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Doctoral Thesis:

Exploring staff experiences of therapeutic relationships and team formulation in inpatient forensic mental health services.

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Thesis Abstract

Forensic Mental Health (FMH) services represent a complex service area with competing political, legal and health care demands. Members of staff working within these services must navigate the competing demands of care and control and have an important influence on how FMH services function and the quality of care that is provided. A systematic search strategy was developed and PsycINFO, Medline, CINAHL, Web of Science, EMBASE and grey literature were searched. A qualitative meta-ethnography of papers from the United Kingdom explored how power, control and risk management influence staff experiences of the therapeutic relationship (TR) in inpatient FMH services. Three third-order themes emerged from this synthesis: 1) Staff team cohesion; 2) Dialectic between care and control; and 3) Structural systems. The findings highlight the dynamic process in which staff hold dual-roles between care and control and the importance of staff team cohesion, safety and containment when fostering TRs.

Semi-structured interviews were conducted with 12 staff members from multi-disciplinary teams in an inpatient FMH service in the UK. A thematic analysis was conducted, yielding three themes: 1) Processes and parallel processes; 2) Mechanisms for change; and 3) Barriers to successful intervention. A process model is presented, which highlights six stages involved in team formulation interventions and is discussed in relation to the themes. This model adds to the limited existing literature and provides facilitators with a flexible framework of key factors to consider during team formulation interventions.

A critical appraisal summarises the findings of the review and research paper and reviews the process of carrying out research in FMH settings. Ethical issues of indirect working are also discussed.

Declaration

The research reported in this thesis was undertaken for the Doctorate in Clinical Psychology Programme at the Division of Health Research at Lancaster University between December 2018 and March 2020. The word length of this thesis conforms to the permitted maximum. The work presented is the author's own, except where due reference is made. The research reported here has not been submitted for any other academic award elsewhere.

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SIGNATURE:

DATE: March 2020

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Section One - Systematic Literature Review

A systematic meta-ethnography of staff experiences of the therapeutic relationship in inpatient forensic mental health services

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Prepared for: Legal and Criminological Psychology (see Appendix 1-A)

Abstract

Forensic mental health (FMH) is described as a difficult area to work in as staff must balance dual-roles, which include providing caring interventions alongside managing risk and security. The current review aimed to synthesise the findings from qualitative studies, which considered experience of staff members working in FMH services when navigating this dual-role, asking the research question 'how do power, control and risk management influence staff experiences of the therapeutic relationship (TR) in forensic inpatient services?' A systematic search for papers from the United Kingdom (UK) across five electronic databases and two grey literature sources was conducted. Ten papers satisfied the inclusion/exclusion criteria and were appraised for their quality using two quality appraisal tools. The selected papers were reviewed using a meta-ethnographic approach. Three third-order themes emerged from this synthesis: 1) The impact of team skill and cohesion; 2) Dialectic between care and control; and 3) Structural systems. The findings highlight the dynamic process in which staff hold dual-roles between care and control and the importance of staff team cohesion, safety and containment when fostering TRs.

Keywords: forensic mental health, staff, experience, qualitative.

In his seminal paper on the working alliance in psychotherapy, Bordin (1979) describes the strength of the alliance between the person seeking change and the person offering support as a key factor in the change process. Subsequent literature has developed this, with the role of the therapeutic alliance being cited as an important factor in the effectiveness of psychotherapy across different models (Norcross & Wampold, 2011; Wampold, 2015; Ackerman & Hilensroth, 2003). The effectiveness of this alliance is dependent on various factors, including empathy, agreement about the goals and tasks of therapy, positive regard and collaboration (Bordin, 1979; Wampold, 2015; Norcross & Wampold, 2011). A good, trusting TR is seen as the basis for treatment and can improve adherence and enhance effectiveness of planned care (Livesley, 2007). Furthermore, the capacity of the therapist to adapt to factors such as stages of change, coping styles, expectations and attachment styles is also important for the effectiveness of change attempts (Norcross & Wampold, 2011).

Bordin (1979) also describes the working alliance as something that can be extended to contexts beyond the therapy room, such as between teachers and students, community groups and leaders, etc. This gives rise to questions about how the TR might be experienced outside of individual therapy contexts, in more unstructured daily interactions and whether principles relating to the therapeutic alliance in therapy are still experienced in these relationships. Such relationships occur in inpatient FMH services where working alliances are a constant feature amongst service users and professionals working in close proximity (Aiyegbusi, 2009) and where multi-disciplinary teams (MDT) contribute to a 24-hour service (Gournay, Benson & Rogers, 2008). TRs have been identified as a central component of care in such settings (Doyle et al., 2017) and TRs outside of individual therapy can have different time scales and foci of support (MacInnes et al., 2014). TRs can have a positive or negative impact (MacInness et al., 2014) but either way represent a human connection between staff and service users that occurs

in a therapeutic context. The current review focusses on where this occurs in the course of everyday activities in FMH inpatient settings.

FMH services sit at an intersection between political, legal and health care systems (Thomson, 2008) and staff roles are juxtaposed between providing therapeutic care and criminal justice interventions (Skipworth, 2005; Ward, 2013; Gournay et al., 2008; Mullen, 2000). This provision of therapeutic care is important in FMH services where there is a high proportion of service users with experiences of trauma (Muskett, 2014) and where mental health, social and legal issues and enforced incarceration may contribute to the trauma experiences of service users (Cromar-Hayes & Chandley 2015; Muskett 2014). In these settings, staff and service user relationships can both support trauma recovery and contribute to re-traumatisation (Miller & Najavits, 2012); therefore, trauma-informed practices, which provide safety, collaboration, trust, choice and empowerment through positive TRs (Procter et al., 2017) are important for minimising additional trauma and should be a foundation for care planning (Muskett 2014).

Principles of least restriction dictate this should occur in the least restrictive environment, so regular and comprehensive risk assessments and risk rehabilitation form a core function of the service (Skipworth, 2005), with an aim of reducing levels of security as service users transition back to community settings (Edwards, Steed & Murray, 2002). Thus, a challenge for staff working in inpatient FMH services is balancing these "competing agendas of care (treatment) and control (security)" (Hamilton, 2010, p. 181).

FMH staff have an important role in this process of assessing risk, and therefore in how service users are understood and how their care pathway is navigated (British Psychological Society [BPS], 2017). This highlights an area where staff hold "considerable power, whereas the client has very little" (BPS, 2017, p.29). Johnstone and Boyle (2018) highlight how power can influence care in mental health services and consequently, power has an important role in

FMH settings, where inherent power imbalances exist (BPS, 2017; Coe, 2012). An example of this is the legislative context, which highlights an area where a significant power differential can occur as people accessing inpatient FMH services do so under a legal framework, such as The Mental Health Act [MHA] (1983, amended 2007) in the UK. Different sections of the MHA can affect levels of restriction. For example, a hospital order under Section 37 of the MHA diverts a person to treatment in hospital as opposed to prison and the individual's responsible clinician can discharge them and make other key decisions about their treatment, without the requirement for higher approval. However, Crown Courts and higher can also apply restrictions under Section 41 of the MHA. For individuals who receive this restriction, leave of absence, transfers in levels of security and discharge must be approved by the Home Secretary and when discharge is approved, conditions are typically attached (Fennell, 2008). This outlines two different levels of restriction for both service users and staff and may therefore impact on experiences of control and TRs.

The notion that the MHA can mandatorily direct somebody for medical treatment in hospital presents a challenge to Bordin's (1979) assumption that the working alliance is formed between someone voluntarily seeking change and someone offering to support change. This presents a challenge for staff navigating TRs in this mandated context (Ward, 2013) where treatment is not sought voluntarily (Wright, 2010) and there may be conflict between services and service users regarding the necessity and readiness for change (Davies, Black, Bentley & Nagi, 2013).

Another factor influencing FMH services is exposure to service user aggression and the subsequent impact on staff wellbeing (Newman-Taylor & Sambrook, 2012). This can include direct and indirect exposure to violence (Lauvrud, Nonstad & Palmstierna, 2009; Way, Van Deusen & Cottrell, 2007) and can lead to intense and overwhelming experiences of fear and trauma (Lauvrud et al., 2009; Way et al., 2007). Staff use various methods of coping or

defending against these emotional experiences, such as detachment, denial and distraction (Lauvrud et al., 2009; Mason, Lovell & Coyle, 2008; Way et al., 2007). These, in turn, negatively influence their capacity to respond therapeutically (Lauvrud et al., 2009) and can lead FMH staff to either deny service users' offences, focussing instead only on their pleasant and vulnerable aspects, or become unavailable emotionally (Aiyegbushi, 2009).

This has parallels with Hamilton's (2010) boundary seesaw model, which uses cognitive analytic (Ryle, 1997; Ryle & Kerr, 2002) and dialectical behavioural (Linehan, 1993a; 1993b) concepts to reflect on different relational roles staff might occupy when working with offenders in FMH services. Hamilton (2010, p. 183) describes "The Security Guard" at one side of the continuum; a judgemental and controlling, offender-focussed role with inflexible boundaries. At the other side of the continuum is "The Pacifier" role, characterised by "emotional closeness", it can be "placating" and "indulging" and focusses on the service user as a victim (Hamilton, 2010, p. 184). The third role Hamilton (2010, p. 185) describes is "The Negotiator"; this involves a balance between care and control, responds to both risk and vulnerabilities and includes "openness, being contained, balanced and respectful and having explicit 'no go' areas yet maintaining a responsiveness to patients' need". Achieving this balance is a "complex and sophisticated process" and it is often staff members with the least formal training that spend the most time with service users and must navigate these relationships for long periods (Hamilton, 2010, p. 191).

In Doyle, Quayle and Newman's (2017) systematic review of staff and service user views of social climate in FMH services, 17 of the 20 papers discussed the TR. Doyle et al. (2017) also identified factors such as respect (Barnao, Ward & Casey, 2016; Brunt & Rask, 2007), empathy (Tapp, Warren, Fife-Schaw, Perkins & Moore, 2013), communication (Abel, 2012), containment (Sainsbury Krishnan & Evans, 2004) and validation (Jacob & Holmes, 2011) to be important elements of positive TRs between nursing staff and service users in FMH

services. Whilst similarities have been noted between TRs in and out of the therapy room, cross-application cannot be assumed due to the inherent differences in the set up and boundaries of these relationships. As highlighted by Brown and Stobart (2008), the typical framework afforded within psychotherapeutic interactions such as scheduled meeting times and endings cannot be replicated in other relationships, such with nursing staff in a ward environment. Livesley (2007, 2012) makes a similar distinction, highlighting the importance of the therapeutic alliance as a foundation for changing behaviours, but appropriate selection of model-specific techniques is also necessary to support individuals through a change process.

Gildberg, Elverdam and Hounsgaard (2010) also reviewed literature on nursing interaction in FMH and described two themes. The first theme, "relational and personal quality-dependent care" (p. 361), was characterised by personal qualities of staff, including friendliness, openness, self-awareness, sincerity and non-threatening interaction. However, the second theme, "parentalistic and behaviour-changing care" (p. 361), was characterised by staff interactions oriented around control, observation, establishing limits, confronting and enforcing rules. These elements were linked to security, managing conflict, gathering information for assessment, care planning and making clinical decisions. Again, these themes may present similarly to Hamilton's (2010) boundary see-saw model.

This literature highlights a dilemma for staff in FMH services, where they negotiate competing demands of therapeutic approaches and maintaining safety (Mason et al. 2008). Gournay et al. (2008) asserted 'care' and 'control' are often viewed as two separate entities and called for a more integrated understanding of these factors, perhaps as two points on the same continuum. This call was perhaps answered by Hamilton (2010) with the boundary see-saw model. However, as identified by Hamilton (2010), more attention should be paid to how professional carers manage relational boundaries in their daily unstructured interactions with service users in FMH settings. This review therefore aims to look further at the experience of

staff members working in FMH services when navigating this dual-role and will seek to answer the research question "how do power, control and risk management influence staff experiences of the TR in forensic inpatient services?"

To address this question a meta-ethnographic approach has been used to review the existing qualitative literature, focusing on staff experiences in the UK in the last 20 years. This focus has been identified because FMH services sit at an intersection between systems and therefore vary dependent on the political and legal system in which they are based. Considerable differences occur between countries in how offenders are processed and managed, with variations in legal arrangements, services, resources and culture (Soothill, 2008) and in care delivery (Mullen, 2000). For example, in the UK, roles around security, management of violence and care fall predominantly to nursing staff, whereas in other countries such as Canada and the United States, these roles are separated between security and nursing staff (Day, 1993; Mason et al., 2008). As differences such as this centre around the dual-role of care and security, it was decided that for this review, it would be necessary to limit studies to a UK setting. Studies have been limited to the last 20 years as significant changes in the provision of secure services has occurred within this time in the UK (Joint Commissioning Panel for Mental Health [JCPMH], 2013), including reductions of beds in high secure services, with a shift towards medium secure provision (Rutherford & Duggan, 2007). Limiting studies to the last 20 years therefore enabled the review to be reflective of contemporary services, whilst also capturing the changing environment for staff working in these services.

Method

Noblit and Hare's (1988) six phase meta-ethnographic approach to synthesising qualitative studies was used to guide this systematic review. Atkins, Lewin, Smith, Engel, Fretheim and Volmink (2008) and Britten, Campbell, Pope, Donovan, Morgan and Pill (2002) were also utilised to guide the phases set out by Noblit and Hare (1988).

Phase 1: Getting Started

A topic area of staff-service user relationships in FMH was identified in line with the researcher's interests and literature outlined in the introduction. Scoping searches and consultation with the department librarian enabled refinement of this and the development of a review question and protocol.

PROSPERO, a register of proposed systematic reviews, was searched using key words to establish whether similar registered systematic reviews were being conducted. Previous reviews had considered staff experiences of working in FMH services (Doyle et al., 2017; Kirkham, 2017) and Doyle et al. (2017) identified the TR was involved in 17 of 20 studies included in their analysis. However, due to the broader nature of these reviews, they did not consider the TR in further detail. Other reviews have considered staff experiences of the caring relationship between staff and service users but did not look specifically into FMH (Wiechula, Conroy, Kitson, Marshall, Whitaker, & Rasmussen, 2016). The closest existing review was Gildberg et al. (2010), a mixed-methods systematic review of characteristics of staff interaction with service users in FMH services with specific reference to significance of staff characteristics from service user perspectives.

Phase 2: Deciding what is relevant to the initial interest

In line with Atkins et al. (2008), this phase is divided into four sections: (1) defining the focus of the synthesis; (2) locating relevant studies; (3) inclusion decisions and (4) quality assessment.

Defining the focus of the synthesis.

As the area of interest was staff experiences of the TR in inpatient FMH services, a plethora of studies was available and it was necessary to focus the scope of the research to avoid over-generalisations (Noblit & Hare, 1988) and ensure a manageable quantity of studies

(Atkins et al., 2008). The review therefore focussed on studies discussing staff experiences of power, control or risk management when navigating the TR in inpatient FMH services.

To preserve the nature, meaning and context of concepts within each study, all data from the results, findings and discussion sections, including author interpretations were treated as data for the synthesis (Noblit & Hare, 1988).

Locating relevant studies.

The SPIDER tool (Cooke, Smith & Booth, 2012) was used to structure the systematic literature search in the following format: [Sample AND Phenomenon of Interest] AND [(Design OR Evaluation) AND Research type]. CINAHL, MEDLINE, Embase, Web of Science and PsycINFO were searched. The search strategy for MEDLINE is shown in Table 1 and was adapted to match the functionality of each database (Appendix 1-B).

[INSERT TABLE 1]

Searching of PsycINFO, Medline, CINAHL, Web of Science, EMBASE yielded 2214 results. Grey literature was also searched, yielding 66 results from Open Grey and 313 from Proquest Dissertations and Theses A&I. After removing duplicates, 1389 results were screened by title and abstract. This left 52 results for full-text screening; 44 were excluded, leaving eight full-texts. The 'Inclusion decisions' section provides further information. Table 2 displays a summary of the primary reasons for exclusion following full-text review. In line with Noblit and Hare (1988), database searches were supplemented by searching reference lists of included papers. The Google Scholar 'cite forward' function was also used. This yielded an additional five studies for full-text review, of which two were considered appropriate for inclusion, bringing the total to 10 studies to be included in the meta-ethnography. See Appendix 1-B for full electronic search strategy and figure 1 for a diagrammatic representation of the inclusion decisions.

[INSERT TABLE 2]

[INSERT FIGURE 1]

Inclusion decisions.

In line with Noblit and Hare (1988), Britten et al. (2002) and Atkins et al. (2008), identification of every possible study in the topic area was not pursued. However, a comprehensive and systematic strategy was developed to enable sufficient confidence the search would yield enough studies for data saturation to be reached. A widely cited difficulty in electronically searching of qualitative research is poor indexing (Atkins et al., 2008) and the key words that qualitative researchers include in their paper titles (Cherry, Smith, Perkins & Boland, 2017). Initial scoping searches therefore used an iterative process to support identification of key texts and sculpt the search strategy accordingly (Cherry et al., 2017).

Table 3 presents the inclusion and exclusion criteria. Unlike Atkins et al. (2008), multiple reviewers were not available to increase the reliability of the review by reaching consensus when applying inclusion criteria, thus representing a methodological weakness.

[INSERT TABLE 3]

Quality assessment of included studies.

Noblit and Hare (1988) and Britten et al. (2002) do not discuss the use of quality appraisal tools. Atkins et al. (2008) highlight the contention among qualitative researchers in the use of such tools but decide, on balance, to use one in their review. The current reviewer elected to use The Critical Appraisal Skills Programme (CASP) qualitative research checklist alongside the three-point rating system for items three to ten of the CASP developed by Duggleby, Holtslander, Kylma, Hammond and Williams (2010). In line with Atkins et al. (2008), quality appraisal was used to critically reflect on the contribution of each study to the current research question and not to exclude studies based on performance on quality appraisal tools, which can be affected by factors such as word-count as much as methodological quality.

This is perhaps highlighted by the high score attained by Barnes (2015), which was taken from a Doctorate in Clinical Psychology Thesis. Therefore, more space was available in this paper in comparison to others, but it does not necessarily mean the study was of greater quality. Table 4 outlines the quality appraisal results. Results have been ordered chronologically and a study number has been identified for each (S1 to S10). This study number is used to reference studies throughout the results.

[INSERT TABLE 4]

Phase 3: Reading the Studies

Studies were read and re-read, data extraction commenced, and key metaphors and concepts were identified. A data extraction sheet (Table 5) included contextual data to support contextualisation of the studies in line with the meta-ethnographic approach and epistemology. Table 5 also includes key data from results, findings and discussion sections relevant to the research question, with interpretations and explanations from studies being treated as data in line with Noblit and Hare's (1988) approach, thus taking into account Schütz's (1971) concepts of first and second order constructs. Only data relevant to the aims of the current synthesis were extracted due to the varied foci of the included studies (Atkins et al., 2008).

[INSERT TABLE 5]

Phase 4: Determining how the Studies are Related

Alongside phase three, relationships between studies were considered and key metaphors and concepts were written out and tabulated to display them across studies, as guided by Britten et al. (2002) and Atkins et al. (2008). Appendix 1-C displays an extract from the meta-ethnography spreadsheet.

Phase 5: Translating Studies into One Another

Papers were organised chronologically so developing and changing contexts could be considered over time (Atkins et al., 2008). This enabled consideration of changes such as

amendments to the MHA in 2007, the introduction of the Mental Capacity Act (2005) and the ongoing changes in inpatient FMH services (JCPMH, 2013). Thus, themes and metaphors from the earliest paper (Baxter, 2002), were compared with those from Trenoweth (2003), and the synthesis of these papers was then compared with Hinsby and Baker (2004). This process was repeated and new themes and metaphors were considered and added as each study was introduced.

Phase 6: Synthesising Translations

As studies were translated into one another, further interpretation of the grouped themes, concepts and metaphors supported the development of third-order interpretations and a line of argument synthesis. These third-order concepts were developed concurrently with phase five as emerging third-order themes were considered with the introduction and interpretation of each new study and were then built upon with further interpretation.

Theoretical Standpoint and Analysis Plan

A critical realist position (Willig, 1999) is assumed throughout. This carries an ontological assumption that there is an underlying reality. However, factors such as social context, language and interpretation, impact on how we can conceptualise this 'reality' (Danermark, Ekström, Jakobsen & Karlsson, 2002). This therefore enables consideration of participants' experiences, whilst recognising the contextual and social influences (Banister et al., 2011). It also considers the researcher's role in the shared research process, including conceptualisation, making meaning, interpreting and analysing data.

Some argue qualitative research is not generalisable and synthesising qualitative research can risk taking results out of context (Sandelowski, Barroso & Voils, 2007). However, a strength of this epistemology and ontology is it enables consideration of these contextual factors.

Reflexivity

In line with critical realism, it is important to recognise the way in which the researcher's context could have influenced the review. Firstly, the topic was conceptualised based within an area of clinical interest for the primary researcher stemming from personal experiences of working in FMH services. The impact of these experiences will be pervasive across the review, with researcher biases in the selection and interpretation of findings from the selected papers, quotations used and the analysis of data. A robust search strategy and approach to selection and analysis are thought to partially negate this impact, as strategies such as rating scales have enabled the researcher to assess the extent to which papers help answer the specific research question and reflect on selection biases. However, biases are likely to remain and another reviewer could take different understandings from the data, thus highlighting the integral role of the researcher and their own experiences and biases.

Results

The synthesis of first and second-order themes enabled the development of a line of argument synthesis and three third-order themes, which address the question of "how do staff experience power, control and risk management when navigating the TR in forensic inpatient services?" Third-order themes and sub-themes are outlined below:

1. The Impact of Team Skill and Cohesion
2. Dialectic Between Care and Control
    a. Control as a (therapeutic) tool
    b. Vulnerable victim vs risky offender
3. Systems and Structures

Theme 1-The Impact of Team Skill and Cohesion

Staff described how individual and team skill and cohesiveness were important when navigating TRs in FMH services and impacted upon: 1) the development and navigation of the TR; 2) judgements about risk; 3) the use of coercive and controlling practices such as restraint

and seclusion; and 4) the impact and perception of controlling practices upon the TR. Each of these will be explored below but have not been separated into sub-themes due to their intricately inter-related nature.

Staff skills and attributes such as communication (S1; S9), competence (S3), confidence (S3; S4; S5), self-awareness (S6) and sensitivity (S6) could contribute to more positive TRs and could reduce the perceived need for controlling practices to be used: "if we use communication skills effectively, we can often avoid situations where physical intervention is required" (S1, p. 1315).

However, an inherent element of the role for staff working in inpatient FMH environments was balancing care and control, as discussed in theme 2. This meant, at times, practices that could be deemed as controlling, such as urinary drug screening in the example below, were unavoidable. In such situations, the skills and attributes of staff were important to ameliorate the impact upon the TR: "the sensitivity with which the procedures were carried out, could ameliorate the impact of the procedure on the staff–patient therapeutic relationship–especially in terms of any long-term impact" (S6). This highlights that staff skill and attributes could help them navigate the TR in circumstances that carried the threat of a rupture.

Staff skill, the development and maintenance of TRs, perceptions of risk and use of restrictive and controlling practices seemed closely linked across the studies reviewed, with staff referring to a connection between these constructs:

> …positive regard, trust, honesty, safety and stability provided by a positive therapeutic alliance. These attributes were often linked with staff self-confidence, as staff appeared to feel valued and competent in the relationship…'I have always felt confident that I could assess her risk as she engages in sessions.' (S4, p. 11).

Confidence appeared to be an important attribute, which could also impact the TR adversely and increase the likelihood of restrictive measures being used, particularly if there

were discrepancies amongst the team. This is illustrated by S6, who described inconsistencies in staff approaches to contribute to differences in the TR, with staff thought to be higher in confidence being more likely to be perceived as using controlling measures:

> Nurses who were confident enough to implement the procedures were labelled as 'strict' by patients, and stated that this perception of the individual staff member could remain even after the involved patient had been transferred to another ward, 'Even when the patient will then move on or move wards and you might, you may go to another ward… not all the time, but some patients will go, Ooh you're, you're dead, dead strict, you always ask me for this or that... and they kind of remember it.' (S6, p. 676).

It is therefore not necessarily the skill or attribute itself that impacts the TR and the use and perception of controlling practices, but it is the way in which staff use their skills as part of a team:

> A lower perception of risk was also associated with effective teamwork and having the confidence in other staff to assist in managing a potentially violent encounter. Participants attempted to use their knowledge of a patient to structure and guide their actions in a potentially violent situation: 'Maybe, had we not known him so well, the medication or possibly the restraint may have come quicker…Because we did know him we tried everything else first.' (S2, p. 283).

Again, this highlighted a multi-directional relationship between risk, control, power and the TR, as a pre-existing relationship and understanding of a service user could contribute to less reliance on coercive measures. This also indicated that more effective staff skill and team cohesiveness contributed to reduced use of restrictive and controlling practices, whilst "variance (and occasional division) in clinical opinion was also felt by some participants to place some therapeutic relationships in jeopardy" (S8, p. 223).

Staff team cohesion therefore formed a basis for developing better understanding of service user needs, and for developing and maintaining TRs based on relational needs, rather than reliance on structural security:

> staff felt that working as a multidisciplinary team, understanding each other's roles within the service and knowing/understanding the women were most important. 'I would take away some of the structural security and replace it with relational security and create an environment where people were valued, staff and patients' (S9, p. 664).

Furthermore, staff team skill and cohesiveness impacted on the perception of controlling practices and the subsequent impact on the TR when they were utilised, "for damage to TRs to be minimised, it appears important for staff to be aware of how their behaviour can be interpreted by patients while implementing the procedures." (S6, p. 676).

This indicates both individual and staff team skill and cohesiveness impacts on how staff navigate the TR and controlling practices in forensic inpatient services. Effective use of staff skills and a cohesive team can support the development and maintenance of TRs and reduce the staff's perceived need to use such measures. This, in turn, appears to strengthen the TR and goes some way towards navigating the ongoing TR when restrictive and controlling measures are used. However, differences in approaches and unhelpful staff approaches were more likely to contribute to increased use of controlling practices and ruptures in the TR.

Theme 2-Dialectic Between Care and Control

The dialectic between care and control was a challenge faced by staff and appears to be an inherent aspect of the role "[It's] a dual role between caring – and counting knives and forks!" (S3, p. 344). This theme featured in each of the studies in the review and formed a central component of the research question. Sometimes these different elements of staff's roles were experienced as contradictory, separate and opposites, thus representing a dialectic. However, as embedded within the concept of a 'dialectic', there is a thesis, an antithesis, and a

synthesis. For staff, synthesising this dialectic between care and control represented an ongoing and difficult balancing act and required integration of both caring and controlling concepts.

2a. Control as a (therapeutic) tool.

Some experienced the use of power and controlling practices as a justified and necessary tool to support engagement and maintain safety, "exercising control over another's behaviour was justified through the conceptualisation of prioritising safety" (S3, p. 346), and use of restrictive and controlling measures were considered a therapeutic response in this context "Well, a therapeutic response was seclusion and injection." (S3, p. 344).

As highlighted in theme 1, the way the staff team navigated the use of controlling practices could ameliorate the negative impact upon the TR. At times, staff felt compelled to use controlling measures as a tool to support navigation through the care-pathway:

> Communication strategies that were perceived to reduce negative impact on nurse–patient relationships included selling the benefits of compliance to patients, in terms of continuing progress towards discharge and creating a positive impression for the patient's clinical team (S6, p. 675).

The inherent power imbalance within the relationship between staff and service users in inpatient FMH services was sometimes used to exert control by staff in a manner highlighting a transgression of power, which negatively impacted TRs:

> I think it almost comes down to power and like...I think the frustration of obviously you tell someone they can't do something and they go and do it. It's very frustrating, whereas obviously we are fully aware of the reasons why the person can't do whatever it is. Erm but then, so I think some people try and reinforce that, they can get a bit up themselves in how they are with the patients if that makes sense which obviously, well it definitely has a negative effect on the patients, incidents have been caused by it (S7, p. 126).

This use of power in order to exercise control could therefore affect the TR negatively. The perception of some participants suggested they experienced a responsibility to recognise their inherent power and to use it appropriately to maintain good TRs:

> The patient's perception of the relationship was also of relevance, particularly if they perceived the relationship as something more than it was. This could have a negative impact on their well-being, thus increasing their level of distress and display of symptoms. It was therefore the responsibility of the participants to remain professional and to reinforce boundaries to minimise the potential for this to become a problem (S5, p. 110).

Whilst staff mostly appeared to perceive they held this power and responsibility, there was also evidence of a reciprocal process whereby staff would react and adapt to communications from service users:

> If somebody's on one-to-one [observations], then they don't feel that they're getting the input that they need and, therefore, they will do something to get the one-to-one, or two-to-one; or actually, I'll try and push the boundaries a little bit more (S9, p. 663).

Again, this represents a dialectic between care and control, which impacts on the TR, as staff felt compelled to increase a potentially controlling practice (in this case the observation level) in a context of providing increased safety and containment.

Exercising power to use control as a tool also appeared to serve a protective function for staff, as the creation and maintenance of boundaries could support both staff and service users to feel contained and safe enough to work together therapeutically and develop TRs: '"They need to know where the boundaries are and then they feel contained, and then we can start working' (participant 2). Boundaries were also presented as essential for staff well-being and safety." (S10, p. 86).

2b. Vulnerable victim vs risky offender.

The dialectic between care and control included staff perceiving service users as either a vulnerable victim or a risky offender:

> The dilemma of seeing the offence versus person reflected opposing positions adopted towards the women as perpetrator or victim. Participants described the need to 'separate the offence from the person' (S10, p. 86).

This fragmentation of offence and person contributed to differences in how individuals and teams would relate with service users. The subsequent focus on the service user as being either a vulnerable victim or a risky offender invited polarised responses, such as "I just think oh that poor girl, that poor girl" (S10, p. 86) and "she murdered her kids, what does she expect?" (S10, p. 86). Such inconsistencies could impact on the TR as service users could be "confused by, and suspicious of, a group of staff that respond inconsistently towards them" (S8, p. 224). To avoid their judgments and responses creating such inconsistencies and negatively impacting on TRs, some staff tried to "compartmentalise their personal judgement and continue working with patients in a professional capacity" (S5, p. 109). However, as outlined by S8, p. 224, "you do get people that can't help but judge, you know, certain maybe index offences mean more to people than others". This therefore suggests inconsistencies across teams, rising from the dialectic between perceiving service users as vulnerable victims or as risky offenders. Such inconsistencies, as highlighted in theme 1, "is potentially a serious issue that may impede the development of TRs" (S8, p. 224) and "achieving relational security" (S8, p. 224).

