"You're Changing the Pattern": **Using Cognitive Analytic Team Formulation to Help Care Staff Working with People with Intellectual Disabilities Understand and Manage Challenging Behaviour**

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Chapter One: Executive Summary

This thesis, comprising three subsequent chapters, explores staff's experiences of receiving facilitated formulation for their clinical work with people with intellectual disabilities. Chapter Two presents a systematic review of research exploring staff's experiences of receiving team formulation and systemic consultation (facilitated formulation) for their direct work with clients with intellectual disabilities. The review highlighted a lack of qualitative research into team formulation in this area, and no investigation of approaches that helped staff formulate relationships with their clients explicitly. This formed part of the rationale for the empirical paper (Chapter Three), which details a qualitative study on care staff's experiences of receiving contextual reformulation, a Cognitive Analytic (CAT) model of team formulation that includes formulating staff relationships with clients, in this case, people with intellectual disabilities who exhibit behaviours that challenge. Chapter Four, (Integration, Impact and Dissemination), integrates the findings from Chapters Two and Three, and discusses the study's implications and plans for dissemination.

Chapter Two: Systematic Review

Over the past fifty years, there have been changes in how people with intellectual disabilities are understood. Shifts from understanding challenging behaviour as functional, relational and systemically influenced rather than individualistic have led to more humanistic conceptions of care provision. People with intellectual disabilities have cognitive and functional impairments that make them more dependent on others. Relationships with carers can impact on wellbeing and incidence of challenging behaviour for people with intellectual disabilities. Facilitated formulation, such as team formulation and systemic consultation, can help staff reframe challenging behaviour from individual conceptions to more systemic, functional understandings. Research suggests that these approaches can also have effects such as improved staff satisfaction and team functioning. Understanding staff experiences of these

approaches can inform their delivery and the development of further theory and research, which is required in this domain. A systematic review can integrate findings.

This review addressed the question: *how do frontline staff in intellectual disabilities settings experience facilitated formulation?* The review defined facilitated formulation as including team formulation or systemic consultation. Staff experiences included interview and survey responses relating to experiences during and after formulation sessions and did not include perceptions of clinical outcomes.

The search strategy was broad and captured two elements of the question: intellectual disabilities and facilitated formulation. Three databases were searched: PsycINFO; PubMed/MEDLINE; and Web of Science. Only published research was included. Studies were included if a) facilitated formulation sessions focused on one client as opposed to generic training on formulation; b) staff attending formulation sessions worked directly with clients with intellectual disabilities as a core part of their work; c) studies were in English. Services could be secure or community-based and no date limits were placed on the search. Studies could be qualitative, quantitative or mixed-methods as long as their main focus was staff experiences. The search returned 39 unique articles and seven articles satisfied inclusion criteria and were included in the review. Quantitative and qualitative findings were extracted and synthesised separately, using thematic synthesis to code findings line-by-line and develop quantitative and qualitative themes.

Eight quantitative themes were developed. (1) *Formulation meetings helpful* indicated staff found sessions useful in general. (2) *Aiding understanding of client* demonstrated sessions helped staff formulate client difficulties. (3) *Work related skills* showed staff gained practical strategies from sessions. (4) *Confidence in work* suggested staff felt more confident in their work after sessions. (5) *Relationship with client* evidenced staff perceptions of staff-client relationships were positively impacted after sessions. (6) *Team working* demonstrated some teams felt more cohesive after sessions. (7) *Able to contribute perspective* suggested staff felt

able to communicate and contribute to sessions. (8) *Others* suggested sessions improved some staff's understanding of risk and facilitators were seen to stay on task and deliver aims.

Five qualitative themes were developed. (1) *Role of facilitator* emphasised staff's experiences of the significance of facilitators' theoretical knowledge and practical expertise, the way they communicated information and structured sessions, and their general approach and style. Facilitators' use and teaching of theory and technique were generally experienced as helpful. Most staff felt validated and involved by facilitators; a minority found the facilitator's approach or use of technique unusual. (2) *Team/systemic processes* showed many staff felt sessions enabled them to step back and see the big picture of their client's situation and difficulties. They felt enabled to reflect rather than immediately find solutions. However, some staff found it frustrating not to have answers. Some staff noticed new ways of conversing happened at a team level such as exploring and allowing multiple perspectives. The importance of buying into the approach was highlighted. Some staff doubted if sessions could help with particularly challenging family contexts. (3) *Client-formulation* demonstrated staff gained skills in formulating developmentally and understanding behaviour in context. Certain staff mentioned sessions helped them understand challenging behaviour. Other mentioned they felt more able to empathise with clients. In cases where clients attended formulation sessions, some staff felt clients gained positive feedback and insight; other staff worried sessions were too overwhelming for clients. (4) *Moving forward* indicated staff felt formulation sessions helped them develop practical strategies in their work with clients, that helped some feel empowered to make changes and try new things out. (5) *Service/organisational context* represented staff's concerns regarding organisational barriers to attendance and experience of formulation sessions, such as shift patterns, cramped environments and service pressures. Quantitative and qualitative themes were integrated into a visual model (p. 51).

The review's findings highlighted staff working with intellectual disabilities benefit from facilitated formulation, gaining theoretical knowledge and practical skills that aid their clinical

work. However, findings did not focus specifically on the management of challenging behaviour, a central clinical issue. Findings suggested systemic barriers and communication of aims should be considered, to optimise the use of facilitated formulation. Avenues for further research include development of staff and team focused theory and outcome measures.

Chapter Three: Empirical Study

Team formulation is an approach used by psychological professionals to facilitate psychological thinking and development of shared understanding and approach in teams of frontline staff. It is a valuable model for use in intellectual disabilities settings for several reasons. Staff-client relationships play a role in the development, maintenance and management of challenging behaviour, a central presenting difficulty for people with intellectual disabilities. Team formulation can help upskill teams and understand challenging behaviour less individualistically and more systemically and relationally. It can also help staff develop a shared understanding and approach, promoting consistency, which is important in providing care to people with intellectual disabilities. There is a small but growing amount of research into formulation and team formulation. Findings suggest a range of outcomes including staff satisfaction and team morale. Research on team formulation in intellectual disabilities settings is mainly focused on staff experiences and has been found to help with developing a shared understanding of clients, giving staff space to think and reflect, and developing new strategies for their work. However, most of this research does not address challenging behaviour specifically, and there is no research on team formulation models that explicitly formulate staff-client relationships. Team formulation informed by cognitive analytic therapy (CAT) is known as contextual reformulation, and explicitly formulates relationships. Research on contextual reformulation is in its infancy and there is no research on its use in intellectual disabilities settings. The current study addressed the question: *What are care staff's perceptions of*

changes in their approach, understanding of and ability to manage behaviours that challenge in

their intellectually disabled clients after team formulation from a cognitive analytic approach?

Eleven care staff were recruited via CAT clinicians providing contextual reformulation. Participants were interviewed using a semi-structured interview schedule, which explored staff's experiences of contextual reformulation and their perceptions of working with intellectual disabilities and challenging behaviour. Interview transcripts were analysed using inductive thematic analysis of the entire data set. Another researcher checked coding to increase reliability.

Five themes were developed, and were checked for resonance with participating staff. (1) *Multiple ways of relating to consultation sessions and clinicians*: staff experienced sessions in various ways, as therapy, as lessons, and as training. Similarly, facilitators were valued for multiple reasons: for their psychological expertise and suggestions, their validation of staff's emotions and the way they supervised staff's application of formulations session-by-session. (2) *Challenging behaviour in relationship*: staff found contextual reformulation helped them understand challenging behaviour as learned in early relationships and re-enacted in current ones. Staff understood their responses as stemming from their own emotions, which could either contain or perpetuate behaviours. (3) *Making links – understanding as enlightening, containing and practical*: staff found diagrammatic formulations helpful for integrating clinical information and planning intervention. Psychological theory was seen as helpful in putting words to staff's intuitive understanding. Staff acknowledged sometimes formulations were difficult to apply in the heat of the moment. (4) *The process of developing a shared perspective and approach*: sessions helped teams form a shared understanding and approach towards their clients and challenging behaviour. Clinicians skilfully integrated multiple perspectives and diagrammatic formulations provided a shared reference point. (5) *Caught between two perspectives*: there was a conflict for some staff between an instinct to find solutions and fix problems, versus accepting problems were likely to be long term and learning how to manage

them differently. It appeared difficult to hold both perspectives in mind. Findings were integrated into a thematic map (p. 91).

Findings suggest contextual reformulation can help care staff understand challenging behaviours more relationally, which can inform the way they respond to challenging behaviour, emotionally and behaviourally. Sessions helped staff teams develop a shared approach, and feel more emotionally contained. As well as being linked with improved care provision, these outcomes are important occupational requirements. The final theme highlights ideological conflicts between mainstream social values and the experience of people with intellectual disabilities. These wider systemic conflicts are experienced most directly by care staff who inhabit both worlds. Social change must accompany advancements in clinical approaches to improve care provision meaningfully and sustainably.

Future research could explore a standardised model of contextual reformulation and integrate qualitative and quantitative methods to investigate the impact on team and system outcomes. There is also the potential for such outcomes to be developed and refined.

Findings indicate contextual reformulation and team formulation in general satisfy the occupational needs of staff in intellectual disabilities settings, such as emotional containment and reflection, and upskilling, which in turn optimise care provision.

Chapter Four: Integration, Impact and Dissemination Summary

Findings from the systematic review and empirical paper demonstrated staff perceived facilitated formulation as helpful in integrating clinical information, informing care planning and developing a shared understanding and approach among the team. The facilitator was seen as an important agent in teaching psychological knowledge, encouraging reflection, providing emotional support and making clinical suggestions. The empirical paper produced additional findings regarding contextual formulation specifically. For example, staff found these sessions helpful for understanding challenging behaviour relationally, and conflicts were found between

traditional, individualistic conceptions of challenging behaviour versus more acceptance-based approaches.

There are various potential impacts of the empirical study. By being interviewed, participating staff may have benefitted from additional reflection and consolidation of what they learned in sessions. Staff working in similar settings or with other clients with complex needs may benefit from the themes discussed, which may help them refer and make use of formulation sessions optimally. Clients may benefit from improved care provision.

The chief investigator has presented the research at the CAT research conference and will submit a poster presentation at an international conference. A lay summary of the findings has been distributed to participating care teams and CAT clinicians, including the CAT learning disabilities special interest group. The final paper will be submitted for journal publication.

Chapter Two: Systematic Review

How Do Frontline Staff in Intellectual Disabilities Settings Experience Facilitated Formulation?

Abstract

People with intellectual disabilities have cognitive and functional impairments, making them more dependent on others including frontline staff. These factors can influence incidence of challenging behaviour. Facilitated formulation, such as team formulation and systemic consultation, helps staff reframe challenging behaviour from individual conceptions to more systemic, functional understandings, aiming to improve care provision. This review synthesised research on staff views of facilitated formulation. PsycINFO; PubMed/MEDLINE; and Web of Science were searched. Seven qualitative, quantitative and mixed-methods studies exploring staff experiences of facilitated formulation in intellectual disabilities settings were included. Thematic synthesis was used to develop themes from study findings. Eight quantitative themes were developed: (1) Formulation meetings helpful; (2) Aiding understanding of client; (3) Work-related skills; (4) Confidence in work; (5) Relationship with client; (6) Team working; (7) Able to contribute perspective; and (8) Others. Five qualitative themes were developed. (1) Role of facilitator; (2) Team/systemic processes; (3) Client-formulation; (4) Moving forward; and (5) Service/organisational context.

The review's findings highlighted staff working with intellectual disabilities benefit from facilitated formulation, gaining theoretical knowledge and practical skills that aid their clinical work. However findings did not focus specifically on management of challenging behaviour, a central clinical issue. Findings suggest systemic barriers and communication of aims should be considered, to optimise use of facilitated formulation. Avenues for further research include development of staff and team focused theory and outcome measures.

Introduction

Over the last 50 years, there have been developments in understanding people with intellectual disabilities and behaviours that challenge[1], and this has affected what is considered appropriate and effective care provision. Intellectual disability is often used interchangeably with learning disability and is defined as significant impairment in intellectual and adaptive functioning that originates in the developmental period (British Psychological Society [BPS], 2015) whereby adaptive functioning is impaired in three domains: conceptual, social and practical (American Psychiatric Association [APA], 2013). The most widely held definition of challenging behaviours is:

> Culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, to seriously limit use of, or result in the person being denied access to, ordinary community facilities. (Emerson, 1995, p.4, in Emerson, 2011).

Historically, medicalised conceptions of intellectual disabilities were widely accepted as most relevant in understanding client difficulties, including challenging behaviours; these difficulties were attributed to the neurobiology of clients, implicating the need for medication, institutionalisation and restrictive intervention (Emerson, 1995). Over time, more humanistic, psychosocially-informed understandings emerged, which recognised people with intellectual disabilities are influenced and affected by their environments, and should be supported to engage in fulfilling activities and relationships in community contexts (Emerson, 1995; NHS England, 2015). Excessively restrictive practices were acknowledged as traumatising and it became accepted that psychosocial approaches, including therapy and psychological formulation

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[1] The terms behaviours that challenge and challenging behaviours are often used interchangeably in the literature, and for the purposes of brevity and flow, the latter term is used for the most part in this article.

were just as relevant to this population as any other (Bender, 1993), and that challenging

behaviours should be seen as serving a function (Emerson, 1995) that can be understood in the

context of societal, environmental, relational, psychological, physical, and medical factors.

The needs of people with intellectual disabilities can be complex; in additional to cognitive

difficulties, they have significantly less independence than the average person and often suffer

from multiple chronic physical health issues, mental health problems and relationship difficulties

(NHS England, 2017). This can affect daily functioning and achievement of personal goals.

Consequently, many people with intellectual disabilities exhibit behaviours that challenge

people around them, such as aggression towards self and others. Due to these additional needs

and challenges, people with intellectual disabilities are often in contact with multiple

professionals and systems that support them, their families and carers. It is vital for carers of

people with intellectual disabilities to understand both the complexity of their needs and the

multiple contexts and relationships that simultaneously define, respond to and impact them

(Rhodes et al., 2011).

Some of the most influential relationships for people with intellectual disabilities other than

family or friends are those with direct care staff who support them in residential or day facilities,

or case managers in social services settings. These relationships have the power to benefit or

adversely affect client wellbeing (Hastings, 2005). The relationship is bi-directional (Hastings,

2005); direct care staff in these settings are likely to experience challenging behaviours

frequently, which affects them and their relationships with clients in many ways (Lambrechts,

Petry, & Maes, 2008). Whilst evidence suggests staff hold multiple interpretations of behaviours

simultaneously (Jahoda & Wanless, 2005), more severe intellectual disabilities presentations

lead staff to understand difficulties less environmentally and more biomedically (Tynan & Allen,

2002); they tend to focus on changing these behaviours rather than understanding them

(Hastings, 1995; Saloviita, 2002), with more individualistic conceptualisations of challenging

behaviours sometimes leading staff to withdraw help (Hill & Dagnan, 2002). Care staff can also

experience burnout in relation to organisational factors such working shifts, lack of support from management, and uncertainty about procedures (Chung, Corbett, & Cumella, 1995). Limited knowledge about how to respond to behaviours is just as stressful as the behaviours themselves (Bromley & Emerson, 1995). It seems unsurprising a third of staff consider leaving their jobs within the next year (Robertson et al., 2005). Understandably, staff often require external support from professionals such as psychologists. In line with recommendations from the Department of Health (DoH, 2007) the last 15 years have seen increasing emphasis on clinical consultation provided to care staff by psychological professionals from specialist intellectual disabilities teams (Ingham, 2015). This fits with clinical psychology's move towards focusing resources on indirect forms of working such as consultation, upskilling unqualified staff in psychological skills.

Two models of clinical consultation are team formulation (Weerasekera, 1996; Lake, 2008; Johnstone, 2014) and systemic consultation (Haydon-Laurelut, Bissmire, & Hall, 2009; Rhodes et al., 2011; Haydon-Laurelut, Millett, Bissmire, Doswell, & Heneage, 2012), both forms of facilitated formulation. Team formulation aims to enable staff teams to develop a shared understanding of client difficulties that integrates multiple staff's perspectives and is grounded in psychosocial theory (Lake, 2008; Johnstone, 2014). Sessions should empower the team rather than provide solutions (Lake, 2008), and while formulations lay the groundwork for effective intervention and care planning, an equally important aim is promoting reflection as opposed to outcome-focus. Diagrammatic representations or categories are used to structure and integrate clinical information from various sources and multiple perspectives, encoding it visually and helping a team make new connections between previously disparate pieces of information.

Systemic consultation derives from systemic approaches to therapy, which have become increasingly popular in intellectual disabilities settings in the past two decades (Haydon-Laurelut, Bissmire, & Hall, 2009; Johnson, 2016). The distinction between systemic therapy and consultation is not always clear, but the uniting principle is that problems are understood to

exist in systems, which is seen as the appropriate focus of intervention rather than the individual. For the purposes of this paper, consultations that involve staff teams are not considered to be therapy. In systemic consultations, facilitators guide conversation about the problem using various techniques which may include a stance of curiosity (Cecchin, 1987), circular questions (Dallos & Stedmon, 2014), identifying strengths and drawing on resources in the system (Fredman, 2014) and highlighting multiple and new perspectives in an attempt to create difference (Andersen, 1987). Facilitators usually form a reflecting team (Haydon-Laurelut, Bissmire, & Hall, 2009; Rhodes et al., 2011; Haydon-Laurelut et al., 2012; Johnson, 2016), discussing what they experienced in front of attendees. These techniques enable consultees to step back (Rhodes et al., 2011) and shift perceptions of "the problem" towards a more relational rather than individualised understanding. Systemic consultations may be attended by the client, family, carers and staff; some models are used with staff teams only (Haydon-Laurelut et al., 2012), and there are examples where one staff member attends alone (Fennessy et al., 2015).

While the two approaches may have their differences, team formulation more often drawing a visual map, systemic consultation emphasising interpersonal processes, they serve a similar purpose: intervening at a systems level (Lake, 2008; Rhodes et al., 2011); facilitating a step back from current views of the problem; and enabling a new, in most cases shared, understanding. Facilitated formulation maps onto Kolb's stages of reflective observation and abstract conceptualisation (Kolb, 1984), two essential stages in learning, often overlooked in busy clinical settings, which enhance staff's ability to adapt flexibly and respond appropriately to complex, dynamic situations with clients.

The evidence for facilitated formulation is limited, including in the area of intellectual disabilities. Research on clinical outcomes in systemic consultation is particularly limited (Johnson, 2016); a cluster randomised trial showed that a staff-focused intervention including systemic consultation led to reduced use of antipsychotic medication in care home residents over one year, compared to controls (Fossey et al., 2006) although findings could not be reliably

attributed to the systemic consultation component. A recent systematic review (Geach, Moghaddam, & De Boos, 2017) integrated definitions of, approaches towards and clinical outcomes of team formulation research. Findings suggested client outcomes can include reductions in challenging behaviour (Ingham, 2011) and improved mental health but also worse functioning (Berry et al., 2015). Arguably, staff outcomes are most relevant in measuring the efficacy of facilitated formulation, since staff are recipients and their experiences are more directly attributable to the intervention. Staff-focused outcomes included improved understanding of, empathy for and attitudes towards clients (Murphy, Osborne, & Smith, 2013; Berry et al., 2009; 2015; Ramsden, Lowton, & Joyes, 2014), although sometimes staff felt left out when unable to attend (Murphy et al., 2013), and more powerful voices could dominate sessions (Summers, 2006).

Most of the research on systemic consultation and team formulation in intellectual disabilities settings consists of small-*n* studies and evaluations focusing on staff views (Ingham, 2011; Wilcox, 2013; Whitton et al., 2016; Turner, Cleaves, & Green, 2018; Rhodes et al., 2014; Johnson & Viljoen, 2017) and staff-focused outcomes such as increasing staff satisfaction (Allen, 2015; Chiffey, Irving Quinn, & Casures, 2015), improving team functioning via collaborative formulations incorporating multiple views (Craven-Staines, Dexter-Smith, & Li, 2010; Hollingworth & Johnstone, 2014; Lewis-Morton, James, Brown, & Hider, 2015; Roycroft, Man, Downie, Gale, & Armstrong, 2015; Whitton et al., 2016), generation of psychologically-informed care plans (Summers, 2006; Wainwright & Bergin, 2010; Ingham, 2011), staff self-efficacy (Maguire, 2006; Fennessy et al., 2015) and perceptions of "stuckness" (Allen, 2015). Staff perceptions are an important mediator in clinical outcomes, for example in impacting the incidence of challenging behaviours (Hastings, 2005; Lambrechts, Petry, & Maes, 2008). Even when intervention does not impact client outcomes immediately or tangibly, shifts in staff's perception may help them better manage clinical work. For example, Emerson (1995) has shown that incidence of challenging behaviours did not reduce significantly over 20 years, and

other authors have argued team approaches in this area can enable staff to understand and manage behaviour more relationally, rather than trying to change it (Elford & Ball, 2014).

Staff play significant roles in the lives of people with intellectual disabilities. Staff perceptions and behaviours impact their clients, and quality of care provision; therefore their experiences of facilitated formulation can help inform understanding of how such approaches enable effective care provision and improved clinical outcomes. The current review addresses the question: *how do frontline staff in intellectual disabilities settings experience facilitated formulation?* For this review, staff experiences meant staff's perceptions of facilitated formulation itself, or subsequent clinical practice, rather than perceptions of client behaviour subsequent to facilitated formulation.   Arguably, distinctions between these concepts are somewhat arbitrary, given staff experiences are often considered outcomes in themselves (Geach, Moghaddam, & De Boos, 2017). However, the focus on staff experiences of the process of facilitated formulation and their personal responses to it rather than any objective changes in client behaviour mirrors the aims of facilitated formulation, which emphasises experiences and perceptions of staff as central outcomes rather than client behaviour (Elford & Ball, 2014; Johnstone, 2014).

Method

PRISMA guidance (Preferred Reporting Items for Systematic Reviews and Meta-Analyses; Moher, Liberati, Tetzlaff, & Altman, 2009) informed the review's procedure and structure.

Eligibility Criteria

Eligible studies explored staff experiences of facilitated formulation for their direct work with people with intellectual disabilities. Facilitated formulation included team formulation, systemic consultation and any other activity whereby the main focus of staff consultation was formulation of one client; studies exploring theoretical training on formulation which was not applied to a particular client were excluded, as this was considered a qualitatively different intervention. Studies could focus on adult or child settings, within secure or community services. Studies focusing on staff who received facilitated formulation to inform their own consultation sessions with direct care staff were excluded, as these staff were considered a different population. Any studies focusing purely on client outcomes were excluded. Studies included were from peer-reviewed journals. Unpublished or grey literature was not included as its number outweighed peer-reviewed literature and in many cases there was a noticeable difference in quality, which may have skewed the review findings. No time limits were applied and only English language studies were reviewed.

Databases Searched

To ensure a comprehensive search, three databases were used: PsycINFO (behavioural and social sciences database); PubMed/MEDLINE (biomedical and life sciences database); and Web of Science (multi-disciplinary database spanning studies from science, social science, arts and humanities).

Search Strategy

Search terms were tested and refined with the databases above, to find optimal terms. There were few studies on the subject, so finalised search terms were broad to maximise results.

Two search concepts were used. The Boolean operator 'OR' was used to differentiate between synonymous conceptual terms. Wildcard asterisks (*) were used to capture multiple spellings or endings, and plurals.

Search terms were as follows:

1. Terms signifying intellectual disabilities: "intellectual disabilit*" OR "learning disabilit*" OR "learning difficult*" OR "mental retardation" OR "developmental delay*"

2. Terms signifying facilitated formulation: "psychological consultation*" OR "team formulation*" OR "case formulation*" OR "case consultation*" OR "systemic consultation*" OR "team consultation*" OR "collaborative formulation*"

Study Selection

Study titles and abstracts were screened for eligibility. When ambiguous, studies were selected for full text review. Study titles (n = 48) were transferred to Excel, allowing duplicates (n = 11) to be identified and removed. To evaluate eligibility decisions, most studies selected for full text review (seven of nine) were sent to the researcher's supervisor; this selection included studies the researcher felt were eligible (n=4) and ineligible (n=3). There was 100% agreement on eligibility decisions.

Data Extraction

Of seven studies meeting eligibility criteria, data was extracted relating to: geographical location; clinical setting; staff population and referral route; client population and clinical

presentation; model of facilitated formulation; study objective; design; data collection method; data analysis, findings relating to staff experience of facilitated formulation.

Quality Appraisal

The researcher agrees qualitative research should be assessed on its own merits rather than in accordance with traditional quantitative research quality guidelines (Mays & Pope, 2007; Hannes, 2011). As eligible studies comprised qualitative, mixed-methods, and quantitative descriptive studies, criteria were amalgamated from two quality measures, one designed for qualitative research (The Critical Appraisal Skills Programme; CASP 2018) and one for mixed-methods research (Mixed Methods Appraisal Tool [MMAT], Hong et al., 2018).

