the inferred power that goes with this title. Indeed, later on a student CMHN goes onto explain their belief that all formulations should "almost be traced back from a consultant level". The nurse explained the belief that they're unable to interfere in the consultant's decisions and "just (.) have to go with it". This statement highlights the perceived power and hierarchical disparity between the nursing staff and consultant level medical professionals, despite the nurse potentially having more experience with that person. In another focus group a CMHN more frankly puts it as "there's still hierarchy in the medical model [ ] approach I guess ((laughs)) is how I'm trying to say".

Alongside the insights into power and hierarchy, came a consideration of professional roles and how they may play out in formulation-based exercises. The role of the psychologist was considered in the focus groups. It was explained by one CMHN as:

> "I see (.) psychologists often (.) as (.) like I'm treading water and going like this ↑oh:::h you know and ↑splashing around …when there's chaos going everyone's treading water and splashing around and psychologists will dip their head under their water and float around and watch from underneath what's happening (.) … do you know what I mean just rather than being involved in that chaos"

The metaphorical description places psychologists as removed from the team who do not get "involved" in the "chaos" but rather provide input as an outsider. The emphasis on "splashing" and "chaos" of the team is particularly applicable when considering the subsequent discourses relating to staff burnout and constraints. Through describing the team "treading water" the speaker is, potentially, alluding to the idea that the team could ultimately drown in their responsibilities if not properly aided. Psychologists are later described as being "credible", "neutral" and "disciplined", although the speakers do note that the role of the psychologist has changed over time becoming more "part of the

team". The ways in which psychologists are referenced by the speakers is also noteworthy, although the discussed psychologists are often at consultant levels themselves, the title is rarely used in comparison to their consultant medical professionals.

"We are opening cans of worms" – Trauma and exclusion of the individual discourse topic

Research has shown that formulations can be distressing to individuals with levels ranging from irritation to tearfulness (Redhead, Johnstone, & Nightingale, 2015). Distress to the individuals receiving the formulations was a common discourse throughout the focus groups and often led to the conclusion that individuals should not be included in these meetings. The discourses discussed below can also be thought of in the context of power and hierarchy discourses as examined above.

During one focus group a carer's assessor described the process as "overwhelming" and also that it "kind of shocked me at how, not brutal, that's the wrong word, but like". The speaker is utilising the mitigating strategy of prefacing "brutal" with "not" to convey that they do believe the formulation meeting was "brutal" but fear the repercussions of the use of the word. The carers assessor goes onto explain:

> "yeah and in fact that's the word I would have used for the one (.) I'm (.) I've got in mind is accusing it did feel very much (.) and I think if somebody had said those things to me °I would have been devastated°(.) you know↑ well I don't think anyone takes criticism well"

In this excerpt the speaker uses several strong words with negative connotations such as "accusing", "devastated" and "criticism". Through the utilisation of judgemental negative words, the formulation meeting can be perceived as almost a trial of the individual, with the members of staff delivering verdict on the individual. Once again,

the apparent dispersion of power in a formulation is not equal and there is a clear elevation in power given to the members of staff. The use of such words also draws attention to the possible negative impacts that hearing service users' traumatic formulations may have on staff. As Campling (2015) discusses, 'contact with emotional distress and disturbance can be…harrowing', and it is clear that the experience of being present at formulation-meetings have had a severe impact on this member of staff.

Other members of staff described formulation meetings as "traumatic", "destabilising" and as making the individual's "mental health worse". One CMHN described the process as:

> "we are opening cans of worms (.) but we do it in a very carefully controlled (.) process but if you're sat-if you have a client sat in a massive team meeting where we're formulating about them we're just ripping all the lids off not necessarily putting them back on and this client poor client will be sat there sort of ((quivering noise)) not knowing what to"

The description of formulation being "about" the client promotes the idea of the meetings taking place exclusive of the individual. There is little attempt at inclusion of the client and the speaker appears flippant as to how the individual may react in this situation. The metaphorical use of "cans of worms" reinforces the lack of control the speaker feels towards the situation which is further re-emphasised by the use of the word "ripping". It could also be that this CMHN is deliberately distancing themselves from the situation through the use of flippancy, to protect themselves from the potentially distressing content.

Perhaps it is a lack of control and the fear of causing "trauma" to the individual that caused staff to focus on the discourse of individual exclusion. As one assistant practitioner described:

> "You know as much as you can try and involve them but I think there's times especially with a formulation that they do °do need to be put to one side and we do have that professionals discussion um around them° but obviously all that needs to be fed back but I think it would definitely be more therapeutic and you'd get more out of it in a group because sometimes you you can hold back some information when a service user's there↑"

Similar to the previous quote, the service user is described as needing to be "put to one side" in the formulation meetings. The use of the word "obviously" in terms of the meeting being fed back to the individual is interesting as it implies that this is common knowledge amongst the speaker's peers. Again, the disparity of power is apparent, with staff being highlighted as being "professionals" and the individual being demoted and depersonalised to "them". Although the speaker implies that this course of action is common and usual, the decrease in volume when describing the discussion is interesting and should be noted. Considering positive discourse analysis (Martin, 2004; Martin & Rose, 2003), as discussed previously, the same speaker does later go on to reference the potential "benefits" of a service user attending and the merits of "even carers" being included.

"There's no cure for mental health…we haven't got that magic bullet" – Staff struggles, burnout (and constraints) discourse topic

The most prominent discourse throughout the focus groups related to staff struggles and burnout. Staff frequently referenced "time" and "availability" as the main barriers to them utilising formulations.

A CMHN explains the pressures that staff are faced with: "I'm on so many different rotas and so many different but yeah (0.2) ((intake of breath)) yeah (.) it's it's I think you have to prioritise that and that's hard". The intake of breath emphasises the content of the speech, physically representing the weight of responsibility. There is also

power disparity as the speaker appears to lack autonomy over their demands. This quote is taken from the first focus group; the prominence of the discourse was apparent approximately halfway through the group and was initiated organically by the group itself. The CMHN continues:

> "when you've got a lot of other pulls in different areas and lots of other responsibilities (.) I would say everybody's priority becomes your priority, but they elect that you (.) and the person who says actually no this is °worthwhile°"

The discourse of multiple responsibilities and "pulls" is echoed in other members of staff as having multiple "hats" to wear or only being "one person". The use of the word "elect" in the above quote could echo feelings of hopelessness in terms of their power over that choice (indicated by the previous intake of breath), contrarily the use of an often-politicised word could indicate a position of power over those that the staff work with. The decrease in volume towards the end of the quote could also indicate fatigue in the idea of the process being "worthwhile" but also echoes of feeling that they are in the minority discourse in a group of their peers.

Within the discourse of staff burnout, defensive practice was also seen to be important. As one Clinical Nurse Specialist outlined:

> "Um I guess one of the °sorry folks° one last thing about formulation is its really really important because especially now when we have to make some really tricky decisions in the under the gaze of the media and um us being named (.) in coroner's court and it being in the media that kind of thing it's really important to have a formulation that supports our (.) professional judgement and our actions"

The timing of this interjection was interesting as it was located towards the end of the focus group when others were preparing to leave, indicating that perhaps the topic is less 'appetising', or the speaker is expecting dissent amongst peers. The pause before the reference to the "coroner's court" could indicate fear of the repercussions of their

statement or perhaps the speaker is waiting to gain majority with their peers. Overall the quote lacks a sense of person-centredness, considering formulation has also been extrinsically linked to a person's "narrative", there is no individualised wording relating to those at the centre of formulation. The focus on the objective and feared outcomes could indicate a sense of cognitive dissonance between working in a caring profession but also feeling that they have to protect their professional identity and make "tricky decisions".

In a different focus group similar concerns were also focused upon, with formulation being cited as a "bit of back up" to wider concerns. In one quote in particular a CMHN explains:

> "this is why we have to document <u>everything</u> becau::se (.) as a nurse there's only one person who's gonna protect my PIN (.) and that's me (0.3) °this is going to be fun for your um tapes° but when I was up at the X they said you document with CARE cover arse retain employment because that's what <u>you've got to do at the end of the day</u>"

The focus on the self, "there's only one person" is interesting as up until this point the group had been discussing formulations as a team approach, requiring other team members. The egocentric focus along with the emphasis on "everything" and ever-increasing pauses, could represent a struggle with balancing self-protection and fear of judgement from the wider group. The acknowledgement of being recorded could act as discourse marker to signpost a potential inflammatory statement, signalling to the researcher and group that they aware of the possible interpretations of the individuals next reference. The reference to the tape is also a sign of observers paradox, through the researcher being present out of the ordinary speech was recorded, and the 'everyday linguistics' of the speaker altered. The reference to the person's nursing "PIN" (their professional registration number) is interesting and reflects, perhaps, the use of

formulations as a method of protecting our profession and our professional titles.

Reflexive critique of own analysis

An important stage of CDA as a method in social scientific research is the point at which the analysis turns "reflexively back on itself" (Fairclough, 1999, pg. 127). Most research in the method of CDA utilises naturally occurring texts, yet the present research utilises deliberately planned semi-structured focus groups, which I established with the intention of creating discourse to analyse. My assumption was that the discourse could reflect conversations that might otherwise occur, formally or informally amongst staff.

