

**An exploration of meaning-making and collaboration in formulation and team
formulation**

‘A thesis submitted to the University of Manchester for the degree of Doctor of Clinical
Psychology in the Faculty of Biology, Medicine and Health in the School of Health Sciences’

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Thesis Abstract

‘An exploration of meaning-making and collaboration in formulation and team formulation’

This thesis comprises three papers. The first paper is a systematic review and narrative synthesis, which explores whether there is support for the claim that formulation and team formulation facilitate meaning-making, and this was considered in relation to staff experiences. Overall, the literature was limited by variable study quality. Findings suggested there is evidence that team formulation facilitates meaning-making for some staff, and identified three processes by which this may occur: introducing psychological theory, sharing of perspectives, and space for reflection. Very few papers have explored staff experiences of meaning-making in individual formulation, and thus it is hard to draw conclusions in this area. Further research of a higher quality is needed.

Paper two presents an empirical study that used Q methodology to explore staff views about whether and how service users should be involved in team formulation. Forty staff members with experience of attending team formulation meetings completed a Q Sort in which they ranked how much they agreed or disagreed with 58 statements about service user inclusion in team formulation. Factor analysis revealed three factors: *‘A safe space for staff’*, *‘Concerns about inclusion and collaboration’* and *‘Service users might find attendance distressing’*. Findings indicated that different approaches may be appropriate across different client groups and settings, and thus further research and guidance in this area is necessary.

Paper three is a critical evaluation and reflection of the research, which includes theoretical and methodological considerations, as well as additional implications and areas for future research. The author also reflects on her experience of the research process.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning

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Paper 1. Systematic Review.

Does psychological formulation facilitate meaning-making for staff: A systematic review

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Abstract

Purpose

The purpose of this systematic review was to consider whether psychological formulation achieves one of its principal claimed functions, which is to facilitate meaning-making. This was explored in relation to the experiences of staff working in mental health and probation services.

Methods

Four electronic bibliographic databases were searched. Papers were included on the basis that they discussed the construct of meaning-making. All studies that met the inclusion criteria were subject to a quality appraisal using the Quality Assessment Tool for Studies with Diverse Designs (Sirriyeh et al., 2012). The extracted data were synthesised using narrative synthesis.

Results

Nineteen studies were included. Designs comprised seventeen qualitative, one quantitative and one mixed-methods study. The quality was variable, and there is a need for further research in this area based on more robust designs. There was some support for the claim that *team formulation* and *consultation-based formulation* facilitate meaning-making for staff. Findings also suggested three processes that may support meaning-making: introducing psychological knowledge, sharing of perspectives, and space to reflect. Very few papers on focused on meaning-making in relation to staff experiences of *individual formulation*, and thus it is hard to draw conclusions in this area.

Conclusions

This paper provides tentative support for the claim that *team formulation and consultation-based formulation* facilitate meaning-making for some staff. Given the paucity of research, it is not possible to confirm whether this is the case for *individual formulation*. Areas for further research have been identified.

Key words

Individual formulation, team formulation, consultation, meaning-making, insights, understanding

Practitioner Points

- Team formulation and consultation-based formulation are useful in helping staff to make sense of service users' difficulties.
- Knowledge of psychological theory, space for reflection, and sharing perspectives are valuable aspects of team formulation, which support the meaning-making process.

1. Introduction

Background

Psychological formulation is a core skill for clinical psychologists (Health and Care Professions Council, 2015); it also features on the curriculum for psychiatrists, and all Health and Social Care staff in England are expected to have some familiarity with it (Department of Health, 2016). A formulation can be described as a hypothesis about a person's difficulties, which integrates theory, research and practice, and informs the intervention (Division of Clinical Psychology, 2011). Formulation has a number of additional claimed benefits which include: clarifying hypotheses and questions, strengthening the therapeutic relationship, and thinking about lack of progress (DCP, 2011). It has been argued that formulation offers a credible alternative to psychiatric diagnosis, which has been criticised for lacking validity, reliability and leading to a loss of meaning in distress (Kinderman et al., 2013).

Team formulation describes the practice in which a group of staff members develop a shared understanding of a person's difficulties (DCP, 2011). This approach has become increasingly popular in the United Kingdom, especially as indirect ways of working with clients, such as consultation, become a more efficient and cost-effective use of psychologists' time (Onyett, 2007). Team formulation can be used in a range of settings, including Adult Mental Health (Johnstone, 2014), Learning Disabilities (Ingham, 2015), Child and Adolescent Mental Health (Hartley, 2021) and Older Adults (Jackman & Beatty, 2015). Team formulation can take a number of different formats, and be based on various therapeutic approaches (Geach et al., 2018). In addition to the claimed benefits of individual formulation, which are listed above, team formulation has been argued to promote more psychosocial ways of thinking in staff groups, increase staff understanding of service users, support collaborative team working, and facilitate culture change in organisations (DCP, 2011).

Despite widespread usage, individual and team formulation are under-researched areas (Cole et al., 2015). There has been considerable debate in the literature about how formulation should be evaluated (DCP, 2011; Bieling & Kuyken, 2003) and currently there is no consensus amongst professionals on this issue (DCP, 2011; Vollm, et al., 2014). One direction of investigation has been to assess formulation against a scientific experimental framework, and consider whether it is reliable, valid and leads to better outcomes. Research that has adopted this approach has mostly focused on individual formulation in cognitive therapy, known as 'case conceptualisation' and support has been variable (Bucci et al., 2016; Aston, 2009). A literature review by Bieling and Kuyken (2003) found limited evidence to

support the reliability, validity and impact of case conceptualisation, concluding that this is 'modest at best'. Kuyken et al (2005) investigated whether mental health practitioners could produce reliable formulations, finding that levels of agreement decreased as formulations became more inferential. More recently, a systematic review by Easden and Kazantzis (2018) evaluated 24 studies that have investigated the reliability and validity of case conceptualisation, concluding that there is some evidence of inter-clinician reliability, but support for its effect on outcomes remains sparse. Some research has taken a similar approach to researching team formulation. A systematic review by Geach et al (2018) found that available evidence is small-scale and lacking in methodological rigour, meaning it is difficult to establish the impact of team formulation on outcomes.

Researching formulation within a scientific framework presents a number of methodological challenges. Firstly, it assumes that it is possible to judge a formulation as being either 'correct' or 'true'. This is problematic, given that guidance suggests formulations can be based on a range of different models, take a number of different perspectives, and should always be open to revision and reformulation (DCP, 2011). Similarly, the varying definitions of formulation make it difficult to operationalise. The studies listed above view formulation as an 'event', an approach which lends itself better to team formulation and certain modalities (e.g. cognitive therapy) (Kuyken et al., 2011) than others (e.g. narrative therapy) (Harper & Spellman, 2013). An additional challenge is determining how to separate the effects of formulation from the rest of therapy (DCP, 2011). These issues may in part explain why there is a paucity of studies in this area; they also raise important questions about the value of these constructs as a means of understanding and evaluating formulation.

An alternative direction is to evaluate formulation in terms of its 'usefulness' in achieving its claimed benefits (Butler, 1998), (DCP, 2011). Butler (1998) stated that 'a formulation does not have to be true, but it does have to be useful' (p.2). This approach avoids some of the methodological challenges listed above, and may be a more appropriate criterion against which to judge modalities that view formulation as a 'process'. A number of qualitative studies have explored usefulness in relation to formulation. Staff interviewed by Small et al (2018) reported individual formulation was helpful for supporting clients to make sense of their difficulties, and service users in a study by Redhead et al (2015) reported mixed reactions to receiving an individual formulation. Research into team formulation has consistently demonstrated that staff find it useful (Wainwright and Bergin, 2010). A systematic review by Short et al (2019) found it led to increased knowledge and understanding, and that staff found it helpful when feeling stuck or challenged. The first pilot randomised control trial to date was carried out by (Berry et al., 2016) who introduced weekly

team formulation meetings on inpatient wards, and found that staff who had received the intervention reported increased confidence and a better understanding of clients' problems.

Rationale for review

The literature suggests that one valuable approach to evaluating formulation is to consider whether or not it is useful (Butler, 1998). This is consistent with the DCP (2011) Guidelines statement that formulation '...is best understood in terms of usefulness than "truth"' (p.21). To our knowledge, no other systemic reviews have explored this question, which is a significant gap in the literature.

DCP Guidelines (2011) suggest that 'usefulness' in relation to formulation can be defined in a number of different ways. For example, their list of benefits and purposes includes clarifying hypotheses, thinking about lack of progress, strengthening the therapeutic alliance, dealing with core issues, and so on (p.8-9). However, the Guidelines place all these benefits in the context of the core principle that psychological formulation is 'an on-going process of collaborative sense-making' (Harper & Moss, 2003, p.8) that is 'centrally concerned with personal meaning'(p.12). This 'integrating factor' (p.9) is said to distinguish a formulation from a simple list of events and causal influences. For the purpose of this review, therefore, 'usefulness' will be operationalised as co-creating and facilitating meaning-making.

This review will focus on the extent to which staff found that formulation facilitated their own meaning-making. This will be explored in relation to team formulation and co-creation of meaning between staff and clients in individual formulation. 'Meaning-making' will be defined as evidence of co-creation of new understandings about a person's difficulties

2. Methods

2.1 Review Protocol

The review protocol was published on PROSPERO (ID: CRD42021287965) and follows the 'Preferred Reporting Items for Systematic review and Meta-Analysis Protocols' (PRISMA) (Moher et al., 2015).

2.2 Search Strategy

A systematic literature search of four electronic databases was undertaken on 10th April 2021 and 24th February 2022. MEDLINE, PsycINFO, CINAHL and Embase were searched for relevant published and unpublished literature from their inception until present day.

The search strategy was developed by generating a list of terms used to describe psychological formulation within the published literature. These terms were combined with 'meaning' and other synonyms. The terms were selected and refined through scoping searches within the selected databases. The search strategy was developed by the first author and an information specialist and discussed with co-authors.

Search terms were (Experience* or meaning* or understand* or insight*) and (psychological formulation, case formulation, case conceptualisation, reformulation, shared formulation, team formulation, reflective sessions, team case reflection, psychology* AND formulat*). Mesh terms were used for case conceptualisation.

All papers were exported from databases into Endnote (Hupe, 2019) where duplicates were removed. The first author screened titles and abstracts according to the eligibility criteria. Approximately, ten per cent of all abstracts and titles were co-screened by an independent reviewer (n=900) and inter-reliability was almost perfect (Kappa = .88). This was a stratified sample, which contained one hundred papers that had been taken to full text screening, and eight hundred titles that had been excluded. A random number generator was used to select the titles that were screened by the second reviewer.

All full text papers were screened against the inclusion criteria by the main author. Any papers where the first author was unsure about eligibility were discussed with co-authors. The authors of the included papers were contacted to see if they were aware of any other relevant literature. Forwards and backwards citation searching of the full-text papers was conducted which generated a further twenty papers.

2.3 Eligibility Criteria

For inclusion in this review, papers needed to: (1) have a description of formulation that is consistent with the DCP (2011) definitions; (2) discuss the construct of meaning-making in relation to psychological formulation. Since no papers directly referred to meaning-making, proxy terms: experience, understanding, insights or meaning were employed; (3) be published

in English; (4) Published within a peer-reviewed academic journal or dissertations and theses
(5) be an empirical investigation; (6) the focus of the article is on the experience of staff.

Papers were excluded if they were (1) book chapters or editorials; (2) secondary analysis of already published datasets.

2.4 Quality Assessment

Quality assessment was carried out using the Quality Assessment Tool for Studies with Diverse Designs (QATSDDD) (Sirriyeh et al., 2012). This is a tool designed to establish the methodological and reporting quality of studies with diverse designs (qualitative, quantitative or mixed). The main author carried out a quality assessment of all the included papers. A second reviewer rated 25% of the included papers. Disagreements in ratings were resolved through discussion, with all reaching consensus.

2.5 Analysis of Studies

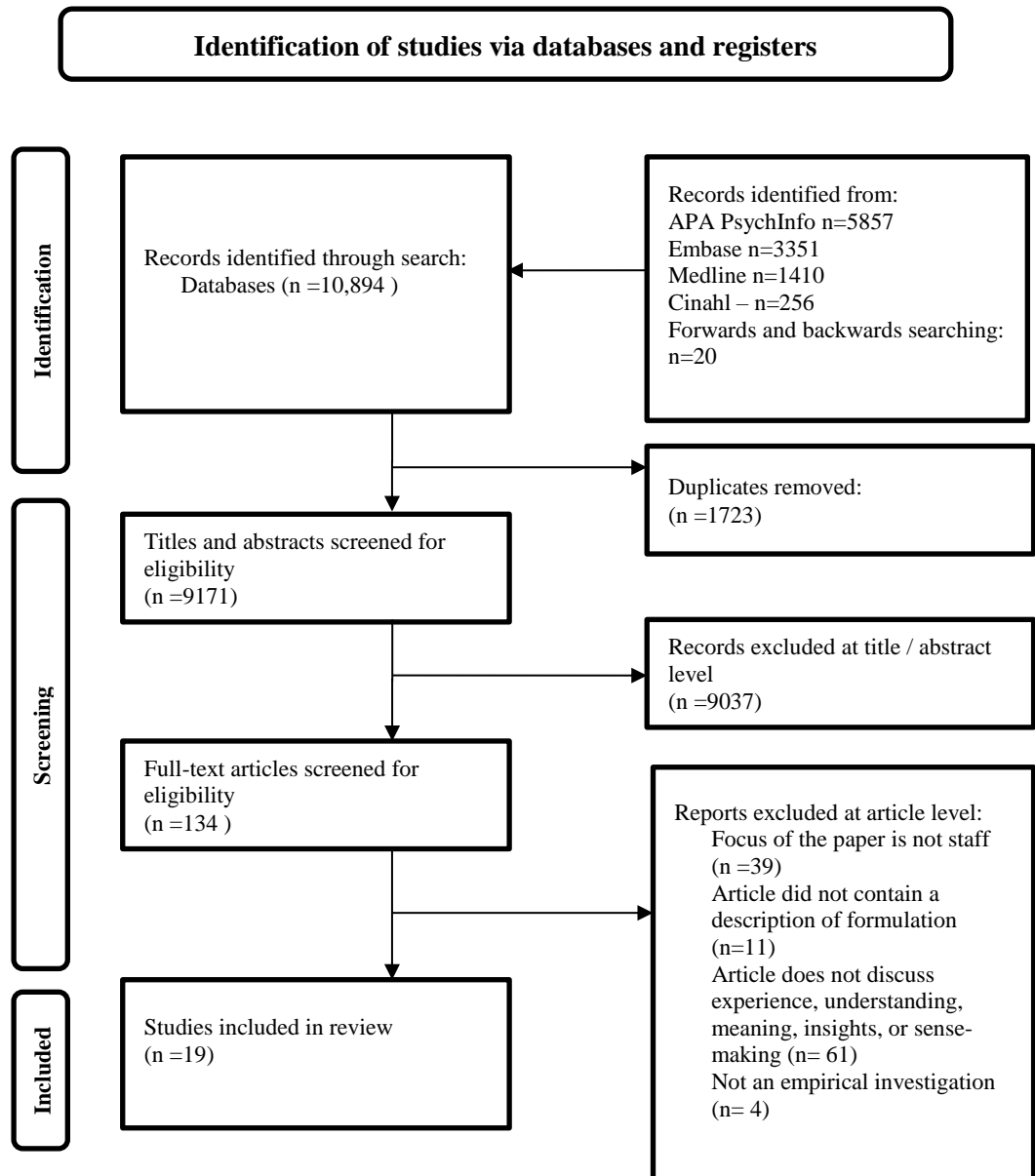
A formal narrative synthesis and appraisal of the robustness and quality of these studies was appropriate. Narrative synthesis is a method for synthesising the findings of multiple studies using words and text (Popay et al., 2006). Narrative methods are recognised as useful for reviews where the literature is underdeveloped, or where the evidence is diverse (Popay et al., 2006). Tabulation and textual descriptions of studies were used to develop a preliminary synthesis. As patterns emerged, the author sought to identify factors that may explain differences within the data (e.g. processes by which meaning arose). Relationships within and across studies were explored. The main author also looked for counterexamples within the papers that went against the themes. Table 1 displays the study characteristics along with the themes that were extracted from each paper. The synthesis has been expressed as a written narrative. Gaps in the literature have also been identified.

3. Results

3.1 Search results

Figure 1 details the systematic screening process and the articles included and excluded at each phase. Electronic searching identified 10,894 articles of which 19 met the eligibility criteria.

Figure 1. Flowchart of paper selection based on PRISMA (Moher et al., 2010)



3.2 Overview of the papers

Nineteen papers met inclusion criteria, with year of publication ranging from 2006 to 2022. Designs comprised seventeen qualitative, one mixed-method, and one quantitative study. Table 1 provides an overview of the papers. All studies were carried out in the United Kingdom, and sample sizes were between five and 378 participants. Fourteen papers focused on team formulation, two papers focused on formulation based consultation, one paper looked at individual formulation, and two papers did not specify. A range of different formulation models were investigated. Fourteen papers had been published in scientific journals, and five were unpublished doctoral theses.

Table 1. *Study characteristics*

Study authors	Aims	Design	Method	N	Key Findings	Themes Identified	Type of Formulation
Kramarz et al. (2022)	To investigate staff experiences of team case formulation sessions on acute psychiatric wards and their impact on staff wellbeing	Thematic Analysis (Braun & Clarke, 2006)	Semi-structured interviews	18 staff participants were recruited from inpatient wards	Formulation supported staff to develop a holistic understanding of service users. Participants reported that these benefits increased their ability to identify and support the needs of service users	Meaning-making, Sharing of perspectives	Team case formulation (theoretical model not made explicit)
Jefferis et al. (2021)	To generate a preliminary model of	Grounded Theory with Interpersonal Process Recall	Semi-structured interview	Six CAT Practitioners	Mapping involves two people coming together, with the	Meaning-making,	Individual formulation

processes involved in the early stages of cognitive analytical therapy (CAT) mapping methods (Charmaz, 2014) following a mapping role-play with a client therapist seeking to capture the client's ideas, work up a shared language and be in dialogue Sharing of perspectives using CAT reformulation

McTiernan et al. (2021)

Explore the multi-disciplinary team understanding of formulation and its evaluation on a psychosis rehabilitation unit Thematic Analysis (Braun & Clarke, 2006) Semi-structured interviews Six staff members: three nurses, one support worker, one occupational therapist and one consultant psychiatrist Team formulation enabled broader knowledge and a deeper understanding of individual clients. It also facilitated staff to have a space to discuss client Meaning-making, Space to reflect, introducing psychological theory Team Formulation based on a Five P's model

James et al. (2021)

To understand the current use Mixed-Methods Survey. A 34-item questionnaire 355 Clinicians Formulation-led approaches enables Meaning-making, space Did not specify

of formulation-led approaches in the UK for the management of dementia	Descriptive Statistics and Framework analysis method (Gale, Heath, Cameron, Rashid & Redwood, 2013)	with forced choice and free-text questions	working in dementia care.	staff to understand the person with dementia better and see the person behind the illness	to reflect, introducing psychological theory
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Radcliffe et al. (2020)	To explore offender managers experiences of psychologically informed, formulation-based consultation	Interpretative Phenomenological Analysis (IPA: Smith et al., 1999)	Semi-structured interviews	Five offender managers	The formulation process is containing and reflective, and can help to bring clarity and make links with the person's childhood experiences	Meaning-making, Introducing psychological theory, space to reflect	Consultation based formulation (theoretical model not made explicit)
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Blinkhorn et al. (2020)	To explore offender managers' views and perceptions of the psychological consultation and formulation process	Interpretative phenomenological analysis (IPA: Smith et al., 1999)	Focus Groups	Twenty-three offender managers	Formulation was an educational experience which supported understanding of service users and enabled reflection	Understanding, Introducing psychological theory, space to reflect	Consultation based formulation (theoretical model not made explicit)
Mellor (2020)	To develop a better understanding of the key components and processes involved in team formulations in inpatient forensic settings	Thematic analysis (Braun & Clarke, 2006)	Semi-structured interviews	Twelve multi-disciplinary team staff members	Psychological understanding was helpful, and could be used to structure exploration and development of understanding	Meaning-making, Introducing psychological theory, sharing of perspectives	Team formulation (theoretical model not made explicit)

Stratton & Tan (2019)	To explore staff experiences of CAT informed team formulation	Thematic analysis (Braun & Clarke, 2006)	Semi-structured interviews.	Six staff members: two nurses, one support worker, two allied health professional and one manager	Formulation helps staff to draw on a service user's history to understand their current experiences. It also provided space to stop and pay attention to their own thoughts and feelings	Meaning-making, Introducing psychological theory, space to reflect	Team formulation based on a CAT model
Russell (2019)	To explore staff perceptions of changes in their approach, understanding of and ability to manage behaviours that challenge in	Thematic Analysis (Braun & Clarke, 2006)	Semi-structured interviews	Eleven care staff working in private residential homes, including support workers,	Staff found formulation helped them to make links, and develop understanding. This was enlightening, containing and practical	Understanding, Introducing psychological theory, sharing of perspectives	Team formulation based on a CAT model

their
intellectually
disabled clients
after
reformulation

managers and
team leaders

Berry et al. (2017)	To identify the effects of formulation on practice from the perspectives of staff and patient participating in the trial	Thematic Analysis (Braun & Clarke, 2006)	Semi-structured interviews	57 staff members made up of nurses and support workers	Formulation improved staff understanding of patients, led to better team collaboration and increased staff awareness of their own feelings	Meaning-making, Introducing psychological theory, space to reflect, sharing of perspectives	Team Formulation based on a Cognitive Interpersonal Model
Dallimore et al. (2016)	To explore the extent to which the evidence-based	Thematic Analysis (Braun & Clarke, 2006)	Semi-structured interviews	Twelve staff members: six nurses, four healthcare	Staff reported benefits of team formulation including:	Meaning-making, Sharing of perspectives	Team Formulation (theoretical model not

components of effective supervision were met by team formulation on an acute inpatient mental health ward

assistants, one occupational therapist and one medic understanding a case, emotional support; learning; and working together as a team

made explicit)