Synthesising this dialectic was a challenge and demanded a "constant balancing act, to maintain a position where one sees the offence and the vulnerability of the person allowing integration or synthesis of this dialectic" (S10, p. 86). This challenge could cause "conflict and stress", as knowledge about the risks posed by individuals was important for managing risk, whilst trying to "establish relationships with patients with an open mind so that their opinions and attitudes did not affect the formation of a relationship." (S5, p. 109).

Theme 3–Structures and Systems

FMH services operate within a systemic, cultural, legal and political context that sets out guidelines, rules and laws. These structures and systems impact on the restrictions placed on staff and service users, set a framework for ways of working and assessing risk and mental health, and dictate how service users and staff engage with this system. This complex system therefore has an important role in how staff and service users develop and maintain TRs in forensic inpatient services and is used as a tool to both safeguard against power violations and justify their use.

Staff perceived working at an interface between legal and health systems to impact their work with service users due to the "nature of the patients and the legal restrictions placed upon many of them" (S1, p. 1316). This contributed to an increased sense of responsibility to understand the legal factors and processes: "Legal issues affect the way we work with patients; therefore we need to know about them" (S1, p. 1316).

These structures could provide containment for staff when working within them: "Policies were construed as ready-made decision making: they drove the response to violence and provided security" (S3, p. 345). However, deviations from the status quo were perceived as risky, and risk avoidance could contribute to the justification of more restrictive practices. Such systems could then also be perceived as restrictive for staff members, having a "stifling effect, restricting imagination, holding staff back" (S10, p. 86). Flexibly navigating these boundaries was difficult and the risk focussed structure impeded the development and quality of the TR:

> Participants reported spending less time with patients when they were responsible for security, such as possessing the keys for locked away items, including cutlery, scissors, knives, and other 'sharps', along with checking patients' whereabouts regularly… which in turn affected the quality of their relationships: 'it's difficult when it's at times

> like that to actually do things with the patients so that in a way affects your relationship with them…. you've got too many things to do and you've got to get things sorted out and stuff like that so, staffing levels and stuff like that and time spent with the patients affects your relationship' (S5, p. 108).

Structures and systems could both exert and maintain power differences and try to safeguard against them. S9, p. 664 highlighted the use of advocacy services "as being important for ensuring women had a voice", but recognised this could be difficult due to the nature of the system, "There's a limit to what you can offer them in choice though, isn't there, but they're detained patients in a psychiatric hospital and they can't go anywhere unless the Ministry of Justice say otherwise" (S9, p. 664). The structures and frameworks could help staff make sense of service user difficulties, which helped increase empathy and possibly contributed to improvements in the TR, "They're deemed mentally ill (sic) under the Mental Health Act. So...you kind of... [pause] are more accepting of them as people" (S10, p. 86). However, there was also evidence of staff members holding and abusing their position of power within this system in response to ruptures in the TR:

> Rather than creating distance in the helping relationship, they took advantage of their position of power to discipline the women, for example withholding items from the women, 'I think sometimes, and I hate to say it, but when they [staff] want one up on the patient sometimes like when the patient has been rude to them and they are like no you can't have that now' (S7, p. 125).

This holding and abuse of the powerful position enabled a perpetuation of ruptures in the TR, as staff described experiencing "people hold grudges or, "I won't do this for them. No. You go do that because I'm not talking to that person" (S7, p. 125).

Discussion

A dialectic between care and control is presented and discussed in relation to the impact on TRs between staff and service users in inpatient FMH services. Skilful and cohesive staff teams could go some way towards synthesising this dialectic, but this remained a dynamic balancing of the dual roles of care and control, akin to Hamilton's (2010) "Negotiator" role (p. 185). It is argued this dialectic between care and control stems from the different tasks and goals of FMH services (Hamilton, 2010). This is exemplified by the commissioning of FMH services to ensure "security measures promote a safe environment which enables therapeutic work to be undertaken to meet an individual's needs" (JCPMH, 2013, p. 3). Consequently, different weights and forces will inevitably contribute to challenges for staff teams relating to TRs, control, risk management and power.

The dual roles of safety and security and therapeutic engagement in FMH services means a skilful balancing act must occur for staff to successfully manage both. The nature of this juxtaposition means pulls on one element of the role can become stronger than those upon the other, which is difficult in a system dominated by control (Aiyegbusi, 2009). This is highlighted by staff prioritising safety above all else, and the understandable pulls towards this, including maintaining their own safety in an environment in which they may feel unsafe and therefore exercise their inherent power to establish a sense of safety and security (Gildberg et al., 2010).

The dialectic between care and control occurred in various ways in the studies reviewed, including a separation of vulnerability and risk. This enabled staff to hold either risk elements or therapeutic elements, therefore finding themselves either side of the dialectic between care and control and finding it difficult to integrate these two factors into a coherent whole. This links to Hamilton's (2010) boundary seesaw model and illustrates a mechanism by which individuals and teams may begin to shift towards either the controlling or pacifying roles. What also appeared to occur for staff was an acceleration and/or exacerbation of shifts

towards one end of the boundary seesaw in response to stress. As highlighted in the introduction, staff may attempt to cope and defend against difficult emotional experiences using detachment, denial and distraction (Lauvrud et al., 2009; Mason et al., 2008; Way et al., 2007). A combination of self-protective strategies in response to this stressful environment was seen in the papers reviewed, including the separation of service users as vulnerable victims or risky offenders. This could contribute to staff focussing more on either risk and control or therapeutic engagement, thus shifting across the boundary see-saw. As staff move away from "The Negotiator Role" (Hamilton, 2010), factors important for maintaining the TR such as openness, empathy, containment, responsivity, respect and collaboration (Bordin, 1979; Wampold, 2015; Norcross & Wampold, 2011; Hamilton, 2010), are not available to them and the TR is negatively impacted.

It is understandable that feeling unsafe could negatively impact on empathy, as higher levels of anxiety and threat reduce capacity to empathise and mentalise[1] (Liotti & Gilbert, 2010; Negd, Mallan & Lipp, 2011; Bateman & Fonagy, 2010; Beyer, Münte, Erdmann & Kräme, 2013). Furthermore, people are also likely to feel more threatened at times when their ability to mentalise is not present (Fonagy, Gergely, Jurist & Hepworth, 2002), resulting in a vicious cycle in which feelings of threat and difficulties mentalising/empathising make TRs harder to establish and maintain. Under circumstances of perceived and/or actual threat, it is understandable staff members would be motivated, consciously or sub-consciously, to move out of this threatened position. Such responses are articulated across various psychological models and constructs, including: procedures in cognitive analytical approaches (Ryle & Kerr, 2002), the three affect regulation systems in compassionate mind approaches (Gilbert, 2009) and psychological defences in psychoanalytic frameworks (as reviewed by Cramer, 1998).

[1] The ability to make sense of the subjective states of ourselves and others (Bateman & Fonagy, 2010)

However these are conceptualised, a response to threat exists across the studies reviewed, which provides a protective function for staff. This occurs by either: 1) moving away from and denying the presence of threat, thus separating away from security and risk management factors, as outlined by the pacifying role; or 2) attempts to regain or establish a sense of safety by increasing coercive, punitive and risk focussed practices and therefore associating with the punitive/controlling role (Hamilton, 2010). The accounts within the current review would suggest that, unless navigated skilfully by a cohesive staff team, these shifts towards overly restrictive and controlling practices are likely to negatively impact the TR and therefore perpetuate the cycle of feeling unsafe, attempting to establish control and negatively impacting the TR.

One of the considerations outlined in the introduction was whether the more unstructured interactions between staff and service users had similarities to structured therapeutic interactions. Livesley (2007, 2012) describes the therapeutic alliance as the basis for structured interventions and something that is required to support the change process. It is suggested here that the current review places a similar importance on these more unstructured TRs as the basis for future successful change. A good TR enabled staff to feel safe enough to explore risk and develop better understanding of the service user, flexibly negotiating some boundaries and taking therapeutic risks ("The Negotiator" position (Hamilton, 2010)). However, the absence of a positive TR contributes to staff feeling unsafe and responding with restrictive measures, which impede or damage the TR and perpetuate this cycle. Therefore, the absence of an existing TR, alongside a prioritisation of safety, makes it more difficult for staff teams to meet the dual aim of providing security and therapy (JCPMH, 2013, p. 3). It is hypothesised that control, power and risk management are not the only ways of making the environment feel safer, and other approaches could support the development of TRs and the synthesis of this dialectic between care and control. Staff team skill and cohesiveness appears

to be one important factor in enabling the TR to develop, as outlined in theme 1, as staff who feel safe and contained within a consistent team appear better able to develop and sustain positive TRs with service-users, perhaps as this environment enables greater empathy and mentalisation (Liotti & Gilbert, 2011). This also sits in line with Edmondson (1999), who identified low psychological safety is likely to contribute to defensiveness and a lack of cohesion.

Clinical Implications

This review develops understanding of some of the processes by which divisions can occur for staff teams working in FMH services in the UK. This is valuable for psychologists as it provides an insight into some of the complexities for staff navigating TRs and control, risk and power and therefore a better understanding of what might be required to effectively support these teams. As highlighted by results of this review, skilled and cohesive staff teams are better able to develop and maintain TRs with service users and are more likely to enable a sense of safety. It is hypothesised that when there is a lack of staff team cohesion, there may be pulls towards the pacifying or controlling roles outlined by Hamilton (2010), with staff finding it difficult to maintain a balanced and empathic view of the whole person (as outlined by the negotiator role of the same model). It is therefore important for psychologists working in FMH services to be attuned to overall staff team cohesiveness and skills and consider systemic interventions that might improve this and foster an environment which maintains a greater sense of safety. Team formulation and reflective practice interventions have been identified to support effective team working and the cohesiveness of staff teams (West and Spendlove, 2005; Onyett, 2007; Kellett, Wilbram, Davis & Hardy, 2014) and can also help increase reflective, empathic and mentalising skills (Wharne & Spilsted, 2011; Whitton, Small, Lyon, Barker & Akiboh, 2016). Kellett et al. (2014) identified increases in information sharing, cohesion, reflection, psychological safety and support within inpatient teams following team

formulation consultation and identified group supervision as important for increasing this sense of safety, a factor echoed by Davies (2015). Such interventions may be helpful in fostering a sense of safety in FMH services and consequently support staff to manage the dual demands of control and care when developing TRs. However, further research in FMH contexts is required.

Specific staff skills and attributes such as communication, competence, confidence, self-awareness and sensitivity were referenced to impact TRs and could reduce the perceived need for controlling practices to be used and ameliorate the impact of controlling practices when they are used. This outlines another clinical implication for stakeholders in FMH services to consider in recruitment and training of staff.

Strengths and Limitations

The UK focus of this review enables contextualisation within a legal system and is therefore relevant to practitioners and researchers working within this context. With the international variability in legal systems and the treatment and management of offenders within criminal justice and mental health systems, and the research question considering the dual-roles of TRs and control, risk and power, it was deemed necessary to limit this review to a UK context, so meaningful conclusions could be drawn. However, this limits the generalisability of findings and those in other legal contexts must consider the appropriateness and the applicability of these findings.

Future Research

Kellett et al. (2014) reported people delivering consultation should be supported by structured models, which guide process and practice. However, this has been identified as an under-researched element of team formulation (Kellett et al., 2014; Geach, Moghaddam & De Boos, 2018; Johnstone, 2014). As this review has highlighted team formulation as a potentially important intervention for staff teams working in FMH services, it would be recommended that

future research should consider the experiences of staff teams who have been involved in such interventions.

Conclusion

In conclusion, this meta-ethnography identified 10 studies that explored staff experiences of how power, control and risk management influence the TR in forensic inpatient services. Relevant findings were synthesised and third-order interpretations of the data were expressed across three themes. These themes identified the impact of staff team skill and cohesion; the dialectic between care and control; and the impact of structures and systems when navigating power, control and risk alongside the TR. The pulls towards care and/or control were understood within the context of dual-roles and dual-aims of inpatient FMH services. Balancing these dual-roles and synthesising this dialectic represented a constant balancing act. Staff's sense of safety was thought to support the necessary environment for the development and maintenance of TRs, which highlighted implications for systemic interventions that have a positive impact on this.

References

Abel, S. E. (2012*). A qualitative investigation of the experiences of nursing staff working in a secure personality disorder unit.* University of Hull. Retrieved from: https://hydra.hull.ac.uk/assets/hull:6342a/content

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical psychology review*, *23*(1), 1-33. Doi:10.1016/S0272-7358(02)00146-0

Aiyegbusi, A. (2009). The Nurse-Patient Relationship with Offenders: Containing the Unthinkable to Promote Recovery. In A. Aiyegbusi, & J. Clarke-Moore (Eds.), *TRs with Offenders: An Introduction into the Psychodynamics of Forensic Mental Health Nursing.* (pp. 15-32). London, UK: Jessica Kingsley Publishers.

*Allen, S., & Beech, A. (2010). Exploring factors that influence nurses: judgements of violence risk in a female forensic population. *The British Journal of Forensic Practice*, *12*(1), 4-14. Doi: 10.5042/bjfp.2010.0033

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: lessons learnt. *BMC medical research methodology*, *8*(21), 1-10. Doi: 10.1186/1471-2288-8-21

Banister, P., Bunn, G., Burnman, E., Daniels, J., Duckett, P., Goodley, D., . . . Whelan, P. (2011). *Qualitative methods in psychology: A research guide*. UK: McGraw-Hill Education.

Barnao, M., Ward, T., & Casey, S. (2016). Taking the good life to the institution: Forensic service users' perceptions of the Good Lives Model. *International journal of offender therapy and comparative criminology*, *60*(7), 766-786. Doi: 10.1177/0306624X15570027

*Barnes, C. M. (2015). *Relating Following Aggression – Women's Medium Secure Services.* University of Essex. Retrieved from: http://repository.essex.ac.uk/16837/

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World psychiatry*, *9*(1), 11-15. Doi: 10.1002/j.2051-5545.2010

*Baxter, V. (2002). Nurses' perceptions of their role and skills in a medium secure unit. *British Journal of Nursing*, *11*(20), 1312-1319. Doi: 10.12968/bjon.2002.11.20.10771

*Beryl, R., Davies, J., & Völlm, B. (2018). Lived experience of working with female patients in a high-secure mental health setting. *International journal of mental health nursing*, *27*(1), 82-91. Doi: 10.1111/inm.12297

Beyer, F., Münte, T. F., Erdmann, C., & Krämer, U. M. (2013). Emotional reactivity to threat modulates activity in mentalizing network during aggression. *Social cognitive and affective neuroscience*, *9*(10), 1552-1560. Doi: 10.1093/scan/nst146

*Boniwell, N., Etheridge, L., Bagshaw, R., Sullivan, J., & Watt, A. (2015). Mental health nurses' perceptions of attachment style as a construct in a medium secure hospital: a thematic analysis. *The Journal of Mental Health Training, Education and Practice, 10*(4), 218-233. Doi: 10.1108/JMHTEP-01-2015-0002

Bordin, E. S. (1979). The Generalizability of the Psychoanalytic Concept of the Working Alliance. *Psychotherapy: Theory, Research and Practice, 16*(3), 252-260. Doi: 10.1037/h0085885

British Psychological Society. (2017). *Practice Guidelines.* (3rd Edition). Leicester: British Psychological Society.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: a worked example. *Journal of health services research & policy*, *7*(4), 209-215. Doi: 10.1258/135581902320432732

Brown, R., & Stobart, K. (2008). *Understanding boundaries and containment in clinical practice*. London, UK: Routledge. Retrieved from: https://ebookcentral.proquest.com/lib/lancaster/reader.action?docID=690187#

Brunt, D., & Rask, M. (2007). Ward atmosphere–the scarlet pimpernel of psychiatric settings? *Issues in Mental Health Nursing, 28*(6), 639–655. Doi: 10.1080/01612840701354513

Cherry, M. G., Smith, H., Perkins, E., & Boland, A. (2017). Reviewing Qualitative Evidence. In A. Boland, G. Cherry, & R. Dickson (Eds.), *Doing a Systematic Review: A Student's Guide* (2nd Ed.). (pp. 193-222). London, UK: Sage.

Coe, J. (2012). Your Friends and Neighbours: Professional Boundary Violations – A Review of Perpetrator Typologies and Impact on Clients. In A. Aiyegbusi, P. Kleinot, A. Motz, & C. Scanlon (Eds.), *The Therapeutic Milieu Under Fire.* (pp. 78-96). London, UK: Jessica Kingsley Publishers.

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research, 22*(10), 1435-1443. Doi: 10.1177/1049732312452938

Cramer, P. (1998). Defensiveness and defense mechanisms. *Journal of Personality*, *66*(6), 879-894. Doi: 10.1111/1467-6494.00035

Critical Appraisal Skills Programme (CASP). (2018). Retrieved from: https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Cromar-Hayes, M., & Chandley, M. (2015). Recovery in a high secure hospital in England. *Mental Health Practice*, *18*(8). Doi: 10.7748/mhp.18.8.32.e972

Danermark, B., Ekström, M., Jakobsen, L., & Karlsson, J. C. (2002). *Explaining society: Critical realism in the social sciences*. London, UK: Routledge.

Davies, J. (2015). *Supervision for Forensic Practitioners.* UK: Routledge.

Davies, J., Black, S., Bentley, N., & Nagi, C. (2013). Forensic case formulation: Theoretical, ethical and practical issues. *Criminal Behaviour and Mental Health*, *23*(4), 304-314. Doi: 10.1002/cbm.1882

Day, R. A. (1993). The challenge: health care vs security. *Canadian Nurse, 79,* 34–36.

Doyle, P., Quayle, E., & Newman, E. (2017). Social climate in forensic mental health settings: A systematic review of qualitative studies. *Aggression and Violent Behavior, 36,* 118–136. Doi: 10.1016/j.avb.2017.06.008

Duggleby, W., Holtslander, L., Kylma, J., Duncan, V., Hammond, C., & Williams, A. (2010). Metasynthesis of the hope experience of family caregivers of persons with chronic illness. *Qualitative Health Research, 20*(2), 148-158. Doi: 10.1177/1049732309358329

Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative science quarterly*, *44*(2), 350-383. Doi: 10.2307/2666999

Edwards, J., Steed, P., & Murray, K. (2002). Clinical and forensic outcome 2 years and 5 years after admission to a medium secure unit. *The Journal of Forensic Psychiatry*, *13*(1), 68-87. Doi: 10.1080/09585180210123294

*Evans, K., Murray, C. D., Jellicoe-Jones, L., & Smith, I. (2012). Support staffs' experiences of relationship formation and development in secure mental health services, *The British Journal of Forensic Practice, 14*(2), 104-115. Doi: 10.1108/14636641211223666

Fennell, P. (2008). The law relating to mentally disordered persons in the criminal justice system. In K. Soothill, P. Rogers, & M. Dolan (Eds.), *Handbook of Forensic Mental Health.* (pp. 291-327). Devon, UK: Willan Publishing.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self.* New York: Other Books.

Geach, N., Moghaddam, N. G., & De Boos, D. (2018). A systematic review of team formulation in clinical psychology practice: Definition, implementation, and outcomes. *Psychology and Psychotherapy: Theory, Research and Practice, 91*, 1-30. Doi: 10.1111/papt.12155

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment, 15*(3), 199-208. Doi: 10.1192/apt.bp.107.005264

Gildberg, F. A., Elverdam, B. E., & Hounsgaard, L. (2010). Forensic psychiatric nursing: a literature review and thematic analysis of staff–patient interaction. *Journal of Psychiatric and Mental Health Nursing, 17,* 359–368. Doi: 10.1111/j.1365-2850.2009.01533.x

Gournay K., Benson, R., & Rogers, P. (2008). Inpatient Care and Management. In K. Soothill, P. Rogers, & M. Dolan (Eds.), *Handbook of Forensic Mental Health.* (pp. 525-554). Devon, UK: Willan Publishing.

*Hinsby, K., & Baker, K. (2004). Patient and nurse accounts of violent incidents in a Medium Secure Unit. *Journal of Psychiatric and Mental Health Nursing, 11*(3), 341–347. Doi: 10.1111/j.1365-2850.2004.00736.x

Hamilton, L. (2010). The boundary seesaw model: good fences make for good neighbours. In A. Tennant & K. Howells (Eds.), *Using time, not doing time: practitioner perspectives on personality disorder and risk.* (pp. 181–194). Chichester, UK: Wiley.

Jacob, J. D., & Holmes, D. (2011). Working under threat: Fear and nurse-patient interactions in a forensic psychiatric setting. *Journal of Forensic Nursing, 7*(2), 68–77. Doi: 10.1111/j.1939-3938.2011.01101.x

Johnstone, L. (2014). Using Formulation in Teams. In L. Johnstone, & R. Dallos (Eds.), *Formulation in Psychology and Psychotherapy* (2nd Ed.). (pp. 216-242). London, UK: Routledge.

Johnstone, L. & Boyle, M. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society.

Joint Commissioning Panel for Mental Health. (2013). *Guidance for commissioners of forensic mental health services.* UK: Raffertys. Retrieved from: https://www.jcpmh.info/wp-content/uploads/jcpmh-forensic-guide.pdf

Kellett, S., Wilbram, M., Davis, C., & Hardy, G. (2014). Team consultancy using cognitive analytic therapy: A controlled study in assertive outreach. *Journal of psychiatric and mental health nursing, 21*(8), 687-697. Doi: 10.1111/jpm.12123

Kirkham, R. (2017). *Exploring the experiences of staff working in forensic mental health settings.* Lancaster University. Doi: 10.17635/lancaster/thesis/178

Lauvrud, C., Nonstad, K., & Palmstierna, T. (2009). Occurrence of post traumatic stress symptoms and their relationship to professional quality of life (ProQoL) in nursing staff at a forensic psychiatric security unit: a cross-sectional study. *Health and Quality of Life Outcomes*, *7*(31), 1-6. Doi:10.1186/1477-7525-7-31

Linehan, M. M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Linehan, M. M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.

Liotti, G., & Gilbert, P. (2011). Mentalizing, motivation, and social mentalities: Theoretical considerations and implications for psychotherapy. *Psychology and Psychotherapy: Theory, research and practice*, *84*(1), 9-25. Doi: 10.1348/147608310X520094

Livesley, W. J. (2007). A framework for integrating dimensional and categorical classifications of personality disorder. *Journal of personality disorders*, *21*(2), 199-224. Doi: 10.1521/pedi.2007.21.2.199

Livesley, W. J. (2012). Integrated treatment: A conceptual framework for an evidence-based approach to the treatment of personality disorder. *Journal of personality disorders*, *26*(1), 17-42. Doi: 10.1521/pedi.2012.26.1.17

MacInnes, D., Courtney, H., Flanagan, T., Bressington, D., & Beer, D. (2014). A cross sectional survey examining the association between therapeutic relationships and service user satisfaction in forensic mental health settings. *BMC research notes*, *7*(1), 1-8. Doi: 10.1186/1756-0500-7-657

Mason, T., Lovell, A., & Coyle, D. (2008). Forensic psychiatric nursing: skills and competencies: I role dimensions. *Journal of Psychiatric and Mental Health Nursing*, *15*(2), 118-130. Doi: 10.1111/j.1365-2850.2007.01191.x

Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: A balance of goals and environment. *European journal of psychotraumatology*, *3*(1), 1-8. Doi: 10.3402/ejpt.v3i0.17246

Mullen, P. E. (2000). Forensic mental health. *The British journal of psychiatry*, *176*(4), 307-311. Doi: 10.1192/bjp.176.4.307

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International journal of mental health nursing*, *23*(1), 51-59. Doi: 10.1111/inm.12012

Negd, M., Mallan, K. M., & Lipp, O. V. (2011). The role of anxiety and perspective-taking strategy on affective empathic responses. *Behaviour research and therapy*, *49*(12), 852-857. Doi: 10.1016/j.brat.2011.09.008

Newman-Taylor, K., & Sambrook, S. (2012). CBT for culture change: formulating teams to improve patient care. *Behavioural and cognitive psychotherapy, 40*(4), 496-503. Doi: 10.1017/S1352465812000069

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing Qualitative Studies.* London, UK: Sage Publications.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy, 48*(1), 98-102. Doi: 10.1037/a0022161

Onyett, S. (2007). *New ways of working for applied psychologists in health and social care: Working psychologically in teams.* Leicester: British Psychological Society.

*Price, O., & Wibberley, C. (2012). An exploratory study investigating the impact of the procedures used to manage patient substance misuse on nurse–patient relationships in a medium secure forensic unit. *Journal of psychiatric and mental health nursing*, *19*(8), 672-680. Doi: 10.1111/j.1365-2850.2011.01842.x

Procter, N., Ayling, B., Croft, L., Degaris, P., Devine, M., Dimanic, A., Di Fiore, L., Eaton, H., Edwards, M., Ferguson, M., Lang, S., Rebellato, A., Shaw, K., & Sullivan, R. (2017). *Trauma-informed approaches in forensic mental health: A practical resource for health professionals.* University of South Australia, SA Health, Adelaide. Retrieved from: https://www.unisa.edu.au/siteassets/episerver-6-files/global/health/sansom/documents/mhsa/trauma-informed-approaches-in-forensic-mental-health-resource.pdf

Rutherford, R., & Duggan, S. (2007). *Forensic Mental Health Services: facts and figures on current provision.* London: The Sainsbury Centre for Mental Health.

Ryle, A. (1997). *Cognitive analytic therapy and borderline personality disorder: The model and the method*. Chichester, UK: Wiley.

Ryle, A., & Kerr, I. (2002). *Introducing CAT principles and practice.* Chichester, UK: Wiley

Sainsbury, L., Krishnan, G., & Evans, C. (2004). Motivating factors for male forensic patients with personality disorder. *Criminal Behaviour and Mental Health, 14*(1), 29-38. Doi: 10.1002/cbm.558

Sandelowski, J., Barroso, C., & Voils, C. I. (2007). Using Qualitative Metasummary to Synthesize Qualitative and Quantitative Descriptive Findings. *Research in Nursing and Health, 30,* 99-111. Doi: 10.1002/cbm.558

Schütz, A. (1971). *Collected Papers: Volume 1.* The Hague, Netherlands: Martinus Nijhoff.

Skipworth, J. (2005). Rehabilitation in forensic psychiatry: Punishment or treatment? *The Journal of Forensic Psychiatry & Psychology, 15*(1), 70-84. Doi: 10.1080/14789940512331309830

Soothill, K. (2008). Understanding the Forensic Mental Health Process and Systems. In K. Soothill, P. Rogers, & M. Dolan (Eds.), *Handbook of Forensic Mental Health.* (pp. 85-88). Devon, UK: Willan Publishing.

Tapp, J., Warren, F., Fife-Schaw, C., Perkins, D., & Moore, E. (2013). What do the experts by experience tell us about 'what works' in high secure forensic inpatient hospital services? *The Journal of Forensic Psychiatry & Psychology, 24*(2), 160-178. Doi: 10.1080/14789949.2012.760642

Thomson, L. (2008). The Forensic Mental Health System in the United Kingdom. In K. Soothill, P. Rogers, & M. Dolan (Eds.), *Handbook of Forensic Mental Health.* (pp. 19-63). Devon, UK: Willan Publishing.

*Trenoweth, S. (2003). Perceiving risk in dangerous situations: risks of violence among mental health inpatients. *Journal of Advanced Nursing*, *42*(3), 278-287. Doi: 10.1046/j.1365-2648.2003.02617.x

*Walker, T., Edge, D., Shaw, J., Wilson, H., McNair, L., Mitchell, H., ... & Abel, K. (2017). Contemporary women's secure psychiatric services in the United Kingdom: A qualitative analysis of staff views. *Journal of psychiatric and mental health nursing*, *24*(9-10), 660-670. Doi: 10.1111/jpm.12416

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270-277. Doi:10.1002/wps.20238

Ward, T. (2013). Addressing the dual relationship problem in forensic and correctional practice. *Aggression and Violent Behavior, 18*(1), 92-100. Doi: 10.1016/j.avb.2012.10.006

Way, I., Van Deusen, K., & Cottrell, T. (2007). Vicarious trauma: Predictors of clinicians' disrupted cognitions about self-esteem and self-intimacy. *Journal of Child Sexual Abuse*, *16*(4), 81-98. Doi: 10.1300/J070v16n04_05

West, M., & Spendlove, M. (2005). The impact of culture and climate in healthcare organisations. In J. Cox, J. King, A. Hutchinson, & P. McAvoy (Eds.), *Understanding doctors' performance* (pp. 91-105). Oxford: Radcliffe.

Wharne, S., & Spilsted, K. (2011). Service user experience: engagement and recovery. In C. Williams, M. Wharne, & R. Macpherson (Eds.), *Assertive outreach in mental healthcare: current perspectives* (pp. 134-52). Chichester, UK: Wiley-Blackwell Publishing.

Wiechula, R., Conroy, T., Kitson, A. L., Marshall, R. J., Whitaker, N., & Rasmussen, P. (2016). Umbrella review of the evidence: what factors influence the caring relationship between

a nurse and patient? *Journal of Advanced Nursing, 72*(4), 723–734. Doi: 10.1111/jan.12862

Willig, C. (1999). Beyond appearances: A critical realist approach to social constructionism. In D. J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice* (pp. 37-51). Buckingham, UK: Open University Press.

Wright, K. M. (2010). Therapeutic Relationship: Developing a new understanding for nurses and care workers within an eating disorder unit. *International journal of mental health nursing, 19*(3), 154-161. Doi: 10.1111/j.1447-0349.2009.00657.x

Wright, K., Duxbury, J., Baker, A., & Crumpton, A. (2014). A qualitative study into the attitudes of patients and staff towards violence and aggression in a high security hospital. *Journal of Psychiatric and Mental Health Nursing, 21*(2), 184–188.

*Denotes paper included in systematic review.