Data Synthesis

Thematic synthesis is a form of thematic analysis developed for synthesising research in systematic reviews, allowing for results sections (Thomas & Harden, 2008) of any research, or in-text quotations of qualitative research (Wheelwright, Darlington, Hopkinson, Fitzsimmons, & Johnson, 2016) to be used to develop descriptive and analytical (interpretative) themes.

Although some authors have used thematic synthesis to synthesise research findings from a wide variety of methodologies (Garcia et al., 2002), it is unclear how appropriate it is to combine quantitative data and qualitative data within the same synthesis. Quantitative data tends to be informed by a deductive perspective whereas qualitative data derives from inductive approaches (Noyes & Lewin, 2011); therefore it may be important to preserve the distinction between findings so they are understood in epistemological context. Therefore, qualitative data and quantitative data of the reviewed studies were synthesised separately using thematic synthesis. For qualitative data the method of extracting all relevant material within the results section, as demonstrated by Thomas and Harden (2008), was used. Quotations of staff relating to their experience of facilitated formulation were included.

Relevant quotations and indirectly reported qualitative findings relating to staff experience of facilitated formulation were extracted and coded line by line, with multiple codes per line if necessary. Data was coded inductively, meaning pre-determined categories were not used; however previous domain knowledge influenced the language and concepts used to interpret and code the data. NVivo, a software developed for qualitative research, was used to code and organise the qualitative data into themes. Microsoft Excel was used to highlight codes which appeared in multiple themes – this helped to identify similar themes that could be collapsed into each other. Qualitative data was then reviewed to ensure themes fitted adequately.

The search found some studies investigated staff experience alongside clinical outcomes such as incidence of challenging behaviours. Quantitative findings were extracted only if they related directly to the review's focus of staff's experience of facilitated formulation, and were not included if they related to objective clinical outcomes. After reading several times through included quantitative findings of the five survey or mixed-methods papers, several themes were identified and findings were organised accordingly.

Results

The search generated 39 articles once duplicate listings were removed. Abstracts were reviewed against eligibility criteria and 30 articles were excluded. References of nine shortlisted articles were reviewed and three additional articles were included for abstract review; one was deemed eligible and ten articles were read in full. Three articles were excluded after full text review; two because sessions trained staff in formulation but did not focus on specific clients (Ingham, Clarke, & James, 2008; Tostevin & Shaikh, 2015); and one because consultations were delivered to staff to help them consult to other staff rather than for direct work (Rhodes et al., 2014). Seven articles were included in the current review. See Figure 1 for a PRISMA flow diagram of article selection.

