Multidisciplinary team members' experiences of team formulation: A thematic analysis.

Thesis submitted in part fulfilment of the degree of

Doctorate in Clinical Psychology

(DClinPsy)

By

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Declaration

I confirm that the research contained within this thesis is my own original work. It was completed in part fulfilment of the degree of Doctorate in Clinical Psychology (DClinPsy) and has not been submitted for any other academic award.

Thesis Abstract

Title: Multidisciplinary team members' experiences of team formulation: A thematic analysis.

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Part 1: Literature Review

It is well-known that burnout is high in Community Mental Health Nurses. This has been associated with the workplace environment and tasks. Despite this, Community Mental Health Nurses are often based within multidisciplinary teams. In order to provide support for fellow team members, as well as offer an 'alternative' perspective, Clinical Psychologists have been offering 'team formulation'. This is of particular interest within the clinical field of 'psychosis' where there continues to be uncertainty about using a diagnostic or formulation-based approach; it remains a highly contested area.

Part 2: Research Report

The review of the literature aimed to examine quantitative studies and determine correlates and predictors of stress and burnout within Community Mental Health Nurses. Nine papers met the inclusion criteria, all of them cross-sectional studies. A narrative synthesis of the findings is presented using a framework of 'individual' and 'situational' factors. There was strong evidence to suggest that situational factors are highly associated with stress and burnout, however factors intrinsic to the individual were not routinely reported. Whilst burnout is operationalised within research by the use of a well-known measure, the relationship to other phenomena, such as stress and distress, is ill-defined.

Part 3: Critical Appraisal

The research aim was to explore the experiences of multidisciplinary team members who have attended Team Formulation sessions within Early Intervention services. A thematic analysis was undertaken on the eleven interviews and three main themes were generated: team formulation offers a different perspective; the difference is valuable; and connection within the collective. These findings are considered within the evidence base for psychological formulation, as well as reflective practice and self-care. A reflective account of the research process is contained within the critical appraisal.

Acknowledgments

I am grateful to the participants who took time away from their extremely busy clinical duties to take part in this research. Thank you for allowing me to try and understand formulation from your perspective. The accounts that you shared were thoughtful and honest, and it is clear that you are very passionate and dedicated within your roles.

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Addenda

Transcripts of research interviews have been provided as an electronic addendum.

List of tables

Part 1

LITERATURE REVIEW

Predictors of stress and burnout in Community Mental Health Nurses.[1]

[1] This literature review has been prepared in accordance with the submission guidelines of the Journal of Psychiatric and Mental Health Nursing; the details of which can be found in Appendix A.

1 Abstract

Work-related distress in nursing staff is a frequent correlate of engagement with difficult client groups. Of distress phenomena, burnout has been most regularly studied with adverse impacts on an individual's mental, physical and emotional wellbeing. There is a growing evidence base revealing prevalence of burnout within the nursing profession generally, and indications that this is increased for those working within the field of mental health. To date, examination of burnout has largely focused on mental health nurses working within inpatient settings, with comparatively less focus on community mental health nurses. The current review aimed to interrogate published literature to examine correlates predictors of burnout and stress within the population of community mental health nurses.

Three databases (Medline, PsycInfo and Web of Science) were searched, and from 1817 papers initially returned, nine were eligible for inclusion. Eligible papers were then quality appraised using a well-utilised tool.

A narrative account of the studies was written within an existing framework of 'individual' and 'situational' factors. The situational factors were more dominant than the individual factors, but demographic information was not always analysed and reported.

Difficulties with the conceptualisation of burnout were considered, particularly in relation to similar concepts of stress, job dissatisfaction and distress. The majority of studies were from the United Kingdom and Ireland, and consideration is paid to the prevalence of burnout internationally, the use of common terms as well as the provision of care within other countries. Clinical implications and recommendations for future research are suggested.

2 Introduction

The introduction to this review provides a discussion of the construction of burnout and related conditions. There is a narrative relating to the impact of burnout and the prevalence within nursing and the mental health workforce.

2.1 The construct of burnout

Substantial research over the last three decades has described, elucidated and sought to understand distress in health professionals. The construct of burnout has been prominent in understanding staff distress. Central to this phenomenon for those working in human services is the depletion of social and emotional resources (Freudenberger, 1974), resulting from sustained psychosocial pressures in the workplace (Maslach, 1982), notably physical, emotional and mental fatigue, as a consequence of exposure to emotionally-demanding situations (Hallsten, 2005).

In its earliest iterations burnout was variously operationalised (Perlman & Hartman, 1982), however the most commonly cited construction of burnout has been described by Maslach and Jackson (1981) as encompassing: 'a syndrome of emotional exhaustion, depersonalisation and reduced person accomplishment'. Emotional exhaustion refers to lessening of emotional reserves, often accompanied by being physically and psychologically drained. Depersonalisation describes the experience of negativity and cynicism, which can manifest in indifference and contempt for colleagues and clients. Lack of personal accomplishment conveys the sense of failing to achieve important goals both personally and in the workplace. This is the conceptualisation of burnout that

occupational literature has used when measuring burnout in staff and is the concept which will be referred to throughout this literature review.

2.2 The impact and consequences of burnout

Research has indicated that burnout is higher in health and social service personnel than other professional groups (Awa et al. 2010). Research into burnout and work distress among healthcare professionals is increasing (Borrill et al. 1996), and has indicated that staff working within the National Health Service (NHS) report higher sickness absence from distress, than equivalent staff working in other sectors (Confederation of British Industry, 1997). According to figures, 27% of healthcare personnel reported high levels of psychological stress in comparison to 18% of those working adults generally within the NHS (Wall et al. 1997). Burnout has been found to have a negative impact on staff members' experiences of the workplace potentially creating organisational pressures in health care services; Pines and Maslach (1978) linked occupational burnout to poor morale, increased absence from work and increased job turnover. It has also been linked to the standard of delivery of care and the cost of human services (Peterson et al. 2008; Vahey et al. 2004).

Further to the impact on the organisation, burnout has also been found to adversely affect healthcare staff members' mental and physical wellbeing (Holmqvist & Jeanneau, 2006), with notable correlates of work-related distress; turnover and wastage of staff within the NHS is elevated an increasing number of doctors are retiring early (Kendell & Pearce, 1997; McBride & Metcalfe, 1995). Burnout has been linked with increased susceptibility for mental health problems (Ahola et al., 2005), including depression

(specifically major depressive disorder), anxiety, impaired memory, alcohol consumption, substance use and sleep problems (Peterson et al. 2008; Ahola et al. 2005; Rohland 2000), and associated with physical health problems. Acker (2010) found that high levels of burnout were associated with flu-like symptoms and gastroenteritis.

2.3 Presence of burnout within the nursing population

It is evident that whilst there are commonalities in burnout features across nursing disciplines, there are also differences, dependent on the specialism (Marshall, 1980; Slater 1993). Whilst Gray-Toft and Anderson (1981a; 1981b) compared distress in five groups of nurses from different specialisms, revealing common sources of stress, workload, inadequate preparation and dealing with death and dying, differences were also found within and between the specialisms. Issues around death and dying were found as a key stressor in coronary care nurses, yet work overload was more stressful for nurses in non-specialised medical and geriatric units (Hipwell et al. 1989), suggesting distress and burnout may be experienced differently dependent on specialty. This enforces the need to avoid focussing research on 'nurses' as a single occupational group.

There is also need for greater discussion of staff distress. Examination of stress in oncology nurses, advance that nurse managers' need to develop work environments that allow for open discussion of stress and difficulties given failure to do so could exacerbate stress levels and decreased job satisfaction for nurses; stress and burnout were shown to be highly correlated with nurses' intention to leave their posts (Heinen et al. 2013). In Turkey, 418 nurses working in a university hospital took part in a study on

burnout (Ilhan et al. 2008); Impacting burnout scores were: total time in the job, hours of employment, shift-patterns and the employment base. The research highlighted the presence of burnout within the nursing population and the impacts both personally and professionally.

2.4 Stressors within mental health nursing

Research has indicated that, compared with other specialities, mental health nurses report elevated burnout (Pompili et al., 2006; Sahraian, Fazelzadeh, Mehdizadeh & Toobaee, 2008). A number of contextual correlates and predictors are offered for these inflated scores, particularly working with severe mental health difficulties in unpredictable environments (Thomsen et al., 1999). Indeed research has indicated that psychiatric nurses working with individuals with severe mental health difficulties, experience higher levels of stress than psychiatric nurses working with physical health or anxiety (McLeod, 1997).

It has been claimed that stress and burnout impact mental health workers in many aspects of their lives; within the service they deliver, their job satisfaction and their own health (Carson & Fagin, 1996). Sources of stress within mental health professionals have been found to include increased workloads, inadequate staffing, limited job security and continuing organisational change. It was also suggested that the intensity of work with clients with severe and enduring mental illness has increased (Thomsen, 1997). Therefore it is important to determine the factors associated with burnout in order to support staff, particularly when the focus of clinical work has changed to be supporting those with an increasing level of difficulty. These factors could be at the

individual or the situational level (Maslach, Schaufeli & Leiter, 2001). 'Individual factors' indicate the individual's personal and demographic information, and 'situational factors' relate to organisational influences.