Tables and Figures

Table 1. MEDLINE search strategy

SPIDER	Search String
Sample	(staff* OR nurs* OR psychiatri* OR psychologist* OR therapis* OR "Allied Health" OR "mental health worker*" OR "mental health professional*" OR "practitioner*" OR "clinician*" OR "health care assistant*" OR "support worker*") AND ((Ward OR Hospital* OR Inpatient OR Intensive psychiatric support unit OR PICU OR Facilit* OR Institution* OR Unit OR therapeutic community OR setting* OR service* OR low OR medium OR high) N5 (Locked OR Secur* OR Forensic)) OR offend* OR forensic*
Phenomenon of Interest	(Atmosphere OR Climate OR milieu OR psychosocial OR social OR environment OR relation* OR alliance OR socioenvironmen* OR social climate OR mutual support) OR ((therap* OR car* N5 (relation* OR alliance)) OR (MH "Nurse-Patient Relations") OR (MH "Therapeutic Alliance") OR (MH "Interpersonal Relations")
Design	Interview* OR focus group* OR content analysis OR constant comparative method OR thematic OR grounded theory OR ethno* OR phenomenological OR semantic analysis OR question* OR survey* OR case stud* OR observ* OR narrative*
Evaluation	perception* OR satisf* OR perspective* OR view* OR experien* OR opinion* OR belie* OR attitude* OR understand* OR feel* OR know*
Research Type	Tx (qualitative OR mixed method*)

Table 2. Rationale for full-text exclusions

Reason for exclusion	Number
Insufficient consideration of control/power/risk and TR	28
Structured therapy setting	4
Quantitative/Insufficient qualitative analysis	4
Not UK	10
Unable to distinguish staff responses from others	1

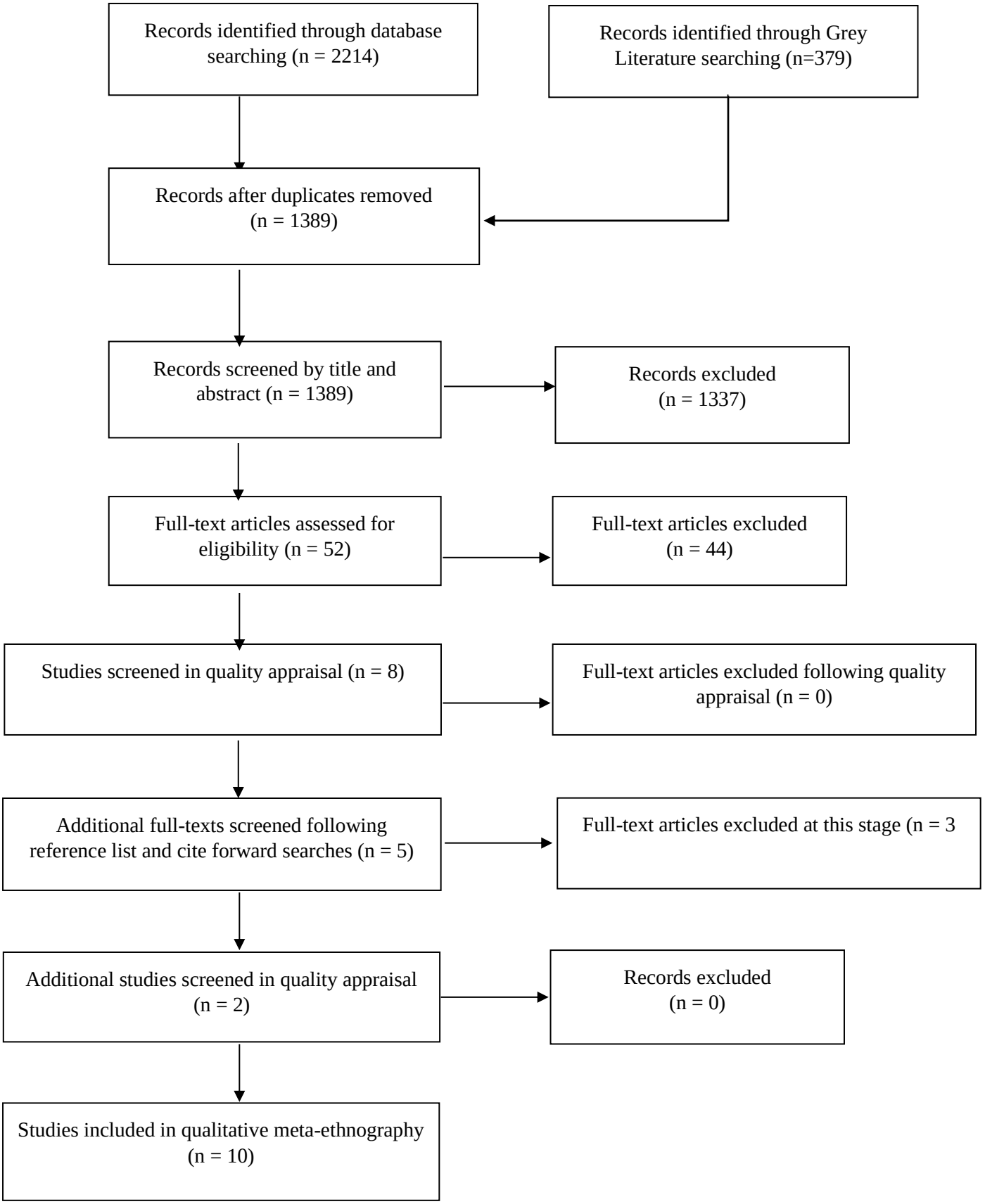

Figure 1. Flow diagram of article selection adapted from PRISMA (2009)

Table 3. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
1) Qualitative research	1) Studies considering the therapeutic alliance/relationship within structured therapies
2) Significant content of findings discusses staff experiences of risk, control or power and the TR with service users in FMH services	2) Insufficient qualitative analysis
3) Participants are staff working in FMH services within the scope of services identified by JCPMH (2013) commissioning of FMH services	3) Community/Out-patient/Prison setting
4) Report available in English	4) Not reporting staff experiences
	5) Staff views could not be separated from those of non-staff participants
	6) Older adult, child and adolescent services

Table 4. Results of quality appraisal tools

Author (Year)	**Study Number**	**CASP and Duggleby et al. (2010) rating score**								
		Appropriate design	Appropriate recruitment strategy	Appropriate data collection	Researcher-participant relationship	Ethical considerations	Rigour of data analysis	Clear statement of findings	Valuable Research	Total (Duggleby et al., 2010)
Baxter (2002)	S1	1	2	2	2	3	1	1	1	13
Trenoweth (2003)	S2	2	1	2	2	2	1	2	1	13
Hinsby and Baker (2004)	S3	2	2	3	1	1	3	2	1	15
Allen and Beech (2010)	S4	2	1	2	1	2	2	2	2	14
Evans, Murray, Jellicoe-Jones and Smith (2012)	S5	2	2	2	2	2	3	3	2	18
Price and Wibberley (2012)	S6	2	3	3	1	2	1	2	2	16
Barnes (2015)	S7	3	3	3	3	3	3	3	2	23
Boniwell, Etheridge, Bagshaw, Sullivan and Watt, (2015)	S8	3	2	3	1	2	2	2	2	17
Walker et al. (2017)	S9	1	2	3	1	2	2	3	2	16
Beryl, Davies and Völlm (2018)	S10	3	2	3	1	2	3	3	2	19

Table 5. Data Extraction Table and Summary of Results

Author (Year) (Study Number) Setting	**Study design**	**Method of analysis**	**Participants**	**Topic and Aims**	**Results**
Baxter (2002) (S1) Medium Secure Hospital	-Semi-structured interview, using a question guide	-Thematic content analysis (Burnard, 1991)	-Stratified random sampling was used to recruit qualified inpatient nurses (N = 25), taking into account clinical grades	-To gain an understanding of what nurses did and identify the skills they used.	Relevant factors included: (1) Perceived role and skills, (2) Differences between forensic and general mental health nursing, and (3) Factors influencing the nursing role and use of skills
Trenoweth (2003) (S2) Secure mental health services of a London mental health NHS trust	-Semi-structured, tape-recorded interview considering clinical situations where participants faced violence or perceived that violence was likely	-Grounded theory (Strauss & Corbin 1990, 1998)	-10 Registered Mental Health Nurses -Selected using purposive sampling on the basis of relevant clinical experience (over 5 years) -All participants were senior clinical nurses	-To attempt to understand how mental health nurses make risk assessments in clinical crisis situations where there is a perceived likelihood of imminent violence.	The following themes were identified from the data: (1) Knowing the patient, (2) Tuning in, (3) Considering the possibilities, and (4) Intervening. Data was extracted from the 'Intevening' theme.
Hinsby and Baker (2004) (S3) 49-bed outer London Medium Secure Hospital	-Semi-structured interviews	- Grounded theory methods (Strauss & Corbin, 1990) and a discursive approach (Potter & Wetherell, 1987)	-Male nurses (N = 4) -Male service users (N = 4) -Purposive and convenient sampling -Minimum of 2 years of experience in the setting	-To understand nursing staff and service user accounts of actual ward-based violence.	A core category and five constituent themes were generated from the analysis of the data: Core category – Control Theme 1 – Construction of identities Theme 2 – Care and control Theme 3 – Parents and children Theme 4 – Following the written rules Theme 5 – Segregation and the outside Data was extracted from Themes 2, 3, and 4.
Allen and Beech (2010) (S4) 30-bed medium secure forensic	-Semi-structured interviews with the staff group	-Qualitative template analysis approach (Crabtree & Miller, 1999; King, 1998).	-In-patient service users (N = 14) -Nursing key-workers (N = 17)	-To explore nursing staff judgements and decision-making regarding service user risk of violence and whether this related to levels of engagement with therapy	Staff considered several factors in when making judgements of patients' risk of violence, including: (1) Patient history, (2) Patient's current presentation, and

Author (Year) (Study Number) Setting	**Study design**	**Method of analysis**	**Participants**	**Topic and Aims**	**Results**
women's NHS mental health service.			-Service-user participants were recruited by referrals from consultant psychiatrists and then their key-workers were approached.		(3) Staff and patient relationship.
Evans et al. (2012) (S5) Two NHS Medium Secure Services	-Semi-structured interviews using a flexible interview schedule.	-Interpretative Phenomenological Analysis (Smith & Eatough, 2007).	-Nursing Assistants and Occupational Therapy Assistants (N = 10) -7 nursing assistants, 3 occupational therapy assistants -3 male, 7 female -5 from each research site -Mean age = 36 years (range = 22-60) -All identified as White British	-To explore how relationships are formed and developed between unqualified support staff and service users within secure mental health services.	Three themes were identified as follows: (1) "Building bridges'': developing relationships with patients; (2) ''You do forget what they've done'': seeing the person and managing risk, and (3) ''Playing your cards close to our chest'': maintaining boundaries. Data was extracted from each theme.
Price and Wibberley (2012) (S6) Medium Secure Service	-Naturalistic inquiry (Lincoln & Guba, 1985; Gubrium & Holstein, 1997).	-Naturalistic Inquiry (Lincoln & Guba, 1985; Gubrium & Holstein, 1997) -Inductive data analysis reflecting a case study reporting mode.	-Purposive sampling was used to recruit staff nurses (N = 10) -4 males, 6 females -Mean age of 35.1 years (range = 29–48). -Mean experience in forensic psychiatry = 6.75 years (range = 1 - 13 years)	-Explore perceptions of Registered Mental Nurses working in a medium secure forensic unit of the impact of the security measures used to manage service user substance misuse on their relationships -Provide evidence that can contribute to service developments, which may improve relationships with service users who misuse substances and nurses working in medium secure forensic services	Staff reported that intrusive procedures had a detrimental effect on TRs. The degree of intrusion impacted the extent and duration of damage to the relationships. Staff communication skills also impacted the degree of impact that the intrusive practice had on the TR.

Author (Year) (Study Number) Setting	**Study design**	**Method of analysis**	**Participants**	**Topic and Aims**	**Results**
Barnes (2015) (S7) Women's Medium Secure Service	-Semi-structured interview using a guide. Open ended questions. Later interviews became more focussed and were influenced by the emerging categories and theory.	Constructivist grounded theory (Charmaz, 2006)	-Staff members working directly with service users (N = 13) *Further demographic information is not provided to protect anonymity.	-To gain a deeper understanding of how forensic frontline staff perceive aggressive incidents in women's medium secure services. -To gain a deeper understanding of how forensic frontline staff perceive therapeutic relationships with service users following an aggressive interaction. -To consider how the TR is perceived by forensic frontline staff supporting women in secure services?	A continuum of approaches to boundaries and relationships was presented. Staff perceptions and responses to the TR and aggression varied. Themes included in the analysis included: Theme 3. Perceiving a Change in Relational Style Following Aggression 3.3. Burning bridges. Theme 4. Transgressions, Retaliating, and Rising to Aggression 4.1. "Losing yourself in the heat of the moment" 4.2. Provoking aggression 4.4. "Bearing grudges" and "asserting power"
Boniwell et al. (2015) (S8) Medium secure service	-Semi-structured interviews using a semi-structured interview schedule	-Inductive Thematic Analysis (Braun & Clarke, 2006)	-Opportunity sampling was used to recruit nurses (N = 5). -The nurses all worked on the same 14-bed male acute admission and assessment ward for service users with a primary diagnosis of mental illness	-To explore nurses' views of service user attachment in a forensic mental health service, and to gain insight into how applicable the concept of Attachment Theory is to frontline practitioners in that context.	Six themes emerged from the data as follows: (1) Staff-service user relationships, (2) Staff diversities, (3) Service user backgrounds, (4) Variability in service users' presentations, (5) Service users with personality disorder are problematic, and (6) Nurses do not use attachment. Data for this review was taken from the 'Staff Diversities' theme and the discussion.
Walker et al. (2017) (S9) Women's Enhanced Medium Secure	-Semi-structured interview schedule -Additional questions were adapted from the Parry-Crooke and	-Thematic analysis (Braun & Clarke, 2006)	-Purposive sampling (May & Pope, 1995), ensuring that the views of individuals with different roles were represented.	-Explore the success of WEMSS from staff perspectives, focusing on staff perceptions of service users' experiences and service operation.	The four main themes which emerged were: (1) Challenges of working with women in secure care, (2) Relational security, (3) Service user involvement, and (4) Factors important

Author (Year) (Study Number) Setting	**Study design**	**Method of analysis**	**Participants**	**Topic and Aims**	**Results**
Services (WEMSS) and Women's Medium Secure Service	Stafford (2009) interview.		-WEMSS practitioners (N = 9) -Non-WEMSS practitioners (N = 9)	-Explore staff perceptions of staffing arrangements, including staff levels and roles, training, supervision and personal development opportunities. -Compare the views of practitioners in WEMSS to those of practitioners in comparator non-WEMSS medium secure services.	for women's recovery. Staff comments about operational aspects of their service centred on three main topics: (1) Staff recruitment and retention, (2) Supervision, and (3) Training.
Beryl et al. (2018) (S10) 50-bed National High Secure Healthcare Service for Women providing detained under the Mental Health Act (1983)	-Interviews guided by a schedule of open-ended, non-leading questions	-Interpretive Phenomenological Analysis (Smith et al. 2013) using a set of guiding principles (Smith & Osborn 2008).	-Purposive sampling used to recruit a sample of nursing staff currently working within the service. -Nursing Staff (N = 7) -2 male, 5 female, -2 team leaders, 2 nursing assistants, 3 staff nurses. -3 to 30 years (median = 8 years) experience at the hospital.	-To understand the experience of providing nursing care to women patients in a high secure hospital -Impact of work in such environments and need for training, support and supervision, and to enhance the resilience of the workforce, while minimising burnout and stress. -Develop understanding of the impact of the work on staff -Provide a language with which to begin to discuss the approaches used and challenges faced in such highly-specialist environments.	Four superordinate themes were identified: (1) Horror, (2) Balancing acts, (3) Emotional hard labour, and (4) Community. Each theme contained sub-themes, and a meta-theme of 'Making sense by understanding' linked the themes. Of primary relevance to this review was the Balancing Acts theme, which included the following sub-themes: (i) Perpetrator vs victim (ii) Offence vs person (iii) Security vs therapy

Appendix 1-A
Guidelines for Authors: Legal and Criminological Psychology

LCP AUTHOR GUIDELINES

Sections

1. Submission
2. Aims and Scope
3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations
6. Author Licensing
7. Publication Process After Acceptance
8. Post Publication
9. Editorial Office Contact Details

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Book

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

Internet Document

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Colour figures. Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author

would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

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

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Appendix 1-B
Search Strategy by database – All searches conducted in June 2019

1. Search strategy for PsycINFO, 13th June 2019

SPIDER	Search Terms	Results
Sample 1	(staff* OR nurs* OR psychiatri* OR psychologist* OR therapis* OR "Allied Health" OR “mental health worker*” OR “mental health professional*” OR “practitioner*” OR “clinician*” OR "health care assistant*" OR "support worker*")	885, 995
Sample 2	((Ward OR Hospital* OR Inpatient OR PICU OR Facilit* OR Institution* OR Unit OR setting* OR service* OR low OR medium OR high) N5 (Locked OR Secur* OR Forensic)) OR offend* OR forensic*	86, 572
S1 AND S2		29, 176
Phenomenon of Interest	(Atmosphere OR interact* OR Climate OR milieu OR environment OR relation* OR alliance OR socioenvironment* OR social climate OR mutual support) OR ((therap* OR car*) N5 (relation* OR alliance))	1, 607, 628
Design	Interview* OR focus group* OR content analysis OR constant comparative method OR thematic analysis OR grounded theory OR ethnograph* OR phenomenological OR semantic analysis OR questionnaire* OR survey* OR case stud* OR observ* OR narrative*	1, 632, 806
Evaluation	perception* OR satisf* OR perspective* OR view* OR experien* OR opinion* OR belie* OR attitude* OR understand* OR feel*	2, 201, 983
Research type	TX (qualitative OR mixed method*)	303, 538
S AND PoI		8, 279
D OR E		2, 922, 919
(D OR E) AND R		273, 065
[S AND PoI] AND [(D OR E) AND R]		773
Limit to English language		757
Limit by year 1999 - 2019		742

2. Search strategy for Medline, 13th June 2019

SPIDER	Search Terms	Results
Sample 1	(staff* OR nurs* OR psychiatri* OR psychologist* OR therapis* OR "Allied Health" OR “mental health worker*” OR “mental health professional*” OR “practitioner*” OR “clinician*” OR "health care assistant*" OR "support worker*")	1, 577, 548
Sample 2	((Ward OR Hospital* OR Inpatient OR PICU OR Facilit* OR Institution* OR Unit OR setting* OR service* OR low OR medium OR high) N5 (Locked OR Secur* OR Forensic)) OR offend* OR forensic*	114, 193
S1 AND S2		16, 194
Phenomenon of Interest	(Atmosphere OR interact* OR Climate OR milieu OR environment OR relation* OR alliance OR socioenvironment* OR social climate OR mutual support) OR ((therap* OR car*) N5 (relation* OR alliance))	4, 530, 275
Design	Interview* OR focus group* OR content analysis OR constant comparative method OR thematic analysis OR grounded theory OR ethnograph* OR phenomenological OR semantic analysis OR questionnaire* OR survey* OR case stud* OR observ* OR narrative*	6, 086, 466
Evaluation	perception* OR satisf* OR perspective* OR view* OR experien* OR opinion* OR belie* OR attitude* OR understand* OR feel*	3, 594, 571
Research type	TX (qualitative OR mixed method*)	1, 157, 325
S AND PoI		4, 111
D OR E		8, 399, 479
(D OR E) AND R		584, 496
[S AND PoI] AND [(D OR E) AND R]		490
Limit to English language		481
Limit by year 1999 - 2019		467

3. Search strategy for CINAHL, 13th June 2019

SPIDER	Search Terms	Results
Sample 1	(staff* OR nurs* OR psychiatri* OR psychologist* OR therapis* OR "Allied Health" OR “mental health worker*” OR “mental health professional*” OR “practitioner*” OR “clinician*” OR "health care assistant*" OR "support worker*")	1, 069, 192
Sample 2	((Ward OR Hospital* OR Inpatient OR PICU OR Facilit* OR Institution* OR Unit OR setting* OR service* OR low OR medium OR high) N5 (Locked OR Secur* OR Forensic)) OR offend* OR forensic*	26, 596
S1 AND S2		7, 334
Phenomenon of Interest	(Atmosphere OR interact* OR Climate OR milieu OR environment OR relation* OR alliance OR socioenvironment* OR social climate OR mutual support) OR ((therap* OR car*) N5 (relation* OR alliance))	831, 233
Design	Interview* OR focus group* OR content analysis OR constant comparative method OR thematic analysis OR grounded theory OR ethnograph* OR phenomenological OR semantic analysis OR questionnaire* OR survey* OR case stud* OR observ* OR narrative*	1, 356, 730
Evaluation	perception* OR satisf* OR perspective* OR view* OR experien* OR opinion* OR belie* OR attitude* OR understand* OR feel*	1, 088, 512
Research type	TX (qualitative OR mixed method*)	172, 337
S AND PoI		1, 960
D OR E		1, 930, 337
(D OR E) AND R		150, 580
[S AND PoI] AND [(D OR E) AND R]		329
Limit to English language		319
Limit by year 1999 - 2019		307

4. Search strategy for Web of Science, 13th June 2019

SPIDER	Search Terms	Results
Sample 1	TS=(staff* OR nurs* OR psychiatri* OR psychologist* OR therapis* OR "Allied Health" OR "mental health worker*" OR "mental health professional*" OR "practitioner*" OR "clinician*" OR "health care assistant*" OR "support worker*") *DocType=All document types; Language=All languages;*	991, 764
Sample 2	TS=((Ward OR Hospital* OR Inpatient OR PICU OR Facilit* OR Institution* OR Unit OR setting* OR service* OR low OR medium OR high) NEAR (Locked OR Secur* OR Forensic)) *DocType=All document types; Language=All languages;*	100, 318
Sample 3	TS= (offend* OR forensic*) *DocType=All document types; Language=All languages;*	96, 795
(S4) S2 OR S3		188, 246
S1 AND S4		14, 679
Phenomenon of Interest 1	TS=(Atmosphere OR interact* OR Climate OR milieu OR environment OR relation* OR alliance OR socioenvironment* OR social climate OR mutual support) *DocType=All document types; Language=All languages;*	8, 192, 893
Phenomenon of Interest 2	TS=((therap* OR car*) NEAR (relation* OR alliance)) *DocType=All document types; Language=All languages;*	210, 255
PoI1 OR PoI 2		8, 192, 893
Design	TS=(Interview* OR focus group* OR content analysis OR constant comparative method OR thematic OR grounded theory OR ethnograph* OR phenomenological OR semantic analysis OR questionnaire* OR survey* OR case stud* OR observ* OR narrative*) *DocType=All document types; Language=All languages;*	9, 370, 204
Evaluation	TS=(perception* OR satisf* OR perspective* OR view* OR experien* OR opinion* OR belie* OR attitude* OR understand* OR feel*) *DocType=All document types; Language=All languages;*	6, 472, 880
Research type	ALL=(qualitative OR mixed method*) *DocType=All document types; Language=All languages;*	753, 683
S AND PoI		3, 947
D OR E		13, 847, 387
(D OR E) AND R		417, 021
[S AND PoI] AND [(D OR E) AND R]		380
Limit to English language		367
Limit by year 1999 - 2019		364

5. Search strategy for EMBASE, 13th June 2019

SPIDER	Search Terms	Results
Sample 1	(staff* OR nurs* OR psychiatri* OR psychologist* OR therapis* OR Allied Health OR mental health worker* OR mental health professional* OR practitioner* OR clinician* OR health care assistant* OR support worker*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]	1, 694, 679
Sample 2	(((Ward or Hospital* or Inpatient or PICU or Facilit* or Institution* or Unit or setting* or service* or low or medium or high) adj5 (Locked or Secur* or Forensic)) or offend* or forensic*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]	126, 473
S1 AND S2		19, 479
Phenomenon of Interest	(Atmosphere or interact* or Climate or milieu or environment or relation* or alliance or socioenvironment* or social climate or mutual support or ((therap* or car*) adj5 (relation* or alliance))).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]	4, 939, 345
Design	(Interview* or focus group* or content analysis or constant comparative method or thematic analysis or grounded theory or ethnograph* or phenomenological or semantic analysis or questionnaire* or survey* or case stud* or observ* or narrative*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]	6, 493, 352
Evaluation	(perception* or satisf* or perspective* or view* or experien* or opinion* or belie* or attitude* or understand* or feel*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]	4, 542, 719
Research type	(qualitative OR mixed method*).af.	299, 584
S AND PoI		4, 825
D OR E		9, 586, 488
(D OR E) AND R		207, 910
[S AND PoI] AND [(D OR E) AND R]		350
Limit to English language		338
Limit by year 1999 - 2019		334

6. Search strategy for ProQuest Dissertations and Theses14th June 2019

SPIDER	Search Terms	Results
Sample 1	noft((staff* OR nurs* OR psychiatri* OR psychologist* OR therapis* OR Allied Health OR mental health worker* OR mental health professional* OR practitioner* OR clinician* OR health care assistant* OR support worker*))	222, 282
Sample 2	noft((((Ward OR Hospital* OR Inpatient OR PICU OR Facilit* OR Institution* OR Unit OR setting* OR service* OR low OR medium OR high) NEAR/5 (Locked OR Secur* OR Forensic)) OR offend* OR forensic*))	29, 640
S1 AND S2		3, 855
Phenomenon of Interest	noft((Atmosphere OR interact* OR Climate OR milieu OR environment OR relation* OR alliance OR socioenvironment* OR social climate OR mutual support OR ((therap* OR car*) NEAR/5 (relation* OR alliance))))	1, 470,702
Design	noft((Interview* OR focus group* OR content analysis OR constant comparative method OR thematic OR grounded theory OR ethnograph* OR phenomenological OR semantic analysis OR questionnaire* OR survey* OR case stud* OR observ* OR narrative*))	1, 386, 574
Evaluation	noft((perception* OR satisf* OR perspective* OR view* OR experien* OR opinion* OR belie* OR attitude* OR understand* OR feel*))	1,415,387
Research type	notft(Qualitative* OR Mixed method*)	218, 903
S AND PoI		1, 934
D OR E		2, 088, 628
(D OR E) AND R		969, 372
[S AND PoI] AND [(D OR E) AND R]		359
Limit to English language		350
Limit by year 1999 - 2019		313

7. Open Grey Search Strategy 14th June 2019

((staff* OR nurs* OR psychiatri* OR psychologist* OR therapis* OR "Allied Health" OR “mental health worker*” OR “mental health professional*” OR “practitioner*” OR “clinician*” OR "health care assistant*" OR "support worker*") AND ((((Ward OR Hospital* OR Inpatient OR PICU OR Facilit* OR Institution* OR Unit OR setting* OR service* OR low OR medium OR high) NEAR/5 (Locked OR Secur* OR Forensic)) OR offend* OR forensic*)) AND ((Atmosphere OR interact* OR Climate OR milieu OR environment OR relation* OR alliance OR socioenvironment* OR social climate OR mutual support OR ((therap* OR car*) NEAR/5 (relation* OR alliance)))) lang:"en"

66 results

Appendix 1-C

Extract from Meta-ethnography spreadsheet, adapted for Word

Author (1st and 2nd Order)	Author (1st and 2nd Order)	Synthesis (3rd Order)	Author (1st and 2nd Order)	Synthesis (3rd Order)	Author (1st and 2nd Order)	Synthesis (3rd Order)	Author (1st and 2nd Order)	Synthesis (Third Order)
Baxter (2002)	Trenoweth (2003)		Hinsby and Baker (2004)		Allen and Beech (2010)		Evans et al. (2012)	
Communication skills important for management of risk Good staff skills can negate need for power/control to be used	TR impacts on use of controlling and restrictive practices. Increased TR lowers use of C&R	Effective staff skills and TR reduce the need/use of restrictive practices/use of power	Competence and confidence in role leading to less restrictive practice	Effective staff skills support TR and vice versa. This appears to contribute to a lower need to use restrictive practices/power.	Risk views related to personal relationship, staff characteristics and service user characteristics Staff confidence linked to TA and risk judgments Positive TA increased staff confidence in understanding of risk and seen as a protective factor for	Competence and confidence of staff linked to better TR and less restrictive practices and more individualised assessment and management of risk TR deemed to be an important precursor to managing violence Better perceived TR linked to less restrictive	Restrictive practices as an inhibitor of TR development Quality over quantity for control and development of TR Confidence impacting risk perceptions Onus on staff to 'manage' TR as over-familiarity could contribute to increased risk Onus on staff skills and 'common	Staff skill important in enabling quality interaction and quality interaction is more important than the quantity. Lots of restrictive engagement worse than a bit of quality engagement. Staff confidence to manage risk and quality of TR linked to lower judgments of

					violence. Positive TA necessary for managing violence and aggression Better understanding linked to better monitoring of risk fluctuations Better TR linked to more individualised approach to risk assessment and management	practices and more individualised assessment and management of risk	factors' to manage risk Perceived risk impacting TR	risk lower use of restrictive practices. Better perceived TR linked to less restrictive practices and more individualised assessment and management of risk. This also goes the other way.