It's also important to consider the researcher's stance and how this may have impacted on the analysis. As the main researcher I clearly hold a positive regard for the use of formulation in teams in order to carry out the present research. I also currently work within the NHS, and hold a left-wing political stance, and as such am wary of the existing political climate and strains towards the public health service. Therefore, during analysis, it was easier to focus on the current strains and pressures facing the members of staff and be sympathetic as to how this can contribute to burn out. Considering this, I may have been more likely to identify discourses around defensive practice and service user exclusion over other potential discourses.

As referenced earlier, the effects of myself as the researcher were palpable, and particularly influential with the researcher's role being clearly defined as a psychologist. Within one focus group in particular this was important and could be seen when an AP refers to the researcher as "you" when referencing psychologists in general. My own viewpoints as main researcher at times were clear, as can be seen in the following quote: "does that vary between difference dis-disciplines are there other disciplines in the team that are a bit more (.) detached I suppose". Within this excerpt, it is clear that I

as the main researcher possibly hold a certain viewpoint towards other disciplines as seen by the repetitive nature of "disciplines" and the hesitation before the use of the word detached.

Discussion

The main topics and dynamics identified from the focus groups using a critical discourse analysis informed approach need to be contextualised within the socio-political constructs and public service organisations that govern them (Choulikari & Fairclough, 1999; Fairclough, 2001). Formulation is currently identified as a main clinical strategy in the researched trust and although not mandated, staff may have had access to brief psychological formulation trainings. However, these members of staff are governed by core standards, such as the Royal College of Psychiatrists Standards for CMHTs (RCPsych, 2017), and their own professional guidelines which highlight formulation as a need (NMC, n.d; RCPsych, 2017). Despite this, it would appear that formulation has become a complex and ambiguous concept, with many members of staff seeing it as a form of protection to their professional role rather than a tool in which to aid service user care. Godin (2006) highlights the rise of risk management as one of the 'insistent imperatives' which shapes mental health nursing practice. The discourses in the current study focused on the risk of staff themselves emphasising a form of defensive practice that had been implemented.

The hegemony of the medical model and the power of the overarching institution were also prominent discourses. Staff frequently referred to medical practitioners by their professional titles i.e. "consultant" and alluded to those individuals holding more power over decisions than other members of staff. Within the literature, the medical model has already been seen as 'dominating' in the mental health sector (Wade, 2004). A further dominating power of the participants appeared to come from

the institution itself. The perceived pressure and 'tick box culture' appeared to lead staff to utilise defensive practices (Menzies, 1959), such as using formulation as evidence and back up to clinical decisions.

The perceived pressure and defensive practices manifested themselves throughout the analysis in several 'unsavoury' comments mainly highlighted in the staff struggles discourse topic. Comments such as the reference to "CARE cover arse retain employment" or having to put the service users themselves "to one side" may indicate staff becoming burnt-out and losing sight of the individual due to the "other pulls" and instead focusing on just getting the job done. The immense workload pressures on these members of staff may be leading to formulation sessions becoming a space in which staff are offloading about other pressures and muddying the service user specific time. The feelings of hopelessness and fatigue that were indicated by the staff would obviously be aided by a reduction in workload, but also by a dedicated psychological space on which to reflect on these difficult emotions.

When considering the researcher's political stance in the analysis, as identified above, it is clear that the discourses will be biased towards ensuring fair practice towards services users, whilst also being sympathetic towards staff constraints. The current study hopes to present the difficulties currently experienced by members of staff in CMHTs and contextualising this in the misapplication of psychological formulations.

Limitations

In terms of methodological limitations, CDA has been criticised for appearing esoteric and being unsystematic in its nature (Breeze, 2011; Kermode & Brown, 1996). Healthcare research has also highlighted limitations of CDA being the transferability of data, particularly when the research is completed in a specific field (Schofield, Tolson, & Fleming, 2012). The current research was completed in one healthcare trust and

solely in CMHT settings, therefore the applicability of the research could be drawn into question. Smith (2007) highlighted that by using multiple discussions and a larger data set the results are made more generalisable. However, the detailed focus on these relatively small amounts of discourse allows for less obvious and more nuanced conversations to be considered in relation to how knowledge is constructed within teams. Cheek (1999) made similar observations and argued such approaches can help clinicians to think about aspects of their practices and possible changes.

Conclusions

Four overlapping major discourses were found in the present research regarding formulations: trauma and exclusion of the individual, the role of power and hierarchy, the power of storytelling and staff struggles, burnouts and constraints. Participating in formulation appeared to enable retention of compassion and empathy towards service users among staff. Professionals also seemed to value enabling service users to tell their story, which subsequently humanised those service users. Several power dynamics were noted throughout, including a potential tension between the hegemony of the medical model and formulation. There also appeared to be a power disparity between staff and service users with service users, at times, being depersonalised and side-lined. Evidence of staff employing formulation as a form of defensive practice was also evident, and hints at a hierarchical pressure leading staff to feel threatened in their professional roles. In conclusion, the study highlights the positive impacts that formulation can have on staff but emphasises the role of power in mental health settings.

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Chapter Five: Extended results

Chapter Five

Extended results

A further two discourse topics were identified within the focus groups completed; formulations in teams and services, and staff transference and the consideration of process. These discourses were less prominent and were not detailed in the main empirical paper.

"Makes it a bit more transparent…more acceptable for people to see what's going on" – Formulations in teams and services discourse topic

Several authors have argued the importance of psychologists working with teams to improve the systems which professionals work within and to increase psychological understanding (Lavender & Hope, 2007; Onyett, 2007). Onyett (2007) has also argued that using formulation in the "wider context" can result in a powerful culture change (p. 23). Throughout the focus groups a discourse was identified related to working as a "team"; sharing "different experiences" together seemed to help staff to feel less alone and increase psychologically informed ways of thinking.

A community mental health nurse (CMHN) explains the importance of a team shared approach to formulation. Within this quote you can see the emphasis that is placed on collaborative working:

> Sometimes you do need that (.) further input because with the best will in the world you're one person and if you're lone working with someone (.) you can work to the best of your ability but you're going to be blind to certain things and so by (.) formulating it whether it be with just the psychology department or having a full MDT someone can come in and easily spot something that you've missed not because you're not good but because that just ↑hasn't occurred to you some of the

> sometimes these things are so obvious they're staring us in the face we just don't see them

The CMHN appears to repeatedly assert that they are working “to the best of” their “ability”. This assertion is repeated several times through the use of different words such as “good” or “best”. This potentially emphasises the slight vulnerability that some staff members experience in a team formulation when others are highlighting things that they may have missed; this is reinforced by the upwards intonation on the phrase “just ↑hasn't occurred to you”. The use of the phrase “staring us in the face” also indicates a sense of loss, loneliness and frustration, that the CMHN has been working almost too closely with the service user in that they are now “blind to certain things”.

The discourse of frustration and loneliness is echoed in other members of staff across the focus groups. An assistant practitioner initially describes it as having to make “that individual (.) decision” and that by using a formulation the “pressure” is taken off and you “know you’ve got the team behind you”. The dialogue appears to come from a position of vulnerability as they explain that if the person goes on to do “something stupid” at least you “know that you’ve actually tried”. The emphasis on the word “tried” indicates that sometimes members of staff can feel hopeless in helping the individuals they work with.

Other members of staff saw team formulations as a way of increasing the cohesiveness of the team. Individuals expressed feeling “entrenched” and named specific service users who they described as being able to “fragment and split” the team. In these cases, formulation was seen as a way of being “holistic” and knitting the team back together. The use of the strong term “fragmented” was echoed throughout the focus groups and in particular the third focus group. Professionals generally referred to service users’ experiences as being fragmented and highlighted the role the team could

play in the fragmentation of service users and their stories. However, the repeated use throughout suggests that the term had a more personal meaning and perhaps reflects the fragmentation of the professionals themselves.

"Formulation is really good for reflection because it holds up a mirror" – Staff transference and consideration of process discourse topic

Reflection and reflective practice have been found to be vital in promoting psychological mindedness and improving practice (Mann, Gordon, & Macleod, 2009). A discourse throughout the focus groups centred upon the ability to reflect on process issues and potential transference when working with service users.

One CMHN explains the strong transference that they feel from one particular service user:

> "I think because we are (.) transferred ever-everything I've got a client whenever (.) I see them I have to go and buy sweets afterwards you know it's like ((laughs)) to sort of self soothe my inner child you know"

The pause before explaining the transference highlights the heaviness of the topic, which is then broken by the incongruent laughter afterwards. It is clear from this quote that the CMHN personally shoulders the responsibility of accepting that transference and taking it away from them "afterwards". The CMHN goes on to explain later that the psychologist is enabled to pick things out that "myself I can't see" such as their default of feeling that they have "failed". The concept of formulation holding a "mirror" up is important here. From this quote it is clear that, although formulations are aimed towards facilitating the individual's story and aid their recovery, there is also a strong therapeutic message for the staff members themselves. Through the consideration of the process between the service user and the member of staff, staff felt able to have a "fresh start" and admit when they were not "coping".