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┌─────────────────┐   ┌─────────────────┐   ┌─────────────────┐
│ PsychINFO (EBSCO)│  │ Web of Science  │   │ PubMED          │
│ (n = 28)        │   │ (n = 16)        │   │ (n = 4)         │
└─────────────────┘   └─────────────────┘   └─────────────────┘
```
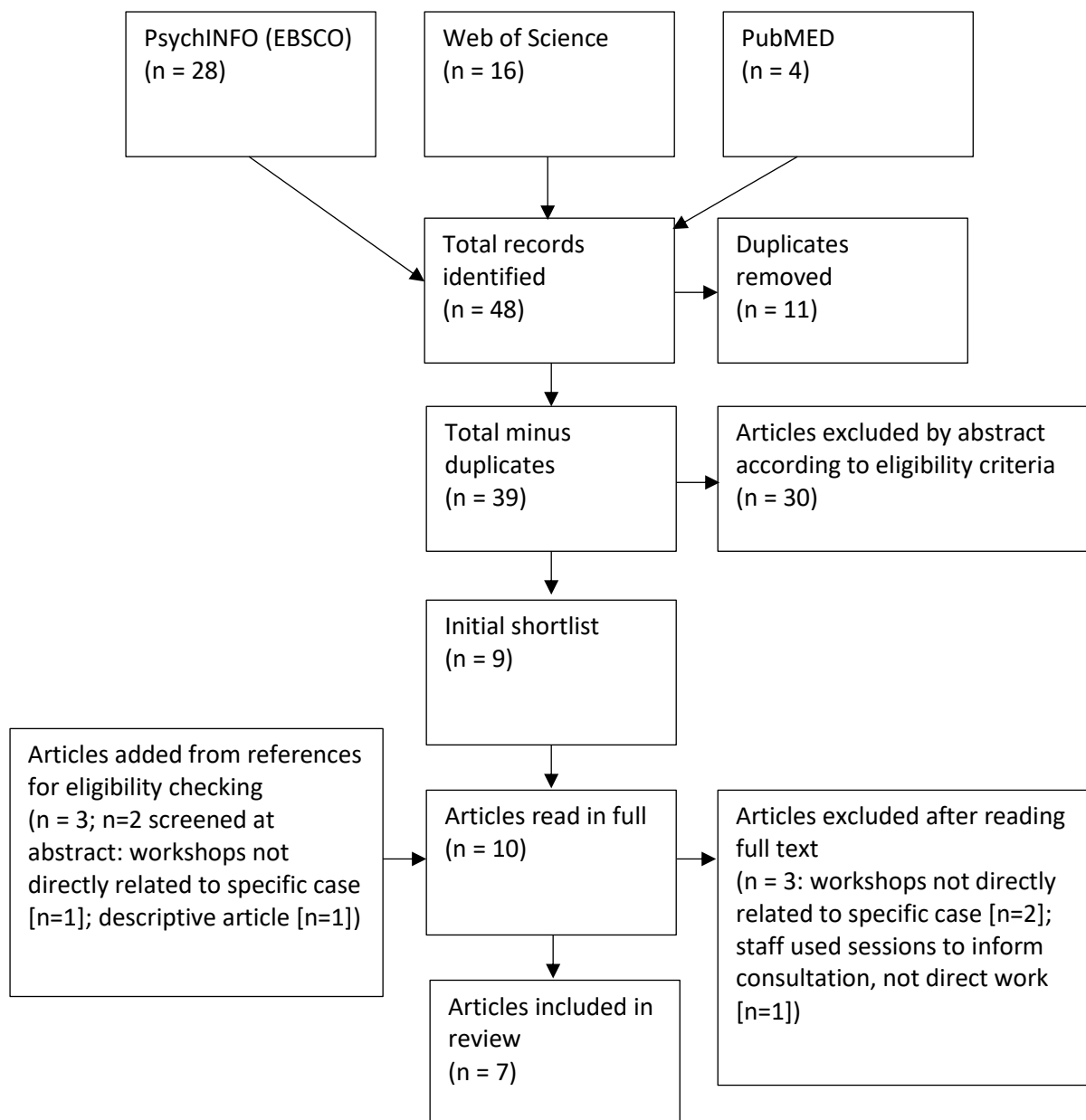
Figure 1. PRISMA flow diagram of the search for articles

Characteristics of Included Studies

Seven studies published between 2008 and 2018 were included in the review. Study

details, and findings relevant to the review question are summarised in Table 1. Six studies took

place in the United Kingdom and one in Australia. Exact numbers of staff were impossible to

calculate as some studies collected anonymised surveys over time, meaning some staff may

have responded more than once. However, 225 responses were recorded, with sample sizes

ranging from two to 89. Two studies stated participants' gender, showing one equally divided

sample (one male, one female), and one predominantly female sample (18 of 24 participants). Five studies had multidisciplinary samples including professionals and direct care staff, one included only direct care staff and one included only case managers. Staff in six studies appeared to be working with adults (although one study did not make this explicit); in one study, staff worked with children and adults. One study focused on staff in forensics, one a specialist intellectual disabilities assessment and treatment unit, and all others were community based. Facilitated formulation was a regular rolling meeting in three studies, was requested via internal referral to a psychology or systemic team in two studies, by external referral to a systemic consultation service in one study, and run as an externally facilitated two-part client-focused pilot workshop in another. Four studies looked at staff referring for facilitated formulation due to complexity or challenges with a particular case, one study described staff members selecting a client for discussion each meeting, and other studies did not specify how or why clients were chosen for formulation. In two systemic consultation studies, clients and family members sometimes attended consultations. Facilitators in three studies provided systemic consultation, in another three studies provided team formulation informed by Lake (2008), and one provided team-focused formulation informed by the 5 P's model (Weerasekera, 1996).

Four studies used questionnaires which had Likert and free-text questions; one of these studies also included staff self-report measures on perceptions of client behaviour. Another study used staff self-report measures on depression, stress and workplace functioning along with facilitator session notes and transcribed recordings of systemic consultations; the remaining two collected data via qualitative interview. Quantitative data were analysed using descriptive statistics, t-tests, Wilcoxon signed-ranks tests, and in one case graphs without clear annotations. Qualitative data were analysed using thematic analysis, content analysis, and were sometimes quoted in text without any signs of having been analysed.

Table 1

Details of Included Studies

Authors (Year) / Country	Staff Population, referral route	SU clinical presentation and referral route	Model of facilitated formulation	Study objective	Design	Data collection method	Data analysis	Summary of findings
Rikberg Smyly et al. (2008) / United Kingdom	(n=59) direct care staff and professional colleagues in community intellectual disabilities team referred internally to receive consultation from psychologists in service; client and family sometimes attended	Adult intellectual disabilities - Complexity, many carers involved	Systemic consultation informed by Partridge et al. (1995)	Evaluation of systemic consultation	Qualitative	Qualitative interview (open-ended questions with prompts)	Qualitative Content analysis	Themes Useful and helpful versus unfamiliar structure/odd and uncomfortable; Able to express a view; Broadened perspectives; Not confusing versus feeling unprepared; A positive focus versus concerns about client attending; Outcome
Ingham (2011) / United Kingdom	(n=7) direct care staff attending externally facilitated pilot training workshop	Adult intellectual disabilities - Significant, complex psychosocial difficulties	Client-focused workshop focused on developing 5 Ps formulation with team	Evaluation of formulation workshops via staff views, staff perceptions of and recording incidence of challenging behaviour pre/post workshop	Quantitative descriptive: survey	Staff self-report: 1. Pre-post bespoke Likert scale questionnaires measuring staff concern about behaviours that challenge 2. Post-workshop evaluation questionnaire (Likert and free text questions) based on Milne & Noone (1996)	Quantitative Descriptive statistics Qualitative: Quotations reported	Quantitative Staff perceptions of concern re: challenging behaviour reduced Average ratings of workshops indicated moderate satisfaction Qualitative Staff indicated utility of formulation workshops in helping understand challenging behaviour and generate new strategies for work

Authors (Year) / Country	Staff Population, referral route	SU clinical presentation and referral route	Model of facilitated formulation	Study objective	Design	Data collection method	Data analysis	Summary of findings
Wilcox (2013) / United Kingdom	(n=29) records of feedback in a multidisciplinary Community Team for People with intellectual disabilities (nurses, occupation therapy, physio, dietician) attending internally facilitated rolling meeting	Adult intellectual disabilities - Not specified	Team Formulation informed by Lake (2008)	Reflections on staff feedback on Team Formulation meetings	Quantitative descriptive: survey (not explicitly specified)	Staff self-report: Pre-meeting free text questionnaire on expectations; post-meeting questionnaire (Likert and free text) evaluating usefulness of meetings	Quantitative Descriptive statistics Qualitative Quotations reported	Quantitative Ratings indicated moderate satisfaction with formulation meetings Qualitative Staff reported meetings helped understand clients, generate strategies and feel more collaborative as a team
Fennessy et al. (2015) / Australia	(n=24) Case managers working in governmental and non-governmental intellectual disabilities services self-referred to external consultation service	Child & Adult intellectual disabilities - complex cases where CM feeling challenged to mediate effective change	Systemic Consultation	Evaluation of systemic consultations	Mixed-methods (within and between group pre-post design)	Session recordings, facilitator field notes, staff self-report measures Pre-consultation and post (4-6 weeks later) measures: **Workflow questionnaire** (adapted from Chung, 2008). **Organisational systems questionnaire** (OSQ; Billings, Kimball, Shumway & Korinek, 2007) perceptions of workplace functioning **Depression, Anxiety and Stress Scale** (DASS-21) over previous week	Quantitative Independent t-tests of demographics, OSQ and DASS between research and control group at time point 1; dependent t-tests of network analysis, OSQ, DASS in each group between time point 1&2. Qualitative Grounded Theory	Quantitative Case managers consulted fewer people about case after consultation, and reported less fused bonds with colleagues, indicating independence Qualitative Themes: Stuck & stressed; zooming out; becoming an agent of change; exceptions (i.e. remaining stuckness)

Authors (Year) / Country	Staff Population, referral route	SU clinical presentation and referral route	Model of facilitated formulation	Study objective	Design	Data collection method	Data analysis	Summary of findings
Whitton, Small, Lyon, Barker, & Akiboh (2016) / United Kingdom	(n=89) records of feedback from multidisciplinary staff in secure forensic intellectual disabilities & autism facility attending internally facilitated regular meetings	Adult intellectual disabilities - Not specified	Team Formulation informed by Lake (2008)	Evaluation of Team Formulation meetings	Quantitative descriptive: survey (within-groups pre-post design & qualitative responses post intervention)	Staff self-report: Pre-post Likert scale questionnaire with some post-only questions	Quantitative Wilcoxon signed-ranks tests; Qualitative Quotations reported	Quantitative Pre-post ratings showed increases in understanding of client problems, increased empathy towards client, increase in feeling listened to by others in the team, and increased consistency in team about client problems. Post ratings indicated staff found the meetings useful for understanding and supporting client as a team. Qualitative Themes: Insightful; working together; self; positive experience; limitations
Johnson & Viljoen (2017) / United Kingdom	(n=2) direct care staff in a Community intellectual disabilities service internally referred to systemic consultation from team of psychologists; client and family sometimes attended	Adult intellectual disabilities, Problems with relationships	Systemic Consultation	Evaluation of systemic consultations	Qualitative	Qualitative interview Schedule devised based on the HATQ (Llewelyn, 1988)	Thematic Analysis	Superordinate themes Differing expectations Enabling for the client Positive techniques Uncertainty regarding "Forum" Composition Strengthening the network

Authors (Year) / Country	Staff Population, referral route	SU clinical presentation and referral route	Model of facilitated formulation	Study objective	Design	Data collection method	Data analysis	Summary of findings
Turner, Cleaves, & Green (2018) / United Kingdom	(n=15) multidisciplinary staff (nursing, managerial, care support staff; unclear if discrete self-reports) of assessment and treatment unit attended regular formulation meetings in handover period led by psychologist and drama therapist	Adult intellectual disabilities (assumption) - whoever the team chose to discuss	Team Formulation informed by Lake (2008)	Evaluation of Team Formulation	Quantitative descriptive: survey	Staff self-report: Bespoke questionnaire - 3 Likert and 5 free text questions - based on one by Bensa and Aitchison (2016).	Quantitative Descriptive statistics Qualitative Quantitative Content Analysis (not explicitly stated)	Quantitative Staff endorsed formulation meetings as helpful, increasing their understanding of clients, and positively impacting on their work. Qualitative Themes (paraphrased summary): New ideas and perspectives, opportunity to think about client, better understanding of client needs history and behaviours, protected time, no clear aims, sharing opinions, thoughts and feelings, team working, empathy, consistent approach, creating new ideas, timings of meetings, no clear aims or practical outcomes, too much to discuss, cramped environment, attitude towards facilitators

Methodological Quality of Included Studies

Quality evaluations are reported in Table 2. Due to limited research in the area, all studies were retained for review regardless of quality. The appraisal process revealed six of seven studies adequately stated their aims, while one did not and appeared to be a mix between a reflective piece and a survey. In all cases, the design seemed appropriate for the question posed and for qualitative designs, the methodology seemed appropriate. Ethical review processes were described in one study; the remaining studies were service evaluations, not formal research, so did not need to. All three qualitative studies used appropriate sources, and five studies of seven had a sample that adequately represented the population. Two studies recruited participants in a way that reduced selection bias. In both studies where between-groups comparisons were made, participants were comparable. In studies where measures were used, two studies adapted standardised measures and variables were clearly stated. The other two studies were unclear about the nature of the measures used. In qualitative studies, one of three clearly applied rigorous data collection techniques; in the other studies, methods were unclearly stated. In three studies where pre-post comparisons were made, there were acceptable rates of follow-up responses. In qualitative and mixed-methods studies, all three chose appropriate qualitative analysis methods, and two described the process of qualitative analysis clearly. In all three, themes were grounded in examples. The five survey or mixed-methods studies used appropriate statistics to analyse data. The mixed-methods study did not integrate qualitative and quantitative data sufficiently. Six of seven studies stated their findings clearly. In all cases, studies' methods supported their findings. In the three studies using qualitative methods, there was coherence between data collection, analysis and findings. However, none of the researchers using qualitative methods reflected sufficiently, if at all, on their role.

Table 2

Methodological Quality of Included Studies (n = 7)

	Rikberg Smyly et al. (2008)	Ingham (2011)	Wilcox (2013)	Fennessy et al. (2015)	Whitton, et al. (2016)	Johnson & Viljoen (2017)	Turner, Cleaves, & Green (2018)
Objectives clearly stated?	✓	✓	**X**	✓	✓	✓	✓
Design relevant?	✓	✓	✓	✓	✓	✓	✓
(Qualitative) Methodology relevant?	✓	N/A	N/A	✓	N/A	✓	N/A
Ethical processes described?	N/A	N/A	N/A	✓	N/A	N/A	N/A
(Qualitative) Sources relevant to question	✓	N/A	N/A	✓	N/A	✓	N/A
Does sample represent population?	✓	✓	✓	✓	✓	P	P
Participants organised/recruited in a way that minimised selection bias?	✓	U	X	✓	X	X	X
Are participants comparable?	N/A	N/A	N/A	✓	✓	N/A	N/A
(Quantitative) Variables clearly defined? Standard instruments?	N/A	P	✓	✓	P	N/A	N/A
(Qualitative) Data collection relevant and rigorous?	U	N/A	N/A	✓	N/A	U	N/A

	Rikberg Smyly et al. (2008)	Ingham (2011)	Wilcox (2013)	Fennessy et al. (2015)	Whitton, et al. (2016)	Johnson & Viljoen (2017)	Turner, Cleaves, & Green (2018)
(Quantitative) Acceptable response/ follow-up rate?	N/A	✓	N/A	✓	✓	N/A	N/A
Risk of non-response bias or confounding variables minimised?	U	✓	✓	U	U	X	U
(Qualitative) Analysis relevant & rigorous?	✓	N/A	N/A	✓	N/A	U	N/A
(Qualitative) Themes supported by quotations?	✓	N/A	N/A	✓	N/A	✓	N/A
(Quantitative) Statistics used appropriate?	N/A	X	✓	✓	✓	N/A	✓
(Mixed-methods) Integration of qualitative and quantitative data relevant? Limitations considered?	N/A	N/A	N/A	X	N/A	N/A	N/A
Findings clear?	✓	P	✓	✓	✓	✓	✓
Supported by methods?	✓	✓	✓	✓	✓	✓	✓
Coherence between data collection, analysis, findings?	✓	N/A	N/A	✓	N/A	✓	N/A
(Qualitative) How findings relate to researchers' influence considered?	X	N/A	N/A	X	N/A	X	N/A

Italics = criteria applied only to study type in brackets; ✓ = met criteria; P = partially met criteria; U = unclear if met criteria; X = did not meet criteria; N/A = criteria not applicable to this study

Quantitative Thematic Synthesis

Of seven reviewed articles, five were survey or mixed-methods designs including quantitative data. Quantitative findings were developed into eight themes suggesting participants found formulation sessions helpful for understanding and relating to clients, developing practical skills, and feeling competent and valued in their team.

(1) Formulation meetings helpful.

Four studies' findings highlighted the general value of facilitated formulation. In team formulation sessions, conversations were seen as useful (Wilcox, 2013; Whitton et al., 2016; Turner, Cleaves, & Green, 2018), staff gave high ratings for satisfaction and said they would recommend the approach (Ingham, 2011).

(2) Aiding understanding of client.

Four studies' findings suggested facilitated formulation helped make sense of clients' difficulties. Staff said sessions improved their understanding of clients (Ingham, 2011; Whitton et al., 2016; Wilcox 2013; Turner, Cleaves, & Green, 2018), including how clients' problems might have developed, without making excuses for clients' behaviour (Whitton et al., 2016). It also helped staff to understand reactions of clients and families, and themselves as a team (Wilcox, 2013), indicating relational and systemic thinking.

(3) Work related skills.

Findings of three studies suggested facilitated formulation aided development of practical skills and actionable formulations. Staff acknowledged team formulation helped them develop skills they would use clinically (Ingham, 2011) and felt sessions positively impacted their client work (Turner, Cleaves, & Green, 2018). Although in pre-post comparisons, formulation meetings did not appear to influence staff's belief that

psychological information influences care planning, ratings were already high (Whitton et al., 2016), indicating existing buy-in to psychological approaches.

(4) Confidence in work.

Findings were generally positive in four studies regarding staff's confidence in their work after facilitated formulation. Staff in one study made fewer contacts and became less fused with colleagues regarding their case after systemic consultation (Fennessy et al., 2015); controls showed no significant differences on measures. Authors concluded case managers felt more able to manage cases independently and flexibly, indicating increased confidence. Staff in two studies who attended team formulation meetings reported feeling slightly to moderately more confident in their work after sessions (Ingham, 2011; Wilcox, 2013). One study showed no change in confidence (Whitton et al., 2016).

(5) Relationship with client.

Two studies reported impact of formulation sessions on staff-client relations. Staff's perceived level of concern about clients' challenging behaviours reduced in one study (Ingham 2011), although data were presented graphically and annotations were not sufficiently clear for scores to be interpretable, so may not be the most reliable evidence. Another study showed staff felt increased empathy toward clients and their difficulties and believed formulation meetings helped them understand client-staff dynamics (Whitton et al., 2016). However, staff reported no changes in negative feelings towards their clients (Whitton et al., 2016).

(6) Team working.

One study (Whitton et al., 2016) asked staff how formulation meetings impacted at the team level. Staff reported feeling more like a team and more consistent in clinical approach. There were no differences between pre and post ratings on whether

formulations aided understanding of how client difficulties impacted on team dynamics, but initial ratings indicated the team already felt formulation was helpful in this way.

(7) Able to contribute perspective.

Two studies showed staff felt formulation meetings were a safe space to share their clinical perspectives and have their voice heard within the team. Staff generally agreed they were able to share their thoughts and contribute in meetings (Wilcox, 2013; Whitton et al., 2016) and showed improved ratings of feeling listened to post-formulation meetings (Whitton et al., 2016). A small but noticeable minority disagreed (9.3%) or remained neutral (4.4%) in their endorsements of feeling able to contribute (Whitton et al., 2016).

(8) Others.

Other interesting findings were that formulation meetings were found to help develop understanding of risk to some extent (Wilcox, 2013), and were perceived to be run by competent facilitators who kept on task and delivered aims effectively (Ingham, 2011).

Qualitative Thematic Synthesis

Qualitative findings included reflections on the facilitator's techniques and approach, awareness of processes within the team and system, new concepts and tools for understanding and working with clients, and organisational barriers to change.

(1) Role of facilitator.

Across studies, staff reflected on the facilitator's role, their expertise, relational skills and techniques they used, processes they initiated or encouraged, and the impact of their presence.

Knowledge and expertise.

Staff in five studies highlighted usefulness of techniques and processes instigated by facilitators (Rikberg Smyly et al., 2008; Wilcox, 2013; Fennessy et al., 2015; Whitton et al., 2016; Johnson & Viljoen, 2017), including theory from Dialectical Behavioural Therapy (Whitton et al., 2016), third-person-perspective questioning, summarising statements (Johnson & Viljoen, 2017) and diagrammatic formulation:

It was helpful to see the different way of seeing behaviour and what factors lead to the challenging behaviour. Diagram is very visual and easy to refer to. (Whitton et al., 2016, p. 152)

In the three studies exploring systemic consultation (Rikberg Smyly et al., 2008; Fennessy et al., 2015; Johnson & Viljoen, 2017), many staff appreciated the reflecting team format, which was reported to serve multiple purposes, including consolidating different perspectives (Johnson & Viljoen, 2017), hearing new ideas (Rikberg Smyly et al., 2008), acknowledging the emotions of the system and thoughtful feedback on the team (Rikberg Smyly et al., 2008; Johnson & Viljoen, 2017).

It's good to hear that feedback coming back from the wider group… hearing it from someone else, like an outsider if you like…very helpful…the positive things, but also, I s'pose the anxiety that was coming from the carer, the anxiety that was coming from us as well, maybe as professionals…they was able to pick all that up and feed it back…in a constructive way. (Johnson & Viljoen, 2017, p. 176).

Reflections were seen by some staff as "*odd*", "*uncomfortable*", "*awkward*" (Rikberg Smyly et al., 2008) and "*unusual*" (Johnson & Viljoen, 2017), and left some feeling "*scrutinised*" and

"*judged*" (Rikberg Smyly et al., 2008). In one case, reflections were sometimes experienced as being of varying quality. This was linked to some facilitators' styles rather than technique:

> *I felt that the feedback coming back was sometimes…the quality was, it varied…and I*
>
> *think also personality as well maybe was involved…the ones who did the most…*
>
> *positive and, really good feedback, I thought they were quite strong characters which*
>
> *was good because that came across quite strongly…* (Johnson & Viljoen, 2017, p.
>
> 177).

Another facilitator technique staff mentioned in three studies (Rikberg Smyly et al., 2008; Whitton et al., 2016, Johnson & Viljoen, 2017) was acknowledgement of strengths of the client, team or system.

> *Very positive information to review things in light of recent behaviours in*
>
> *highlighting progresses.* (Whitton et al., 2016, p. 152).

How facilitator structured and explained consultation.

Staff in three studies (Rikberg Smyly et al., 2008; Wilcox, 2013, Turner, Cleaves, & Green, 2018) commented on facilitators' use of structure, specific to facilitated formulation model. Some staff found this structure helpful, saying that "*structured format and conversations about client [is good]*" (Wilcox, 2013), allowing all staff to contribute:

> *The structure allowed you to consider what they were saying and you were able to*
>
> *have your say at the appropriate time. You were more focused and more disciplined*
>
> *and that was a good thing as people usually will immediately say their bit.* (Rikberg
>
> Smyly et al., 2008, p. 20).

Some staff (Rikberg Smyly et al., 2008) felt session structure and purpose were explained clearly. However, some felt sessions did "*not appear to have clear aims*" (Turner, Cleaves, & Green, 2018), and for others, unfamiliar structure felt uncomfortable:

> *Even though the format was explained to us at the start of the meeting, it did not allow us to have enough time to think it through – felt we were "thrown into it". There was no time to think about our goals of the meeting and what we wanted to achieve.* (Rikberg Smyly et al., 2008, p. 20).

Approach.

Staff in three studies also highlighted the facilitators' approach and professional status, which enabled some to feel open discussing their feelings (Rikberg Smyly et al., 2008; Johnson & Viljoen, 2017), listened to and contained:

> *For the support staff to have an opportunity to be really honest and open about their feelings, erm, and to just have confidence that there was a team of professionals, psychology professionals, and me as the [profession], listening to their point of view…* (Johnson & Viljoen, 2017, p.177).

However, staff did not always feel contained by facilitators, with some wondering about the effect of changing facilitators in the reflecting team from week to week (Johnson & Viljoen, 2017) and others finding it unhelpful that facilitators did not work with clients regularly (Turner, Cleaves, & Green, 2018), indicating perhaps this affected the quality of their client-focused reflections.

(2) Team/systemic processes.

All studies included staff accounts of the team and systemic processes that occurred in facilitated formulation.

Stepping back.

The time and space facilitated formulation provided was appreciated by staff in two studies (Whitton et al., 2016, Turner, Cleaves, & Green, 2018), who noted the importance of "*protected time to discuss difficult situations*" (Turner, Cleaves, & Green, 2018), and acknowledged the benefit of changing pace:

> *Love having time to think deeply about a patient when otherwise we are all too busy*
> *rushing.* (Whitton et al., 2016, p. 152).

All staff felt sessions provided an opportunity to prioritise "*discussing all aspects of the situation*" (Ingham, 2011), and integrate different sources of information (Rikberg Smyly et al., 2008; Ingham, 2011; Wilcox, 2013; Fennessy et al., 2015; Whitton et al., 2016; Johnson & Viljoen, 2017; Turner, Cleaves, & Green, 2018), into a "*bigger picture*" (Rikberg Smyly et al., 2008; Fennessy et al., 2015; Whitton et al., 2016). Staff felt enabled to see things from a "*different angle*" (Rikberg Smyly et al., 2008), which made things seem more "*clear*" (Whitton et al., 2016) and less "*stuck*" (Rikberg Smyly et al., 2008):

> *Last session here when I was talking I was like "oh my gosh there's so much work to*
> *do, this is such a huge case"…and then this time I'm coming in and I feel much better*
> *and more open to talk.* (Fennessy et al., 2015, p. 266).

Staff in two studies mentioned sessions encouraged them to stay with the process of

generating ideas and not jumping to problem solving, and felt zooming out was helpful in

progressing:

It was helpful to look at the issues but not to resolve them. The objective was to have

the reflection. It was essential for a way to move forward. (Rikberg Smyly et al.,

2008, p. 21).

Helpful in the sense of we didn't need to get a quick solution. It was about moving

away from the actual [problem behaviour] to what the underlying causes might be.

(Johnson & Viljoen, 2017, p. 176).

However, staff in three studies expressed reservations about how practical sessions were.

Some felt there was "*too much to discuss*" (Turner, Cleaves, & Green, 2018), and the amount

of "*ideas and information*" while useful, may not translate into action in services under

pressure (Fennessy et al., 2015). Some staff hoped sessions would "*fix things*" (Johnson &

Viljoen, 2017) and felt disappointed when this was not the case:

Did not get a lot of help. I was expecting some guidelines but did not get them.

(Rikberg Smyly et al., 2008, p. 22).

Team conversational processes.

In the six studies where staff teams received facilitated formulation, staff alluded to

team-level processes that enabled expression of multiple perspectives (Rikberg Smyly et al.,

2008; Ingham, 2011; Wilcox, 2013; Whitton et al., 2016; Johnson & Viljoen, 2017). While the

structure enabled "*everyone in the group to talk, and not particular people to dominate discussions*" (Rikberg Smyly et al., 2008), staff also felt listened to:

>*It was helpful to hear others opinion and feel listened to.* (Whitton et al., 2016, p. 152).

Staff acknowledged the value of acknowledging "*different perspectives*" within the team (Wilcox, 2013; Johnson & Viljoen, 2017; Turner, Cleaves, & Green, 2018):

>*Able to share different experiences of working with the client which was helpful.* (Rikberg Smyly et al., 2008, p. 20).

This gave a sense of morale for one staff who was "*impressed at the collective knowledge of the team*" (Whitton et al., 2016) and another who felt "*like we achieved something*" (Wilcox, 2013)*. S*taff appeared to feel safe reflecting on their feelings with each other (Rikberg Smyly et al., 2008; Whitton et al., 2016; Johnson & Viljoen, 2017), and found this helpful:

>*Very useful to realise your own feelings about patients and that of other members of staff.* (Whitton et al., 2016, p. 152).

These "*wide conversations*" were seen to help staff come "*together in their thinking*" (Whitton et al., 2016), to "*share ideas and experiences*" (Whitton et al., 2016), and "*develop a shared formulation*" (Wilcox, 2013) and a "*consistent approach*" (Wilcox, 2013):

Reassuring that the team are working together to support patient complex needs.

(Whitton et al., 2016, p. 151).

This "*team working*" (Turner, Cleaves, & Green, 2018) appeared to be "*strengthening the relationships between themselves*" (Johnson & Viljoen, 2017), and preventing people from feeling they were "*working alone*" (Wilcox, 2013).

Engagement with the process.

Three studies (Rikberg Smyly et al., 2008; Fennessy et al., 2015; Johnson & Viljoen, 2017) cited engagement of staff in the team and wider system as vital in benefitting from facilitated formulation. One staff member acknowledged the importance of believing in the process:

I think what was helpful and what was absolutely key was that after week one we all knew what it entailed and everyone bought into it. You can't, in my opinion, you can't go into this type of therapeutic work if you're not buying into it… (Johnson & Viljoen, 2017, p. 176).

Interestingly, one study interviewing care workers and professional staff noticed professional staff's accounts were generally more negative than care staff (Rikberg Smyly et al., 2008), which may suggest lower engagement. Additionally, a caseworker receiving individual systemic consultation felt despondent applying what she had learned, thinking her client's family would not engage with this new approach:

I guess we can only try to get to have a meeting. But it's very discouraging because

as soon as you get there, you think something's going to come about and she puts a

stop to it you know, so... (Fennessy et al., 2015, p. 267).

(3) Client and problem formulation.

Staff formulating and empathising with client.

Staff in all studies reported facilitated formulation helped them understand their clients more effectively. It helped staff "*focus on one patient*", "*brought the team together in their thinking*", to get a "*clear picture*" and "*overview of the patient's problem*" (Whitton et al., 2016) and an "*understanding of the situation*" (Rikberg Smyly et al., 2008). Staff in three studies specified formulating developmentally gave them "*better insight into the patient's past*" and the "*impact this has on presenting behaviours*" (Whitton et al., 2016), "*thinking about [client] needs, history and behaviours*" (Turner, Cleaves, & Green, 2018) and considering problems in context:

It was about moving away from the actual [problem behaviour] to what the

underlying causes might be. (Johnson & Viljoen, 2017, p. 176).

Staff in two studies found facilitated formulation helped make "*challenging behaviour easier to understand*" (Ingham, 2011):

It was helpful to see the different way of seeing behaviour and what factors lead to

the challenging behaviour. (Whitton et al., 2016, p. 152).

And that it helped make sense of the current care plan, and "*treatment groups attending at present*" (Whitton et al., 2016).

Staff in four studies (Wilcox, 2013; Fennessy et al., 2015; Johnson & Viljoen, 2017; Turner, Cleaves, & Green, 2018) felt facilitated formulation helped them "[*gain] more empathy*" (Turner, Cleaves, & Green, 2018) for clients, and their families (Fennessy et al., 2015):

> *I think what's really helpful was, err, trying to put yourself into [client]'s perspective of why things might be challenging and why things might be difficult.* (Johnson & Viljoen, 2017, p. 176).

Staff perceiving clients who attended as understanding themselves more compassionately.

In two studies on systemic consultation, clients sometimes attended (Rikberg Smyly et al., 2008; Johnson & Viljoen, 2017). Staff felt sessions allowed "*clients to develop insight and understanding of their own situations, and their own solutions and strategies*" (Johnson & Viljoen, 2017). Staff also felt clients developed "*self-worth and self-awareness*" because "*emotional expression*" was enabled, and also because "*the observing therapist's point of view…was very positive*" (Rikberg Smyly et al., 2008).

> *Made [client] strong… she felt important, and I think that was good for her at the time because she felt that there was, she was listened to, she wasn't on her own, and there's a lot of people who care about her and want her to be well…* (Johnson & Viljoen, 2017, p. 176).

> *It was a "good pat on the back" for what they had already been doing.* (Rikberg Smyly et al., 2008, p. 21).

However, some staff felt consultations were not always the best environment for clients to develop insight:

> *Wondered whether the clients would have coped especially with two psychologists reflecting. They may find it difficult to understand and make sense of it.* (Rikberg Smyly et al., 2008, p. 21).

(4) Moving forward.