Manuel (2016)

To explore the experience of staff participating in team formulation meetings

Grounded Theory (Charmaz, 2012)

Semi-structured interviews

Ten staff members: nurses, support work and occupational therapists

Team formulation facilitated changes in relationships within the team, increased staff confidence, and facilitated a new understanding of service users

Introducing psychological theory, understanding

Team formulation (theoretical model not made explicit)

Mohtashemi et al. (2016)	To explore how psychiatrists understand and use formulation within adult psychiatry practice	Grounded Theory (Charmaz, 2014)	Semi-structured interviews	Twelve psychiatrists	Formulation was described as a heuristic device to which enhanced understanding	Meaning-making, Introducing psychological theory	Individual formulation and team formulation (theoretical model not made explicit)
Wood (2016)	To gain a better understanding of clinical psychologists' experiences of using team formulation meeting	Thematic Analysis (Braun & Clarke, 2006)	Semi-structured interviews	Twelve clinical psychologists	Team formulation creates space to broaden thinking, reflect and discuss different perspectives. This leads to a shift towards psychosocial perspectives	Introducing psychological theory, space to reflect, Understanding	Team formulation (theoretical model not made explicit)

Blee (2015)	To explore the helpful or unhelpful aspects of team formulation and what factors may influence these outcomes	Thematic Analysis (Braun & Clarke, 2006)	Semi-structured interviews with psychologists and focus groups with other staff members	Twelve staff members: clinical psychologists, nurses, occupational therapists and support workers	Formulation broadened staff understanding of service users	Sharing of perspectives, Understanding	Team Formulation (theoretical model not made explicit)
Murphy et al. (2013)	To examine the impact of team formulation on the practice of staff working on mental health and dementia inpatient units	Thematic Analysis (Braun & Clarke, 2006)	Semi-structured interviews.	Ten staff members working in older adults or dementia care	Team formulation enabled staff to view clients in the context of their history. This helped them develop more positive, supporting	Meaning-making, sharing of perspectives	Team Formulation (theoretical model not made explicit)

					relationships with clients		
Christofides et al. (2012)	To investigate the use of psychological formulation in multidisciplinary team working as reported by clinical psychologists based in inpatient or community adult mental health services	Thematic Analysis (Braun & Clarke, 2006)	Semi-structured interviews	Ten clinical psychologists	Formulation helped staff to have a broader understanding of the clients' difficulties and helped staff relate to clients	Introducing psychological theory, Understanding	Team formulation (theoretical model not made explicit)
Berry et al. (2009)	To explore the effects of the	Likert scales	Staff perceptions of	30 staff from rehabilitation	Staff reported an increase in	Meaning-making	Team formulation

formulation process on staff appraisals	service users' mental health problems were measured before and after the intervention using Likert scales.	units made up of nurses and support workers	understanding of service users' problems, more positive feelings towards service users, and an increase in the confidence in their work	based on a Cognitive Interpersonal Model
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Summers (2006)

To understand staff views on the benefits and limitations of using psychological formulations for patients with severe mental illness	A Grounded Theory Based Methodology (Miles & Huberman, 1994)	Semi- structured interviews	Twenty-five staff members: nurses, support workers, doctors, occupational therapists and a drama therapist,	Formulations benefited care planning, staff- patient relationships, staff satisfaction and team-working, through increasing understanding of patients, bringing together staff with	Introducing psychological theory, sharing of perspectives, Understanding	Team formulation (theoretical model not made explicit)
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different views and
encouraging more
creative thinking

3.3 Quality Assessment

The methodological quality of studies was assessed using the QATSDD (Sirriyeh et al., 2012). Study quality was variable, with a significant proportion being judged as weak. However, given the paucity of studies in this field of research, no studies were excluded on the basis of poor quality, as it was considered that all of them made a contribution to the research question. A breakdown of study ratings can be found in Table 2. Berry et al (2017), Mellor (2020) and Radcliffe et al (2020) were considered to have the strongest designs. In these studies, participant interviews were carried out by independent researchers, reporting was transparent, and adequate consideration was given to the impact of the researchers' position on findings.

Studies by Summers (2006), Dallimore et al (2016), Stratton and Tan (2019) and Russell (2019) were judged as being poor quality. These papers lacked sufficient detail about how participants were recruited and whether researchers had a prior relationship with participants. The researchers' epistemological position was often mentioned but without explanation about how this impacted the findings. This seems particularly relevant given in a number of cases it was clear the researchers knew the participants. Some of the papers that were published in scientific journals were limited by small word counts, which made it difficult to complete a comprehensive quality appraisal. For example, Summers (2006) reported that data was analysed using grounded theory, but did not provide detail about whether and how this process was followed, raising questions about how the data were managed.

Across all papers there were limitations, and it should be noted that the higher scoring papers were not free of methodological issues. All studies required participants to self-select, which is a threat to the validity of the findings, as participants may have been more likely to participate if they already had a particular viewpoint on the topic (Oppong, 2013). Clinical psychologists or trainee clinical psychologists carried out all of the studies, and as formulation is a core skill for the profession (HCPC, 2015), it is hard to escape the potential for bias. The findings in these papers were overwhelmingly positive in favour of the impact of formulation, which may reflect this fact. In light of this, all conclusions should be drawn cautiously.

Table 2. *Quality assessment of included articles*

	Theoretical Framework	Aims/objectives	Research setting	Sample Size	Sample	Data collection	Data collection tools	Recruitment	Measurement tools (quant)	Method (quant)	Method (qual)	Analysis (qual)	Analytical methods	Reliability (qual)	User Involvement	Strengths/limitations discussed
Kramarz et al (2022)	3	2	2	0	0	1	2	2	n/a	n/a	3	3	2	2	0	2
Jefferis et al (2021)	3	3	2	0	0	3	2	1	n/a	n/a	2	3	1	1	1	2
McTiernan et al (2021)	2	2	3	0	0	3	3	2	n/a	n/a	3	3	0	2	1	2
James et al (2021)	0	2	2	0	0	3	0	2	n/a	n/a	2	3	0	1	1	2
Radcliffe et al (2020)	3	3	2	3	0	2	2	3	n/a	n/a	3	3	3	3	0	2
Blinkhorn et al (2020)	3	2	2	0	0	2	3	2	n/a	n/a	2	3	3	2	0	2
Mellor (2020)	3	3	3	3	0	3	2	2	n/a	n/a	3	3	2	0	3	1
Stratton & Tan (2019)	0	3	3	1	0	2	1	2	n/a	n/a	2	3	0	2	0	1

Russell (2019)	3	3	2	2	0	1	2	3	n/a	n/a	1	2	2	1	0	1
Berry et al (2017)	3	3	3	1	1	3	1	2	n/a	n/a	2	3	3	3	0	2
Dallimore et al, (2016)	1	3	3	0	0	1	1	1	n/a	n/a	2	3	1	2	0	1
Manuel (2016)	3	3	2	2	1	2	2	2	n/a	n/a	2	3	2	2	0	2
Mohtashemi et al (2016)	2	3	1	2	0	1	0	0	n/a	n/a	0	3	2	1	0	2
Wood (2016)	3	3	2	0	0	2	2	2	n/a	n/a	3	3	2	2	0	2
Blee (2015)	3	2	2	0	0	2	2	2	n/a	n/a	3	3	2	3	0	3
Murphy et al (2013)	3	3	3	0	0	2	1	2	n/a	n/a	2	3	3	1	0	2
Christofides et al (2012)	3	3	2	0	0	2	1	2	n/a	n/a	1	3	3	2	0	3
Berry et al (2009)	2	3	3	0	0	2	3	2	2	3	n/a	n/a	1	n/a	0	3
Summers (2006)	1	2	3	0	3	2	1	2	n/a	n/a	1	2	1	1	0	1

*0 = not at all, 1 = very slightly, 2 = moderately, 3 = complete.

3.4 Does formulation facilitate meaning-making?

Papers were included on the basis that they were judged as referring to the construct of meaning-making. Terms taken as describing the process of meaning-making were: 'insights', 'understanding' and 'sense making'. Papers were also included if they contained a description of a meaning-making process, such as, '*by allowing everyone to see the person not just the behaviour*' (James et al., 2020, p2350). No counterexamples within the papers that went against the themes were identified.

This section will firstly summarise the evidence in relation to meaning-making, with papers about individual formulation considered alongside those about team formulation and consultation. Secondly, processes by which meaning-making occurred are described. Study quality is commented on in areas where it is considered particularly relevant. It should be noted that the themes are not discrete and there are inevitable overlaps.

Meaning-making

Staff consistently reported that formulation enhanced their understanding of service users, which enabled them to make sense of the service users' difficulties. This is illustrated by psychiatrists who were interviewed by (Mohtashemi et al., 2016): '*if you haven't done the formulation you don't understand what's going on*' (p.214). Berry et al (2017) interviewed 57 staff about their experiences of being part of a trial where team formulation meetings were introduced on inpatient wards. '*Improved understanding of patients*' (p.1217) emerged as a key theme: '*I got to appreciate the patients a bit better and understand what they've been through and why they might be feeling like they are or acting like they do*' (p.1217). An earlier study by Berry et al (2009) explored the effects of team formulation meetings on staff appraisals of service users. The degree to which staff believed they understood service users was measured using Likert scales. Findings demonstrated that staff reported a significant increase in their understanding of the service user's problems following the intervention.

Stratton and Tan (2019) interviewed six inpatient staff from nursing, support work and management about their experiences of Cognitive Analytic Therapy (CAT) team formulation. Participants identified a number of ways in which the sessions facilitated meaning-making such as: '*understanding the service user's story*' (p.90) and '*understanding of their own reciprocal roles*' (p.91) which allowed them to '*make links*' (p.91) and '*notice patterns*' (p.91). It should be noted that, in this study, the researchers facilitated the team formulation

meetings, which raises questions about whether the participants would have felt able to provide an honest and open account of their experiences.

A number of papers described how knowledge of relevant psychological theory had led to 'new insights'. Two studies that were judged to be of a relatively high quality described this process. Forensic inpatient staff who were interviewed by Mellor (2020) reported: *'it gave the whole MDT insight into how they were working'* (p.218). Radcliffe et al (2020) interviewed offender managers who had attended formulation consultations, *'clarity'* (p.322) emerged as an outcome, and participants described how the consultation had *'opened something up'* (p.322) and allowed them to *'gain new insight and awareness'* (p.322). Other participants described formulation as a process of sense making: *'they opened my eyes into kind of attachment stuff... so brilliant, wow that makes perfect sense to me'* (p.322).

Other studies where it was reported that team formulation facilitated meaning-making were: Dallimore et al (2016), where *'understanding a case'* (p.110) emerged as a theme, with participants reporting that they had gained a *'richer'* (p.112) understanding of service users; CAT therapists who were interviewed by Jeffris et al (2021) reported that a key process in individual formulation is *'listening out for emergent meanings'* (p.142); Manuel (2016) also reported *'understanding of the service user'* (p.103) as a theme, with staff describing how formulation meetings had supported them to develop an understanding about why service users used certain behaviours. Murphy et al (2013) reported that team formulation, *'makes you understand the reasons why people are like they are'* (p.445), and similarly Kramraz et al (2022) found that team formulation enabled staff to develop a broader understanding of service users, which included considering the context in which the person exists, rather than looking at their behaviour in isolation.

Although slightly less clear, it was judged that the following two studies also indicate a meaning-making process McTiernan et al (2021) explored the perspectives of staff using team formulation on a rehabilitation unit; participants felt it allowed them to see the *'whole person'* (p.584). Similarly, participants from James et al (2021) described how formulation had increased their awareness and allowed them to *'allowing everyone to see the person, not just the behaviour'* (p.2350).

These studies suggest that team formulation, and formulation based consultation have the potential to facilitate meaning-making for staff by providing a rich understanding of the service user and their difficulties. There is some suggestion that this may apply to individual formulation as well. The process appears to involve thinking about the person holistically,

taking into account their history, past experiences and current environment. Despite the variable quality of the studies, the consistency increases confidence in this finding. However, overall study quality remains weak, and given that most studies raise questions about the impact of researcher bias, and the potential for social desirability, it is important that conclusions are drawn tentatively.

3.5 Processes that support meaning-making

The papers also described processes by which meaning-making occurred. These were: introducing psychological theory, space to reflect and sharing of perspectives.

Introducing Psychological Theory

Psychological knowledge was crucial for helping staff to understand a person's difficulties, and make links with their histories, resulting in changes in their practice. Participants interviewed by Mellor (2020) discussed how knowledge about psychological models (e.g. Hamilton's Boundary Seesaw) and constructs enabled exploration and development of their understanding: *'I did feel I could understand, what he was saying was going into this mode and that mode, it sort of made sense'* (p.217) and *'it was quite useful in explaining, what the schema was and what it meant to the patient and how he formed his ideas'* (p.217). Likewise, staff interviewed by Stratton & Tan (2019) identified the CAT map as a tool that supported them to make links with client's histories and notice patterns: *'so it will help you to understand, oh okay she is pushing me away because she is used to being pushed away'* (p.91). Staff used this knowledge to think about how they interacted with service users and reshape some of their practices: *'just noticing how people are talking about particular women... I've been able to... support a different way of reframing and thinking about things'* (p.91).

Staff members working in dementia care who were interviewed by Murphy et al (2013) described how psychological knowledge allowed them to think about the impact of people's histories: *'It just gives you this bigger picture...I didn't realise things like that had an effect on people'* (p.444). A strength of this paper is that the researcher did not play a role in the recruitment or interview process, thus increasing the likelihood that participants would have felt able to provide an accurate account of their experiences of team formulation. Similarly, Russell (2019) described how CAT theory helped staff understand how behaviours can be learned in formative relationships and repeated in current ones: *'this is the reason why she starts to reject you, cos...that's what people have done to her'* (p.81). However, this study

had a number of limitations, such as that the interview schedule asked leading questions, and thus its findings should be interpreted cautiously.

Wood (2016) found that introduction of psychological knowledge (e.g. awareness of the role of trauma) contributed to a general shift towards the team holding a more psychosocial perspective, which impacted on how staff members supported clients: *'I do think that formulations have helped the team's responses to crises and have helped the team to react in ways that... is a lot more psychologically minded'* (p.37). Staff interviewed by Berry et al (2017) also described how psychological understanding had led to behaviour change: *'I've certainly seen people approaching issues and problems in a way that I haven't seen them do previously'* (p.1217).

Clinical psychologists who were interviewed by Christofides et al (2012) reported that without formulation they could feel like they were: *'fumbling in the dark . . . because if there's no theory or structure to hang an understanding on then they're floundering with an intervention, not really knowing why it's not working'* (p.430). This is similar to participants interviewed by Mohtashemi et al (2016) who described how formulation gave them knowledge about *'where is this person likely to be going on their psychological journey and how can we prevent things from happening or understand why they're happening'* (p.214).

This suggests that knowledge of psychological theory may help staff to develop a more coherent understanding of the service users, which integrates factors such as past experiences, and current relationships. With this awareness, staff report adapting their practice so they can respond to the service users' needs more appropriately and therapeutically.

Space to reflect

The opportunity to stop, think and reflect was an important part of formulation, which allowed meaning-making to take place. Participants from Berry et al (2017) reported: *'the main thing was actually having chance to take stock of what we're doing with patients and where we're going'* (p.1217). Staff also valued the opportunity to reflect on their own feelings and emotions, participants who were interviewed by Stratton and Tan (2019) described *'...giving me insight into maybe what I'm seeing, what I'm feeling, what I'm experiencing'* (p.90). Wood (2013) highlighted a similar process *'...it's about trying to slow people down... And get people to think and reflect more on what we're doing and why we're doing it rather than just doing it'* (p.33).

The papers that interviewed offender managers also recognised the value of having space to think. Blinkhorn et al (2020) identified *'enabling reflection'* (p.103) as a theme, and Radcliffe et al (2020) described: *'...it makes you stop and think about the relationship, because sometimes you're so busy just doing, that you don't actually have the time to think about ... what impact is this actually having on this person'* (p.321).

These studies clearly indicate that staff value the opportunity for reflection, and this appears to be a necessary part of the meaning-making process. There is also suggestion that in order to develop a rich understanding of a service user, staff need to explore their own feelings and reactions to working with them. Formulation is one forum that facilitates reflection; however other mediums, such as reflective practice can also provide this.

Sharing of perspectives

The papers that looked specifically at team formulation suggested that integrating the views and knowledge of different members of the multi-disciplinary team enabled staff to consider different perspectives, which ultimately led to a more coherent and comprehensive understanding of the person and their difficulties. This process was described in Dallimore et al (2016): *'we come to a common understanding of the problem I guess, through putting all our ideas into the pot, and a richer understanding of the problem'* (p.112). Participants from Kramraz et al (2022) also shared this view: *'I think everyone sees a different part of it depending on what you observe on the ward, so it's really good to sort of bring that together'* (p.219).

Part of coming to a shared understanding also involves considering alternative perspectives. Berry et al (2017) described: *'getting everyone's ideas and then realizing people had different ideas and how we can tweak the different angles'* (p.1218). Mellor (2020) echoed this: *'I think everyone came up with something that maybe another person didn't think about....to find out other perspectives makes it better'* (p.219).

Other papers that recognised this process were Blee (2015) who described how a *'broadened understanding'* (p.180) led to a *'better understanding'* (p.180). Similarly, McTiernan (2021) and Russell (2019) described that hearing from a range of professionals enabled integration of knowledge, thus providing a richer understanding of a service user. The value of bringing together different perspectives was also highlighted by staff working in dementia who participated in Murphy et al (2013): *'there's probably more information coming together than has probably ever happened before... It's just like a nucleus'* (p.445).

These studies emphasise the specific benefit of a formulation which is derived by the team and draws on the perspectives of a range of different staff members, in contrast to an individual formulation.

4. Discussion

The aim of this review was to establish whether the extant research base supports the claim that psychological formulation facilitates meaning-making for staff, in both its individual and team formats. This review adds to the limited research in this area (Cole et al., 2015) and offers insights into formulation that are not available elsewhere in the literature. Specifically, to date there have been no systematic reviews addressing whether formulation fulfils one of its key functions, i.e. that of facilitating meaning-making, as described in some of the key literature (DCP, 2011). A narrative review was chosen, rather than a meta-synthesis, as the literature was judged as being underdeveloped and papers were anticipated to be both qualitative and quantitative in design (Popay et al., 2006).

Given only three of the studies included in this review discussed co-creation of meaning between staff and service users in individual formulation, it is hard to draw any firm conclusions about staff meaning-making in this context. In these studies, staff indicated meaning-making was taking place by describing how formulation enabled them to understand the service user, see the 'whole' person, and listen out for meanings. There are a number of explanations as to why so few papers have explored meaning in relation to staff experiences of individual formulation. One possibility is that psychologists tend to just assume this is the case; alternatively it could just be a consequence of formulation being an under-researched area, it is also possible that it may be because the focus of co-creation of meaning in individual formulation is the client (DCP, 2011). Irrespectively, this is not an area that should go under-researched and further research in this area is necessary. However, these limited findings are consistent with research that has explored service users' experiences of individual formulation, such as Small et al (2018) who found that formulation helped service users to make sense out of their difficulties, and Pain et al (2008) who found that formulation enabled service users to feel understood.

The review found some evidence that team formulation and formulation-based consultation can support staff in the process of meaning-making. Staff consistently reported that formulation gave them insight, which enabled them to make sense of service users'

difficulties, and the reasons behind their behaviours. This is consistent with a systematic review by Bealy et al (2021) which explored staff opinions of formulation, and found that team formulation was seen as a sense-making process; it also corroborates quantitative research conducted by Berry et al (2016) which found that staff find team formulation useful. A novel finding from this review is that it suggests three processes which appear to facilitate meaning-making: 'introduction of psychological knowledge', 'space to reflect', and 'sharing of perspectives'. These findings have some similarities with other research into team formulation. Kellett et al (2014) found that staff valued space for reflection, and a review by Short et al (2019) also highlighted the value of psychological awareness informed by psychological theory. This current review builds on this finding by suggesting that knowledge and understanding informed by psychological theory may enable staff to reshape their practices. This is relevant given a previous review by Geach et al (2018) found only weak evidence for the potential benefits of team formulation.

It is worth noting that *'sharing of perspectives'* and *'space to reflect'* are not processes that are unique to formulation. This has also been noted in recent literature that has explored the overlap between team formulation and other forums in which reflection and sharing of perspectives may take place, such as reflective practice (Association of Clinical Psychologists, in press). It might therefore be expected that meaning-making processes are taking place in those settings, although in reflective practice there is likely to be a greater focus on processing staff feelings, and a correspondingly lesser one on psychological theory and on intervention plans for a specific service user (ACP, in press). However, it is likely that meaning-making plays a part in many clinical activities, including supervision, and therapy itself.

In summary, there was modest support for the specific question about the role of meaning-making in formulation; however, there are a number of important caveats. Firstly, this evidence comes from a set of qualitative studies, which are of variable quality, and as such, are an insufficient evidence base upon which to draw conclusions. The dependability of the findings is significantly weakened by the fact that clinical psychologists have conducted all of the research, which raises questions about bias. This finding is consistent with reviews by Geach et al (2018) and Bealy et al (2021) who also note the poor quality of available evidence in the team formulation literature. Clearly, there is a need for future research to adopt more rigorous designs. On the basis of this review we can suggest that formulation is experienced by some staff as facilitating meaning-making, but it is unclear how common this is, or to what extent this is seen as central to the process. These are all possible areas for further research.