The discourse of formulation being therapeutic for the staff as well as the service user was carried across two of the focus groups. One CMHN highlights her belief that: "formulation is a chance to talk about those underlying mechanisms you know, sort of transference…projection". The increase in volume that is placed on "underlying" and the use of the word "chance" resembles the emphasis that is placed on the importance of these mechanisms but the infrequency with which they are spoken about.

In the second focus group a CMHN highlights how formulation helps them to "see how it's affecting" them and goes on to explain: "[Yep °we're all human°]". The fact that this comment is said quieter than the rest of the talk in the focus group, and whilst another person is speaking is interesting. It could indicate that perhaps the CMHN is half saying it to themselves and musing on the idea whilst others are talking, or perhaps it indicates a sense of vulnerability. The CMHN could potentially be indicating vulnerability in admitting that behind the professional façade there is a human being. A different CMHN goes on to say:

> "a::nd (.) °you know° it affects our mental health because we've all got mental health just as we've all got physical health a::nd the formulation sometimes it's a bit of therapy as we(h)ll you know whether we bel-realise it or not"

The CMHN appears to initially say 'believe' rather than "realise" and the substitution of the word could be an important feature in the dialogue. The substitute word "realise" is a more substantial verb that indicates a truth to be realised rather than the word 'believe' which indicates a less substantiated claim. The CMHN appears confident in discussing "all" of us having mental and physical health as there is no decrease in volume or lessening in intonation which is contrast to the other CMHN who indicates all us being "human" quietly and in the background of the group. Overall there is a discourse topic across the groups that would indicate staff viewing formulations as potentially

therapeutic, and humanising, for themselves as well as the individuals they work with.

Chapter Six: General Discussion and Critical Evaluation

Chapter Six

General Discussion and Critical Evaluation

The aim of this thesis was to explore staff views and opinions on formulations in mental health teams and advance the current research field. The research hoped to identify potential positive experiences of staff but also explore the barriers to the utilisation of formulations with an empirical study of discourses about formulation in multi-professional staff teams in one mental health NHS trust.

Summary of Findings

A systematic review synthesised relevant literature relating to staff views and opinions on team formulations. Due to team psychological formulations being mainstream practice within the United Kingdom (UK), and with the *Good Practice Guidelines* published by the British Psychological Society Division of Clinical Psychology only studies from the UK were included. The results of 16 studies were thematically synthesised and seven mainly positive themes emerged. Staff generally found team formulations difficult to define but felt that the purpose was to be given a reflective safe space in which to express their opinions. Team formulations were mainly viewed as forums in which open discussions and idea generation were possible. Professionals also felt an increase in empathy and compassion towards service users, as well as aiding a sense of professional validation. Staff generally felt listened to and valued during team formulations but barriers, such as a lack of time, were also identified.

Following the systematic review, an empirical study was conducted examining discourses of community mental health staff in relation to their views and opinions of

formulations. Focus groups of staff from three multidisciplinary community mental health teams were held and recorded. The focus group transcripts were subsequently analysed utilising a critical discourse informed approach. Four overlapping major discourse topics were found; trauma and exclusion of the individual, the role of power and hierarchy, the power of storytelling and staff struggles, burnouts and constraints.

Combined Discussion

Throughout both studies formulations were seen as a positive method by which service users were often empowered and enabled to tell their stories. Staff felt that the important aspect of formulation was the process of giving service users a space in which to tell their narrative, never mind the content. Similarly, narrative psychologists and the Division of Clinical Psychology would argue that formulations are an individual's story concerned with a 'personal meaning to the individual' but grounded in empirical literature (Division of Clinical Psychology, 2011; Strawbridge, 2018). Staff within the focus groups felt it humanised service users whilst reinforcing professionals' own compassion and empathy for the individual. Previous research, such as that by Murphy, Osborne et al. (2013) also found that formulation aided staff to see individuals as a whole.

Although formulation was seen as humanising individuals, a power disparity was alluded to in favour of the professional. Participants in the study believed service users were not always included in formulation meetings and felt that this enabled more honest conversations to be had. Staff also tended to depersonalise service users by referring to "them" rather than as individuals. Staff may have utilised this strategy as a means to distance themselves from distressing content, similar to defensive mechanisms cited by Menzies (1959). Research has found that formulation can be a distressing

experience for individuals (Redhead, Johnstone, & Nightingale, 2015), and the current research suggests that they may be distressing for staff also.

Within the systematic review, and other studies such as Undakat, Irving Quinn, Jones and Casares (2015), staff felt listened to during formulation meetings and they provided a time for reflection. Providing staff with a space in which they feel listened to and validated is important, as professionals within the empirical study seemed overpowered by the institution they worked in and appeared to have little autonomy over their workload or decisions. Staff cited multiple pulls and responsibilities which appeared to link with staff using formulations as a form of defensive practice (Menzies, 1959). These forms of defensive practice resulted in formulations forming evidence of their care, for 'just in case' situations, rather than a meaningful piece of work.

A prominent discourse throughout the staff focus groups was the hegemony of the medical model and the effects of hierarchy. Although this discourse was not adopted as a group, individuals throughout the transcripts cited cynicism of the medical model and its hierarchical impacts. Throughout the groups there still appeared to be an inherent power in the medical model with the ultimate power still being held by the consultant psychiatrist. Within the review it was also cited that at times formulation was seen as a direct challenge to the medical model or the "fly in the ointment" (Manuel, 2016, p. 88).

Critical Evaluation of Systematic Review

The presented systematic review focused on thematically synthesising staff views and opinions on team formulations within mental health settings.

The search terms included in the systematic review were finalised and chosen after several practice tests utilising different search terms. It was felt that the final search terms encompassed a large amount of literature but did not include excessive

papers that were of little relevance. A limitation of the systematic review is the focus purely being on studies conducted in the UK. Studies from the UK were isolated, due to their being frameworks and a consistency to formulations set out by professional bodies. However, excluding studies from outside of the UK may have resulted in the review not fully encapsulating a diverse selection of staff views and opinions and a cross-cultural approach may have yielded a richer and more diverse understanding of the concept of formulation and its potential implications. Reviews in the future would benefit from including global studies in their search terms and identifying the relevant grey literature to also search.

The review aimed to encapsulate a large range of grey literature and included searches on thesis databases and other publications that are not easily searchable. The incorporation of grey literature is a positive of the current review, and improving its comprehensiveness promoting a balanced view on the searched literature (Paez, 2017). The presented systematic review incorporated eight out of 16 studies as grey literature. A potential negative of this, is the increased length of doctoral theses in comparison to published studies. The additional material available in these papers may have meant that a larger collection of relevant data was available for some themes but not others. In addition to this, many of the included studies did not contain a sufficient consideration of the impact that the researcher may have had on data collection. The impact of the researcher in this field of research has been highlighted previously (Summers, 2006), particularly as facilitators and data collectors were often known to the participants potentially hindering openness and honesty. The unknown impact of the researcher in the included studies should be considered a potential limitation of the presented review.

Finally, a Thematic Synthesis can be seen to be heavily influenced by the reviewer and their own views. The Thematic Synthesis was carried out by a lone

researcher and may have benefitted from a co-reviewer who could have coded alongside the researcher to ensure consistency. The addition of a co-reviewer would have also enabled discussion and the generation of potentially more abstract and creative analytical themes (Thomas & Harden, 2008). A reflective log would also have been beneficial as it would have allowed the reviewer space in which to explore thoughts and feeling related to the review and may have provided a space in which to be creative in ideas, mimicking the group discussions with other reviewers.

Critical Evaluation of Empirical Paper

The presented empirical paper aimed to identify discourse topics relevant to opinions and viewpoints on the everyday use of psychological formulations in staff focus groups. The study employed a discursive analytical informed approach to analyse staff focus groups that took place across different community mental health teams.

An important stage of critical discourse analysis is the point at which the analysis turns "reflexively back on itself" (Fairclough, 1999, pg. 127). To aid reflection and to account for personal impact which will have altered and shaped the discourses made by the participants a reflective diary was kept throughout the process, this is recommended by Noble and Smith (2015) to aid the 'truth' value of the research. Throughout the reflective diary it is clear that the idea of discourse analysis was initially "overwhelming". My professional position as a psychologist is clear throughout the diary entries and there are many aspects of the research that appeared to surprise me. I appear continually surprised that participants turn up to the focus groups and also some of the viewpoints expressed throughout. During analysis it was easier to focus on the strains and pressures facing the members of staff, as a member of the NHS myself, and it may have been easier for me to identify discourses around defensive practice and service user exclusion.

The effects of myself, as a trainee clinical psychologist, conducting the focus groups were also potentially vast. Discourse analysis informed approaches allow the analysis of any set of data, and the group should be considered a whole (including myself). One assistant practitioner specifically referenced the researcher as "you" when referring to psychologists in general, clearly demonstrating I was viewed as a clinician not just the researcher. Through individuals interacting and drawing on our own discourses a shared understanding of a topic is created (Warburton, 2016). Developing an understanding of myself and my contribution to the discourse is important in helping to maintain a critical lens, as well as considering my analyses themselves as the product of the discourses (Jäger, 2001; Warburton, 2016).