2.5 Existing reviews

To date there have been only circumscribed reviews examining factors associated with burnout in mental health nursing. In an international review of stress and stress management interventions for mental health nurses, Edwards and Burnard (2003) reviewed 77 papers encompassing studies pertaining to concepts of burnout, stress, job dissatisfaction and psychological distress. Burnout was positively correlated with role conflict, insufficient support, little organisational involvement, job dissatisfaction and sickness absence. Since this review covered psychiatric staff, including registered nurses and nursing students, and undertook no detailed breakdown of grades of nurse, stressors relating to each professional group could not be distinguished. Papers included did not only examine nursing staff working within the field of mental health, and the majority of the papers used ward-based team populations rather than community teams. This review highlighted the relative gap in the knowledge base for the community population.

A meta-analytic review by Melchior et al. (1997) of 43 variables within nine studies reporting data on burnout in mental health nurses sought to determine the relationship between these variables and burnout. Studies encompassed diverse settings, including staff working in the community, with findings indicating that burnout was negatively correlated with job satisfaction, support, and involvement with the organisation, but was

positively correlated with role conflict. This indicated the importance of considering burnout within mental health nursing, but did not distinguish between this and other settings, for example Community Mental Health Teams.

2.6 Community Mental Health Teams

Community Mental Health Teams originated in the United Kingdom in the late 1970's to provide a multidisciplinary team approach to mental health care across sectors of primary and secondary health, and social care (Coffey & Hannigan, 2005). With the advent of service transformation in England, since 1980, and the closure of large psychiatric hospitals psychiatric (bed numbers in England have fallen significantly and continue to do so (Green & Griffiths, 2014), more individuals requiring support within the community, recognised with the introduction of the NHS and Community Care Act (1990).

Yet, the shift to community-based care seems to have engendered stressors, with Community Mental Health Nurses (CMHNs) reporting amongst the highest levels of distress (Rees & Smith, 1991). Indeed it has been argued that across all categories of mental health personnel, CMHNs are vulnerable to increased levels of stress and burnout (Brown et al. 1995), with a well-validated measure of stress used with CMHNs indicating an association between stress levels, sickness absence and general health (Carson et al, 1994). Edwards et al. (2000) conducted a systematic review of the prevalence of stress and burnout in community mental health nursing. The high prevalence was linked to organisational rather than patient factors. Staff members were seeking to retain a high quality service despite long waiting lists, limited resources and

frequent interruptions in the office. Although the review question aimed to address predictors of stress within CMHNs, diverse nursing groups utilised and pooling of data, precluded separate analyses for CMHNs.

2.7 Rationale

The is a substantial evidence base that presence and experience of burnout in nursing staff is associated with health problems, underperformance and reduced service delivery over time (Bakker, Demerouti & Sanz-Vergel, 2014). There is considerable evidence to suggest that distress and burnout is prevalent in across differing domains of nursing staff, and more elevated for those working in mental health. However much of the literature to date has focussed on those psychiatric nurses working within physical health or inpatient mental health. With the process of 'deinstitutionalisation', and provision of care moved from institutions to communities, there appears potential strain on mental health nurses working within the community Given much of the work undertaken by CMHNs is remote and lone, with often large caseloads, it seems timely to assess the extent and predictors of burnout within this population, through a systematic review. This may offer potential for consideration of how it might be addressed.

Due to the multiplicity of definitions of 'burnout' evidenced in previous nursing literature (Edwards et al. 2000), often encompassing distress, studies pertaining to occupational stress and job dissatisfaction were also included in the current review. It has been stated that burnout can only be separated in a relative way from related

concepts such as stress and occupational dissatisfaction, and that the difference relates to the process and multidimensionality of this experience (Maslach & Schaufeli, 1993).

2.8 Aim of the current review

The aim of the current review was to identify correlates and predictors of burnout, stress and job dissatisfaction in CMHNs.

3 Method

3.1 Search strategy

Initial scoping searches using the broad terms 'stress' and 'staff' returned numerous papers yet helped to define the strategy used in the current review by identifying alternative search terms, and existing reviews in this area. A systematic search was then undertaken across three databases including PsycINFO, Web of Science and Medline. Because it appeared that burnout was little explored in CMHT populations, that operationalization of staff distress utilised in research examining workplace stress was broadened to ensure distress phenomena were captured for this population, thus similar concepts such as 'stress', 'compassion fatigue' and 'job dissatisfaction' were included. Different search terms and combinations were used depending on the capability of each database. Appendix B contains details of these searches. Articles were limited to those that had been peer reviewed and published in the English language, but there was no limit placed on date of publication. Searches were conducted in November 2015 and again in January 2016.

Since the review sought to assess literature examining correlates and predictors of stress and burnout, quantitative papers were privileged. Librarians with expertise in literature searching provided consultation on the search strategy and management of databases.

3.2 Exclusion criteria

Studies were excluded if they comprised: qualitative methods, reviews and studies with the use of pooled data, whereby data pertaining to CMHNs could not be separated out from a wider sample, for example ward-based nurses or the wider CMHT.

3.3 Outcome of search

Following the search of databases, 1817 titles were returned reducing to 1491 papers after duplicates were omitted. Titles were then screened against the inclusion criteria, a process that left 131 papers, and a subsequent secondary screen of the abstracts was undertaken; papers were excluded at this stage for being qualitative or review papers. The remaining 32 papers were sourced and reference lists were consulted, eliciting further papers. This meant that 34 papers were read in full and re-evaluated against the exclusion criteria. This process left nine papers; reasons for the exclusion of 25 papers at this stage were documented (Appendix C). Reasons for papers being considered ineligible were mainly due to the use of pooled data; data for CMHNs was not reported separately from other groups, such as ward-based mental health nurses. A PRISMA flowchart detailed the search process from identification to selection of final papers (Appendix D). Seventeen of the papers included in the Edwards et al. (2000) review

were excluded from the current review due to the use of pooled data. Papers that were explicit about the source of results were included. Three of the papers used by Edwards et al. (2000) were appropriate for inclusion within the current review due to their adherence to the criteria; Fagin et al. (1995), Snelgrove (1998) and Parahoo (1991).

3.4 Data extraction

A data extraction form was used to elicit information from the studies relevant for the current review (Appendix E). This form ensured that comparable information was extracted from each paper, and included: setting of the research, study aims, sample size and demographic information, outcome measures used and correlates or predictors of burnout and stress.

3.5 Quality appraisal

In order to evaluate quality of the included papers, a dedicated tool was utilised (Downs & Black, 1998). It comprises a checklist of domains typically associated with robust research. Although originally developed to appraise intervention-based studies, the tool was adapted based on modification in an earlier review (Thompson & McCabe, 2012) to better suit the cross-sectional studies involved (Appendix F).

The factors used to assess study quality comprised: reporting, external validity, internal validity and study design. Study quality scores were developed in order to categorise papers for review (Thompson & McCabe, 2012). Downs and Black (1998) categorised the quality of papers based on the score they attained. Of the nine studies, one had a low

score (<50%) and 6 had moderate scores (>50%) and 2 achieved a high score (>70%). Results of the quality assessment can be found in Table 1. In consideration of the methodological quality of research, it has been argued that all studies should be included in a review to limit researcher bias (Glass et al. 1981). Despite this, the quality scores were important for the consideration and interpretation of results.

Table 1. Table of study quality.

Label	Paper	Reporting	External validity	Internal validity	Study design	Study quality score %
A	Cottrell (2001)	5/5	1/1	1/3	0/2	64%
B	Edwards et al (2001)	5/5	0/1	2/3	1/2	73%
C	Edwards et al (2006)	5/5	0/1	2/3	0/2	64%
D	Fagin et al (1995)	5/5	1/1	2/3	1/2	91%
E	Hannigan et al (2000)	5/5	0/1	2/3	0/2	64%
F	McTiernan et al (2015)	5/5	0/1	1/3	1/2	64%
G	Snelgrove et al (1998)	4/5	1/1	2/3	0/2	64%
H	Pinikahana et al (2004)	3/5	1/1	2/3	0/2	55%
I	Parahoo (1991)	2/5	1/1	1/3	0/2	36%

3.6 Analysis

A meta-analysis was deemed unsuitable due to the insufficient homogeneity in the way the included studies were undertaken. Studied varied in their definitions of burnout, use of measures and method of analysis. Therefore the findings within the systematic

review were narratively synthesized. Existing literature categorized factors associated burnout as ‘Individual’ and ‘Situational’ (Maslach, Schaufeli & Leiter, 2001). This framework was used to help organise the findings of the current review.

4 Results

4.1 Overview of results

The main characteristics of the studies included in this review are outlined in tables 2, 4 and 5, with abbreviations for the measures noted in table 3. Nine papers fulfilled the inclusion criteria.

Table 2: Outline of studies and key findings.