A further caveat is that the construct ‘meaning-making’ is ambiguous, and intrinsically hard to define, identify and measure, as are the terms that have been used to describe it. Like formulation itself, there are no clear boundaries to this activity, which makes it difficult to draw firm conclusions. As discussed in the introduction, the very nature of formulation is hard to research, and methodological weaknesses are almost unavoidable (Bieling & Kuyken, 2003). This is even truer of the concept of meaning-making, and thus, quantitative research into this question would be faced with the same challenges of defining and operationalising the concept.

Strengths and limitations

The review followed several processes important for developing systematic reviews. The protocol was registered on Prospero, transparency of reporting followed PRISMA guidance (Moher et al., 2015), searching was developed in line with the PICOS framework (Forrest & Miller., 2002), and the main author used a practice guide throughout (Boland et al., 2017). The potential for bias was minimised as 10% of titles and abstracts, and 25% of quality appraisals were rated by an independent reviewer (Boland et al., 2017).

A limitation is that inclusion of the grey literature was limited to dissertations and theses, and unpublished articles were excluded. Publication bias is a significant problem in research, which can result in important studies being missed, or only positive findings being reported (Easterbrook, 1991). Additionally, given the eligibility criteria were for papers published in English only, it is possible that other relevant papers were not included (Paez, 2017).

It is worth noting that there may be high variability in the formulation practices covered in the review, in addition to some practices that have not been included. Different formats might have varying emphasis on the importance of meaning-making, and similarly the processes described might have different degrees of relevance to each. Additionally, certain kinds of meaning-making practices, such as the use of reflecting teams in family therapy, were not included in this review because they do not fall under the DCP definition of formulation that was used in this paper.

The looseness of the inclusion criteria is a potential limitation. The item ‘discuss the construct of meaning-making in relation to psychological formulation’ is open to subjective interpretation, and since no papers directly referred to meaning-making, proxy terms: experience, understanding, insights or meaning were employed. However, the high level of agreement with the independent reviewer suggests the inclusion criteria were used

objectively. A further safeguard was that any papers the lead researcher was unsure about were discussed with the research team.

The researchers' own positions are a potential limitation of this research. The research team was made up of two clinical psychologists and a trainee clinical psychologist, all of whom have an interest in formulation. It is possible that this investment in the practice may have biased the process of data extraction, and development of the narrative synthesis.

Clinical Implications

The findings of this review suggest that team formulation offers the potential, for at least some staff, to support them to make meaning and sense out of people's difficulties and that where this happens, it is seen as an important benefit. Staff suggested that having greater insight into the reasons behind the service users' difficulties enabled them to evaluate their own responses and reactions, which would be expected to foster better working relationships, and better care. This is particularly relevant in the context of recommendations from Ebrahim (2021) about the urgent need to improve the quality of care in psychiatric services, and to promote more psychosocial ways of thinking. These findings add some support for the suggestion that formulation, particularly when conducted within a team, may be one method for achieving this.

New areas for research

Further research in this area is clearly necessary, and indeed the lack of exploration of this topic, particularly in relation to individual formulation, is a finding in itself. The most important priority is for future research into formulation to adopt more robust research designs, which are less vulnerable to issues such as researcher bias and social desirability. There is some evidence that this is already happening, as Berry et al (2016) recently conducted the first randomised control trial into team formulation. Given the paucity of studies that explored staff experiences of individual formulation, there is a need for future research to explore co-creation of meaning between staff and service users. Additionally, further research should seek to explore the impact of meaning-making on staff responses, e.g whether it leads to behaviour change, better relationships, better care and so on.

It is also worth noting that the majority of research into team formulation has been conducted within inpatient settings, which limits the generalisability of the findings; there is a need for further research in other settings such as community mental health teams.

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**Indicates papers that have been included in the review.*

Paper 2. Empirical Paper.

Staff views about involving service users in team formulation

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Abstract

Objectives

To explore staff views about whether and how service users should be involved in the process of team formulation.

Design

This study used Q methodology to explore healthcare professionals' views about service user involvement in team formulation meetings.

Methods

Forty staff members with experience of attending team formulation meetings completed a Q Sort in which they ranked how much they agreed or disagreed with 58 statements about service user inclusion in team formulation. Factor analysis was used to identify viewpoints within the dataset.

Results

A three-factor solution accounting for 60% of the variance was considered the best fit for the data. The factors were: '*A safe space for staff*', '*Concerns about inclusion and collaboration*' and '*Service users might find attendance harmful*'. Consensus statements identified areas where all participants agreed.

Conclusions

This is an important area for exploration, given the growing practice of team formulation and the professional and ethical issues raised by service user involvement. Different approaches are likely to be appropriate for different populations or in different settings.

Practitioner Points

- The issue of service user involvement is recognised as important and clinically relevant by staff.
- Staff identified a need for a protected space to express their views and feelings openly.
- There are number of ways to promote service user involvement in team formulation.

1. Introduction

Team formulation

A psychological formulation can be described as a shared hypothesis about a person's difficulties, which integrates theory and research, and informs the intervention (Division of Clinical Psychology, 2011). Formulation aims to place the person's difficulties within the social and relational context of their life, and works on the premise that 'at some level, it all makes sense' (Butler, 1998, p4). Bentall (2009) argues that formulation provides a more person-centred and meaningful alternative to psychiatric diagnosis, which has been criticised for lacking reliability, validity and leading to a loss of meaning in distress. Formulation is a core skill for Clinical Psychologists, as described in the core competencies of the profession (The Health and Care Professionals Council, 2015).

Team formulation is a practice in which a group of healthcare professionals meets to develop a shared understanding of a service user's difficulties (DCP, 2011). Unlike individual formulation, staff reactions, frustrations and 'stuck points' may also be included (Cole et al., 2015). Team formulation has become increasingly popular in mental health services, especially as the roles of psychologists change, and indirect ways of working are considered a more cost-effective use of psychologists' time (Onyett, 2007). Team formulation has a number of claimed benefits, which include promoting more psychosocial ways of thinking, improving team working, and increasing staff understanding of service users (DCP, 2011). It has also been argued that team formulation is one way to improve the quality of psychiatric care in the context of limited resources (Tarran-Jones et al., 2019).

Team formulation is an under-researched area (Cole et al., 2015). The research that does exist is generally supportive of the practice, but often lacks methodological rigour (Geach et al., 2018). Two systematic reviews have found positive findings overall for its impact on the team, suggesting that team formulation challenges usual ways of thinking, gives staff a broader understanding of service users' difficulties, increases psychological awareness, and provides a space to reflect (Short et al., 2019; Bealy et al., 2021). Notably, both papers also reported that evidence is of a variable quality.

Berry et al (2016) conducted the first randomised control trial into team formulation which explored the feasibility of introducing regular meetings delivered by a clinical psychologist on inpatient mental health wards. Outcome data were collected in relation to relationships, staff wellbeing and patient functioning. Findings were cautiously promising; compared to

treatment as usual, trend level data favoured the intervention group on measures of staff stress and perceptions of relationships, and found that service users felt significantly less criticised by staff. The authors note that the power of the study to detect significant differences may have been limited by its small sample size, and concluded that there is a need for more large-scale research in the area.

Co-production

The National Health Service values the inclusion of service users across different areas of healthcare activity, since user involvement is considered to be an essential part of building a patient-focused health system (Pizzo et al., 2015). This also applies in mental healthcare (Boyle & Harris, 2009). Co-production refers to the principle that service users should be treated as equal partners with professionals. This is relevant to the practice of team formulation in terms of whether and how service users are involved, with most teams not having the service user present for the meeting (Cole et al., 2015). Wainwright & Bergin (2010) have argued that this absence raises issues such as lack of transparency, power imbalances, and exclusion of the service user voice. A forthcoming report from the Association of Clinical Psychologists notes that ‘Service users, psychologists and other mental health professionals have raised questions about the practice of team formulation... Themes around an imbalance of power in mental health systems, and lack of service user involvement in decisions... are evident in the concerns raised’ (Association of Clinical Psychologists, in press, p11).

Very little research has considered the issue of service user involvement in team formulation. Tarran-Jones et al (2019) explored how older adults and their carers experience team formulation within mental health inpatient services. In this format, the service user was present for the meeting. Thirteen participants were interviewed, and the data were analysed using interpretative phenomenological analysis. Participants’ responses to the process were mixed: some described it as a positive experience, which made them feel hopeful and empowered; others reported that attending the meeting had left them feeling vulnerable and fearful. The participants who had negative experiences attributed this to the large group format, and the number of professionals at the meeting. In response to the findings, the authors developed a set of practical recommendations for carrying out team formulation, which state that attenders should be limited to a small and relevant group, service users and carers should always be invited to the meeting, and there should be a ‘pre-formulation’ meeting beforehand to explain the process to the service user.

A study by Lewis-Morton et al (2017) used thematic analysis to explore the process in which a service user on an inpatient ward co-produced their formulation alongside the team. The service user reported feeling empowered, 'heard' and listened to, while all staff members felt that the experience had enhanced their understanding of the service user's issues. The authors concluded this case study demonstrated how collaborative working can help to shift power imbalances and challenge dominant hierarchal systems.

Research into clients' experiences of reflecting teams (Anderson, 1987) may also be relevant. Reflecting teams are a practice used in family therapy in which a group of therapists observe the therapy session and then discuss what they noticed, in the presence of the family (Anderson, 1987). This practice was reportedly developed in response to concerns about lack of collaboration with clients (Haley, 2002). Research into families' experiences of reflecting teams is limited and has found mixed results. A systematic review by Harris and Crossley (2021) found that families initially reported that this was an unusual experience, but that they then went on to find it helpful. Earlier work by Kleist (1999) found that clients felt reflective teams were helpful for supporting them to develop different perspectives on their issues, but also reported that having the team present could be intimidating. However, this specific practice was beyond the scope of the current project.

A number of other ways to increase collaboration in team formulation have been proposed. Ingham (2012) describes an approach used in a Learning Disability setting where the therapist shares the team formulation with the service user in individual therapy, and gives them the chance to provide feedback, and make adaptations. Milson and Philips (2015) outline a method used on an adolescent inpatient ward where the service user's comments and thoughts are shared during the meeting, and the psychologist meets the service user after the meeting to discuss the outcome and support them to develop their own formulation letter. These studies suggest that collaboration, or co-production, can take a range of forms, whether or not the service user is physically present.

It is clear that the issue of service user inclusion in the team formulation process is becoming increasingly relevant as the practice is adopted across specialties, including Adult Mental Health (Johnstone, 2014), Learning Disabilities (Ingham, 2015), Child and Adolescent Mental Health (Hartley, 2021) and Older Adults (Jackman & Beatty, 2015). For example, the Association of Cognitive Analytic Therapy (ACAT) states 'One of the key issues in debates/controversies around team formulation is collaboration and the extent to which service users are centred, included and involved in the process' (Carradice, 2004, p. 20) A number of professionals have expressed concerns about the absence of service users, as well

as ongoing questions about how to ensure service users are involved in a way that is meaningful and collaborative (Association of Clinical Psychologists, in press). However, some have argued that having the service user present is not always appropriate, for example if staff counter-transference feelings are being explored, and have suggested that there are a number of other ways to include their views (Johnstone, 2014; Hartley, 2021).

The debate has reached social media, with some service users sharing fears about formulations being drawn up or imposed without their input: ‘The staff would use the “team formulation” as yet another, more sophisticated method to dehumanize and deride the clients, and take their own narrative away from them’ (@FalteringlyOn, 2020). Equally strong views have also been voiced by some professionals: ‘Team based formulation can get things terribly, terribly wrong. We need to formulate with patients, not behind their backs’ (@psalkovskis, 2018).

While some research has, as noted above, explored the general experiences of staff and service users in relation to team formulation, none has directly addressed the issue of whether and how service users should be involved. The Division of Clinical Psychology Guidelines (DCP, 2011) only discuss the issue briefly, acknowledging that there may be reasons for not having service users present, but that the same good practice principles apply to both individual and team formulation. Recognising the ethical, professional and service user aspects of this debate, the Association of Clinical Psychologists has commissioned a discussion document on the involvement of service users in team formulation (ACP, in press). Among its recommendations is the need for further research in the area.

As ultimately it is healthcare professionals who make decisions about service user inclusion, this paper will explore their views on the issue, which will provide insight and understanding into their reasoning. It is hoped that this information will help to form the basis of updated recommendations, suggest parameters for service user inclusion, and lead to more transparent and systematic decision-making.

2. Method

2.1 Design

Q Methodology (Stephenson, 1953) is a mixed-methods approach used to study people's viewpoints on a topic of interest (Watts & Stenner, 2012). Participants complete a sorting task where they rank their relative agreement with a set of statements that relate to the subject. The data is subject to factor analysis, and organised into 'factors', thought to represent the different viewpoints (Watts & Stenner, 2005).

2.2 Procedure

Ethical approval was granted by the University of Manchester Research Ethics Committee and the Health Research Authority. The study had four discrete phases: Q-Set development, recruiting participants, data collection and data analysis.

2.2.1 Q-Set development

The first task was to develop the 'Q-Concourse', which is a set of statements thought to represent all the possible viewpoints on the subject of interest (Watts & Stenner, 2012). The Q-Concourse was developed over a period of six months. The lead researcher gathered statements from the academic literature, social media, Internet blogs and magazine articles. Statements were organised into themes, and were collected until no new themes emerged (Watts & Stenner, 2005). This process generated 124 statements (see Appendix G), which were reduced to a 58-item Q-Set (Appendix G). Duplicate statements were either removed or combined, resulting in 80 items, which were scrutinised by the research team to check for relevance, content appropriateness, and phrasing. The Q Set was adapted in line with feedback, and this process was repeated until a consensus on the final 58 items was reached.

2.2.2 Participants and recruitment

Eligibility criteria and sample size: studies using Q Methodology do not need large participant samples, and the number of participants should be less than the number of Q-Set items (Watts & Stenner, 2012); accordingly, the recruitment target was 40. Participants were healthcare staff who were eighteen or more years of age, able to speak and read English, provide informed consent and have attended at least one team formulation meeting in the past two years.

2.2.4 Data Analysis

Q Methodology uses by-person factor analysis (Watts & Stenner, 2005) to identify patterns among the Q sorts, known as ‘factors’. Data were analysed using PQMethod, which is a Q Methodology specific statistical software package (PQMethod, version 2.34; Schmolck, 2002). The first stage is to enter each person’s Q Sort manually into the software, which computes inter-correlations between the sorts, resulting in a correlation matrix. Next, the data were subject to a factor analysis using a Principal Components Analysis (PCA). A Varimax rotation was applied to provide the best statistical fit.

The meaning of each factor was interpreted by considering how the statements had been ranked for each factor configuration, with particular importance being given to statements that had been highest and lowest ranked (Webler et al., 2009). ‘Distinguishing statements’ (items which had been ranked in a different way for specific factors at a statistically significant level) and ‘consensus statements’ (items that were not ranked significantly differently between groups of respondents) were also examined. Taken together this generated a description of the viewpoint.

3. Results

3.1 Sample Characteristics

Forty-two participants expressed an interest in taking part, of whom forty successfully completed the Q Sort. The lead researcher approached sixteen services which included inpatient, Community Mental Health, Early Intervention, Primary Care, and Behavioural Support Services. The sample comprised five men and thirty-five women, with an age range of 21 to 65 years. Participants were drawn from a range of professions: 23 clinical psychologists, four assistant psychologists, two psychiatrists, seven nurses, one physiotherapist, one formulation training manager, one applied psychologist and one person who did not specify. The number of team formulation meetings participants had attended ranged from 1-150, with a mean of 50.7. Participant demographic data can be found in Table 3.

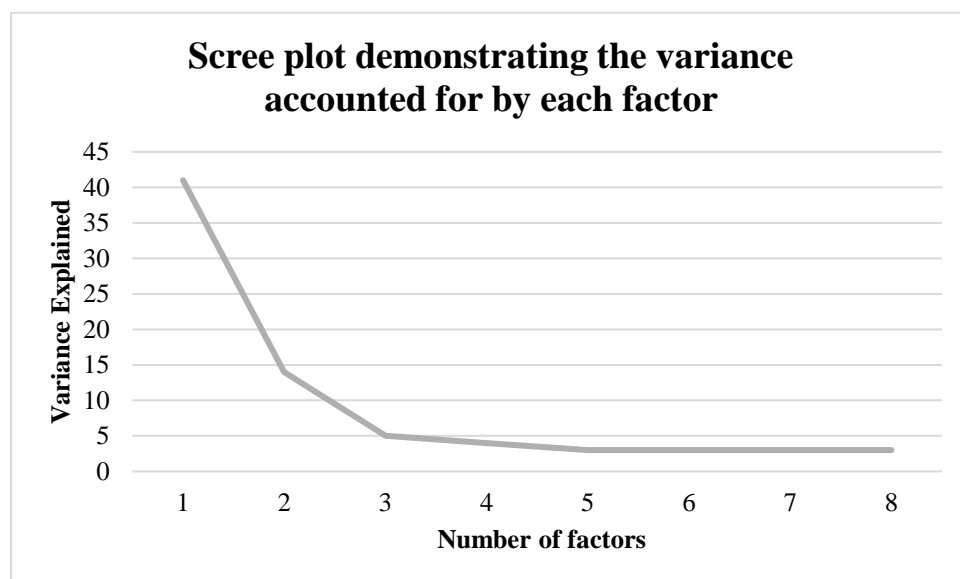
Table 3. *Demographic information for study participants*

Sample	Participants (n = 40)
Sex	5 male (12.5%), 35 female (87.5%)
Age	Range: 21-65, Mean: 38.6
Ethnicity	35 White British (87.5%), 2 Other Mixed Ethnic Background (5%), 1 Indian (2.5%), 1 African (2.5%), 1 White & Asian (2.5%).
Professional Role	23 clinical psychologists (57.5%), 4 assistant psychologists (10%), 2 psychiatrists (5%), 7 nursing staff (of which five were from behavioural support services) (17.5%), 1 physiotherapist (2.5%), 1 formulation training manager (2.5%), 1 applied psychologist (2.5%), and 1 who did not specify (2.5%).
Number of team formulation meetings attended	Range: 1-150, Mean: 50.7

3.2 Q Sort Analysis and Interpretation

The PCA initially produced eight un-rotated factors with Eigen Values above 1. A Scree plot (Figure 3) was used to demonstrate the decreasing rate at which variance was explained by each factor (Holland, 2008), and suggested that either a two or three-factor solution was appropriate. The research team explored both options; considering the amount of variance explained by each, correlations between the factors, and the contents of the statements. The three-factor solution was felt to be the best fit for the data, on the basis that it explained the most variance (60% versus 55%), and offered an additional, distinctly different viewpoint.

Figure 3. Scree plot



Thirty-six Q Sorts loaded onto one of the factors. 15 participants loaded on Factor 1, (accounting 41% of the variance), 16 participants onto Factor 2 (14%), five onto Factor 3 (5%) and four participants did not load onto any of the factors. The viewpoints were labelled: *'A safe space for staff'*, *'Concerns around inclusion and collaboration'* and *'Service users might find attendance harmful'*.

Variance explained refers to how well defined each particular factor is, as indicated by stronger inter-correlations between participants' Q Sorts (Watts & Stenner, 2005). Factor 1 is the 'strongest' viewpoint, since it explains the most variance, and as such can be seen as the most clearly defined perspective. Variance explained is not an indication of popularity or frequency of agreement. Both Factors 1 and 2 were comparably popular, as a similar number of participants loaded onto each.

The different viewpoints are described below; 'distinguishing statements' refer to items where the ranking was statistically significantly different ($p < .01$) between factors. There were weak correlations between factors 1 and 2 ($r = 0.33$), and factors 2 and 3 ($r = 0.44$) indicating these pairs are distinct from each other. Factors 1 and 3 were strongly correlated ($r = 0.74$) which suggests there was some overlap in perspectives; the implications of this are discussed below. The only notable differences observed between factors was based on professional group, as the majority of participants who worked in behavioural support services loaded onto Factor 1. Factor arrays can be found in Table 4.