Methodologically, critical discourse informed approaches have been criticised for the limits to its applicability (Schofield, Tolson & Fleming, 2012) but also its unsystematic nature (Breeze, 2011; Kermode & Brown, 1996). The research was completed in a single healthcare trust and only in community mental health settings, therefore the generalisability and applicability could indeed be questioned. It is important to hold in mind that by focusing the research on smaller sets of discourse, more detailed (and less obvious) nuances of the conversation could be considered. Cheek (1999) made similar observations and argued such approaches can help clinicians to think about aspects of their practices and possible changes.

Conclusion

The results of the research are drawn from a social constructionist empirical paper, in which attitudes, social groups and identities are socially constructed, and a UK-specific qualitative systematic review. Taking this into consideration the results cannot be generalised to all members of staff working in community mental health settings and should be interpreted with caution. However, the research does provide illuminating

insights into staff views and opinions of team formulation. The research suggests that staff members find formulations helpful to themselves on both a personal level, validating their professionalism and helping them feel listened to, and on a service user level, broadening staff understanding and the exploration of therapeutic relationships. Power dynamics and hierarchy seemingly played an important role in both the relationship between staff and service users and the relationship between staff themselves. Future practice should place importance on the process of team formulations, consideration of the impact of power and help to negotiate some of the barriers highlighted to its use. Further research should focus on broadening the research field into other areas of mental health and encapsulating more professional discipline viewpoints alongside voices of service users.

Chapter Seven: Researcher's Reflections

Chapter Seven

Researcher's Reflections

"You can never fully transcribe what someone else has just told you because you're going to be influenced by your own views, your own prejudices, your own everything"

– Community Mental Health Nurse, Focus Group Two.

My Own Truth

The focus of my research came from my experiences of the impact of formulation in mental health services. Throughout my career thus far I have felt that my own 'truth' regarding formulation has been that it undeniably has a positive impact on those who experience it, yet it still feels under researched and mythical to those outside of psychology. Within my reflective diary (Appendix K) I reflect on the experience of recruitment and the feelings of being surprised at how quickly I recruited for my empirical study, citing that it was:

> "my own bias thinking that formulation is not well explained to other disciplines and seems to sometimes be a bit of a 'mystery' to people outside psychology I assumed people would avoid it because they didn't know what it meant."

I feel that my own views on formulation throughout this process have become more positive, myself referring to formulations at one point as a "cornerstone", but my views on mental health services and institutional bodies have evolved to be more critical. The majority of discourses still related to institutional pressures bearing down on staff members and leaving them feeling that formulation was sometimes an extra 'tick box' they did not have time to pursue. There is also a sense of power of conformity and hegemony of the medical model at times, which is interesting when considering throughout the groups medical professionals were usually referred to as their title (e.g. consultant or doctor) whereas psychologists were referred to by their profession or first

name. Indeed, similar institutional pressures were placed on me throughout this process. For example, at the beginning of the process I believed writing my empirical paper in the first person would be more in line with the study's beliefs and values. Yet, as time moved along, I felt the institutional pressure to conform and present the 'status quo' resulting in my empirical paper taking the form of third person, a style which I am less comfortable writing in.

Making Decisions

The choice of methodology in this empirical paper felt very led by the topic. In my diary I describe picking a discursive approach because I felt that it "fit my idea of formulation quite well". I wonder if this is because of the social constructionist nature of discourse analysis focusing on 'truth' being socially constructed through our interactions with others. The idea of what is 'true' being constructed through our interactions with others seems to be the basis of formulations, through formulations we discuss events in a person's lives and shape the truth to fit the person. For example, if different professionals constructed a formulation with the same service user, each formulation would have a slightly different emphasis or lens placed upon it despite it having the same service user at its centre.

Throughout my portfolio it also felt important to consider the power dynamics that play out in mental health services. In my experience of different mental health settings, power can manifest itself in various ways between members of staff and also between staff and the service user. Many of the findings of Staniszewska et al.'s (2019) study related to service user experiences of in-patient mental health services resonate with me, particularly those findings that consider the relationships between staff and service users and the innate power differentials that come with this. My own personal,

and my supervisors', interest in power and hierarchy is the reason why the study utilised a critical discourse informed approach.

Long road of analysis

I feel my own opinions and viewpoints on formulation throughout the focus groups may have affected the participants social constructions of their own 'truths'. Throughout my research diary I am continually surprised at the staff viewpoints; I'm surprised at the lack of experience some participants had with formulation, the lack of involvement of service users in their own formulations and the role of certain professionals within community mental health teams. I wonder at times whether this came across in my facilitation of the groups and what impact this may have had. I reflected on the fact that I was "shaping the truth in that moment" and decided to code my own inputs alongside the rest of the transcript.

Piecing together the jigsaw

At one point in my diary I reflect on the process of putting together the thesis portfolio and how each section may have impacted on the other: "I wonder how much [the empirical paper] affects the themes for my Thematic Synthesis". During the course of my portfolio the first paper to be written was my empirical paper, and it makes me wonder how much of an impact the discourses and views that I had heard in the process of my focus groups affected the lens that I subsequently placed on my Thematic Synthesis in my systematic review.

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Appendices

Appendix A

Author Guidelines: Journal of Mental Health

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This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

Psychology and Psychotherapy: Theory Research and Practice is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies and Registered Reports. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in *Psychology and Psychotherapy: Theory, Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

- Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered.

4. PREPARING THE SUBMISSION

Free Format Submission

Psychology and Psychotherapy: Theory, Research and Practice now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at **https://www.editorialmanager.com/paptrap/default.aspx** and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use **this template** for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Acknowledgments.

Authorship

Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the **Project CRediT** website for a list of roles.

Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.

- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the **APA FAQ**.

Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, *159*, 483–486. doi:**10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from **http://www.youtube.com/watch?v=Vja83KLQXZs**

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote

symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Colour figures. Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

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Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

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For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

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- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

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Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available **here.** In particular, we encourage authors to consult Wiley's best practice tips on **Writing for Search Engine Optimization**.

Article Preparation Support: **Wiley Editing Services** offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for **Preparing Your Article** for general guidance and the **BPS Publish with Impact infographic** for advice on optimizing your article for search engines.

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Except where otherwise stated, the journal operates a policy of anonymous (double blind) peer review. Please ensure that any information which may reveal author identity is blinded in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, please read **the terms and conditions of submission** and the **declaration of competing interests**.

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The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)
- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and

collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **https://www.crossref.org/services/funder-registry/**

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

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Data Sharing and Data Accessibility

Psychology and Psychotherapy: Theory, Research and Practice recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed

preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

It is not necessary to make data publicly available at the point of submission, but an active link must be included in the final accepted manuscript. For authors who have pre-registered studies, please use the Registered Report link in the Author Guidelines.

In some cases, despite the authors' best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or laws, or the nature of data gathered. In such cases, authors must inform the editors at the time of submission. It is understood that in some cases access will be provided under restrictions to protect confidential or proprietary information. Editors may grant exceptions to data access requirements provided authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

Finally, if submitting authors have any questions about the data sharing policy, please access the **FAQs** for additional detail.

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Authors are reminded that *Psychology and Psychotherapy: Theory, Research and Practice* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). The Journal generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and

subscribes to the principles of the Committee on Publication Ethics (**COPE**). Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county.

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As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. This takes around 2 minutes to complete. **Find more information here.**

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- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receivea publication alert and free online access to the article.

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9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (**papt@wiley.com**) or phone +44 (0) 116 252 9504.

Author Guidelines updated 28th August 2019

Appendix C

Research and Ethical Approval

Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia

Research & Innovation Services
Floor 1, The Registry
University of East Anglia
Norwich Research Park
Norwich, NR4 7TJ

Email: fmh.ethics@uea.ac.uk

Web: www.uea.ac.uk/researchandenterprise

Rebecca Bealey MED

19 February 2019

Dear Rebecca

Title: We are all full of discourses that we only half understand and half mean': Discursive analysis of staff views on personal stories in Mental Health Services

Reference: 201819 - 006

Thank you for your response to the recommendations from the FMH Ethics Committee to your proposal. I have considered your amendments and can now confirm that your proposal has been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and also that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Please can you also arrange to send us a report once your project is completed. Yours sincerely

Professor M J Wilkinson
Chair, FMH Research Ethics Committee

Appendix D

Health and Research Authority Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Rebecca Bealey
Trainee Clinical Psychologist
Cambridge and Peterborough Foundation Trust
University of East Anglia
Research Park
Norwich
NR4 7TJ

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

15 April 2019

Dear Miss Bealey

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

Study title:	**"We Are All Full of Discourses That We Only Half Understand and Half Mean": Discursive Analysis of Staff Views on Personal Stories in Mental Health Services**
IRAS project ID:	**248351**
Sponsor	**University of East Anglia**

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

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **248351**. Please quote this on all correspondence.