	Author, year of publication and setting.	Study aims	Study design	Sample size (response rate) and demographic details	Construct of burnout and measure used.	Statistical analyses	Findings	Strengths	Weaknesses
A	Cottrell (2001) United Kingdom: North Wales NHS Trust, single semi-rural area.	To examine stress and job satisfaction in CMHNs and to consider focussed interventions to enhance work satisfaction and help ameliorate occupational stressors.	Cross sectional	N=7	Pressure: PMI	T-tests	Sources of burnout: relationships; workload; home/work balance; personal responsibility.	PMI is a validated measure. P values reported.	Main focus of the study was largely on intervention. Small sample size.
B	Edwards et al (2001)* United Kingdom: Across Wales.	To examine the variety, frequency and severity of stressors experienced by CMHNs in Wales.	Cross sectional	N=301 (49%)	Stress: CMHNSQ-R Coping: PNMCQ Self-esteem: RSES Psychiatric distress: GHQ-12 Burnout: MBI	Pearson's correlations	Correlates of burnout: unsupportive line manager; specific client group; job insecurity; self esteem.	Relatively large sample size. Used a number of validated measures. P values reported. Study deemed to be high in quality.	Relatively low response rate of less than 50% limits generalisability. Only 45% of variance in total stress score was explained by analysis. So a number of undetermined factors exist. Study did not account for personality type

									or locus of control.
C	Edwards et al (2006) United Kingdom: Across 11 NHS trusts in Wales.	To establish he degree to which clinical supervision might influence levels of reported burnout in CMHNs in Wales, UK.	Cross sectional	N=260 (32%)	Burnout: MBI Clinical supervision: MCSS	Correlations	Correlates of burnout: six sessions of clinical supervision; being younger; being male; finding time for supervision; trust/rapport in supervisory relationship; supervisor advice and support; and valuing clinical supervision.	Numerical size of sample was reasonable enough to draw conclusions from. P values reported.	32% response rate so need to interpret carefully re: generalisability, unsure if responses received are representative of the total sample. Potentially those not responding did not receive clinical supervision. Correlation so cannot state causal relationships. Confounding variables not controlled for.
D	Fagin et al (1995) United Kingdom: North East Thames region.	To examine the variety, frequency and severity of stresssors amongst CPNs in the North East Thames regional health authority (NETRHA). To describe coping	Cross sectional	N=250 (unknown)	Stress: CPN stress Q Burnout: MBI Psychiatric distress: GHQ-28 Job satisfaction: MJSS Coping: Coping SQ	Stepwise linear regression.	Happiness with life; caseload; sickness absence and relationship with line manager had an R value of 10%. Fitness level; happiness with life and completion of ENB course had an R value of 34%.	Relatively large sample size. Sample taken from across different departments within a region, including inner city & rural areas, thus helping	Focus of the study was to compare CPNs with ward based nurses, thus the results and discussion focussed on this aspect. Unclear whether all CPNs included worked within CMHTs or across more specialist

		strategies used by CPNs to reduce levels of occupational stress. To compare occupational stress in CPNs with WBPNs.						to make the data generalizable. With only one district refusing to participate. Study deemed to be high in quality.	services. Regression analyses did not elaborate on the individual contribution of each factor.
E	Hannigan et al (2001)* United Kingdom: Across Wales.		Cross sectional	N=301 (49%)	Stress: CMHNSQ-R Coping: PNMCQ Self-esteem: RSES Psychiatric distress: GHQ-12 Burnout: MBI	T-tests.	Correlates of burnout: urban location of work; unsupportive line manager; elderly caseload; job insecurity and being male.	Large sample size. A number of validated measures used. P values reported.	Relatively low response rate, so cautious about generalisability.
F	McTiernan & McDonald (2015) Ireland: 13 community locations.	The current research, undertaken in 2011, aimed to (1) identify the variety and severity of stressors of psychiatric nurses in a Dublin region; and (2) compare occupational stress, coping strategies and burnout of hospital nurses	Cross sectional	N=33 (unknown, 76.6% of total study)	Sources of stress: MHPSS Burnout: MBI Coping strategies: PNMCQ	T-tests.	Correlates of burnout: Workload and home/work balance.	Validated measures used. Recruited from across different locations in Ireland. P values reported.	Small sample size from a single locality therefore cannot be generalised.

		with community nurses.							
G	Snelgrove (1998). United Kingdom: A single district health authority.	To examine self-reported stress and job satisfaction of health visitors, district nurses and CPNs in one health authority in the UK. To examine for similarities and differences between these groups.	Cross sectional	N=19 (57.6%)	Psychiatric distress: GHQ-12	Correlations.	Correlates of burnout: failed visits and feelings of pressure from boredom.	Utilised statistical analyses. P values reported.	Only one health authority and geographical area was invited to participate so findings not necessarily generalizable. Very small sample size so findings not generalizable. Main focus of the study was to compare different occupational groups (health visitors, district nurses and community psychiatric nurses).
H	Pinikahana et al. (2004). Australia: Across 2 rural mental health services in Victoria.	To measure the level of stress, burnout and job satisfaction in rural psychiatric nurses in Victoria, Australia.	Cross sectional	N=136 (61%) No demographic information reported.	Burnout: MBI. Job satisfaction: Job satisfaction scale of the NSI. Stress: NSS	Descriptive statistics.	Stressors identified: workload; inadequate preparation; conflict with physicians.	Utilised an appropriate sample size, with adequate response rate. Utilised valid measures.	Reported descriptive statistics only. The predominant focus of this paper is on the presence of distress within this population. Participant responses on the NSS were categorised as

									either ‘no stress’ or ‘stressful’ and did not take into account the degree of stress or the strength of certain items within the subscales.
I	Parahoo (1991) United Kingdom: Northern Ireland.	To find out the respondents' level of job satisfaction and factors which contribute to their job satisfaction and dissatisfaction.	Cross sectional	N=77	Job satisfaction: Author’s own 5-point scale.	Descriptive statistics.	Paperwork/clerical duties; lack of finances/resources; heavy caseload; lack of community facilities; poor communication with GP.	Utilised a homogenous group within a small locality.	Reported descriptive statistics only. Does not utilise any validated measures. Low study quality.

Table 3: Table of abbreviations.

Abbreviation	**Long form**
PMI	Pressure Management Indicator
CPN Q	CPN Stress Questionnaire
MBI	Maslach Burnout Inventory
GHQ-28	General Health Questionnaire (28 item)
RSES	Rosenberg self-esteem scale
MJSS	Minnesota job satisfaction scale
Coping SQ	Coping skills questionnaire
MHSDD	Maslach Human Services Demographic Data Sheet
CMHNSQ-R	Community Mental Health Nurse stress questionnaire (revised)
PNMCQ	PsychNurse methods of coping questionnaire
GHQ-12	General health questionnaire (12 item)
MCSS	Manchester Clinical Supervision Scale
MHPSS	Mental Health Professional Stress Scale
NSI	Nurse Stress Index
NSS	Nursing Stress Scale

Table 4: Table of significant predictors.

Study label	Factor	Significance	Individual(I) or Situational(S)
A	Relationships	P<0.001	S
	Workload	P<0.001	S
	Home/work balance	P<0.001	S
	Managerial role	P<0.001	S
B	Unsupportive line manager	P=0.000	S
	Working in the field of severe mental illness and rehabilitation	P=0.002	S
	Job insecurity	P=0.006	S
	Self-esteem	P=0.01	I
C	Six sessions of clinical supervision	P=0.003	S
	Being younger	P=0.007	I
	Being male	P=0.000	I
	Finding time for supervision	P<0.008	S
	Trust/rapport in supervisory relationship	P<0.002	S
	Supervisor advice and support	P=0.002	S
	Value of clinical supervision	P=0.02	S
D	Happiness with life	R = 10%	I
	Caseload	(no p values reported)	S
	Sickness absence		S
	Relationship with line manager		S
	Fitness level	R = 34%	I
	Happiness with life	(no p values reported)	I
	Completion of ENB course		S
E	Urban location of work	P=0.047	S

	Unsupportive line manager Elderly caseload Job insecurity Being male	P=0.004 P=0.05 P<0.01 P<0.01	S S S I
F	Workload Home/work balance	P<0.05 P<0.05	S S
G	Failed visits Feelings of pressure from boredom	P<0.014 P<0.031	S S

Table 5: Table of descriptive statistics.

Study label	Factor	Descriptive statistics	Individual(I) or Situational(S)
H	Workload Inadequate preparation Conflict with physicians	82.7% 82.4% 79.4%	S S S
I	Paperwork/clerical duties Lack of finances/resources Heavy caseload Lack of community facilities Poor communication with GPs.	31% 25% 19% 13% 12%	S S S S S

4.2 Study populations and study designs

Studies were undertaken in developed countries; one in England (D), five in Wales (A, B, C, E, G), two in Ireland (F, I) and one in Australia (H). The studies reported data from community teams from urban areas (G), rural areas (A, H) or from both (B, C, D, E, I). The majority of studies collected data from different community mental health departments within a geographical area or district health authority, with only one study describing a single department (A). Samples mainly consisted of participants who were female in their forties and who had spent an average of 16.4 years in the role of a CMHN and an average of 6 years in their current role as a Grade G nurse. Study H was the only study which did not report demographic information of the sample. Ethnicity was not reported as a demographic factor in any of the studies. Two of the studies aimed to compare the data on CMHNs with ward-based psychiatric nurses (D, F) or health

visitors and district nurses (G), but were included as data for CMHNs could be independently discerned. The sample sizes varied and ranged from N=7 (A) to N=301 (B, E).

4.3 Study Measures

Six of the studies measured 'burnout' as operationalised by the Maslach Burnout Inventory (MBI; Maslach et al. 1986) (B, C, D, E, F, H). Two utilised the same dataset, and this data was only used once for analysis (Table 6). Five of the studies measured 'stress' using one or more of the following measures: the CPN Stress Questionnaire (CPN SQ; Brown et al. 1995) (B, D, E), the Nursing Stress Scale (NSS; Gray-Toft & Anderson, 1981) (H) and the Mental Health Professional Stress Scale (MPHSS; Cushway et al. 1996) (F). The third concept of 'psychiatric distress' was measured on the General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988) (B, D, E, G). All psychometric measures used are reported in the table in Appendix F.