Table 4. *Factor Arrays for Factors 1, 2 and 3 (consensus statements in grey, ** indicates distinguishing statements)*

Item no.	Statement	Factor Arrays		
		F1	F2	F3
1	Involving service users in team formulation meetings does not occur as often as it should	0	3	-1
2	Service users should always be present at team formulation meetings	-4	-1	-4
3	It is not appropriate for service users to be present for all aspects of the team formulation meeting	0	-3	2
4	Service users should be invited to team formulation meetings, even if they do not want to attend	-3	3	-2
5	Team formulation meetings are a kind of staff supervision	3	-3	-3
6	It is not appropriate to share all aspects of the team formulation discussions with service users	1	-2	3
7	Service users should be informed that team formulation meetings about them are taking place	0	4	0
8	Service users should be given the option to provide feedback on both the content and the process of team formulation meetings	-1	5	-1
9	Team formulation meetings where the service user is not present is still care that is 'done to' rather than 'done with'	-4	0	-3
10	Service users should not be talked about when they are not present	-5	-4	-5
11	Team formulation meetings operate within the power imbalance inherent in mental health services	-3	2	1
12	Team formulation meetings should be a safe space for staff to voice their own emotional reactions**	5	-3	1
13	The main 'client' in team formulation meetings is the team	-1	-5	-3
14	Team formulation meetings create the perfect conditions for institutional abuse	-5	-4	-5
15	Team formulation meetings without the service user present can lead to vulnerable people having a story projected onto them	-1	1	-2
16	An on-going issue with team formulation is the extent to which service users are centred, included and involved in the process	-1	4	4

17	In team formulation we should follow the principle of 'nothing about me without me'	-3	1	-2
18	Staff need to be able to use team formulation meetings to name difficult emotions and become aware of unhelpful responses**	5	-3	2
19	Service user involvement in team formulation needs to be balanced with their levels of distress/ stability	2	2	5
20	Service users are not welcome at team formulation meetings	-4	-5	-4
21	Staff should spend time before the team formulation meeting gathering the service user perspective	4	-3	-3
22	Team formulation meetings should go ahead regardless of whether the service user is willing or able to attend	0	-2	2
23	All aspects of team formulations should be developed with service users	-2	0	-4
24	We need to consider how to involve service users on an individual basis depending on their circumstances	5	4	5
25	Co-producing team formulations with service users can lead to a significant shift in power dynamics	1	2	1
26	Co-producing team formulations allows service users to take an active role in their own care	1	5	0
27	Attending team formulation meetings can give service users a sense of hope and optimism	-1	2	-2
28	Team formulation meetings could feel exposing and distressing for service users	2	1	5
29	Service users should be invited to a pre-formulation meeting where the purpose of the meeting is discussed	0	2	-1
30	One way of involving service users is for the key worker to develop a collaborative formulation with them and refer to it within the team formulation meeting	3	1	-1
31	There is a balance to strike between the need of the staff team to feel safe enough to express their emotional reactions, alongside the value of the service user being present	4	-1	1
32	Team formulation can help challenge unhelpful or abusive practices.	4	1	3
33	Talking about a service user without them there, is a fundamentally abusive act.	-5	-5	-5

34	Team formulation is a process of taking control away from the service user and putting it directly into the hands of the mental health system	-4	-3	-4
35	It is not trauma-informed to impose a team formulation on clients	-1	0	-3
36	Ideally, one-to-one formulation work with the service user proceeds in parallel with the team formulation.	3	0	-1
37	Informed consent should be sought from service users before their cases are discussed in team formulation meetings	-3	0	-2
38	There are many other ways of including service users in the team formulation process besides them attending the meeting	3	1	4
39	Service users are not always willing or able to participate in a team formulation meeting	1	0	1
40	We must distinguish between 'our' formulation (for the team) and 'your' formulation (for the service user)	1	-2	2
41	A main purpose of team formulation is to prepare the team to hear the client's story	2	-4	-3
42	Team formulations should be kept in a separate supervision file unless or until agreed with the service user	-2	-2	-1
43	We can't forbid staff from talking about the reasons for someone's difficulties unless that person is present.	1	-1	0
44	Team formulation with the client can be a very positive experience for both team and client	0	4	-1
45	Team formulation meetings need to be places where staff feel safe to express their views without feeling judged	4	-2	3
46	Sharing difficult staff feelings and emotions is more difficult in front of the service user, who may be upset or distressed by it	1	0	4
47	Service users should not attend team formulation meetings if relationships with staff have broken down	-3	-4	0
48	Trusting relationships between staff and service users need to be developed before service users attend team formulation meetings	-1	-1	1
49	There is a need for more guidance in the area of service user involvement in team formulation	2	3	3
50	Service users should be invited to part, but not all of the meeting	-2	-2	-2
51	Having the service user in the room is not necessarily the same as involving them in the process, and not having them is not necessarily the same as excluding them	3	2	4

52	Involving service users in team formulation can take many forms, such as asking for their views beforehand and feeding back afterwards	2	1	2
53	Staff should avoid sharing sensitive information about the service user in the team formulation meeting unless it is essential	-2	-1	0
54	Staff who are not directly involved in the service user's care should not be present at a team formulation meeting	-2	-1	0
55	We need more information about how service users view and experience the process of team formulation	2	5	0
56	Both staff and service users need to be at the right stage of readiness in order to have a successful shared team formulation meeting	-2	-1	2
57	Having too many people in a team formulation meeting can feel exposing and silencing to the service users	0	3	0
58	Different client groups (e.g. Learning Disability, Older Adults) raise different issues about involvement in team formulation meetings	0	0	1

3.3 Factor 1. A safe space for staff

Demographic Information

This factor had an eigenvalue of 16.26 and accounted for 41% of the variance, suggesting that this was the most coherent viewpoint. Fifteen participants loaded onto this factor: 10 clinical psychologists, one assistant psychologist and four nurses, of whom three worked in behavioural support services with people who did not have capacity. The mean number of team formulation meetings attended was 33.

Interpretation

Participants who loaded onto Factor 1 were mainly concerned with ensuring staff needs for safety and emotional expression were met during team formulation meetings. This may be because they saw team formulation as a form of supervision. They did not view service user absence as a particularly relevant issue, or as raising ethical concerns, and felt there are other ways to include their views besides having them attend the meeting.

This viewpoint endorsed statements which prioritised the experience of staff within meetings: *'Staff need to be able to use team formulation meetings to name difficult emotions and become aware of unhelpful responses'* (18; +5); *'Team formulation meetings should be a safe space for staff to voice their own emotional reactions'* (12, +5) and *'There is a balance to strike between the need of the staff team to feel safe enough to express their emotional reactions, alongside the value of the service user being present'* (S31 +4). Interestingly, this was also the only viewpoint that agreed with the statement: *'Team formulation is a form of staff supervision'* (S5, +3). These were all distinguishing statements meaning their ranking was unique to Factor 1.

This perspective did not identify lack of service user attendance at team formulation meetings as a primary concern: *'An on-going issue with team formulation is the extent to which service users are centred, included and involved in the process'* (S16, -1); this opinion differentiated Factor 1 from Factors 2 and 3, which both ranked this statement at (+4). They also disagreed with statements that suggested this raises issues with the practice: *'Team formulation meetings where the service user is not present is still care that is 'done to' rather than 'done with'* (S9, -4); *'Team formulation is a process of taking control away from the service user and putting it directly into the hands of the mental health system'* (S34 -4) and *'Team formulation meetings operate within the power imbalance inherent in mental health services'* (S11 -3), which was a distinguishing statement.

When considering how service users should be involved in team formulation, this perspective agreed that meeting attendance should be decided: *'...on an individual basis depending on their circumstances'* (S24 +5). They were neutral about the value of service users attending meetings: *'Attending team formulation meetings can give service users a sense of hope and optimism'* (S27, -1). *'Team formulation with the client can be a very positive experience for both team and client'* (S44, 0). They also endorsed a number of other ways to include service users in the process: *'There are other ways of involving service users in team formulation meetings, besides having them present at the actual meeting'* (S38 +3); *'One way of involving service users is for the key worker to develop a collaborative formulation with them and refer to it within the team formulation meeting'* (S30 +3).

3.4 Factor 2. Concerns around inclusion and collaboration

Demographic Information

This factor had an eigenvalue of 5.66 and accounted for 14% of the variance. Sixteen participants loaded onto this factor: eight clinical psychologists, two psychiatrists, two nursing staff, one applied psychologist, one assistant psychologist, one formulation-training manager, and one participant who did not specify. The average number of team formulation meetings attended was 57.

Interpretation

Participants who loaded onto Factor 2 recognised service user involvement in team formulation as an important issue, and highlighted lack of collaboration in the process. They felt that more needed to be done to promote inclusion. While recognising that it might not always be appropriate for service users to attend, they felt that their presence in the room could be a beneficial experience. They did not regard team formulation primarily as supervision.

In contrast to Factor 1, staff who loaded onto this factor identified service user involvement in team formulation as a pertinent issue: *'An on-going issue with team formulation is the extent to which service users are centred, included and involved in the process'* (S16, +4); *'Involving service users in team formulation meetings does not occur as often as it should'* (S1, +3), and *'We need more information about how service users view and experience team formulation'* (S55, +5).

This perspective agreed with statements that suggested service user presence at meetings could be valuable, and this opinion distinguished Factor 2: *'Attending team formulation meetings can give service users a sense of hope and optimism'* (S27, +2); *'Co-producing team formulations allows service users to take an active role in their own care'* (S26, +5); *'Team formulation with the client can be a very positive experience for both team and client'* (S44, +4).

This viewpoint endorsed a range of ways to promote inclusion and involve service users in the team formulation process: *'Service users should be invited to team formulation meetings, even if they do not want to attend'* (S4, +3); *'Service users should be given the option to provide feedback on both the content and the process of team formulation meetings'* (S8, +5) and *'Service users should be informed that team formulation meetings about them are taking place'* (S7, +4). Like Factor 1, this group also recognised that it may not always be appropriate for service users to attend: *'We need to consider how to involve service users on an individual basis depending on their circumstances'* (S24, +4).

Staff who loaded onto this factor disagreed that the purpose of team formulation is primarily about supporting the team: *'The main 'client' in team formulation meetings is the team'* (S13, -5); *'Team formulation is a form of staff supervision'* (S5, -3); *'The main purpose of a team formulation meeting is to prepare the team to hear the client's story'* (S41, -4). They also diverged from Factor 1 in their opinion that team formulation should provide a reflective space for staff: *'Staff need to be able to use team formulation meetings to name difficult emotions and become aware of unhelpful responses'* (S18, -3), which was a distinguishing statement.

3.5 Factor 3. Service users might find attendance harmful

Demographics

Factor 3 had an eigenvalue of 1.9, and accounted for 5% of the variance. Five participants loaded onto this factor: three clinical psychologists, one nurse and one assistant psychologist. The average number of team formulation meetings attended was 40.

Interpretation

Participants who loaded onto Factor 3 were very concerned that attending team formulation meetings could be distressing for service users, and believed that there were alternative ways of involving them. This factor was highly correlated with Factor 1 ($r=0.74$) meaning there was considerable overlap between viewpoints. Both had concerns about service users attending team formulation meetings, although participants who loaded onto factor 3 were particularly concerned about the welfare of service users, and there was a difference in their position on team formulation as supervision.

These participants agreed with statements that suggested service users might find it upsetting to attend their team formulation meeting: *'Team formulation meetings could feel exposing and distressing for service users'* (S28, +5), was ranked significantly differently to factors 1 and 2; they also agreed that: *'Sharing difficult staff feelings and emotions is more difficult in front of the service user, who may be upset or distressed by it'* (S46, +4). They did not feel that: *'All aspects of team formulation meeting should be shared with service users'* (S23, -4), which may also be due to concerns that this could be distressing or upsetting.

Like Factor 1, this perspective endorsed other ways to include service users in the process, besides attending meetings: *'Having the service user in the room is not necessarily the same as involving them in the process, and not having them is not necessarily the same as excluding them'* (S51, +4); *'There are many other ways of including service users in the team formulation process besides them attending the meeting'* (S38, +3).

Interestingly, and in contrast to Factor 1, they did not feel the purpose of team formulation is primarily about providing support to the team: *'Team formulation meetings are a kind of staff supervision'* (S5, -3); *'The main 'client' in team formulation meetings is the team'* (S13, -3).

3.6 'Non-loaders'

Four people did not load onto any of the factors, they were: two clinical psychologists, one assistant psychologist and one physiotherapist. The average number of team formulation meetings attended was 28. The implications of this are considered in the discussion.

3.7 Distinguishing statements

The following distinguishing statements which were ranked statistically differently ($p < .01$) by all three factors: *'Staff need to be able to use team formulation meetings to name difficult emotions and become aware of unhelpful responses'* (S18, 5, -3, 2); *'Team formulation meetings should be a safe space for staff to voice their own emotional reactions'* (S12, 5, -3, 1). Factor 1 participants strongly agreed with these statements, Factor 2 participants disagreed with these statements and Factor 3 participants agreed, but not strongly, suggesting these were not their primary concerns.

3.8 Consensus Statements

Factor analysis also identified 'consensus statements' - items that were not ranked significantly differently amongst respondents. Staff strongly agreed with the following statement: *'We need to consider how to involve service users on an individual basis depending on their circumstances'* (S24, 5, 4, 5). There was also agreement that service user involvement in team formulation can take many forms: *'Having the service user in the room is not necessarily the same as involving them in the process, and not having them is not necessarily the same as excluding them'* (S51, 3, 2, 4). Staff also unanimously felt: *'there is a*

need for more guidance in the area of service user involvement in team formulation' (S49, 2, 3, 3).

Additionally, staff consistently disagreed with the following statements: *'Team formulation is a process of taking control away from the service user and putting it directly into the hands of the mental health system'* (S34, -4, -3, -4), *'Talking about a service user without them there, is a fundamentally abusive act'* (S33, -5, -5, -5).

4. Discussion

This research is the first to directly explore staff views about whether and how service users should be involved in the practice of team formulation. The aim of Q Methodology is to define the perspectives represented within a population, rather than measuring their frequency or occurrence, as would typically be done by survey methods (Webler et al., 2009). Factor analysis identified three main viewpoints on the issue. These findings have important clinical implications and offer novel insights that are not available elsewhere in the literature.

It is worth noting that the consensus statements indicate a considerable degree of agreement in this potentially controversial area. None of the factors endorsed an 'always' or 'never' position on service user attendance in team formulation meetings; all recognised that the appropriateness of this depended on circumstances and that there were other possible forms of involvement. However, there was general agreement that more guidance was needed in order to make these decisions.

Also of note is that fact that there was strong disagreement with some of the more extreme statements about team formulation as an abusive act which directly removed power from service users. This suggests that fundamental concerns about whether this practice should be taking place at all, are not seen as justified by participant in this study.

'A safe space for staff' was the most dominant factor, and accounted for the greatest amount of variance in participants' rankings. Participants who loaded onto this factor saw team formulation as a form of staff supervision, and were mainly concerned with ensuring staff needs for reflection and sharing emotions were met. As discussed in recent literature (ACP, in press), these opportunities for reflection are not unique to team formulation, and there are a number of forums which can meet this need, such as reflective practice. However, the endorsement of statements which identified different ways to include service users, suggests

their preference is likely to be a format where service users do not attend the meetings. This is an important finding given there is controversy amongst some staff and patients groups about whether formulation meetings should ever take place without the service user (ACP, in press).

There is a potential conflict between this viewpoint and the principle of ‘Nothing about us without us’, the slogan deriving from the disability rights movement (Charlton, 1998), which is also endorsed by approaches like Open Dialogue (Seikkula & Oslon, 2003). This is one of several indications of the need for clearer guidance in this area.

‘Concerns about collaboration and inclusion’, was the second strongest viewpoint; participants who loaded onto this factor felt more needed to be done to involve service users in the practice. This suggests recognition that the issue of service user involvement in team formulation is important. Similarly, Clare (2020) and Hartley (2021) have raised ethical questions about the potential for disempowerment if service users are not meaningfully involved in these meetings. Furthermore, these participants believed that having the service user present in the room could be a valuable experience for all parties, as suggested by Lewis-Morton et al’s (2017) thematic analysis of a service user’s co-production of their formulation alongside their team. Clearly, this perspective is consistent with the principle of co-production.

‘Service users might find attendance harmful’ highlights concerns that attending team formulation meetings could be distressing for service users. The apprehensions are also reflected in Tarran-Jones et al (2019) who found that some service users reported feeling fearful and vulnerable in team formulation meetings. Once again, the need for guidance, such as that suggested by Tarran-Jones et al (2019), is apparent.

A novel finding was that participants’ attitudes towards service user involvement appeared to be influenced by their beliefs about what the primary purpose of team formulation is. Participants who loaded onto Factor 1 agreed that team formulation is a form of staff supervision, whereas participants who loaded onto Factors 2 and 3 disagreed. These differing viewpoints reflect wider literature which acknowledges that team formulation can take a number of formats, perform a number of functions, and be based on a range of different models (Cole et al., 2015). This may help explain different attitudes about whether and how to involve service users. Geach et al (2018) criticised team formulation for lacking a uniform definition; however these findings suggest there may be many different, but equally valid, team formulation models and formats, and thus a number of different ways to navigate the

issue of service user presence. In any given team, it may be important to be clear about which stance is being taken, and why.

Given the dominance of clinical psychologists within the sample, it is not possible to establish whether professional role substantially influenced factor loading. However, an interesting finding was that the majority of participants who indicated they worked in Behavioural Support Services loaded onto Factor 1. This may reflect the fact they work with individuals who may not have capacity, and thus the issue of service user involvement may apply somewhat differently. For example, there would be additional considerations, such as best interest procedures for people with traumatic brain injury or severe learning difficulties. This finding also tentatively suggests that as well as team formulation having different primary purposes, particular client groups may require different considerations, and there will be no single resolution. For example, in instances where the service user is highly distressed, or is not considered to have capacity, the focus might be on ensuring meeting discussions are meaningfully fed back afterwards; whereas in community settings, where individuals are further along in their recovery, it may be a more routine practice to invite them to the meeting. Exploring the needs of different client groups across different settings is an important area for future research.

Four participants were not significantly associated with any of the factors, suggesting they did not align with any of the viewpoints. This may be because they were unfamiliar with the issue, and thus had not formed a particular opinion or standpoint. Professional role may have had some influence; one of these participants was a physiotherapist, who would be expected to have a different level of familiarity with formulation compared to the other participants, who all came from mental health backgrounds. However, given the other participants were two clinical psychologists and an assistant psychologist, this explanation is incomplete.

As discussed above, the consensus statements shed light on the areas where there was unanimity, indicating possible ways forward that are acceptable across the board. All participants strongly agreed that service user attendance at meetings should be decided on an individual basis. There was also consensus that there are other ways to achieve co-production, besides having the service user present at the meetings. In conjunction with the three main factors, this study can offer a provisional template for what a more collaborative approach to team formulation might look like. It might start by acknowledging that service user involvement as much as possible is desirable; that it needs to be balanced with staff need for space to share their feelings; that a range of ways of promoting collaboration should be considered in any given situation; and that all possible steps must be taken to ensure that

service users are not distressed by being in the meeting (if that is the format), or excluded and silenced by not being in the meeting (if that is the preferred format and/or the service user's choice). There are clearly challenges in developing checks and balances to make sure these issues are fully considered in decision-making.

However, it is essential to be aware that this study has not explored service user perspectives, and therefore only represents one side of the argument. Although the majority of staff strongly disagreed with the statement '*Team formulation is a process of taking power away from service users and back into the mental health system*', we cannot assume that service users feel the same. Clearly, some have experienced team formulation as unhelpful or even re-traumatising. Ownership of one's own narrative is extremely important in co-production and trauma-informed care (Sweeney et al., 2018), and further research into service user perspectives is a necessary step towards co-produced guidelines.

Limitations

One limitation of this study is that the Q Set is not exhaustive, and a number of additional areas for exploration surfaced during the data collection process, for example, statements that relate to the role of carers, and to the language used in meetings. Similarly, as mentioned above, it would have been useful to explore the area of capacity.

Sampling bias is a potential limitation of this study. Although purposive sampling helped to ensure that participants were 'information rich' (Hennink et al., 2020), participants may have been more likely to take part if they already had a particular view on the topic, and this could have influenced how widely applicable the study findings are. Similarly, as the majority of participants were clinical psychologists, their views are not necessarily representative of the wider multi-disciplinary team.

Future research

The most important priority is for future to investigate the views of service users on this issue (ACP, in press). The findings from this study have identified areas of consensus amongst healthcare professionals, and an interesting next step would be to see whether these findings extend to service users. If agreement between the two groups were found, this would provide a solid basis upon which to draw future guidance and recommendations. One option is to repeat the present study, recruiting service users as participants; alternatively, combining the two groups into a single sample may provide a way of identifying areas of consensus and

divergence. In this instance it would be advisable to update the Q Set to include statements that relate to the areas identified above. Collecting data on staff members settings and services would also be helpful in order to elucidate whether this influences their perspectives.

The focus of the present study has largely been on the principles of service user involvement in team formulations, rather than what this might look like in practice. Further research may want to explore how to implement these ideas, or to evaluate these different formats.

Clinical Implications

This study has a number of important clinical implications. Firstly, it shows that service user involvement in team formulation is recognised as an important issue. It suggests that healthcare professionals who are using team formulation should consider a range of ways to make their practice more collaborative. It should be recognised that service user inclusion can take a number of different shapes and forms, and different approaches to service user involvement are likely to be appropriate to different clinical populations. Additionally, these findings suggest that staff members value a separate space for reflection, and gaining insight into their own practice. Therefore, services may wish to consider what forums they currently have which can meet these needs. Finally, we need to be sensitive to the potential distress caused to service users both in attending or not attending team formulation meetings, and to develop guidance to make all versions of team formulation as constructive and collaborative as possible.

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Paper 3. Critical Appraisal

Word Count: 4774

1. Overview

This paper presents a critical reflection of the research undertaken as part of the trainee's literature review and thesis. The systematic review and empirical study are firstly summarised and links between the papers explored, and then the theoretical, methodological and clinical implications of the research are discussed. Finally, the author adds her personal reflections about the topic area, findings, and experience of the research process.

The systematic review considers whether the evidence-base provides support for the claim that psychological formulation facilitates meaning-making, and this was considered in relation to staff experiences. Findings suggested that the available research is variable in quality; however, overall, there was some support for the claim that team formulation supports staff with meaning-making. However, since very few papers had explored the issue in relation to individual formulation, it was difficult to draw firm conclusions in this area.

The empirical paper used Q methodology to investigate staff views about whether and how service users should be involved in the process of team formulation. Factor analysis identified three main viewpoints: '*A safe space for staff*', '*Concerns about inclusion and collaboration*', and '*Service users might find attendance harmful*'. The findings also indicated that different approaches may be appropriate in across different settings or client groups.

There are a number of links between the papers. Both papers contribute to the limited research on formulation in both individual and team versions. Additionally, both papers explore staff experiences and viewpoints in relation to formulation, an under-researched area with obvious clinical relevance (DCP, 2011). An interesting finding that emerged from both papers was that staff highly value the space for reflection that team formulation can offer, in order to share emotions and gain insight into their own practice.

2. Systematic Review

The following areas will be explored in this section: deciding on a question; the focus on meaning-making; the focus on staff views; conceptual differences between individual and team formulation; issues relating to bias and quality; analytical decisions, and future directions.