Staff in all studies felt facilitated formulation provided new ideas and practical strategies to take forward in clinical work.

New ideas for pragmatic steps forward.

Formulation was thought to be useful in "*thinking of ways to help manage problems*" (Whitton et al., 2016), creating "*new ideas on working with service users*" (Turner, Cleaves, and Green, 2018), and made it "*easier to understand and provide support*" and "*put better understanding into practice*" (Ingham, 2011) in a way that felt pragmatic:

> *Very useful, future planning clarified and realistic intervention formulated.* (Whitton et al., 2016, p. 152).

The link between formulation and intervention was acknowledged by some staff:

> *Once there's a model developed of understanding for this family, they are more likely to get the services they need.* (Fennessy et al., 2015).

One way formulation was grounded into intervention in sessions was by "*establishing goals*

and outcomes" (Ingham, 2011), "*draw[ing] up some actions points*" (Rikberg Smyly et al., 2008), having a "*bullet-pointed action plan*" (Wilcox, 2013) and making "*some positive plans*" (Whitton et al, 2016). There was acknowledgement by one staff member of the benefits of trying new ideas:

> *There comes a point where you just say it's not working and you just have to let it go*
>
> *and try something else, and that's what we did and it's worked really well.*
>
> (Fennessy et al., 2015, p. 266).

However some staff felt meetings, systemic consultations specifically, did "*not appear to have…practical outcomes*" (Turner, Cleaves, & Green, 2018) and one staff member felt confused about the outcome at the end of a consultation she attended:

> *I wondered what the purpose of the meeting was after it was decided to close the*
>
> *case. I did not quite understand the decision.* (Rikberg Smyly et al., 2008, p. 22).

Sense of hope and empowerment.

Staff in one study on systemic consultation (Fennessy et al., 2015) felt "*more hopeful*" afterwards and also noted that understanding things differently helped them feel empowered in becoming an agent of change:

> *I think now I'm being a little bit more assertive and saying "this is my role, this is*
>
> *what I do, use your role to do this, can it be done?" "I'm here to do my job and I'm*
>
> *going to do it well, and if that means politely instructing you, then so be it." I think*
>
> *that's definitely something that I've just got more confidence in since the last*
>
> *session.* (Fennessy et al., 2015, p. 266).

(5) Service/organisational context.

Although responses to facilitated formulation were mostly positive, staff in some studies (Wilcox, 2013; Fennessy et al., 2015; Turner, Cleaves, & Green, 2018) indicated service-related issues impacted effective use of session. For example, staff in two studies noted limited "*physical resources of the meeting room*" (Wilcox, 2013) and the "*cramped environment*" (Turner, Cleaves, & Green, 2018), while others noted the "*staff rota*" was a "*barrier to attendance*" (Turner, Cleaves, & Green, 2018). One staff also mentioned difficulties taking ideas forward in context of organisational demands:

> *It's worthwhile giving it a go…I aspire to that, but there is too much pressure on the service.* (Fennessy et al., 2015, p. 267).

Thematic Map

Themes were integrated into a visual model (see Figure 2), with qualitative theme headings comprising quantitative themes (*in brackets*) as follows: (1) role of facilitator; (2) team/systemic processes (*team working*; *able to contribute perspective*); (3) client and problem formulation (*aiding understanding of client*; *work related skills*); (4) moving forward (*work related skills*; *confidence in work*; *relationship with client*); and (5) service/organisational context (*others*). Facilitators' roles appeared central in influencing team and systemic processes, teaching and role modelling techniques and approaches, and identifying new approaches for clinical work. Team processes such as new forms of team conversation and reflection in sessions enabled new understandings of clients and problems, and new clinical strategies, which in turn influenced ongoing team processes, highlighting a learning cycle between these three factors. Organisational context influenced the impact of

formulation sessions, and was also impacted by all aspects of sessions. One limitation of the

model is that it is based on a relatively small amount of studies' findings.
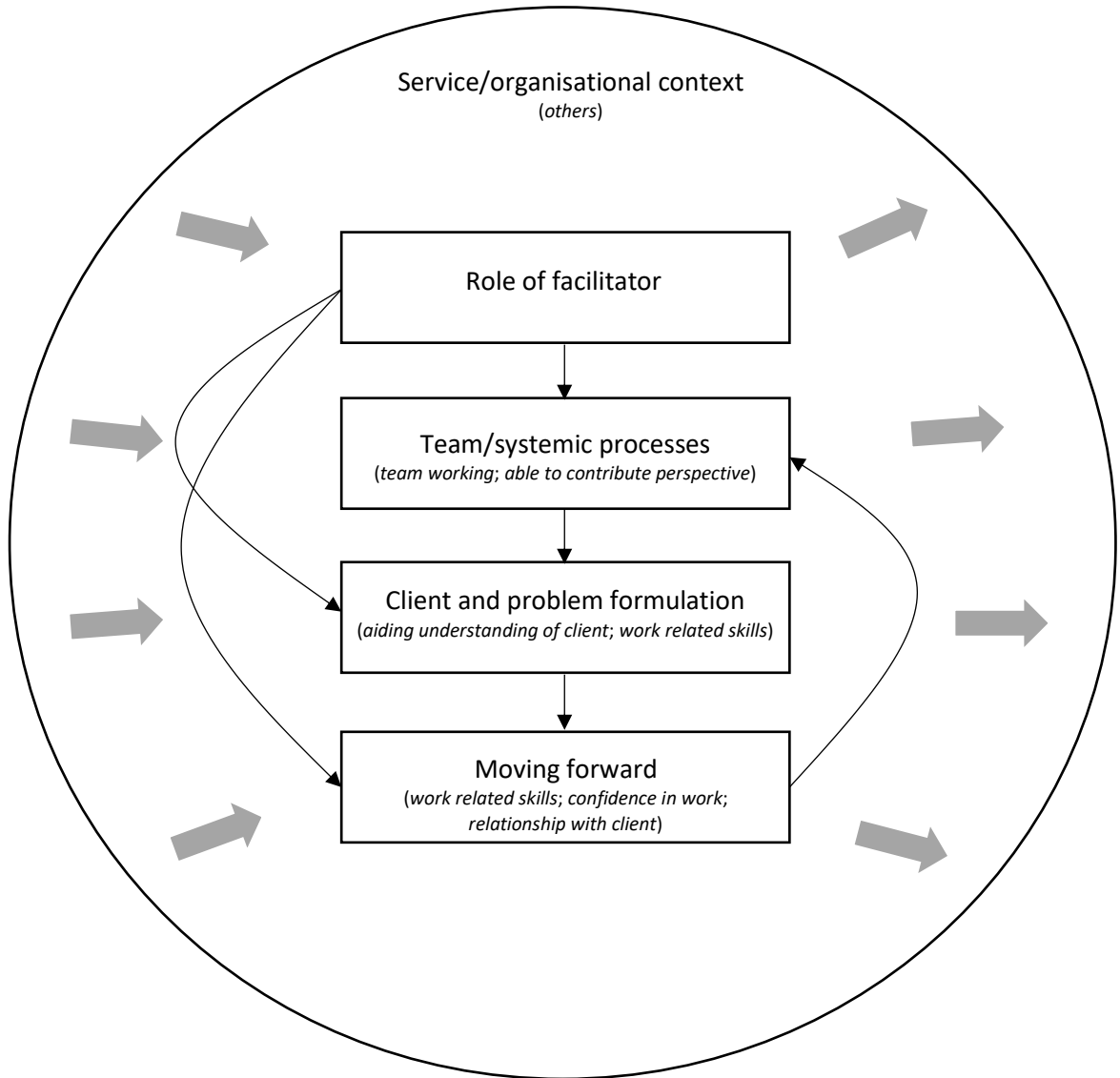
Figure 2. Thematic map of qualitative and quantitative findings

Discussion

The thematic synthesis of seven studies addressed the question: *how do frontline staff in intellectual disabilities settings experience facilitated formulation?* Eight quantitative themes and five qualitative themes were developed.

Consistent with the aims of team formulation and systemic consultation (Lake, 2008; Johnstone, 2014; Haydon-Laurelut, Bissmire, & Hall, 2009; Rhodes et al., 2011) findings suggested sessions helped staff step back and make sense of clients' difficulties, including challenging behaviours, in new ways, integrating multiple people's perspectives, and through the lenses of developmental history and systemic processes. This included staff reflecting on the impact of their relationships with clients. This would be expected to lead to improved care provision, as research has shown staff's understandings of challenging behaviour can impact their inclination to help clients (Hill & Dagnan, 2002). Although research often focuses on clinical outcomes, such as reductions in challenging behaviours (Hastings, 1995; Saloviita, 2002), literature on facilitated formulation emphasises the process of staff formulating as an outcome in itself, aiming to help staff shift from problem-solving to reflection (Lake, 2008) and in line with third wave principles, relate differently to clinical work (Hayes & Hofmann, 2017). This was supported by this review's findings, with staff valuing time spent understanding client's difficulties contextually, the process of reflecting, and moving away from problem solving. Findings suggest facilitated formulation helped staff see the bigger picture, reduce frustrations and judgements of clients and behaviours, and develop acceptance and resilience towards challenging aspects of their work. This shift in objective may be particularly beneficial in intellectual disabilities settings, considering challenging behaviours do not always reduce over time (Emerson, 1995), therefore staff's efforts may be best channelled into understanding and relating to behaviours differently, rather than only trying to reduce them. This cultural shift in

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expectations could benefit staff's wellbeing and inclination to continue in their role, which

are often adversely affected (Chung, Corbett, & Cumella, 1995; Robertson et al., 2005).

Future research could explore how facilitated formulation in intellectual disabilities settings

impacts on staff morale, self-reported burnout and job satisfaction. These are important

outcomes themselves as well as mediating optimal care. In cases where clients attended

facilitated formulations, specifically systemic consultations, findings suggested sessions

could help clients feel positive about themselves and supported by the team. However,

some staff worried sessions were overwhelming for clients. This presents a dilemma around

including clients in sessions or not; this may be assessed on a case-by-case basis. Including

clients could alter what is discussed; one option is including clients and family for half the

session and teams having their own space to develop formulations for the subsequent half.

While systemic consultation and team formulation do not explicitly aim to provide

solutions or action plans (Lake, 2008; Rhodes et al., 2011), formulation in clinical settings

and reflective learning in general (Kolb, 1984) necessarily pre-empts and informs

intervention. Therefore, it makes sense staff gained new, actionable strategies from

facilitated formulation meetings. Sometimes these came from colleagues and facilitators;

others developed naturally from formulations. Staff from one study showed a more flexible

and independent approach to their complex cases after facilitated formulation and felt more

empowered to make changes. Others mentioned developing clear, realistic action plans

during sessions. This suggests facilitated formulation helped staff, via explicit formulation,

practical suggestions in group and facilitated discussion, and agreed actions plans, to extend

their repertoire of responses to challenging behaviours. Considering staff find uncertainty

about how to respond to challenging behaviours equally stressful to behaviours themselves

(Bromley & Emerson, 1995), it makes sense new ideas and strategies explored in facilitated

formulation increase staff's confidence and optimism. This likely benefits staff-client

relationships, thus care quality and client experience (Hastings, 2005). Different staff found

different aspects of sessions helpful, so future research could explore specific mechanisms

and processes of facilitated formulation contributing towards staff outcomes. Some staff

receiving systemic consultation felt uncertain about the purpose of sessions, saw no clear

outcomes, or did not understand outcomes. This seemed at least partially related to

unfamiliarity of approach. It could also reflect the culture in intellectual disabilities settings,

which emphasises responding more than reflecting (Hastings, 1995; Saloviita, 2002). This

highlights the importance of facilitators making the format and purpose of sessions as clear

as possible; this "warming of the context" is vital for engagement (Bateson, 1972; Burnham,

2005, p.9) and reflects the collaborative aims of facilitated formulation (Lake, 2008; Haydon-

Laurelut, Bissmire, & Hall, 2009). Some teams or staff may take longer to socialise to the

process. For example, one staff member was unsure how new ideas and ways of working

explored in sessions would translate to work with certain families. Clinicians must therefore

adapt facilitated formulation, ideally delivering a series of sessions and working gradually,

while accepting that shared understanding of the majority of rather than all attendees, or a

small broadening in perception over a period of time rather than a marked change, may be

most realistic.

The most prevalent qualitative theme emphasised facilitators' roles, their expertise,

relational skills and techniques they used, processes they initiated or encouraged, and

impact of their presence. Interestingly, this theme was only reflected in the quantitative

data in one study. This suggests it is an important aspect to include in future quantitative

research on facilitated formulation. The techniques, theory and approach of facilitators

helped some staff formulate and understand their clients. Others noted reflective questions

and the reflecting team helped them explore new thought processes and gain broader

clinical perspectives. Still others commented on facilitators' use of structure and the ability

to integrate multiple perspectives. While Lake (2008) argues model of consultation is less important than the culture it encourages in the team, it is clear staff found specific benefits from specific techniques, and certain teams seemed more or less receptive to certain models. Some techniques, such as structuring sessions and keeping discussion focused seemed universally helpful regardless of model. However, specific techniques are emphasised in certain models and may be more accessible and appropriate to certain teams, depending on levels of experience, psychological mindedness and "fullness". However, in many settings, only systemic consultation or a particular facilitator's brand of team formulation may be available. Ideally, facilitators would be familiar with various approaches, allowing them to adapt and select appropriate models for a team's learning needs. It may also be important for research to explore how skills and techniques such as reflection and formulation are learned by staff, such as via explicit and implicit role modelling by facilitators, didactic teaching, experiential aspects of sessions, and practical application of ideas and techniques outside of sessions. The facilitator's outside, expert perspective came across in qualitative findings. Their position one step above and away was experienced as reaffirming, containing, and giving a sense of perspective. However, some staff reported finding some facilitators' ways of doing things odd or unhelpful, even critical, suggesting they felt unprepared for or unsuited to the approach used. It could equally indicate the facilitator did not spend enough time getting to know the team or emphasising strengths. This, in conjunction with the prominence of the facilitator theme across studies, suggests facilitator-team alliance may be important to explore in future research.

Qualitative and quantitative findings highlighted processes happening at team and systemic levels during facilitated formulation that may have mediated new clinical understandings and approaches. Staff in teams appreciated everyone, including less dominant voices, having space to talk, and felt perspectives were valued by colleagues and

facilitators. This indicates facilitated formulation may improve staff relationships,

communication and morale. This would merit further research. Staff found it interesting

hearing multiple perspectives on clinical challenges, and felt impressed at the team's

collective knowledge. While some staff felt there was too much to discuss, most felt

allocated time and space allowed for conversation, reflection, taking a step back and

understanding clients and behaviours systemically, which felt novel and valuable. Staff in

teams felt they came together in their perspectives, developing a shared understanding, a

central aim of team formulation (Johnstone, 2014) that fosters clinical consistency. This is

particularly important for clients with intellectual disabilities, as challenging behaviours can

be influenced by staff behaviour (Hastings, 2005) and consistent reinforcers enhance

positive behaviour change (Pryor, 1999). While some staff and teams attended regular

facilitated formulation meetings within their service, many received a time-limited external

offering. Considering significant, chronic need of clients and teams in intellectual disabilities

settings, and the multiple benefits staff experienced from facilitated formulation, it seems

wise to develop a culture where sessions can be offered more regularly to teams who do not

have a psychological professional in house. Facilitated formulation sessions are common

practice for psychological professionals working in intellectual disabilities community teams

(Lloyd & Brown, 2014; Ingham, 2015); however, psychology teams are often under-

resourced. Equally, some findings indicated service pressures inhibited attendance of

formulation sessions. Despite the objectives of the Transforming Care agenda (NHS England,

2017), which aimed to invest in community services for people with intellectual disabilities

and allow them to move from restrictive hospital environments, the initiative has been seen

by many as unsuccessful, with limited evidence of investment and increases rather than

decreases in clients' use of private beds (Taylor, 2019). The current review's findings suggest

a target for investment is resourcing psychology teams so they can provide regular support to teams in the community and maintain clients' community placements.

Limitations of Reviewed Studies

All included studies were relatively small scale, reducing the external validity of findings.

Some studies did not specify numbers of participants as opposed to responses. Equally, it was not always clear how many staff chose not to participate; one study indicated just under 50% of those invited did not participate. There was no reflection on which staff attended formulation meetings versus those who did not. There could be important differences between staff who attended sessions, completed surveys and participated in interviews and those who did not. Non-participating staff may have been less open to psychological approaches, or more overwhelmed. These staff may benefit most from formulation meetings and facilitators should consider how to adapt formulation approaches to reach these staff more effectively. Future research could record reasons for attendance or non-attendance of sessions, and reasons for non-participation in research.

While this review found good quality explorative qualitative research into systemic consultation in intellectual disabilities settings, no such papers on team formulation were found. Although survey designs included qualitative comments, quotations were often sparse or could have been better explored. Qualitative research findings lay important groundwork for further research (Barker, Pistrang, & Elliott, 2016). To allow for rich understanding of staff experience of team formulation in intellectual disabilities settings, there is scope for formal qualitative research.

In qualitative or mixed-methods studies included, the researcher's role was not adequately considered. Furthermore, qualitative analyses were not always clearly

described. This prevented the reader from judging how influenced findings were by authors' epistemological outlook.

Most studies did not ask specifically about intellectual disabilities or challenging behaviours, making findings applicable to facilitated formulation more generally. As formulation is idiosyncratic, and focuses on specific themes depending on the population staff work with, future research could include more exploration of its utility in facilitating difficulties relating to intellectual disabilities and challenging behaviour specifically.

Finally, most studies included were conducted by the clinicians delivering facilitated formulation, or their colleagues. Although this may have increased ecological validity, it may also have meant that participants' accounts were affected by reduced anonymity, and researchers may have been more biased in interpreting data.

Limitations of Current Review

One researcher conducted most aspects of the review alone. While a second reviewer conducted eligibility checks, two or more reviewers comparing results at each stage would have increased reliability.

The current review included English language studies from the UK and Australia. Although search terms were broad, no foreign language papers appeared in the shortlist. Findings may not generalise to different cultures.

Conducting a citation search may have broadened the initial pool of articles and thus the external validity of the synthesis.

The paucity of formal research in the area limited what could be synthesised. Grey literature, non-peer-reviewed and unpublished literature were not included. Known literature of this nature may have supplemented findings but may have also outweighed formal research and increased bias. Conversely, studies were included regardless of quality;

if strict quality standards had been applied, there may have been insufficient literature to review and synthesise.

The review subsumed systemic consultation and team formulation under the term facilitated formulation, which some may argue are sufficiently epistemologically distinct to warrant separate investigation. However, this decision was made due to the limited research in this area, and the similar function these approaches serve in intellectual disabilities settings.

Future Research

Future research should explore processes and change mechanisms in facilitated formulation, so existing models can be formally evaluated, informed by and adapted according to findings.

The facilitator's approach was a qualitative theme most quantitative studies overlooked. Future research should explore staff's experience of facilitator approach, techniques and facilitator-team alliance in facilitated formulation sessions.

Staff are the clients of facilitated formulation approaches, thus staff and team outcomes are central. Fennessy et al. (2015) used staff-focused measures, with promising outcomes. Further research could explore how facilitated formulation in intellectual disabilities settings impacts on staff outcomes including self-reported burnout, job satisfaction and confidence in work, and team outcomes including team morale, effectiveness of team communication and perceived consistency. These outcomes mediate provision of optimal care. While client-focused outcomes may take time to manifest, these could be explored in tandem with team outcomes, longitudinally.

The traditional, nomothetic approach to research, which is deductive and discriminating, is not always optimal for exploring facilitated formulation approaches, which are inductive and holistic. Although this may be a false dichotomy, and there is great value

in deducing general properties and reliable outcomes of facilitated formulation, it is important to ensure integrity of the intervention is preserved, and that ecological validity is given at least equal weight to internal validity, external validity, and reliability. It seems contextualist approaches to research, which explore vertical and horizontal variables in conjunction (Pettigrew, 1985), may be most appropriate.

Experienced facilitators are best placed to develop realistic outcome measures and should be consulted when designing formal research, as it is important to capture the complexity of the process and domain-specific staff-focused outcomes of facilitated formulation that may not manifest as immediate changes in observable client or staff behaviour. These may be more influenced by third wave thinking. For clinicians who have the resources, facilitated formulation could be explored using single case experimental designs, a method whereby a series of "pre" time points form a baseline control for time points during active treatment. This may be easier in settings where the facilitator or researcher is embedded, because of the practical obstacles of having staff fill out measures regularly.

Conclusions

This synthesis explored staff's experiences of facilitated formulation in intellectual disabilities settings. Findings demonstrated staff generally found facilitated formulation helped them understand clients in a broader context, knowing better how to respond, including to challenging behaviours. Staff noticed facilitated formulation meetings helped them think and communicate in novel ways, and they reported feeling contained, supported and upskilled by facilitators. These findings indicate the utility of facilitated formulation in intellectual disabilities settings, and suggest avenues for further research including development of staff and team focused theory and outcome measures.

Chapter Three: Empirical Paper

"You're Changing the Pattern": **Using Cognitive Analytic Team Formulation to Help Care Staff Working with People with Intellectual Disabilities Understand and Manage Challenging Behaviour**

Abstract

Care staff working with people with intellectual disabilities often refer to psychology for help with challenging behaviours. Team formulation involves facilitated sessions which help teams develop shared psychologically-informed understandings of behaviours; these inform care provision. Team formulation informed by cognitive analytic therapy is called contextual reformulation; by explicitly (re)formulating relationships, it can help teams in intellectual disabilities settings understand challenging behaviour relationally rather than individualistically. This study explored care staff's experiences of receiving contextual reformulation in intellectual disabilities settings. Eleven participants were interviewed and five themes were developed using thematic analysis: (1) multiple roles and functions of sessions and clinicians; (2) challenging behaviour in relationship; (3) making links – understanding can be enlightening, containing and practical; (4) the process of developing a shared understanding and approach; and (5) caught between two perspectives. The findings suggest care staff in these settings benefit from collaboratively developing a shared formulation and value reflection and containment.

Introduction

Psychological formulation involves the reiterative application of psychological theory to clinical information gathered during initial and ongoing assessment, with the aim of understanding client difficulties at a descriptive and predictive level, informing intervention (Johnstone & Dallos, 2014; Cole, Wood, & Spendelow, 2015). Formulation is guided by pragmatic rather than correspondence theories of truth (Barker, Pistrang, & Elliott, 2016); it does not produce a right answer, but informs intervention and is in turn informed and revised in light of intervention (Kolb, 1984), optimising understanding and care. Where multiple systems engage with clients and needs are complex, such as in intellectual disabilities settings, frontline staff benefit from psychological consultation (Kerr, Dent-Brown & Parry, 2007); effective implementation is promoted by follow-up support and supervision of psychologically-informed skills (Georgiades & Phillimore, 1975). Clinical psychologists use formulation in direct work with clients and indirectly, with frontline non-psychology staff (Johnstone, 2014; Elford & Ball, 2014). Formulations developed collaboratively with staff teams are called team formulations. Team formulations integrate clinical information from multiple staff perspectives and usually incorporate systemic factors, upskilling and supporting staff to develop comprehensive, shared formulations of client difficulties (Johnstone, 2014; Elford & Ball, 2014). At a process level, team formulation is thought to provide staff containment which transfers to client relationships (Elford & Ball, 2014).

Team formulation can benefit care staff in intellectual disability settings for several reasons. People with intellectual disabilities are commonly referred to professionals by carers for behaviours that challenge services (Emerson et al., 1994; 2011). Intellectual disability, a term most often used interchangeably with learning disability, is defined as significant impairment in intellectual and adaptive functioning, originating in the developmental period (British Psychological Society [BPS], 2015) whereby adaptive

functioning is impaired in three domains: conceptual, social and practical (American

Psychiatric Association [APA], 2013). A widely held definition of challenging behaviour is:

"Behaviour…of such an intensity, frequency, or duration as to threaten the quality of

life and/or the physical safety of the individual or others and…likely to lead to responses

that are restrictive, aversive or result in exclusion."

(Royal College of Psychiatrists [RCP], BPS & Royal College of Speech and Language

Therapists [RCSLT], 2007, p.10)

The definition of behaviours that challenge has evolved in line with clinical approaches

to its management; historically, understanding was informed by medicalised narratives

which overlooked environmental factors (such as cognitive and power differentials with

carers) and functional aspects of behaviours, attributing them to individual pathology

(Emerson, 2011). Conceived in an attempt to recognise behaviours as challenging rather

than clients, the term challenging behaviour eventually became used pejoratively (National

Institute for Clinical Excellence [NICE], 2015). Lovett (1996, in Lloyd & Clayton, 2014)

highlighted the social construction of challenging behaviour, reframing to "behaviours that

challenge" thus emphasising the relationship with carers and environment.[2] Indeed,

environments that provide limited social support, use restrictive interventions and do not

enable meaningful activities, have been described as challenging themselves (McGill,

Bradshaw, Smyth, Hurman, & Roy, 2016) and can increase incidence of challenging

behaviour. These settings are contrasted with capable environments, which encourage

positive social interactions, meaningful activity, consistency, choice, and are staffed by

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[2] Despite this, the terms 'behaviour that challenge' and 'challenging behaviours' are often used interchangeably in the literature, and for the purposes of brevity and flow, the latter term is used for the most part in this article.

competent carers who are supportively managed in an effective organisation. The aims of team formulation dovetail with these features and can help staff understand behaviours more relationally and systemically, promoting effective and compassionate management of challenging behaviours (RCP, BPS & RCSLT, 2007). Team formulation also satisfies the recommendations of positive behaviour support (PBS) the current dominant framework in intellectual disabilities settings, which recommends a comprehensive formulation of factors in understanding and managing challenging behaviours (Care Quality Commission [CQC], 2015).

The quality and nature of carer relationships is central in the development and maintenance of challenging behaviours (Emerson et al., 1994; Grey et al., 2002; Hastings, 2005). Frontline staff are often unqualified and have varying understanding of and experience working with people with intellectual disabilities, complex needs and challenging behaviours; they often feel ill-equipped, under-supported, time-pressured and require containment (Bromley & Emerson, 1995; Chung, Corbett, & Cumella, 1995; Hastings, 1995; Hill & Dagnan, 2002; Saloviita, 2002; Lloyd & Williams, 2003). Research shows negative emotion in response to challenging behaviours and lack of support or relevant knowledge cause staff distress in addition to challenging behaviour itself; this can lead to staff burnout and reduced team morale (Robertson et al., 2005; Mills & Rose, 2011). Finally, people with intellectual disabilities are often supported by multiple individuals in a team environment which increases potential inconsistency in care provision and thus aggravation to staff-client relationships.

Therefore team formulation with staff in intellectual disabilities settings serves multiple functions: developing a cohesive team narrative and clinical approach regarding challenging behaviours; upskilling and educating staff in psychological models; formulating staff-client relationships, and providing containment for staff, which would all be expected to improve

understanding and management of challenging behaviour.   While team formulation is

common practice in intellectual disabilities settings (Lloyd & Brown, 2014), various models

are used and research on impact is limited.

Formulation is still developing an evidence base. As Cole, Wood, & Spendelow (2015)

highlight, formulation is idiosyncratic and varies by clinician depending on favoured models.

Team formulation, due to its integration of various staff members' perspectives, and often

external facilitation, is even more complex to evaluate. Most outcome research consists of

small-n studies and evaluations focusing on staff-focused outcomes such as increasing staff

satisfaction (Allen, 2015; Chiffey, Irving Quinn, & Casures, 2015), improving team functioning

(Craven-Staines, Dexter-Smith, & Li, 2010; Hollingworth & Johnstone, 2014; Lewis-Morton,

James, Brown, & Hider, 2015; Roycroft, Man, Downie, Gale, & Armstrong, 2015), generation

of psychologically-informed care plans (Summers, 2006; Wainwright & Bergin, 2010), self-

efficacy (Maguire, 2006) and perceptions of "stuckness" (Allen, 2015). Research on team

formulations and systemic consultations in intellectual disabilities suggest staff experience

sessions as helpful for developing a shared understanding of clients, allowing space to think

and reflect, and developing new clinical strategies (Rikberg Smyly et al., 2008; Ingham, 2011;

Wilcox, 2013; Fennessy et al., 2015; Whitton, Small, Lyon, Barker, & Akiboh, 2016; Johnson,

2016; Johnson & Viljoen, 2017; Turner, Cleaves, & Green, 2018).

Findings regarding client outcomes are limited (Geach, Moghaddam, & De Boos, 2017).

Team focused outcomes may be more relevant and directly attributable. Furthermore,

challenging behaviours in people with moderate to severe intellectual disabilities settings

may not always reduce in frequency despite intervention (Emerson, 2011). The paradoxical

theory of change (Beisser, 1970) argues aiming to reduce behaviours, however humanely,

may inadvertently promote frustration and thus maintain or aggravate behaviours. It may

therefore be most helpful to see team formulation as a staff intervention, which aims to

influence staff perceptions and behaviours (Johnstone, 2014). A limitation of the research in intellectual disabilities services is that most findings do not specifically explore staff's approach towards and understanding of challenging behaviour. Furthermore, the relationship between staff and clients is not considered explicitly when considering the management of challenging behaviour. This risks focusing too narrowly on the client and overlooking the emotional impact on staff, which influences how they intervene (Greenhill, 2011).