Table 6: Reporting scores of the MBI.

Study label	Number of participants	Emotional Exhaustion	Depersonalisation	Personal Accomplishment
B and E	301	21.2 (SD 10.3)	5.2 (SD 4.5)	34.8 (SD 6.5)
C	260	22.32 (SD 11.42)	6.02 (SD 5.25)	31.45 (SD 5.42)
D	250	21.5 (SD 11.5)	5.4 (SD 5.3)	34.4 (SD 7.3)
F	33	17.6 (SD 10.8)	3.0 (SD 3.73)	38.35 (SD 5.59)
H	136	15.9 (SD 13.9)	5.7 (SD 7.01)	37.2 (SD 11.8)

The MBI measures emotional exhaustion, depersonalization and personal accomplishment to culminate in an overall score of burnout. Studies B, C, D, E, F and H all used the MBI, meaning that it was the most widely used measure within the included studies. Overall reported scores for Emotional Exhaustion fell within the 'medium'

range, this was similar for reported depersonalisation scores where four of the five scores fell within the ‘medium’ range. Personal accomplishment showed more variance, with three studies reporting scores within the medium range and two scores reporting within the ‘low range’.

Overall, the studies utlising the MBI reported similar levels of burnout, however this was not consistent across all studies as one study (F) reported scores of ‘low’ for Depersonalisation and ‘medium’ for Personal Accomplishment , this suggests that a sample of participants were reporting less impact of burnout than participants in the other studies. However it is important to acknowledge that this was a small sample of thirty-three participants within one locality and therefore responses could have been monitored or a less accurate picture gained. Overall, results from the MBI indicated that the populations studied comprised CMHNs who had acknowledged experiencing symptoms associated with burnout.

4.4 Results

All papers were of cross-sectional studies. Seven studies (A, B, C, D, E, F, G) undertook statistical analysis, including correlations and regressions, and two studies reported descriptive statistics (H, I).

4.4.1 Individual factors

Studies B, C, D and E reported that individual factors have a relationship with experience of burnout. Individual factors that were assessed included mainly demographic information and personal psychological and physical factors, suggesting

that the individual either had existing vulnerability to, or could some influence over the experience. Two studies of moderate quality found strong correlations between burnout and being male ($p=0.000$ & $p<0.01$) (C, E). Being younger was also found to be associated with increased burnout in study C ($p=0.007$). Self-esteem, as measured on the Rosenberg Self-Esteem Scale (Rosenberg, 1965), was found to be a correlate of burnout ($p=0.01$) in study B which was deemed to be of high quality. Fitness level and happiness with life were reported to be significant predictors of burnout in the regression analyses, however the individual contribution of these variables was not detailed (D), despite this study being considered high quality. Despite the significance reported in studies of appropriate quality, consideration of why individual factors played a role in burnout in CMHNs, or the extent of this role, was not explored within the studies.

4.4.2 Situational factors

Situational factors were considered in all nine studies and consist of relationships and experiences in the environment. The relationships between colleagues and other professionals were reported to be associated with burnout across five studies (A, B, D, H, I). Study B reported that having an unsupportive line manager was significantly associated with burnout ($p=0.000$), whilst study D also reported that the relationship with the line manager was significant, no p-values were reported. Relationships with other colleagues was a factor correlated with burnout ($p<0.001$) (A). Whilst it was identified in three separate studies that relationships at work are associated with burnout, there are differences in the reporting of this, for example whether it is related to colleagues, as in moderate quality study A, the relationship with the line manager or

specifically feeling unsupported by the line manager, both of which were from high quality studies (B & D). The descriptive statistics also looked at some of the difficulties in working with others: conflict with physicians was reported to contribute to burnout in study H (79.4%) and study I found that poor communication with GPs was a stressor for staff (12%). Due to the nature of these as involving "conflict" and "poor communication" it is reasonable to think that they would have some link with negative responses and burnout. Whilst these percentages varied, the quality of the studies were deemed moderate (H) and low (I) in quality, therefore the higher percentage in study H is privileged over the lower percentage in study I. Overall, there was evidence to suggest a relationship between interpersonal relationships in the workplace and burnout.

Workload was identified as a significant correlate of burnout in three studies (A, D, F) and this was supported by the descriptive statistics (H, I). The significance level was reported as $p<0.001$ (A), $p<0.05$ (F) and study D reported caseload size as a significant predictor in their regression analysis, however the individual contribution of this factor was not reported. The descriptive statistics showed that 82.7% (H) and 19% (I) of CMHNs in the sample reported workload as contributor to burnout. The studies were of high (D), moderate (A, F, H) and low quality (I), demonstrating the strength of evidence for this factor's association with burnout.

Regarding clinical work, study B found that working in the field of severe mental illness and rehabilitation was associated with increased burnout ($p=0.002$) and study E found that working with a largely elderly caseload ($p=0.05$) and working in an urban area ($p=0.047$) correlated with burnout. These studies were deemed to be of high (B) and moderate (C) quality providing credibility to their findings. The indication was that working with a specific client group, whether severely mentally ill or elderly, and working in inner-city rather than rural areas, had an association with increased burnout.

Study B found that job insecurity was positively correlated with burnout ($p=0.006$), a finding supported in study E ($p<0.01$). These are both strong correlates from studies of high (B) and moderate (E) quality, evidencing a strong association between feeling insecure within the employment and burnout.

Holding a managerial role was significantly associated with burnout in study A ($p<0.001$), a study of moderate quality. Completion of a post-qualification training course was found to be associated with burnout; the direction and strength of this relationship was not reported, however it was deemed to be of high quality (D). It can be assumed that those with further training and those in a managerial position may have some similarities in terms of their ambition and level of responsibility. There is evidence to suggest a relationship between the level of achievement at work and the experience of burnout.

There was evidence to suggest that personal factors may have a role to play in burnout. Struggling to maintain an effective home/work balance was strongly associated with burnout in two studies of moderate quality (A, F). The significance levels reported were $p<0.001$ and $p<0.05$ respectively. Sickness absence was reported as a predictor of burnout in study D, although the individual contribution of this factor was not identified the study was deemed to be of high quality. It is reasonable to think that sickness necessitating time off work and difficulties keeping work and home life separate, would be associated with burnout.

Study G found that, at work, failed visits ($p<0.014$) and feelings of pressure from boredom ($p<0.031$) were both positively correlated with burnout. In study H, 82.4% of participants reported that feeling inadequately prepared for clinical work contributed to burnout. There is some evidence from these two moderate quality studies to suggest that

these negative feelings, around failure, boredom and inadequacy, are associated with burnout, however one of them only utilised descriptive statistics limiting the inferences that can be drawn about feeling unprepared.

Study C focused solely on the relationship between clinical supervision and burnout, and reported strong correlations for the link. Having trust/rapport in the supervisory relationship ($p<0.002$), being able to seek advice from the supervisor ($p=0.002$) and valuing clinical supervision ($p=0.02$) were reported to be the most significant correlations in the study. Having six sessions of clinical supervision ($p=0.003$) and finding time for supervision ($p<0.008$) were also found to be significantly associated with reduced burnout. These findings are from a study of moderate quality, however support for the role of supervision was not found in any other papers and the response rate for this study was low which limited the generalisability of findings. The results indicated that the interpersonal nature of the supervisory relationship is perhaps more crucial than the practicalities of setting up clinical supervision in the moderation of burnout.

From the descriptive statistics reported in study I, the volume of paperwork (31%), lack of resources in the team (25%) and lack of community resources (13%) were all identified as stressors. This information pertained to a single study deemed to be of low quality and utilised descriptive statistics only, therefore the evidence is too limited to suggest an association between inadequate resources and burnout.

4.5 Methodological Issues

Due to the variety of psychometric measures employed, the factors considered varied between each study. Burnout was conceptualised differently across the papers with

reference to stress (A, D, F, H), burnout (B, C, E), distress (G) and job dissatisfaction (I). This was noted in the variety of measures employed and the different focus of the studies; however 'burnout' was the concept used for the purpose of the current review. It is possible that these differences in the conceptualisation of burnout and variety of measures limits the potential findings.

Only three of the studies reported a response rate of over 50% (F, G, H), and the sample sizes for two of these three studies were low (19 & 33) (G & F). The sample size for study A was particularly small (n=7). It is therefore difficult to ascertain whether results are representative of the whole sample. All studies employed self-report measures, therefore it is important to consider the possibility of social desirability bias and participants potentially moderating their responses. The nature of each study was to 'opt in', therefore it is possible that those suffering with burnout did not engage with the research or perhaps those who did not self-identify with this experience declined to.

5 Discussion

The aim of the current review was to identify the correlates and determinants of burnout within the CMHN population. The findings were synthesised in keeping with the framework of individual and situational factors. This discussion provides a summary of the findings in the context of existing literature, consideration of the strengths and weaknesses of the current review and clinical implications.