2.1 State of the evidence base and deciding on a question

The trainee initially carried out scoping searches in line with relevant guidance (Liberati et al., 2009; Boland et al., 2017). These suggested that research into both individual and team formulation was limited (Cole et al., 2015), an interesting finding given The Division of Clinical Psychology (2011), and the Health and Care Professions Council (2015) promote the use of psychological formulation. The searches also brought up a number of methodological and conceptual challenges associated with researching formulation which included: formulation has no single definition, can take a range of different formats, and can be either an ‘event’ or a ‘process’ (DCP, 2011). All of these factors make it difficult to design research that can assess its impact on outcomes, and establish its reliability and validity (DCP, 2011).

The wider literature suggested that research that had explored the reliability and validity of formulation had proven largely inconclusive (Bucci et al., 2016; Mumma et al., 2016). Kuyken et al (2005) found variable levels of agreement between therapists for inferential aspects of formulations, and a literature review by Bieling and Kuyken (2003) noted a ‘striking paucity of research examining the validity of formulation, or the impact on outcome’. These findings had led to a lack of clarity about how formulation should be evaluated (Vollm et al., 2014; DCP, 2011). This challenge is summarised by Bieling and Kuyken (2003) who state that a formulation can be reliable and valid, but have no impact on treatment outcome, or it can be unreliable and invalid but lead to improved outcomes.

The trainee also found that an alternative perspective, as summarised by Butler (1998, p.2) is that a formulation ‘...*does not have to be correct, but it does have to be useful*’. The trainee decided that developing a question in line with this largely unexplored position would be an interesting and novel approach. However, there were still several decisions that needed to be made before a question was finalised.

2.2 Why focus on meaning-making?

The research team started discussions by thinking about how to define ‘usefulness’ in relation to formulation. The DCP (2011) Good Practice Guidelines state that the main purpose of a formulation in any setting is ‘*identifying the best way forward and informing the intervention*’, and initially, the trainee thought this could be a suitable focus for the review. However, scoping of the literature suggested that since virtually no research studies had investigated this question, a systematic review on this topic was not feasible. A number of other ways to operationalise ‘usefulness’ were considered; the DCP (2011) guidelines suggest these include strengthening the therapeutic relationship, predicting responses and difficulties,

and clarifying hypotheses. Again, the trainee was surprised to discover that these areas had not been researched either.

Through the process of wider reading, it emerged that according to a number of definitions, and to the DCP (2011) guidelines, a central and overarching principle across all formulations is that they should be '*centrally concerned with personal meaning*' (p.7) which is the '*integrating factor*' (p.9). In other words, 'meaning' is central to what a formulation actually is. The trainee had found a body of mostly qualitative research that had explored people's experiences of formulation, and much of this had covered areas such as meaning and sense making. Interestingly, meaning-making in formulation was not an area that had been explored by any other reviews. The trainee felt that investigating whether the evidence-base supports the claim that formulation facilitates meaning-making would be feasible, interesting and clinically relevant, and would address one of the main claims made for the process of formulating.

2.3 Why focus on staff?

The original plan was to include papers that considered meaning-making in relation to staff *and* service user experiences. Inclusion of both perspectives felt important given 'collaboration' is frequently referred to as a key part of the formulation process. For example, Harper & Moss (2003) describe formulation as '*a process of ongoing collaborative sense-making*' that is '*based on personal meaning and constructed collaboratively with service users and teams*' (p.30).

Unexpectedly, this generated too many papers for the scope and feasibility of the current project. The research team discussed a number of possible ways to reduce the total number. One option was to focus on papers which explored the experiences of service users. However, since the vast majority of these studies had focused on 'reformulation' in Cognitive Analytic Therapy, it was felt that this might narrow the shape and direction of the project. After some discussion, the research team decided to focus only on papers that had considered staff experiences. This was consistent with the focus of the empirical paper, which explores staff views about service user involvement in team formulation.

The focus on staff had implications for the paper. Service users are clearly an essential part of understanding the meaning-making process, and excluding this literature limited the conclusions that could be drawn. Lack of service user perspectives in relation to formulation

is a major gap in the published literature (DCP, 2011). Interestingly, most of the papers that focused on service user experiences were unpublished doctoral theses, which were identified by forwards and backwards literature searching. While exploring staff views is legitimate in its own right, the trainee felt disappointed not to be able to address this gap, and this is obviously a priority for future research.

2.4 Developing the eligibility criteria

The eligibility criteria were developed as a means of judging the relevance and appropriateness of studies for inclusion in the review (Boland et al., 2014). A criterion needed to be developed to identify papers that referred to the underlying construct of meaning-making; however, given that most papers did not explicitly refer to ‘meaning-making’, this was challenging. Following lengthy discussion with the research team, the criterion ‘*discusses the construct of meaning-making in relation to psychological formulation*’ was taken to be indicated by terms that had been found to be synonyms for the meaning-making process in the trainee’s reading of the relevant literature. These were: *experience, understanding, insights or meaning*.

2.5 Minimising bias

Systematic reviews should seek to use explicit and systematic methods that are able to minimise bias (Moher et al., 2009). The trainee was mindful of potential areas for bias in the present review.

The author’s own position as a trainee clinical psychologist is an obvious possible area for bias. The trainee is committed to the practice of formulation, and believes it is a useful way to promote more psychosocial understandings of distress. This could have meant that she was more inclined to interpret findings as positive, or reluctant to acknowledge negative impacts. Strategies utilised to manage this risk included discussing and checking all findings regularly in supervision, and keeping a reflective log, which facilitated monitoring of the meaning making process.

The looseness of the eligibility criteria is another potential area for bias. The criterion ‘*discuss the construct of meaning-making in relation to psychological formulation*’ is subjective, and could be open to different interpretations. This risk was addressed in the same way as described above.

Publication bias is another potential issue with this paper (Boland et al., 2017). Some of the grey literature was included, but this was limited to theses and dissertations. Publication bias is a significant problem in research (Easterbrook, 1991), and can result in only positive findings being reported, known as the file drawer effect (Rosenthal, 1979). Given the overwhelmingly positive findings reported in the included studies, it is possible this factor was at play.

2.6 Quality Assessment tool

Study quality was assessed using the Quality Assessment Tool for Studies with Diverse Designs (QATSDD) (Sirriyeh et al., 2012). This tool was initially chosen as it was anticipated that studies would have a range of different designs, and the trainee judged that assessing all studies against the same tool would be a more coherent and consistent approach, especially given it was her first experience of carrying out a systematic review. However, given that the majority of the papers ended up being qualitative, on reflection it might have been appropriate to have chosen a tool specifically aimed at appraising this type of design, for example the Critical Appraisal Skills Programme (CASP) (Long et al., 2020).

The trainee found the QATSDD helpful in assessing study quality; however, a number of drawbacks were noted. Some items were difficult to define and appeared to be open to subjective interpretation; for example, the criterion '*explicit theoretical framework*' felt vague and difficult to apply systematically, a critique also noted by Fenton et al (2015) in a paper reflecting on the effectiveness of the QATSDD. Additionally, the tool did not have an item that related specifically to bias in the analysis of the results, and the trainee felt this limited her ability to conduct a thorough critical appraisal. In light of these omissions, the trainee ensured she gave adequate consideration to these areas in the narrative synthesis.

Interestingly, these are both areas that are covered by the CASP, thus suggesting this tool might have been more appropriate.

A 'component approach' to reporting the results of the quality appraisal was taken as opposed to a 'composite approach' (Liberati et al., 2009). This involves reporting the individual items of the different domains, rather than just a single overall score. Reporting in this way is recommended as being more appropriate (Liberati et al., 2009), as it allows the reader to consider the impact of the different aspects of the research design process on the overall quality of the study. The trainee found that following this process enabled her to compare and contrast different aspects of the study designs, which facilitated a richer and more comprehensive understanding of the studies. She also felt it provided the reader with an

accurate reflection of each study and its strengths and weaknesses, which would not have been possible had single scores been reported on their own.

2.7 Analytical decisions

In addition to a narrative synthesis (Popay et al., 2006), the trainee also considered analysing the data using meta-synthesis (Walsh & Downe, 2005). Meta-synthesis is a method for bringing together qualitative data, and this approach might have been appropriate given the large proportion of studies used qualitative designs. However, this approach also focuses on interpreting and explaining data, rather than drawing conclusions in a particular area, which was felt to be less appropriate for the current research question. Additionally, searching had brought up one quantitative and one mixed-method paper, and the trainee was keen to include their findings in the overall synthesis.

Narrative synthesis (Mays et al., 2005) was felt to be more appropriate, given its use is advocated in areas where the literature is underdeveloped and variable, and the studies have a range of different designs. Narrative synthesis is also recommended for studies where it is hoped the findings will inform clinical practice (Popay et al., 2006), a key aim for the project from its inception.

Initially, the trainee had planned to analyse the individual and team formulation papers separately within the synthesis. However, since so few papers directly addressed individual formulation, both types of formulation were amalgamated. This felt appropriate given the theme of meaning-making was judged to be the same in both. It is possible that had there been more examples of individual formulation, conceptual differences in the process of meaning-making in each situation might have emerged.

2.8 Clinical and research implications

Firstly, it is worth noting the papers included in this review represent a small proportion of the overall formulation literature. This indicates that meaning-making is not a theme that is prevalent in the formulation evidence base. It is interesting that very little other research has asked whether formulation facilitates meaning-making, let alone attempted to provide an answer. One possible explanation for this is that psychologists tend to assume this is the case. Alternatively, it might be that the subjective nature of the question is not easily accommodated within dominant research questions and designs. It could also be the case that some papers were not picked up by the eligibility criteria. It is also possible that within the

various versions of formulation, some models (e.g. CBT) place less emphasis on meaning as a process. Irrespective of these factors, the area should not be left untested and unexplored.

The review has a number of research and clinical implications in addition to those discussed in the main paper. In relation to research, a previous systematic review by Geach et al (2018) argued there is a need for the definition and practice of team formulation to be standardised, in order for future studies to be able to evaluate efficacy and outcomes more robustly. The current review concurs with the need for higher quality research in the area, but also suggests that a range of different models and formats of formulation can support staff meaning-making, and that therefore, there may not be a need for the practice to be standardised. Rather, it is possible that team formulation should be recognised as taking a range of different formats, some of which are more consultative, and some more directly co-produced. Given the varied nature of services and settings, it is a valuable aspect of the practice of team formulation that it can be used flexibly, in line with local needs and aims.

The review identified three processes which support staff meaning-making: *'introducing psychological theory'*, *'space to reflect'* and *'sharing knowledge and perspectives'*. These findings may provide a helpful guide for facilitators of team formulation meetings, and for teaching about the use and value of team formulation. Alternatively, as the need for standardised ways of measuring the quality of team formulation has been discussed in the literature (Bucci et al., 2021), these findings could inform the development of future audit tools and guidelines.

3. Empirical Paper

This section will cover: rationale for choice of topic; focus on staff views; choice of methodology; recruitment; procedure; analytical decisions; service user consultation; and future implications.

3.1 Rationale for choice of topic

The trainee first became aware of the issue of service user involvement in team formulation when she saw some of the debates that were taking place on social media. Formulation is an important part of the trainee's practice, and she was concerned to see allegations that team formulation can be seen as unethical and potentially harmful, principally through excluding the service user presence and voice. She was also surprised that no other research had sought to explore this area, and felt addressing this gap in the literature was important. Given the trainee hopes to use team formulation post-qualifying, conducting this research has important clinical implications for her future practice.

3.2 Decision to focus on staff views

The process was initiated in April (2020) when the trainee submitted a research proposal to the research sub-committee. They fed back that the initial idea to recruit 80 participants, made up of both staff and service users, was beyond the remit of a ClinPsyD project, advising that she focused on just one group. This was a difficult decision given the trainee considered both populations as having important and valuable perspectives to share on the issue of whether and how to include service users in team formulation. However, following a discussion with research team, she decided to focus on staff views, since establishing current practice and decision-making about this issue felt like the most appropriate first step.

Focusing on staff had a number of implications for the study. The issue of service user involvement cannot be sufficiently understood without also exploring the views of service users, and there are clearly ethical issues to omitting the perspectives of those who have expressed their unhappiness with the practice of team formulation. Consequently, this present study offers only an initial step towards filling the gap in the literature, and further research into the views service users is necessary. This is particularly important given the need for co-production is increasingly being recognised within healthcare settings (Department of Health, 2014), with the aim that service users should be equal partners in the design, commissioning, delivery and evaluation of services (Boyle & Harris, 2009).

3.3 Choice of methodology

The research team considered using a number of different methodologies. One option was to conduct qualitative interviews with participants and analyse them using thematic analysis (Braun & Clarke, 2006). This is a useful method for identifying rich patterns of meaning, and the trainee was initially keen to use this approach, since she had some familiarity with it. However, a number of possible limitations were also identified, such as that qualitative research is vulnerable to social desirability, for example participants wanting to come across as saying the ‘right thing’ (Grimm, 2010). Given the potentially contentious nature of the subject, there was some concern that participants may have felt unable to speak openly and honestly about their viewpoints. Additionally, as service user inclusion in team formulation is an under-researched area, it is likely that not all staff have a particularly established view on the topic, which again risks leading to poor quality data. The team also briefly discussed using focus groups (Morgan, 1996); however the same concerns arose about the sensitivity of the subject matter hindering participants from feeling able to speak honestly.

The trainee finally settled on Q Methodology, which is a useful method for exploring points of view around a single topic (Herrington & Coogan, 2011), and in addition, is a design that is less vulnerable to social desirability (Wittenborn, 1961). Furthermore, as Q methodology is based on forced choices, it always generates some data. The trainee was initially apprehensive about using this method, as she had very little familiarity with it; however, she found it to be an accessible, structured and containing method with which to explore the topic. This was also reflected in feedback from the participants, many of whom reported that they enjoyed the research experience.

3.4 Recruitment

There were a number of challenges to recruitment, which are discussed below. These are thought to partly explain why clinical psychologists came to be so overrepresented in the sample.

The entirety of the project took place during the Covid-19 pandemic, with recruitment commencing whilst the country was in lockdown. This made it difficult to secure an NHS collaborator, as many services were overwhelmed and struggling, which left very little room for additional research activities. This was particularly the case for inpatient services, a

setting the trainee had initially hoped to target. It also meant that the trainee could not visit services in person, and all the study promotion had to take place remotely. This made it harder to develop relationships with service leads and participants.

In light of these challenges, the sampling and recruitment strategy took a more opportunistic approach than had originally been planned. Rather than concentrating on a few services, and aiming to recruit a diverse range of professionals from each, the trainee approached as many different services as possible. It is unsurprising that this strategy led to a disproportionate number of clinical psychologists in the sample, since they are the professional group most likely to be interested in formulation. In addition, as they conduct their own research as part of their clinical training roles, arguably this makes them more likely to volunteer for ClinPsyD research projects. Adopting a more purposive sampling approach (Etikan et al., 2016) would have undoubtedly increased the diversity of the sample, which would have made the results more reflective of the wider multi-disciplinary team; however given the time-limited nature of the project, this was not feasible. Conversely, it could be argued that clinical psychologists are the most likely MDT members to be setting up team formulation meetings and deciding on the format they should take, and as such, their views may be more relevant to the issue.

Participants were 88% female and 93% identified as being white. Given that the majority of participants were clinical and assistant psychologists, the demographics of the sample are unsurprising, and reflect the fact that the wider clinical psychology profession is dominated by white females (Cullen et al., 2020; Gale & Turpin, 2010). However, this is not true of the other professional groups that make up the multi-disciplinary team (Hussein et al., 2020), and is another reason why these results may be less representative of their views. This has implications for the generalisability and representativeness of the findings (Cullen et al., 2020). It is important that future research seeks to obtain a most diverse sample of participants, in terms of profession, ethnicity and gender.

3.5 Procedure

The trainee found it helpful to conduct the Q Sorts in person with the healthcare professionals, using a videoconferencing platform. Webler et al (2009) recommends being present while the participant completes the Q Sort as a means of ensuring meaningful data; this felt preferable to sending out the materials with instructions for participants to complete in their own time. This process also helped the trainee to become immersed in the data,

enabling a rich understanding of participants' opinions, dilemmas and quandaries, all of which was invaluable knowledge for the data analysis phase (Webler et al., 2009).

This process also generated useful information that can help to shape future research in this area. Discussions with participants shed light on a number of important issues that were not covered by the statements e.g. the issue of capacity and the role of carers.

3.6 Analytical decisions

Data analysis of a Q sort includes scrutinising a Scree plot, a graphical tool used in the selection of the number of factors to be considered. The Scree plot for this study confirmed that either a two or three factor solution was appropriate. The three-factor solution was chosen on the basis that it explained the most variance, and offered three distinctly different viewpoints on the topic. The aim of Q Methodology is to find the most parsimonious solution for the data (Webler et al., 2009), rather than explain the most variance. It could therefore be argued that a two-factor solution would have been simpler and offered more clarity. This was an area of significant discussion and deliberation amongst the research team.

3.7 Service user consultation

The trainee initially arranged a meeting with the Community Liaison Group, which is an advisory group of service users, carers and community members who support the University of Manchester Doctorate in Clinical Psychology course. She had hoped to explore their views about relevance of the topic, whether they were familiar with these controversies, and the decision to focus on staff views. However, due to Covid-19, the meeting was unable to go ahead. This was disappointing, and is an obvious limitation of the project, given that the need to include service users at all levels of research and service delivery is increasingly recognised (Boyle & Harris, 2009).

3.8 Theoretical, Clinical and Research Implications

The most important priority for future research is to explore the views of service users, since without this we only have a partial perspective on the issues. It would also be useful for future research to explore the question with healthcare professionals from a more diverse range of

professions, in order to be able to draw conclusions about views of the whole multi-disciplinary team.

While this study has demonstrated that Q Methodology is a useful methodology to explore this issue, it may be beneficial to consider different approaches as well; for example, a thematic analysis may provide a richer understanding of the reasons behind some of the viewpoints that have been identified in this study.

The study also has a number of clinical implications. The most dominant viewpoint was that healthcare professionals want team formulation meetings to be a protected space, where they feel safe to express their opinions without being judged or criticised. This is useful information for staff members who are making decisions about the planning, delivery and implementation of team formulation meetings. The findings also indicate that healthcare professionals think service user inclusion in team formulation is an important issue, and that more needs to be done to promote it. Therefore, services and professionals who are currently running team formulation meetings should consider what steps they are taking to enhance co-production and inclusion. The consensus statements suggest some areas to consider in order to take a more collaborative approach.

Lack of guidance in the area of service user involvement in team formulation was the reason for the new ACP (in press) recommendations, which were still being finalised as this study was being carried out. However, the ACP working party was aware of the trainee's research. The intention is that, as with formulation itself, the ACP guidance will continue to evolve in the light of feedback, and the trainee was assured by the convenor that the results of her study, once available, would be a helpful contribution to this process.

4. Dissemination

Both papers will be submitted to the journal *Psychology and Psychotherapy Theory Research and Practice*. All participants will be sent a copy of the final manuscript, and a lay summary that can be circulated around colleagues and teams. The findings will also be communicated via the study Twitter account, which will be a method for reaching both staff and service users. The trainee will present the results at the University Postgraduate Research Conference, which is due to take place in June 2022.

5. Personal Reflections

The trainee found the process of completing this thesis thought provoking and rewarding. At times it felt difficult to juggle the workload along with managing the demands of the doctorate. The main challenges completing the systematic review were developing a question, and managing the possibility for subjectivity and bias. For the empirical paper, applying for ethical approval was a particularly time-consuming and demanding phase, as the trainee had no previous experience of doing this. Prior experience of recruiting participants as a research assistant meant the trainee did have experience of liaising with services, speaking in team meetings, and managing databases, all of which proved helpful.

The trainee particularly enjoyed the experience of meeting with participants to complete the Q Sorts and was encouraged to hear many of them feedback that they felt this was an important and relevant piece of work. She is very much looking forward to disseminating the results to participants and hearing their feedback.

Reflecting on the process of this literature review and empirical study, the trainee feels that it offers some genuinely novel insights into a growing area of practice. She is personally committed to developing the core clinical psychology skill of formulation, and to do so in a way that respects service users' contributions and experiences. She looks forward to implementing some of the findings in her clinical work, and building on her interest in this area, both in practice and in future evaluations and research.

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Appendices

Appendix A: Author Guidelines for PAPTRAP

2. AIMS AND SCOPE

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

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

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

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

Word limits for specific article types are as follows:

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

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

Please refer to the separate guidelines for [Registered Reports](#).

All systematic reviews must be pre-registered.

Brief-Report COVID-19

For a limited time, the *Psychology and Psychotherapy: Theory, Research and Practice* are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal's main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured (according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the

authors. Appendices are included in the word limit; however online supporting information is not included.

4. PREPARING THE SUBMISSION

Free Format Submission

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

Before you submit, you will need:

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

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

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

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

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

Revised Manuscript Submission

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

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

Parts of the Manuscript

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

Title Page

You may like to use [this template](#) for your title page. The title page should contain:

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's [best practice SEO tips](#));

- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see [Data Sharing and Data Accessibility Policy](#));
- Acknowledgments.

Authorship

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

Abstract

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

Keywords

Please provide appropriate keywords.

Acknowledgments

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

Practitioner Points

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

Main Text File

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

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

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

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

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

authors' names or affiliations and always refer to any previous work in the third person.

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

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

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.

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.

[Click here](#) for Wiley's FAQs on supporting information.

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

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.
- **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).

Wiley Author Resources

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

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

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

Appendix B: PROSPERO review protocol

See URL for further details in relation to amendments:

https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=287965

Does psychological formulation facilitate meaning-making for staff: a systematic review

Alissa Miners, Daniel Pratt, Louisa Jackman

Review methods were amended after registration. Please see the revision notes and previous versions for detail.