Contextual reformulation, a model of team formulation which explicitly formulates relationships, is informed by cognitive analytic therapy (CAT). CAT integrates theory from dialogism, object relations theory and personal construct theory among others (Lloyd & Potter, 2014), conceptualising the development and reinforcement of behaviours within relationships, and therapeutic relationships, explicitly formulating them using dyadic conceptualisations called reciprocal roles (Ryle & Kerr, 2002). These roles, for example, perfectly helping-perfectly helped, derive from early experience, and form more or less helpful schemata for behaving in relationships with others, who respond with the corresponding more or less powerful role in the dyad. Reciprocal roles are drawn out to create a reformulation map, in its final form called a sequential diagrammatic reformulation (SDR), and as it is developing, known informally as a CAT map. CAT draws from Vygotsky's zone of proximal development (ZPD; Vygotsky, 1978 in Lloyd & Brown, 2014) to conceptualise how clients or consultees are guided to learn skills just outside their skill level, "scaffolded" with tools and concepts such as the CAT map. The map delineates patterns such as vicious circles, highlighting new approaches or exit strategies (Lloyd & Potter, 2014). On a process level, CAT clinicians engage in the Helper's Dance (Potter, 2014) with clients or consultees, collaboratively noticing and sidestepping clinical dilemmas between unhelpful polarities. Contextual reformulation does not aim to change client presentation, but helps

staff manage their own distress in relationship to client difficulties, enabling them to develop alternative, relational strategies for managing client difficulties (Elford & Ball, 2014).

Research on contextual reformulation is in its infancy. Most studies employ small-*n* and case study designs. Carradice (2012) outlined a five-session model of contextual reformulation in a community mental health team; anecdotal findings showed increases in staff's understanding of client behaviour, feelings of containment and confidence. Staff in a psychiatric inpatient team received contextual reformulation including a theoretical training component and felt significantly less emotionally exhausted and more accomplished at follow-up, more engaged with clients, and more cohesive as a team (Caruso et al., 2013). A randomized controlled trial in assertive outreach showed contextual reformulation comprising theoretical training and CAT team supervision led to improvements in team cohesiveness, communication and shared understanding between staff at 3-month follow-up (Kellett, Wilbram, Davis, & Hardy, 2014). There is only descriptive literature concerning contextual reformulation in intellectual disabilities settings (Lloyd & Williams, 2003; Moss, 2007; Murphy, 2008; Fisher & Harding, 2009; Elford & Ball, 2014), indicating a need for formal research. Furthermore, there is no formal qualitative research exploring team formulation more generally.

Therefore, the current study explored the question: *what are staff's perceptions of changes in their approach, understanding of and ability to manage behaviours that challenge in their intellectually disabled clients after contextual reformulation?*

Method

Design

A cross-sectional qualitative design was adopted; participants were interviewed using semi-structured interviews and data was analysed using thematic analysis.

Analysis

Thematic analysis can be flexibly adapted to any epistemological approach (Braun & Clarke, 2006; Maguire & Delahunt, 2017). This methodology was adopted with an epistemological stance of critical realism, to allow exploration of wide-ranging themes including phenomenological accounts of contextual reformulation as well as the more concrete representations of how it works. Realism or essentialism emphasise the existence of objective reality that can be measured impartially, and relativism sees reality as constructed subjectively. Critical realism sits between, acknowledging that while an objective reality may exist, it can only be accessed indirectly, through individual and social constructions such as belief and discourse, which must be considered when assessing validity of an account (Houston, 2001; Harper, 2011).

Thematic analysis involves decisions at various levels of analysis. Deductive thematic analysis organises data into pre-defined themes while inductive thematic analysis stays close to the data and builds themes from the ground up. The former may be more appropriate in areas of research in which specific categories of interest have already been defined; the latter for where there is less research and more open-ended investigation is required (Braun & Clarke, 2006). Therefore, an inductive approach was adopted. Semantic themes explore explicit meanings, while latent themes explore underlying assumptions and ideologies that inform semantic content. Latent coding and theming were adopted, as meaning was informed by psychological theory, clinical experience and clinical context.

Therefore, participants' accounts in this study are seen to represent subjective yet informative views which when underpinned by psychological theory and current policy and practice, can elucidate the phenomenon of interest.

Participants

Inclusion criteria.

Participants were direct care staff considered eligible according to the following criteria:

- The primary focus of staff's paid work was supporting adults with intellectual disabilities
- Teams referred to clinicians for support with clients' challenging behaviours
- Clinicians provided one or more sessions of contextual reformulation and developed a CAT map with staff
- Staff worked in community-based care homes
- Staff spoke English fluently

Sample characteristics.

The sample consisted of 11 direct care staff working at private residential care homes for adults with intellectual disabilities. Ten participants were female, one was male. Participants were aged from 26 to 57 years. Their experience in care work ranged from nine months to 40 years. Some participants were managers, others were support workers. Table 3 reports further characteristics of participants. Given the small and specific sample of participants and clients, characteristics are presented in aggregate form to minimise chances of identification.

Table 3
Participant characteristics

Characteristics	Summary Data (n=11 across three NHS trusts and four care homes; unless otherwise stated)
Age	26 – 57 years [range] 37 years [mean] 32 years [median]
Ethnicity	White/White British (8) Asian/Indian (1) Asian/Other (1) Mixed Black/Caribbean (1)
Job titles	Service manager (4) Deputy Manager (1) Team Leader (1) Senior Support Worker (3) Support Worker (2)
Years of care work (*in intellectual disabilities settings*)	9 months – 40 years (*6 months – 40 years*) [range] 12 years (*10 years*) [mean average] 10 years (*8 years*) [median]
Previous careers	None (5) Other care work (3) Other (3) Not stated (1)
Training attended	In house training including PBS (8) NCFE Training; Care Skills Academy (1) LDQ qualification (1) Not stated (1)
Sessions attended	1-10 [range] 4 [mean and median average]

Referred clients were aged between 26 and 48, were assessed as having mild to moderate intellectual disabilities and were reported to show challenging behaviour that was moderately to highly chronic. Three clients were female; one was male. Further characteristics are found in Table 4.

Table 4

Referred client characteristics

Characteristics	Summary Data (n=4 across three NHS trusts and four care homes; unless otherwise stated)
Age	26-48 [range]
	33 [mean average]
	29 [median]
Ethnicity	White: White British
Gender	3 female; 1 male
Chronicity of challenging behaviour	Moderate (1-2 years) to highly chronic (2+ years)
Impact on life	Some implications to far reaching implications in every aspect of life
Risk to self/others	Mild to moderate
Comorbidities	Autism (3; 1 suspected but undiagnosed)
	Epilepsy (1)
	ADHD (1)
	Blindness (1)
	Bipolar (1)
Level of intellectual disability	Mild to moderate
Length of residency	6 months-10 years [range]
	5 years [mean and median average]

Sample size.

No strict sample size guidelines exist for thematic analysis. One way of gauging appropriate sample size is by ensuring data saturation. This occurs when the majority of data gained during an interview duplicates data from previous interviews; this often occurs by around the twelfth interview in homogeneous groups (Guest, Bunce, & Johnson, 2006). It is wise to conduct enough interviews to observe this level of repetition in several cases to ensure saturation has been reached (Latham, 2014), however, practical factors must be considered. Crouch and McKenzie (2006) emphasise the importance of in-depth interviews, which maximize accounts' authenticity and thus ecological validity. Balancing these factors, and considering the resource and time available, the aim was to interview between eight and 12 participants and to monitor for indications of saturation. The final sample was 11 and the final three interviews showed high levels of saturation, as the experiences discussed repeated rather than built on or added to the material from previous interviews. This indicated an appropriate sample had been achieved.

Recruitment.

Participants were identified via CAT clinicians nationally who delivered contextual reformulation. The project's field supervisor was one such clinician, who identified three suitable CAT clinicians via their professional contacts and a regular CAT special interest group for clinicians working in intellectual disabilities (CAT LD SPIG). Once initial clinician interest and projected referrals were confirmed, Royal Holloway ethics approvals and Health Research Authority (HRA) research and development approvals for four national sites were sought. Once received, additional approvals were sought and received from NHS Scotland (NRS) for a Scottish site. Local research and development approvals were sought from clinicians' employing NHS trusts (Surrey & Borders NHS Trust, Nottinghamshire Healthcare NHS Trust, Merseycare NHS Trust, NHS Fife). Once received (see Appendices 1-6), clinicians identified teams for the project, passed on information sheets and consent forms (see Appendices 7-8) and relayed contact details of verbally consenting staff. The chief investigator shadowed one of the field supervisor's sessions to gain familiarity with contextual reformulation; in this case three staff were recruited directly. One clinician contacted five staff at two care homes who were recruited and interviewed. One clinician dropped out as all their sessions were in forensic settings. This clinician contacted six Trust colleagues, one of whom contacted three care staff who were recruited and interviewed. One clinician was unable to provide contacts due to difficulties setting up sessions with referring teams during the pre-recruitment period. Staff who verbally consented were contacted over telephone by the chief investigator to confirm consent and arrange interviews. Eleven care staff provided informed consent and completed participation (see Figure 3). Prior to interview, the purpose of the research was reiterated, the consent form was reviewed and completed electronically and any questions were answered. Participants were reminded of their right to withdraw data at any time.
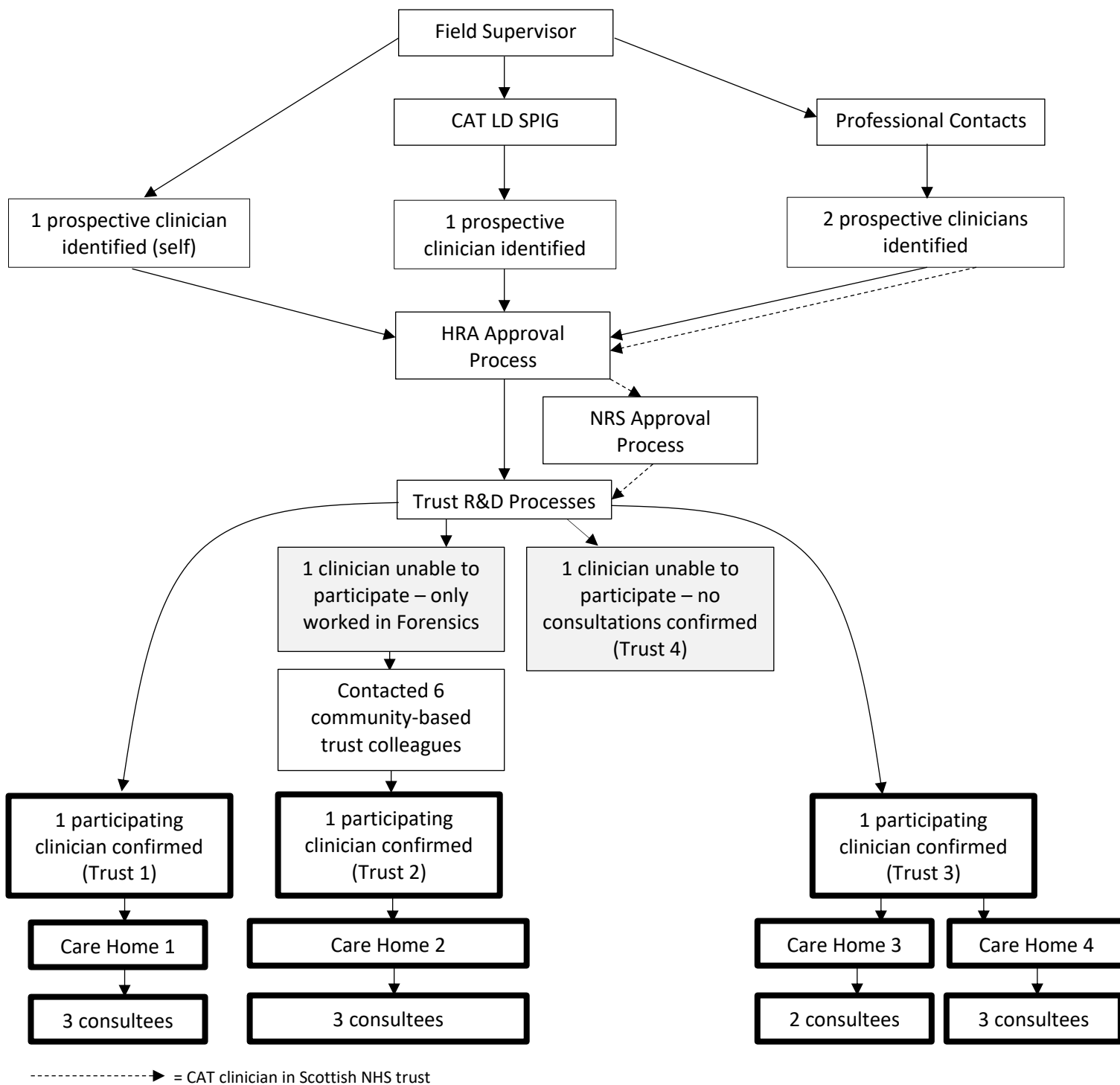
Figure 3. Flow chart of study recruitment process

Procedure

As participants were located nationally, all were interviewed by telephone. They

were encouraged to ask questions over the telephone directly prior to interview, voice any

discomfort during interview and ask for breaks or stop the interview if required. A post-interview debrief encouraged staff to express any further questions or concerns. The next steps in the research process were explained and participants were encouraged to contact the chief investigator with any further questions; none did so.

All interviews were completed in one sitting and lasted between 22 and 70 minutes. Participants were put on speakerphone and recorded with an encrypted Dictaphone. Interviews were transcribed verbatim and anonymised shortly afterwards; subsequently audio files were destroyed.

Once data had been developed into themes, a summary of themes was developed and sent out to participants for feedback on resonance.

Materials

Participating care staff completed a staff demographics form (Appendix 9), stating age, ethnicity, length of time working with people with intellectual disabilities, previous careers and training received. The service manager from each home also completed a client demographics form (Appendix 10) detailing client age, severity and chronicity of intellectual disabilities, additional diagnoses and impact on functioning.

To encourage focused and deep accounts, a semi-structured interview based loosely on one used by Kellett et al. (2014) was used (see Appendix 11). This was reviewed and developed in supervision. Questions explored areas including: staff perceptions of client presenting problems leading to referral for facilitated formulation; experience of facilitated formulation sessions including the CAT map; the nature of intellectual disabilities and challenging behaviour; and how or whether staff saw their understanding or approach to clients changing as a result.

During interviewing and transcription, it seemed in early interviews, prompts were used too soon and questions were not ordered optimally; this was considered in supervision.

In subsequent interviews, participants were given more space to answer questions and

questions were re-ordered to increase fluidity. For the updated schedule, see Appendix 12.

A sample of interview questions used is shown in Figure 4.

Perceptions of the problem

- Why was client referred, initially? / What problems were going on when your team decided to refer?

- Has your understanding of the problems/challenging behaviour changed since consultation, and if so, how?

Perceptions of consultation

- Were there specific parts/activities that you remember finding helpful/not helpful? If so, please describe these and explain how they were helpful?

- Did you have conversations with your colleagues regarding your perceptions of consultation?

Experience of CAT map

- Did clinician draw out anything in diagram form?
- Tell me about that?
- How was it helpful / not helpful?

Learning disabilities & challenging behaviour

- Has your understanding of the terms intellectual disabilities or challenging behaviour changed at all since working with (clinician name)/CAT?

Managing the difficulties

- Has the way in which you work with your client changed in any way? If so, could you describe the changes?

Figure 4. Sample of interview questions

Data Analysis

Thematic analysis involves the development of themes from qualitative data by identifying "repeated patterns of meaning" (Braun & Clarke, 2006, p. 15). The entire data set was analysed, allowing rich description of the data and minimising researcher bias. This approach is favoured for under-researched areas. Data was coded inductively using NVivo, a qualitative research software programme. The analysis followed Braun and Clarke's (2006) steps and involved the following stages:

1. Familiarisation with the data via transcription and re-reading transcribed accounts.

2. Reviewing transcripts in depth and coding line-by-line using NVivo.

3. Ordering Individual codes by frequency and breadth across accounts and combining into themes, staying close to the data. Codes were both semantic and latent, and themes leant towards latent meaning which related to the chief investigator's experience of and knowledge of consultations and intellectual disabilities settings.

4. Reviewing themes in light of supporting codes and extracts. Themes containing considerable overlapping content were collapsed into each other. Transcripts were re-read to ensure themes adequately represented the data.

Quality Control

Guidelines by Elliott, Fischer, and Rennie (1999) and Mays and Pope (2001) were used to optimise research quality. Methods were described in detail to allow for replication, methodological stance was reflected on, and sample situated to contextualise findings. Themes were grounded in examples and were reviewed by the research supervisor. All participants were invited to feedback on themes developed (respondent validation; resonance). Feedback from two participants from separate care homes suggested themes

helpfully articulated participant experiences. The inclusion of participants from four care homes in different regions and receiving contextual reformulation from three facilitators increased generalisability of findings; however the limitations of a relatively small sample were also considered. The research supervisor reviewed the thesis to ensure coherence.

Reflexivity.

Part of quality considerations is the owning of one's own perspective (Elliott, Fischer, & Rennie, 1999; Mays & Pope; 2001). The chief investigator was a trainee clinical psychologist with experience of working with people with intellectual disabilities and providing psychological consultation to care staff. They had worked in two other teams providing staff consultation and were mindful of the influence of these experiences on the research process.

A reflective journal was kept throughout the project (see Appendix 13 for an extract), and reflection in supervision informed interpretive processes. Coding of part of one interview transcript was reviewed by the research supervisor and formed part of eligibility checks. This helped reduce bias and encouraged coding that was more specific and less all-inclusive. For an example of coding, see Appendix 14.

Results

Five themes were developed. Participants and clients were given pseudonyms.

Table 5 shows participants contributing to each theme. For additional theme extracts see

Appendix 15.

Table 5
Correspondence between Participants and Themes

Participant	Themes				
	Multiple relationships to sessions and clinicians	Challenging behaviour in relationship	Understanding can be enlightening, containing and practical	Developing a shared perspective and approach	Caught between two perspectives
Sally	✓	✓	✓	✓	✓
Jennifer	✓	✓	✓	✓	✓
Edie	✓	✓	✓	✓	X
Mandy	✓	✓	✓	✓	✓
Sital	✓	✓	✓	✓	✓
Daniel	✓	✓	✓	✓	✓
Sarah	✓	✓	✓	✓	✓
Karen	✓	✓	✓	✓	✓
Chelsea	✓	✓	✓	✓	X
Lizzy	✓	✓	✓	✓	X
Emily	✓	✓	✓	✓	X

(1) Multiple Relationships to Sessions and Clinicians

Within and across participants, staff described different ways of relating to

reformulation sessions and CAT clinicians, suggesting multiple functions. Sessions were

called "*lessons*" (Sital), "*training*" (Mandy), and "*therapy for the staff*" (Daniel) that could

"*move things forward*" (Sally; Karen; Lizzy). Most staff appeared to value them for multiple

reasons. This seemed partially related to differing referral reasons; in two cases, the client

had showed repeated or increasing incidents of challenging behaviour and staff mentioned

"*struggling to cope*" (Sital) and wanting:

> *Just somebody to…come and help I think, in any way that they could, offer some*
>
> *advice, anything.* (Jennifer)

In another case, the client was increasing contact with family and hoping to move on from their placement. Staff perceived their management of the client's behaviour as different from the family's, and saw potential for sessions to help integrate these approaches:

> *It's all new to this family member as well, all these things that we're suggesting, it's*
>
> *almost like, getting them to understand the benefit…of things being done a*
>
> *particular way.* (Mandy)

In another team, the client's behaviour led their previous care home to refer to psychology, which was quickly followed by the placement breaking down. Staff in the new home worked with the CAT clinician to manage challenging behaviour but also to get to know the client and plan her care pro-actively:

> *To plan a formulation, and, and, erm, try and support Betty, and to staff basically, in*
>
> *the best way we can.* (Emily)

The clinician held multiple roles in relationship with staff. Staff valued having "*another pair of eyes*" (Mandy), "*somebody from outside*" (Sally), who made suggestions (all) and gave "*advice*" (Sally; Jennifer; Daniel; Sarah; Emily), as a clinical supervisor might do:

When, you just have a question to ask…a simple question, but you just want some

advice, it's very difficult to find it, these days, it's good to have her on hand…

(Daniel)

She wants to know…what's next, what's worked, what hasn't, anything else that's

come up. (Sarah)

The clinician was also seen as a teacher, who taught staff new concepts to apply clinically and develop their understanding:

She was talking about the templates…you know, when you're a child…you're

nurtured, and you understand that feeling so you can offer that to somebody else…

(Karen)

Some staff perceived the team as students or supervisees who prepared for sessions:

One of my colleagues speak to my manager, "I think we need to discuss that with

[Clinician]" and I thought "that's really good!" <Laughs> "we're checking our

homework!" (Sital)

The clinician also adopted the role of containing staff's feelings, allowing them to express themselves:

It felt good to erm…be able to get things off our chest, about, erm, how like, dealing

with it and stuff, cos she was asking about our, how we felt and stuff like that…and

generally when you're in work, you don't really get to feel, er think about how you

feel…she was quite understanding…about it all really. (Chelsea)

[Clinician] almost said … that it is ok for us to feel frustrated sometimes with Bob, it is

a normal thing to do, and scared, it's just a natural thing, and that was quite nice to

think "yeah it is alright to feel like that"…just because we are support workers, you

are allowed to have those sorts of feelings as well. (Jennifer)

(2) Challenging Behaviour in Relationship

Staff found sessions supported them to understand how challenging behaviour was

learned, experienced and reinforced by people in relationships rather than being an

individual property of clients. Sessions helped staff reflect on the personal impact of

working with challenging behaviours:

She just generally asked us how his behaviours can lead to staff feeling

afterwards…it can leave you…exhausted, it can leave you confused…it can leave you

upset, it can leave you in lots of different ways. (Jennifer)

CAT theory helped staff understand how behaviours were learned in formative relationships

and repeated in current ones, eliciting similar emotions in staff to those experienced by the

client:

[Clinician] will say "this is now, then, why she rejects you when she's, you know

hitting, getting quite agitated, this is the reason why she starts to reject you,

cos…that's what people have done to her". (Daniel)

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Staff learned their own emotional reactions could be challenging for the client:

If you act out, and start, you know shouting or ranting or raving, you are

feeding…them, their base instincts...you are reacting as her mother would have

reacted, therefore she's gonna react to you straight back at you. (Karen)

This new perspective helped staff feel more accepting of the behaviours and take them less personally. Other effects included increased feelings of empathy towards clients, more realistic expectations of their own influence, increased calmness and differences in how they responded:

You kind of get a bit frustrated yourself, you think, "why is she being like this? I'm

trying and trying", but, with knowing that information we've got from the session, I

kind of know to just sit back and allow her to…kind of vent… (Sarah)

Staff learned it was important to relate to themselves and their colleagues in a caring way, as well as clients:

It is ok to step outside afterwards to 5 mins and have a cigarette…stamp your feet

for a little bit yourself and then go back in.

Make a cup of tea, sit with the person who's supported Bob through the behaviour

and just talk about it…and just say…"what you did was ok, it was good." (Jennifer)

As new understanding of behaviours and emotional containment provided by the clinician helped staff manage the emotional impact of challenging behaviour, they saw how this would in turn impact the client positively:

If you can keep your cool, if you can not get upset by what she's doing, and ride the storm out with her, you're changing the pattern. (Karen)

They were encouraged to see themselves as attachment figures, serving multiple functions of containing clients' emotions, working pro-actively, setting clear boundaries, and engaging in meaningful, relationship-based intervention:

As a mother, you, you bit firm with your children, but you show love as well, so it's like, when she demands something, then we say "ok, we work, we do this way, that, that, do this one", …supportive …and whatever I say, I always do this, she know that. (Sital)

The thing I found most helpful was probably…replacing the…the materialistic with the memories…and the more…meaningful activities. (Sarah)

(3) Understanding can be Enlightening, Containing and Practical

Reformulation sessions gave staff tools and concepts that helped make links between clinical information, leading to new insights and strategies. Asking particular questions helped put clinical information in meaningful context:

[Clinician] was asking questions…things that make him start behaviour…we said her that this is unpredictable…but…he keeps, um, saying…like somebody has stolen his

stuff…so…knowing his, um, previous history…in his previous maybe care home, or,

the places he has been, they have stolen his stuff…maybe he…keeps remembering

then, he keeps recalling that, and then, that makes him angry…and frustrated. (Edie)

Some staff had previous psychological knowledge, and contributed ideas that were incorporated by the clinician:

I suggested…that it's as though she's trying to fill a void…and then we've kind of ran

with that. (Sarah)

Sessions helped staff make cross-sectional and developmental links. This helped them identify triggers for behaviour as well as understanding how clients might feel and what functions behaviours served for them:

She makes…like a chart, telling that um, he's very demanding, um, asks for, um,

questions constantly…which may, er, like trigger him for a behaviour, and like, what

helps to stop the behaviour, and then what happens after the behaviour. (Edie)

The abuse when she were younger, erm…behaviours, even, like she could be feeling

like… "well…bad things happened to me, so I must be a bad person". (Lizzy)

Just helping us understand…how Betty was trying to…regulate that, that feeling and

that emotion…without having a little bit more understanding, you wouldn't

necessarily make those links, of, of some of the behaviours we may see, that could

link back to…some of their historic abuse…and past. (Emily)

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The CAT map was seen as a visual and memory aide, helping the team integrate, understand and retain information:

> *She'll actually do diagrams, or like, words…I think that's a good thing because um, you can see it visually, as she's explaining it…I think it sinks in a bit more that way…she can flip back to what we've done before, and, and yeah it's just like bringing it all together.* (Daniel)

Clinicians used the CAT map to help staff recognise predictable patterns and cycles of behaviour and use that information to intervene at the most helpful point to pre-empt or de-escalate:

> *Find at what point within that cycle we can intervene and, and, de-escalate the situation.* (Daniel)

The CAT map was complemented by psychological concepts that were intellectually interesting, practical and containing for staff. For example, the concept of reciprocal roles helped put words to intuitive understanding and helped staff make sense of behaviour in the moment:

> *When she put in the…template form…of nurturing, being nurtured, feeling nurtured, all that kind of thing…and rejection…all them different aspects of all the different emotions…it kinda just joined all the dots up. It put it in…an educational form I suppose, in a format that made you think – yeah. And so now when you look at her*

doing things, you can relate it back, to "well yeah she's doing that because she was

taught that, and that's that, that's that". (Karen)

Many staff found the concept of the amygdala hijack (Goleman, 1995) helpful in

understanding behaviour and informing their response:

[Clinician] basically told us that, like, their mind's still like, high up and, like agitated

and stuff, so you should leave it until they've calmed down, to speak to them about

why they've behaved in that way…if you're after them straight away after the

incident, you're not gonna get…any answer, or, they just don't wanna talk to you,

but if you leave it a little bit, you do, you do tend to get more out of them. (Chelsea)

In line with clinicians' suggestions, staff found they could share aspects of reformulation

with clients in a way that provided containment:

[Clinician] mentioned as well maybe, um, talking her through her emotions as well…

like in the middle of like a meltdown kind of thing, or about to kick off say, um...I've

explained her emotions to her…she's kind of like "oh right, that's why I'm feeling that

way!" and it's calmed her down. (Sarah)

However, some staff mentioned it could be difficult to remember and apply reformulations

in the heat of the moment:

You do try and think of what you've been taught…but actually…in the situation when the typewriter's going across the room, y'know you're thinking of safety for the other guys…for the person…for the staff. (Sally)

(4) Developing a Shared Perspective and Approach

Sessions were seen to integrate each staff member's perspective into a shared understanding that informed a consistent clinical approach. Staff acknowledged the importance of consistency and clear boundaries across the team. Most gave examples of the consequences of splits in the team:

Where one…[client] get[s] away with too much with one [staff member]...but the other one, they don't…because they think that they can do the same, with that person…they think they can do that with everybody. (Lizzy)

Staff felt all staff could have their say in sessions, with the clinician balancing and integrating different views:

[Clinician] took everybody's view into account…and it kind of worked for everyone…she always had a suggestion to please everyone in a way. (Sarah)

It's like making a cake…putting all the ingredients in, to come up with, a bigger picture, what'll suit best for the person. (Lizzy)

Staff recognised the importance of making time to meet and coming together in their thinking. The clinician's input was described as helping staff develop a shared understanding that increased clinical consistency:

> *Just having that time basically to, group together…I think we would have had the conversation anyway…I don't think we would've been able to…come up with…such a consistent way of managing it…* (Emily)

> *Everybody knows then don't they?…and then, they're all practically, thinking the same and doing the same.* (Lizzy)

Whilst some staff felt ideally all service staff should attend, this was considered impractical for various reasons. These included staff needing to cover the shift during sessions, some staff knowing the client better, and the sense there was an optimal number of members when developing a shared formulation:

> *Too many people is not as effective as a smaller group, but the smaller group can help the other staff to understand…there's certain members that are more key, to the service user.* (Mandy)

Clinicians in all settings worked towards developing a collaborative formulation with staff in session, that could be shared with the rest of the team. Conversations, ideas and CAT maps were shared in team meetings and in practice:

We…have staff meetings as well, so we discuss…what we're coming away with

from…sessions with [Clinician]. (Emily)

It gives me something to use as well…as a senior talking to 'em, "can you remember

when we talked about that?"…to remind her…"that applies here". (Karen)

Some staff indicated concerns about their ability as care staff to accurately convey

reformulations without the CAT map.

I would need the CAT map, to say, "this is what we talked about with this, and this is

how it works, this is why we've done it", and there's a visual guide to also show

them, because I think trying to talk about it, just first hand, without the

information…it could get confusing, or misconstrued. (Mandy)

(5) Caught between Two Perspectives

Staff across seven interviews expressed conflicting perspectives on clients and how

to relate to them; it seemed difficult to hold these in mind simultaneously. There was a self-

consciousness about how behaviours were labelled, suggesting staff were careful not to

pathologise. For example, while staff acknowledged the role of perceptions in whether

behaviours were deemed challenging, some behaviours seemed clearly challenging in

themselves:

I mean I know, we kind of have to call it, behaviours that may *challenge, because of*

how they're punched in the face, to name as challenging, but someone else might

not be challenged, something along those lines, which I think's ridiculous…yeah, I

think it's…I think, erm…<pause> <sigh> oh it's so…I dunno, I s'pose any, anything