5.1 Findings

Nine articles met the criteria for inclusion in the current review, however the heterogeneous nature of the studies provided challenges to synthesis. Seven of the studies reported results from correlation or regression analyses and two reported descriptive statistics. The results of the studies were summarised within the framework of the individual and situational factors associated with burnout (Maslach, Schaufeli & Leiter, 2001). Individual factors, such as gender and age, were only reported in four of the studies, and then only briefly. All of the nine studies reported on the situational factors, such as workload and supervision, therefore this provided a stronger evidence base in the current review.

5.1.1 Individual factors

The studies indicated that being male was related to burnout. This is in contrast to the majority of burnout literature that suggests burnout is predominantly a female experience, however it is reported that males generally score higher for cynicism (Maslach, Schaufeli & Leiter, 2001). Being younger was another factor associated with burnout and is in keeping with existing evidence that individuals are more prone to burnout earlier on in their working life. This has been attributed to 'survival bias'; that those who have experienced burnout have left the profession and subsequently those who remain are those less vulnerable to burnout (Maslach, Schaufeli & Leiter, 2001). The findings relating to gender and age were interesting given that the sample mainly consisted of females in their forties, however it could indicate that those younger participants and males were more prone to participation due to already self-identifying with the experience of burnout. Self-esteem was identified as a factor associated with burnout in one study. Although the current evidence for self-esteem was limited, it has

been considered a key moderating factor for the effects of stress (Carson et al. 1997). Due to the nature of the studies and the predominant focus on situational rather than individual factors, demographic information was only drawn into the analyses for three of the studies and was not explored within any of the discussions, therefore the evidence pertaining to individual factors remains inconclusive.

5.1.2 Situational factors

There was evidence from five studies to suggest an association between interpersonal relationships and burnout. The inferences that could be drawn from the descriptive statistics was limited, however difficulties with other professionals was identified as a stressor. The relationship with the line manager was deemed a significant correlate in three studies, crucially that experiencing the manager as 'unsupportive' was linked with higher levels of burnout. Further analysis of CMHNs found that those with a difficult managerial relationship had higher stress levels and were more likely to be emotionally drained from their work (Hannigan et al. 2000). The calibre of relationships at work have been identified as crucial to both individual and organisational wellbeing (Hingley & Cooper, 1986).

Due to its presence in five of the nine studies included in the current review, there was strong evidence to suggest that workload was associated with burnout. The descriptive statistics varied considerably in the percentage of those who viewed workload as a stressor, however the study with the smallest percentage used the author's own measure without reporting any data on reliability and validity. Despite the limitations of this one study, there remains evidence to support this factor with strong p-values being reported in three studies. This is in keeping with the current literature that has conceptualised

burnout as a response to the overloading of job demands (Maslach, Schaufeli & Leiter, 2001).

There was evidence from two studies to suggest that the clinical work and setting contributed to burnout. Working in the field of severe mental illness and rehabilitation and working with the elderly were found to be associated with burnout. Consideration also needs to be given to the opportunity for 'rehabilitation' and perhaps the role of hope in working with those client groups. McLeod (1997) found that CMHNs working with those with severe and enduring mental health difficulties reported increased stress, however the sample size was small in the study and therefore inferences can only be drawn tentatively. Regarding the setting, Wykes et al. (1997) supported a finding from one of the studies suggesting that an urban environment is associated with higher levels of burnout, however in the current review this factor was only found in a single study.

Job insecurity was associated with burnout in two studies and this is in keeping with existing research. Coffey (2000) attributed uncertainty within healthcare to ongoing changes in the NHS and difficulties with staff retention. Given the threat that exists in the system around them, it is therefore reasonable that CMHNs might lack a sense of job security. However, it is difficult to ascertain whether job insecurity leads to burnout or whether burnout leads to people feeling less secure in their jobs.

It was suggested in two studies that the increased level of responsibility or training that the individual reaches is linked with burnout. It has been established in the literature that the absence of recognition from others at work undervalues both the job and the employees, and is associated with feelings of inefficacy (Cordes & Dougherty, 1993; Maslach & Schaufeli, 1993). This is in contrast to the findings in the current review, as it would be reasonable to assume that someone within a management role, or who is

more highly trained, was in receipt of recognition for this. Therefore it is possible that this is linked with the individual's appraisal of receiving recognition and whether they believe this to be sufficient.

There was some evidence from two studies to suggest that a poor home/work balance was associated with increased burnout. It has been established within the burnout literature that both work-to-life and life-to-work conflict is associated with increased levels of stress and burnout (Anderson, et al. 2002). However, it is difficult to determine the cause and effect between these two experiences.

Negative feelings potentially relating to job dissatisfaction were found to be associated with burnout in three studies. The link between feelings of dissatisfaction at work and burnout has been well established in the burnout literature (Maslach, Schaufeli & Leiter, 2001). What cannot be established presently is whether these negative feelings, such as boredom and failure, are predictors of burnout or whether experiences of burnout lead to such negative feelings.

Supervision emerged from the current review as a strong correlate of burnout. Effective supervision was determined to be when facilitated by a supervisor who is accessible and attuned to the supervisee's needs (Watkins, 1997). This supported the need for sufficient time for supervision, feeling able to seek advice from the supervisor and nurturing a trusting relationship, all of which were associated with burnout. Whilst the evidence for the relationship between clinical supervision and reduced burnout appears robust, it is important to note that all of this information originated from a single study and was not supported by any of the other papers. It is unknown whether participants in other studies would have reported similar benefits had they been asked about clinical supervision.

Inadequate resources were identified as stressors which is in keeping with the Job Demands-Resources model of burnout (Demerouti et al. 2001); suggesting that resources can act as a buffer to the demands of occupational stress. However the evidence for this was from the descriptive statistics of a single study deemed to be low quality. Therefore the inference to be drawn is that participants in that study were dissatisfied with the adequacy of the resources offered in their locality, but whether this posed a problem for others or not was not explored in the remaining studies.

From the results, it was clear that more situational, rather than individual, factors were associated with stress and burnout. However the papers focussed more attention on the situational rather than individual factors, providing a stronger evidence base for them. In contrast, the demographic information was not collected in every study and not always reported, therefore it is possible that associations with individual factors remain undiscovered. Whilst there is evidence to demonstrate a relationship between the situational factors discussed and the reported experience of burnout, the majority of the evidence is from correlational analyses which, whilst demonstrating a strong relationship, are unable to determine causality. These results were in keeping with earlier literature reviews into mental health staff (Edwards and Burnard, 2003) and mental health nurses working in a variety of settings (Melchoir et al. 1997). Both earlier reviews indicated a relationship between burnout and situational factors, including: job dissatisfaction, lack of support, role conflict and limited involvement with the organisation. The current findings also supported a literature review into community mental health nurses which suggested that burnout was related to situational rather than patient factors (Edwards et al. 2000).

5.2 Quality of research

Six of the studies were appraised as moderate, two as high and one as low in quality. This is reflective of the cross sectional natures of the studies and difficulties establishing causality. All studies utilised self-report measures therefore it is possible that there was some social desirability bias when participants were responding to questions. All of the studies were based on CMHNs working in the community. They included a variety of different geographical locations and settings, and included studies from other countries. Whilst this may have represented a wide overview of the experiences of the profession, it may have limited the representativeness of each study. The predominant focus of the included studies was mainly around the situational factors. A couple of the papers drew demographic information into their analyses enabling consideration of individual factors, this is perhaps due to the perception that burnout is a construct related to occupation and job dissatisfaction rather than personal stress. However, when considering the vulnerabilities to, or predictors of, burnout it would be prudent to explore both.

5.3 Conceptualisation of phenomena

Of note within the current review is the variability of the concepts of 'burnout', 'stress', 'distress' and 'job dissatisfaction' used within the studies. Consideration needs to be given to whether these are distinct, linked or describe similar concepts. The studies within the current review used a range of measures to explore these concepts. It has been stated that burnout can only be separated in a relative way from related concepts such as stress and occupational dissatisfaction, and that the difference relates to the process and multidimensionality of this experience (Maslach & Schaufeli, 1993). Job

dissatisfaction was found to be negatively correlated with emotional exhaustion and depersonalisation but only weakly associated with personal accomplishment (Maslach & Schaufeli, 1993). It has been stated that depersonalisation is a key component of the burnout phenomenon (Schaufeli, 1990). Brill (1984) stated that a person with burnout, rather than stress, would get worse and need external assistance to adapt, rather than a person with stress who may be able to adapt. It is not just sickness absence or burnout itself that must be considered within the literature, but also feelings of helplessness and frustration which have been noted to instigate the burnout process (Schaufeli, 1990). A systematic review conducted by Edwards and Burnard (2003) made use of similar concepts and viewed them all as end processes of negative stress outcomes. There may well be some difference between the way that the phenomenon of burnout is described and operationalised within research, however it would appear to have links to stress and occupational dissatisfaction, which is why these concepts were included in the current review.