Author (1st and 2nd Order)	Synthesis (3rd Order)	Author (1st and 2nd Order)	Synthesis (3rd Order)	Author (1st and 2nd Order)	Synthesis (3rd Order)	Author (1st and 2nd Order)	Synthesis (Third Order)	Author (1st and 2nd Order)	Synthesis (Third Order)
Price and Wibberley (2012)		Barnes (2015)		Boniwell et al. (2015)		Walker et al. (2017)		Beryl et al. (2018)	
How is also important, not	Staff skill determines	Staff confidence	Staff skill determines	Staff differences	Both individual	Importance of staff skills	Effective staff skill,	Differenc e in staff	Effective staff skill,

just what Staff skill - sensitivity Degrees of restrictive practices, higher personal impact = greater violation Staff skill and manner can ameliorate up to a point Therapeutic engagement skills- maintaining dignity, respect etc. Overly controlling or abuse of power can damage TR Staff self-awareness important when using controlling or restrictive practices so as not to damage TR	how restrictive practices are experienced and the impact on TR Better TR linked to better acceptance of restrictive practices and nuanced and more effective use of and management of restrictive measures Staff skill determines how restrictive practices are experienced and the	linked to use of controlling practices and TA Inconsistencies in staff approach lead to differences in TRs with SUs. High confidence>more likely to use control>more likely to be viewed as strict - this is different to a study above where increased confidence meant less likely to use control.	how restrictive practices are experienced and the impact on TR - Not necessarily the attribute e.g. 'confidence', it is the skilfulness that appears important. - If done badly, can have a negative impact on TR, skilful use limits the negative impact on TR and can contribute to alliance building - though it	and differences in restriction Staff perspectives and opinions impact on restriction Inequity Subsequent impact on TR	and staff team skill determines how restrictive practices are experienced and the impact on TR - Not necessarily the attribute e.g. 'confidence', it is the skilfulness that appears important. - If done badly, can have a negative impact on TR, skilful use limits the negative impact on TR and can contribute to alliance building - though it can also be experienced	Importance of communication Good skills and relational security can reduce the need for structural security Inconsistencies in TR and staff make relational security less effective and increase likelihood for restrictive and controlling practices such as increased observation Difficult balance to strike Balancing care vs control and impact on	team cohesiveness, and the way in which skills are used impacts on the levels of restrictiveness Both individual and staff team skill determines how restrictive practices are experienced and the impact on TR - Not necessarily the attribute e.g. 'confidence', it is the skilfulness that appears important. - If done badly, can have a negative impact on	approaches leading to TR ruptures	team cohesiveness, and the way in which skills are used impacts on the levels of restrictiveness Both individual and staff team skill determines how restrictive practices are experienced and the impact on TR - Not necessarily the attribute e.g. 'confidence', it is the skilfulness that appears important. - If done badly, can have a negative impact on

Collaboration supports engagement Positive TR likely to make control and restrictive practices easier/more accepted Staff confidence linked to use of controlling practices and TA Inconsistencies in staff approach lead to differences in TRs with SUs. High confidence>more likely to use control>more likely to be viewed as strict	impact on TR - Not necessarily the attribute e.g. 'confidence', it is the skilfulness that appears important		can also be experienced as stifling. Cohesiveness and consistency of approach important		as stifling. Cohesiveness and consistency of approach important. Perceived and actual inequality or personalisation of restrictive practices are more likely to negatively impact the TR	staff Complex interpersonal dynamics Managing boundaries and TR Inconsistencies in TR and staff make relational security less effective and increase likelihood for restrictive and controlling practices such as increased observation	TR, skilful use limits the negative impact on TR and can contribute to alliance building - though it can also be experienced as stifling. Cohesiveness and consistency of approach important. Perceived and actual equality or personalisation of restrictive practices are more likely to negatively impact the TR		TR, skilful use limits the negative impact on TR and can contribute to alliance building - though it can also be experienced as stifling. Cohesiveness and consistency of approach important. Perceived and actual inequality or personalisation of restrictive practices are more likely to negatively impact the TR

Section Two - Empirical Paper

Understanding Staff Experiences of the Processes Involved in Team Formulation Interventions in Forensic Inpatient Services

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Prepared for: Legal and Criminological Psychology (see Appendix 2-A)

Abstract

Purpose: Team formulation has been highlighted as an important systemic intervention where psychologists can support change and introduce psychologically informed practice at various levels of an organisation. However, differing definitions, conceptualisations and implementations of team formulation have contributed to difficulties in understanding its role, function and effectiveness. Indirect intervention plays an important role in forensic mental health (FMH) services, where various factors can limit the effectiveness of traditional one-to-one approaches. The current research aims to develop a better understanding of the key components and processes involved in team formulations in inpatient FMH settings. *Methods:* Multi-disciplinary staff team (MDT) members were interviewed using a semi-structured narrative interview schedule and data was analysed using thematic analysis. *Results:* A process model is presented, which highlights six stages involved in team formulation interventions and is discussed across three themes: 1) Processes and parallel processes; 2) Mechanisms for change; and 3) Barriers to successful intervention. *Conclusions:* This model adds to the very limited existing literature that considers processes involved in team formulation in forensic services and provides facilitators with a flexible framework of key factors to consider during team formulation interventions.

Keywords: forensic mental health, staff, team formulation.

The Joint Commissioning Panel for Mental Health [JCPMH] (2013) outlines the core purposes for FMH care pathways. These include supporting people's mental health needs and the assessment and management of the risk of re-offending, which Kennedy (2002) claimed to be the most important roles for these services. Psychological formulation has been identified as an important tool for supporting these dual purposes (Rushbridge, Tooze, Griffith & Wilkinson-Tough, 2018) as it is able to draw upon and integrate various theories and models to inform understanding and develop individualised treatment plans (Hart, Sturmey, Logan & McMurran, 2011) based on personal experiences, difficulties, strengths and resources (Division of Clinical Psychology [DCP], 2011). In doing this, formulation serves a function that diagnosis and offence classification cannot, as it provides an individualised understanding of pathways into offending and possible future risk (Hart et al., 2011) and identifies appropriate interventions related to this risk (Knauer, Walker & Roberts, 2017), whilst also considering social factors and personal meanings of distress (Johnstone, 2018).

Formulation is viewed by many professional groups as a core competency in evidence-based forensic and mental health practice (Royal College of Psychiatrists, 2018; Health and Care Professions Council [HCPC], 2015) and is a central tenet for the profession of clinical psychology (HCPC, 2015; DCP, 2010; 2011). Despite this, formulation has historically been neglected in research and has no singly agreed definition (Johnstone & Dallos, 2014), and various professions, such as psychologists, psychiatrists and nurses, adopt different understandings (DCP, 2011).

Within clinical psychology, some common elements of formulation have been identified. For example, DCP (2011), p. 2 describe it as integrating "a broad range of biopsychosocial causal factors…based on personal meaning and constructed collaboratively with service users and teams" and the "generation of a hypothesis about a person's difficulties, which links theory with practice and guides the intervention". Tarran-Jones, Summers, Dexter-

Smith and Craven-Staines (2019) describe formulation as drawing on theories and models to develop understanding of experiences, difficulties, strengths and resources, proposing hypotheses about how problems have been developed and maintained and using the explanation to support interventions. Johnstone and Dallos (2014) reviewed several definitions of formulation and identified common elements of it involving a shared hypothesis about a person, which is based on personal meaning and draws from psychological theory. Therefore, based on the integration of these definitions, formulation should provide a shared understanding of a person, which includes hypotheses about their strengths and difficulties, is underpinned by psychological theory, and can be used to guide intervention.

Formulation can refer to both a process and an object (Hart et al., 2011; DCP, 2011). The process of formulation involves the development of the understanding and application of psychological theory, whilst the object of formulation is typically the product of this process, such as a written formulation (Hart et al., 2011; DCP, 2011).

In FMH services many factors impact upon how the process of formulation with service users can be navigated. For example, engaging service users in psychological work can be difficult due to barriers such as fear of failure, previous negative experiences of treatment attempts and difficulties maintaining relationships (Clarke, Fardouly & McMurran, 2013). Rushbridge et al. (2018) highlighted further barriers for service users engaging in formulation in FMH services, particularly when this involves discussing their offence history, such as experiences of shame and fear of consequences. This can impact on the understanding of risks and navigation through the care-pathway (Doyle et al., 2014). As outlined above, FMH services maintain dual roles of supporting mental health needs and the assessment and management of the risk of re-offending and staff must balance therapeutic care and risk management (Taylor, 2017; Ward, 2013). Formulation has been highlighted as a mechanism to support integration of care and control roles and develop a holistic understanding of the service user (Davies,

Black, Bentley & Nagi, 2013) This presents a challenge for psychologists working in these services who may need to work systemically to support teams with these aims.

Working systemically with staff teams forms an important part of the role of clinical psychologists as it enables greater influence and wider provision of psychologically-informed practice than working one-to-one (DCP, 2010). The "New Ways of Working" report, which aims to give guidance to psychologists working systemically with teams, recommends psychologists should use training, supervision and support to improve team working and psychological understanding (Onyett, 2007). Newman-Taylor and Sambrook (2012) argue formulation can help us to understand interpersonal processes within teams and can contribute to improvements in care. The Clinical Psychology Leadership Development Framework (Skinner & Toogood, 2010) indicates the importance of psychologists being able to develop and use psychological formulations with teams to support communication, understanding and development and learning about service users. HCPC (2015) guidelines, which recommend the use of formulation in teams, and accreditation criteria for clinical psychology training courses (BPS, 2019) also advocate using formulations with teams. Team formulation therefore represents an opportunity for psychologists to support psychological thinking and planning at team and service levels (DCP, 2011; Johnstone, 2018) and may be a powerful systemic intervention for staff and service users (Kennedy, Smalley & Harris, 2003) in circumstances where the service user is unable to participate (Johnstone, 2018).

Team formulation also has no single definition (Geach, Moghaddam & De Boos, 2018). Johnstone (2014) p. 216 refers to it as the "process of facilitating a group or team of professionals to construct a shared understanding of a service user's difficulties", which provides a structure for integrating information from an MDT and generates hypotheses to inform intervention planning. Johnstone (2018) outlined some common elements of team formulation meetings, such as occurring as part of a weekly schedule, typically being facilitated

by a psychologist who should support the team to reflect and encourage thinking about the service user to help develop a shared formulation about their difficulties, including staff reactions and counter-transference. Berry, Haddock, Kellett, Awenat, Szpak and Barrowclough (2017) identify team formulation as including a whole staff team understanding a service user's unique life experiences, needs, goals, values and strengths and using this to inform treatment plans. As with formulation, these definitions share common components, such as involving a team and developing a shared understanding, which informs treatment plans. Geach et al. (2018) identified the following definition of the function of team formulation: "to enable team members to develop a shared psychological understanding of presenting difficulties; which summarises their nature, explains their development and maintenance, and guides intervention planning" (p. 27).

Geach et al. (2018) also identified that in practice, the team formulation process varied from unstructured discussions, such as those outlined by Christofides, Johnstone and Musa (2012) to highly structured consultation, such as that described by Berry, Barrowclough and Wearden (2009) and Berry et al. (2017). Geach et al. (2018) posited this lack of uniformity in the definition and application of team formulation may represent a significant limitation.

Various models have been utilised to help guide the team formulation process, including cognitive behavioural (Kennedy, 2008; Ingham, 2011; Berry et al., 2017, Summers, 2006), cognitive analytical (Carradice, 2004, 2013), emotion focussed (Clarke, 2015), psychodynamic (Davenport, 2002) and integrative approaches (Lake, 2008). These outline some of the more structured approaches to team formulation; however, the process of team formulation might need more attention from facilitators, as the team bring thoughts, feelings and information, which is reflective of their relationship with the service user and impacted upon by the system and context (Johnstone, 2014). FMH teams must negotiate a range of factors associated with the system, which impacts on their work with service users and this is

where this study will focus. One such factor is balancing therapeutic care and control (Taylor, 2017; Ward, 2013), covered extensively in section one of this thesis. Formulation has been highlighted as a mechanism to support integration of care and control roles and develop holistic understanding (Davies et al., 2013) and could therefore form an important part of the process of team formulation in inpatient FMH services.

Johnstone (2014) identifies three overarching process categories: 1) "Co-constructing a team formulation in response to a particular request"; 2) "Facilitating regular formulation meetings for the whole team"; and 3) "Integrating formulation into the work of the team and the service at entry level" (p. 217-219). These categories incorporate different methods of facilitating team formulation across various settings, including informal and structured approaches. As highlighted by Day (2017) when discussing forensic case formulation, flexibility in the approach could stem from practitioners choosing different approaches to fit the individual needs of teams and service users and, by extension, the same strengths could be argued for team formulation, in contradiction to Geach et al's. (2018) assertion that inconsistency represents a weakness.

Geach, De Boos and Moghaddam (2019) published a paper in August 2019 (after the current study was conducted), which attempted to address some of the gaps in the literature regarding the practical application and processes involved in team formulation. Geach et al. (2019) surveyed clinical psychologists working in the United Kingdom (UK) who had experience of facilitating team formulations, identifying four approaches to team formulation: 1) case review; 2) formulating behaviour experienced as challenging; 3) formulating the staff-service user relationship; and 4) formulating with the service user perspective. They also discuss factors that were common across the four approaches and how these may facilitate or impede the successful implementation of team formulation. It is of note, however, that only

five of their sample of 49 clinical psychologists worked in inpatient FMH services, meaning just 8.9% representation.

The current study aimed to consider the processes of team formulation in depth, specifically in a forensic inpatient setting and from a multi-disciplinary perspective. Despite the growing evidence base, there remains little research on team formulation within FMH services, with the exception of Whitton et al. (2016), who considered the impact of team formulation in learning disability FHM services, finding team formulation enhanced psychological understanding, helped to increase empathy and consistency, and that staff felt listened to.

This study therefore aimed to answer the research question, "what are the key components and processes involved in team formulations in inpatient FMH settings, from the perspective of staff who have taken part in them?" A broad definition of team formulation was adopted, including any team-based approach or intervention using consultation informed by psychological formulation as a means of understanding and working with a service-user or group of service users.

Ontology and Epistemology

A critical realist position has been adopted, which assumes an underlying single reality can exist theoretically, but due to contextual, social and cultural structures, and impact of language and interpretation from both the researcher and participants, we cannot properly access this 'reality' through empirical research (Gorski, 2013). This is important to consider in complex settings (Wood, Giles & Percy, 2009), such as FMH where there are complex social, political, legal and contextual factors (McMurran, Khalifa & Gibbon, 2013).

Furthermore, this position enabled consideration of the impact of the researcher. For example, the research area was chosen due to personal clinical interest, stemming from personal experiences of working as a healthcare support worker in inpatient FMH settings. The

researcher therefore cannot be a neutral part of the research process as discussed further in the Critical Appraisal Section.

Method

Ethics

Ethical approval was gained via Lancaster University Faculty of Health and Medicine Research Ethics Committee (FHMREC). Following this, research governance approval was gained from The Health Research Authority (HRA). Full documentation of ethical applications and approvals has been collated in the Ethics Section.

Design

Semi-structured interviews were conducted with staff who had been involved in team formulations. These were guided by a narrative interviewing approach (Anderson & Kirkpatrick, 2016), which places emphasis on eliciting participants' stories and understanding the meaning they assign to their experiences. Gaining multiple perspectives on the same examples of team formulation interventions enabled in-depth exploration from different perspectives. This privileged personal meaning and recognised that we cannot properly access a 'reality', but gathering multiple perspectives of the same event highlighted some explanations of the shared reality, whilst recognising the limitations of empirical research, thus in line with the critical realist epistemology.

Braun and Clarke's (2006) method of Thematic Analysis (TA) was used to analyse the resulting data. TA does not assume a particular epistemology (Braun and Clarke, 2006) and therefore accommodated the epistemological position outlined above.

Participants

All 12 participants had experienced involvement in a team formulation intervention whilst working within a forensic inpatient service, which was essential for participants to be

able to contribute (Etikan, Musa & Alkassim, 2016). Participants came from various disciplinary backgrounds (psychology, nursing, occupational therapy, medical) to fulfil aims of gaining multidisciplinary perspectives. Table 1 outlines the inclusion and exclusion criteria and table 2 provides an overview of participant demographics. Due to the small sample size and single recruitment site, certain details have been withheld and participants have been assigned a participant number (P) to support anonymity.

[INSERT TABLE 1]

[INSERT TABLE 2]

Procedure

Consultation.

Consultation occurred with individuals working within inpatient FMH services to support development of the recruitment strategy and design of research materials. This included consultation around use of language in the materials, for example, referring to team formulations as "formulation meetings".

Service.

The host service provides medium and low secure FMH services and is separated into three service areas: 1) Men's Service; 2) Women's Service; and 3) Acquired Brain Injury (ABI) Service. The ABI service pathway includes a team formulation meeting at the end of an assessment period. The Men's and Women's services do not have any formal procedure or pathway or format for team formulation interventions.

Recruitment.

Recruitment was purposive in the selection of the service, which enabled access to multi-disciplinary staff teams who have engaged in team formulation interventions. Staff teams and individuals who met the inclusion criteria were identified and provided with information packs about the study (Appendix 4-B, C, E, F, G) by the field supervisor, managers and team

psychologists working within the service. The researcher guided this process to support recruitment of participants representing different components of the MDT.

Participants who indicated their interest had the option to either directly contact the researcher, or for their details to be passed to the researcher. If contact information was provided, the potential participant was contacted to arrange an interview at the participant's work place (NHS site) or via telephone/skype call.

Recruitment was conducted in line with purposive sampling's emphasis on saturation and thus was stopped when no further information was being acquired (Etikan et al., 2016). An a priori sample size of 12-15 was identified to be appropriate based on the research aims, question and design (Francis et al., 2010). This was used to inform the research protocol and ethics application. When this sample size was reached, the researcher identified no new concepts were being identified within the interviews and recruitment was ended.

Data collection.

Semi-structured narrative interviews were conducted between July and September 2019 using a topic guide/schedule (Appendix 4-D). Anderson and Kirkpatrick's (2016) guide to narrative interviewing included four main sections: 1) Introduction and explanation of the research; 2) Interviewee's narrative; 3) Questions based on narrative and semi-structured schedule; and 4) Conclusion.

The interview schedule contained topic areas which included the processes experienced before, during and after team formulation interventions and was developed following consultation with the author's field and research supervisors and engagement with relevant literature. This broadly covered Johnstone's (2014) three main areas of team formulation interventions, with the "before" section covering the "particular request", the "during" looking to cover any experiences of co-constructing a team formulation and facilitation of meetings

with the team, and the "after" aiming to consider any experiences related to the integration of the team formulation into the work of the team.

Data analysis.

Interviews were transcribed verbatim then read several times and notes were made on initial ideas. An inductive approach to TA was taken, analysing the data without applying a pre-conceived theoretical framework (Braun & Clarke, 2006). This sat in line with the research aims and rationale as there was little research into team formulation in FMH services, so pre-conceived theoretical frameworks and extant literature from other contexts may not have been applicable. A thematic description of the whole dataset enabled the research to answer questions about the common factors across the experiences of different members of MDTs and across different approaches to team formulation.

Transcripts were coded line-by-line and then collated into potential themes. Emerging themes were then reviewed to ensure they corresponded with the extracts and the participants accounts and a thematic map was developed (Appendix 2-B). From this process, with the development and refinement of themes and the links between them, it was apparent that a process model could be a helpful way to help explain and report the themes. This was then developed from the themes, and the discussion of the themes alongside the process model represents a best attempt at discussing the underlying "reality" through the veil of the interpretation of participants' experiences, in line with the stated epistemology.

Results

Three themes are presented alongside a model of processes involved in team formulation in inpatient FMH services. Table 3 outlines the themes and sub-themes that emerged from the analysis of participants' accounts. From the themes, a "team formulation process model" for team formulation interventions in FMH services is also presented. The corresponding phases of the model are also presented in Table 3. The model is displayed diagrammatically in Figure

1, which illustrates the processes through six stages, alongside factors that can inhibit the success of the intervention. The model is discussed more conceptually through the themes and in the discussion. Each stage of the model represents a different process involved in team formulation, for consideration by the facilitator. As outlined by theme three, if adequate attention is not given to the processes involved in each stage, the team will find it more difficult to progress through the stages of the model, thus limiting the effectiveness of the intervention. Each stage should be considered in turn. For example, if the problematic processes and parallel processes outlined in stages one and two are not adequately named, heard and validated (stage three), the latter stages, where psychological understanding, reflection and future planning are introduced, will be less effective or ineffective.

[INSERT TABLE 3]

[INSERT FIGURE 1]

Theme 1–Processes and Parallel Processes

Participants discussed various problematic processes, which precipitated referrals for team formulation meetings. These could include: a team divide; strong emotional responses such as anxieties, anger, feeling stuck and frustrated; and having a difficult relationship with the service user. These processes were either causing, perpetuating or exacerbating difficulties in the TR and the treatment pathway and presented reasons for referral for team formulation. They all appeared to impact on the functionality of the team as a cohesive unit. This is represented in stage one of the process model.

1.1 Team functioning.

Difficulties in the functioning of the team as a cohesive unit were represented across participants' accounts; they would commonly be a precipitant to referral for team formulation and could be manifested in different ways. Team divides were commonly evident and could

adversely impact on the functionality of the team, contributing to inconsistencies in understanding a service user's needs and the most appropriate treatment approach:

> It was quite important to have the formulation meeting because there was quite a divide in the MDT and quite, two opposite ways of working really, half the team…so if you were looking at it on the see saw, half the team were really on the kind of controlling side, other half were on the really relaxed, kind of, unboundaried side (P1).

As highlighted above, team divides could often be centred around control and boundaries and the subsequent impact this had upon care pathway planning "because it was if the individual should go back to prison or not and it was a lot of kind of people thinking they should, real team split" (P10). In these circumstances, people would hold "very strong opinions" (P3) of a service user. These strongly held opinions contributed to and exacerbated team divides and could be associated with strong emotional responses, including feeling stuck and frustrated:

> It was quite emotional for the staff because they were very much like, 'we feel like we can't do anything, what can you do?' and then the other team were seeing how difficult she was and then potentially a little bit like 'ohh is this going to be right for her?' So there was…yeah, it felt like people had very strong opinions of her. (P3).

Another significant area impacting team functioning prior to referrals was a perceived lack of understanding of the service user:

> We felt like the meeting was needed when he came to us so that we could understand him better. In order to be able to move him forward. he kind of difficulty is cos he's not very open, the chap, and none of the team felt like they knew him (P2).

1.2 – Parallel processes within the meeting.

These problematic processes were then paralleled within the team formulation meeting, with staff teams bringing their opinions and emotional responses into the room, seemingly as a form of counter-transference:

> I: So those processes that were occurring on the ward, or within and between the team, on the run up to that intervention, they come into the room as well do they?
>
> P7: Yeah well they can do, often, I think people kind of, people will try and leave them outside the room when they come in. But for some that's quite, it's quite, I think, my experience has been that for some people, who come perhaps from the paternal perspective, it's actually quite a raw, kind of experience, so they don't hide it, they bring it in and they'll talk about it (P7).

Thus, processes precipitating referrals would then be apparent within the meeting itself. For example, if difficulties in engagement and how to understand and work with a service user had been a precipitant to referral, this would be evident within the team formulation meeting itself, and would form a part of the dynamic within the room, hence forming a parallel process:

> So we all shared, about this particular patient, very little, because this patient doesn't open up and talk to anybody on the ward. What our experiences were was quite negative really because this person doesn't engage with any of the nursing intervention…so the room was a real negative vibe, when staff started to either share they know very little so can't offer, or they do know, a little bit, but it was framed in a negative light (P9).

These parallel processes could also extend to the physical space, with some participants describing a physical divide within the room, according to the divisions amongst the team:

> I felt like I was sitting there in the middle and it was like a tennis match. It just so happened that they had naturally divided onto their own sides. And it was quite heated at the start but, worked through it, and it became a very helpful meeting, yeah (P1).

This highlights these parallel processes could be an opportunity for the team to move towards a more shared consensus. However, first, the team must experience sufficient safety and opportunities to name their experiences, and to feel listened to and validated:

> [The facilitator] found it very interesting to see our perspective on this patient because

> he doesn't necessarily see the anti-social side, doesn't see the security subversion side of him. He sort of sees the yes man, pleaser, wanting to answer the questions and things like that so it was almost a learning curve for him as well, being able to understand our frustrations and how we perceive the patient, but also he put forward his experiences of contact with him, which was very, very interesting to see the different ways of, that he interacts with different people (P12).

Theme 2 – Mechanisms for Change

2.1 - Common factors.

For team formulation meetings to move beyond the problematic processes precipitating referral, staff teams needed to feel safe, valued and validated, and they needed a space in which their opinions, emotions and counter-transference could be expressed, named and heard:

> Sometimes it's just nice to be able to say how a patient's making you feel, and that it won't be taken in an unprofessional manner, so you can quite openly say, this annoys me and this frustrates me, and this is the reason why, is there anything that we can do differently to help us to change the way we're feeling and help the patient in the same respect. So yeah, it's sort of bouncing ideas off people, getting some feedback on different ways of doing it, self-reflection, helping other people reflect (P12).

If the facilitator could foster this safe environment, team formulation meetings could become a space where exploration and developing understanding could occur:

> Quite a good place to be sort of, safe, a safe uncertainty, like people were sort of saying, well, I'm thinking this but I don't really know because I've only had it a couple of times, I think we need to investigate that a little bit more, so it's quite good to sort of air all of that out and then have a bunch of actions that are gonna come out of it (P8).

Facilitators had an important role for managing these processes within the room, and

supporting the team to feel safe enough to explore their feelings and reactions:

> The person that facilitates it really kind of sets the tone, if you feel comfortable enough to share things. And even just by him saying, 'look, what do you as a team want out of this meeting?' was really, really helpful, and it evoked thought. (P10).

When this safety, containment and validation were not experienced, it was viewed as something that limited the success of the intervention and could therefore inhibit progression through the stages of the model presented above. This is explored further in theme three.

2.2 – Application of a model- the introduction of psychological understanding.

If adequate safety was established, psychological models and constructs could then be used to structure exploration and development of understanding. Various constructs were used in participants' accounts, including schema focussed, Hamilton's (2010) boundary seesaw, cognitive behavioural and cognitive neurorehabilitation. If the psychological model or construct captured and reflected the difficulties experienced by the team and helped them to make sense of the presenting difficulties, it was more likely to support improvements or changes in how the team understood and worked with the individual:

> It was a good explanation of the formulation, a good way of conceptualising their particular difficulties and, so I thought it was useful, I'm not that familiar with schema therapy. From what I've seen explained, it did sort of resonate, I did feel I could understand, what he was saying was going into this mode and that mode, it sort of made sense (P11).

These frameworks could therefore offer some structure and containment to the interventions, and provided a framework within which to psychologically formulate the service user's experiences:

> [It was] quite useful in explaining, what the schema was and what it meant to the patient, and how he formed his ideas and how he sees himself, and all the different sort of modes

> that he would go into. So that was very useful because obviously you could see the fight or flight, and the child and the different aspects that, depending on how he was approached and what was going on on the ward and how the environment was, so it was, he sort of gave us a very basic understanding of what it was and sort of put it into a diagram form, which was easy to sort of point out, through his behaviours (P12).

Conversely, if the psychological model or construct was not able to adequately conceptualise the difficulties experienced by the team precipitating referral, it could limit the perceived effectiveness of the team formulation intervention. Again, this is explored in theme three.

2.3 – Integration, new insights and planning.

When a safe environment was fostered and psychological thinking could adequately conceptualise the difficulties staff were experiencing, there were opportunities for team formulation to be a mechanism for change. This could occur in various ways, such as changing views and perspectives, introducing shared aims, finding a middle ground and recognition of the problematic processes precipitating referral:

> There's still ongoing difficulties but there's a much more consistent way of working and I think it gave the whole MDT insight into how they were working. They thought, so both sides kind of thought they were being helpful. 'No let's be more firm, let's be more controlling and kind of punishing and he'll miraculously be fine' kind of thing, and the other side thinking, 'no let's be really relaxed, let's let him do whatever'. And I think it kind of opened both sides eyes to that, actually 'yeah, we're not, both our ways aren't great and aren't helping this guy, so we need to kind of meet in the middle, be more consistent' (P1).

When sufficient space and opportunity was available for team discussion and exploration, the team were able to voice their differing perspectives and move towards a shared

understanding, which integrated these perspectives and moved towards this middle ground:

> I think everyone came up with something that maybe another person didn't think about, or came up with a different sort of theory for things, so, I think it, for me anyway, it was good to think in a different way because sometimes, if you get something in your head, like I find that I'll just go with that one but, to find out other perspectives makes it, I don't know, I found, that's what I found anyway (P4).

Again, the psychologist's role was to facilitate this exploration, and it was important for them to integrate the views of different team members, create a sense of safety and introduce a framework for psychological understanding. This enabled staff to reflect on some of the processes that were occurring, and move towards planning different ways of working, which were psychologically informed and based on a shared understanding:

> It was really quite useful to see him, like how he presents, broken up into all these different areas, to be able to relate how he's reacting to us in one of those sort of boxes. So it was, the visual aspect was very, very, very useful and it just sort of helped us with the understanding of why he acts how he does and how we can maybe tailor our questions and the way we approach him differently to how he may be responding to us (P12).

This shared understanding could be integrated into care planning, which would identify new ways of working based on the shared understanding, "So when we had the formulation meetings there were things that came out that we'd not thought about…so once we'd looked at all those areas, and put a plan in action, there was an improvement in him" (P5).

Theme 3 – Factors Inhibiting Success

Various factors could inhibit the effectiveness of the intervention at each stage of the process. Some of these have been briefly highlighted in previous themes, however, this theme aims to discuss these inhibiting factors in further detail.

3.1 – Remaining stuck.

For teams to be receptive to introducing psychological understanding, considering different perspectives and contemplating different ways of working, their concerns, anxieties, viewpoints and responses must be heard, validated and valued. When this did not occur, it would limit the perceived helpfulness of the intervention, and could mean key elements, such as formulation and reflection did not receive sufficient attention:

> We heard a bit of a summary of historical, information and then the team leader gave us a current presentation. And then, it sort of led on to 'what do we do' basically, so it turned into a lot more of, I'm speaking in my own opinion, but it was more of a problem solve than it was a reflection (P3).

This highlights the importance of the exploration of viewpoints and if a sense of safety and containment was not achieved, staff would find the subsequent steps either more difficult, less effective or absent:

> She probably did manage the situation quite well, but she wasn't given the chance to kind of explain or to, you know, explain her reasons to why that happened or what her understanding is of how that happened. And I think stuff like that can then create issues where people don't want to talk about anything and people are almost too scared to then say, you know, if they're unsure about something because if they think people are gonna shut them down and give them a blaming response it kind of creates a culture then I think of secrecy (P6).

Each of these examples included anxiety as a precipitant to referral and reflected a parallel process within the meeting whereby staff were acting in a way that was "anxiety driven" (P6) or were "[trying to] take away the staff anxiety" (P3). This inhibited the effectiveness of the intervention by limiting the extent to which staff were able to explore their experiences and the application of psychological understanding.

Another factor that could inhibit the effectiveness of the team formulation was an absence of a psychological model or if the framework did not sufficiently conceptualise the difficulties the team were experiencing prior to referral:

> There's not a sort of section for like, you know, psychological opinion, or the history for instance. I'd be wanting to think, if I could sort of change that, I'd perhaps be wanting to have a section at the beginning where we go over somebody's life experiences and history and sort of bring that into our thinking (P8).

If staff were not able to progress through these stages of the model, they could be left feeling that the formulation meeting was unfinished, and were more likely to experience ongoing difficulties in line with the initial problematic processes discussed in theme 1:

> It was difficult, I think it did go round in circles a little bit and it did, I know it went over the time that was allocated as well, so it felt like quite a long meeting. And it felt like, almost, we just had so many more questions than we did answers, and I think the more people that were contributing their own hypotheses, the more confusing it got and then the more we all just realised, actually we don't know that much and we need to do a little bit more work here (P6).