where it's…<pause>…er…I don't wanna sound ridiculous – just say anything that's

challenging, but, er, anything…I s'pose it's sort of your interpretation of

what's…what is challenging, I guess…you know…behaving…I dunno…I dunno…I can't

answer it, I can't answer it… (Daniel)

CAT clinicians reminded staff of the limits of intervention, with no "fix" for intellectual

disabilities and challenging behaviours, but it sometimes seemed difficult to accept:

She also reminds us that…there's no cure to this. You know, we're just talking about

how we can manage this, but it's never gonna stop…and…sometimes you have to try

different things…if it doesn't work, then move onto the next kind of thing…so

sometimes [I] think "oh god…are these sessions helpful?" But they are…when you

look at it as a whole, they are…but then, you think "uh…nothing's going to work,

because she just, she's obsessed about that item, and that's it". (Sarah)

This was also reflected at the systems level. While staff were making good use of sessions

based on clear need for support, they also felt just the right amount of consultation could be

the "answer" that would alleviate the emotional challenges of the work:

It would be great if we could all sit and talk about it for five hours…we can't. (Karen)

I understand…psychologists – they're busy…but I'm just thinking like how much more

you could probably do for somebody, if you had time, to, stand with that person as

well…because we could be telling her something, and that, she, she could be getting

it, but then she might pick up on something that we're not… (Sarah)

Additionally, some formulation-based interventions were seen both as being "the most helpful" outcome, and also as not providing the answer. This seemed to be partly because the result may not be "effective" in reducing behaviour, but also because there was no way of knowing for sure if the reformulation was accurate and was fulfilling a need:

> *I'm struggling with it because…this memory making, more loving, and, showing more of your time...if that makes sense…it's hard to determine yet whether that – it is effective…but it might not be, what actually what <laughs> she wants, really!* (Sarah)

While sessions were focused on helping staff manage their own responses to current patterns which might not change, there was also the idea that change could happen further in the future:

> *[Clinician] said…"this isn't a thing that's gonna happen over six month to a year, this is a five year thing"…she's…changed a lot, from…when I first met her and was supporting her…she's completely different…so I do know that over the stage of six years, change can happen…I'm just hoping that that can happen again in the next five years.* (Sarah)

Thematic Map

Figure 5 represents the five themes diagrammatically. In this description, themes are denoted in bold text. The outer circle illustrates how **opposing perspectives** represented in practice and society (as discussed later) define and reinforce the multiple needs of people with intellectual disabilities, reflected in the **multiple relationships** of staff receiving

contextual reformulation. Sessions help **develop a shared understanding and approach**,

which comprises a balance between **conceptual understanding** and the process of **relating**

to clients and challenging behaviour. These latter aspects are mutually influential, as new

understandings influence behaviour in relationship, which in turn influences what is known.
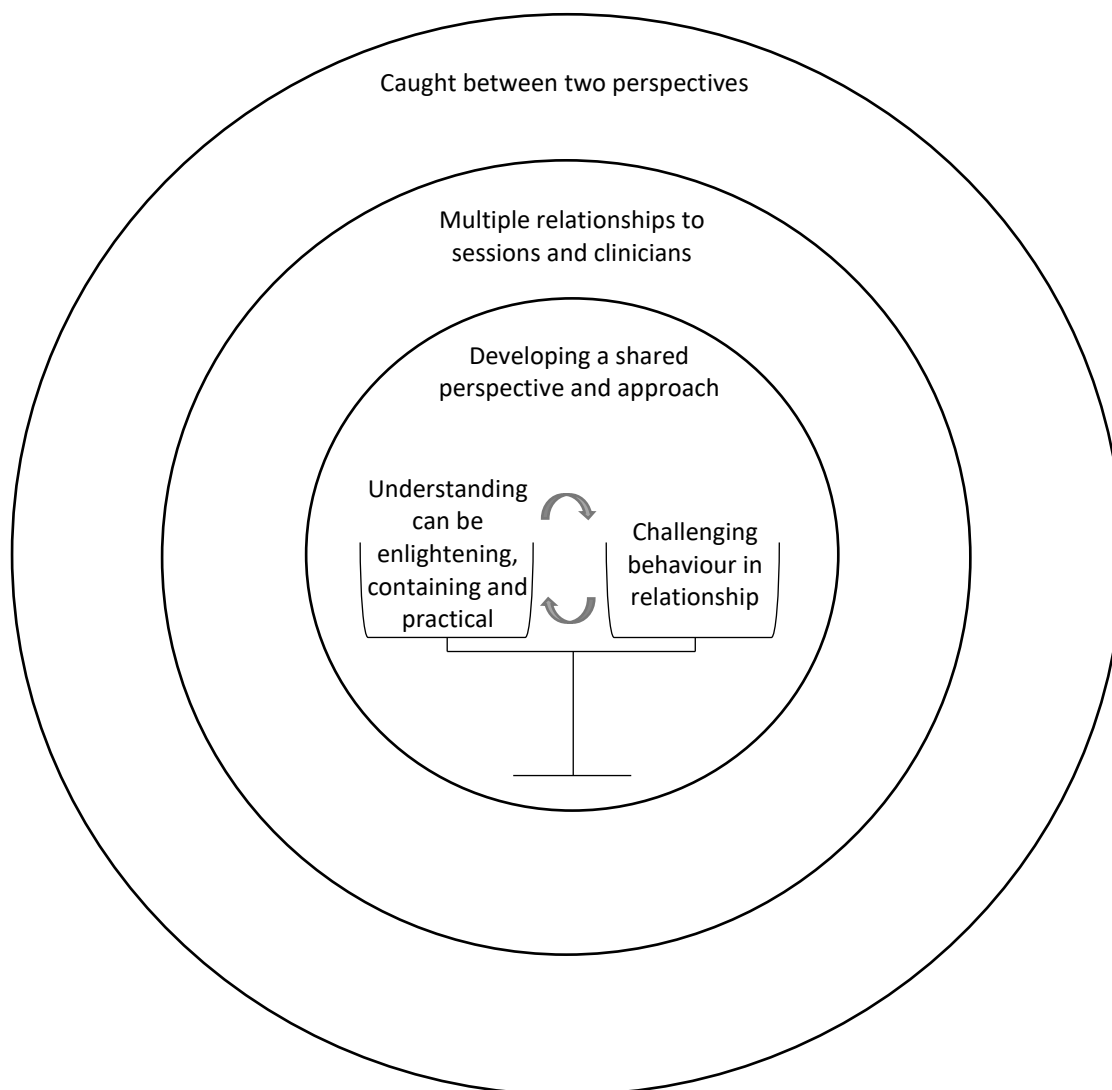
Figure 5. Thematic map of study findings

Discussion

This study explored care staff's experiences of contextual reformulation, a CAT-informed model of team formulation, and their perceptions of how it impacted their understanding and management of challenging behaviour in clients with intellectual disabilities. Five themes were developed using thematic analysis. Findings are considered in relation to the existing literature and potential clinical implications. The study's strengths and limitations are discussed, and suggestions for future research made.

Findings reflected the complexity of psychological formulation, which comprises various techniques and processes at multiple levels. Staff's experiences of contextual reformulation included learning and applying psychological theory, collaboratively creating visual CAT maps and developing a shared language for understanding clients and their behaviour. They also described process-focused elements including the relationship with the clinician and how this informed staff's relationship to themselves, their clients and the way they understood and responded to behaviour.

Reformulation sessions served various purposes for staff, who described multiple ways of relating to consultations and clinicians, within and across participants. This seemed partially related to the referral, its description of the problem, and what the request was for. Elford and Ball (2014) suggest teams in intellectual disabilities settings often refer framing problems from a "dreaded" state, defined in opposition to hopes external intervention will produce an "ideal" state. Problems in these services are inherently complex; referrals from staff, carers and families to psychology seeming to centre around client behaviour can unwittingly combine motives, perspectives and needs from different stakeholders in the system (Haydon-Laurelut, 2011). Furthermore, clients' complex needs and the all-encompassing and multiple roles staff play in their lives, are reflected in the multiple needs staff themselves experience, an example of parallel processes (Cardona, 1975). Additionally,

in three of four participating care homes, service managers were aged 30 and under. Managing services for complex clients and providing containment for staff teams at this relatively young age is a huge responsibility; it seems unsurprising both managers and staff desired various forms of support. While clinical need shaped understanding of sessions, so may have contextual reformulation, which draws from dialogic and Vygotskian principles, supporting the development of concrete knowledge within consultees' ZPD in the context of relationship (Vygotsky, 1975; Bahktin, 1981; in Lloyd & Clayton, 2014). This reflects staff experiencing sessions as educational or clinicians as supervisors. Contextual reformulation also draws from psychoanalytic principles, and appeared to allow staff to explore and process emotional impact of the work. Staff indicated this helped regulate their emotions; clinicians validating staff's distress helped staff validate themselves and each other, and hopefully respond more compassionately to clients. Reformulation therefore, appears to foster features of capable environments: proficient carers, effective management, staff support, and effective organisational context (NICE, 2015; McGill et al., 2016), thus promoting good care and reducing risk of challenging behaviour.

Psychological concepts and tools combined with emotional reflection allowed staff to understand challenging behaviour on multiple levels, as: responses learned in early relationships, serving a function such as emotional expression, repeated in staff-client relationships, and impacting emotionally on staff thus leading to unhelpful interventions. Linking these elements helped staff see behavioural sequences or "procedures" (Lloyd & Clayton, 2014) that without reflection, perpetuated unhelpful relationship patterns and thus challenging behaviour. This understanding simultaneously contained staff and inspired new approaches. This supports theory showing that psychological knowledge helps regulate emotions (Izard et al., 2011; Leiper, 2014), and also the therapeutic principle that insight enables choice, and thus change (Hayes, 2004). Some staff integrated information from

multiple levels of formulation, while others made initial links at one or two levels, for example between behaviour and client history, or between their own emotions and behaviours. This indicated more developmental and relational understandings of challenging behaviour and seemed to inspire interventions focused more on how staff could contain themselves and clients rather than changing behaviour. This is congruent with the paradoxical theory of change (Beisser, 1970). Examples of formulation-based interventions included staff validating their own emotions, perceiving clients and behaviours less pathologically thus triggering fewer negative emotions, talking clients through their emotions, and recognising when to give clients space to process emotions. Distress can mediate the relationship between experiencing challenging behaviour and burnout (Mills & Rose, 2011), so emotional regulation seems vital in providing effective care. There was also evidence of staff being supported to develop more relationally-informed interventions, such as "making memories" to enhance clients' positive feelings, rather than buying possessions. This represents meaningful activity, another feature of capable environments (McGill et al., 2016).

Unsurprisingly, staff who attended several regular sessions appeared more socialised to CAT principles and processes of change. Even these staff, however, sometimes felt uncertain communicating psychological knowledge to others for fear of getting it wrong, and some highlighted challenges in remembering and using reformulations in the moment. This demonstrates the real challenges staff experience in responding to behaviours. It also shows producing, applying and revising formulations is a complex skill requiring time to learn and integrate, preferably during ongoing supervision in sessions but also in service meetings with colleagues, as practiced by some participating teams. This is essential to long term implementation, which can take years (Georgiades & Phillimore, 1975) as some participants recognised. Although resources are limited, providing regular psychologically-informed

support or supervision to intellectual disabilities care home staff would seem to have significant systemic and clinical benefits that may enhance care as well as reducing recruitment and sickness costs long term.

Staff described discussing and integrating clinical information to develop a shared understanding of the client and challenging behaviours. This supports the aims of team formulation (Johnstone, 2014) and requirements for teams working with people with intellectual disabilities to provide consistent, joined-up care (NICE, 2015). Staff felt encouraged to express their views, which the clinician skilfully integrated with psychological concepts, creating a shared, collaborative formulation staff could refer to during conversations outside of sessions, providing consistency in clinical approach. This reflected another aspect of capable environments: increased predictability and consistency (McGill et al., 2016).

The final theme of care staff's accounts reflected the conflict between two apparently opposing perspectives. These "dilemmas", for example fixing versus managing (Hayes, 2004) and problems as individualistic versus relational (Levins & Lewontin, 1985 in Linehan, 1995) seemed to reflect wider philosophical contradictions between realism and relativism (Houston, 2001; Harper, 2011), content and process (Held, 1991), and individualism versus collectivism about how problems should be defined and approached. The traditional, individualist view of locating a problem (such as challenging behaviour) and reducing it, contrasted with the paradoxical theory of change (Beisser, 1970), accepting the problem, thus changing one's relationship with it, often affecting the problem as a result. This dilemma is relevant to two parallel and related contexts: the process of learning (for example via the consultative or therapeutic relationship) and the position of people with intellectual disabilities in society. It has been argued in philosophical, psychodynamic and cognitive-behavioural literature (Hegel, 1816/2004; Leiper, 2014; Linehan, 1995) that we

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learn through ongoing conflicts between opposing feelings and concepts, which eventually

synthesise to form an integrated understanding, which is defined against a new opposite

and so on. It is tempting to avoid the uncertainty and cognitive dissonance (Festinger, 1957)

of learning and maintain an idealised worldview by identifying with one position and

ignoring inconvenient exceptions described in CAT literature in the helper's dance list

(Potter, 2014). This is demonstrated in society's relationship to people with intellectual

disabilities; social values of individualism, choice and self-sufficiency are easily accepted by

the majority. However, people with intellectual disabilities are socially and physically

dependent on others, on the less powerful end of a reciprocal role relationship more often

(Psaila & Crowley, 2006), and inherently *less able to choose* or embody societal values, which

clearly exclude them. This creates frustration for people with intellectual disabilities and

those around them, perpetuating the misattribution of problems within them. Care staff

must learn to navigate both realities, despite their incongruence. This was reflected in the

confusion and frustration of some staff's accounts. Contextual reformulation helped staff

manage these dilemmas with its own dual approach: mapping and understanding the

concrete reality of client's challenges and offering practical strategies, while acknowledging

the limits of traditional intervention and fostering emotional and relational intelligence in

the face of challenging situations and behaviour. One participant fed back on this theme of

dissonance, commenting that increased acceptance came with experience. Contextual

reformulation may therefore particularly benefit less experienced or younger staff. This is

reinforced by the fact that staff whose accounts did not reflect the final theme and whose

perspectives of sessions appeared more focused towards practical solutions were staff who

were less experienced and received the least amount of consultation. When contextual

reformulation is provided as a relatively short-term intervention, this may inadvertently

imply it provides a quick fix or lasting answer. However, if funding was adequate and clinical

need was prioritised, support for formulation would be integrated into standard practice as a vital tool requiring ongoing input and refinement.

Clinical Implications

Contextual reformulation seems a fitting model for teams working with intellectual disabilities and challenging behaviour. It provides a structured language for understanding challenging behaviour relationally, and through this and the team's relationship with the clinician enables the containment of self and other in staff, leading to more effective management of challenging behaviours. It has been argued that relational approaches likely correspond to reduced frequency and intensity of behaviours (Skelly, 2016), thus, the approach is congruent with the aims of PBS.

Current findings in light of previous research suggest benefits of reformulation compound and deepen as more sessions are provided. Ideally, reformulation sessions or an equivalent approach should be an ongoing integral wraparound service for staff in care homes for people with intellectual disabilities displaying challenging behaviour. Where resource prevents this, (re)formulation sessions should be provided in blocks of regular sessions with regular attendance by core staff members, allowing for socialisation, integration of concepts and processes, and initial supervision. Sessions should include a theoretical teaching component and the development of a CAT map as these provide staff with a shared language and aid integration and application of formulation. Teams and staff vary in psychological competence and clinical need, thus reformulation should be tailored and targeted accordingly in line with ZPD.

It is important to acknowledge the limits of service level intervention. The difficulties delivering the Transforming Care Agenda (Taylor, 2019) indicate the need for intervention beyond the levels of client and service, as people with intellectual disabilities

cannot simply be subsumed into dominant social structures; these must evolve in tandem, via policy, adequate funding and social action.

Methodological Evaluation

The study's strengths included the collection of high-quality data via in-depth qualitative interviews, from several care homes, across a sufficient number of participants. Analysis was rigorous and credibility checks were conducted, ensuring coding adequately represented data. Staff were consulted on the resonance of themes, and confirmed that findings reflected their experiences.

Some limitations were that the intervention was not standardised; and there was noticeable variation in how staff teams experienced reformulation sessions. This seemed to vary as a factor of how many sessions were offered/attended, how they were structured, and the extent of CAT theory taught in initial sessions. Furthermore, observed changes could not be reliably attributed to contextual reformulation.

Participants were predominantly women; this may have made findings more applicable to women, who are socialised differently in terms of relationships and emotional expression. Most participants were senior support workers, team leaders or service managers, who may have had more time to participate due to less direct contact with clients. More senior staff may also have been more able to make use of sessions due to prior experience and knowledge, thus making them more willing to be interviewed. This may suggest current findings are less applicable to junior care staff. Additionally, teams who received sessions may have been more organised and more able and may not represent the average team. To illustrate this, one clinician was unable to provide consultees, partly because he felt teams that were engaging were not ready for CAT, and partly because many teams in his area were not confirming or attending sessions. In one care home that did provide participants, the service manager said junior staff were less likely to have time for

interviews. Future research would benefit from investigating experiences of junior care staff and struggling teams particularly, as contextual reformulation may need to increase its accessibility to these harder to reach populations.

Future Research

This was an exploratory study and as such no causal attributions were possible. Investigating a standardised model of contextual reformulation (such as the five-session model described by Carradice [2012]), with a single case experimental design (SCED) would allow causality to be inferred. Idiographic and standardised measures could be taken at multiple time points and measured against baseline – this would allow a more precise picture of how reformulation is experienced, integrated and applied over time in clinical practice. Equally, a standardised model of contextual reformulation could be compared against a wait-list control, and models such as team formulation, systemic consultation and PBS to assess relative effectiveness.

As multiple factors seemed to influence how much staff understood and applied what was provided in sessions, such as age, years of experience and number of sessions provided, research into moderating and mediating factors would help inform optimal delivery of reformulation sessions.

Conclusions

The study explored care staff's experiences of contextual reformulation in relation to clients with intellectual disabilities and challenging behaviours. Contextual reformulation helped staff see challenging behaviour as relational, provided them with the space to reflect on their emotions and relate compassionately to themselves and others, and ultimately helped them to focus their interventions on understanding and relationally managing rather than reducing behaviour. These findings appeared to suggest that contextual reformulation

enables several features of capable environments (McGill et al., 2016), including meaningful

intervention, consistent care, modelling of helpful relating, proficient carers, effective

management and staff support, and effective organisational context. Systemic limitations

can present challenges regarding contextual reformulation's optimal delivery; future

research could explore this and influence practice and policy.

Chapter Four: Integration, Impact and Dissemination

Integration

Relationship of Empirical Paper to Systematic Review

The systematic review question related directly to the subject of the empirical paper (the latter being a subset of the former), and helped identify research gaps and contribute to the rationale for the current research. It was clear that research into facilitated formulation in intellectual disabilities was fairly limited.

Developing the Systematic Review Question

It took time to develop the systematic review question and search terms so that the reviewed research held together appropriately. At first, only team formulation articles were reviewed, including grey literature (including Clinical Psychology Forum articles) and unpublished doctoral theses. However, unpublished or grey literature seemed to outweigh peer-reviewed literature, which may have skewed the review findings. Equally, it seemed systemic consultation was used almost interchangeably with team formulation depending on the service providing consultation. This seemed to outweigh any potential differences in theoretical approach, which differs across team formulation anyway. Once systemic consultation was included in the review, the amount of articles became too large for the scope of a doctoral systematic review. The decision was made to only include literature of a certain quality – peer-reviewed literature and unpublished doctoral theses. Unfortunately the one doctoral thesis (Johnson, 2016) was of such a quality as to have as much data as the rest of the studies combined, which again posed the risk of a skewed review. In accordance with university guidelines, only published articles were included. This may mean there are important findings from grey and unpublished literature that were not represented in my systematic review, perhaps due to publication bias.

Relationship between Systematic Review and Empirical Project Findings

There were many similar findings in the systematic review and empirical paper, demonstrating that facilitated formulation has some cross-model effects. For example, findings in both papers suggested staff found facilitated formulation helpful for making links between clinical information, integrating individual staff perspectives into a shared team understanding, leading to practical clinical strategies for working with people with intellectual disabilities and challenging behaviour. The role of the facilitator seemed important in both papers' findings, although this was only in the qualitative systematic review research findings. Specific elements and findings were unique to the empirical paper. The focus of this paper was on team formulation from a cognitive analytic (CAT) approach (contextual reformulation), which was novel research in the domain of intellectual disabilities. It was also, as far as I was aware, the first in-depth qualitative project on team formulation in intellectual disabilities. These prior research gaps partially formed the rationale for the project. Additionally, the project produced novel findings indicating a shift in staff's thinking towards third-wave conceptualisations. For example, staff learned to see the way they related to clients as just as important as the concrete actions they took, sometimes more so. The relationship comprised tendencies in how they understood clients, interpreted behaviour, and responded to behaviour rather than one-off examples of these elements. As part of this, staff reported reflecting on their emotions in sessions, and how they related to themselves. This focus on staff's relationship to their own emotions and self-management was not apparent in the findings of the systematic review and may indicate an important focus for future research and practice. Staff's accounts in the empirical paper also implied the conflict between these more third-wave perspectives and traditional ways of understanding and managing behaviour. This may be an important factor to consider and acknowledge when delivering all models of facilitated formulation in intellectual disabilities

settings, as it may provide containment and context for the challenges in the work, as well as managing staff's expectations of what intervention can provide.

Developing the Research Question and Design

The project was originally conceived as a case series exploring a three-session model of contextual reformulation, with idiographic and standardised measures taken before the first and after the second and third sessions, as well as post-intervention qualitative interviews. Having consulted with my field supervisor, the plan was to contact five or six CAT clinicians working with one or two teams apiece. Teams rather than individuals would have represented data points; thus individual scores would have been averaged to produce a team score. My proposal was submitted, reviewed and resubmitted several times as there were some concerns around the feasibility of the project as well as the robustness of design. As an inexperienced researcher with no established experience with or contacts in CAT or intellectual disabilities, I found it difficult to assess this, and consulted regularly with my field and academic research supervisors. After discussions with my field supervisor and other clinicians at the CAT intellectual disabilities special interest group, it seemed that standardising contextual reformulation to a three-session model would make it difficult to recruit, as many clinicians may only have the capacity to provide one or two sessions, whereas others may prefer to intervene for a much longer time. Equally, any problems in recruitment might mean very few data points if using team scores as data points and any participants attending fewer than three sessions could easily skew the data. Feeding back these ideas to my academic supervisor, we agreed to propose a qualitative post-intervention interview design, whereby staff attended one or more sessions of contextual reformulation. While this precluded the opportunity to make claims of causality, and increased variability between the intervention different participants experienced, it also allowed for increased recruitment opportunities and in-depth qualitative exploration of the data.

Overall, it was six months from initial proposal submission to approval. I had not realised the amount of development the project would need when I selected it; this was partially due to my own inexperience and partially due to the project being relatively underdeveloped to start off with. It was only by going through the approval process that I understood the scale of the original project and how challenging, and potentially impossible it would have been without any prior research experience and the time constraints of the doctorate. The current project may inform more statistically controlled research into contextual formulation, such as a case series or single case experimental design, but from my experience this would need to either be led by a more experienced and resourced researcher or clinician in the area, or to be sufficiently developed and set up before being handed over to a clinical psychology trainee.

Ethical Approval Process

After having my project approved, I prioritised contacting CAT clinicians who may be able to provide me with participants who received consultation from them. Partially due to my own oversights, and partially due to my project being fairly unusual (the staff I planned to interview were non-NHS, but were receiving consultation from the NHS), there was some confusion on my part and on others' (for example trust Research & Development [R&D] departments) about whether my project required approvals from the Health Research Authority (HRA) and thus whether I needed to submit an IRAS form. One trust R&D department directed me towards guidance that suggested this was required, as the NHS services would count as Participant Identification Centres (PICs). It felt challenging to consolidate the nature of research as reflexive and iterative, with the necessarily linear, hoop-jumping aspects of the approval processes. For example, I had to build relationships with CAT clinicians before submitting the IRAS form, so I could identify multiple sites on the form, even though by the time the approvals came back, I might have identified new

clinicians or lost some of the original ones. Again, my inexperience contributed to me

finding it difficult to hold all these aspects in mind and visualise how each step fit in. In

hindsight, I gained some valuable experience in keeping multiple contacts "warm" over

extended periods and chasing people regularly.

Recruitment

I was regularly in email contact with CAT clinicians throughout the approval process

(another six months from submission of RHUL ethics to approval from trusts), giving them

estimates for data collection times and target numbers, and checking in with their

expectations of how many participants they could provide. Even so, one clinician was

unable to provide any participants due to low referral numbers and inappropriateness of

CAT for the staff they had seen in past months. Another had fewer participants to offer due

to low referral rates and changes in career plans. Yet another was working exclusively in

forensics, which I had not been aware of at the time of original contact, and due to

infrequent replies had not realised. Luckily, this clinician was able to put me in contact with

other colleagues in their trust, one of whom was able to provide participants. This

demonstrates both the benefits and the drawbacks of multi-site research.

In some cases, multiple care staff within the team were willing to be interviewed

and elsewhere were not as forthcoming. Because of the time and energy care staff's roles

require, in the context of organisational pressures and limitations, I thought this may reduce

their ability or inclination to put aside 30-60 minutes for an interview, making them a more

difficult group to access as research participants perhaps. I also considered other factors, for

example time limitations, team morale, manager buy-in and encouragement of staff versus

protection of staff, staff confidence and staff's relationship with the clinician.

Recruited Sample

Ten of eleven participants I interviewed were women. I thought this may reflect gender representation in care work to an extent, as women outnumber men in helping professions. One of the two studies in the systematic review that specified gender of participants showed a marked majority of female participants. However, the one participant I invited to interview (via his manager) who declined was a man. One speculation is that men may feel more comfortable saying no whereas women may feel more pressure to help out, perhaps leading to male views being under-represented in the research.

Participants held various levels of seniority within the team. I found it interesting to consider to what extent people self-selected or were selected, either by clinicians (who often identified potential participants before contacting them) or managers, and for what reasons. With one team, all participants interviewed were quite senior and provided comprehensive accounts but I was aware several other colleagues had attended sessions and did not come forward for interview. I wondered if these colleagues would have responded similarly or if they had understood or integrated less from sessions, and if this was linked in any way, consciously or not, to them not being interviewed.

Process of Interviews

When conducting the first two interviews, I felt conscious of taking participants' time, maybe related to the fact that both participants mentioned their busyness, but also due to my nervousness at the beginning of the process. This led to feeling rushed, and not having as much space to respond flexibly to what they told me. I reflected on this quickly and "warmed up" before subsequent interviews, as well as taking the time to write down reminder notes during particularly rich dialogue rather than getting distracted by the conversation and missing simultaneous strands.

I realised I felt pulled in several directions during interviews. Staff often described their understanding of intellectual disabilities work in depth, and I had to remind myself to

link this to their experience of sessions, rather than just listening, validating and exploring the richness of their knowledge. Some staff also described clients' experiences in depth, and it was tempting to be drawn into assessment and formulation territory; again, I had to continually steer back to how sessions had impacted staff's understanding. Similarly, I had to remind staff (and myself) that this was not an evaluation of the CAT clinician, and that ambiguities, ambivalence or negative feedback were just as relevant and important as positive and constructive experiences.