5.4 Burnout as a single event for the individual

Despite the results in the current study indicating the large part that situational factors have to play in the development of burnout, it is still often viewed as intrinsic to the individual. This is evidenced in the individualised nature of the NHS in services such as IAPT. It has been suggested that this is due to ideas around individual responsibility and an assumption that changing an individual is less costly and difficult than changing an organisation (Maslach & Goldberg 1998). Within the intensive care nursing population, burnout has been conceptualised as contagious; bringing a social element into the equation (Bakker, Le Blanc & Schaufeli, 2005). It is possible that burnout is

individualistic and therefore an experience unique to the person and difficult to capture within the relative simplicity of cross-sectional questionnaire studies. Research has indicated that the effects of burnout can be constant for a five, ten or even fifteen year period (Bakker et al, 2000; Hakanen, Bakker & Jokisaari, 2011; and Schaufeli et al, 2011). In addressing some of the difficulties in researching this phenomenon, it has been suggested that research studies tend to reduce burnout down to a single experience rather than consider it as an evolving process that continues to occur over a period of time (Ten Brummelhuis, Ter Hoeven, Bakker & Peper, 2011).

5.5 Improvements to research

The concept of burnout lacks solid conceptualisation. The links to stress, compassion fatigue, job dissatisfaction and distress are well documented, however further research is needed in this area in order to understand these phenomena better and how they fit together. It would be helpful for future research to thoroughly investigate the role of individual factors in relation to burnout as this would support consideration of individual vulnerabilities. Further research using the same psychometric measures is also needed to draw clear conclusions about predictors.

There is evidence to suggest that burnout and its effects are not a single event, rather an experience that evolves. All of the papers in the current review utilised cross-sectional methodology, whereas longitudinal research would be helpful to explore the development of burnout over time within the same individuals. Intervention studies were excluded in the current review to focus on determinants, however the next logical step would be to solidify the evidence base for interventions.

5.6 Strengths and limitations of the review

A key strength of the current review was that it utilised a systematic and reproducible method. The current review had limitations; the search was completed by the author only, leading to a potential bias in the inclusion and exclusion of studies. There was the potential for a publication bias because all of the studies included in the current review were required to be published ones. Qualitative studies were not included and, given the complex and potentially individualistic nature of burnout within mental health nursing, an understanding of the lived experience of those individuals would have been useful. Due to the heterogeneity of the methodology and measures used, and ambiguity of concepts, a meta-analysis was not appropriate. All of the studies utilised only self-report measures, calling into question the credibility of data due to influences such as social desirability bias. Six of the included studies were appraised as moderate, two as high and one as low for quality, whilst all were included as a representation of the evidence base within this area, limited the conclusions could be drawn from the low quality study. Although the current review utilised a relatively homogenous group of subjects, there were a number of studies that compared CMHNs with another professional group or type of nurse (for example a mental health nurse working in an inpatient setting). These studies were excluded if they pooled the data, meaning the target data could not be extracted in isolation. Whilst this was in keeping with the methodology and supported by a solid rationale, there is potentially a pool of information pertaining to this subject group that was not included.

It has been suggested that there may be difficulties in generalising burnout studies across cultures due to considerable variation in the levels of burnout reported (Madathil Heck, Schuldberg, 2014; Schaufeli & Janczur, 1994; Heinen et al. 2013). Potentially the current review should have been restricted to papers from the UK only because previous

research has shown that burnout levels vary dependent on the country (Priebe et al. 2005). However, by limiting the remit of the current study solely to those articles printed in the English language, a western culture is potentially already being privileged. Although international studies were not excluded from the current review, the studies were mainly from the UK and Ireland. It is possible that in some other countries the majority of care is provided either informally by families or within inpatient facilities, rather than formalised community care as found within the UK. Therefore it is possible that, due to the remit of the current review being about CMHNs, studies from the UK were naturally privileged over international studies. It has been indicated that the term 'burnout' does not translate in a considerable number of countries around the world (Maslach, Schaufeli & Leiter, 2001), therefore limiting the number of countries that use well-known measures like the MBI and conduct research in this area.

5.7 Clinical implications

Due to the heterogeneity and sparsity of studies, the implications of the findings are limited. In itself, this is a finding that there is perhaps little evidence-based policy or support for CMHNs in relation to burnout.

It is important to distinguish between individual or situational factors associated with burnout because it is likely this will impact on the intervention needed, for example coping skills addressing individual factors may not suffice if the factors are solely related to the environment. There were associations between burnout and situational factors pertaining to employment and the work environment, as such it would be helpful to seek feedback from CMHNs regarding their satisfaction within the workplace and

areas for improvement. Whilst some of the drawbacks may not be negotiable, for example when related to staffing or holding managerial responsibility, it is reasonable to consider that factors such as supportive line management and post-qualification training could be addressed.

Given the number of associations between burnout and situational factors, it might be helpful to consider changing the way that concepts such as ‘stress’ and ‘burnout’ are talked about; rather than being seen as something originating from within the individual and a failing on their behalf to instead be seen as a product of the situation that they are in. This approach might feel less blaming for struggling staff and might encourage CMHNs to voice concerns and seek early help. One way that staff could be supported to voice concerns is through clinical supervision, which there was some evidence for in the current review.

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Part 2

RESEARCH REPORT

Multidisciplinary team members' experiences of team formulation: A thematic analysis

1 Abstract

Historically a medical approach has been taken to understand the phenomenon of 'psychosis', however recently this approach has received substantial criticism (Boyle, 1992); opinion is divided and this remains a contested area (Coles, 2010). Early Intervention (EI) services were developed to embrace the notion of 'diagnostic uncertainty' within multidisciplinary teams (MDTs). Using their 'core skill' of formulation (Division of Clinical Psychology, 2010), psychologists have facilitated 'team formulation', developing a shared understanding with staff of client strengths and difficulties (Johnstone & Dallos, 2014).

The current study aims to explore MDT members' experiences of team formulation within EI services. Eleven staff members across two Trust sites were individually interviewed. Data was analysed using Thematic Analysis.

Three main themes were generated from the data: *team formulation offers a different perspective*; *the difference is valuable*; and *connection within the collective*. Overall, team formulation was generally viewed positively. Importantly it was seen as a vehicle for self-reflection and self-care. However, formulation alone was considered insufficient to understand everything about patients. At times of crisis it was evident that certainty was sought from the medical framework.

These results are considered within the context of the existing literature, particularly in relation to the evidence base for 'psychosis' and the notion of 'safe uncertainty' within

the reflective practice literature (Mason, 1993). Clinical implications deriving directly from this study are suggested, as are ideas for future research.

2 Introduction

The field of 'psychosis' has been a debated area over the years and in many ways opinion remains divided between whether a medical model or a psychosocial model best explains psychosis. The current introduction contains a narrative of both the medical and critical perspectives of 'psychosis' and considers the formation of Early Intervention, multidisciplinary teams, psychological formulation, and its use within teams.

2.1 'Psychosis' as a diagnosis

The term 'psychosis' has been used as a description for people who have presented with behaviours or beliefs that indicate a flight from reality including: hearing voices; struggles with thinking and concentrating; and holding strong beliefs that others do not

share. Historically, these experiences were considered key indicators of 'schizophrenia' and other 'psychotic illnesses' ('Understanding Psychosis', BPS, 2014).

Historically, in order to distinguish between types of 'mental illness', diagnostic categories were developed, comparable to the approach taken in physical health. Emil Kraepelin (1899-1900) is recognised as one of the pioneers of this approach in the 19th century. The assumptions for the categorisation of psychiatric disorders remains present in modern psychiatry. Authors of the third and subsequent editions of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM; American Psychiatric Association, 1980, 1994, 2013) considered themselves 'neo Kraepelinians', leaders of a revived interest in diagnostic classification (Klerman, 1986). These assumptions included: (i) a clear divide between mental health and mental illness; (ii) distinct categorical diagnoses, for example 'schizophrenia'; and (iii) that illnesses stem from a biological aetiology (Bentall, 2014). Within psychiatry, the emphasis has been on categorising symptoms with the objective of providing a diagnosis. However, it has been argued that this approach has caused the content and individual meaning of experiences to be lost (Boyle, 1992; Thomas, 1997). It has been argued that simply 'giving something a name, and even being very clear about its definition, doesn't mean that it necessarily exists in reality' ('Understanding Psychosis', BPS, 2014). Van Os et al. (2009) asserted that the term 'schizophrenia' falsely indicates that it is a disease of the brain that exists in nature. Within physical health, medical diagnoses can be helpful by indicating the cause and prognosis of a problem, however this is different for some mental health diagnoses, which tend to categorise rather than explain ('Understanding Psychosis', BPS, 2014). The DSM states that it is 'neutral with respect to theories of aetiology', clearly asserting that its categories explain nothing about the cause (American Psychiatric Association, 2013). It has also been argued that diagnoses are

predominantly based on social rather than medical decisions about suitable thoughts, feelings and behaviour (Onyett, 2007).

In contrast to the perception of psychosis as an illness, it has been argued that this phenomenon can be understood as a transient or enduring experience that can be worked through or lived with. In fact, a large epidemiological study indicated that between 4-10% of the general adult population will hear voices at some point during their lifetime, and that only a third of these people will access services (Tien, 1991; van Os, 2000; van Os et al., 2001). This strengthens the concept that 'psychosis' is situated at one end of a continuum of human experience (Verdoux & van Os, 2002; Claridge and Davis, 2003; Linscott and van Os, 2010). It has been suggested that distress and need for intervention is not a consequence of the experience, for example hearing voices, but is determined by an individual's capacity to manage it (Romme & Escher, 1989).