Citation

Alissa Miners, Daniel Pratt, Louisa Jackman. Does psychological formulation facilitate meaning-making for staff: a systematic review. PROSPERO 2021 CRD42021287965 Available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42021287965

Review question [1 change]

Does psychological formulation facilitate meaning-making?

Searches

A systematic literature search of four key electronic databases was undertaken. MEDLINE, PsycINFO, CINAHL & Embase were searched for relevant published and unpublished literature from their inception until present day.

Search terms: (Experience* or meaning* or understand*) and (psychological formulation, case formulation, case conceptualisation, reformulation, shared formulation, team formulation, reflective sessions, team case reflection, psychology* AND formulat*).

Searching took place on 10.04.2021 and will be repeated prior to the final analysis. Results were limited to publications written in or translated in to the English language.

Types of study to be included [1 change]

Inclusion:

1. Setting is relevant to practitioner psychologists (e.g. mental health services, forensic services)
2. Article contains a description of formulation that is consistent with the DCP (2011) definition.
3. Article discusses experience, understanding insights or meaning in relation to psychological formulation.
4. Published in English
5. Published within a peer-reviewed academic journal
6. Empirical investigations
7. Grey literature (dissertations and theses only)
8. Focus of the article is on the experience of staff

Exclusion:

1. Book chapters / editorials
2. Secondary analysis of already published datasets.

Condition or domain being studied

Psychological formulation is a core skill for clinical psychologists (DCP, 2011). It is a method for developing a shared understanding about a person's difficulties that integrates research, theory and practice. Hypotheses are made about the factors causing and maintaining the distress, and this is used to guide the intervention (Johnstone & Dallos, 2006)

Participants/population [3 changes]

Inclusion:

Staff members with experience of using psychological formulation

Exclusion:

Not applicable

Intervention(s), exposure(s)

DCP (2011) define formulation as: 'psychological formulation summarises and integrates a broad range of biopsychosocial causal factors. It is based on personal meaning and constructed collaboratively with service users and teams'.

Team formulation is when a group or team of professionals meet to develop a shared understanding of a service user's difficulties. This can be based on a specific therapeutic approach, or on an integrative model (Johnstone & Dallos, 2006).

Studies will only be included if they contain a description of formulation that is consistent with either of these definitions.

Comparator(s)/control

Not applicable.

Context [2 changes]

The types of studies that will be included will be those that consider how psychological formulation is / has been experienced by staff. Papers will only be selected if they focus on formulation that has taken place in settings relevant to psychologists (e.g. forensic, pain management, mental health services).

Main outcome(s) [4 changes]

The review aims to achieve the following:

1. The most important outcome will be to establish whether the extant literature provides evidence that psychological formulation (as defined by the DCP, 2011) may facilitate meaning-making for staff. Included papers are expected to be mainly

qualitative in nature; therefore relevant themes will be extracted in order to develop a preliminary synthesis that informs an answer to the question. Outcomes from included quantitative papers will also be included in the synthesis (e.g. pre and post scores on measures of understanding, alliance etc..).

2. Shed light on how staff experience psychological formulation in clinical practice (including positives, negatives and utility). This will inform whether psychological formulation fulfils its main purpose, which is to facilitate meaning-making.

Measures of effect

Additional outcome(s)

None.

Measures of effect

Data extraction (selection and coding) [1 change]

Data will be recorded and reported using the Preferred Reporting Items for Systematic Reviews and Meta- Analyses (PRISMA) flow chart. Selection

1. Five electronic databases were searched to find studies that explored whether psychological formulation facilitates meaning-making for staff, service users & teams.
2. Search results were exported into the software EndNote and duplicates removed. The first author has commenced screening of titles and abstracts. Studies that do not meet the inclusion / exclusion criteria will be removed. An independent reviewer will screen 10% of abstracts to check for agreement. Any discrepancies will be resolved in supervision.
3. The first author will conduct full text screening of all studies that meet the inclusion / exclusion criteria. An independent reviewer will conduct parallel full-text screening of 10% papers.
4. Studies that do not meet the criteria will be excluded.
5. The studies that are included will be assessed for methodological quality by the first author. These quality ratings will be presented as part of the narrative synthesis. 10% of the included studies will also be co-rated by an independent reviewer.
6. Authors of the chosen papers will be contacted about any other relevant published or unpublished papers.

Extraction

The first author will extract data from the selected studies into a standardised extraction spreadsheet. Data collected will include: author, year of publication, country, study design, sample size, sample characteristics, study design, inclusion / exclusion criteria, number of participants, intervention (s) and comparator (s), study outcomes, analyses, study sponsorship, relevant findings.

Tabulation and textual descriptions of findings will be used to identify patterns across data and to develop a preliminary synthesis.

Data will be recorded and reported using the Preferred Reporting Items for Systematic Reviews and Meta- Analyses (PRISMA) flow chart.

Risk of bias (quality) assessment [1 change]

Quality assessment will be carried out using the Quality Assessment Tool for Studies with Diverse Designs (QATSDD) (Sirriyeh et al, 2012). This is a tool designed to establish the methodological and reporting quality of studies with diverse designs (qualitative, quantitative or mixed). A quality assessment of all of the included papers using this tool will be carried out by the main author. A second reviewer will rate 25% of the included papers. Disagreement in ratings will be discussed.

Strategy for data synthesis [3 changes]

Neither meta-analysis or meta-ethnography are feasible for this review, given the expected heterogeneity of the papers in terms of methods, participants, nature of implementation etc..

A formal narrative synthesis and appraisal of the robustness and quality of these studies is appropriate. Narrative methods are recognised as useful for reviews that include studies with a range of different designs. Narrative synthesis is a method for synthesising the findings of multiple studies using words and text to 'tell the story of the data'. Tabulation and textual descriptions of studies will be used to develop a preliminary synthesis. As patterns emerge, the author will look to identify factors that may explain differences within the data (e.g. why formulation has been experienced differently for different people). Relationships within and across studies will be explored. The synthesis will be expressed as a written narrative. Assessing the robustness of the included studies will shed light on how widely applicable the findings are, and provide an assessment of the strength of evidence. Gaps in the literature will also be identified.

Analysis of subgroups or subsets

Not applicable.

Contact details for further information

Alissa Miners
alissa.miners@postgrad.manchester.ac.uk

Organisational affiliation of the review

University of Manchester

Review team members and their organisational affiliations

Miss Alissa Miners. University of Manchester
Dr Daniel Pratt. University of Manchester
Dr Louisa Jackman. University of Manchester

Collaborators

Dr Esmira Ropaj. University of Manchester

Type and method of review

Narrative synthesis, Systematic review

Anticipated or actual start date

28 February 2021

Anticipated completion date

30 September 2022

Funding sources/sponsors

None

Conflicts of interest

Language

English

Country

England

Stage of review

Review Ongoing

Subject index terms status

Subject indexing assigned by CRD

Subject index terms

Adaptation, Psychological; Humans; Personal Satisfaction

Date of registration in PROSPERO

16 November 2021

Appendix C: Quality assessment tool

Table 1 Quality assessment tool and scoring guidance notes

Criteria	0 = Not at all	1 = Very slightly	2 = Moderately	3 = Complete
Explicit theoretical framework	No mention at all.	Reference to broad theoretical basis.	Reference to a specific theoretical basis.	Explicit statement of theoretical framework and/or constructs applied to the research.
Statement of aims/objectives in main body of report	No mention at all.	General reference to aim/objective at some point in the report including abstract.	Reference to broad aims/objectives in main body of report.	Explicit statement of aims/objectives in main body of report.
Clear description of research setting	No mention at all.	General description of research area and background, e.g. 'in primary care'.	General description of research problem in the target population, e.g. 'among GPs in primary care'.	Specific description of the research problem and target population in the context of the study, e.g. nurses and doctors from GP practices in the east midlands.
Evidence of sample size considered in terms of analysis	No mention at all.	Basic explanation for choice of sample size. Evidence that size of the sample has been considered in study design.	Evidence of consideration of sample size in terms of saturation/information redundancy or to fit generic analytical requirements.	Explicit statement of data being gathered until information redundancy/saturation was reached or to fit exact calculations for analytical requirements.
Representative sample of target group of a reasonable size	No statement of target group.	Sample is limited but represents some of the target group or representative but very small.	Sample is somewhat diverse but not entirely representative, e.g. inclusive of all age groups, experience but only one workplace. Requires discussion of target population to determine what sample is required to be representative.	Sample includes individuals to represent a cross section of the target population, considering factors such as experience, age and workplace.
Description of procedure for data collection	No mention at all.	Very basic and brief outline of data collection procedure, e.g. 'using a questionnaire distributed to staff'.	States each stage of data collection procedure but with limited detail, or states some stages in details but omits others.	Detailed description of each stage of the data collection procedure, including when, where and how data were gathered.
Rationale for choice of data collection tool(s)	No mention at all.	Very limited explanation for choice of data collection tool(s).	Basic explanation of rationale for choice of data collection tool(s), e.g. based on use in a prior similar study.	Detailed explanation of rationale for choice of data collection tool(s), e.g. relevance to the study aims and assessments of tool quality either statistically, e.g. for reliability & validity, or relevant qualitative assessment.
Detailed recruitment data	No mention at all.	Minimal recruitment data, e.g. no. of questionnaire sent and no. returned.	Some recruitment information but not complete account of the recruitment process, e.g. recruitment figures but no information on strategy used.	Complete data regarding no. approached, no. recruited, attrition data where relevant, method of recruitment.
Statistical assessment of reliability and validity of measurement tool(s) (Quantitative only)	No mention at all.	Reliability and validity of measurement tool(s) discussed, but not statistically assessed.	Some attempt to assess reliability and validity of measurement tool(s) but insufficient, e.g. attempt to establish test-retest reliability is unsuccessful but no action is taken.	Suitable and thorough statistical assessment of reliability and validity of measurement tool(s) with reference to the quality of evidence as a result of the measures used.
Fit between stated research question and method of data collection (Quantitative)	No research question stated.	Method of data collection can only address some aspects of the research question.	Method of data collection can address the research question but there is a more suitable alternative that could have been used or used in addition.	Method of data collection selected is the most suitable approach to attempt answer the research question
Fit between stated research question and format and content of data collection tool e.g. interview schedule (Qualitative)	No research question stated.	Structure and/or content only suitable to address the research question in some aspects or superficially.	Structure & content allows for data to be gathered broadly addressing the stated research question(s) but could benefit from greater detail.	Structure & content allows for detailed data to be gathered around all relevant issues required to address the stated research question(s).
Fit between research question and method of analysis	No mention at all.	Method of analysis can only address the research question basically or broadly.	Method of analysis can address the research question but there is a more suitable alternative that could have been used or used in addition to offer greater detail.	Method of analysis selected is the most suitable approach to attempt answer the research question in detail, e.g. for qualitative IPA preferable for experiences vs. content analysis to elicit frequency of occurrence of events, etc.
Good justification for analytical method selected	No mention at all.	Basic explanation for choice of analytical method	Fairly detailed explanation of choice of analytical method.	Detailed explanation for choice of analytical method based on nature of research question(s).
Assessment of reliability of analytical process (Qualitative only)	No mention at all.	More than one researcher involved in the analytical process but no further reliability assessment.	Limited attempt to assess reliability, e.g. reliance on one method.	Use of a range of methods to assess reliability, e.g. triangulation, multiple researchers, varying research backgrounds.
Evidence of user involvement in design	No mention at all.	Use of pilot study but no involvement in planning stages of study design.	Pilot study with feedback from users informing changes to the design.	Explicit consultation with steering group or statement or formal consultation with users in planning of study design.
Strengths and limitations critically discussed	No mention at all.	Very limited mention of strengths and limitations with omissions of many key issues.	Discussion of some of the key strengths and weaknesses of the study but not complete.	Discussion of strengths and limitations of all aspects of study including design, measures, procedure, sample & analysis.

29.06.2020

Research Sub-committee
Clinical Psychology, 2nd Floor Zochonis Building
University of Manchester
M13 9PL

Dear Research Sub-committee,

Re: Response to changes suggested by the Research Sub-Committee

Thank you for taking the time to consider and provide feedback on my LRSP proposal. I found the suggestions very helpful, and in response I have made the following changes:

Change 1:

- *The panel felt the sample size of $n = 80$ staff and service-users was excessive. It was felt that just selecting one group or the other and focussing on this sample would be preferable (i.e. either staff or service-users). If the project focuses on service-users the recruitment of staff could still be included as a contingency plan. There were concerns around the feasibility of recruiting the planned sample of $n = 80$, as it is unusual for a single trainee project adopting the methods described here to achieve this.*
- I have now decided to focus on recruiting only staff, and will aim for $N = 40$ participants. I have updated the proposal to reflect this change. Please see **Page 11 & 13**.

Change 2:

- *It was unclear if the Q-sort is being conducted separately for both samples, or if a single Q-sort is taking place. This point may not require a response if the trainee decides to drop one sample as recommended above.*
- In line with the above recommendation, I have now chosen to focus on just one group, which will be staff.

Change 3:

- *The inclusion criteria for staff appeared overly broad. These could include staff members who had attended a single team formulation meeting a decade or more ago, for example. Since practice and principles around team formulation are constantly changing, it may be important to recruit staff with relatively recent experience of team formulation, for example. Or it may make sense to recruit staff with multiple experiences of team formulation.*
- I have now stated in my inclusion criteria that all staff will need to have attended at least one team formulation meeting in the last two years. I have also updated my recruitment strategy section to reflect the fact that I would like participants to represent a breadth of experience in terms of professions. Please see **Page 11 & 12**.

Change 4:

- *It was felt that the plan to post out materials for the Q-sort, for participants to undertake at home, felt quite cumbersome and placed a lot of reliance on the participant to follow the correct procedure. The panel wondered if there may be a means of completing the Q-sort using online or electronic versions of the materials. It was also noted that having a trainee present (even via phone or Zoom) was important for a Q-sort given the complexity of the task.*
- Following a discussion with Austin Lockwood, I have now decided that I will use the online Q Sort software HTMLq, which has been successfully used by previous trainees for LSRPs. Prior to completion of the task, I will arrange a time to talk participants through the exercise (either via Zoom or by phone). I will also ensure that I am available (either by phone or telephone), when they are completing the exercise, should they encounter any difficulties. Please see **Page 13**.

Thank you for drawing my attention to the additional considerations. Although no formal response is required, I have discussed them in supervision, and comments can be found below.

- Further consideration is being given to the title / methods of the systematic review. Specific supervision to discuss this has been booked.
- A systematic method for generating the items on the Q concourse is being developed by the trainee.
- Recruitment has been extended until the end of 2021 and the GANTT chart has been updated to reflect this change.

I hope you feel this letter provides a satisfactory response to your suggestions. My updated proposal is attached to this document. I would like to thank you again for taking the time to look at my proposal.

Yours sincerely,

Alissa Miners

Alissa Miners
Trainee Clinical Psychologist
Clinical Psychology Doctorate

**University of Manchester
Clinical Psychology Doctorate**

**Large Scale Research Project
PROPOSAL SUBMISSION PROFORMA**

Trainee name: Alissa Miners

Title of project: Experiences and views of staff about how to involve service users in Team Formulation

Is this LSRP linked to another LSRP? No

If so, please provide name(s) of other trainee(s):

Primary academic supervisor: Louisa Jackman

Other academic supervisors: Dan Pratt

NHS Clinical Collaborators: -

Statement on minimum standards expected for a ClinPsyD thesis:

- a. *The research thesis is expected to be an original piece of empirical work of relevance to clinical psychology, demonstrating the candidate's ability to apply scientific principles and undertake rigorous investigation. It should be of a **quality** comparable to publications within peer-reviewed professional / academic journals, make a distinct **contribution** to the knowledge of the subject and show evidence of **originality**.*
- b. *The work done for the thesis must not have been submitted in fulfilment of the requirements of any other degree, and it must be the candidate's own work. If the candidate is working in a team or analysing previously collected data the candidate's personal contribution must be substantial and clearly defined. The criterion of acceptability is that the candidate is making a substantial independent contribution to the study. Although research supervisors are required to offer guidance and advice to trainees throughout, ultimate responsibility for decisions relating to the conduct and completion of this work rests with the trainee.*
- c. *The ClinPsyD programme supports a pluralistic approach to research. The candidate is free to choose from a range of approaches and paradigms as long as the research methods are appropriate to the research questions or hypotheses being investigated.*

Checklist for submission with proforma

- Letters of support from service leads/managers (NOT clinical collaborators unless they have the authority to confirm local approval and access to potential participants) indicating willingness to support research where recruitment involves input from external agencies (e.g., clinical services, charitable organisations, schools etc.): X
- Questionnaires: N/A
- Interview schedule: N/A
- Online requirements discussed with Austin Lockwood: N/A
- Power calculations and statistical analysis discussed with statistician: N/A

BRIEF SUMMARY OF PROPOSAL IN LAY TERMS

Please provide a summary of the proposed study including background information, aims, methods and implications in lay terms.

300 words maximum. Please include measures of readability (e.g., Flesch Indices.)

'Team Formulation' (TF) describes meetings in which a group of professionals discuss their shared understanding of a service user (SU)'s difficulties. This information can then be used to guide their care. TF is a common practice in Adult Mental Health services.

One question about TF is how and when to involve SUs. There has been very little research in this area.

Most TF meetings take place without the SU being in the room. Some professionals think this is the most appropriate format. Reasons for this include: TF is a form of staff supervision; it is not always appropriate to share difficult staff feelings directly with the SU; the SU may not feel able to attend the meeting; and there are other ways of including their views. However, some SUs and professionals have argued that not having the SU in the room means their views might be excluded and their difficulties might be misunderstood. It is also argued that this goes against the principle of 'co-production', where SUs are involved as equals in their care. There is little professional guidance in this area.

This study will explore the opinions of staff about how SUs should be included in TF. Findings will be used to suggest new guidance that would meet the concerns of both SUs and professionals.

This study will use Q-methodology, which is a way of exploring opinions about a particular topic. The researcher will put together statements relevant to the topic of SU inclusion in TF from resources, such as research papers and social media. The participants will complete a sorting task in which they are asked to say how much they agree or disagree with each statement. The results will then be analysed to see if there are patterns or differences in people's responses.

Word Count: 296

Flesch Index: 61.5

INTRODUCTION / SUMMARY OF CONTEXT

Provide a brief summary of the relevant literature.

400 words maximum

Co-production is the notion that service users (SUs) should be treated as equal partners to professionals; its importance is increasingly being recognised in mental healthcare (Boyle & Harris, 2008).

Team formulation (TF) is the process in which staff members meet to develop a shared understanding of a service user's difficulties (Johnstone, 2014). Most TF practice does not have the SU present in the room, and this raises issues in relation to co-production such as: lack of transparency, power imbalances, and exclusion of the SU voice (Wainwright & Bergin, 2010). However, it is also argued that the SU's presence is not always appropriate, for example if counter-transference feelings are being explored, and that their views can be included in other ways (Cole et al., 2015).

A very limited amount of research has investigated this area, and has found mixed results. Research conducted in Older Adults services found that SUs felt attending TF meetings had helped them to make sense of their difficulties; however the experience was often emotionally draining, and some felt not listened to (Tarran-Jones et al., 2019).

The DCP Guidelines (DCP, 2011) only discuss the issue briefly, acknowledging that there may be reasons for not having SUs present, but that the same good practice principles apply to both.

There has been particular concern in Adult Mental Health (AMH) work. ACAT, the Cognitive Analytic Therapy organisation states: 'One of the key issues in debates/controversies around team formulation is collaboration and the extent to which service users are centred, included and involved in the process'. A senior clinical

psychologist has claimed that 'Team formulation without the presence of the SU risks being abusive' (@palkovskis 17th September 2018). On social media, some SUs report concerns about lack of involvement in TF. In response to an Association of Clinical Psychologists (ACP) article about TF one SU wrote: *'This is basically a guide how to create perfect conditions for institutional abuse. Allow staff to talk about a vulnerable person in secret (without them there)...'*

This issue has come into focus along with the increasingly widespread practice of TF (Cole et al., 2015), and there is now a clear need to address these concerns about professional and ethical practice in this under researched area. Exploring the views of staff will help to form the basis of updated recommendations, and suggest parameters for SU inclusion.

CONTRIBUTION TO BE MADE BY THE PROPOSED RESEARCH

What is the gap in the literature that the proposed research aims to address?

*What **novel** and **significant** contribution to the knowledge base would be made by your proposed research?*

250 words maximum

Changes to the role of clinical psychologists working in the NHS have led to new ways of working, such as a greater emphasis on leadership, consultation and indirect work (Wright, 2012). TF is one example of this, and is a rapidly expanding practice (Cole et al., 2015). A very limited amount of research has explored TF, and within this, role and experience of SUs in TF is a significant gap (Cole et al., 2015).

However, professionals and SUs have raised concerns about TF on alternative platforms. These include reports of inconsistent practice, ethical issues around exclusion, and absence of adequate guidelines. Existing DCP Guidelines (DCP, 2011) do not provide guidance about whether and how to involve SUs in TF, stating only briefly that there may be reasons for not having SUs present. It is important for the profession to show that these concerns are being listened to and addressed, particularly in the wider context of the principles of co-production.

This research will directly address some of these concerns, as well contributing to the very limited wider literature on TF. Recommendations for ensuring ethical and professional practice in this sensitive area will be made. Findings could also inform the development of future guidelines.

OUTLINE OF PROPOSED LITERATURE REVIEW

Provide the title, aims and a brief outline of the proposed literature review (e.g. systematic review, meta-synthesis, mixed-methods review, etc.), along with a brief justification for undertaking this review and the conceptual link to the empirical study.

400 words maximum

The suggested systematic review will explore the views about, and experiences of, staff, service users and teams in relation to psychological formulation including but not limited to team formulation. This will be a mixed-methods view as there are a limited number of published studies in this area.