If I had more clinical experience, in CAT and in general, or more research experience, I might have asked more skilful questions, and known how better to encourage participants' views, especially those who felt nervous, or who communicated things ambiguously. I noticed the negotiation between rapport and information-gathering similar to that in clinical interviewing. I often realised when transcribing that I had taken certain lines of questioning, whereas I could have taken more pertinent or interesting ones; equally sometimes I had taken things at face value where I could have explored further. On the other hand, there were times I did this and received the same response, worded slightly differently; this made me wonder whether I was tailoring my questioning in line with an intuitive sense of what participants would understand, partly to maintain rapport. However, there were also examples of when I did "push" participants and received very informative responses I was not expecting.

As participants were located nationally, all interviews were conducted by telephone. This was convenient, but there were several drawbacks. I felt face-to-face interviews would have allowed increased rapport, comfort for both parties, ability to read nonverbal cues and contextualise accounts, better pacing based on being able to gauge pauses versus completed sentences, among other things. All of these aspects may have improved the quality and interpretation of accounts.

Additionally, focus groups may have been a more congruent method for collecting data, since the intervention was at a team rather than individual level.

Service User Involvement

Member checking is one method for improving the credibility and validity of qualitative research. A lay summary of the themes was sent by email to all care teams in which staff were interviewed (see Appendix 16). No responses were received by email, however I followed up with two staff members by telephone. One manager said the themes aptly reflected the experience she and her team had during consultations. In reference to the fifth theme "caught between two perspectives", she confirmed this reflected classic clinical dilemmas such as how to manage risk such as self-harm while encouraging client independence. She also interpreted this theme as representing the time it took for new staff to move from a perspective of "fixing" towards acceptance of what could not be changed and needed to be managed.

It would have been beneficial to consult care staff on the development of the interview schedule. There would have been opportunity to do this during my intellectual disabilities placement, which took place during summer 2018. However, due to multiple demands at the time, this did not occur to me.

Interpreting Data

I developed just under 500 codes using NVivo. Having developed themes, I noticed that my codes were rather concrete, and often spanned multiple themes, some of which felt much more relational. Although the codes provided important markers, there was an equally important aspect of the process that was not easily represented concretely, and was more of a felt sense or an image. Although I developed a thematic map of findings, I was aware there may be many other possible visual representations.

Personal Reflections

I was drawn to this project initially as I had a prior interest in staff approaches, and had been an assistant psychologist in a psychological consultation team. I was also interested in learning more about CAT. As I had no experience or knowledge of working with people with intellectual disabilities, I saw this as a valuable opportunity to learn more. Because research into intellectual disabilities, CAT and team formulation is under-developed, this provided the opportunity to do more explorative research, which I prefer to deductive research that aims to refine and separate out. This kept me interested and motivated at key stages such as writing up the research.

I was aware that my interest in third wave approaches and previous (and current final year placement) experiences of consultation presented some advantages when interviewing participants. For example, I noticed prior knowledge helped me understand what participants were referring to (for example, the amygdala hijack, acceptance versus problem-solving) and what clinicians were likely to have been intending in their approach. Previous theory and knowledge also influenced my coding, one reason I considered it latent rather than semantic.

Impact

There are various potential beneficiaries of the research. Each will be discussed with consideration of the method of dissemination and potential impact.

Care Staff who Participated

Some participants noticed the benefits of taking part in the research, citing benefits such as the chance for reflection. One participant mentioned in the interview debrief that:

You made me think…about things that I haven't even, um, told in the, in the

consultation. (Edie)

Another participant felt being interviewed for the research gave additional time to reflect on what the team learned and what she learned more individually, as the sessions were necessarily more client-focused. This additional reflection during interviews appeared to help staff further develop and integrate what they had experienced in sessions. The lay summary of the findings disseminated to care staff could have a similar effect of grounding and formalising session processes in a way that expedites learning, encourages socialisation to sessions, optimises use of sessions and increases benefits.

Staff Working Directly with People with Intellectual Disabilities and Complex Clients

Aside from the lay summary sent to participating care teams, there are plans to publish in a journal relevant to intellectual disabilities. The findings may give other staff working directly with people with intellectual disabilities insight into the multiple processes and benefits of team formulation, specifically contextual reformulation, and how this could help manage challenging behaviour and clinical work more broadly. This could have the effect of motivating staff to refer for, attend and make use of sessions optimally. With reference to participants' experience of research, the findings may also help their colleagues and other care staff reflect further on any consultations they have received previously, and on their formulations of clients. The more general findings relating to contextual reformulation benefits may apply similarly to staff working directly with complex clients in other settings who receive or would benefit from facilitated formulation.

People with Intellectual Disabilities

Facilitated formulation, including contextual reformulation is focused on staff developing comprehensive, shared understanding of their clients in a way that helpfully informs intervention. As participants experienced benefits, and reported their responses to clients changing, it would be expected that their clients also experienced a positive difference in their interactions with staff, perhaps feeling more understood, contained and cared for. Further research could build on the current findings and influence practice, theory and policy which could in turn improve the provision of services for people with intellectual disabilities.

Clinicians who Provided Participants

The lay summary of findings was distributed to clinicians who provided participants. Certain findings particularly related to clinicians' delivery of sessions, such as the functions served by the facilitator (theme one), the dilemmas and questions expressed by participants (theme five), and the relational aspects of the sessions. One clinician found the lay summary "*very rich and very interesting*" but had also hoped for more constructive feedback – "*I am interested to hear anything less positive too as it gives us thoughts for change*". Perhaps findings validated their own practice more than it gave ideas for improvement. Also, in-depth findings in the full submission may be more informative and will be sent to any clinicians who want to receive it in its final post-viva form.

Clinicians Providing Team Formulation to Staff Working with People with Intellectual Disabilities or Complex Clients

Findings supported theory of contextual reformulation and team formulation and led to recommendations for its delivery in intellectual disabilities settings, which may extend to other clinical settings. Some recommendations included the structure and set-up of sessions, including in consideration of the specific team needs. There are some implications that may, however, be out of the hands of clinicians delivering consultation. For example,

they may be limited in how many sessions they are able to offer due to funding and resources.

Researchers Investigating People with Intellectual Disabilities, CAT or Team Formulation

I aim to publish both the systematic review and empirical paper in a peer-reviewed journal. The findings are relevant to several domains of research, all of which are relatively underdeveloped. They validate the benefits of contextual reformulation, CAT theory, team formulation, and staff approaches in intellectual disabilities settings and develop the knowledge and evidence base in this area. This will be evidenced by the citation of this research in other publications. The findings also provide a foundation for further research in these areas, for example testing a more protocolised model of contextual reformulation, or investigating client outcomes. The recommendations may encourage researchers to use more contextualist approaches to research that meaningfully incorporate qualitative and quantitative data, as well as developing theory, idiographic and standardised measures that capture concepts such as the clinician-team alliance and other relevant staff and team outcomes.

Policy Makers in Intellectual Disabilities

While researching the previous literature, there did not seem to be any recommendations for teams working with intellectual disabilities to receive facilitated formulation of any kind. However, consistency and other features of capable environments (McGill et al., 2016), which the current findings suggest that team formulation may support, were cited as essential in care provision. Future policy and clinical guidelines (such as the National Institute for Clinical Excellence) could draw from the findings and recommend the integration of regular facilitated formulation into standard practice. All the same, the extent to which policy guidelines can be integrated into practice depends on funding and resource,

and as alluded to earlier, a realistic and holistic approach towards the existential and philosophical conflicts between mainstream social values and the experience of people with intellectual disabilities. In other words, change must happen at multiple levels of the health system, local and national government (for example the Department of Health), and society more broadly to effect lasting change in clinical practice. The last fifty years suggest that this is possible, and that change happens gradually when momentum is sustained over time by clinicians, researchers, campaigners and politicians.

Dissemination

I have presented the research in a poster, in a provisional form (with initial findings from seven participants) at the second CAT Research conference (The Research Journey from Start to Finish: Motivating-to-Motivated) in March 2019 in London, where there were about 30 attendees. I will also submit a poster presentation of the complete project to be presented by my internal supervisor at the International Association of the Scientific Study of Intellectual and Developmental Disabilities World Congress conference (IASSIDD 2019) in Glasgow in August 2019.

As mentioned previously, a lay summary of the findings has been sent to staff participants and CAT clinicians who delivered sessions which the research investigated. I have sent the lay summary to the CAT learning disabilities special interest group (CAT LD SPIG), and will also offer to send the full thesis submission post-viva and present findings in person if I am available to attend a meeting.

I plan to submit the research for publication in Advances in Mental Health & Intellectual Disabilities and may also submit to the International Journal of Cognitive Analytic Therapy and Relational Mental Health (ICATA). The first journal choice should optimise impact for the research and allows submissions of between 3,000-6,000 words which is feasible for qualitative research. The second journal is less widely known but is important in

the CAT community and may influence follow-up research in the area. Once the research

has been published, I will post links on my Research Gate page and request to have a link

posted on the CAT research Twitter account. I will also submit abstracts for both papers to

the BPS DCP Faculty for People with Intellectual Disabilities practitioner journal.

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Appendices

Appendix 1: Royal Holloway Ethics Approval Confirmation

Result of your application to the Research Ethics Committee (application ID 1006)

ES Ethics Application System <ethics@rhul.ac.uk>   🔁 Reply all | ∨
    Fri 30/11/2018, 09:34
    Russell, Rowena (2016); Alex.fowke@live.rhul.ac.uk; ethics@rhul.ac.uk ⌄

Inbox

You forwarded this message on 30/11/2018 10:47

PI: Dr Kate Theodore / Dr Alex Fowke
Project title: What are staff's perceptions of changes in their approach, understanding of and ability to manage challenging behaviour in their learning disabled clients after a CAT contextual reformulation?

REC ProjectID: 1006

Your application has been approved by the Research Ethics Committee.
Please report any subsequent changes that affect the ethics of the project to the University Research Ethics Committee ethics@rhul.ac.uk

Appendix 2: HRA Approval Letter

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Ms Rowena Russell
Royal Holloway, University of London
Egham, Surrey
TW20 0EX

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

13 December 2018

Dear Ms Russell

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

Study title: What are staff's perceptions of changes in their approach, understanding of and ability to manage behaviours that challenge in their learning disabled clients after CAT team formulation?
IRAS project ID: 255999
Sponsor: Royal Holloway, University of London

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.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- 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 the site positively confirms that the research may proceed.

If not already done so, 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. After entering your IRAS ID you will be able to access a password protected document (password: **Redhouse1**). The password is updated on

Page 1 of 7

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a monthly basis so please obtain the relevant contact information as soon as possible; please do not hesitate to contact me should you encounter any issues.

Commencing research activities at any NHS organisation before providing them with the full local information pack and allowing them the agreed duration to opt-out, or to request additional time (unless you have received from their R&D department notification that you may commence), is a breach of the terms of HRA and HCRW Approval. Further information is provided in the "*summary of assessment*" section towards the end of this document.

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

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 the devolved administrations of 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) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

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.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Ms Rowena Russell
Email: ndjt007@rhul.ac.uk

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 255999. Please quote this on all correspondence.

Yours sincerely

Michael Higgs
Assessor

Email: hra.approval@nhs.net

Copy to: Dr Kate Theodore, Royal Holloway, University of London (Academic supervisor)
            Mrs Annette Lock, Royal Holloway, University of London (Sponsor contact)
            Ms Olga Balazikova, Surrey & Borders NHS Foundation Trust (Lead NHS R&D office)

List of Documents

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

Document	Version	Date
Evidence of Sponsor Insurance or Indemnity [Professional Indemnity]		26 July 2018
Evidence of Sponsor Insurance or Indemnity [Public Liability]		09 July 2018
HRA Schedule of Events	1	12 December 2018
HRA Statement of Activities	2	12 December 2018
Interview schedules or topic guides for participants	3	11 December 2018
IRAS Application Form [IRAS_Form_19112018]		19 November 2018
Participant consent form	3	12 December 2018
Participant information sheet (PIS)	4	12 December 2018
Research protocol or project proposal	4	11 December 2018
Summary CV for Chief Investigator (CI) [Rowena Russell]		26 October 2018
Summary CV for supervisor (student research) [Julie Lloyd]		07 November 2018
Summary CV for supervisor (student research) [Kate Theodore]		26 October 2018
Summary of protocol in non-technical language	4	11 December 2018

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/ consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	Although formal confirmation of capacity and capability is not expected of participating in this study, and such organisations would therefore be assumed to have confirmed their capacity and capability should they not respond to the contrary, we would ask that these organisations pro-actively engage with the sponsor in order to confirm at as early a date as possible. Confirmation in such cases should be by email to the CI and Sponsor confirming participation based on the relevant Statement of Activities and information within this letter.
4.2	Insurance/ indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No application for external funding has been made. The sponsor does not intend to make funds available to participating organisations.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments

Section	Assessment Criteria	Compliant with Standards	Comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	The study does not involve NHS patients or service-users or their data or tissue.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is a single type of participating NHS organisation at which NHS employed staff ('CAT clinicians') deliver team formulation sessions to non-NHS staff working in supported living environments. Although delivered by NHS staff, the team formulation sessions involve only non-NHS staff receiving the training and no patients or service users attend. The target participants for this qualitative interview study are those non-NHS staff receiving the training.

Therefore there are no NHS staff as participants in the research, and the involvement of the NHS is limited to NHS staff asking non-NHS staff (but not patients/service users) if they would be happy to have their contact details passed to research team.

Study documents will not be shared with participating NHS organisations in England and Wales because no specific arrangements are expected to be put in place at each organisation to deliver the study.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).

There is no expectation for a local Principal Investigator or Local Collaborator to be in place at participating NHS organisations for this study, although local contacts have been identified for the sites listed in Part C of the IRAS form. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

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HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

The involvement of the NHS in this study is limited to participant identification activity which shall be conducted by local staff. Therefore, access arrangements and pre-engagement checks are not expected to be relevant for this study.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Research & Development Department
Maghull Health Campus
Parkbourn
Maghull
Merseyside
L31 7AN
Karen.bruce@merseycare.nhs.uk

Ms Rowena Russell
Doctorate of Clinical Psychology
Royal Holloway
University of London
Egham
Surrey
TW20 0EX

20th December, 2018

Dear Ms Russell

Letter of access for research

Project: 2018/42: What are staffs perceptions of changes in their approach, understanding of and ability to manage behaviours that challenge in their learning diabled clients and CAT team forumulation?

As an existing NHS employee you do not require an additional honorary research contract with Mersey Care NHS Foundation Trust (the "Organisation"). The Organisation is satisfied that the research activities that you will undertake in the Organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to the Organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in the Organisation. Evidence of checks should be available on request to Surrey & Borders NHS Foundation Trust.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this Organisation. The Confirmation of Capacity and Capability email was issued on the 20th December, 2018.

You are considered to be a legal visitor to Mersey Care NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by the Organisation to employees and this letter does not give rise to any other relationship between you and the Organisation, in particular that of an employee.

Chairman Beatrice Fraenkel   Chief Executive Joe Rafferty

While undertaking research through the Organisation, you will remain accountable to your employer but you are required to follow the reasonable instructions of your nominated manager in the Organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the Organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the Organisation's policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with the Organisation in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the Organisation's premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Organisation's Research & Development Department prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The Organisation will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the Organisation accepts no responsibility for damage to or loss of personal property.

Cont.../

Chairman Beatrice Fraenkel   Chief Executive Joe Rafferty

This letter may be revoked and your right to attend the Organisation terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the Organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the Trust that employs you through its normal procedures. You must also inform Mersey Care's Research & Development Department.

Yours sincerely

Pauline Parker
Head of Research

* Confirmation of capacity and capability issued 20.12.18

Chairman Beatrice Fraenkel   Chief Executive Joe Rafferty

Appendix 4: Nottinghamshire Healthcare NHS Foundation Trust R&D Approval

↻ Reply all | ⌄   🗑 Delete   Junk | ⌄   ⋯

RE: Research project

R   R and I Enquiries <RandIenquiries@nottshc.nhs.uk>   👍   ↻ Reply all | ⌄
     Tue 25/12/2018, 00:32
     Russell, Rowena (2016); Morton Sally - Research and Development Support Off ⌄

Inbox

Hello Rowena

Thank you for your documents re the following study:

Title: Does CAT team formulation change staff understanding of and ability to manage challenging behaviour in their clients with learning disabilities?
Chief Investigator: Dr Kate Theodore
Principle Investigators: Rowena Russell
Sponsor: Royal Holloway University of London
Study Type: Academic PIC study – multi-centre (staff interviews)
Setting: CAT LD Special Interest Group (one site only)

As you now have full HRA approval for your study, I am formally acknowledging your study to commence within NHCFT.

This is on the basis of your protocol and supporting documents/communication which state that Dr ▮▮▮▮▮▮ (Clinical Psychologist) will assist in identifying potential participants (non-NHS staff) only and that the interviews will be discussing non-NHS patients. No Letter of Access is required if no study activities (i.e the interviews) are to happen on NHS premises.

The total duration of your study is anticipated to be 3 months and local target has been stated to be 4-5 participants.

Please can you send us the interview schedule version reviewed by HRA as the one we have is entitled 'provisional'.

Kind regards

Andrea Duncan

Andrea Duncan
R&D Support Officer

Nottinghamshire Healthcare NHS Foundation Trust
Duncan MacMillan House, Mapperley, NG3 6AA

✉ andrea.duncan@nottshc.nhs.uk
m: 07771945522

🐦 Follow us on Twitter @NottsHCRandD

For more information about conducting research within Nottinghamshire Healthcare NHS Foundation Trust, please visit our website: www.mentalhealthclinicians.org.uk

Appendix 5: Surrey & Borders Partnership NHS Foundation Trust R&D Approval

Surrey and Borders Partnership **NHS**
NHS Foundation Trust

Rowena Russell
Doctorate of Clinical Psychology

Royal Holloway
University of London
Egham
Surrey

TW20 0EX

Human Resources Department
C/O Research & Development Office
Abraham Cowley Unit
Holloway Hill, Lyne
Chertsey, Surrey
KT16 0AE
Tel: 01932 722704
Fax: 01932 728622
Email: Research@sabp.nhs.uk

07 January 2019

Dear Rowena,

Re: What are staff's perceptions of changes in their approach, understanding of and ability to manage behaviours that challenge in their learning disabled clients after CAT team formulation?

Letter of access for research

This letter confirms your right of access to conduct research through Surrey and Borders Partnership NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on 07/01/2019 and ends on September 2019 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until you have received a letter from us giving permission to conduct the project.

The information supplied about your role in research at Surrey and Borders Partnership NHS Foundation Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to Surrey and Borders Partnership NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through Surrey and Borders Partnership NHS Foundation Trust, you will remain accountable to the

For a better life

Trust Headquarters, 18 Mole Business Park, Leatherhead, Surrey KT22 7AD
T_0300 55 55 222 F_01372 217111 www.sabp.nhs.uk

Camden & Islington NHS Foundation Trust but you are required to follow the reasonable instructions of the Principal investigator in this NHS organisation or those given on his/her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with Surrey and Borders Partnership NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with Surrey and Borders Partnership NHS Foundation Trust in discharging its duties under the Health and Safety at Work Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on Surrey and Borders Partnership NHS Foundation Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust's Research and Development Office, Abraham Cowley unit, Holloway Hill, Chertsey, KT16 0AE prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your

2

employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Camden & Islington NHS Foundation Trust is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

Surrey and Borders Partnership NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Olga Balazikova
Research & Development Manager

3

Re: Capacity & Capability for IRAS: 255999 CAT team formulation with teams working with learning disabilities.

AB   **Alicja Baniukiewicz** <Alicja.Baniukiewicz@sabp.nhs.uk>   👍   ↩ Reply all | ∨
Wed 09/01, 10:50
Russell, Rowena (2016); Olga Balazikova <Olga.Balazikova@sabp.nhs.uk> ∨

Inbox

You forwarded this message on 09/01/2019 11:26

Dear Rowena,

RE: IRAS:255999 Confirmation of Capacity and Capability at Surrey & Borders Partnership Foundation NHS Trust.

Full Study Title: What are staff's perceptions of changes in their approach, understanding of and ability to manage behaviours that challenge in their learning disabled clients after CAT team formulation?

This email confirms that Surrey & Borders Partnership Foundation NHS Trust has the capacity and capability to deliver the above referenced study and the research project can commence at Surrey & Borders Partnership Foundation NHS Trust.

If you wish to discuss further, please do not hesitate to contact me.

Regards,

Alicja Baniukiewicz
Research Facilitator
Adult Mental Health Services

T: 01932722704
E: Alicja.Baniukiewicz@sabp.nhs.uk

Surrey and Borders Partnership NHS Foundation Trust
Research & Development
Abraham Cowley Unit
Holloway Hill
Chertsey
Surrey
KT16 0AE

www.sabp.nhs.uk

Appendix 6: NHS Fife R&D Approval

Medical Director

Hayfield House
Hayfield Road
KIRKCALDY
KY2 5AH

NHS Fife

Miss Rowenna Russell
Royal Holloway, University of London
Egham
Surrey
TW20 0EX

31 January 2019

Our Ref   18-085 255999

Enquiries to Aileen Yell
E-mail   aileenyell@nhs.net
Telephone   01383 623623 Ext
*   20940*
Website   www.nhsfife.org

Dear Miss Russell

Project Title: CAT team formulation with teams working with learning disabilities

Thank you for your application to carry out the above project. Your project documentation (detailed below) has been reviewed for resource and financial implications for NHS Fife and I am happy to inform you that NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Document	Version	Date
IRAS R&D Form	5.9.1	19 November 2018
University Research Ethics approval		30 November 2018
Provisional Interview Schedule		
Interview Schedule	3	11 December 2018
Protocol	4	11 December 2018
Participant Information Sheet	4	12 December 2018
Participant Consent Form	3	12 December 2018
Study-Wide Governance Report (England)		13 December 2018
Study-Wide Governance Report (Scotland)		15 January 2019
IRAS SSI Form	5.10	29 January 2019

The terms of the approval state that you are the Principal Investigator authorised to undertake this study within NHS Fife, with assistance from Dr Jamie Kirkland, Lynebank Hospital, Dunfermline.

I note that review by an NHS Research Ethics Committee has not been necessary since the study involves NHS staff only. The sponsors for this study are Royal Holloway, University of London. Please note that it is the responsibility of the Sponsor to ensure that adequate and appropriate insurance is maintained throughout the course of the study.

Details of our participation in studies will be included in annual returns we are expected to complete as part of our agreement with the Chief Scientist Office. Regular reports of the study require to be submitted. Your first report should be submitted to Dr A Wood, R&D Manager, R&D Department, Queen Margaret Hospital, Whitefield Rd, Dunfermline, KY12 OSU (Amanda.wood3@nhs.net) in 12 months time and subsequently at yearly intervals until the work is completed. A Lay Summary will also be required upon completion of the project.

In addition, approval is granted subject to the following conditions:-

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ᴱ NHS Fife was awarded the Carbon Trust Standard in February 2010 and is the first Scottish NHS Board to achieve this accolade.
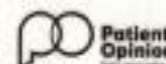
All research activity must comply with the standards detailed in the UK Policy Framework for Health and Social Care Research http://www.nhsresearchscotland.org.uk/uploads/tinymce/uk-policy-framework-health-social-care-research.pdf, health & safety regulations, data protection principles, other appropriate statutory legislation and in accordance with Good Clinical Practice (GCP).

Any amendments which may subsequently be made to the study should also be notified to Aileen Yell, R&D Research Coordinator (aileenyell@nhs.net) , as well as the appropriate regulatory authorities. Notification should also be given of any new research team members post approval and/or any changes to the status of the project.

This organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.   You will be required to assist with and provide information in regard to monitoring and study outcomes (including providing recruitment figures to the R&D office as and when required).

As custodian of the information collated during this research project you are responsible for ensuring the security of all personal information collected in line with NHS Scotland IT Security Policies, until the destruction of this data. Permission is only granted for the activities for which a favourable opinion has been given by the REC (and which have been authorised by the MHRA where appropriate).

The research sponsor or the Chief Investigator or local Principal Investigator at a research site may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office (aileenyell@nhs.net) should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

I would like to wish you every success with your study and look forward to receiving a summary of the findings for dissemination once the project is complete.

Yours sincerely

DR FRANCES ELLIOT
Medical Director
NHS Fife

Cc : Aileen Yell, R&D Research Coordinator, NHS Fife, Queen Margaret Hospital, Dunfermline
Dr Jamie Kirkland, NHS Fife

Participant Number:

Department of Psychology
DOCTORATE IN CLINICAL PSYCHOLOGY

IRAS ID: 255999
Name: Rowena Russell
Version number: 4
Date: 12/12/18

Information Sheet

Investigating perceptions of impact of CAT staff consultation

Rowena Russell, Trainee Clinical Psychologist, Royal Holloway University
Email: Rowena.Russell.2016@live.rhul.ac.uk

I am a Trainee Clinical Psychologist at Royal Holloway University of London and I am conducting research for my thesis. The project will be looking at the experiences of teams receiving CAT consultation with regard to their work with clients with learning disabilities displaying challenging behaviour.