Yours sincerely,

Hayley Henderson
Approvals Manager

Email: hra.approval@nhs.net

Copy to: *Miss Mercedes Mills, Sponsor contact*

List of Documents

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

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [FMH Ethical Approval]	V.1	19 February 2019
Copies of advertisement materials for research participants [Lay Summary]	V.1	18 February 2019
Costing template (commercial projects) [UEA Funding Request]	V.1	18 June 2018
Interview schedules or topic guides for participants [Moderators Guide]	v.2	18 February 2019
IRAS Application Form [IRAS_Form_22032019]		22 March 2019
Letters of invitation to participant [Letter of Intro to Gatekeepers]	v.2	18 February 2019
Participant consent form [Consent to Contact Form]	v.2	15 April 2019
Participant consent form [Consent Form]	v.2	18 February 2019
Participant information sheet (PIS) [Participant Information Sheet]	V.4	15 April 2019
Referee's report or other scientific critique report [Feedback on Thesis Proposal from Academic]		18 February 2019
Research protocol or project proposal [Research Protocol]	v.2	06 March 2019
Summary CV for Chief Investigator (CI) [CV]	V.1	19 February 2019
Summary CV for supervisor (student research) [Supervisor CV]	v.1	31 January 2019

IRAS project ID	248351

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
There is only one participating NHS organisation therefore there is only one site type.	Organisations will not be required to formally confirm capacity and capability, and research procedures may begin 35 days after provision of the local information pack, provided the following conditions are met. • You have contacted participating NHS organisations (see below for details) • HRA and HCRW Approval has been issued • The NHS organisation has not provided a reason as to why they cannot participate • The NHS organisation has not requested additional time to confirm. You may start the research prior to the above deadline if HRA and HCRW Approval has been issued and the site positively confirms that the research may proceed.	As this is a student project, no agreement is required	No study funding will be provided to sites	A Principal Investigator should be appointed at study sites	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access if focus groups were held in clinical areas. Letters of Access would not be expected if focus groups were held in non-clinical/administrative buildings.

	You should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. The password to access the R&D contact list is Redhouse1.				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
No additional information

Appendix E

Focus Group Guide

Moderators Guide

- Introduction:
    - Summary of the study and what it will be examining
    - Including obtaining full consent
    - Reminder of confidentiality
    - Try not to use identifying features/labels such as names
- Warm-up
    - Discussion of previous uses of formulations and what their experiences may be
    - How formulation is currently used in the team
- Clarification of terms
    - Possible clarification of what formulation is?
- Easy and non-threatening questions
    - How might formulations help practice?
- More difficult questions
    - Potential barriers to formulations in practice?
- Wrap-up
    - Summary of what was discussed?
- Member check and closing statements (debrief)
    - Checking in with how people feel about the study
    - Re-iterate confidentiality
    - Remind of deadline with which to withdraw

Appendix F

Email of Introduction to Gatekeepers

Dear whomever it may concern,

I am a Trainee Clinical Psychologist training within University of East Anglia and I am going to be completing my thesis research project into staff opinion on the use of formulations and personal stories in general mental health community team practice. I am writing to you as the CTL of such a service in the hope that you would be interested in your team taking part in the research.

The research study would involve a group of approximately eight different professionals coming together to discuss their views on the use of formulations with service users and whether they see any barriers or enablers to their use in practice. I am hoping for these discussions to be around 60-90 minute in length and am flexible to attend during time put aside for reflection or to treat the group as a working lunch. I have attached the patient information sheet about the study, as this may be helpful for further clarification of the study objectives.

Taking part in the research is voluntary and if you would prefer for your team not to be included, please just let me know. There is also a potential for the group to be cancelled if the research study reaches maximum capacity before the current focus group can take place.

Due to ethical reasons I am unable to approach members of staff directly without having consent from them to do so, therefore I would greatly appreciate it if you could circulate the attached participant information sheet and ask interested participants to complete the consent to contact form that is also attached to this email. If there are participants willing to take part could you please let me know and I will collect the consent to contact forms.

Best wishes,

Rebecca Bealey

Trainee Clinical Psychologist
Great Yarmouth & Waveney Services

Appendix G

Participant Information Sheet

Staff Views on Personal Stories in Community Mental Health Services

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or you would like more information. Take time to decide whether or not to take part.

Purpose of the Study

I am a Trainee Clinical Psychologist and as part of my studies I am required to undertake a piece of research. The study aims to looks at staff opinions on the use of formulations and personal stories in general mental health community team practice

Why have you been invited?

The study is recruiting members of staff, who currently work in a multi-disciplinary, community mental health team. Members of staff currently working in a multi-disciplinary team are being recruited as the method of examining the data will also look at how the team interacts with each other. All disciplines of staff are invited to take part as this accurately reflects the diversity of a real community mental health team.

Do I have to take part?

No, taking part in the study is completely voluntary and your own choice. At the beginning of the focus groups we will describe the study and go through the information sheet, which we will give to you. We will then ask you to sign a consent form to show

you agreed to take part. You are free to withdraw until the end of the debrief which will take place after the focus groups, withdrawal cannot be facilitated after this point as data will be anonymised at the point of transcribing and identities will not be able to made through the audio recording.

What will happen to me if I take part?

The study consists of participating in a focus group. This will involve you, and approximately six other colleagues, gathering to discuss formulations and personal stories in a group setting. These groups will be audio recorded to aid data collection; however the data will be anonymised and you will not be identifiable in the final research project. These groups will last approximately 60-90 minutes. After this, participants will be offered a final debrief of the study and will be invited to receive a summary of the completed research. Refreshments will be provided at the end of the focus group.

The data collected from these focus groups will be examined by the researchers, which includes me and one other co-researcher working in my field. The analysis will look at themes discussed and also the manner in which these are discussed.

What the possible disadvantages and risks of taking part?

Participants may feel uncomfortable discussing their current practice in a group setting, however all data collected is confidential and the participants will not be identifiable in the final research.

What are the possible benefits of taking part?

We cannot promise the study will directly benefit you, but the information we get from the study will help to increase the understanding of formulation and its current use in practice. It is hoped that by increasing our understanding of this area, practice will be improved by helping all staff become involved in personal story and formulation development.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. The lead researcher can be contacted through email; r.bealey@uea.ac.uk

If you remain unhappy and wish to complain formally you can do this through the University of East Anglia by contacting Professor Niall Broomfield (N.Broomfield@uea.ac.uk)

Will my taking part in the study be kept confidential?

Data will be stored on one-drive (which is approved by the NHS Trust). Only data that is required for the study will be collected to comply with GDPR data minimisation requirements. All data will be anonymised as the transcript of the group is created, therefore any stored data will be anonymous. All anonymised data will be stored for 10 years after the end of the study to comply with research data storage protocols. At the end of the 10 years the data will be destroyed.

The University of East Anglia is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for

looking after your information and using it properly. The University of East Anglia will keep identifiable information about you 10 years after the study has finished.

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

You can find out more about how UEA manages Personal Data by contacting UEA Data Protection Team (dataprotection@uea.ac.uk)

Further information and contact details

The researcher can be contacted at r,bealey@uea.ac.uk, if the participant has any further questions.

Appendix H

Consent to Contact Form

15/04/19 (Version 2.0) IRAS ID: 248351

NHS
Norfolk and Suffolk
NHS Foundation Trust

UEA
University of East Anglia

CONSENT TO CONTACT FORM

Title of Project: Staff Views on Personal Stories in Community Mental Health Services

Name of Researcher: Rebecca Bealey

Please initial box

1. I confirm that I give consent for the researcher, Rebecca Bealey, to contact me about this study. I provide below an email address and a telephone number by which the researcher can contact me. ☐

_____	_____	_____
Name	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Email address of participant consenting to be contacted: _____

Telephone number of participant consenting to be contacted: _____

Appendix I

Consent to Participate Form

18/02/19 (Version 2.0) IRAS ID: 248351

NHS
Norfolk and Suffolk
NHS Foundation Trust

UEA
University of East Anglia

CONSENT FORM

Title of Project: Staff Views on Personal Stories in Community Mental Health Services

Name of Researcher: Rebecca Bealey

	Please initial box
1. I confirm that I have read the information sheet dated 15/04/19 (version 4.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw up until the end of the focus group, withdrawal cannot be facilitated after this point as data will be anonymised at the point of transcribing.	☐
3. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers.	☐
4. I agree to take part in the above study.	☐

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

Appendix J

Lay Summary of Research

What do we mean by 'formulation'

A formulation usually means a story or narrative which helps us to understand a person's difficulties. Formulations are usually written.

Formulations are often used by psychological therapists to help them and the service user understand their history and experiences.

Formulations can be a helpful tool for anyone working in mental health to understand a person's journey and, often, what is important to them and why.

Why was this study done?

Formulations are generally considered to be good practice but there are many different ways people think about them and use them.

Often services do not use or find it difficult to use formulations and the reasons why are not well understood.

What will the researchers do?

The researchers will gather groups of mental health professionals from community mental health teams and ask them about their experiences of formulations.

The groups will also be asked what the current issues with using formulations might be.

The content of these groups will then be looked at by the researcher to see if there are any main themes throughout.

These main themes will then be summarised and reported.

What's the point?

It is hoped that the research will help to improve the practise of mental health staff by exploring

staff views and opinions on using formulations and what might make it difficult (or easy) for them.