Psychological formulation is a key competency for all Clinical Psychologists (Health and Professionals Council, 2009). The aim of formulation is to collaboratively develop a shared understanding of the client's difficulties, which can inform interventions (Johnstone & Dallos, 2013). Formulation should be a collaborative, two-way process that is done with the service user, rather than to them (Boyle & Harris, 2009). A limited amount of research has explored the views of service users and staff about formulation, whether individual or team, and to my knowledge, there have not been any literature reviews in this area. The proposed paper will provide important foundations and grounding for the proposed empirical study.

Initial scoping of the literature took place on 12.05.2020 using 'Google Scholar' and the search terms: (formulation); (service users or patient or client); (experience or perceptions or feedback); (psychological); (staff); (team). This resulted in 2600 results, of which approximately 15 looked relevant to the proposed paper.

The method will be to search a number of databases including, but not limited to, MEDLINE, PsychInfo, Web of Science, and CINAHL.

AIMS AND RESEARCH QUESTIONS OF THE EMPIRICAL STUDY

Briefly state the principal and subsidiary aims of the research and the research questions to be investigated
150 words maximum

The primary aim will be to explore and understand the attitudes and viewpoints of staff about the issue of SU involvement in TF.

STUDY DESIGN

Provide an outline of the design to be used (e.g. correlational, group comparison, etc.), stating dependent/target and independent/predictor variables where appropriate
100 words maximum

This research will use Q-Methodology, which is a mixed methods approach (Watts and Stenner, 2012). Participants complete a Q sort task where they rank how much they agree or disagree with a set of statements in relation to a particular topic. The data is then subject to a Q factor analysis, which provides insight into the different patterns and preferences held by distinct groups of participants (Roberts et al., 2015).

Q methodology has been chosen as the most appropriate approach as it was primarily designed to measure attitudes (Coogan & Herrington, 2011).

STUDY HYPOTHESES

State, in formal terms, the hypotheses to be tested and how these relate to the research aims
200 words maximum

This is an exploratory piece of research, and therefore there are no formal hypotheses being tested.

PARTICIPANTS

Describe the types of participants (service users or students, age and sex ratios if appropriate, inclusion / exclusion criteria). Provide an estimate of the number of eligible, potential participants who would have to be screened in order to attain your sample size, accounting for any possible drop outs. Please explain what these estimates are based upon, and justify any calculations provided.
300 words maximum

Q methodology does not require a large number of participants, as it does not aim to make generalisations to a larger population (Watts & Stenner, 2012). Instead, greater emphasis is placed on ensuring that participants have a relevant viewpoint to express (Watts and Stenner, 2012). In light of this, participants will need to have attended at least one TF meeting in the past two years.

Based on research of a similar nature (Absalom-Hornby, Hare, Gooding & Tarrier, 2012; Morera, Bucci, Randal, Barret & Pratt, 2017), the study will aim to recruit N = 40 participants, and the Q sort will have approximately 60 items. This is in accordance with recommendations from Watts and Stenner (2012) that there should be fewer participants than Q sort items.

Inclusion criteria for staff

- Staff who are currently working and have experience of attending at least one TF meeting in the past two years
- Over 18 years of age
- Able to speak and read in English
- Able to provide informed consent

RECRUITMENT STRATEGY

Describe the proposed recruitment strategy.
300 words maximum

The intention will be to recruit participants who work in a range of AMH settings, including inpatient, community and possibly third sector. Participants will also be recruited from DClinPsy programmes. The intention will be to recruit participants who represent a breadth of experience in terms of profession and level of qualification. AM has already contacted all the programmes in England and Wales to request their support with this. Eight programmes have confirmed they would be happy for their staff to be approached about participation in the project (see Appendices).

AM has contacted clinical psychologists from GMMH to ask if they are able to act as 'NHS collaborators' and support recruitment to the project. Due to Covid-10, no clinicians have agreed to this at the moment, but have asked that AM gets back in contact in September.

Once NHS collaborators have been agreed, and potential services have been identified, AM will arrange visits to teams to promote the project. AM will meet clinicians, attend team meetings, and distribute recruitment literature. If lockdown / social distancing continues, the plan will be to attend remote team meetings (via Zoom / MS Teams), and send study recruitment information out via email.

Potential participants will be able to contact AM directly (either by phone or by email). AM will arrange a time to discuss participation in the project and answer any questions. All participants will have 24 hours to consider the information on the PIS before consenting the study. If participants are happy to take part, and subject to meeting requirements for inclusion criteria, two copies of written informed consent will be obtained prior to completion of the Q sort.

POWER CALCULATION/EXPECTED NUMBER OF PARTICIPANTS

Please describe your power or sample size calculation, or the expected number of participants if qualitative research.

150 words maximum

Q sorts are only intended for a relatively small number of participants; therefore power calculations are not necessary (Watts & Stenner, 2012). Stainton Rogers (1995) stated that having between 40-60 participants is sufficient for a multiple participant Q sort. Taking this into consideration, and based on other research of a similar nature, the project will aim to recruit N = 40 participants.

MEASURE(S)

List the measures that will be used in the study, the rationale for using them, any validation work that may be required and any training required to use them.

400 words maximum

1. Demographic Information
2. Q Sort

Demographic information will be collected from each participant. A self-report measure, will ask about: age, gender, ethnicity, job role, and what experience they have of TF (including approx. number of meetings attended). This information will be useful for providing contextual information about the sample (Watts & Stenner, 2012), and will be reported on in the empirical paper.

A 60 item Q sort will be developed by AM from a range of different sources, including Twitter, academic literature, blogs, and online media. The items will be reviewed in supervision to ensure their appropriateness, and will then be subjected to readability checks.

Participants will have the option to complete the Q Sort either in person or remotely. For those who wish to complete it in person, each Q Sort item will be written on a separate piece of card, and participants will be asked to rank them in order of agreement. For remote completion, an electronic version will be available using HTMLq software. AM will arrange a time to explain the software to participants over the phone, before they complete the task. She will also be available whilst they complete the task, should any difficulties arise.

PROCEDURE

Describe the study procedure, in replicable detail.

400 words maximum

The first step will be to gain approval from the ClinPsyD Research Subcommittee (due to take place in July 2020). Following this, applications to NHS Ethics (IRAS), GMMH R & D Department and the University Ethics panel will be submitted. UREC approval will also be sought to allow the study to run in 3rd Sector (non-NHS) organisations.

Once all approvals have been received, the project will be open to recruitment (anticipated January 2021). AM will visit services to promote the project and distribute recruitment literature. AM will arrange to meet with all potential participants, either in person or via Zoom, which will be an opportunity to discuss any questions or concerns they may have. PIS will be sent to all participants prior to obtaining informed consent. AM will discuss with participants how they are going to complete the Q Sort and make necessary arrangements to support this. Once participants have completed the Q sort, there will be an opportunity to ask questions. All participants will be given the contact details of the research team should they require further support.

Data will be entered into a database (likely to be SPSS) as soon as possible following data collection. All databases will be password protected. All participant identifiable information (PID) will be stored separately from the data in locked drawers in the University. No staff outside of the research team will have access to it. The data will be analysed using Q Factor Analysis.

The empirical paper will be written up by AM. The aim will be to submit it for publication in April 2022 and to disseminate via DCP conferences and in-house third year conferences.

DATA ANALYSIS

Provide an outline of the procedures to be used in data analysis in relation to each hypothesis/aim.

400 words maximum

Q Methodology will be used to meet the primary aim, which is to explore the views and attitudes held by staff about including SUs in TF. A 60 -item Q set will be developed from a range of different mediums including academic literature, social media, the Internet, magazines and newspapers etc. Once an initial Q concourse has been developed, all items will be reviewed and discussed in supervision before the 60-item Q set is finalised.

All participants will complete the Q sort, and will be asked to rank the statements according to how much they agree / disagree with each. The responses from each person's Q set will be entered into a database and will be subject to a factor analysis using principle components analysis.

DIFFICULTIES

Please include a list of the potential challenges or difficulties that this research presents you with and describe how these will be managed. Include practical pitfalls and potential confounds.

300 words maximum

Recruitment

Given the current circumstances in relation to Covid-19, there are a number of potential difficulties with recruitment:

1. It may be difficult to establish links with clinical psychologists who work in the NHS. AM has already contacted clinical psychologists working in GMMH, who have said they do not have capacity to support any additional research activity during the lockdown. They have suggested that AM gets back in contact in September; however there is no guarantee that the situation will have changed by then.
2. If social distancing measures remain in place, AM may struggle to promote the study as she will be unable to have face-to-face contact with teams (e.g. visiting services, presenting in team meetings etc.)

In the event that these circumstances arise, the contingency plan will be to recruit only staff participants from ClinPsyD programmes in England and Wales. All Q Sorts would be completely remotely. AM has contacted all course programmes and has received letters of support from eight programmes (see Appendices).

Distress

Participants may find the experience of completing the Q sort distressing. The Q set will represent a wide range of different viewpoints, some of which may be considered to be offensive or upsetting. Prior to completing the Q sort, AM will discuss arrangements for how to best manage any potential distress with participants. A clinical member of staff will be identified whom participants can contact if necessary.

CONTINGENCY PLAN

Include details of contingency plan and when this would be implemented (i.e. stop-go criteria for main study and dates this will be determined). More detailed contingency plans would be required for 'high-risk' projects, e.g. recruiting from 'difficult to engage' populations. Please note that the contingency plan should have a revised research question and alternate design to the original study. The contingency plan must contain more than recruitment extensions for the original study.

300 words maximum

The contingency plan will be to use staff from DClinPsy programmes in England and Wales as study participants (they will also be included in the main recruitment strategy).

If by November 2020, it has still not been possible to visit and make links with NHS staff and services; the study will default to the contingency plan. All other areas of the study design would remain the same. If social distancing measures are still in place, all Q sorts will be conducted remotely.

COSTS

Estimate the research costs (e.g., cost of tests/measures, travel, photocopying, service user consultation costs, foot pedals, recorders etc.) and provide an itemised budget. All trainees have an allocated budget of £400 for their LSRP. Sums slightly larger than this can be requested if justified, but these are at the discretion of the Research Sub-Committee and cannot be guaranteed. Trainees should therefore ensure that a meaningful project can still be conducted should funding be limited to £400.

300 words maximum

Participant packs:

Two physical Q Sorts will be made-up. Prices are approximations.

Card: £12.00 (based on Amazon prices)

Colour printing for Q-sort: £20 (36 sheets of coloured printing per pack, based on UOM printing price of 0.21 per coloured sheet).

Laminating Q-set and resources: £40 (based on prices from Ryman - £1.09 per sheet)

Other:

PPI Consultancy - £20

Mobile phone & credit - £50

Travel - £50

TIME BUDGET

Provide a GANTT chart with a list key activities from RSC until September Year 3.

Please see Appendix A.

PATIENT AND PUBLIC INVOLVEMENT (PPI)

Describe the potential utility and benefit of the proposed research project to service users and their supporters. If you have had any discussion or consultation with service users, please describe these activities and how exactly they have informed your proposal. Please describe any PPI throughout the research process.

400 words maximum

Potential benefit and utility of the proposed project to service users and their supporters:

- This project will directly address concerns raised by SUs that TF is against the principles of co-production, and can have a potentially detrimental impact.
- It is hoped that the project will provide the basis for revised guidelines, which takes these concerns into account.

Consultation with the Community Liaison Group (CLG):

Due to current circumstances relating to COVID-19, the CLG is not able to offer consultation meetings. However, the intention will be to use the research budget to get PPI input at a later date (once social distancing measures have been relaxed).

DISSEMINATION STRATEGY

Please outline your plans to disseminate the findings from your research including dissemination via academic publications and conferences AND to wider stakeholders such as clinicians, service users and/or the wider public.
300 words maximum

A lay summary of the findings of the project will be written and distributed to all study participants.

The empirical and review papers will be submitted to a scientific journal for publication. The aim will be to present the findings at the following conferences: DCP conferences and in-house third year conferences.

Appendix E: Research Ethics Committee approval



Research Governance, Ethics and
Integrity 2nd Floor Christie
Building
The University of Manchester

Tel: 0161 275 2206/2674

Email:
research.ethics@manchester.ac.uk

Dear Miss Alissa Miners, Dr Daniel Pratt, Dr Louisa Jackman

Study Title: Experiences and views of staff about how to involve service users in Team Formulation Proportionate UREC

I write to thank you for submitting the final version of your documents for your project to the Committee on 03/11/2020 08:57 . I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

COVID-19 Important Note

[Please ensure you read the information on the Research Ethics website in relation to data collection in the COVID environment as well as the guidance issued by the University in relation to face-to-face \(in person\) data collection both on and off campus.](#)

[A word document version](#) of this guidance is also available.

Please see below for a table of the title, version numbers and dates of all the final approved documents for your project:

Document Type	File Name	Date	Version
Additional docs	Demographics	09/10/2020	V1
Additional docs	Demographics	09/10/2020	V1
Additional docs	Sample Q Sort Items	09/10/2020	V1
Letters of Permission	Email to potential participants	26/10/2020	V1
Data Management Plan	DMP V2 26.10.2020	26/10/2020	V2
Participant Information Sheet	Participant Information Sheet V2 26.10.2020	26/10/2020	V2
Advertisement	Poster V2 26.10.2020	26/10/2020	V2
Additional docs	Distress and disclosure Protocol_AM	26/10/2020	V2
Additional docs	Consent form V2 26.10.2020	26/10/2020	V2
Additional docs	Study Design Protocol V2 26.10.2020	26/10/2020	V2
Letters of Permission	Email to service leads V2 26.10.2020	26/10/2020	V2
Additional docs	UREC Response Letter 26.10	26/10/2020	V1

This approval is effective for a period of five years however please note that it is only valid for the specifications of the research project as outlined in the approved documentation set. If the project continues beyond the 5 year period you will be required to submit a new ethics application.

If you wish to propose any changes to the methodology or any other specifics within the project, including the dates of data collection, an application to seek an amendment must be submitted for review. Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

1. [Amendments](#): Guidance on what constitutes an amendment
2. [Amendments](#): How to submit an amendment in the ERM system
3. [Ethics Breaches and adverse events](#)
4. [Data breaches](#)
5. [Notification of progress/end of the study](#)

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a UREC Feedback Form. Instructions for completing this can be found in your approval email.

We wish you every success with the research. Yours sincerely,



Mrs Genevieve Pridham Secretary to Proportionate UREC

Miss Alissa Miners

Trainee Clinical Psychologist at the University of Manchester
Greater Manchester Mental Health Foundation Trust Division of
Psychology and Mental Health, Faculty of Biology, Medicine and Health
Zochonis Building, University of Manchester Oxford Road
M13 9PL

Email: approvals@hra.nhs.uk

04 February 2021 Dear

Miss Miners

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

Study title:	Experiences and views of staff about how to involve service users in Team Formulation
IRAS project ID:	288484
Protocol number:	20.08.2020
REC reference:	21/PR/0030
Sponsor	University of Manchester

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 "[After HRA Approval – guidance for sponsors and investigators](#)" document on the HRA website 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 **288484**. Please quote this on all correspondence. Yours

sincerely,

Gemma Oakes

Approvals Specialist

Email: approvals@hra.nhs.uk

Appendix F: GMMH Approval



**Greater Manchester
Mental Health**
NHS Foundation Trust

Miss Alissa Miners
2nd Floor Zochonis Building
University of Manchester
Brunswick Street
Manchester
M13 9PL

Research & Innovation
1st Floor, Harrop House
Bury New Road
Prestwich, Manchester
M25 3BL

Tel: 0161 271 0607
Email: researchoffice@gmmh.nhs.uk
Date: 07 April 2021

Confirmation of Capacity & Capability at GMMH

Re: Experiences and views of staff about how to involve service users in Team Formulation
IRAS Reference: 288484
Research & Innovation Reference: x506
Sponsor: University of Manchester

Dear Miss Miners

On behalf of Greater Manchester Mental Health NHS Foundation Trust, I am pleased to confirm Capacity and Capability for the above research to commence at our site.

Approved Documents

Protocol Version 1 dated 20/08/20 is recognised as the most current to date.

The documents approved for use at this Trust are as listed in the Health Research Authority Letter dated: 04/02/2021.

Any subsequent, relevant amendments are additionally approved to date.

Metrics and Recruitment

First Participant Target	Total Target Recruitment	Recruitment Target Date
06/05/2021	5	20/09/2022

Recruitment Updates

To help R&I monitor the progress of the study, and recruitment activity within GMMH, please record your recruitment data on the attached spreadsheet. We ask all study teams to complete this on a monthly basis and return it to researchoffice@gmmh.nhs.uk by the 01st of each month.

We will then update our study database, R-PEAK, and report on trust-wide recruitment to the R&I Committee.

Study Staff

We will then update our study database, R-PEAK, and report on trust-wide recruitment to the R&I Committee.

Study Staff

The CV and relevant training of the PI has been reviewed.

Conditions of Approval

The following conditions apply to this approval:



C&C Letter Template non-portfolio & non-interventional studies version 02/05/08/2020

Page 1 of 2



**Greater Manchester
Mental Health**
NHS Foundation Trust

- a) The study is conducted in compliance with all the relevant legislation and the relevant GMMH Policies and R&I SOPs. These can be found on the R&I website: www.gmmh.nhs.uk/standard-operating-procedures-sops-and-guidance-documents
- b) All staff working on the study have the appropriate training and experience and have responsibilities formally delegated to them. A Research Passport is required for non-GMMH staff that require access to GMMH services or facilities.
- c) Serious Breaches of GCP or the protocol will be notified to Research & Innovation within one working day of awareness.
- d) All relevant documents will be maintained and will be made available to R&I personnel, to facilitate compliance checks, formal audits and regulatory inspections.
- e) You will notify R&I of any subsequent protocol amendments.
- f) You will promptly inform R&I of the end of the study and share a copy of the end of study notification.

I wish you every success with the study.

Yours sincerely,

Mark Dawson
Research Initiation and Delivery Manager (Operations)

Appendix G: Q Concourse & Final Q Set Items

Q Sort Statements:

INCLUDED

1. Involving service users in team formulation meetings does not occur as often as it should
2. Service users should always be present at team formulation meetings
3. It is not appropriate for service users to be present for all aspects of the team formulation meeting
4. Service users should be invited to team formulation meetings, even if they do not want to attend
5. Team formulation meetings are a kind of staff supervision
6. It is not appropriate to share all aspects of the team formulation discussions with service users
7. Service users should be informed that team formulation meetings about them are taking place
8. Service users should be given the option to provide feedback on both the content and the process of team formulation meetings
9. Team formulation meetings where the service user is not present is still care that is 'done to' rather than 'done with'
10. Service users should not be talked about when they are not present
11. Team formulation meetings operate within the power imbalance inherent in mental health services
12. Team formulation meetings should be a safe space for staff to voice their own emotional reactions
13. The main 'client' in team formulation meetings is the team
14. Team formulation meetings create the perfect conditions for institutional abuse
15. Team formulation meetings without the service user present can lead to vulnerable people having a story projected onto them
16. An on-going issue with team formulation is the extent to which service users are centred, included and involved in the process
17. We should follow the principle of 'nothing about me without me'
18. Staff need to be able to use team formulation meetings to name difficult emotions and become aware of unhelpful responses
19. Service user involvement in team formulation needs to be balanced with their levels of distress/ stability
20. Service users are not welcome at team formulation meetings
21. Staff should spend time before the TF meeting gathering the service user perspective
22. Team formulation meetings should go ahead regardless of whether the service user is willing or able to attend
23. All aspects of team formulations should be shared, clarified and developed with service users
24. We need to consider how to involve service users on an individual basis depending on their circumstances
25. Co-producing team formulations with service users can lead to a significant shift in power dynamics
26. Co-producing team formulations allows service users to take an active role in their own care
27. Attending team formulation meetings can give service users a sense of hope and optimism
28. Team formulation meetings can be intimidating for service users
29. Team formulation meetings could feel exposing and distressing for service users

30. Service users should be invited to a pre-formulation meeting where the purpose of the meeting is discussed
31. It is sufficient for the primary nurse / key worker to develop a collaborative formulation with the service user and refer to it within the team formulation meeting
32. There is a balance to strike between the need of the staff team to feel safe enough to express their emotional reactions, alongside the value of the service user being present
33. Team formulation can help challenge unhelpful or abusive practices.
34. Talking about a service user without them there, is a fundamentally abusive act.
35. Team formulation is a process of taking control away from the service user and putting it directly into the hands of the mental health system
36. It is not trauma-informed to impose a team formulation on clients
37. Ideally, one-to-one formulation work with the service user proceeds in parallel with the team formulation.
38. Informed consent should be sought from service users before their cases are discussed in team formulation meetings
39. There are many other ways of including service users in the team formulation process besides them attending the meeting
40. Service users are not always willing or able to participate in a team formulation meeting
41. We must distinguish between 'our' formulation (for the team) and 'your' formulation (for the service user)
42. A main purpose of team formulation is to prepare the team to hear the client's story
43. Team formulations should be kept in a separate supervision file unless or until agreed with the service user
44. We can't forbid staff from talking about the reasons for someone's difficulties unless that person is present.
45. Team formulation with the client can be a very positive experience for both team and client
46. Team formulation meetings need to be places where staff feel safe to express their views without feeling judged
47. Sharing difficult staff feelings and emotions is more difficult in front of SU, who may be upset or distressed by it
48. Service users should not attend TF meetings if relationships with staff have broken down
49. There is a need for more guidance in the area of service user involvement in team formulation
50. Service users should be invited to part, but not all of the meeting
51. Having the service user in the room is not necessarily the same as involving them in the process, and not having them is not necessarily the same as excluding them
52. Involving SUs in TF can take many forms, such as asking for their views beforehand and feeding back afterwards
53. Staff should avoid sharing sensitive information about the SU in the TF meeting unless it is essential
54. Staff who are not directly involved in the SU's care should not be present at a TF meeting
55. We need more information about how SUs view and experience the process of TF
56. Both staff and service users need to be at the right stage of readiness in order to have a successful shared TF meeting