Research has shown the impact that stress and environmental factors can have on the development of 'psychosis'. It has been found that children are more likely to develop 'psychosis' as an adult if they have grown up in very socially deprived conditions (Pedersen & Mortensen, 2001; Wicks, Hjern & Daman, 2010) or if there has been fragmented and difficult communication from the parents (Wahlberg et al. 1997). Links have also been drawn between childhood trauma (sexual and physical abuse, bullying by peers and separation from parents) and the development of 'psychosis' in adulthood (Varese et al. 2012).

2.2 Early Intervention services

'Early Intervention' (EI) services were developed for individuals experiencing their first episode of 'psychosis' between the ages of 14-35 years, for a maximum period of 3 years. The aim of EI is for teams to provide a timely response to individuals diagnosed

with ‘psychosis’ to minimise the impact of difficulties before they develop further. This service is recommended within the NICE guidelines (National Institute for Health and Care Excellence, 2014) and it has been suggested that these popular services be expanded (The Schizophrenia Commission, 2012). Antipsychotics and other medication treatments were developed for people with ‘psychosis’ (Healy, 2004). Behavioural family therapy and cognitive behaviour therapy were also suggested interventions for people with ‘psychosis’ (Pilling et al., 2002).

2.3 Multidisciplinary teams

As within other areas of mental health, EI services are structured on Multi-Disciplinary Teams (MDTs). MDTs were developed on the principle that individuals from different professional disciplines will have certain approaches to treatment, management and care and therefore, through team communication, the optimum way to support the service user can be found (Colombo, 1997). Research has suggested that community psychiatric nurses and psychiatrists tended to utilise the medical model (Kirk, 2005), whereas social workers and psychologists have favoured a social and psychological approach respectively (Strauss & Carpenter, 1981). Colombo et al. (2003) argued that in the absence of definitive evidence regarding the medical model, one framework should not be privileged over another and a collaborative approach should be taken within teams. However, it has been suggested that the medical model continues to dominate within mental health services (Pollard, 2010).

2.4 Psychological formulation

Within the NHS, clinical psychologists are called on not only to work directly with service users, but also to input to services in a way that makes effective use of their skills and knowledge (Lavender & Paxton, 2004). Formulation has been considered a fundamental skill for all clinical psychologists (Division of Clinical Psychology, 2010). However the British Psychological Society (2011) have acknowledged that there is not one true definition of formulation, perhaps due to the differences that each psychologist brings to the formulation or the various theoretical models available. A broad definition of a formulation is a hypothesis, grounded in psychological theory and principles, that offers an explanation of a client's problems (British Psychological Society, 2011; Johnstone & Dallos, 2006). Psychological formulation is considered a narrative that is 'constructed rather than discovered' (Harper & Spellman, 2006), thus the client's personal meaning is central to formulation. Rather than an assertion from an expert, formulation is understood as a 'plausible account' (Butler, 1998) and is considered for its usefulness rather than representing 'truth' (Butler, 1998; Johnstone, 2006). It is recommended that a psychiatric diagnosis is not used as the basis for formulation, rather the individual's experiences that led to that diagnosis be formulated (British Psychological Society, 2011). Some have argued that the diagnosis becomes unnecessary if this is done well: 'once these complaints have been explained, there is no ghostly disease remaining that also requires an explanation' (Bentall, 2003, p.141).

2.5 Type of formulation

The British Psychological Society advocates for the use of person centred formulations which view the problems within the context of a person's lived experience. However it does acknowledge the use of problem-specific formulations, for example within the Improving Access to Psychological Therapy service when the focus is brief intervention

with ‘mild anxiety’ or ‘depression’ (NICE guidelines, 2010). Formulation is a fundamental part of some of the key theoretical orientations that clinical psychologists make use of, for example cognitive behavioural therapy, psychodynamic and cognitive analytic therapy. Each model draws on different ideas in their formulations (e.g. negative automatic thoughts and the unconscious), and each adopts a specific term for formulation e.g. ‘case conceptualisation’ (Beck, 1995) and ‘reformulation’ (Ryle, 1995). Despite these nuances in the conceptualisation of formulation, it has been claimed that the similarities are more important than the differences and that, regardless of the orientation, the most important element is a shared understanding of the presentation (Butler, 1998; Goldfried, 1995). It has been suggested that evidence-based formulation, as a basis for intervention, maintains psychological practice within the scientist-practitioner model (The British Psychological Society, 2011).

2.6 Team formulation

Formulation is used increasingly within MDTs; ‘team formulation’ refers to the development of a shared understanding of a service user’s strengths and difficulties within a group or team (Johnstone & Dallos, 2014). Kennedy et al. (2003) argued that team formulation could provide “a powerful systemic intervention”. By including perspectives from different professional disciplines, Onyett (2007) argued that team formulation could lead to the development of a more rounded and psychosocial construction of the service user and subsequently enable a more consistent and recovery-orientated intervention. The report indicated that when psychologists are visible in team decision-making meetings, the role of psychological processes in distress are advocated (Onyett, 2007). Professional practice guidelines for clinical

psychologists have recommended that they take an active role in the facilitation of a formulation-based approach in teams (DCP, 2011; HCPC, 2009).

There is no single process for psychologists when formulating within teams. Christofides, Johnstone and Musa (2012) interviewed ten clinical psychologists about their use of formulation within adult mental health MDT's, and developed two overarching themes: the need for space and a framework to collaboratively understand clients' difficulties, and the notion that 'chipping in' with psychologically informed ideas was an ongoing process. However, as well as providing psychological perspectives informally, there have also been attempts to create structure around the process of team formulation.

Formulation has been used in different ways with teams, whether diagrammatic and intended to directly inform care planning (Robson & Quayle, 2009) or understanding client difficulties by drawing on cognitive and attachment models and encouraging reflective practice in staff (Lake, 2008). Working with an inpatient rehabilitation team, Davenport (2002) emphasised the importance of understanding client strengths and difficulties following assessment by a psychologist or a responsible medical officer; in practice they focussed on particular concerns relating to inpatient settings, such as abuse and institutionalisation. Staff members' experience was evaluated qualitatively; staff reported that formulation assisted with the development of staff-patient relationships, improved staff satisfaction, improved team working and helped to inform interventions. However staff members were also concerned that ideas could be too hypothetical and have minimal impact on care (Summers, 2006). This concept was further evaluated by Hollingworth and Johnstone (2014), who evaluated staff views of team formulation meetings running across community and inpatient mental health settings. All 17 staff members reported developing a shared understanding of clients' strengths and

difficulties, the ability to learn from different professional disciplines, gaining ideas about new ways of working with clients and developing ways of planning for intervention and risk management. The evidence base for team formulation is emerging, however research into staff experience of formulation is limited; to date research suggests that team formulation is helpful for staff members.

2.7 Using team formulation for 'Psychosis'

Berry, Barrowclough and Wearden (2009) conducted a study on the impact of staff formulation meetings within an inpatient setting for people with 'psychosis'. Following formulation, staff reported a better understanding of service users' difficulties, indicated that their feelings towards service users were less negative and that their confidence in working with service users had increased. The researchers suggested that psychological input can be difficult for frontline staff to access, and that an appropriate use of clinical psychologists' time could be to provide supervision to staff from other disciplines (British Psychological Society, 2002). The study indicated that psychological formulation is a useful way to provide access to psychological perspectives, however this study focussed specifically on using formulation to modify staff perceptions of blame and control. The study used prepared statements which were rated on Likert scales, therefore results were very much driven by the researchers and did not explore staff experience. Similar to previous research into shared formulation, this was conducted within 24-hour staffed settings (Davenport, 2002; Summers, 2006). Therefore, this cannot be generalised to community settings where the role of staff members is different and service users' family and social networks may play a more central role.

2.8 Rationale and main research question

Formulation is deemed to be a core skill of clinical psychologists (Division of Clinical Psychology, 2011), however with 'psychosis' there is a long history of using a medical approach. This remains a highly contested area (Coles, 2010) and a recent publication by the British Psychological Society encourages a move away from a diagnostic approach and towards a more psychological understanding of individual experiences ('Understanding Psychosis', BPS, 2014). Service user views and experiences have often been overlooked within mental health services (Borg et al. 2009; Deegan, 1990) and psychological formulation aims to address this.

Therefore the current research was focussed on how this is experienced by multidisciplinary staff members working with people with 'psychosis'. Unlike previous research in this area the current study was based in a community setting and was exploratory in nature. Although there is some research into team formulation within inpatient settings, that is a very different culture to the more lone working aspect of EI teams.

The main research question was: How do non-psychologist professionals experience psychological formulation within Early Intervention Teams?

2.9 Aims and objectives

The aim of this study was to develop an understanding of the experiences of non-psychologist team members who have attended team formulation meetings, run by a clinical psychologist within Early Intervention for Psychosis services.

The objectives of the study are:

a) To explore how formulation is experienced by members of the MDT.

b) To explore how individual team members view formulation within the team.

c) To explore the conduct and content of meetings.

3 Method

3.1 Study context

As part of the DClinPsy, the researcher had spent a placement working as a Trainee Clinical Psychologist within an EI team in the locality, one of the teams recruited from. The researcher was not involved in the facilitation of team formulation sessions and had limited contact with just one of the participants; the researcher offered brief therapy to a client that the participant was care coordinator for. The researcher had not worked clinically with the other participants whilst on placement.