Appendix K

Reflective Diary

Trying to understand discourse analysis (1.10.18 until the end of time…)
Met with N today to talk about discourse analysis (DA) and which approach to take etc. slightly overwhelming to think of all the different intricacies that have to be considered and just how in-depth it all goes! N's study sounded fascinating and the power dynamics etc. that she was talking about is leaning me towards doing critical discourse analysis… Strikes me that it is slightly like English Literature studies that takes a body of text and analyses it for themes, different methods of descriptions etc. that the author has used except for spoken language. Feels very different to some of the other quantitative research that I've done in the past that has pretended that the researcher has no bias on the outcome and embraces this more. Ns going to send me some articles to start reading and start understanding a bit more of what goes on…

I picked DA because it sounded interesting and that it fit my idea of formulation quite well – it sounded like a method that embraced the idea of researcher bias whilst picking up on participants unintended actions and meanings. Never knew it would be quite so full on and now I'm realising why everybody warned me not to do it!

Getting participants – AAH! (24.05.19)
Something I thought about before the first group, when I was surprised at how many people signed up to the study. Why do people want to take part? I was very surprised at how quickly people signed up – possibly my own bias thinking that formulation is not well explained to other disciplines and seems to sometimes be a bit of a 'mystery' to people outside psychology I assumed people would avoid it because they didn't know what it meant.

Struck me how busy staff members are when trying to organise the focus groups – nobody could do the same time as each other and I begin to wonder whether I'll ever get everyone in the same focus group. I've deliberately chosen a time I know most people have a lunch break after staff meetings – Are these people even breaking for lunch or are they so busy that they work through it? When hearing previously that most clinicians don't carry out research, I assumed this was because recruitment was difficult, and nobody wanted to take part – however having recruited for this study I'm beginning to wonder if its more just about the time and focus of clinicians. If they're so busy firefighting and working maybe research that would improve that is at the bottom of their lists?

First Focus Group (16.07.19)
Poor turn out for first focus group partly due to participants being unwell or being too busy to attend. Brief chat before transcription started with participants who did show up

– believe that the poor turn out is a reflective of the stress of the current climate in the trust. People being burnt out and too busy to do things that may inform their practice.

Felt under pressure myself to 'get it done' and wondered if I was picking up on the overall atmosphere of the team and the pressures they were under. Surprised at the lack of experience the participants had with formulation (mainly one) considering the person is expected to case manage quite complex service users. Felt that there were things that participants did not feel comfortable sharing on tape due to fear of retribution, especially one participant who did not have a positive viewpoint on formulations.

Surprised at the lack of involvement by service users in their own formulations and the one example that was used showed the service user as almost a passive recipient of the care and just being 'present' rather than involved? Interesting that it was too overwhelming for them due to the amount of people – indicates no prior preparation before the formulation meeting and also possibly that there were people in the meeting who did not need to be there and were added extras to add to the number of attendees? That sense of tick boxing so that everyone can say they were there to add to their notes – rather than a sense of involvement and team/multidisciplinary working.

Mental health nurse as dominant figure, marginalised narratives of AP and CarersAssesor? But then that could be due to experience rather than anything else.

<u>Second Focus Group (23.07.19)</u>
Really glad that I offered lunch to my focus groups! After a bit of running around to organise people I was only missing one participant who apologised and said she may join late. Made me understand what it must feel like working there – running around after everyone and everyone being too busy to 'spare the time'. Already had to give reassurances to the participants who attended that I'd be prompt and end on time because they all had to be somewhere else. Felt like everything was a bit of a squeeze to fit in.

Sounds funny but I think offering lunch really helped – I'm also glad that I allowed the participants to eat during the focus group rather than asking that they wait until the end or have it at the beginning. I think it 'loosened' something up and everyone felt really relaxed after the first 20 minutes or so. Some of the nurse's viewpoints were surprising – C.A.R.E particularly surprised me; I'd heard this before when working in inpatient, but I was surprised that the individual felt comfortable enough to say it in a recorded focus group. Made me wonder about, although everyone laughed when the participant said it, was it actually a joke or had it become so entrenched that people just accepted it without thinking?

Once again everyone said that the service user was not to be included in the formulation – even hinting that they may suffer from trauma if this happened?? Much in the same vein as secondary trauma, I think this is something people worry about more than it

actually happens. Formulation appears to have become a 'tick box' something that people can do to make sure all avenues are covered before discharged? Beginning to wonder whether the psychologists in these teams are either promoting psychological thinking and the culture has not yet shifted or whether psychologists are complicit in this thinking?

Also surprised at the role of the OT in the team. The OT role seems to have blurred and merged with that of a nurse. Made me wonder, in a different research study, whether it would be interesting to look at professional roles and boundaries and whether OT's feel qualified to be doing this job or unskilled in more OT specific activities?

Transcribing (will it ever end)

Started transcription and although it is going faster than I expected it is still taking a long time. I'm having to have regular breaks because my concentration begins to wander, and I just end up typing gibberish rather than keeping up with what the people are saying. My wrists are sore from leaning on the laptop and I'm beginning to wonder if I can get repetitive strain injury in all 10 fingers because that would be awkward for when I'm on placement! It has made me realise just how intricate spoken language is and just how many different themes and meanings can be communicated in the unspoken parts. The amount of seemingly awkward laughter there is throughout is interesting and the times where there is a silence and I can remember someone mouthing something to someone else that they obviously didn't want recorded verbally. Also reading between the lines is interesting – like with the discussion in the first focus group about medical doctors and how they must be really busy and there phone never stops beeping, although reading this on paper it may seem like the person has empathy, when hearing it is clear the person feels annoyance and conveys a deeper message of hierarchies.

Myself as a researcher (10.09.19)

Beginning to code the transcripts and becoming aware of my impact on the discourses that are spoken about. Aware that in the first focus group I potentially interrupted too quickly (such as at 3.41) being too eager to summarise and guide the discussion rather than being neutral. Do I code my own responses? I am shaping the truth in that moment so maybe my own interruptions should be coded alongside the rest of the transcript. Finding it difficult to separate myself from the data – but then within discourse analysis this is acceptable as it is my own perspective and my own take on the data that is important. Reflecting on what N said regarding it being about me putting my own peg in the ground and not claiming this reflects what everyone else is thinking but that it reflects what I think.

Aware that as a trainee psychologist I feel I influenced what others may have been saying or thinking. Especially now I'm listening to the first focus group back again and there were a few times, nurses especially when they referred to me as a psychologist. Wonder whether that impacted people's ability to be honest or whether because I was

'just a trainee' they felt that they could be open and honest. But again, maybe they felt willing to engage because something might change from it if it's a psychologist conducting the researcher?

Coding the first focus group (23.08.19)

First focus group is very focused on setting goals and moving forward in formulations, whether that fits in with discharge or not. Does not align with my own thoughts on formulation as an ongoing process that can be reviewed – does not feel comfortable for me especially when one participant said that they would not want the history included because they did not see how that was beneficial. Felt tension between participants particularly in relation to bringing in other members of staff to the formulation meetings.

Decided that I need to establish more of a context behind the teams and what they're access to training etc. has been in regard to formulation. It seems that many staff think of formulation as like a professional's meeting set up that just requires people to be present. Also shocked at how little the SU's are involved in their own formulations. Some staff felt actively against this.

Still coding the first focus group (18.09.18)

Pleased at how much input the carers assessor had into the group because I felt that they were contributing something valuable and felt that carers have previously potentially been overlooked. Interesting reaction to the medical doctors being present in formulations. Nobody refers to the psychologist as a doctor – cultural context that a doctor means a medical doctor. Seen as too busy to attend – but nobody mentioned the value of their input? It did not seem that people were upset that they would not have input but maybe that is because it's an accepted way of being in the team?

Coding the second focus group (27.09.19)

Second focus group is much more focused on formulation as being beneficial to them and their work with service users. In comparison to the first focus group which was more focused on goals and moving forward. Second focus group much more reflective and focused on reflecting on the SU's progress and thinking about what they could be doing differently this far.

"You can never fully transcribe what someone else has just told you because you're going to be influenced by you're own views your own prejudices you're own everything" - CMHN

Above is the best quote of the focus group so far to summarise what DA is all about! Thinking about putting it in the title of the paper, it's like the person knew what the ins and outs of DA were (which they might know).

Still coding the second focus group (1.10.19)

Just restarted coding the second focus group again. It's an interesting perspective on formulation that people have that they're almost not for 'risky' situations and should be kept there for when the staff is stuck rather than the service user...? Interesting quote from nurse that basically said there was no point doing them repeatedly because what changes? That's an interesting thought because I feel like people change every day that they exist and particularly when working with service users the formulation is always changing because they tend to be people with a lot of experience.

It's interesting because when I ask in the group "what makes a formulation a formulation" they all give answers that I would expect someone to give about a formulation like about the client being the centre about looking for patterns and a discussion. Yet they've spent the last 33 minutes talking about excluding the service user and (especially in the first focus group) excluding the persons history because it should be goal focused? Makes you think that the concept and the good heartedness is there, but the concept is not played out in practice. Perhaps because of the other constraints that they've discussed. Maybe because of the constraints and the current political climate of the trust formulations have become a risk management/discharge tool, even though people do understand them. If this was true is it something training would fix?