57. Having too many people in a TF meeting can feel exposing and silencing to the SU
58. Different client groups (eg ID, Older Adults) raise different issues about involvement in TF meetings

REMOVED

1. Team Formulation may bring up things such as transference or counter-transference feelings which should not be shared with service users
2. Team formulation meetings should provide a safe space for staff to express difficult feelings evoked by working with people
3. Team formulation meetings should provide a safe space for staff to discuss their unease with current practises and ways of doing things
4. Team formulation meetings should provide a space that is safe for staff to express their concerns
5. Blaming statements about the service user should be avoided
6. Sharing formulations with clients could feel disempowering
7. Team formulation is a staff forum, therefore it is not beneficial for clients to attend
8. Service users do not want to attend meetings
9. Service users should only attend meetings once staff have come to some kind of understanding
10. There are advantages to team formulation being a closed staff forum only
11. Co-producing formulations allows service users to guide the staff
12. Using the formulation with the team enables service users to gain control
13. Team formulation meetings are a space where staff reflect on the struggles they are having with service users
14. Team formulation meetings should be a place in which staff can make sense of their experience and their own responses.
15. Team formulation can empower service users and give them a renewed sense of agency
16. Meeting with service users and their carers before meetings can help to develop rapport
17. Not having service users present minimises the service's users voice
18. Not having service users present is disempowering
19. We can all too easily fall into an 'expert' stance where we can assume to hold the understanding for ourselves as professionals but forget the most important person in the process.
20. It is not trauma-informed to share secrets without their knowledge
21. TF should be a place where staff can be supported in managing uncertainty
22. If not done correctly, it is a violation of trust
23. 'Team formulation meetings where the service user is not present is similar to institutional abuse
24. Sharing formulations with clients can increase distress
25. Being a meeting for professionals only gives staff a freedom to discuss and air difficult feelings
26. Service users and carers should be invited to team formulation meetings
27. Co-produced understandings enable empowerment of the service user, which counteracts the potential for feeling oppressed or controlled
28. Attending TF meetings can be a very positive experience for service users
29. It is important for service users and their carers to develop an emotional connection with the process of team formulation
30. Meeting with service users and carers before meetings take place is imperative
31. Staff and service users and carers should all arrive at team formulation meetings together

32. Including service users after the formulation is done still takes away their control
33. Service users being talked about when they are not present can be retraumatising
34. "Team formulation" without the presence of the SU risks being abusive
35. TF meetings can be exposing for service users
36. Fundamental to team formulation appears to be the availability of a space or system that allows staff to articulate concerns and uncertainties
37. It goes against the notion of collaboration to not include service users and their carers in Team Formulation meetings
38. TF without SU's being present can lead to staff ganging up on Sus
39. In inpatient settings (which are particularly distressing) it is important for staff to be able to reflect on how they feel in response to the service user
40. Team formulation functions best as a closed staff forum where staff can discuss client cases
41. Service users can find it very distressing for a group of staff to get together to 'discuss their case' and have private matters discussed
42. Staff should not talk about vulnerable people behind their back in team formulation meetings
43. You would not want a doctor to diagnose you without seeing or speaking to you, team formulation meetings without the service user being present are the same
44. Although psychological formulations can be thought of as just another meeting that is necessary for a person's care, it is important that we don't lose sight of their potential to cause harm
45. Service users do not have to be in the room, or agree to a one-to-one formulation process, or agree to contribute to a team formulation
46. Having the service user in the room is not necessarily the same as involving them in the process, and not having them is not necessarily the same as excluding them
47. High levels of distress can lead staff to cut off from their emotions
48. Team formulation meetings should provide a space where alternative approaches to a person's care can be generated
49. Service users should be present in order to voice their understandings in a team formulation meeting.
50. Involving carers in team formulation meetings does not occur as often as it should
51. Carers should be given the option to provide feedback on the content and process of the meetings
52. Service users may not want to attend team formulation meetings where the staff are still trying to understand the person themselves
53. There is a need to strike a balance between helping service users and supporting staff to help them.
54. Team formulation is part of supervision
55. In a system where diagnostic narratives don't dominate, it would be easier to have 'Nothing about me without me'
56. Meeting with service users and carers before meetings take place is imperative
57. Co-producing formulations can be an empowering experience for the MDT and the service user
58. Team formulation meetings where the service user is not involved are patronising
59. Staff need a space to develop an understanding of a clinical presentation that is unclear to them
60. Sharing team formulations has the potential to distress clients

61. Although team formulation can be thought of as just another meeting, it is important that we don't lose sight of its potential to cause harm
62. If the SU is present there needs to be very careful consideration of the power differentials to avoid reinforcing them
63. Space for staff-only reflection during team formulation meetings is important
64. Team formulation meetings should provide a space for staff feelings to be contained and 'detoxified'
65. Trusting relationships between staff and service users need to be developed before service users attend TF meetings
66. We need to formulate with service users, not behind their backs

Appendix H: Participant Information Sheet



The University of Manchester

Experiences and views of staff about how to involve service users in Team Formulation

Participant Information Sheet (PIS)

You are being invited to take part in a research study to explore the attitudes and viewpoints of staff about how Service Users (SU) should be involved in Team Formulation (TF). Before you decide whether or not to take part, it is important that you understand why the research is being conducted, and what it will involve. Please read the following information carefully, and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please feel free to ask. Thank you for taking the time to read this.

About the research

➤ Who will conduct the research?

This research is being conducted by Alissa Miners, a Trainee Clinical Psychologist from the Division of Psychology and Mental Health at the University of Manchester. She is working under the supervision of Dr Daniel Pratt (Senior Clinical Lecturer and Clinical Psychologist) and Dr Louisa Jackman (Clinical Lecturer & Chartered Clinical Psychologist).

➤ What is the purpose of the research?

‘Team Formulation’ (TF) describes a meeting in which a group of professionals discuss their shared understanding of a service user’s (SU) difficulties. Discussions from the meeting are then used to inform decisions about the SU’s care.

Most TF meetings take place without the SU being present. Professionals and SUs have raised concerns about this, arguing that it raises issues in relation to co-production such as: lack of transparency, power imbalances and exclusion of the SU voices (Wainwright & Bergin, 2010).

This research will directly address some of these concerns by using Q methodology to explore the opinions of staff about how SUs should be included in TF. The intention is to recruit 40 participants who will be asked to complete a Q Sort exercise where they rank how much they agree or disagree with statements about SU inclusion in TF. Findings will be used to suggest new guidance that would meet the concerns of both SUs and professionals.

➤ What is Q Methodology?

This study will use Q-methodology, which is a way of exploring opinions about a particular topic. The researcher will put together statements relevant to the topic of SU inclusion in TF from resources, such as research papers and social media. Participants complete a sorting task, in which they are asked to say how much they agree or disagree with each statement. The results are analysed to see if there are patterns or differences in people's responses.

➤ **Will the outcomes of the research be published?**

The study will be written up as part of the Chief Investigator's thesis. The empirical and review papers will be submitted to a scientific journal for publication. The aim will be to present the findings at the following conferences: DCP conferences and in-house third year conferences.

No identifiable personal data will be used in the write-up / dissemination of this study. A lay summary of the findings of the project will be written and distributed to all study participants.

➤ **Who has reviewed the research project?**

The University of Manchester Proportionate Research Ethics Committee has reviewed this project and given it ethical approval.

What would my involvement be?

➤ **What would I be asked to do if I took part?**

If you decide to take part in this research, you will meet with Alissa Miners on just one occasion, in a meeting that will take place over a videoconferencing platform. All data will be collected during this meeting, which should take 60-90 minutes. There will be an opportunity to ask questions or discuss any concerns you may have. You will be asked give consent in the form of a digital signature, and complete a demographics questionnaire. The Q Sort will be completed using the videoconferencing screen share function. Alissa will share the Q Sort table on her screen, and you will direct her as to where you would like each statement to go. Once the meeting is finished, you will have 7 days to withdraw your data. You will be asked whether you are happy for the meeting to be recorded; this is so the researcher can listen back and check that all the data has been collected accurately. The recording will be deleted two weeks after the meeting, and no one outside the research team will have access to it.

➤ **Will I be compensated for taking part?**

Participants will not receive any compensation for taking part in this study.

➤ **What happens if I do not want to take part or if I change my mind?**

Participation in the study is voluntary, and it is entirely your decision whether or not to take part. If you decide to take part, you will be asked to sign a consent form. Once you have signed the consent form, you are free to withdraw at anytime without giving a reason. All data will be pseudoanonymised by the lead researcher immediately after it is collected. You will have seven days to withdraw your data once it has been collected. After this it will not be

possible to identify your specific data. This does not affect your data protection rights. If you decide not to take part you do not need to do anything further.

Data Protection and Confidentiality

➤ What information will you collect about me?

To participate in this research project, we will need to collect information that could identify you called “personal identifiable information”. Specifically we will need to collect:

- Name and email address
- Demographic information (age, ethnicity, gender, job role)
- Experience of TF and approx. how many meetings you have attended
- Recording of meeting (stored for a period of two weeks before it is deleted).

➤ Under what legal basis are you collecting this information?

We are collecting and storing this personal identifiable information in accordance with data protection law, which protect your rights. These state that we must have a legal basis (specific reason) for collecting your data. For this study, the specific reason is that it is “a public interest task” and “a process necessary for research purposes”.

➤ What are my rights in relation to the information you will collect about me?

You have a number of rights under data protection law regarding your personal information. For example you can request a copy of the information we hold about you. If you would like to know more about your different rights or the way we use your personal information to ensure we follow the law, please consult our [Privacy Notice for Research](#).

➤ Will my participation in the study be confidential and my personal identifiable information be protected?

In accordance with data protection law, The University of Manchester is the Data Controller for this project. This means that we are responsible for making sure your personal information is kept secure, confidential and used only in the way you have been told it will be used. All researchers are trained with this in mind, and your data will be looked after in the following way:

- Only the study team at The University of Manchester will have access to your personal information, which will be pseudoanonymised by the lead researcher immediately after it is collected. Your name and any other identifying information will be removed and replaced with a random ID number. Only the research team will have access to the key that links this ID number to your personal information. Your consent form and contact details will be retained for 5 years and stored electronically in a password-protected database.
- The recording of the meeting will be kept for a period of 2 weeks only. It will be stored on a secure, confidential drive, which can only be accessed by the research team. The researcher will listen back to the recording to ensure that the data has been accurately collected.

- Your email address will be stored confidentiality in a password-protected document, which can only be accessed by the research team. We will not pass it on to anyone else. We will use this to send you a summary of the findings once the research has finished. Once we have done this, it will be permanently deleted.

Potential disclosures

- If, during the study, you disclose information about misconduct/poor practice, we have a professional obligation to report this and will therefore need to inform your employer/professional body.
- If, during the study, you disclose information about any current or future illegal activities, we have a legal obligation to report this and will therefore need to inform the relevant authorities.

Please also note that individuals from The University of Manchester or regulatory authorities may need to look at the data collected for this study to make sure the project is being carried out as planned. This may involve looking at identifiable data. All individuals involved in auditing and monitoring the study will have a strict duty of confidentiality to you as a research participant.

What if I have a complaint?

➤ **Contact details for complaints**

If you have a complaint that you wish to direct to members of the research team, please contact: **Daniel Pratt or Louisa Jackman** in the first instance (daniel.pratt@Manchester.ac.uk / Louisa.Jackman@Manchester.ac.uk) or leave a message for **Daniel Pratt or Louisa Jackman** at the **Clinical Psychology office on 0161 306 0400**.

If you wish to make a formal complaint to someone independent of the research team or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact

The Research Ethics Manager, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing:

research.complaints@manchester.ac.uk or by telephoning 0161 275 2674.

If you wish to contact us about your data protection rights, please email

dataprotection@manchester.ac.uk or write to The Information Governance Office, Christie Building, The University of Manchester, Oxford Road, M13 9PL at the University and we will guide you through the process of exercising your rights.

You also have a right to complain to the [Information Commissioner's Office about complaints relating to your personal identifiable information](#) Tel 0303 123 1113

Contact Details

If you have any queries about the study or if you are interested in taking part then please contact the researcher **ALISSA MINERS** on Alissa.miners@postgrad.manchester.ac.uk or leave a message for Alissa at the **Clinical Psychology office on 0161 306 0400**.

Appendix I: Consent form



Experiences and views of staff about how to involve service users in Team Formulation

Consent Form

If you are happy to participate please complete and sign the consent form below

	Activities	Initials
1	I confirm that I have read the attached information sheet (V5 10.03.2021) for the above study and have had the opportunity to consider the information and ask questions, which have been these answered satisfactorily.	
2	I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself. I understand that it will not be possible to remove my data from the project once it has been anonymised and forms part of the data set (7 days). I agree to take part on this basis.	
3	I agree that any data collected may be published in anonymous form in academic books, reports or journals.	
4	I agree to the meeting being recorded, and stored for a period of 2 weeks before it is permanently deleted.	
6	I understand that data collected during the study may be looked at by individuals from The University of Manchester or regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	
10	I understand that there may be instances where information is revealed which means that the researchers will be obliged to break confidentiality, for example if I disclose information about misconduct / poor practice or illegal activities. This has been explained to me in more detail in the information sheet.	
11	I agree to take part in this study.	

Data Protection

The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the [Privacy Notice for Research Participants](#).

(Please type your name)

Date

Appendix J: Demographics form



The University of Manchester

Demographic Information

Please complete the following questions:

- **Age:** _____

- **Gender identity:** _____

- **What is your ethnic group?**
 - White
 - English / Welsh / Scottish / NI / British
 - Irish
 - Gypsy or Irish Traveller
 - Any other white background, please describe:

 - Mixed / Multiple ethnic groups
 - White and Black Caribbean
 - White and Black African
 - White and Asian
 - Any other mixed / multiple ethnic background, please describe:

 - Asian / Asian British
 - Indian
 - Pakistani
 - Bangladeshi
 - Chinese
 - Any other Asian background, please describe:

 - **Black / African / Caribbean / Black British**
 - African
 - Caribbean
 - Any other Black / African / Caribbean background, please describe

- **Marital status:**
 - Single
 - Married
 - In a relationship
 - Co-habiting

- Divorced/separated
- Widowed

- **Job Title:**

- **Number of TF meetings attended (approximately):**

Appendix K: PQ Method Outputs

↑
 PQMethod2.35 Service user involvement in TF
 Path and Project Name: C:\PQMethod\projects\TeamForm

Unrotated Factor Matrix

	Factors							
	1	2	3	4	5	6	7	8
SORTS								
1 F1	0.7276	0.0944	-0.0911	0.0104	-0.0073	-0.1811	-0.2249	-0.0861
2 2	0.6451	0.3232	-0.0417	0.1654	0.1089	0.2481	-0.2299	-0.1379
3 3	0.6204	0.2034	0.0906	0.5606	0.1246	-0.1518	0.0376	0.0006
4 4	0.7090	-0.3855	0.1895	0.1703	-0.1677	-0.0970	0.0690	0.0002
5 5	0.4393	0.5411	0.0899	0.0586	0.0941	0.4092	-0.1536	0.1125
6 6	0.4817	0.5607	0.0107	-0.3413	-0.0136	-0.0151	-0.0086	0.3126
7 7	0.3142	0.5754	0.3476	0.2565	-0.0294	0.1533	0.2409	-0.1645
8 8	0.7271	-0.3655	0.1904	0.1095	0.2943	-0.0494	0.0246	0.1474
9 9	0.5509	-0.2928	-0.3738	0.1227	0.0305	0.3539	0.0497	0.1560
10 10	0.7164	-0.3709	-0.1581	0.0738	-0.0523	-0.0415	-0.0655	0.1088
11 11	0.6816	-0.0414	-0.0438	-0.0484	0.1474	0.1571	0.3327	-0.1558
12 12	0.6934	0.0918	0.0310	-0.2973	0.0204	0.2364	0.0962	0.1689
13 13	0.5962	0.3169	-0.2996	0.2350	0.2599	-0.2867	-0.1143	-0.0877
14 14	0.5702	-0.5562	0.3339	-0.0812	-0.1235	0.0551	0.0491	-0.1581
15 15	0.8481	-0.0522	-0.0542	-0.1598	-0.1344	0.1261	-0.1146	-0.1313
16 16	0.5925	-0.3255	-0.3456	-0.1415	-0.1604	-0.2378	-0.0497	-0.1137
17 17	0.7394	-0.0315	0.1729	-0.0591	-0.2179	-0.3508	0.1476	-0.0411
18 18	0.7221	-0.1382	0.3028	0.1498	-0.0771	-0.0487	-0.1014	0.0072
19 19	0.6695	-0.2715	-0.2907	-0.0696	0.1376	-0.2534	-0.0172	0.2347
20 20	0.7702	-0.2176	0.0470	0.1984	-0.3188	0.1397	0.1665	0.0033
21 21	0.5681	-0.4283	0.2134	-0.2289	-0.1570	0.0775	0.1241	0.1822
22 22	0.6739	0.4365	-0.1267	-0.0878	-0.2304	-0.1268	-0.1466	0.0430
23 23	0.7698	-0.0452	-0.3884	-0.0581	-0.0373	0.0513	-0.0606	-0.0953
24 24	0.5840	-0.5557	0.0279	0.1538	0.0532	-0.0185	-0.1838	0.2357
25 25	0.6723	0.3358	-0.3187	-0.1527	-0.1590	0.0016	-0.0669	-0.0705
26 26	0.3977	0.5184	0.3497	-0.1213	-0.3480	0.0378	-0.1926	-0.1694
27 27	0.7021	-0.0542	-0.3590	0.2188	-0.0265	-0.0303	0.2665	-0.2018
28 28	0.6541	0.2662	0.1459	0.0444	-0.2401	-0.1079	-0.0699	0.3832
29 29	0.4510	0.6908	-0.1510	0.3002	-0.1602	0.1578	-0.0844	-0.0245
30 30	0.6025	0.4720	0.2523	-0.2114	0.0592	-0.2322	0.1578	-0.1734
31 31	0.7128	-0.1644	-0.0435	-0.2014	0.1989	0.1748	-0.3289	-0.0793
32 32	0.7233	-0.1131	0.1861	0.0574	0.3878	-0.0443	0.0096	-0.2437
33 33	0.5193	0.5164	-0.0421	-0.1646	0.0781	0.0875	0.2421	0.0116
34 34	0.6043	0.2891	-0.0159	-0.2744	0.1238	-0.0912	0.3789	0.1111
35 35	0.6553	-0.0829	0.4044	0.1388	0.2262	-0.0047	-0.1417	0.2668
36 36	0.6269	-0.4784	-0.0974	-0.2763	0.2373	0.1778	0.1132	-0.0939
37 37	0.4471	0.6457	-0.2227	0.1922	0.0326	-0.0345	0.2034	0.2234
38 38	0.7320	-0.3255	0.0083	-0.0694	-0.2431	0.0505	-0.1505	-0.1954
39 39	0.6263	0.3125	0.2482	-0.2381	0.3532	-0.1271	-0.1792	-0.1256
40 40	0.5716	-0.5508	0.0796	0.2152	-0.0962	0.1184	0.1569	-0.0041
Eigenvalues	16.2595	5.6580	1.9219	1.5538	1.3074	1.1268	1.0978	1.0079
% expl.Var.	41	14	5	4	3	3	3	3

↑
 PQMethod2.35 Service user involvement in TF
 Path and Project Name: C:\PQMethod\projects\TeamForm

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 Path and Project Name: C:\PQMethod\projects\TeamForm

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3 3	0.6204	0.2034	0.0906	0.5606	0.1246	-0.1518	0.0376	0.0006
4 4	0.7090	-0.3855	0.1895	0.1703	-0.1677	-0.0970	0.0690	0.0002
5 5	0.4393	0.5411	0.0899	0.0586	0.0941	0.4092	-0.1536	0.1125
6 6	0.4817	0.5607	0.0107	-0.3413	-0.0136	-0.0151	-0.0086	0.3126
7 7	0.3142	0.5754	0.3476	0.2565	-0.0294	0.1533	0.2409	-0.1645
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14 14	0.5702	-0.5562	0.3339	-0.0812	-0.1235	0.0551	0.0491	-0.1581
15 15	0.8481	-0.0522	-0.0542	-0.1598	-0.1344	0.1261	-0.1146	-0.1313
16 16	0.5925	-0.3255	-0.3456	-0.1415	-0.1604	-0.2378	-0.0497	-0.1137
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19 19	0.6695	-0.2715	-0.2907	-0.0696	0.1376	-0.2534	-0.0172	0.2347
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21 21	0.5681	-0.4283	0.2134	-0.2289	-0.1570	0.0775	0.1241	0.1822
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28 28	0.6541	0.2662	0.1459	0.0444	-0.2401	-0.1079	-0.0699	0.3832
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37 37	0.4471	0.6457	-0.2227	0.1922	0.0326	-0.0345	0.2034	0.2234
38 38	0.7320	-0.3255	0.0083	-0.0694	-0.2431	0.0505	-0.1505	-0.1954
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Eigenvalues	16.2595	5.6580	1.9219	1.5538	1.3074	1.1268	1.0978	1.0079
% expl.Var.	41	14	5	4	3	3	3	3

↑ PQMethod2.35 Service user involvement in TF
 Path and Project Name: C:\PQMethod\projects\TeamForm

Correlations Between Factor Scores

	1	2	3
1	1.0000	0.3399	0.7246
2	0.3399	1.0000	0.4479
3	0.7246	0.4479	1.0000

method2.35 Service user involvement in T