3.2 – System factors.

Various factors associated with the system of working within an inpatient FMH service could also present inhibiting factors for the success of the team formulation. A combination of hierarchy, shift patterns and competing demands made it difficult for nursing and support staff to attend and have their voices heard:

> It's a shame because I think sometimes support workers don't always get involved and they're probably working more day-to-day with service users. So they're probably missing out on a lot of the historical information and its function and everything. So yeah, we probably missed out on quite a bit of useful information there [laughs] even

just being able to pass it on to the nursing team as well (P4).

This could contribute to an ongoing team divide, even if the team formulation meeting itself had apparently been successful in developing a shared understanding, as those who were not present in the meeting were not able to benefit in the same way:

> You've engaged people in a formulation and a discussion and you kind of feel that you've got a bit of an idea about how we're now going to work, then you walk back on the ward and the people who didn't attend, who have that paternalistic view, are on shift, and you find out that the service user's now moved (P7).

Dissemination of information was not perceived as being sufficiently effective for team members that were not involved in the formulation meeting, with participants highlighting an added value for attending the meeting, as opposed to receiving minutes or a report, "If I'm reading something, then it goes in but if somebody's asking me questions alongside when I'm reading it, it kind of evokes thoughts into little bits of other things that I don't think I would've necessarily thought about" (P10).

Participants highlighted that these limitations could impact on the success of the intervention and might contribute to a perpetuation or a re-emergence of the problematic processes that precipitated referrals, "I wouldn't be surprised if that anxiety emerged again. And if another formulation meeting was requested, given that there was quite a few people that couldn't attend the first one" (P8).

Discussion

This study aimed to illuminate common processes involved in team formulation in inpatient FMH services, addressing a gap in the literature. A growing body of research has opened discourse regarding approaches to team formulation interventions and some of the common factors involved. However, as highlighted in the introduction, a common difficulty for practitioners working in FMH services is a limited evidence base, with interventions

generally being based on research from general mental health, rather than forensic settings (McInnes & Masino, 2019). The current study therefore builds on previous research into team formulation, whilst introducing a forensic perspective.

The four typologies outlined by Geach et al. (2019) separated team formulations based on function, facilitation approach, features of the intervention, target of change and reported outcomes. Alongside this, Geach et al. (2019) outlined several common factors across these approaches and how these factors can support or obstruct the intervention. Rather than presenting typologies and common factors separately, the current study presents a staged model for team formulation intervention, which integrates common factors involved across different approaches. In doing so, it outlines commonly experienced processes involved across team formulation interventions and illustrates how they are linked together. The proposed model therefore provides practitioners with a framework, which includes important factors to consider when supporting a team through a team formulation intervention. Its integrative nature enables facilitators to adapt their theoretical framework based upon the needs of the referring team.

Many factors discussed by Geach et al. (2019) are represented in the model presented in the current paper. For example, Geach et al. (2019) discuss concepts such as “shared understanding”, which can be supported by contextualising and explaining the service user’s difficulties, or obstructed if context is not considered or the team is unwilling or unable to consider different perspectives. The current study also outlines how exploration of the service user’s needs could support the development of shared psychological understanding. However, by contextualising these factors within a process model, the current study can guide facilitators in a way that recognises the importance of attending to different factors, and the stage at which they might require this attention. For example, a staff team might not be able or willing to develop a shared understanding if earlier stages of the model have not been attended to first, such as difficult experiences not being validated. This can therefore highlight why Geach et al.

(2019) identified that certain obstructions might be found, as there may be other factors that require resolution earlier in the intervention.

The proposed model relates to other theories of change in psychological intervention. For example, the common factors outlined in stage three of the model are consistent with therapeutic alliance and common factor theories discussed by Bordin (1979), Norcross and Wampold (2011), Wampold (2015) and Ackerman and Hilensroth (2003). The therapeutic alliance is an important factor supporting change across psychotherapeutic models (Ackerman & Hilensroth, 2003) and involves agreement on the goals and tasks of therapy and "the development of bonds" (Bordin, 1979, p. 253). Strong and successful therapeutic alliances are contingent upon the therapist being able to explore experiences in depth, be supportive and affirming, attend to the experience of the service user and facilitate the expression of emotion (Ackerman & Hilensroth, 2003). Agreement about the goals and tasks of therapy, positive regard and collaboration are also widely cited as important common factors for the therapeutic alliance (Bordin, 1979; Wampold, 2015; Norcross & Wampold, 2011). In team formulation interventions, the referring team effectively become the primary client (DCP, 2011; Johnstone, 2018) and therefore facilitators must be able to display these skills and foster a therapeutic alliance between themselves and the team. The proposed model gives consideration to these processes, with stages two and three representing opportunities for alliance building and an important time for the facilitator to develop group cohesion, convey empathy and manage counter-transference, all common factors outlined by Norcross and Wampold (2011).

Therapeutic alliance alone is insufficient for supporting change and needs to be supported by a coherent structure or therapeutic framework, which provides sufficient explanation for the difficulties and further mechanisms for change (Wampold, 2015). This is where stage four – the application of a model, structure or framework – can support. As highlighted by Livesley (2007, 2012), no single theoretical model can support treatment

attempts for the diversity of needs often presented by service users in forensic populations. This therefore calls for an eclectic approach, which is tailored to the specific needs of the referral (Livesley, 2007) and fits in line with the aims of this research, which are not to find a unified model for clinicians to dogmatically stick to, but to develop a better understanding of the key factors involved in team formulation interventions. It is therefore argued that the team formulation process model provides a framework that practitioners can then use, applying an integrative approach that is able to draw upon different theoretical modalities to meet the specific needs of the referring team.

Livesley (2007) presents a stages of change model, which is based within the six-stage change process (precontemplation, contemplation, preparation, action, maintenance, and termination) outlined by Prochaska and DiClemente (1983). Livesley's (2007) model explains stages of change within four steps: 1) problem recognition; 2) problem exploration; 3) identification of alternative behaviours; and 4) consolidation and generalisation. In Livesley's (2007) model, as in the team formulation process model proposed in the current study, each step must occur in order. It is argued that the team formulation model presented in the current study includes similar processes, with problem recognition being a precipitant to referral, problem exploration occurring within stages two and three, and the identification of alternative behaviours occurring within stages five and six. One of the factors limiting the success in the accounts explored in the current study appeared to occur following the formulation meeting itself, where dissemination, application and generalisation were ineffective or did not occur. This has not been considered in detail, partly due to the aims to move away from outcomes, and could represent a possible direction for future research and clinical implications for how these interventions can be accessible across the whole team and how changes following team formulation meetings could be better maintained.

Working in FMH services can present practitioners with intense emotional experiences, which understandably can be met with psychological defences (Lauvrud et al., 2009; Mason, Lovell & Coyle, 2008; Way et al., 2007). It is difficult for these unconscious processes and emotional responses to be monitored, particularly though informal day-to-day practices (Aiyegbusi, 2009). These unconscious processes, emotional responses and defences may be present in the problematic processes precipitating referral and in parallel processes in team formulation interventions. Team formulation can therefore play a role in bringing these processes and responses into the consciousness, through recognising, naming, discussing, conceptualising and making sense of them, as outlined within stages three, four and five of the model and within the mechanisms for change theme. This process of bringing the unconscious into the conscious is an aim of Hamilton's (2010) see-saw model, which was discussed as an example in participants' accounts.

Strengths, Limitations and Avenues for Future Research

Inpatient services are busy environments, and staff availability can be unpredictable. The study design enabled flexibility around recruiting and interviewing participants to account for some of these difficulties, such as enabling interviews to occur on the ward and in the work place of participants. This enabled recruitment to include various disciplines, with representation from psychology, nursing, occupational therapy and psychiatry. However, the study failed to recruit health care support workers or occupational therapy assistants. People in these roles spend the most time with service users (Aiyegbusi, 2009) and could have valuable contributions to research in these settings. Whilst this highlights an unrepresented occupation in the research, it also reflects wider systemic difficulties highlighted within the results, whereby these occupations are also under-represented in MDT meetings, including team formulation meetings.

A limitation of the study is that by only conducting retrospective interviews it was not possible to gain insights into how staff experienced and conceptualised the difficulties prior to team formulation interventions and it is possible that processes within the meeting enabled conscious processing and subsequent articulation of these experiences that might not have been articulated prior to the intervention. Furthermore, if processes remained unconscious, staff may not have been able to consciously identify them and articulate them in the research interviews. The research design could have been improved by including interviews from before the team formulation interventions, alongside observational studies of team formulation meetings so the researcher could observe these processes first hand.

This project is taken from a single site and therefore generalising and transferring findings beyond this context should be done with caution. However, further research should be conducted to further develop the proposed model and consider application in other contexts where teams may experience similar difficulties precipitating team formulation referrals.

As outlined in the introduction, several positive outcomes have been identified for team formulation interventions in various settings. However, little research has been undertaken in FMH services and generalisability of findings from general mental health to FMH settings should not be assumed (Barnao & Ward, 2015; MacInnes & Masimo, 2019). Future research could therefore consider the outcomes of team formulation interventions in FMH services, perhaps comparing experiences and outcomes where the proposed model has been used with interventions where it has not.

Clinical Implications

The model presented provides a framework for practitioners to bear in mind whilst facilitating team formulation interventions. It outlines stages to consider when supporting a team through a change process and may help to identify mechanisms by which a team may be able to progress and reasons why they may become stuck, unable or unwilling to change. For

example, factors precipitating referral were often re-enacted within the meeting itself. This highlights an area where facilitators may be able to prepare for team formulation meetings by developing an awareness of, and a sensitivity to, the difficulties precipitating referral. Facilitators can then expect these processes to be paralleled in the room, so creating sufficient safety for these processes to be named and explored is likely to be necessary for progression through the change process.

As previously highlighted, the model proposes several factors that could inhibit success, some of which are structural and procedural. Awareness of these potential barriers and practical solutions for overcoming them could support the success of their intervention.

Conclusion

The themes and corresponding team formulation process model presented here provides a framework for practitioners when facilitating team formulation interventions in FMH services. It outlines key processes and challenges that a practitioner should be aware of when facilitating team formulation interventions in this setting. It is argued the process model provides facilitators with a framework for guiding these interventions through the necessary stages and may provide insight into why a team may become stuck at various stages throughout a team formulation intervention. The model is not stringent or ‘one size fits all’; it provides a framework for practitioners to tailor their intervention according to the needs of the referral and relevant theoretical modalities. Future research comparing outcomes for when this model is used for team formulation interventions in FMH settings would be advantageous.

References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical psychology review*, *23*(1), 1-33. Doi:10.1016/S0272-7358(02)00146-0

Aiyegbusi, A. (2009). The Nurse-Patient Relationship with Offenders: Containing the Unthinkable to Promote Recovery. In A. Aiyegbusi, & J. Clarke-Moore (Eds.), *TRs with Offenders: An Introduction into the Psychodynamics of Forensic Mental Health Nursing.* (pp. 15-32). London, UK: Jessica Kingsley Publishers.

Anderson, C., & Kirkpatrick, S. (2016). Narrative Interviewing. *International Journal of Clinical Pharmacy*, *38*(3), 631–634. Doi: 10.1007/s11096-015-0222-0

Barnao, M., & Ward, T. (2015). Sailing uncharted seas without a compass: a review of interventions in forensic mental health. *Aggression and Violent Behavior*, *22*, 77-86. Doi: 10.1016/j.avb.2015.04.009

Berry, K., Haddock, G., Kellett, S., Awenat, Y., Szpak, K., & Barrowclough, C. (2017). Understanding Outcomes in a Randomized Controlled Trial of a Ward-based Intervention on Psychiatric Inpatient Wards: A Qualitative Analysis of Staff and Patient Experiences. *Journal of Clinical Psychology*, *73*(10), 1211-1225. Doi: 10.1002/jclp.22434

Berry, K., Barrowclough, C., & Wearden, A. (2009). A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural and Cognitive Psychotherapy*, *37*(1), 39-48. Doi: 10.1017/S1352465808005018

Bordin, E. S. (1979). The Generalizability of the Psychoanalytic Concept of the Working Alliance. *Psychotherapy: Theory, Research and Practice, 16*(3), 252-260. Doi: 10.1037/h0085885

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. Doi:10.1191/1478088706qp063oa

British Psychological Society (2019). *Standards for the accreditation of doctoral programmes in clinical psychology.* Leicester: British Psychological Society. Retrieved from: https://www.bps.org.uk/sites/bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%202019.pdf

Carradice, A. (2004). Applying cognitive analytic therapy to guide indirect working. *Reformulation, 23*, 18-23.

Carradice, A. (2013). 'Five-Session CAT'Consultancy: Using CAT to Guide Care Planning with People Diagnosed with Personality Disorder within Community Mental Health Teams. *Clinical psychology & psychotherapy*, *20*(4), 359-367. Doi: 10.1002/cpp.1812

Christofides, S., Johnstone, L., & Musa, M. (2012). 'Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research and Practice*, *85*(4), 424-435. Doi: 10.1111/j.2044-8341.2011.02041.x

Clarke, I. (2015). The Emotion Focused Formulation approach: Bridging individual and team formulation. *Clinical Psychology Forum, 275,* 28-33.

Clarke, M., Fardouly, P., & McMurran, M. (2013). A survey of how clinicians in forensic personality disorder services engage their service users in treatment. *The journal of forensic psychiatry & psychology*, *24*(6), 772-787. Doi: 10.1080/14789949.2013.862292

Davenport, S. (2002). Acute wards: problems and solutions. *Psychiatric Bulletin, 26*, 385-388.

Davies, J., Black, S., Bentley, N., & Nagi, C. (2013). Forensic case formulation: Theoretical, ethical and practical issues. *Criminal Behaviour and Mental Health*, *23*(4), 304-314. Doi: 10.1002/cbm.1882

Day, A. (2017). Reporting Case Formulation and Opinion. In S. Brown, E. Bowen, & D. Prescott (Eds.), *The Forensic Psychologist's Report Writing Guide.* (pp. 56-65). Oxon, UK: Routledge.

Division of Clinical Psychology (2010). *The core purpose and philosophy of the profession.* Leicester: British Psychological Society.

Division of Clinical Psychology (2011). *Good practice guidelines on the use of psychological formulation.* Leicester: British Psychological Society.

Doyle, M., Coid, J., Archer-Power, L., Dewa, L., Hunter-Didrichsen, A., Stevenson, R., ... & Shaw, J. (2014). Discharges to prison from medium secure psychiatric units in England and Wales. *The British Journal of Psychiatry, 205*(3), 177-182. Doi:10.1192/bjp.bp.113.136622

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics, 5*(1), 1-4. Doi: 10.11648/j.ajtas.20160501.11

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health, 25*(10), 1229-1245. Doi: 10.1080/08870440903194015

Geach, N., De Boos, D., & Moghaddam, N. (2019). Team formulation in practice: forms, functions, and facilitators. *Mental Health Review Journal, 24*(3), 145-159. Doi: 10.1108/MHRJ-01-2019-0002

Geach, N., Moghaddam, N. G., & De Boos, D. (2018). A systematic review of team formulation in clinical psychology practice: Definition, implementation, and outcomes. *Psychology and Psychotherapy: Theory, Research and Practice, 91,* 1-30. Doi: 10.1111/papt.12155

Gorski, P. S. (2013). What is critical realism? And why should you care? *Contemporary Sociology, 42*(5), 658–670. Doi: 10.1177/0094306113499533

Hamilton, L. (2010). The boundary seesaw model: good fences make for good neighbours. In A. Tennant & K. Howells (Eds.), *Using time, not doing time: practitioner perspectives on personality disorder and risk* (pp. 181–194). Chichester, UK: Wiley.

Hart, S., Sturmey, P., Logan, C., & McMurran, M. (2011). Forensic Case Formulation. *International Journal of Forensic Mental Health, 10*(2), 118-126. Doi: 10.1080/14999013.2011.577137

Health and Care Professions Council. (2015). *Standards of proficiency: Practitioner psychologists.* London: HCPC. Retrieved from: https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-proficiency---practitioner-psychologists.pdf

Ingham, B. (2011). Collaborative psychosocial case formulation development workshops: a case study with direct care staff. *Advances in Mental Health and Intellectual Disabilities, 5*(2), 9-15. Doi: 10.5042/amhid.2011.0107

Joint Commissioning Panel for Mental Health. (2013). *Guidance for commissioners of forensic mental health services: Practical Mental Health Commissioning*. London: Raffertys. Retrieved from: https://www.jcpmh.info/wp-content/uploads/jcpmh-forensic-guide.pdf

Johnstone, L. (2014). Using Formulation in Teams. In L. Johnstone, & R. Dallos (Eds.), *Formulation in Psychology and Psychotherapy* (2nd Ed.). (pp. 216-242). London, UK: Routledge.

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology, 58*(1), 30-46. Doi: 10.1177/0022167817722230

Johnstone, L. & Dallos, R. (2014). Introduction to Formulation. In L. Johnstone, & R. Dallos (Eds.), *Formulation in Psychology and Psychotherapy* (2nd Ed.). (pp. 1-17). London, UK: Routledge.

Kellett, S., Wilbram, M., Davis, C., & Hardy, G. (2014). Team consultancy using cognitive analytic therapy: A controlled study in assertive outreach. *Journal of psychiatric and mental health nursing, 21*(8), 687-697. Doi: 10.1111/jpm.12123

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

Kennedy, H. G. (2002). Therapeutic uses of security: mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment, 8*(6), 433–443. Doi: 10.1192/apt.8.6.433.

Kennedy, F., Smalley, M., & Harris, T. (2003). Clinical psychology for in-patient settings: Principles for development and practice. *Clinical Psychology Forum, 30*, 21–24.

Knauer, V., Walker, J., & Roberts, A. (2017). Offender personality disorder pathway: the impact of case consultation and formulation with probation staff. *The Journal of Forensic Psychiatry & Psychology*, *28*(6), 825-840. Doi: 10.1080/14789949.2017.1331370

Lake, N (2008) Developing skills in consultation 2: a team formulation approach. *Clinical Psychology Forum*, *186*, 18-24.

Lauvrud, C., Nonstad, K., & Palmstierna, T. (2009). Occurrence of post traumatic stress symptoms and their relationship to professional quality of life (ProQoL) in nursing staff at a forensic psychiatric security unit: a cross-sectional study. *Health and Quality of Life Outcomes*, *7*(31), 1-6. Doi:10.1186/1477-7525-7-31

Livesley, W. J. (2007). A framework for integrating dimensional and categorical classifications of personality disorder. *Journal of personality disorders, 21*(2), 199-224. Doi: 10.1521/pedi.2007.21.2.199

Livesley, W. J. (2012). Integrated treatment: A conceptual framework for an evidence-based approach to the treatment of personality disorder. *Journal of personality disorders, 26*(1), 17-42. Doi: 10.1521/pedi.2012.26.1.17

MacInnes, D., & Masino, S. (2019). Psychological and psychosocial interventions offered to forensic mental health inpatients: a systematic review. *British Medical Journal Open, 9*, 1-16. Doi: 10.1136/bmjopen-2018-024351

McMurran, M., Khalifa, N., & Gibbon, S. (2013). *Forensic mental health* (2nd Ed.). Oxon, UK: Routledge.

Newman-Taylor, K., & Sambrook, S. (2012). CBT for Culture Change: Formulating Teams to Improve Patient Care. *Behavioural and Cognitive Psychotherapy, 40*(4), 496–503. Doi: 10.1017/S1352465812000069

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy, 48*(1), 98-102. Doi: 10.1037/a0022161

Onyett, S. (2007). *New ways of working for applied psychologists in health and social care: Working psychologically in teams.* Leicester: British Psychological Society.

Prochaska, J., & DiClemente, C. (1983). Stages and processes of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390-395.

Royal College of Psychiatrists. (2018). *Safe patients and high-quality services: Job descriptions for consultant psychiatrists.* Retrieved from:

https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr207.pdf?sfvrsn=b2229b95_2

Rushbridge, S., Tooze, O., Griffith, E., & Wilkinson-Tough, M. (2018). Clinical psychologists' perceptions of barriers and facilitators to engaging service users in index offence assessment and formulation within a medium secure unit. *The Journal of Forensic Psychiatry & Psychology*, *29*(1), 106-123. Doi: 10.1080/14789949.2017.1347803

Skinner, P., & Toogood, R. (2010). *Clinical Psychology Leadership Development Framework.* Leicester: British Psychological Society.

Summers, A. (2006). Psychological formulations in psychiatric care: staff views on their impact. *Psychiatric Bulletin*, *30*, 341-343. Doi: 10.1192/pb.30.9.341

Tarran-Jones, A., Summers, S. J., Dexter-Smith, S., & Craven-Staines, S. (2019). Team psychological formulation to create a shared understanding of distress: a qualitative study in an older people's mental health inpatient setting. *Quality in Ageing and Older Adults*, *20*(2), 67-79. Doi: 10.1108/QAOA-11-2018-0056

Taylor, J. (2017). Compassion focussed working in secure forensic care. *Journal of Criminological Research, Policy and Practice*, *3*(4), 287-293. Doi: 10.1108/JCRPP-04-2017-0016

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270-277. Doi:10.1002/wps.20238

Ward, T. (2013). Addressing the dual relationship problem in forensic and correctional practice. *Aggression and Violent Behavior*, *18*(1), 92-100. Doi: 10.1016/j.avb.2012.10.006

Way, I., Van Deusen, K., & Cottrell, T. (2007). Vicarious trauma: Predictors of clinicians' disrupted cognitions about self-esteem and self-intimacy. *Journal of Child Sexual Abuse*, *16*(4), 81-98. Doi: 10.1300/J070v16n04_05

Whitton, C., Small, M., Lyon, H., Barker, L., & Akiboh, M. (2016). The impact of case formulation meetings for teams. *Advances in Mental Health and Intellectual Disabilities*, *10*(2), 145-157. Doi: 10.1108/AMHID-09-2015-0044

Wood, C. P., Giles, D., & Percy, C. (2009). *Your psychology project handbook: Becoming a researcher*. Essex, UK: Pearson Education.

Tables and Figures

Table 1. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Involvement in team formulation meetings or process in the past 12 months in forensic inpatient services	No involvement with team formulation in the past 12 months
Staff from any discipline working in forensic inpatient services	No involvement in teams where team formulations have occurred within a forensic environment
Had involvement in the care of the service user around whom the team formulation was held	

Table 2. Participant Demographics

Participants	Role
Total - 12	Psychology Related Discipline – 6 (3 qualified, 3 un-qualified)
(Female 9, Male 3)	Psychiatry Related Discipline 3 (1 qualified, 2 un-qualified)
Mean age – 33.42	Nursing Staff – 1
	Occupational Therapy Staff - 2

*Two of the psychology staff reflected on team formulations they had facilitated

Table 3. Themes, sub-themes and corresponding section of process model.

Theme	Sub-theme	Corresponding Section of Process Model
1. Processes and Parallel Processes	1.1. Team Functioning	Stage 1. Problematic Processes and Reasons for Referral
	1.2. Parallel processes within the meeting	Stage 2. Parallel Processes
2. Mechanisms for Change	2.1. Common Factors	Stage 3. Common Factors/ Therapeutic Skills
	2.2.Application of a model – The introduction of psychological understanding	Stage 4. Model, Structure or Framework for Understanding
	2.3. Integration, new insights and planning	Stage 5. Integration and new Insights
		Stage 6. Planning
3. Factors Inhibiting Success	3.1. Remaining Stuck	Factors Inhibiting Success
	3.2. System Factors	

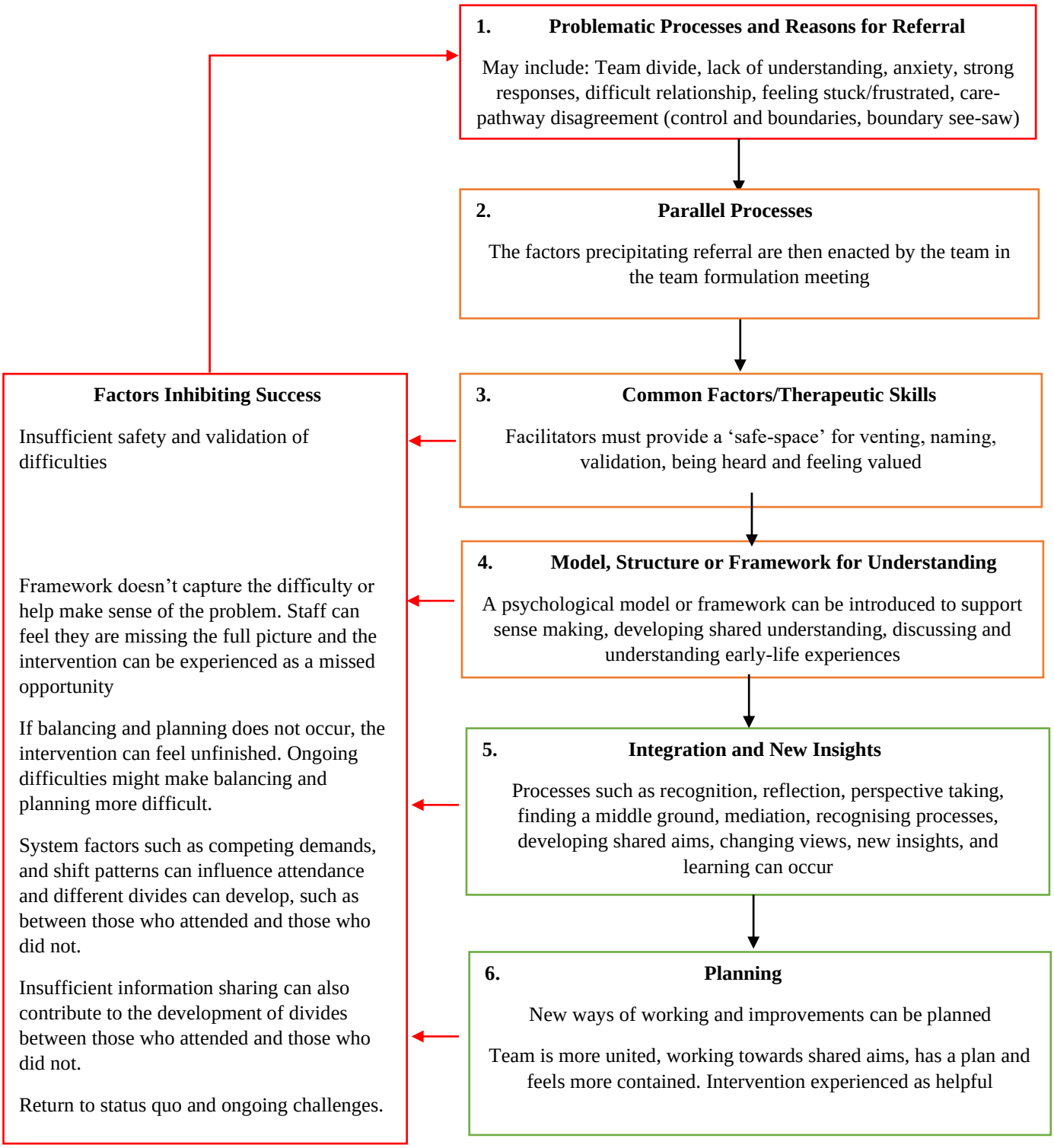

Figure 1. Team Formulation Process Model for Inpatient Forensic Mental Health Services

Appendix 2-A

Guidelines for Authors: Legal and Criminological Psychology

LCP AUTHOR GUIDELINES

Sections

1. Submission
2. Aims and Scope
3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations
6. Author Licensing
7. Publication Process After Acceptance
8. Post Publication
9. Editorial Office Contact Details

Chapter 1 1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://www.editorialmanager.com/lcp

Click here for more details on how to use Editorial Manager.

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

Chapter 2 2. AIMS AND SCOPE

Legal and Criminological Psychology publishes original papers which advance professional and scientific knowledge in the conjunction of legal psychology and criminological psychology. This field, constructed as ‘forensic psychology’, is defined broadly as the application of psychology to the understanding of offenders’ behaviour, the investigative and judiciary processes that bring them to justice, their treatment and the outcomes of their criminal actions. The topics covered include the causes of different types of crimes, psychopathy, criminal investigation, investigative interview and questioning, information eliciting, applied memory, deception detection, criminal profiling and crime linkage, professional training, legal and investigative decision making, expert testimonies, offender management, treatment and assessment, crime victimization, legal and public responses to crime. The journal aims to stimulate conversations and debates, to serve as a platform for communication amongst various

disciplines, academic researchers, professionals and practitioners, and to provide a compelling picture of current state-of-art research in the field.

The journal welcomes the submission of empirical and review articles, meta-analyses and target papers. For specific submission requirements, please view the Author Guidelines below. To be accepted for publication in Legal and Criminological Psychology, the paper has to make a substantive contribution to the field. The journal is interested in papers that provide theoretical advancement, extend existing theories, launch a new research line, or take a body of work in a new direction. Empirical studies are required to be methodologically sound and theoretically framed. Incremental contributions, or contributions devoid of a theoretical rationale, are less likely to get accepted.

Legal and Criminological Psychology is committed to open science and offers a registered reports track. Please view detailed guidelines here.

Chapter 3 3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

The word limit for papers submitted for consideration to Legal and Criminological Psychology is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, tables and figures. Appendices however are included in the word limit. In very exceptional cases, the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). The authors should contact the Editor first in such a case.

LCP frequently invites target articles that give readers access to the very latest in the field, particularly but not limited to new theoretical or methodological approaches. In those cases deemed appropriate, peer commentaries on these papers/reviews will be solicited from other researchers. These peer commentaries are published immediately after the target article, with the authors(s) of the article also on occasion being invited to write a response to the commentaries. If you believe that your article should be considered for the basis of an invited article, please select the 'Target Article' article type on submission and justify your decision in an accompanying cover letter.

All systematic reviews must be pre-registered. The pre-registered details should be given in the methods section but blinded for peer review (i.e., 'the review was preregistered at [BLINDED]'); the details can be added at proof stage.

Please refer to the separate guidelines for Registered Reports.

Chapter 4 4. PREPARING THE SUBMISSION

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

Cover Letters

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

Parts of the Manuscript

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

Title Page

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

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;

- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Acknowledgments.

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

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Please provide a structured abstract of up to 250 words with the following headings: Purpose, Methods, Results, Conclusions. Other types of papers (e.g., reviews) should include an abstract comprising one paragraph up to 250 words, with no headings.