Coding the third focus group (19.10.19)

Felt like I've ignored my thesis what with all the other bits of work going on but trying to get back into it now!

The third focus group does feel a bit like it has a 'healthier' (if that's the right word) view on formulation at the beginning. People seem gutted that certain formulation slots have been taken away, but then other participants are saying that these were stopped because of a lack of attendance – cognitive dissonance around how people feel about formulations? Saying they're really helpful but then not attending them when they have a chance? One of the psychological therapists really hit the nail on its head when he said that the meetings were just becoming 'professional meetings' rather than formulations which is the sense I've got from the other groups too.

There's also this sense kind of thread going through all the groups that formulation is for the 'complex' and the 'risky' rather than for everyone. Which is interesting if you think of formulation in terms of storytelling – that everyone has a story to tell. But in this case, you're stories only worth(?) listening to or people will only take the time to listen if its associated with mental health complexity and risk. Kind of makes me think of the way that we set services up in general, many tier three services won't accept referrals from people who are low risk or 'simple'. So, your worthiness for intervention

is at times based on your risk? I wonder how that would reflect on the model (????) which talks about applying the extremes of mental health to the general population. Rather than focusing on applying a model of wellness we're applying a model of sickness to everyone.

Interesting slightly negative view of medic model and 'consultants'… view of them potentially taking over formulations and making them 'too medical'?

Still coding the third focus group (22.10.19)
Much talk about fragmentation in the third focus group. Fragmentation of notes, fragmentation of roles, fragmentation of people's stories… wonder if the team is fragmented and that's why it's being reflected on lots of different areas?

At 57 minutes there's a bit where one of the nurses is reaching for a snack and another nurse picks her up on it and it feels awkward like a confrontation. Wonder if this is reflective of the relationships in the team – whether the strain of burnout is reflecting in how the team works together. Interestingly it's between the clinical nurse specialist and the nurse who described leaving the team... Use of the word darling, passive aggressive?

Hegemony – Medical model? Everybody in a society acquiesces in one way or another to a dominant person or social group

Beginning to organise the chaos (5.11.19)
Beginning to put together different codes to unpick dominate discourses. There're many themes related to staff difficulties, or potential burnout. I've identified different strands such as formulation as being "absolving" or an "added extra". Beginning to realise that personally I am shocked by the lack of... respect I guess for the concept of formulation. Some people see it as just something to do but as a trainee it feels like an important cornerstone of our work...

Six Themes have emerged (11.11.19)
I realise that I've got engrossed in putting the discourse topics together that I've neglected to talk about the process of doing so. I've ended up with four major discourse topics related to staff burnout, exclusion of service users, role of power and hierarchy and the power of storytelling. I've also identified two less prominent discourses of transference/process type discussions and formulation of the team and the service being at the forefront. I'm surprised at how readily the discourses map onto my own understanding of some of the difficulties of formulation – but then maybe I should not be surprised as I alone have shaped them and are lensed through my own views and opinions.

I think putting quotes in the titles of the discourse sections in the results should be more engaging to the reader and some of them are bomb shells like “nobody’s ever spent that time talking to me”. I have also realised that the themes are generally quite positive towards the service user (other than the exclusion of service user topic) which surprises me after getting lost in the rabbit warren of negative themes that arose. Putting it together now to send a draft to my supervisor.

Draft sent! (15.11.19)

Just sent a draft to my supervisor and it feels like a fledgling has left the nest!

Been neglecting my work lately… (07.01.20)

Cannot believe its 2020 already!

Due to personal reasons I’ve been neglecting my work lately but ready to crack on with some corrections and to re-engage again with the work.

Started making corrections to my SECOND DRAFT of my empirical but having to do them in blue because I’ve shuffled so many things around!

Finished first complete draft (7.02.20)

Just completed first complete draft of my portfolio and I cannot believe how well it has come together! The themes from my systematic review really do flow through to my empirical paper. I suppose I should not be surprised because I must have had the ideas in my mind from my empirical to inform my systematic review – I wonder how much that affects the themes for my Thematic Synthesis…

Appendix L

Example from Transcript with Topics (Empirical Paper)

Excerpt of transcript from Focus Group 2 with relevant highlighting of topics

Start Time	End Time	Transcript	Speaker	Topics
12:31.2	13:00.0	But al-also (.) if that does happen and °you know° you explain that and you discharge it (0.2) the client than you can (.) call home treatment and say listen we've had this meeting this formulation you know (.) unfortunately we <u>can't</u> provide their needs can't be met met we're just letting you know because it <u>will</u> escalate because obviously you're not doing you're not saving↑ me	CMHN2	Staff as the experts
13:00.0	13:00.8	Mm	Researcher 1	
13:00.8	13:14.5	So I'm just gonna go an::d do what I've got to do <u>I want psychology</u> that's the answer t:o my prayers however unfortunately it's not	CMHN2	Lacking Service User Empathy Us and them – Power Hierarchy
13:14.5	13:20.4	Mmm (0.2) and are the service users normally involved in the formulations (.) o:::r would you do them just with staff	Researcher 1	

13:20.4	13:21.0	[I normally do them just with staff]	CMHN3	Service user exclusion
13:21.0	13:22.0	[Just with staff]	CMHN2	Service user exclusion
13:22.0	13:23.0	[Yeah just with staff]	OT1	Service user exclusion
13:23.0	13:35.6	Yeah never never had a service user involved their °obviously the outcomes and everything gets actioned afterwards and we'll speak to them and said we've had- we've had a meeting we've had this kind of professional's meeting talk about ya↑ um here's what we're we're going to move on for but yeah generally their not involved in that°	AP2	Us and them – Power hierarchy Staff as the experts Service user exclusion
13:39.7	13:41.1	But we do feed it back don't we?	CMHN2	Service user exclusion
13:41.1	13:41.9	Yeah	AP2	
13:41.9	13:48.8	So you know I'm wondering why this is um (0.3) °you know but that's helpful as well°	CMHN2	
13:48.8	13:50.9	Yeah (.) and are there benefits↑ to them not being there?	Researcher 1	
13:50.9	13:53.8	Probably traumatise them	CMHN2	Formulation as traumatising

13:53.8	13:55.0	°I wonder whether it would yeah°	OT1	
13:55.0	13:55.3	Yeah	AP2	
13:55.3	13:56.0	Because you literally talking about them	OT1	
13:56.0	14:08.9	If you're saying in front of em they they want this holy grail of psychology which is going to fix everything and then you've got a psychologist going actually they wouldn't be able to tolerate that if they were there they'd be going ↑yes I would you need to fix me so I can't really see how that would be beneficial in their best interest	CMHN2	Doing to not doing with Staff as the experts Formulations as traumatising Service user exclusion
14:15.4	14:22.2	I think in in this area of work there is times when you do need meetings without the service user	AP2	Us and them – Power hierarchy Formulations as an aide for staff Service user exclusion
14:22.2	14:22.3	Yeah	OT1	
14:23.2	14:44.0	You know as much as you can try and involve them but I think there's times especially with a formulation that they do °do need to be put to one side and we do have that professionals discussion um around em° but obviously all that needs to be fed back but I think it would definitely be	AP2	Us and them – Power hierarchy Lacking service user empathy Staff as the experts

		more therapeutic and you'd get more out of it in a group because sometimes you you can hold back some information when a service user's there↑		Service user exclusion
14:44.0	14:44.8	Yeah	OT1	
14:44.8	14:54.7	That maybe like you either need to talk about some sensitive information u:m so to be open and honest and get a full account I think they do need to be away from that meeting but obviously you need to feed back that	AP2	Us and them – Power hierarchy Service user exclusion
14:54.7	15:12.7	Especially depending on their insight as well because if they're if ↑your talking about saying someone who hears voices saying look they're hearing this voice but to them (.) this is a very real thing what you're effectively saying into that service users mind is I don't believe what you're saying I don't believe that you can hear this	CMHN3	Discourses of illness

Appendix M

Table with Topics from Discourse Analysis

Discourses	Major topics	Topics
The role of power and hierarchy	Power and Hierarchy	Lack of doctor involvement Professional roles Psychology top up Role of the psychologist Us and them – power hierarchy
Formulations in teams and services	Service Level	Between service tension Formulation as perspective gathering Formulation for consistency Formulations to prevent 'splitting' Fragmentation of viewpoints Record keeping Service level formulation Team working
Staff struggles, burnouts and constraints	Staff Burnout	Case management Consultation rather than formulation Doing to not with Formulation as security 'just in case' Formulation as a stand-alone action Formulation as a time for reflection and pause Formulation as absolving staff Formulation as an 'action' and 'tick box' Formulation as an aide for staff Formulation as unimportant Formulation's as pressure for staff Formulations as an 'added extra' and a 'luxury' Goals Informal formulation (outside meetings) Lacking SU empathy Making a difference (Staff) Next steps Peer support Staff as advocates Staff as the experts (rather than the service user) Staff burnout Staff guilt Staff hopelessness Staff reassurance

		Staff reflection Time and other constraints
	Staff Burnout and constraints	Formulation as constraining Formulation as rigid Formulations as negative events Formulations as traumatising Justification of lack of Service user Service user exclusion
The importance of story telling	Story Telling	Being about the person Collaboration Formulation as 'unsticking' Formulation as a process Formulation as evolving Formulation as story telling Formulations needing to be joint Historical information used in formulations Hypothesising Making a difference Pattern formulating Service user empathy Service user empowerment Subjectivity
Staff transference and consideration of process	Transference	Communication Endings Therapeutic relationships Transference reflections
Trauma and Exclusion of the individual	Trauma and Exclusion	Discourses of diagnosis Discourses of illness Discourses of risk Formulations for complex people

Appendix N

Systematic Review CASP Quality Assessment

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐ Can't Tell ☐ No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐ Can't Tell ☐ No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐ Can't Tell ☐ No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

Section C: Will the results help locally?	
10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used
Comments:	

Appendix O

Excerpt of example systematic review paper with coding for Thematic Synthesis

Paper excerpt from Stratton & Tan (2018)

Making links, noticing patterns, using the map

This theme highlighted an ability to draw from service-users' histories, to understand problematic procedures and to use the map as a tool to support them in noticing links between past experiences and current difficulties:

[…] this is what they only know […] so it will help you to understand oh okay she is like pushing me away because what she is used to is being pushed away (P6).