My research involves interviewing staff working in learning disability teams about their experiences of consultation from a CAT perspective. Referrals tend to include concerns around challenging behaviour, and I am interested in staffs' perceptions of how consultation affects views of challenging behaviour and their approach to it.

This study is supervised by Dr Kate Theodore from the Doctorate in Clinical Psychology programme at Royal Holloway University of London. Interviews will last for approximately 30 minutes to one hour and will happen either face-to-face or by Skype or telephone. Interviews will be recorded, either using a Dictaphone or software on the computer. Data will be stored securely and once this is done, will be

removed from any non-secure devices. Information from the interviews may be shared during supervision, for the purposes of analysis and interpretation.

Royal Holloway University of London is the sponsor for this study based in the United Kingdom. We will be using information from you 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. Royal Holloway University of London will keep identifiable information about you for 5 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 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 we use your information and the contact details for the data protection officer for Royal Holloway at the following link: https://www.royalholloway.ac.uk/about-us/more/governance-and-strategy/data-protection/

CAT clinicians from the local NHS organisation will collect your contact details from you for this research study in accordance with our instructions.

Royal Holloway University of London will use your name and contact details to contact you about the research study, and make sure that relevant information about the study is recorded and to oversee the quality of the study. Individuals from Royal Holloway University of London and regulatory organisations may look at your research records to check the accuracy of the research study. The only people in Royal Holloway University of London who will have access to information that identifies you will be people who need to contact you to arrange the interview or audit the data collection process.

Information collected during the study may contribute to a publication, and in this case will not identify you and will not be combined with other information in a way that could identify you.

If you agree to take part in this study, please sign the consent form and provide your contact details so that I may contact you to set up the interview.

If you are interested in taking part in the study, or have any further questions, please email me at Rowena.Russell.2016@live.rhul.ac.uk.

Supervisor contact details

Dr Kate Theodore
Doctorate of Clinical Psychology, Royal Holloway University
Egham, Surrey
☎ 01784414303
E-Mail: Kate.Theodore@rhul.ac.uk

Appendix 8: Consent Form

Participant Number:

Department of Psychology
DOCTORATE IN CLINICAL PSYCHOLOGY

IRAS ID: 255999
Name: Rowena Russell
Version number: 3
Date: 12/12/18
Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Investigating staff perceptions of impact of CAT staff consultation
Name of Researcher: Rowena Russell, Trainee Clinical Psychologist

Please initial box

1. I confirm that I have read the information sheet dated.................... (version............) 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 at any time without giving any reason, without my legal rights being affected.

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   Date   Signature
taking consent

When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.

Appendix 9: Staff Demographics Form

Age_____years

Gender (please circle):   Male   Female   Prefer not to say

Ethnicity (please circle):

White / White British
        British / Irish / Other
Mixed / Mixed British
        White and Black Caribbean / White and Black African / Other
Asian / Asian British
        Indian / Pakistani / Bangladeshi / Other
Black / Black British
        Black African / Black Caribbean / Other
Other ethnic group.
        Please state_____
Prefer not to say

Furthest level of education (please circle):

Skills for Life
GCSEs
O-Levels
A-Level
Baccalaureate
Higher National Certificate
Higher National Diploma
Bachelor's degree
Master's degree
Doctoral degree
Postdoctoral qualification
Other_____
Prefer not to say

How long have you been a support worker?

_____ years _____months

How long have you worked supporting people with learning disabilities?

_____ years _____months

Previous careers?   Yes / No

If yes, please list below

_____

Have you had specific training in working with people with learning disabilities? Yes/No

If yes, please give details

_____

Appendix 10: Client Demographics Form

Information about referred person

Age_____years

Gender (please circle):   Male   Female

Ethnicity (please circle):

White / White British
      British / Irish / Other
Mixed / Mixed British
      White and Black Caribbean / White and Black African / Other
Asian / Asian British
      Indian / Pakistani / Bangladeshi / Other
Black / Black British
      Black African / Black Caribbean / Other
Other ethnic group.
      Please state_____

Risk Factors

1 = Individual or others not at risk if problem not resolved
2 = Individual or others mildly at risk if problem not resolved
3 = Individual or others moderately at risk if problem not resolved
4 = Individual or others severely at risk if problem not resolved

Chronicity

1 = not chronic
2 = low chronicity (under 1 year)
3 = moderate chronicity (1-2 years)
4 = highly chronic (above 2 years)
9 = not rated

Severity of overall problem (in addition to learning disability)

1 = mild   2 = moderate   3 = severe   9 = not rated

Breadth of overall problem

1 = constrained problem only affecting circumscribed area of daily living
2 = problem has negative implications for several areas of individual's life
3 = problem has far reaching implications across all areas of individual's life
9 = not rated

Co-Morbidity – number of other problems (in addition to Learning Disability)

1 = no additional problems
2 = one additional problem
3 = two or more problems currently described
9 = not rated

Nature of other problems

1= Autism Spectrum Disorder
2 = Behaviour that presents challenges
3 = Mental Health Problem
4 = Physical health problem or disability
5 = Sensory difficulty or disability
6 = Other, please specify:

Duration of other problems

1 = not chronic
2 = low chronicity (under 1 year)
3 = moderate chronicity (1-2 years)
4 = highly chronic (above 2 years)
9 = not rated

Physical problems

1 = no difficulties   2 = mild handicaps or sensory loss
3 = disabling condition that severely restricts life style   9 = not rated

IQ

1 = average IQ   2 = mild learning disability
3 = moderate learning disability   4 = severe learning disability
5 = profound learning disability   9 = not rated

Residence

1 = own independent home   2 = family home
3 = semi-independent living with some external support
4 = community home with day staff but no night staff
5 = community home with night staff (sleeping or waking)
6 = large hostel   7 = adult placement
8 = low - secure unit   9 = Moderate secure unit
10 = High Secure Unit

Client's social network

1 = No close relationships
2 = some degree of relationships but only with staff or family
3 = some peer acquaintances
4 = close family or staff relationships

5 = close peer relationships.

Occupation

1 = full time paid work   2 = full time voluntary work
3 = full time day centre
4 = a range of activities making up full-time hours spent outside home
5 = a range of activities making up part-time hours spent outside home
6 = in house activities plus some outings   7 = none
9 = not rated

Daily Activities? (please list below)
_____

Reason for referral to Psychology:
_____

How long has the resident been living in your service?

_____years _____months

Has the client had previous Psychology input? Yes / No

If yes, please give some details:

_____

Information about team

Number of staff members

       Permanent_____
       Bank / locum_____

Number of job roles vacant _____

Appendix 11: Original Interview Schedule

IRAS ID: 255999
Name: Rowena Russell
Version number: 3
Date: 11/12/18

Interview schedule

Intro

- Thank you very much for coming to speak to me today.

- Do you have any questions about anything at all on the information sheet?

- How are you feeling about talking to me today?

- Is there anything I can do to make it feel more comfortable?

- If you want to stop the interview at any time, please let me know.

- If you want to take a break for any reason at any point, please let me know and we can do that.

Confidentiality

As explained in the information sheet, everything that we discuss today will be treated confidentially. The only reason I would need to involve anyone else in our discussion today or tell anyone else anything that we talk about is if you told me that you, or someone else were at risk of harm. If that did happen, I would discuss it with you before talking to anyone else. Do you have any questions?

Interview Themes

Context

- Which sessions did you attend out of the number provided to your service?

- What do you remember about the sessions you did attend?

- Were there specific parts/activities that you remember finding helpful? If so, please describe these and explain how they were helpful

Learning disabilities

2. a) What is your understanding of learning disability?

   b) What does the word challenging behaviour mean to you?
   b) Has that changed at all since working with (clinician name)/CAT?

Perceptions of the problem

3. Why was client referred, initially? / What problems were going on when your team decided to refer?

4. Has your understanding of the problems changed, and if so, how?

Managing the difficulties

5. How do you feel about your relationship with this client now?

6. Has the way in which you work with your client changed in any way? If so, could you describe the changes?

Experience of CAT

7. What was your experience of CAT?

8. What did you think CAT helped you with?

9. How did you find the way you worked within the sessions?

Additional

10 Is there anything else that you think is worth mentioning?

Debrief

- How did you find talking to me today?

- Is there anything that we have not covered that you think is important or that you would like to tell me about?

- Do you have any questions about anything that we have talked about or the study in general?

Explain what will happen next –

- I will be talking to other staff members in a few teams and asking them similar questions. I will listen to each interview and transcribe them. After I've done that, each recording will be deleted. The transcribed file will not have your name on it. I will analyse all of the written interviews, looking for themes and links. Then I will write them up into a thesis for submission.

- Would you like more information about what I have found when I have it?

Appendix 12: Updated Interview Schedule

IRAS ID: 255999
Name: Rowena Russell
Version number: 3
Date: 11/12/18

Interview schedule

Intro

- Thank you very much for coming to speak to me today.

- Do you have any questions about anything at all on the information sheet?

- How are you feeling about talking to me today?

- Is there anything I can do to make it feel more comfortable?

- If you want to stop the interview at any time, please let me know.

- If you want to take a break for any reason at any point, please let me know and we can do that.

- If you could describe how your day has been in three words, what would they be?

Confidentiality

As explained in the information sheet, everything that we discuss today will be treated confidentially. The only reason I would need to involve anyone else in our discussion today or tell anyone else anything that we talk about is if you told me that you, or someone else were at risk of harm. If that did happen, I would discuss it with you before talking to anyone else. Do you have any questions?

Interview Themes

Context

- Which sessions did you attend out of the number provided to your service?

- How many members of your team were present aside from you?

- Perceptions of the problem

- Why was client referred, initially? / What problems were going on when your team decided to refer?

- Has your understanding of the problems/chb changed since consultation, and if so, how?

- What do you remember about the sessions you did attend?

  o Can you describe what you remember happening during the session(s)?

- Were there specific parts/activities that you remember finding helpful? If so, please describe these and explain how they were helpful?

- What was not helpful, and why?

  (if anything is mentioned, make sure to try and link it back to consultation – "what was it about the consultation that had that effect?")

- Do you think the session helped the team develop a shared understanding of the client?

- Did you have conversations with your colleagues regarding your perceptions of consultation?

Learning disabilities

  2. a) What is your understanding of learning disability?

    b) What does the word challenging behaviour mean to you?
    c) Has that changed at all since working with (clinician name)/CAT?
  d) Have conversations about the client within in the team changed at all?

Managing the difficulties

  5. How do you feel about your relationship with this client now?

  Did consultation get you to think about your relationship to the client or the impact of working with this client on you?

  Did consultation get you to think about the staff-client relationship and how that influences client behaviour?

  6. Has the way in which you work with your client changed in any way? If so, could you describe the changes?

Experience of CAT

Did clinician draw out anything in diagram form?
        Tell me about that?
        How was it helpful / not helpful?

    7. What was your experience of CAT?

    8. What did you think CAT helped you with?

    9. How did you find the way you worked within the sessions?

Additional

    10 Is there anything else that you think is worth mentioning?

Debrief

- How did you find talking to me today?

- Is there anything that we have not covered that you think is important or that you would like to tell me about?

- Do you have any questions about anything that we have talked about or the study in general?

Explain what will happen next –

- I will be talking to other staff members in a few teams and asking them similar questions. I will listen to each interview and transcribe them. After I've done that, each recording will be deleted. The transcribed file will not have your name on it. I will analyse all of the written interviews, looking for themes and links. Then I will write them up into a thesis for submission.

- Would you like more information about what I have found when I have it?

Appendix 13: Extract from Reflective Journal

4th February – Interview X reflections

- A lot more interesting info that I wasn't necessarily expecting. One of the newer members of staff – quiet when I spoke to [them] previously
- Process of reflection during interview – lots of interesting things – explicitly mentioned interview had make [them] think
- Also – all [staff at this care home] said hadn't had a chance to reflect after consultation. Process of interview makes me think would be helpful for embedding. Especially for more junior staff.
- Interview as a constructive process
- When someone answers that something changed due to consultation, try and get them to specify what it was that helped them?
- Different perspectives depending on level of experience. Level of nuance. Ability to self-reflect
- Consultation as an ongoing process – develops each time.
- Once socialised get more out of it

5th February – Interview Y reflections

- Much more obviously CAT
- Level of understanding seems higher
- Seems as if more space to think – 1 hour interview
- Openly offered a lot more info
- Reflection on/discussion of more systemic/relational factors
- CAT map much more prominent
- "Buy-in" important
- Leadership – very important
- If I were more experienced, I may be asking more insightful questions. My understanding of the context/model is fairly limited. Pros and cons
- Some things it sounds as if [they are]…[trying to show how much {they know}?]
- Level of engagement, experience – things to "pin it on"
- How the sessions have been set up in a given service – makes a difference – in this care home – feels like a set training – same staff attend?
- Others – more ad hoc, less joined up
- Often feel I should have gone further in my questions in certain areas – e.g. impact on staff – didn't really cover it in this interview. And staff self-reflection
- Could I add in some questions?
- Also feels as if some people aren't ready to go there/don't quite understand the questions/ both. Am I over-thinking that though?
- Maybe not, because one theme of all of them is wanting to feel validated they are working hard, doing their best
- Should there be a question in there about changing approach since CAT?
- Interesting – formulation incorporates lots of processes (as I will cover in my SR) – that eventually start linking up together and working more as a whole over time. At first, may be difficult to hold all of it in mind, at once. Different levels of consciousness. Meta-cognition

Participant 6: …what, why is she controlling, why is she, why does she push people away, um…what the reasons for it….it's quite…when you, when you…..when we've looked at it with [Clinician 2], it does kind of make sense to be honest. **RR:** Ok…ok, so it sounds like, er, [Clinician 2] helps, er, or kind of helps to put together, cos it sounds like, are you kind of, are you all giving ideas about things anyway in the sessions? **Participant 6:** Yeah, yeah! Yeah, she kind of puts things into context I suppose, so, erm….where….this person's been rejected throughout her life….that's the reason, then [Clinician 2] will say "this is now, then, why she rejects you when she's, you know hitting, getting quite agitated, this is the reason why she starts to reject you, cos that's how people have done – that's what people have done to her, so she will then do it to you, she'll push you away, she kind of puts a lot of it into context, makes it a little bit….breaks it down, so, for yous, you know, I mean we can have a rough idea of why she does what she does, but…..[Clinician 2] has a lot more insight into it, you know, a lot more knowledge, so, she you know, makes things a lot more clearer. **RR:** Brilliant, ok that makes sense. So part, part of it is based on, um…. Yeah, on the client's history and what's happened to her, and that affects how she behaves, at the moment. **Participant 6:** Yeah. **RR:** Ok. **Participant 6:** Yeah. **RR:** Ok, ok that's interesting. Um…ok, and then what impact does that have on you understanding that in that new way? **Participant 6:** Erm….what impact does it have on me? **RR:** Yeah, as staff, yeah. **Participant 6:** Erm…<pause> **RR:** How does it change things I guess I'm kind of getting at…	Code: client controls Code: client pushes people away Code: clinician explaining Code: made things clearer Code: making links Code: behaviour as communication Code: behaviour expresses emotion Code: behaviour serves a function Code: challenging behaviour Code: client relationships Code: clinician as expert Code: clinician explaining Code: developmental understanding Code: made things clearer Code: psychological-MH knowledge Code: putting things into context Code: understanding behaviour Code: understanding client

Participant 6: Erm….I think….<sigh> well it is…I suppose in a way it's designed to make it a little bit easier cos I think that the reason I referred to um [Clinician 2] or psychology to begin with anyway, was with, with that person, because it was just so frustrating, like say it's like Monday morning, and we're in some more, I'm agitated, you know, there's been a lot of problems over the weekend and um, and I had originally referred to psychology, it was happening so frequently, and the behaviours would go on for several hours, I think – we're at a point now, because we know more, we understand more, you know, there's something that [Clinician 2] once said to us, she basically said that, that, that she, she, this person, she, she,…..not she's subconsciously thinks that she shouldn't be happy, because of how, because of how her life's been, she shouldn't be happy, but we knowing that….when that was kind of said to us….you feel a lot more empathy towards her, you don't you know, that, the, the feeling of, of distress I s'pose, or she's displaying behaviour, you just feel a lot calmer when she's showing behaviours…	Code: challenging behaviour Code: client beliefs Code: client difficult past Code: client negative emotion Code: clinician explaining Code: developmental understanding Code: empathy for client Code: frequency of behaviours Code: impact of client history on behaviours Code: length of behaviours Code: made things clearer Code: makes job easier Code: mentalising client Code: nature of referral to psychology Code: purpose of sessions Code: staff changing approach Code: staff feel contained Code: staff listen to clinician Code: staff negative emotion Code: staff reflection Code: staff response to challenging behaviour Code: stressful job Code: team frustrations Code: understanding behaviour Code: understanding client
RR: Ahh. **Participant 6:** …you don't feel as angry or annoyed, or you know, you feel a lot more sorry for her, because, because this, this is, the how she feels, she doesn't think that she can be happy, so…	Code: client beliefs Code: empathy for client Code: making links Code: mentalising client Code: staff negative emotion Code: understanding client
RR: Ok… **Participant 6:** …and it makes it a little bit easier I s'pose for us, we're able to stay a bit calmer, because we know more about her.	Code: makes job easier Code: staff feel contained Code: understanding client

Appendix 15: Additional Theme Extracts

Challenging behaviour in relationship

Jennifer

"Yeah, I mean, y'know it's, the relationship between the staff and Bob, it can be quite difficult at times…especially if, y'know, if he's had a behaviour, and you know it's building and there's gonna be possibly another one, y'know, it is a bit of…you're you're on edge, you're thinking all the time to be supporting him in the correct way, um, and making sure if y'know he's asking for something…[pauses]…this may sound that we don't support them but do you see what I mean, it's getting in there first, but before another behaviour ummm starts".

Chelsea

"So say like after a behaviour, if we try to talk to the, the service user…straight away, [Clinician] basically told us that, like, their mind's still like, high up and, like agitated and stuff, so you should leave it until they've calmed down, to speak to them about why they've behaved in that way.

…

RR: And does that, that changes the way that you respond then does it?

Participant 9: Yes, because if you, if you're after them straight away after the incident, you're not gonna get, sometimes you don't get any answer, or, they just don't wanna talk to you, but if you leave it a little bit, you do, you do tend to get more out of them".

Lizzy

"Like actually giving her time, do you know, sitting down, and like, a lot more reassurance sort of thing".

Emily

"I think it, it helps, it help, it helps everyone just, just to be able to relate to Betty a little bit, a little bit more, and support her a little bit better than what we would have been able to without, erm, without attending those sessions".

"I think now that we know a little bit more and we've had these sessions, erm, we approach it in, again, a consistent way, but also, in a way we know works well with Betty, so, depending on the situation, erm, we know that, some, sometimes, just giving her that bit of time, will help, or, sometimes just giving Betty, erm, do you know, a ten minute one-to-one, sit down, just to have a chat, will help, so, it-, I think that…"

Understanding can be enlightening, containing and practical

Jennifer

"I don't know, she turned the page over, she was doing like bullet points, and this would lead to that, and that could lead to this, and it all became much clearer".

<u>Sital</u>

"It's like, um, attachment, emotions, feeling unskilled, you know, cos she had a rough childhood, the dad and the mother that are supporting, she took her from the care, when she was after her mum's dad, so it's all that".

"Yeah, they all linked together, how things….how to cope with emotion, how to, when how to cope with it when Dad come, after that, and with when you, with her diet, with her other obsessions, mainly it's about obsession, but sometimes when you talk, it all can get linked better".

<u>Mandy</u>

"And then – it ends up becoming almost like a cycle diagram, so this is what happens, this is what the person then does, this is maybe the things they might do following this….and then this is what we can do as a staffing team, to bring it back, sort of like, round to the top again."

Developing a shared perspective and approach

<u>Sally</u>

"Well I guess it, you know, all singing from the same hymn sheet, being, y'know, pro-active, and umm, being a team, working together".

<u>Jennifer</u>

"Some people can respond….sometimes you can get a warning with Bob, and it will be [him saying] 'oh my goodness, oh Christ' and you need to, to, go to him straight away, to see what the problem is before it escalates, into a problem, some of the staff weren't doing it so he was having a behaviour from not being listened to, he wasn't being listened to and of course he was getting anxious, which can cause behaviours".

"sort of …'this is the thing to do', yeah."

<u>Edie</u>

"Yeah, yeah…because like we, we, like me, Jennifer, [Clinician], we were like telling our own, like you know, like what we experience with Bob, and um, yeah I think that's helped, like when we were telling our own story of him…."

<u>Sital</u>

"Like you clashing but you all got the same aim? To give that care to the service user…and er…and er… so that help us support her better".

"You know that very calmly, very strictly, with consistent boundary…we have to be consistent with Dora, that works really well".

<u>Daniel</u>

"Cos then, it might be all things that we're talking about could work for us four, but then, she's still targeting these staff that are unaware of some of these things we've been talking about, so. I think that, that was discussed last time, about how we're gonna…..kind of get on board with – you know get everyone on board with it".

<u>Chelsea</u>

"Yeah, yeah we were on the same level really, um, about it all".

Caught between two perspectives

<u>Sally</u>

"Ummm….yeah we all, y'know, he's he's a great guy, we all get on with him, um, but it's just y'know, making sure that we're doing right for Bob and right for staff and the other people we support, y'know, it's, it's quite tiring when, um, y'know he's screaming and shouting all the time, um y'know and you're on edge waiting for something to happen, 'specially when you know, it's y'know if he's constantly, um, behaving in a certain way, that's when you know something is brewing…"

"Um…that um…y'know we try not to focus on the disability, it's the ability, of, of our guys, but there's just more um y know, having more of an understanding that, um, they can't perhaps do, um, everything that we can do in the way we do it, they have their ways, and they need support".

<u>Jennifer</u>

"Ummm….it's a very fine line with feeling very, almost feeling sorry for Bob, then frustrated that you can't help him yourself, there's nothing that you can do that is gonna make this better, or Bob – It's frustration".

<u>Mandy</u>

"I know that sounds really bizarre, like [Clinician]'s explained to us, that sometimes there isn't always a "fix", if that makes sense, to these things?"

"But we also know that actually there isn't always going to be a fix with everything, and I think for staff, that's good because sometimes people can come and do training sessions and people get different things out of it, and it's like, 'well you've had this training session, so you should know all of these things' whereas with this, there's no right or wrong answer, and sometimes, there isn't an answer to it"

<u>Sital</u>

"Yeah I think we….we changed. We just…we just learned….we changed. We do working hard, and it's still long work."

Appendix 16: Lay Summary of Themes[3]

Relationship as intervention, intervention as relationship

i)   **Multiple ways of relating to consultation sessions and clinicians**

Care staff saw consultations in varying different ways – as lessons, training, and sometimes like "therapy for staff" in that they allowed staff to reflect on emotions.

The clinician was seen as someone who had valuable experience and psychological expertise that came through in how they explained things, and the suggestions they made.

They were also seen in some cases as a supervisory figure. This supervisory aspect sometimes took different forms - staff feeling like the clinicians was "backing them up", staff bouncing ideas off the clinician, and staff feeling bolstered or validated in the presence of the clinician to express their views with other colleagues.

Staff also felt the clinician allowed them to express their feelings, validated them and normalised them. This often felt like a relief for staff and had a calming effect.

ii)   **Challenging behaviour in relationship**

Consultations allowed staff to apply psychological models to their experience to see how challenging behaviour can be understood as having been learned in early relationships and impacted by staff-service user relationships.

Staff in some cases learned psychological theory about why service users might feel and behave how they did. This included learning about how early relationships set up a pattern that sometimes ended up being played out in staff-service user relationships. This sometimes included learning about "reciprocal roles" e.g. loving-loved; rejecting-rejected. This helped staff take behaviours or failed attempts at de-escalating behaviour less personally.

Staff learned about the concept of the "amygdala hijack" and understood there were times when service users were too emotional to engage in conversation, and that talking might actually increase the likelihood or intensity of behaviours.

Through learning these things, staff felt calmer and more able to manage challenging behaviour, even if it was not significantly reduced.

Formulation as relating, making links, moving things forward

iii)   **Making links – understanding as enlightening, containing and practical**

Staff appreciated the CAT maps (diagrammatic formulations/charts) as they linked information up in a helpful way that pointed towards new ideas for managing behaviour.

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[3] This summary may be redrafted with simpler language if distributed to audiences/staff who have not yet received consultation.

The charts helped everyone stay on the same page, served as a memory aide for staff and clinician, and showed cycles of behaviour, which made it easier to know when was best to intervene, and how.

Psychological theory was seen as helpful because it put words to intuitive/experiential knowledge of staff.

Staff tried new ideas out between sessions and fed back to the clinician. Some people pointed out that keeping the formulation in mind "in the heat of the moment" was challenging, and most staff expressed the fact that it took time to absorb and apply information.

iv)   The process of developing a shared perspective and approach

Having group conversations in sessions and having a shared map/chart/diagram helped staff "sing from the same hymn sheet". This was seen as very important, as many people mentioned the need for consistency in working with people with learning disabilities.

Everyone said they had felt able to share their view in sessions, and that they were encouraged by the clinician to do so. In cases where there were disagreements or different perspectives, staff said the clinician managed to integrate different people's views into a shared plan and approach which left everyone feeling satisfied and heard.

The CAT map/diagram/chart or shared formulation was something that staff could then refer to in their daily work, with other staff who had attended sessions, and sometimes to explain things to staff who hadn't been there.

In all cases, the plan was to develop a CAT map/diagram/chart that could be shared with the whole team.

v. Caught between two perspectives

Some staff named some conflicts in their work. There was a conflict between an instinct to fix/cure/solve problems, versus accepting that problems were likely to be long term and that the "answer" was to learn to manage them differently.

Some staff felt that more consultation or more input from the clinician would improve things, but at the same time recognised how skilled they and other staff already are.

There was also a dilemma about whether the formulation reflected the truth of what the service user was experiencing, versus what felt most pragmatic/best plan of action for staff.