Keywords

Please provide appropriate keywords.

Acknowledgments

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

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

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

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

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

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

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

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

Reference examples follow:

Journal article

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

Book

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

Internet Document

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

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

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

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

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

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

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

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General Style Points

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

- Language: Authors must avoid the use of sexist or any other discriminatory language.
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- Units of measurement: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
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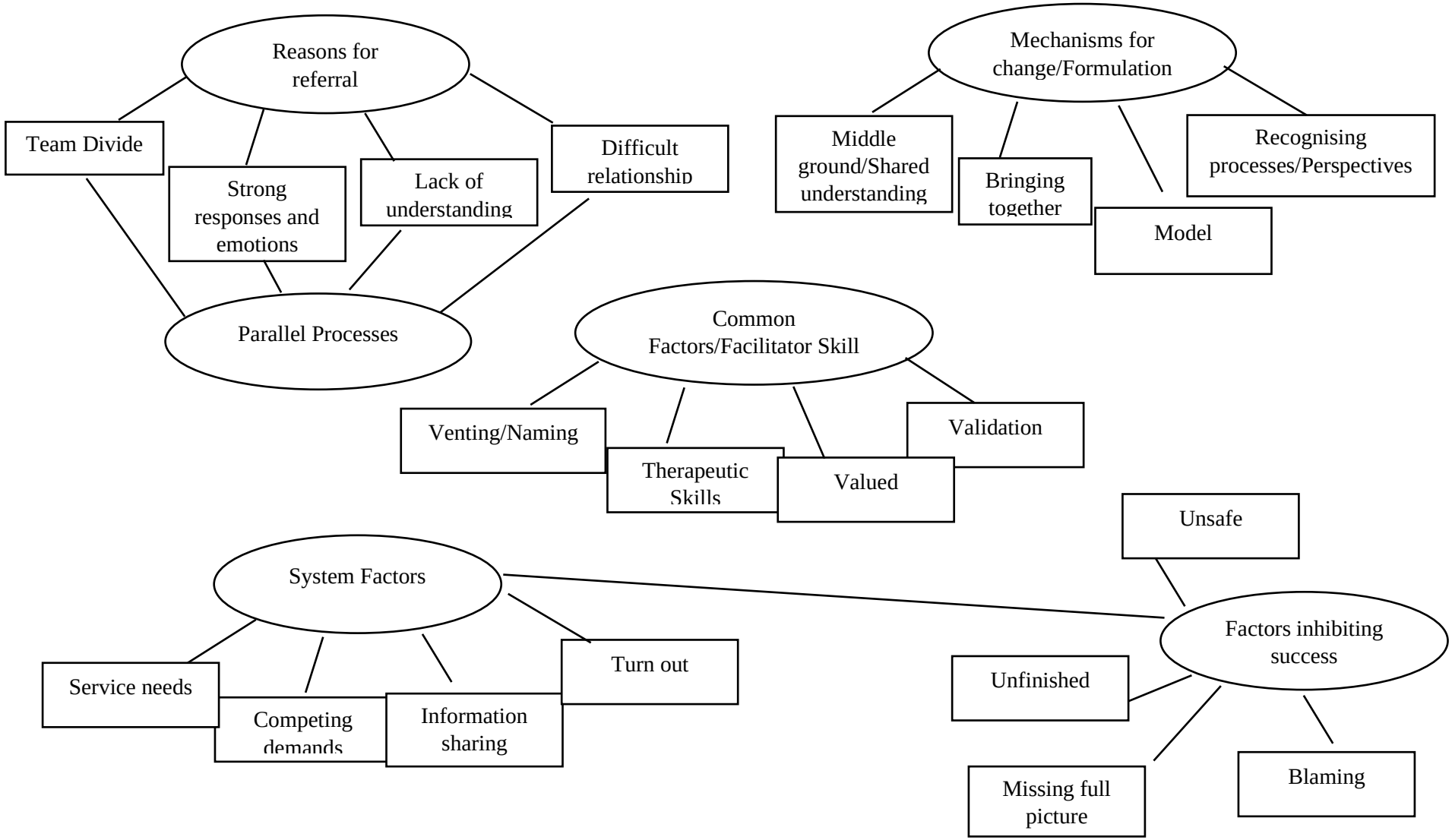
Also, check out our resources for Preparing Your Article for general guidance and the BPS Publish with Impact infographic for advice on optimizing your article for search engines.

Appendix 2-B

Thematic Map



Section Three – Critical Appraisal

Critical Reflections on research in forensic mental health services

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Critical Appraisal of Research in Forensic Mental Health Services

This critical appraisal will first provide an overview of the research, including how the topic area was conceptualised and reflections on the decisions and processes involved in developing and conducting the research. This summary will also provide an overview of the key findings from the research. Following this, links between the systematic literature review (SLR) and empirical paper will be explored. The third section of this paper will reflect on the research process, including: conducting research in forensic mental health (FMH) settings; ethical considerations; and the ethics of indirect working.

Research Summary

The topic area of this thesis was borne from personal interest in how psychology teams work with multi-disciplinary staff teams in challenging environments, such as FMH inpatient services. As mentioned in the SLR, this stems from personal experience working as a health care support worker in a medium secure FMH service. During this time, I experienced a disconnect between psychological services and work on the ward, with psychology sessions often appearing to occur directly between service users and a member of the psychology team. Little information from these sessions would be disseminated through the team, with 'formulations' being a seemingly very abstract concept and not representing a shared understanding across the team. As a result, my perception was that day-to-day practice was not informed by psychological formulations, and psychological intervention and formulation sat separate to daily practices. As my first experience of working in mental health services, I believed this was perhaps the norm, but found myself wanting more from the psychology team. Reflecting on this time, I believe that opportunities were missed for the team to work more effectively with the people they were supporting, using psychologically informed formulations to support more positive risk taking, and less reliance on coercive and controlling practices. Furthermore, in line with Division of Clinical Psychology [DCP] (2010), I believe more

systemic ways of working could have supported the staff team, who were working in a difficult and challenging service, to better support the service users with whom they were working.

This thesis therefore represented an opportunity for me to further explore some of these processes. Initial ideas included: 1) Consideration of the role of compassion amongst staff working in FMH; 2) Staff experiences of working with people who have offended and how they might reconcile possibly conflicting judgments and emotions; and 3) Staff experiences following incidents of violence. As I read more, and further developed the project, I linked these ideas with the body of research into common factors and therapeutic alliance in psychotherapies (Bordin, 1979; Wampold, 2015; Norcross & Wampold, 2011; Ackermann & Hillensroth, 2003); I had developed an interest in this during my clinical psychology training. The pervasive impact of these factors across models and approaches highlighted to me an important building block for any therapeutic interaction and represents an important pre-requisite for successful intervention (Livesley, 2007, 2012). The difficult and challenging environment of FMH services therefore represented an interesting area, where common factors and the therapeutic alliance must be navigated with a service user population who are not voluntarily seeking treatment and are mandated to reside in a hospital setting, where their treatment may also be subject to governmental oversight (Livingston, Nijdam-Jones, & Brink, 2012).

Systematic Literature Review

The SLR aimed to develop understanding of how staff navigate their dual-roles between managing risk of re-offending and providing therapeutic approaches to support service users mental health needs (Mason, Lovell & Coyle, 2008; Joint Commissioning Panel for Mental Health, 2013). The review therefore set out to answer the research question: “how do power, control and risk management influence staff experiences of the therapeutic relationship in forensic inpatient services?” A meta-ethnographic approach was selected to support the review

to answer this research question, using an interpretation of Noblit and Hare (1988). For this review, I elected to utilise further structured guidance from Atkins et al. (2008) and Britten, Campbell, Pope, Donovan, Morgan and Pill (2002). As a novice researcher who has not conducted a meta-ethnography before, utilising a more structured approach helped to guide rationale for decision making throughout and felt more containing when facing such a large and overwhelming research task.

Synthesis of first and second order themes enabled a line of argument synthesis, which included the following three third-order themes:

1) The Impact of Team Skill and Cohesion
2) Dialectic Between Care and Control
    a. Control as a (therapeutic) tool
    b. Vulnerable victim vs risky offender
3) Systems and Structures

The dialectic between care and control formed an important part of the experience of navigating therapeutic relationships in FMH services. This, in and of itself, is not surprising to see as a third-order theme in this systematic review, as inclusion criteria involved discussion of care and control. However, the content of this theme explored how staff experience this dialectic and how the relationship between caring and controlling interventions is navigated alongside the therapeutic relationship. Skilful and cohesive staff teams could go some way towards synthesising this dialectic, but there remained a dynamic balancing of the dual-roles of care and control. Staff perceptions of safety also appeared to impact the balancing of care and control, as they may be more inclined to use the inherent power they have within a FMH context by using coercive and controlling measures that establish a sense of safety and security (Gildberg, Elverdam & Hounsgaard, 2010). This highlighted a role of the system and structures inherent within the FMH context, which could be experienced as both containing, but also

restrictive and stifling. Results are discussed in relation to Hamilton's (2010) seesaw model, which highlights three roles that staff can occupy within FMH services. These roles (The Security Guard, The Negotiator, and The Pacifier) sit on a continuum of care and control, with extremes of each representing abusive and dangerous positions, and a middle ground (represented by the negotiator role) being an ideal, which balances the competing pulls from each extreme.

Empirical Paper

The empirical paper is an extension of my interest in how staff can be better supported by psychology teams in FMH services and is based upon the assertion that indirect working plays an important role for clinical psychologists when working with teams (DCP, 2011; Onyett, 2007). Formulating with teams can help understanding of interpersonal processes within teams and can contribute to improvements in care (Newman-Taylor & Sambrook, 2012) and communication (Skinner & Toogood, 2010). It also provides an opportunity for psychologists to support psychological thinking and planning at team and service levels (DCP, 2011; Johnstone, 2018).

The study aimed to consider the processes of team formulation in depth, specifically in a forensic inpatient setting and from a multi-disciplinary perspective. Specific information about the team and sample were not collected to better protect the anonymity of participants. This was an important consideration with a small sample of 12 participants from the same service and formed part of the ethical application for the project. This is also why the decision was taken to withhold clarity on participants' specific roles.

Recruitment was considered carefully in consultation with the field supervisor for this research. The difficult and busy nature of inpatient services was hypothesised to make staff availability limited and unpredictable, and other research in FMH settings has had difficulties with recruitment (MacInnes & Masino, 2019). Flexibility was therefore built into the

recruitment strategy. With these difficulties in mind, ethical approval was sought to recompense participants for their time and efforts with eligibility to receive a £15 Amazon gift voucher. I was pleasantly surprised by the uptake from participants across different disciplines at the research site and was able to recruit within a reasonable time frame. I believe the attention paid to the recruitment strategy supported successful recruitment. Two participants from psychological professions reflected on team formulation interventions in which they had been the facilitator. Including facilitators as participants introduces the possibility that their accounts could be tainted by their expectations of what team formulation interventions should involve, or how they would like them to be experienced. However, this enabled the study to fulfil aims around understanding the processes involved in team formulation interventions from multiple perspectives and therefore the experiences of the facilitators are also important and contribute to the processes involved in the intervention.

Data was analysed using Braun and Clarke's (2006) approach to Thematic Analysis (TA). Much consideration was given to the approach to take, with Interpretive Phenomenological Analysis (IPA) (Smith & Osborn, 2003) and Constructivist Grounded Theory (GT) approaches (Charmaz, 2014) also being considered.

Rationale for using a GT approach included its capacity to develop a theoretical analysis, which is grounded in the data and acknowledges the roles of the researcher's subjectivity and social contexts within the construction of the research and findings (Charmaz, 2014).The complex social contexts involved in FMH services are an important consideration and it is therefore important to select an approach that enables this. Further rationales for a GT approach were the assertion that processes involved in team formulation have had little empirical attention (Johnstone, 2014) and that there are inconsistencies in how team formulation is defined and implemented in clinical practice (Geach, Moghaddam & De Boos, 2018). GT could have aimed to construct a grounded theory about what elements constitute a

team formulation from the perspectives of people who have been involved in this process. However, as this project was only recruiting from a single site, the theoretical generalisability of any GT would have been limited. Recruitment from multiple sites was pursued but other prospective sites declined to be involved, stating that they would not have the capacity and capability to support the research. Furthermore, the potential recruitment difficulties outlined above, such as availability of staff members with specific recent experience of team formulation could have resulted in too small a sample and in limited opportunity for theoretical sampling.

IPA also aims to recruit a homogenous sample, and places importance on the 'lived experience' of participants (Smith & Osborn, 2003). However, IPA focusses less on the social context and processes, which, as previously highlighted, form an important part of my study and is therefore not in line with the study aims.

TA was selected as a flexible approach to data analysis and several decisions were made about how exactly to approach the TA, in line with Braun and Clarke (2006). The flexibility of this approach enabled considerations such as whether to provide a "rich description of the data set, or a detailed account of one particular aspect" (Braun and Clarke, 2006, p.86) and whether to adopt an inductive or theoretically driven approach to analysis. An inductive approach, which considered the whole dataset was adopted. This enabled the study to take a more exploratory approach, which was not aimed at developing an integrated model of the process of team formulation, but at developing an in-depth understanding of the different elements and processes involved in team formulation in a FMH context. Following the development of themes, it became apparent that a team formulation process model could emerge from the analysis, and the flexibility of TA enabled this to happen. This process model was interpreted to be a helpful approach to understanding the experiences of participants and not as an expectation from the research design. I felt that this also fit in line with the stated critical realist

epistemological and ontological stance, as it represented my best attempt at portraying the "reality" of the processes involved in team formulation through my inherently skewed interpretation of participants' experiences and the research process.

The themes that emerged from participants' accounts represented how difficult and challenging factors precipitating referrals for team formulations would be brought into the room by staff teams engaging in team formulation meetings. Facilitators held an important role in enabling team members to feel safe and contained enough to name and explore these processes. This seemed to link with literature related to the therapeutic alliance, as it set the bed-rock for introducing psychological understanding and supporting the team to work towards shared goals and more cohesive ways of understanding and working with each other and service users. Various factors could make it difficult for the team to get to this point, including the factors described above not being sufficiently attended to, or the chosen psychological framework not suitably conceptualising the difficulties. Structural and systemic factors could also inhibit the effectiveness of team formulation meetings, as difficulties in accessing all members of the team and effectively disseminating information contributed to ongoing inconsistencies and difficulties.

From the themes, a model of processes involved in team formulation in inpatient FMH services was developed. This model involves six stages for the consideration of facilitators of team formulation interventions in FMH services and also outlines factors that may inhibit the effectiveness of the intervention at each stage. The processes in the model are presented in a linear manner, highlighting how early stages are important for the success of later stages. It is acknowledged that team formulation interventions do not necessarily neatly follow these steps in order and more dynamism could exist between the stages, with teams moving between stages, and facilitators having to be attuned to these switches. This therefore highlights how

the model presents a framework for facilitators to be aware of whilst supporting teams and recognising common processes involved in team formulation interventions.

Results are discussed in relation to common factor theories and Livesley's (2007) stages of change model. Common factors are described as an important prerequisite for providing teams with a sense of safety, validation of difficulties and developing shared aims, before a psychological model, structure or framework are explicitly introduced. No single theoretical model or framework is suggested, as the diversity of needs presented by service users in forensic services suggests an eclectic approach, tailored to the specific needs of the team is required (Livesley, 2007). The team formulation process model that is presented therefore outlines a framework of processes for practitioners to be aware of when facilitating team formulation interventions. With a grounding in common factors and no alliance to specific therapeutic modalities, it is possible that this framework could be applied outside of forensic mental health services and may be helpful for teams from various services who may also experience similar processes precipitating referrals for team formulation interventions.

Links Between the Systematic Review and Empirical Paper

I believe clinically important links exist between the systematic review and empirical paper of this thesis. Primarily, a systemic intervention, such as team formulation interventions outlined in the empirical paper, can support staff teams with some of the challenges they face when navigating dual-roles between risk management and therapeutic interventions and developing and maintaining therapeutic relationships. A relationship between staff team cohesion, the experience of controlling practices and the therapeutic relationship is discussed in theme 1 of the SLR. The empirical paper outlines examples of a lack of team cohesion, in the form of a divide between ways of understanding a service user, or how to best work with them, with members of staff teams possibly finding themselves either side of the "boundary seesaw" (Hamilton, 2010). This exemplifies a possible reason for referral for team formulation

interventions, and ultimately a goal of these interventions is to introduce a balance and integrate these conflicts, so that teams can provide a more cohesive approach when working with service users, and, in turn, develop better therapeutic relationships.

A second important issue highlighted in both papers relates to the role of control and staff perceptions of safety. The SLR discussed how staff may prioritise safety above all else, which could occur at the expense of increasing controlling and coercive practices and cause ruptures to the therapeutic relationship. Again, team formulation interventions may support a team to feel more contained, and develop a shared plan for working with service users. This moves towards a middle ground, or "negotiator role" (Hamilton, 2010), which provides an optimal balance between caring and controlling roles and fosters therapeutic relationships.

Conducting Research in Forensic Mental Health Services

There is a limited evidence base for psychological interventions within FMH services, (Barnao & Ward, 2015; MacInnes & Masimo, 2019) with therapeutic interventions generally being based upon research from general mental health settings (MacInnes & Masino, 2019). There are concerns about the efficacy of applying research from general mental health settings in this way, as interventions with apparently effective evidence bases in general settings do not necessarily remain effective in FMH services (MacInnes & Masimo, 2019). This highlights the importance of conducting research specifically in FMH services.

A possible reason for the currently limited evidence base is outlined by Barnao and Ward (2015) who argue that research in FMH services has mostly focussed on either: risk assessment, legal classification and the role of expert witnesses; or, where interventions are involved, these have focussed on the mental health of service users. This again represents an example of a separation of the dual-roles of managing risk and providing therapeutic interventions, with the systemic clinical split being represented in the research base. Future research could focus on integrating/synthesising these factors, to consider how FMH services

can provide evidence-based interventions, which hold risk management and therapeutic intervention in mind.

The current thesis aims to integrate these dual-roles and suggests a framework for team formulation interventions, which can support teams working in FMH services in understanding the needs and challenges faced by themselves and service users in these settings. For example, stage six of the model outlines that treatment planning can occur as part of the process of team formulation interventions, and it is suggested working as a cohesive and empathic team may form a part of this treatment planning. However, it is recognised that outcomes and treatment interventions following this intervention remain largely unexplored and as outlined above, treatment plans may not be based on evidence-based research that is applicable in FMH settings. This therefore represents a clear avenue for future research considering the outcomes of team formulation interventions in FMH services, as well as the applicability of interventions and treatment plans in these settings.

Ethical Application Process in Forensic Mental Health Services

Having previously conducted a small-scale research project in a FMH service, I anticipated additional difficulties and barriers to gaining ethical approval for this project. The previous project had included service users as participants, and delays were incurred in gaining ethical approval as the project was deferred to a specific social care research ethics committee so that due consideration could be given to the proposal. For the current project, there were no additional barriers with regards to the process of gaining ethical approval, other than, as a novice researcher, navigating the confusing bureaucracy of the process. I believe this to be due to the current project involving staff as participants as opposed to service users.

The primary nuance that I would like to reflect on is the relationship between risk and sensitivity of data. Gaining approval from the Senior Leadership Team at the research site was an understandable pre-requisite for gaining ethical approval and for the confirmation of

capacity and capability for the host trust to allow the research to take place. Approval was granted, on the proviso that transcriptions of the interviews occurred on-site. No other additional requirements or requests were made with regards to the way in which data was stored or what happened after transcription. To my understanding, such requests are not typical across services and I felt this highlighted an interesting example of the relationship between risk management and the sensitivity of data in FMH services, with perhaps an additional level of security to what is expected when gathering data in other research settings. The additional focus on risk management that is inherent within the aims of FMH services and discussed throughout this thesis was perhaps also occurring within this nuance to accepting research to be undertaken within the service and highlighted a possible consequence of a culture that must always consider risk.

Ethics of Indirect Working

The ethics of working indirectly and possibly without the consent of the service user should also be reflected upon here. Davies, Black, Bentley and Nagi (2013) question whether the service user should be aware and involved in team formulation interventions, which could direct treatment and care planning. They also question what effect and power this intervention could give to the team as they discuss and formulate the service user's apparent needs, typically without their involvement. Improving service user involvement in their care has rightly gained increased importance over recent years, with the Health and Social Care Act (2012) stating that services should "promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to— (a) the prevention or diagnosis of illness in the patients, or (b) their care or treatment." (part 1, Section. 26).

Again, FMH services represent an interesting context for such ethical dilemmas, as staff working in these services often experience difficulties in engaging service users in psychological intervention (Clarke, Fardouly & McMurran, 2013; Rushbridge, Tooze, Griffith

& Wilkinson-Tough, 2018). This understandably creates a difficulty for staff teams, who maintain their role around understanding and managing risks (Doyle et al., 2014) and must balance the assessment and management of risk and public protection alongside providing care and treatment (Barnao & Ward, 2015; Taylor, 2017; Ward, 2013). Therefore, in situations where there is a lack of engagement, service users remain mandated to receive treatment, and cannot simply be discharged from the service, as may be the case when engagement difficulties are experienced in other services. Systemic interventions such as team formulations can therefore provide an opportunity for the team to develop some understanding of the risks, difficulties and strengths of a service user, which can then be used to inform care planning in the absence of the service user and in situations where the service user is not able to participate (Johnstone, 2018).

Another associated factor here is the difficult environment, the importance of protecting and supporting the staff team, and the question of who the primary service user is in team formulation interventions. Team formulation requests are often made because staff teams are "stuck or struggling, or have strong counter-transference feelings about a service user" (DCP, 2011, p. 21) and the team become the primary service user (DCP, 2011; Johnstone, 2018). DCP (2011) also highlight that sharing the entirety of this with the service user may therefore not be helpful. Again, this represents an ethical dilemma about what is spoken about a person, but is not shared with them, particularly if decisions are being made about their care and treatment. If a service user desires involvement in their team formulation, this presents an important consideration for the facilitator and the rest of the team to incorporate this into the intervention in a way that could be mutually beneficial. This would, of course, depend upon the specific situation, but may include involving the service user in part of the meeting, or through consultation with the service user before and/or afterwards. Again, due to the complex nature of FMH services, these factors must be carefully considered on an individual basis.

Conclusion

Staff working in FMH possess a challenging role, which balances care with security in a complex system. Listening to how staff experience and navigate these challenges can enable us to develop a better understanding of their needs and can, in turn, guide interventions to better support these needs to be met. Navigating their dual-roles remains a constant balancing act, but staff working in FMH services feel better able to do so when there is a sense of team cohesion and when they feel safe, contained, validated and valued. Systemic interventions that have a positive impact on this can therefore have an important role in these settings and this thesis outlines a framework of key challenges and processes that practitioners should be aware of when facilitating team formulation interventions in FMH settings.

References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*(1), 1-33. Doi:10.1016/S0272-7358(02)00146-0

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: lessons learnt. *BMC medical research methodology*, *8*(21), 1-10. Doi: 10.1186/1471-2288-8-21

Barnao, M., & Ward, T. (2015). Sailing uncharted seas without a compass: a review of interventions in forensic mental health. *Aggression and Violent Behavior*, *22*, 77-86. Doi: 10.1016/j.avb.2015.04.009

Bordin, E. S. (1979). The Generalizability of the Psychoanalytic Concept of the Working Alliance. *Psychotherapy: Theory, Research and Practice*, *16*(3), 252-260. Doi: 10.1037/h0085885

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. Doi:10.1191/1478088706qp063oa.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: a worked example. *Journal of health services research & policy*, *7*(4), 209-215. Doi: 10.1258/135581902320432732

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd Ed.). London: Sage.

Clarke, M., Fardouly, P., & McMurran, M. (2013). A survey of how clinicians in forensic personality disorder services engage their service users in treatment. *The journal of forensic psychiatry & psychology*, *24*(6), 772-787. Doi: 10.1080/14789949.2013.862292

Davies, J., Black, S., Bentley, N., & Nagi, C. (2013). Forensic case formulation: Theoretical, ethical and practical issues. *Criminal Behaviour and Mental Health*, *23*(4), 304-314. Doi: 10.1002/cbm.1882

Division of Clinical Psychology (2010). *The core purpose and philosophy of the profession.* Leicester: British Psychological Society.

Division of Clinical Psychology (2011). *Good practice guidelines on the use of psychological formulation*. Leicester: British Psychological Society.

Doyle, M., Coid, J., Archer-Power, L., Dewa, L., Hunter-Didrichsen, A., Stevenson, R., ... & Shaw, J. (2014). Discharges to prison from medium secure psychiatric units in England and Wales. *The British Journal of Psychiatry*, *205*(3), 177-182. Doi:10.1192/bjp.bp.113.136622

Geach, N., Moghaddam, N. G., & De Boos, D. (2018). A systematic review of team formulation in clinical psychology practice: Definition, implementation, and outcomes. *Psychology and Psychotherapy: Theory, Research and Practice*, *91*, 1-30. Doi: 10.1111/papt.12155

Gildberg, F. A., Elverdam, B. E., & Hounsgaard, L. (2010). Forensic psychiatric nursing: a literature review and thematic analysis of staff–patient interaction. *Journal of Psychiatric and Mental Health Nursing*, *17*, 359–368. Doi: 10.1111/j.1365-2850.2009.01533.x

Hamilton, L. (2010). The boundary seesaw model: good fences make for good neighbours. In A. Tennant & K. Howells (Eds.), *Using time, not doing time: practitioner perspectives on personality disorder and risk* (pp. 181–194). Chichester, UK: Wiley.

Johnstone, L. (2014). Using Formulation in Teams. In L. Johnstone, & R. Dallos (Eds.), *Formulation in Psychology and Psychotherapy* (2nd Ed.). (pp. 216-242). London, UK: Routledge.

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, *58*(1), 30-46. Doi: 10.1177/0022167817722230

Joint Commissioning Panel for Mental Health. (2013). *Guidance for commissioners of forensic mental health services: Practical Mental Health Commissioning*. London: Raffertys. Retrieved from: https://www.jcpmh.info/wp-content/uploads/jcpmh-forensic-guide.pdf

Livingston, J. D., Nijdam-Jones, A., & Brink, J. (2012). A tale of two cultures: Examining patient-centered care in a forensic mental health hospital. *Journal of Forensic Psychiatry & Psychology*, *23*(3), 345-360. Doi: 10.1080/14789949.2012.668214

Livesley, W. J. (2007). A framework for integrating dimensional and categorical classifications of personality disorder. *Journal of personality disorders*, *21*(2), 199-224. Doi: 10.1521/pedi.2007.21.2.199

Livesley, W. J. (2012). Integrated treatment: A conceptual framework for an evidence-based approach to the treatment of personality disorder. *Journal of personality disorders*, *26*(1), 17-42. Doi: 10.1521/pedi.2012.26.1.17

MacInnes, D., & Masino, S. (2019). Psychological and psychosocial interventions offered to forensic mental health inpatients: a systematic review. *British Medical Journal Open*, *9*, 1-16. Doi: 10.1136/bmjopen-2018-024351

Mason, T., Lovell, A., & Coyle, D. (2008). Forensic psychiatric nursing: skills and competencies: I role dimensions. *Journal of Psychiatric and Mental Health Nursing*, *15*(2), 118-130. Doi: 10.1111/j.1365-2850.2007.01191.x

Newman-Taylor, K., & Sambrook, S. (2012). CBT for culture change: formulating teams to improve patient care. Behavioural and cognitive psychotherapy, 40(4), 496-503. Doi: 10.1017/S1352465812000069

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing Qualitative Studies.* London, UK: Sage Publications.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy, 48*(1), 98-102. Doi: 10.1037/a0022161

Onyett, S. (2007). *New ways of working for applied psychologists in health and social care: Working psychologically in teams.* Leicester: British Psychological Society.

Rushbridge, S., Tooze, O., Griffith, E., & Wilkinson-Tough, M. (2018). Clinical psychologists' perceptions of barriers and facilitators to engaging service users in index offence assessment and formulation within a medium secure unit. *The Journal of Forensic Psychiatry & Psychology, 29*(1), 106-123. Doi: 10.1080/14789949.2017.1347803

Smith, J. A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Methods* (pp. 53-80). London: Sage.

Skinner, P., & Toogood, R. (2010). *Clinical Psychology Leadership Development Framework.* Leicester: British Psychological Society.

Taylor, J. (2017). Compassion focussed working in secure forensic care. *Journal of Criminological Research, Policy and Practice, 3*(4), 287-293. Doi: 10.1108/JCRPP-04-2017-0016

Thomson, L. (2008). The Forensic Mental Health System in the United Kingdom. In K. Soothill, P. Rogers, & M. Dolan (Eds.), *Handbook of Forensic Mental Health* (pp. 19-63). Devon, UK: Willan Publishing.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270-277. Doi:10.1002/wps.20238

Ward, T. (2013). Addressing the dual relationship problem in forensic and correctional practice. *Aggression and Violent Behavior*, *18*(1), 92-100. Doi: 10.1016/j.avb.2012.10.006

Section Four – Ethics Section

Lancaster University

Doctorate in Clinical Psychology

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2016 intake

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Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Understanding factors involved in Team Formulation in Forensic Service

1. Is your project research?

(●) Yes ( ) No

2. Select one category from the list below:

( ) Clinical trial of an investigational medicinal product

( ) Clinical investigation or other study of a medical device

( ) Combined trial of an investigational medicinal product and an investigational medical device

( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice

( ) Basic science study involving procedures with human participants

( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

(●) Study involving qualitative methods only

( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)

( ) Study limited to working with data (specific project only)

( ) Research tissue bank

( ) Research database

If your work does not fit any of these categories, select the option below:

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	Yes	(●) No
b) Will you be taking new human tissue samples (or other human biological samples)?	Yes	(●) No
c) Will you be using existing human tissue samples (or other human biological samples)?	Yes	(●) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

[✓] England
[ ] Scotland

☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

◉ England
◯ Scotland
◯ Wales
◯ Northern Ireland
◯ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

◉ Yes ◯ No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

☐ Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Research limited to use of previously collected, non-identifiable information
☐ Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
☐ Research limited to use of acellular material
☐ Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
☑ Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

◉ Yes ◯ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or Medtech and In Vitro Diagnostic Cooperative in all study sites?

Please see information button for further details.

◯ Yes ◉ No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ◉ No

The NIHR Clinical Research Network provides researchers with the practical support they need to make clinical studies happen in the NHS e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.