I think the maps are useful […] just looking at what patterns we can expect, what reciprocal roles we can look at that we might be getting into without really knowing about it (P4).

Finding a way out. Exits and professional responses. This theme described the ways in which staff were able to incorporate new knowledge into their interactions, and their ability to find therapeutic exits from unhelpful procedures, both in direct and indirect interventions:

[…] bearing in mind like their maximum level of functioning, because we don't want to stretch them because we end up doing more damage […] so this will also guide us, like okay we can go, we can stretch this far […] but just remembering as well where they come from, what are their triggers erm how much they suffered (P6).

I suppose […] just noticing how people are talking about particular women especially in times of crisis […] I've been able to […] support a different way of reframing and thinking about things (P1).

Codes	Higher Order Codes
Considering patients history	Understanding complexity of the individual
Linking past and present	Understanding complexity of the individual
Linking past and present	Understanding complexity of the individual
Visual Aids	Importance of tangible action
Utilising new knowledge	Understanding complexity of the individual
Finding therapeutic exits	Importance of tangible action
Knowing people's limits	Understanding complexity of the individual
Linking past and present	Understanding complexity of the individual
Reframing	Positive effects

Appendix P

Summary of Studies Included in Systematic Review

Authors	Title	Analysis	Context
Beardmore (2016)	Psychological formulation in a community learning disability team	Thematic Analysis	Community team for people with learning disabilities (age range not specified) Open-ended questionnaire qualitatively analysed Number of participants not detailed
Bensa & Aitchson (2016)	An evaluation of inpatient staff perceptions of psychological formulation meetings	Thematic Analysis	Two 14 bedded male and female acute inpatient units based within a large NHS Mental Health Trust Open-ended questionnaire qualitatively analysed *N* = 23, 12 from female ward, 11 from male ward. Six participants were unqualified, and 17 participants were qualified (no information provided regarding gender)

Blee (2015)	Community mental health team members' perceptions of team formulation in practice	Thematic Analysis	Three community mental health teams (including one assertive outreach team and one early intervention for psychosis team) Three focus groups and three interviews conducted. *N*= 12, three psychologists, seven community psychiatric nurses, one occupational therapist and one support time recovery worker (no information provided regarding gender)
Christofides et al. (2012)	Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working	Thematic Analysis	Adult mental health services, including community mental health teams, assertive outreach, rehabilitation and recovery, forensic services, early intervention in psychosis, an acute inpatient ward, and a high dependency inpatient ward Interviews qualitative analysed *N*= 10, six female and four males
Eyres & McKay (2011)	Qualitative evaluation of a case consultation group within a multidisciplinary home treatment team	Thematic Analysis	Home treatment team situated within an urban community mental health team Interviews qualitative analysed *N* = 11, six community psychiatric nurses, one team leader, two support workers, two social workers and a specialist registrar
Harris-Waller & Jacyna (2014)	Using a solution-focused model for case discussion with non-psychology colleagues	Content Analysis	Early Help Team (no further information provided) Open ended questionnaire qualitatively analysed *N*= 6 (no further information provided)

Harrison et al. (2018)	Team psychological formulations in assertive outreach teams: Evaluating staff experiences.	Thematic Analysis	Assertive Outreach team Interviews qualitative analysed *N* = 25, 11 male and 14 females. 12 community mental health nurses, six healthcare support workers, three occupational therapists, two psychiatrists, one team manager and one social worker.
Kellet et al. (2014)	Team consultancy using cognitive analytic therapy: a controlled study in assertive outreach.	Content Analysis	NHS Assertive Outreach team Interviews qualitative analysed *N* = 15 (no further information provided)
King (2016)	Psychological formulation in residential teams working with people with dementia: an exploration of multidisciplinary views using Q-methodology	Q-methodology	Conducted across a number of independent sector residential/nursing homes, NHS mental health care teams and Staffordshire University. Interviews qualitatively analysed *N*= 17, five residential staff members, 10 clinical psychologists and two other mental health professionals (not specified)

Lewis-Morton et al. (2017)	Co-producing formulation within a secure setting: A co-authorship with a service user and the clinical team	Thematic Analysis	Secure inpatient service (no further information) One focus group *N*= 5, one psychologist, one service user, one psychosocial recovery worker, one senior nurse, one psychiatrist (no additional information provided regarding gender)
Manuel (2016)	Multidisciplinary team members' experiences of team formulation: a thematic analysis	Grounded Theory	Two adult mental health teams (one community setting and one inpatient) Semi-structured interviews qualitative analysed *N*= 10, eight females and two males. Three members of staff from an Independent Living Support Service, two occupational therapists, two staff nurses, one ward manager, one deputy ward manager and an activities co-ordinator
Stratton & Tan (2019)	Cognitive analytic team formulation: learning and challenges for multidisciplinary inpatient staff	Thematic Analysis	Tier four inpatient unit for women with a diagnosis of personality disorder Semi-structured interviews analysed qualitatively *N*= six, all female. Two from a nursing background, two allied health professionals, one management, one support worker.

Turner et al. (2018)	Team formulation in an assessment and treatment unit for individuals with learning disabilities: An evaluation through staff views.	Thematic Analysis	Seven-bedded inpatient Assessment and Treatment Unit for individuals with learning disabilities who display behaviours that challenge and/ or may be experiencing mental health difficulties Open ended questionnaire qualitative analysed *N*= 15 (completed anonymously so no further information provided)
Walton (2011)	Complex case consultation forums: A thematic analysis	Thematic Analysis	Complex case consultation forums (CCCF) in the adult network (including inpatient and community) Qualitative analysed CCCF outcome reports *N*= 89. 58 reports from community settings, 31 from inpatient settings. 58 CCCF reports concerned female cases and 31 male cases.
Weedon (2017)	Multidisciplinary team members' experiences of team formulation: a thematic analysis	Thematic Analysis	Four Early Intervention In psychosis teams across two NHS trusts Semi-structured interviews qualitatively analysed *N*= 11, six female and five males. Eight nurses and three occupational therapists were included.
Wood (2016)	Clinical psychologists' experiences of moving towards using team formulation in multidisciplinary settings	Thematic Analysis	NHS Adult Mental Health settings, including seven community mental health teams, two rehabilitation and recovery units, two outreach and recovery teams. Semi-structured interviews qualitative analysed *N*= 12 clinical psychologists, eight female and four males.

Appendix Q

Second investigator ratings of systematic review articles

Authors	Title	Analysis	Quality Appraisal
Eyres & McKay (2011)	Qualitative evaluation of a case consultation group within a multidisciplinary home treatment team	Thematic Analysis	High-quality design and methodology. No in-depth discussion of analysis process does clarify that the findings were clarified with team. Findings are related back to research aims but no evidence for researcher's arguments or discussion of credibility Valuability of research not discussed Limited ethical consideration but informed consent is discussed
Harrison et al. (2018)	Team psychological formulations in assertive outreach teams: Evaluating staff experiences.	Thematic Analysis	High-quality design and method Data analysis not rigorous, uses quotes to support themes but unclear as to how these quotes were selected No discussion of credibility, but some explanation of findings in relation to research question Valuability of research well discussed Ethical consideration given in detail

Appendix R

Systematic Review Quality Appraisals

Study	Quality Appraisal
Beardmore (2016)	Moderate
Bensa & Aitchson (2016)	Poor
Blee (2015)	High
Christofides et al. (2012)	High
Eyres & McKay (2011)	Poor
Harris-Waller & Jacyna (2014)	High
Harrison et al. (2018)	High
Kellet et al. (2014)	Moderate
King (2016)	High
Lewis-Morton et al. (2017)	Moderate
Manuel (2016)	High
Stratton & Tan (2019)	High
Turner et al. (2018)	Moderate
Walton (2011)	Poor
Weedon (2017)	High
Wood (2016)	High