6. Do you plan to include any participants who are children?

○ Yes ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The student is the lead researcher and the project is for a thesis in partial completion of a Doctorate in Clinical Psychology

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

Integrated Research Application System

Application Form for Research involving qualitative methods only

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Understanding factors involved in Team Formulation in Forensic Service

Please complete these details after you have booked the REC application for review.

REC Name:

REC Reference Number: **Submission date:**

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Understanding Staff Experiences of the processes involved in Team Formulation Interventions in Forensic Inpatient Services

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title Forename/Initials Surname
	Mr Sam Mellor
Address	37 Mosses Farm Road
	Longridge
	Preston
Post Code	PR3 2BG
E-mail	s.mellor2@lancaster.ac.uk
Telephone	07737666020
Fax	

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title Forename/Initials Surname
	Dr Suzanne Hodge
Address	Clinical Psychology, Div. Of Health Research
	Lancaster University
	Lancaster
Post Code	LA1 4YG
E-mail	s.hodge@lancaster.ac.uk
Telephone	01524 592754
Fax	

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	**Academic supervisor(s)**
Student 1 Mr Sam Mellor	☑ Dr Suzanne Hodge

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- (●) Student
- ( ) Academic supervisor
- ( ) Other

A3-1. Chief Investigator:

	Title Forename/Initials Surname
	Mr Sam Mellor
Post	Trainee Clinical Psychologist
Qualifications	BSc (Hons) Psychology - 2:1
ORCID ID	0000 0002 5338 0602
Employer	Lancashire Care NHS Foundation Trust
Work Address	Clinical Psychology, Division of Health Research
	Lancaster University
	Lancaster
Post Code	LA1 4YG
Work E-mail	s.mellor2@lancaster.ac.uk
* Personal E-mail	sammellor39@gmail.com
Work Telephone	07737666020

* Personal Telephone/Mobile 07737666020

Fax

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title Forename/Initials	Surname
	Becky	Gordon
Address	Deputy Head of Research Services	
	Lancaster University	
	Lancaster	
Post Code	LA1 4YG	
E-mail	sponsorship@lancaster.ac.uk	
Telephone	01524592981	
Fax		

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	
Sponsor's/protocol number:	
Protocol Version:	
Protocol Date:	14/01/2019
Funder's reference number (enter the reference number or state not applicable):	N.A
Project website:	

Additional reference number(s):

Ref.Number	Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

The current research aims to develop an in-depth understanding of the factors involved in team formulations and how the process of team formulation is experienced from the perspectives of multiple staff members involved in multi-disciplinary forensic inpatient teams. It is hoped that gaining multiple perspectives from the same teams will enable the study to develop understanding of the components that comprise team formulation.

Participants will be staff members who work in a low or medium secure forensic inpatient service and have been involved in a team formulation in the past 12 months. Individual semi-structured interviews will be carried out and a Thematic Analysis will be conducted on the interview data. The interview will consider how staff members experienced the processes involved in the team formulation.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Berry et al. (2016, 2017) highlight that team formulation has received limited uptake across mental health settings and hypothesised that this may be due to a lack of understanding of the organisational barriers and facilitators to implementing formulations in routine practice. This may impact on access to participants. A field supervisor working in an inpatient service in Blackpool has been identified and will support with identification of services and recruitment of participants.

Geach et al. (2017) highlights the lack of uniformity in the definition and application of team formulation. This highlights a possible issue as different services involved in the study may practise team formulation in different ways. Therefore, whilst analysis of different experiences of the same team formulation may be possible, integrating results found across services may be difficult if common factors are not present. I plan to overcome this by exploring recent examples of team formulations with members of each team. This would support exploration of similarities and differences across the different team formulation meetings.

This will enable the study to meet some of its aims of understanding common components that make up team formulations, which can then be researched further. Also, whilst the lack of uniformity in the application of team formulations across services may represent a limitation, it is also representative of how team formulation is currently being applied in practice and therefore enables the study to investigate the phenomenon in real clinical settings.

Inpatient services are busy environments and staff availability can be unpredictable. Careful planning which is sensitive and flexible to the needs of the shift will therefore be important to support participation. Communication such as telephoning prospective participants on scheduled interview days prior to travelling for an interview will also be important to maximise time efficiency.

Telephone and skype calls will also be possible methods for interviews to increase flexibility in the research methods and support recruitment.

Staff are being asked to contribute potentially difficult professional experiences. As described above, they are not going to be asked to go into details about the content of team formulation interventions so sensitive information is unlikely to be discussed. However, there is a possibility that they will be recalling processes surrounding a difficult time for themselves and/or their team. Resources for people who may become distressed during the study are incorporated into the information for participants.

The project aims to develop a better understanding of processes involved in team formulation interventions and does not seek to obtain any information about service users for whom such interventions have taken place. However, asking staff members about their experiences of such interventions means that the project will be indirectly asking about an element of a service users' care and treatment. Service users are not directly involved in this research project and will remain anonymous but an element of their treatment and care is getting discussed.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply*:

- [ ] Case series/ case note review
- [ ] Case control
- [ ] Cohort observation
- [ ] Controlled trial without randomisation
- [ ] Cross-sectional study
- [ ] Database analysis
- [ ] Epidemiology
- [ ] Feasibility/ pilot study
- [ ] Laboratory study
- [ ] Metanalysis
- [x] Qualitative research
- [ ] Questionnaire, interview or observation study
- [ ] Randomised controlled trial
- [ ] Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

The current research aims to develop an understanding of the components that comprise the process of team formulation from the perspective of staff members involved in multi-disciplinary forensic in-patient teams.

Understanding key themes across different approaches to team formulation, as experienced by staff members who have been directly involved in this process might provide a starting point for understanding the processes commonly involved.

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

Developing this understanding may then, in turn, support understanding of what would be important to include in future measurements which evaluate the effectiveness of team formulations.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

The Joint Commissioning Panel for Mental Health (2013) outlines the 'core purposes' for forensic mental health care pathways. This includes supporting people's mental health needs and the assessment and management of the risk of re-offending, which Kennedy (2002), claimed to be the most important roles for these services. Hart, Sturmey, Logan and McMurran (2011) highlight that diagnosis and offence classification is not sufficient to support understanding an individual's history and future risk of offending. Formulation can improve this understanding, but individual formulation is not always possible or appropriate in inpatient forensic services and working with the care-team can be important (Rusbridge, Tooze, Griffith & Wilkinson-Tough, 2018). This therefore highlights a role for team formulation in these settings.

Formulation is an important skill of Clinical Psychologists (Health and Care Professions Council [HCPC], 2015; DCP, 2011), which can have various possible benefits for teams (DCP, 2011). There is no singly agreed definition of formulation and various professions adopt different understandings (DCP, 2011). Johnstone and Dallos (2014) identify formulation as a shared hypothesis about a person, which is based on personal meaning and draws from psychological theory. Overall, common elements of formulation have been identified within the field of clinical psychology, which have identified formulation as a theory based, collaborative framework focussed on personal meaning, which guides intervention (DCP, 2011).
Working systemically with staff teams forms an important part of the role of clinical psychologists and enables greater influence and wider provision of psychologically-informed practice than working one-to-one (DCP, 2010). The Clinical Psychology Leadership Development Framework (2010) also indicates that forensic psychologists must 'be able to

use psychological formulations to assist multi-professional communication and the understanding, development and learning of service users.' Team formulation may therefore represent an opportunity for psychologists to support psychological thinking at team and service levels (DCP, 2011) and may be a powerful systemic intervention for staff and service users (Kennedy, Smalley & Harris, 2003).

Team formulation also has no single definition (Geach et al., 2017). However, different definitions also appear to have incorporated common elements. For example, Geach et al. (2017) p. 27 define the function of team formulation as enabling 'team members to develop a shared psychological understanding of presenting difficulties; which summarises their nature, explains their development and maintenance, and guides intervention planning'. Johnstone (2014) p. 216 also refers to the 'process of facilitating a group or team of professionals to construct a shared understanding of a service user's difficulties' which provides a structure for integrating information from a multidisciplinary team (MDT) and generate hypotheses to inform intervention planning (Johnstone, 2014).

Much of the existing literature about team formulation has focussed on outcomes such as increased empathy (Waugh et al., 2010; Wharne & Spilsted, 2011; Whitton et al., 2016), enhanced therapeutic relationships (Berry et al., 2016; Waugh et al., 2010; Summers, 2006), assisting the development of care-plans (Craven-Staines et al., 2010; Summers, 2006), improving communication (Dexter-Smith et al., 2010), improving psychological understanding (Dexter-Smith et al., 2010; Whitton et al., 2016), improving staff morale (Totman, 2011) and improving team working (Summers, 2006; Kellett et al., 2014 Whitton et al., 2016). This study wants to consider the processes involved in team formulations to develop a better understanding of what components may be driving the reported outcomes.

Geach et al. (2017) claim a lack of consistency in the approach to team formulation raises concerns due to inconsistency and replicability of team formulation as an evidence-based practice. They also called for future research to measure the factors that mediate and moderate the outcomes of team formulations and whether any components of team formulation contribute to change. However, it appears that these components are not well known or understood and therefore qualitative research is needed to develop an understanding of what the components that make up team formulation may be.

Therefore, the current research aims to develop an understanding of the components that comprise the process of team formulation from the perspective of staff members involved in multi-disciplinary forensic in-patient teams. Developing this understanding may then, in turn, support understanding of what would be important to include in future measurements which evaluate the effectiveness of team formulations. Therefore, understanding key themes across different approaches to team formulation, as experienced by staff members who have been directly involved in this process might provide a starting point for understanding the processes commonly involved. The current research will adopt a broad definition of team formulation and will consider any team-based approach or intervention that has used consultation informed by psychological formulation as a means of understanding and working with a service-user or group of service-users.

As highlighted by Day (2016) when discussing individual forensic case formulation, flexibility in the approach could stem from practitioners choosing different approaches to fit the individual needs of teams and service users. This study does not look to promote a unified model or approach to team formulation, but it aims to develop an understanding into the common factors experienced by team members involved in team formulations with different psychological professionals and service users.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Participants will be recruited following consultation with the field supervisor who will highlight teams who have engaged in team formulation meetings in the past 12 months. Managers/Psychologists working in these teams will then identify potential participants and provide them with information packs about the study, including the participant information sheets, expressions of interest, consent form, email and the advertising materials (all to be found in the attached documents). These will also be distributed in the work place of the identified teams. Participants will be able to indicate whether they would be interested in taking part in the project and if they would like to discuss the project further. Participants will not have to do this immediately and they will be given time to consider whether they wish to take part in the research however, if participants do decide to take part immediately, this will be possible. Participants will be able to provide verbal consent for their details to be passed to the research team or they can contact the research team themselves via the contact information provided, or using the expression of interest form. If contact information is provided to the research team, the potential participant will then be contacted to provide further information. If potential participants maintain their interest, arrangements will be made to go through the participant information sheet, obtain informed consent and conduct a semi-structured interview at the participant's work place (NHS site) or via telephone/skype call. This interview will be audio recorded.

The researcher will also visit the teams to introduce the project and to support recruitment of prospective participants.

If participants express their interest and consent to participate on that day, arrangements can be made to gain full consent and conduct the interview. The rationale for this is due to the nature of secure inpatient services being busy environments and it will therefore be necessary to have this flexibility in the event that participants identify their availability on the day.

This process may be repeated with a second call to recruit if necessary to support recruitment. Once potential participants have been identified and given their consent to be contacted, arrangements will be made for consent to participation and to arrange the interview.

Once recruited, participants will be asked to attend a single interview session which is expected to last 30 minutes to 1 hour. The interview will consider various stages involved in the process of team formulation interventions, from prior to the referral to any follow-up after the team formulation meeting(s) have taken place. An interview topic guide is included in the attached documentation.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- [x] Design of the research
- [x] Management of the research
- [x] Undertaking the research
- [ ] Analysis of results
- [ ] Dissemination of findings
- [ ] None of the above

Give details of involvement, or if none please justify the absence of involvement.
This research pertains to staff experiences of an intervention that is conducted in conjunction with staff members and does not directly involve service users, it has therefore not been deemed appropriate to involve service users in this piece of research.
The field supervisor for the research is a staff member at the research site and has been involved in many areas of the research design and management of the research, including developing the interview topic guide and will be involved in supporting recruitment.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- [ ] Blood
- [ ] Cancer
- [ ] Cardiovascular
- [ ] Congenital Disorders
- [ ] Dementias and Neurodegenerative Diseases
- [ ] Diabetes
- [ ] Ear
- [ ] Eye
- [ ] Generic Health Relevance
- [ ] Infection
- [ ] Inflammatory and Immune System
- [ ] Injuries and Accidents

- [x] Mental Health
- [ ] Metabolic and Endocrine
- [ ] Musculoskeletal
- [ ] Neurological
- [ ] Oral and Gastrointestinal
- [ ] Paediatrics
- [ ] Renal and Urogenital
- [ ] Reproductive Health and Childbirth
- [ ] Respiratory
- [ ] Skin
- [ ] Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit: 100	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Inclusion Criteria
- Involvement in team formulation meetings or process in the past 12 months in forensic inpatient services.
- Staff from any discipline working in forensic inpatient services.
- Had involvement in the care of the service user around whom the team formulation was held.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Exclusion Criteria:
- No involvement with team formulation in the past 12 months.
- No involvement in teams where team formulations have occurred within a forensic environment.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Seeking consent	5	0	40 minutes	1. Initial contact will be made through potential participant's work place (email/manager/field supervisor/team meeting) where the invitation to participation sheet will be provided. 2. Potential participants will be able to contact the research team to express their interest in being involved.

				3. Arrangements will be made to go through the Participant Information Sheet and consent form. 4. Go through Participant Information Sheet 5. Participants complete consent form to provide informed consent.
Interviews	3	0	60 minutes	1. Make arrangements for interview. 2. Conduct single semi-structured interview. 3. Debrief
Feedback	1	0	45	1. Optional attendance for provision of feedback of overall findings.

A21. How long do you expect each participant to be in the study in total?

Up to 1 month.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Risk to participants

Minimal risks are associated with taking part in this study. However, participants may find discussing their experiences to cause distress. If participants become distressed during the interview, the researcher will offer to pause or stop the interview. If this occurs during or after participation in the study, participants will have the opportunity to discuss it with the interviewer, or use the resources provided on the Participant Information Sheet.

It is unlikely that sensitive information will be discussed, as the study focuses on the processes involved in team formulation meetings, rather than the content. However, participants are members of staff who will be asked to discuss aspects of their work place. This could evoke some discomfort if they want to discuss things that they have been unhappy about. Linked to this, team formulation interventions often occur in circumstances where a team is experiencing difficulties when supporting a service user or feel stuck (DCP, 2011). Therefore, it is important to acknowledge that there is a possibility for distress to be experienced whilst people recall their experiences of these interventions. Information has been incorporated into the participant information sheet for the event that any participants feel they would like to seek support following their participation in the study.

Participants may find it difficult talking about aspects of their work in the work place, particularly if those experiences are not positive ones. Confidentiality will be maintained (notwithstanding confidentiality limits) and this will be explained clearly to participants. Options will also be available for interviews to be done via telephone or Skype, which will provide additional options for the location from which participants take part in the study and may therefore further protect anonymity.
Participants are welcome to withdraw from the study at any time. However, the removal of their data will have a time limit of two weeks following their interview. After this, it may not be possible to remove data once analysis is started and the data has been pooled.

Risk to researchers
The interviews may be conducted within a forensic environment, which may present some risk to the researcher. The researcher will be escorted by a staff member to and from the interview location and will be interviewing members of staff.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

(●) Yes ( ) No

If Yes, please give details of procedures in place to deal with these issues:

It is unlikely that sensitive information will be discussed, as the study focuses on the processes involved in team formulation meetings, rather than the content. However, team formulation interventions often occur in circumstances where a team is experiencing strong counter-transference or feel stuck (DCP, 2011). Therefore, it is important to acknowledge that there is a possibility for distress to be experienced whilst people recall their experiences of these interventions. Information has been incorporated into the participant information sheet for the event that any participants feel they would like to seek support following their participation in the study.

Confidentiality and its limits will be clearly explained prior to the interview taking place and participation in the project. If the researcher feels confidentiality needs to be broken due to concerns regarding risk/safeguarding, lines of discussion through the research team and/or other appropriate services and/or safeguarding teams will be pursued.

A24. What is the potential for benefit to research participants?

Taking part gives participants the opportunity for their opinions and experiences to be heard and this could provide valuable information about how to change and improve services for the benefit of both staff and service users.

Participants will be recompensed for their time and efforts with a £15 Amazon voucher.

A26. What are the potential risks for the researchers themselves? *(if any)*

The interviews may be conducted within a forensic environment, which may present some risk to the researcher. The researcher will be escorted by a staff member to and from the interview location and will be interviewing members of staff.

When lone working the researchers will abide by [redacted] procedures. The interviewer will provide details on their location, interview time and participant to another member of staff and will make telephone contact following the interview. If this telephone call does not occur, the team will follow procedure of attempting to make contact. If this is unsuccessful, appropriate services will be informed. Interviews will take place in a risk assessed NHS location or via telephone/skype call where the researcher will work from their home address or on-site at Lancaster University.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Participants will be recruited following consultation with the field supervisors who will highlight teams who have engaged in team formulation meetings in the past 12 months. Managers/Psychologists working in these teams will then identify potential participants and provide them with information packs about the study, including the participant information sheet, expression of interest/opt-in form, consent form, email and the advertising materials (all to be found in the collated ethics document). These will be available in hard copies, which will be distributed in the work place of the identified teams. The materials will also be distributed as attachments to the email.
Participants will be able to indicate whether they would be interested in taking part in the project and if they would like to discuss the project further. Participants will not have to do this immediately and they will be given time to consider whether they wish to take part in the research, however, if participants do decide to take part immediately, this will be possible. Participants will be able to provide verbal consent for their details to be passed to the research team or they can contact the research team themselves via the contact information provided or using the expression of interest form. If contact information is provided to the research team, the potential participant will then be contacted to provide further information. If potential participants maintain their interest, arrangements will be made to go through the participant information sheet, obtain informed consent and conduct a semi-structured interview at the participant's work place (NHS site) or via telephone/skype call. This interview will be audio recorded.
The researcher will also visit the teams to introduce the project and to support recruitment of prospective participants. If participants express their interest and are happy to participate on that day, arrangements can be made to gain full consent and conduct an interview. The rationale for this is due to the nature of secure inpatient services being busy environments and it will therefore be necessary to have this flexibility in the event that participants identify their availability on the day.
This process may be repeated with a second call to recruit if necessary to support recruitment.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ◉ No

Please give details below:
Participants will be staff members identified via the field supervisor, managers and psychologists working in the research site, no records will be accessed.

The lead researcher will visit the work place to explain the research project following the identification of potential participants.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◉ Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

The publicity will include a poster/invitation to participate around the service in which the research is taking place. Potential participants will receive an email to their work email address, including the research information pack.

A29. How and by whom will potential participants first be approached?

Potential participants will initially be approached by the field supervisor (Clinical Psychologist working in the service), the ward team manager, or a psychologist working within the team where team formulations have taken place. They will introduce the project and provide them with an information pack about the study, including the invitation to participate, email and the advertising materials. Advertising materials will also be distributed to team members in the work place. The researcher will then visit the teams to introduce the project and to support recruitment of prospective participants. This may be repeated if necessary to support recruitment.

Participants will be able to indicate whether they would be interested in taking part in the project and if they would like to discuss the project further. Participants will not have to do this immediately and they will be given time to consider whether they wish to take part in the research, however, if participants do decide to take part immediately, this will be possible. Participants will be able to provide verbal consent for their details to be passed to the research team or they can contact the research team themselves via the contact information provided or using the expression of interest form. If contact information is provided to the research team, the potential participant will then be contacted to provide further information.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Participants will be informed about the study through the information pack and will have the opportunity to discuss this and ask any questions. Participants will complete a written consent form outlining that that the understand various aspects of the study, including that the study is voluntary. Consent will be taken by the lead researcher.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

Potential participants will have a period of up to approximately 2 months to decide whether to take part.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Interpreters will not be available for this study due to budget restrictions. It is anticipated that as participants are members of staff working in a secure service in England, there will be sufficient verbal use of the English language for interviews to take place. Any written information can be accompanied by verbal explanations as required.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

- ○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- ◉ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- ○ The participant would continue to be included in the study.
- ○ Not applicable – informed consent will not be sought from any participants in this research.
- ○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

Capacity to consent to participating in the study will be assessed dynamically throughout any contact the researcher has with prospective participants from the initial contact. Capacity will be assessed in line with the Mental Capacity Act (2005) Code of Practice. If, after this has been adhered to, an individual is thought to lack capacity to consent to participation in the study, they will not be included.

If you plan to retain and make further use of identifiable data/tissue following loss of capacity, you should inform participants about this when seeking their consent initially.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:

- [ ] Manual files (includes paper or film)
- [ ] NHS computers
- [ ] Social Care Service computers
- [x] Home or other personal computers
- [x] University computers
- [ ] Private company computers
- [x] Laptop computers

Further details:
Work emails may be used for correspondence.
Personal telephone numbers may be used for correspondence with participants if that is what they provide.
Direct quotes will be used in the thesis write up and possible future publication.
Audio recordings will be taken.
Data will be anonymised and stored onto the encrypted and password protected university server using the chief investigator's personal laptop computer.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Interviews will be recorded using a voice recorder. This device will not be encrypted but the recordings will be uploaded and stored on the the encrypted and password protected Lancaster University server Audio recordings will be transferred onto the secure, encrypted Lancaster university drive and will be written up into anonymised transcripts. Recordings will then be stored on the researcher's university drive until the successful examination of the thesis project is complete. Following this, recordings will be deleted.
Any personal data that is kept will be stored in the encrypted university storage space.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Pseudonyms will be used to replace participant names and data will be anonymised by the removal of identifying information. This will be in line with the NHS Code of Confidentiality.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

The lead researcher. Participants are staff, so no care team is involved in participation for this study.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Data will be analysed by the researcher at the researcher's home address on-site at Lancaster University.
Transcription of recordings will be conducted at the research site in line with local agreements with the research site.
The voice recorder will not be encrypted, but data will be moved to the encrypted Lancaster university storage space at the soonest convenience following interviews. Transcription will occur at the research site. Other devices will be password protected and confidential information will not be stored on these devices as it will be stored onto the encrypted Lancaster University server.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Dr	Suzanne	Hodge
Post	Lecturer in Health Research		

Qualifications	PhD, MSc, BA
Work Address	Clinical Psychology, Div. Of Health Research
	Lancaster University
	Lancaster
Post Code	LA1 4YG
Work Email	s.hodge@lancaster.ac.uk
Work Telephone	01524 592754
Fax	

A43. How long will personal data be stored or accessed after the study has ended?

- (•) Less than 3 months
- ( ) 3 – 6 months
- ( ) 6 – 12 months
- ( ) 12 months – 3 years
- ( ) Over 3 years

A44. For how long will you store research data generated by the study?

Years: 10
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

At the end of the study audio recordings from the interviews will be deleted. All other data will be saved electronically, including consent forms which will be scanned and saved, and the paper copies destroyed. All electronic files will be encrypted and transferred via the University's secure file transfer software to the Research Coordinator who will save the files in password-protected file space on the university server where they will be stored for 10 years after the study has finished or after it is published, whichever is longer. At the end of this time, they will be permanently deleted.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

(•) Yes ( ) No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
Participants will be eligible to receive a £15 amazon gift voucher to recompense them for their time and efforts of participating in the study which is expected to take around 90 minutes of their time.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

( ) Yes (•) No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

◉ Yes ○ No

If yes, please give details including the amount of any monetary payment or the basis on which this will be calculated:
The chief investigator is employed within the same trust in which the proposed research will take place. The chief investigator is not however employed by the service in which the proposed project is taking place and is not managed or line managed by people within this service. The chief investigator has, however, accepted a job offer with the research site to commence following the completion of their clinical training.

The field supervisor works within the service in which the proposed research is taking place.

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

○ Yes ◉ No

Please give details, or justify if not registering the research.
No suitable public database exists.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- ☑ Peer reviewed scientific journals
- ☑ Internal report
- ☑ Conference presentation
- ☐ Publication on website
- ☐ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- ☐ No plans to report or disseminate the results
- ☐ Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Any quotes used will be given pseudonyms, and any identifying information will be removed.

A possible limit of confidentiality is that it might be difficult to make quotes fully anonymous in the report. Personal details will not be used but there is a chance that people could be identified due to the small sample size and

relatively small number of facilities in the region.

A53. Will you inform participants of the results?

(●) Yes ( ) No

Please give details of how you will inform participants or justify if not doing so.
Participants will be asked if they wish to receive a summary of the research findings at the end of the study.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- [ ] Independent external review
- [ ] Review within a company
- [ ] Review within a multi−centre research group
- [x] Review within the Chief Investigator's institution or host organisation
- [x] Review within the research team
- [x] Review by educational supervisor
- [ ] Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The project has been reviewed by the research tutors of the Doctorate in Clinical Psychology training course at Lancaster University and the chief investigator's research supervisor.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 12
Total international sample size (including UK):
Total in European Economic Area:

Further details:

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Estimation of likely participants and suitable qualitative study sample size.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Thematic Analysis

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co−applicants, protocol co−authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title Forename/Initials Surname
	Dr Suzanne Hodge
Post	Lecturer in Health Research
Qualifications	PhD, MSc, BA, FHEA
Employer	Lancaster University
Work Address	Clinical Psychology, Div. Of Health Research Lancaster University Lancaster
Post Code	LA1 4YG
Telephone	01524 592754
Fax	
Mobile	
Work Email	s.hodge@lancaster.ac.uk

	Title Forename/Initials Surname
	[redacted]
Post	Consultant Clinical Psychologist
Qualifications	
Employer	[redacted]
	[redacted]
	[redacted]
	[redacted]
	[redacted]
	[redacted]
	[redacted]
Fax	
Mobile	
Work Email	

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ○ NHS or HSC care organisation
- ◉ Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)
- ○ Other

Commercial status: Non-Commercial

If Other, please specify:

Contact person

Name of organisation	Lancaster University
Given name	Becky
Family name	Gordon
Address	Deputy Head of Research Services
Town/city	Lancaster University
Post code	LA1 4YG
Country	UNITED KINGDOM
Telephone	01524 592981
Fax	
E-mail	sponsorship@lancaster.ac.uk

A65. Has external funding for the research been secured?

Please tick at least one check box.

- ☐ Funding secured from one or more funders
- ☐ External funding application to one or more funders in progress
- ☑ No application for external funding will be made

What type of research project is this?

- ◉ Standalone project
- ○ Project that is part of a programme grant
- ○ Project that is part of a Centre grant
- ○ Project that is part of a fellowship/ personal award/ research training award
- ○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ◉ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title Forename/Initials Surname [redacted] [redacted]
Organisation	[redacted] NHS Foundation Trust
Address	Research & Development
	[redacted] NHS Foundation Trust
	[redacted]
Post Code	[redacted]
Work Email	Research.office@l[redacted].nhs.uk
Telephone	[redacted]
Fax	
Mobile	

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 07/05/2019
Planned end date: 30/09/2019
Total duration:
Years: 0 Months: 4 Days: 24

A71-1. Is this study?

- (●) Single centre
- ( ) Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

- [x] England
- [ ] Scotland
- [ ] Wales
- [ ] Northern Ireland
- [ ] Other countries in European Economic Area

Total UK sites in study 1

Does this trial involve countries outside the EU?

( ) Yes (●) No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

- [x] NHS organisations in England 1
- [ ] NHS organisations in Wales
- [ ] NHS organisations in Scotland
- [ ] HSC organisations in Northern Ireland
- [ ] GP practices in England
- [ ] GP practices in Wales
- [ ] GP practices in Scotland

☐ GP practices in Northern Ireland

☐ Joint health and social care agencies (eg community mental health teams)

☐ Local authorities

☐ Phase 1 trial units

☐ Prison establishments

☐ Probation areas

☐ Independent (private or voluntary sector) organisations

☐ Educational establishments

☐ Independent research units

☐ Other (give details)

Total UK sites in study: 1

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ◉ No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

Regular, monthly supervision with research supervisor at Lancaster University and with field supervisor at [redacted]

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:* in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland**

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☐ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☑ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ◉ No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name
IN1	(•) NHS/HSC Site ( ) Non-NHS/HSC Site	F name Sam ame e Mellor .mellor2@lancaster.ac.uk
	Organisation [redacted] NHS FOUN	Hons) Psychology
	name [redacted]	
	Address [redacted]	GDOM
	Post Code	
	Country ENG	

[redacted]

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 2018.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:

    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.

11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.
12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further

information. We would be grateful if you would indicate one of the contact points below.

- ◯ Chief Investigator
- ◯ Sponsor
- ◯ Study co-ordinator
- ◯ Student
- ◯ Other – please give details
- ◯ None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Mr Sam Mellor on 03/05/2019 13:27.

Job Title/Post:	Trainee Clinical Psychologist
Organisation:	Lancaster University
Email:	s.mellor2@lancaster.ac.uk

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co−sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at ethics@lancaster.ac.uk on 03/05/2019 13:56.

Job Title/Post:	Head of Research Quality and Policy
Organisation:	Lancaster University
Email:	b.gordon@lancaster.ac.uk

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr Suzanne Hodge on 03/05/2019 13:29.

Job Title/Post:

Organisation:

Email:

Appendix 4-A

Version 0.2 26/04/2019 IRAS: 259347

Staff Experiences of Team Formulation in an Inpatient Forensic Service

Protocol

Applicants

Principal Investigator

Sam Mellor

Trainee Clinical Psychologist, Lancaster University, Lancaster, LA1 4YG

Phone: 07852516499

Email: s.mellor2@lancaster.ac.uk

Co-investigators

Dr Suzanne Hodge

Lecturer in Health Research, Clinical Psychology, Division of Health Research, Lancaster University, Lancaster, LA1 4YG

Phone: 01524 592712

Email: s.hodge@lancaster.ac.uk

[redacted]

[redacted]

Phone: [redacted]

Email: [redacted]

Introduction/Rationale

The Joint Commissioning Panel for Mental Health (2013) outlines the 'core purposes' for forensic mental health care pathways. This includes supporting people's mental health needs and the assessment and management of the risk of re-offending, which Kennedy (2002), claimed to be the most important roles for these services. Hart, Sturmey, Logan and McMurran (2011) highlight that diagnosis and offence classification is not sufficient to support understanding an individual's history and future risk of offending. Formulation can improve this understanding, but individual formulation is not always possible or appropriate in inpatient forensic services and working with the care-team can be important (Rusbridge, Tooze, Griffith & Wilkinson-Tough, 2018). This therefore highlights a role for team formulation in these settings.

Formulation is an important skill of Clinical Psychologists (Health and Care Professions Council [HCPC], 2015; DCP, 2011), which can have various possible benefits for teams (DCP, 2011). There is no singly agreed definition of formulation and various professions adopt different understandings (DCP, 2011). Johnstone and Dallos (2014) identify formulation as a shared hypothesis about a person, which is based on personal meaning and draws from psychological theory. Overall, common elements of formulation have been identified within the field of clinical psychology, which have identified formulation as a theory based, collaborative framework focussed on personal meaning, which guides intervention (DCP, 2011).

Working systemically with staff teams forms an important part of the role of clinical psychologists and enables greater influence and wider provision of psychologically-informed practice than working one-to-one (DCP, 2010). The Clinical Psychology Leadership Development Framework (2010) also indicates that forensic psychologists must 'be able to use psychological formulations to assist multi-professional communication and the understanding, development and learning of service users.' Team formulation may therefore represent an opportunity for psychologists to support psychological thinking at team and service levels (DCP, 2011) and may be a powerful systemic intervention for staff and service users (Kennedy, Smalley & Harris, 2003).

Team formulation also has no single definition (Geach et al., 2017). However, different definitions also appear to have incorporated common elements. For example, Geach et al. (2017) p. 27 define the function of team formulation as enabling 'team members to develop a shared psychological understanding of presenting difficulties; which summarises their nature, explains their development and maintenance, and guides intervention planning'. Johnstone (2014) p. 216 also refers to the 'process of facilitating a group or team of professionals to construct a shared understanding of a service user's difficulties' which provides a structure for integrating information from a multidisciplinary team (MDT) and generate hypotheses to inform intervention planning (Johnstone, 2014).

Much of the existing literature about team formulation has focussed on outcomes such as increased empathy (Waugh et al., 2010; Wharne & Spilsted, 2011; Whitton et al., 2016), enhanced therapeutic relationships (Berry et al., 2016; Waugh et al., 2010; Summers, 2006), assisting the development of care-plans (Craven-Staines et al., 2010; Summers, 2006), improving communication (Dexter-Smith et al., 2010), improving psychological understanding

(Dexter-Smith et al., 2010; Whitton et al., 2016), improving staff morale (Totman, 2011) and improving team working (Summers, 2006; Kellett et al., 2014 Whitton et al., 2016). This study wants to consider the processes involved in team formulations, in order to develop a better understanding of what components may be driving the reported outcomes.

Geach et al. (2017) claim a lack of consistency in the approach to team formulation raises concerns due to inconsistency and replicability of team formulation as an evidence-based practice. They also called for future research to measure the factors that mediate and moderate the outcomes of team formulations and whether any components of team formulation contribute to change. However, it appears that these components are not well known or understood and therefore qualitative research is needed to develop an understanding of what the components that make up team formulation may be. Therefore, understanding key themes across different approaches to team formulation, as experienced by staff members who have been directly involved in this process might provide a starting point for understanding the processes commonly involved.

Therefore, the current research aims to develop an understanding of the components that comprise the process of team formulation from the perspective of staff members involved in multi-disciplinary forensic teams. Developing this understanding may then, in turn, support understanding of what would be important to include in future measurements which evaluate the effectiveness of team formulations. The current research will adopt a broad definition of team formulation and will consider any team-based approach or intervention that has used consultation informed by psychological formulation as a means of understanding and working with a service-user or group of service-users.

As highlighted by Day (2016) when discussing individual forensic case formulation, flexibility in the approach could stem from practitioners choosing different approaches to fit the individual needs of teams and service users. This study does not look to promote a unified model or approach to team formulation, but it aims to develop an understanding into the common factors experienced by team members involved in team formulations with different psychological professionals and service users.

Method

Participants

Participants will be members of staff from multi-disciplinary teams working in a forensic service. Participants will have had recent experience of being involved in a team formulation intervention. The study is looking for between 12-15 participants.

Inclusion Criteria

- Involvement in team formulation meetings or process in the past 12 months in forensic inpatient services.
- Staff from any discipline working in forensic inpatient services.
- Had involvement in the care of the service user around whom the team formulation was held.

Exclusion Criteria

- No involvement with team formulation in the past 12 months.
- No involvement in teams where team formulations have occurred within a forensic environment.

Design

Individual semi-structured interviews will be conducted with participants, using a narrative approach. These will be analysed using thematic analysis (Braun and Clarke, 2006).

Materials

Semi-structured interview schedule, audio recorder and transcription equipment (foot pedal).

Consent

Obtain ethical approval from Lancaster University FHMREC, alongside an application to HRA. [redacted] NHS R&D approval will also be required once FHMREC and HRA approval is obtained to confirm permission of capacity and capability. This agreement has been sought in principle. Local level approval has also been agreed in principle via the senior leadership team, pending the necessary ethical reviews.

As the project will involve working with a number of teams, provisional consent to work with the team may be necessary prior to gaining ethical approval. Again, this permission has been obtained in principle, prior to ethical approval. Following this, more formal team and individual consent will be gained.

Procedure

Participants will be recruited following consultation with the field supervisors who will highlight teams who have engaged in team formulation meetings in the past 12 months. Managers/Psychologists working in these teams will then identify potential participants and provide them with information packs about the study, including the participant information sheet, expression of interest/opt-in form, consent form, email and the advertising materials

(all to be found in the collated ethics document). These will be available in hard copies, which will be distributed in the work place of the identified teams. The materials will also be distributed as attachments to the email.

Participants will be able to indicate whether they would be interested in taking part in the project and if they would like to discuss the project further. Participants will not have to do this immediately and they will be given time to consider whether they wish to take part in the research, however, if participants do decide to take part immediately, this will be possible. Participants will be able to provide verbal consent for their details to be passed to the research team or they can contact the research team themselves via the contact information provided or using the expression of interest form. If contact information is provided to the research team, the potential participant will then be contacted to provide further information. If potential participants maintain their interest, arrangements will be made to go through the participant information sheet, obtain informed consent and conduct a semi-structured interview at the participant's work place (NHS site) or via telephone/skype call. For participants conducting the interview via skype, consent will be audio recorded. The interview will also be audio recorded.

The researcher will also visit the teams to introduce the project and to support recruitment of prospective participants. If participants express their interest and are happy to participate on that day, arrangements can be made to gain full consent and conduct an interview. The rationale for this is due to the nature of secure inpatient services being busy environments and it will therefore be necessary to have this flexibility in the event that participants identify their availability on the day.

This process may be repeated with a second call to recruit if necessary to support recruitment.

Once recruited, participants will be asked to attend a single interview session which is expected to last 30 minutes to 1 hour. The interview will consider various stages involved in the process of team formulation interventions, from prior to the referral to any follow-up after the team formulation meeting(s) have taken place.

Interviews will be recorded onto a voice recording device. This will not be encrypted, or password protected but will be kept securely by the researcher and data will be transferred to the secure, encrypted Lancaster University drive at the earliest opportunity. Following this, recordings will be transcribed into anonymous transcripts. The first recording will be checked by the research supervisor.

Potential Barriers

Berry et al. (2016, 2017) highlight that team formulation has received limited uptake across mental health settings and hypothesised that this may be due to a lack of understanding of the organisational barriers and facilitators to implementing formulations in routine practice. This may impact on access to participants. A field supervisor working in a forensic service has been identified and will support with identification of teams and recruitment of participants.

Geach et al. (2017) highlights the lack of uniformity in the definition and application of team formulation. This highlights a possible issue as different services involved in the study may practise team formulation in different ways. Therefore, whilst analysis of different experiences of the same team formulation may be possible, integrating results found across

services may be difficult if common factors are not present. I plan to overcome this by exploring recent examples of team formulations with members of each team. This would support exploration of similarities and differences across the different team formulation meetings. This will enable the study to meet some of its aims of understanding common components that make up team formulations, which can then be researched further. Also, whilst the lack of uniformity in the application of team formulations across services may represent a limitation, it is also representative of how team formulation is currently being applied in practice and therefore enables the study to investigate the phenomenon in real clinical settings.

Inpatient services are busy environments and staff availability can be unpredictable. Careful planning which is sensitive and flexible to the needs of the shift will therefore be important to support participation. Flexibility in scheduling interviews and good communication such as telephoning prospective participants on scheduled interview days prior to travelling for an interview will also be important to maximise time efficiency.

Telephone and skype calls will also be possible methods for interviews to increase flexibility in the research methods and support recruitment.

Management of Professional Role and Researcher Role

It is acknowledged that the researcher's role transcends two areas, due to simultaneously holding positions as a mental health professional and a researcher. The researcher's professional role does not sit within the network in which the research is being carried out. In circumstances where the researcher believes it to appropriate or necessary, such as if there are concerns about a participant's wellbeing, risk, or practices within the service, information will be shared using the appropriate structures available, such as the

researcher's field supervisor, research supervisor, safeguarding etc. If possible, this will be agreed with the participant in the first instance.

Analysis

Data will be collected from individual semi-structured interviews, using a narrative approach asking participants to describe a recent experience of team formulation. A Thematic Analysis approach as outlined by Braun and Clarke (2006) will be used to analyse the data. The study will aim to develop a thematic description of the whole data set to support the research to answer questions about the common factors that exist across different experiences and different approaches to team formulation. It would be important to approach the thematic analysis in this way because team formulation has no singly agreed definition, so gathering common themes across the data set would therefore be important to support understanding of common processes and experiences across the differing approaches.

An inductive approach to TA will be used to code data without applying a pre-conceived theoretical framework or pre-existing themes (Braun & Clarke, 2006). This is in line with the rationale for conducting this research as little is known about commonly experienced themes and processes involved in team formulation meetings and further research is needed to establish a shared understanding of factors involved (Geach et al., 2017).

Dissemination

The findings will be written in a report for submission to Lancaster University in partial fulfilment of a Doctorate in Clinical Psychology. The findings will also be fed back in written and verbal format to members of staff in the services involved in the study. The findings may

also be published in an academic/professional journal and may be presented at conferences. Participants will also receive a copy of the findings or a summary at their request.

Ethical concerns

Risk to participants

Minimal risks are associated with taking part in this study. However, participants may find discussing their experiences to cause distress. If participants become distressed during the interview, the researcher will offer to pause or stop the interview. If this occurs during or after participation in the study, participants will have the opportunity to discuss it with the interviewer, or use the resources provided on the Participant Information Sheet.

It is unlikely that sensitive information will be discussed, as the study focuses on the processes involved in team formulation meetings, rather than the content. However, participants are members of staff who will be asked to discuss aspects of their work place. This could evoke some discomfort if they want to discuss things that they have been unhappy about. Linked to this, team formulation interventions often occur in circumstances where a team is experiencing difficulties when supporting a service user or feel stuck (DCP, 2011). Therefore, it is important to acknowledge that there is a possibility for distress to be experienced whilst people recall their experiences of these interventions. Information has been incorporated into the participant information sheet for the event that any participants feel they would like to seek support following their participation in the study.

Participants may find it difficult talking about aspects of their work in the work place, particularly if those experiences are not positive ones. Confidentiality will be maintained (notwithstanding confidentiality limits) and this will be explained clearly to participants.

Options will also be available for interviews to be done via telephone or Skype, which will provide additional options for the location from which participants take part in the study and may therefore further protect anonymity.

Participants are welcome to withdraw from the study at any time. However, the removal of their data will have a time limit of two weeks following their interview. After this, it may not be possible to remove data once analysis is started and the data has been pooled.

Risk to researchers

The interviews may be conducted within a forensic environment, which may present some risk to the researcher. The researcher will be escorted by a staff member to and from the interview location and will be interviewing members of staff.

Approximate Timescale

ACTIVITY	**DATE**
Submit ethics proposal	January 2019
Data collection	April 2019- June 2019
Data analysis	May-July 2019
Submit Thesis	September 2019

References

Anderson, C., & Kirkpatrick, S. (2016). Narrative interviewing. *International Journal of Clinical Pharmacology, 38,* 631–634. doi: 10.1007/s11096-015-0222-0

Berry, K., Haddock, G., Kellett, S., Awenat, Y., Szpak, K., & Barrowclough, C. (2017). Understanding Outcomes in a Randomized Controlled Trial of a Ward-based Intervention on Psychiatric Inpatient Wards: A Qualitative Analysis of Staff and Patient Experiences. *Journal of clinical psychology*, *73*(10), 1211-1225.

Berry, K., Haddock, G., Kellett, S., Roberts, C., Drake, R., & Barrowclough, C. (2016). Feasibility of a ward-based psychological intervention to improve staff and patient relationships in psychiatric rehabilitation settings. *British Journal of Clinical Psychology*, *55*(3), 236-252.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa.

Division of Clinical Psychology (2012). Commissioning and Delivering Clinical Psychology in Acute Adult Mental Health Care. Leicester: British Psychological Society.

Division of Clinical Psychology (2011). Good practice guidelines on the use of psychological formulation. Leicester: British Psychological Society.

Division of Clinical Psychology (2010). The core purpose and philosophy of the profession. Leicester: British Psychological Society.

Donaghay-Spire, E. G., McGowan, J., Griffiths, K., & Barazzone, N. (2016). Exploring narratives of psychological input in the acute inpatient setting. *Psychology and Psychotherapy: Theory, Research and Practice*, *89*(4), 464-482.

Geach, N., Moghaddam, N. G., & De Boos, D. (2017). A systematic review of team formulation in clinical psychology practice: Definition, implementation, and outcomes. *Psychology and Psychotherapy: Theory, Research and Practice*, 1-30.

Hart, S., Sturmey, P., Logan, C., & McMurran, M. (2011). Forensic Case Formulation. *International Journal of Forensic Mental Health, 10*(2), 118-126. doi: 10.1080/14999013.2011.577137

Joint Commissioning Panel for Mental Health. (2013). Guidance for commissioners of forensic mental health services: Practical Mental Health Commissioning. *Raffertys*.

Johnstone, L. & Dallos, R. (2014). Formulation in Psychology and Psychotherapy. *East Sussex: Routledge*.

Kellett, S., Wilbram, M., Davis, C., & Hardy, G. (2014). Team consultancy using cognitive analytic therapy: A controlled study in assertive outreach. *Journal of psychiatric and mental health nursing*, *21*(8), 687-697.

Kennedy, F., Smalley, M., & Harris, T. (2003). Clinical psychology for in-patient settings: Principles for development and practice. *Clinical Psychology Forum, 30,* 21–24.

Mind. (2011). Listening to experience. An independent inquiry into acute and crisis mental health care. London: Author. Retrieved from https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf

Summers, A. (2006). Psychological formulations in psychiatric care: staff views on their impact. *Psychiatric Bulletin*, *30*, 341-343.

Totman, J., Hundt, G. L., Wearn, E., Paul, M., & Johnson, S. (2011). Factors affecting staff morale on inpatient mental health wards in England: a qualitative investigation. *BMC psychiatry*, *11*(68), 1-10.

Whitton, C., Small, M., Lyon, H., Barker, L., & Akiboh, M. (2016). The impact of case formulation meetings for teams. *Advances in Mental Health and Intellectual Disabilities*, *10*(2), 145-157. Doi: 10.1108/AMHID-09-2015-0044

Appendix 4-B

Version 0.2 26/04/2019 IRAS: 259347

Participant Information Sheet

Staff Experiences of Team Formulation in an Inpatient Forensic Service

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

My name is Sam Mellor and I am conducting this research as a student in the Doctorate in Clinical Psychology programme at Lancaster University.

What is the study about?

We would like to hear about your experiences of being involved in formulation meetings in forensic services.

Why have I been approached?

You have been approached because you have been involved in formulation meetings and your views are important to help us better understand the processes involved in these meetings. It is hoped that this research will then support future developments in practice for interventions to help staff and service users.

Do I have to take part?

No. Taking part is completely optional and it will not affect your relationship with the workplace and the team whether or not you take part. Also, you can decide to take part and then change your mind.

What will I be asked to do if I take part?

If you agree to take part you will be asked to do an interview where you will answer some questions and talk about your experiences of a recent formulation meeting that you were involved in. The interview will last about 30 minutes to 1 hour and would take place in person in a private room at your work place, by telephone or using an application such as skype. You can stop the interview at any time and it can be done in two parts if required. The interviews will be audio recorded and then written up.

Will my information be confidential?

The information you provide will be kept confidential and stored safely. Your personal information will be kept securely and will be destroyed at the end of the project.

Only the researchers conducting this study will be able to access the data.

Audio recordings from the interviews will be written up and then the recording will be destroyed securely at the end of the project.

- Lancaster University will keep copies of the anonymised transcripts for 10 years after the study has finished or after it is published, whichever is longer. At the end of this time, they will be destroyed securely.
- Files held on computer will be password protected.
- The write up of your interview will not have any personal information like your name. Anonymised quotes from your interview may be used in the report or in publications of the study, but your name will not be used with them.
- Personal data will be confidential and will be kept separately from your interview.

The researchers will not tell your employer that you have participated in the study, unless serious concerns are raised such as concerns about risk towards yourself or others.

The researchers will not directly inform others that you have participated, however, as interviews will possibly be taking place at your workplace and with the agreement of your manager, this presents a limitation to the confidentiality of participation.

If it is felt that there is a risk of harm to yourself or someone else or if there are concerns about your wellbeing, confidentiality would have to be broken. This would most likely be my supervisor in the first instance and would then be followed up through whatever channel is appropriate. If it is possible, I would speak to you and agree a plan together before doing this.

Another possible limit of confidentiality is that it might be difficult to make quotes fully anonymous in the report. Your personal details such as your name will not be used but there is a chance that people who know you and work with you might be able to identify you from the quotes. However, all quotes will be as general as possible.

Participants using Skype should be aware that the internet cannot be guaranteed to be a completely secure means of communication.

What will happen if I decide to leave part way through?

You can choose to leave the study at any time. You can also ask for your data to be taken out, up to a period of two weeks after the interview.

What will happen after I take part?

The results will be written up in a research report and may be published in an academic journal and may be presented at conferences. The results will also be presented to staff in

participating services either verbally and/or in written form. If you would like a copy of the results, please ask the researchers.

Are there any risks?

We expect there to be minimal risks associated with taking part in this study. If you experience any distress during or after the interview, please discuss it with Sam (the interviewer), or the resources provided at the bottom of this sheet.

Are there any benefits to taking part?

Taking part may give you the opportunity for your opinions and experiences to be heard and this could provide valuable information about how to change and improve for the benefit of both staff and service users.

You will be eligible for a £15 Amazon gift voucher for your time and effort taking part in the study.

Who has reviewed the project?

This study has been reviewed and given approval by the Lancaster University Faculty of Health and Medicine Research Ethics Committee, the Health Research Authority and the Secure Services Clinical Audit and Research Network. The local NHS Foundation Trust Research and Development Offices have also given their agreement for the project.

Who is organising and funding this study?

The project is being completed in partial completion of a Doctorate in Clinical Psychology at Lancaster University and is supported by [redacted] NHS Trust.

How do I take part?

If you are interested in taking part then you can contact Sam Mellor at s.mellor2@lancaster.ac.uk or on 07852516499. Sam is a Trainee Clinical Psychologist and a member of the research team. Sam will be able to give you more information about taking part.

Research team

Members of the research team are:

Sam Mellor (Trainee Clinical Psychologist, Lancaster University)

Dr Suzanne Hodge (Lecturer in Health Research, Lancaster University)

[redacted]

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Bill Sellwood, Programme Director of the Doctorate in Clinical Psychology
Faculty of Health and Medicine
Lancaster University
Tel: +44 (0)1524 593998
Email: b.sellwood@lancaster.ac.uk
or
Professor Roger Pickup Associate Dean for Research
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG
Tel: +44 (0)1524 593746

Email: r.pickup@lancaster.ac.uk

GDPR

"Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection*"*

Lancaster University is the sponsor for this study based in England. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Lancaster University will keep identifiable information about you for 10 years after the study has finished/is published.

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

[redacted] will collect information from you for this research study in accordance with our instructions.

[redacted] *will use your name, and contact details to contact you about the research study, to oversee the quality of the study. Individuals from Lancaster University and regulatory organisations may look at your research records to check the accuracy of the research study. The only people in Lancaster University who will have access to information that identifies you will be people who need to contact you to audit the data collection process.*

Resources

It is not anticipated that taking part in this research will cause distress. However, should you feel distressed as a result of taking part you can contact:

- The Samaritans if you feel you need to talk to someone using their local helpline: 01524 61666 or website www.samaritans.org
- You can contact Mind on the following number: 0300 123 3393, or by email on: info@mind.org.uk or by text message on: 86463

- Your employer's occupational health service.

Thank you for taking the time to read this information sheet.

Appendix 4-C

Version 0.1 14/01/2019 IRAS: 259347

Staff Experiences of Team Formulation in an Inpatient Forensic Service

Consent Form

We are asking you to participate in a study which investigates experiences of formulation meetings. Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with a tick if you agree. If you have any questions or queries before signing the consent form please speak to a member of the research team.

	Please tick box
1. I confirm that I have read the participant information sheet and understand what is expected of me in this study	
2. I confirm that I have had the chance to ask any questions and to have them answered.	
3. I understand that my involvement is voluntary and I can withdraw at any time.	
4. I understand that if I wish to withdraw my data, I can do so up to 2 weeks after the interview without giving a reason.	
5. I understand that my interviews will be audio recorded and then made into an anonymised written transcript.	

6. I understand that the information from my interviews will be anonymised along with information from others and may be published.	
7. I consent to information from the study including quotations from my interviews being used in reports and conferences.	
8. I understand that any information I give will remain confidential unless there may be a risk of harm to myself or others. In these circumstances, information may need to be shared with appropriate people.	
9. I consent to Lancaster University keeping the anonymised data from the study for up to 10 years after the study has finished or after publication.	
10. I consent to take part in the study.	

Name of Participant_____ Signature_____ Date _____

Name of Researcher _____Signature _____Date _____

Appendix 4-D

Version 0.1 14/01/2019 IRAS: 259347

Staff Experiences of Team Formulation in an Inpatient Forensic Service

Interview Schedule

This interview schedule outlines areas to be discussed in the interview with some example questions. The interview will use a narrative approach based on that set out by Anderson and Kirkpatrick (2016) and will therefore prioritise the participant's experiences. The interview will therefore start broad to try to gain the participant's story. Exact questions will depend on participants' responses and content that the individual being interviewed finds important and discusses. Below are some examples of possible questions and prompts if required.

Introduction

Introduce self. Cover participant information sheet, consent and purpose of interview. Check any necessary demographic information not already collected at point of consent and any changes in circumstances. Orientate participants to think about their recent example of involvement in a team formulation-based intervention. The interview will then begin with open questions asking the participants for their story. Following this, follow up questions will be used based on the content described by the participant. This may include questions about before, during and after the formulation-based intervention and some examples are outlined below.

Before the meeting

Example questions:

Thinking back to the team formulation meeting/intervention, what was it like for the team on the run up to referral?

How did the referral come about? Why was it needed? Who made it? Was it a team decision? Ward review? Psychology suggestion?

Are team formulation meetings a regular exercise embedded in practice?

During the intervention/meeting

Example questions:

How would you describe the meeting/intervention itself? What was your experience of the meeting? Whose voices were heard?

How was the meeting set up? Did it seem structured/unstructured?

Was the focus on the service user/the team/interactions between/working with the person/understanding the person?

Who led? Were they using a model?

How were different views incorporated?

Without discussing individual details, what topics were discussed?

Did the team talk about the service user's early life experiences?

How did the team make sense of things?

Did you feel able to contribute?

After the meeting

The interviewer will ask about the period following the intervention. Again focusing on processes.

Example questions:

What happened after the meeting?

Did anything from the meeting change the way you worked with, understood the service user?

Did any actions come from the meeting? Were they formal/informal? Who were they assigned to? Extra work?

Was there any follow-up? Was it a one-off meeting? If the whole team weren't able to be present, was information shared? If so, how did this happen?

Conclusion

In this part of the interview the participant will be thanked for taking part. The interviewer will ensure the participant has not been distressed by the interview by asking how the participant feels. If necessary, participants will be directed to sources of support on the participant information sheet.

Appendix 4-E

Version 0.2 26/04/2019 IRAS: 259347

Email to staff teams/manager for distribution

*Email Subject: Research at [site name] - Staff experiences of formulation meetings - £15 Amazon voucher to all participants

Dear Team Member

RE: Participation in research study

We would like you to participate in a research study about your recent involvement in a formulation meeting.

You would be asked to attend a one-off interview in which you would talk about your experiences and it would last approximately 30 minutes to 1 hour. The interview would be at work or by telephone/skype.

You will receive a £15 Amazon gift voucher for your time and effort.

More details are available in the attachments. If you have any queries or you are interested in taking part, please contact Sam Mellor (Trainee Clinical Psychologist) on s.mellor2@lancaster.ac.uk or 07852516499, or (insert appropriate team member) or [redacted] on [redacted]

Yours sincerely

Sam

Sam Mellor

Trainee Clinical Psychologist

Lancaster University

s.mellor2@lancaster.ac.uk

Appendix 4-F

Version 0.2 26/04/2019 IRAS: 259347

Leaflet/Advertisement

Research on Staff Experiences

Would you like to take part in a research study about your involvement in a formulation meeting?

Your experiences are valuable to help improve services for staff and service users.

If you take part you would be invited to a **30 – 60 minute** interview to share your experiences.

You will receive a **£15 Amazon gift voucher** for your time and effort.

Contact Sam Mellor at s.mellor2@lancaster.ac.uk or on 07852516499 or the team psychologist for more details

Appendix 4-G

Version 0.1 14/01/2019 IRAS: 259347 Expression of interest/ Opt-In Form

Participant Opt-In Form

Staff experiences of team formulation in an inpatient forensic service

I would like to be contacted further about this research project:

Name	Signature	Email/Contact number

You can return this form by posting it to me in the envelope provided or you can contact me using the details below:

Sam Mellor

Trainee Clinical Psychologist

Lancaster University

Email: s.mellor2@lancaster.ac.uk

Mobile: 07852516499

Thank you.

Appendix 4-H

Confirmation of Capacity and Capability

LD [External] RE: Understanding Staff Experiences of the processes involved in Team Formulation Interventions in Forensic Inpatient Services (259347)

Follow up. Start by 24 December 2019. Due by 24 December 2019.

Action Items

Sent: 17 June 2019 10:53
To: Mellor, Sam <s.mellor2@lancaster.ac.uk>
Cc: [redacted]; IRAS Sponsorship <sponsorship@lancaster.ac.uk>
Subject: Understanding Staff Experiences of the processes involved in Team Formulation Interventions in Forensic Inpatient Services (259347)
Importance: High

Dear Sam,
Thank you for your research submission to carryout your above named project at [redacted]
As confirmation of capacity and capability is not required (as per the HRA approval letter). I am pleased to confirm that your study can now commence in the Trust.

As you are employed by [redacted]

Please can you now liaise with [redacted]

I wish you every success with your project

Regards
[redacted]

Appendix 4-I

FHMREC Letter of Approval

Applicant: Sam Mellor
Supervisor: Suzanne Hodge
Department: Health Research
FHMREC Reference: FHMREC18051

24 April 2019

Dear Sam

Re: Staff Experiences of the factors involved in Team Formulation Interventions in Forensic
Inpatient Services

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;

- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);

- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

[redacted] Research Ethics Officer, Secretary to FHMREC.

Appendix 4-J

Health Research Authority Letter of Approval

Mr Sam Mellor

Trainee Clinical Psychologist

Lancashire Care NHS Foundation Trust

Clinical Psychology, Division of Health Research

Lancaster University

Lancaster

LA1 4YG

Email: hra.approval@nhs.net

Research-permissions@wales.nhs.uk

11 June 2019

Dear Mr Mellor

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

Study title:	**Understanding Staff Experiences of the processes involved in Team Formulation Interventions in Forensic Inpatient Services**
IRAS project ID:	**259347**
REC reference:	**19/HRA/2996**
Sponsor	**Lancaster University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.
Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

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

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

How should I work with participating non-NHS organisations?

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

What are my notification responsibilities during the study?

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

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

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

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **259347**. Please quote this on all correspondence.

Yours sincerely,

Sharon Northey

Approvals Manager

Email: hra.approval@nhs.net

Copy to: [redacted]

List of Documents

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

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [FHMREC Ethics Approval]	0.1	24 April 2019
Copies of advertisement materials for research participants [Advertisement materials V0.2]	0.2	26 April 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]	0.1	19 July 2018
HRA Schedule of Events [HRA Schedule of Events]	2	09 May 2019
HRA Statement of Activities [HRA Statement of Activities]	2	09 May 2019
Interview schedules or topic guides for participants [Interview Schedule 0.1]	0.1	14 January 2019
IRAS Application Form [IRAS_Form_03052019]	03 May 2019	
Letter from sponsor [FHMREC Ethics Approval Letter]	0.1	02 May 2019
Letters of invitation to participant [Email Invitation V0.2]	0.2	26 April 2019
Participant consent form [Consent form V0.1]	0.1	14 January 2019
Participant information sheet (PIS) [Participant Information Sheet]	0.2	26 April 2019
Research protocol or project proposal [Protocol]	0.2	26 April 2019
Summary CV for Chief Investigator (CI) [CI CV]	0.1	25 April 2019
Summary CV for student [Student CV]	0.1	25 April 2019
Summary CV for supervisor (student research) [Supervisor CV]	0.1	01 August 2017

IRAS project ID 259347

Information to support study set up

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

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
There is one NHS participating organisation; therefore there is one site type.	Organisations will not be required to formally confirm capacity and capability, and research procedures may begin 35 days after provision of the local information pack, provided the following conditions are met. You have contacted participating NHS organisations (see below for details) HRA and HCRW Approval has been issued. The NHS organisation has not provided a reason as to why they cannot participate. The NHS organisation has not requested additional time to confirm.	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No application for external funding has been made.	Neither a local Principal Investigator or collaborator is expected to be in place. A local contact has been identified to help with identifying NHS staff.	Research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would not be expected to hold Letters of Access where staff interviews are held in non-clinical rooms.

	You may start the research prior to the above deadline if HRA and HCRW Approval has been issued and the site positively confirms that the research may proceed. You should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. The password to access the R&D contact list is Redhouse1.				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.