3.2 Study Design

Qualitative methodology has become increasingly popular in psychological research (Madill & Gough, 2008). The research question was investigated through individual interviews conducted by the researcher. Data was in the form of written documents transcribed from the individual interviews conducted and audio-recorded by the researcher. Prior to commencing data collection, approval was obtained from the University of Leicester Research and Ethics Committee and the relevant NHS Trusts Research and Development Committees (Appendix G).

3.3 Participants and recruitment

Eleven participants were recruited from four separate EI teams across two NHS Trusts. Two sites ensured that findings were not solely a function of local practice and culture. The researcher attended each team's team meeting in order to present the research aims and disseminate participant information sheets (Appendix H). Participants were invited to 'opt in' to the research by contacting the researcher. Participants provided signed consent for their voluntary participation in the study and interviews were audio recorded (Appendix I). Participants were asked to talk about a recent experience of team formulation in order to ground the interview in their experience. This also permitted participants to talk freely, and the topic guide was used to ask further questions.

3.4 Semi-structured interviews

A topic guide was developed (Appendix J) in order to seek to gain all of the relevant information from participants, whilst allowing them to talk freely about their experiences. The topic guide was developed based on the researcher's own knowledge and experience of Early Intervention and formulation, as well as in liaison with research supervisors and practicing Psychologists. An understanding of the literature helped to develop the questions. The length of research interviews ranged between 26 and 67 minutes.

3.5 Methodology and epistemology

Thematic Analysis (TA) was selected as the most appropriate approach due to its systematic method and ability to offer a detailed interpretation of the data. This has been recognised to be of particular utility where there is a paucity of research (Braun & Clarke, 2006). The current study aimed to explore the thoughts and feelings of staff in relation to team formulation and a strength of TA is its capacity to describe affective,

cognitive and symbolic elements across an entire dataset, rather than solely focussing on individual responses (Joffe, 2011). Due to the exploratory type of this research, a data-driven inductive approach was used for analysis (Patton, 1990). This permitted the researcher to find themes freely in the data as opposed to coding with a pre-determined framework of interest. Themes did not passively emerge from the data, rather the researcher was an active participant in the generation and organisation of themes. The researcher decided to seek out latent, rather than purely semantic themes, considering underlying patterns and assumptions, thus adopting a more interpretative stance. Further details of the researcher's epistemological position can be found in Appendix K.

3.6 Methods to enhance quality

Within supervision, the researcher engaged in a bracketing interview to seek to suspend judgment about the world in order to pay attention to the participant's experience as objectively as possible (Elliott, 1995). Themes were discussed with other researchers within peer supervision (detailed within Table 7) and a reflexive diary was kept by the researcher throughout the research process. These processes were followed in order to enhance the credibility of the research and analysis.

3.7 Data analysis

Data analysis was undertaken in line with Braun and Clarke's stage model of thematic analysis (2006).

Table 7: Stage model of thematic analysis.

Stage	Details	Appendix
Familiarisation with the data	The researcher conducted every interview and therefore had an initial familiarity with the data. Although formal transcription of the data was shared between the researcher and an external service, the transcripts that the researcher did not complete were checked against the original audio recordings to ensure accuracy. The final transcripts were read and reread by the researcher to ensure familiarisation. Initial impressions and reactions were noted by the researcher.	L
Generating initial codes	Notes were made throughout the transcribed material on the entire data set. As required by Braun and Clarke, the researcher coded at the latent level, aiming to recognise underlying assumptions, rather than at a semantic level. Key quotations were tabulated from each transcript.	M
Searching for themes	As suggested by Braun and Clark, the list of initial codes from individual analysis of transcripts were placed onto separate pieces of paper in order to move them around and aid the generation of themes. Codes were collated into thematic groups. Thematic groups were then considered in relation to each other, developing the meta and subthemes; each were named and described.	N
Reviewing themes	Themes were reviewed against the coded quotations taken from transcripts to ensure that the themes were closely linked to the data itself. Two transcripts were subject to independent review by the researcher's supervisor and two by a fellow qualitative researcher. Points of similarity and difference were discussed and this process of auditing the data allowed the researcher to elaborate on their original analysis. The use of multiple analysts was encouraged by Elliott, Fisher and Rennie (1999) as a method of quality assurance and increased credibility within qualitative research.	O
Defining and naming themes	Themes were compared to ensure distinguishable properties and discussion between the researcher and research supervisor ensured that themes were named in a way that told a story about the participants' experience of team formulation. Subthemes were added or removed where necessary.	P
Writing up	Using extracts of the data the researcher constructed an analytic narrative, aiming to tell a story of the data within the context of existing literature.	

4 Results

Participants comprised 11 qualified staff from EI teams; 6 were female and 5 were male. All participants were in the role of Care Coordinator; with a professional background as either a Mental Health Nurse or Occupational Therapist. Years since qualification ranged from 7 to 45 years, and participants had worked in the EI team from 6 months to 11 years. Pseudonyms were adopted to maintain confidentiality.

Table 8: Participant information.

Name	Team	Gender	Professional discipline	Years since qualification	Years in EI	Approximate no. of team formulation sessions attended*	
						Annual average	Total to date
Rachael	1a	Female	Occupational Therapist	16	11	4-6	
Jessica	1a	Female	Nurse	12	7.5	1	
Samuel	1a	Male	Nurse	45	5		6
Edward	1a	Male	Nurse	14	6		12
Eleanor	1a	Female	Nurse	7	1.5		6
Gerry	2a	Male	Nurse	28	11	1	
John	2a	Male	Nurse	8	5	8	
Anna	1b	Female	Occupational Therapist	11	1.5		2
Sean	1b	Male	Nurse	18	0.5		4
Julia	2b	Female	Nurse	9	4	2	
Gemma	2b	Female	Occupational Therapist	8	2	1	

*dependent on the information provided by participants at interview. Sometimes this has been worked out by the researcher as a result of participant estimations.

From the data, three main themes and seven subthemes that reflected participants' experiences of team formulation were generated. The three main themes identified were: team formulation offers a different perspective; the difference is valuable; and connection within the collective. The subthemes were identified as being component of the main theme, yet having enough difference to avoid being absorbed within the main

theme. Quotes have been provided to reflect the themes identified, further quotes and evidence of themes are evidenced in Appendix Q.

Table 9: Overview of themes and subthemes.

Theme	Subtheme
Team formulation offers a different perspective	• Structure • Formulation vs. diagnosis • Not stuck in the medical model
The difference is valuable	• Broadening perspectives changes practice • Having views heard • Pour out the anxieties • Looking after ourselves
Connection within the collective	• Not being alone • Learning from others

4.1 Team formulation offers a different perspective

The predominant overarching theme was 'team formulation offers a different perspective', running through the entirety of the dataset. Participants felt that team formulation offered something different than would otherwise be experienced within the team. This difference was concerned with the setup of the meeting itself, as well as the contrast with a traditional diagnostic approach. This difference was perceived as positive in that it seemed to open up discussions and allow for a more questioning position of the role played by services. However there were also times when it was considered less helpful, such as during times of stress, when a framework offering certainty was preferred.

4.1.1 Structure

The structure and form of the session was discussed by participants, with varying views. The structure was perceived as different compared with other forums where agendas

were often in use. Some participants spoke about the structure of formulation meetings being flexible, without a set agenda, which was considered helpful and it was implied that this facilitated the space feeling safe for individuals to open up.

> *"I think it's quite flexible which is what's kind of positive about it"* Jessica.

However Gerry felt that the sessions lacked necessary formality.

> *"I think, I mean currently the, the process of formulation is just too informal now"* Gerry.

Other participants considered that having a more structured session was positive, but that more structure would feel too rigid and be reminiscent of teaching. Potentially the amount of structure needed for the environment to feel appropriately 'safe' would vary for each person, and it can be assumed that a middle ground was needed; enough to feel contained without it being too prescriptive which could feel constricting.

> *"I think it's about having the safe space and you do need some structure but not to the point where, you know, I think you need a lot of listening and a lot of talking"* Eleanor.

4.1.2 Formulation vs. diagnosis

This subtheme related to the distinction that participants noted between psychological formulation and medical diagnosis in the understanding of an individual's experiences. Diagnosis was felt to be helpful at times, particularly when immediate action was

needed, but formulation was considered to offer something more comprehensive, less stigmatising and useful.

Some participants saw diagnosis as helpful because it provided a framework with which to understand and treat the client, there was a sense that this was clear and certain. However it was also seen by some to label individuals, which was seen as a negative, and 'tick boxes' were referred to which seemed too simplistic.

> *"Diagnosis is, uh, trying to look at sort of, for want, labelling somebody… so it's trying to differentiate between the person and the, and the illness. The diagnosis does help us in as much as, you know, it's a ticking box to tell us what we are dealing with"* Samuel.

Formulation was deemed to provide more information, empower the client and be conducive to the development of an effective therapeutic relationship. It was seen to go deeper and be more inclusive than diagnosis.

> *"Diagnosis doesn't tell you anything does it really… the formulation actually tries to capture that rather than just the, uh, for want of a better term the headline event you know… the headlining event would be like 'young man with psychosis'. Uh, but it's the, the, the story that actually, uh, can explain the headline is what you want… it's those such things that you can actually get out of a formulation rather than just off a, you know, one size fit all"* Gerry.

Formulation was, however was also perceived as insufficient alone, this fed into the understanding that formulation does not offer certainty, and therefore can be used as an

addition to diagnosis rather than a replacement for it. This was captured well by Julia when she spoke about medication as a first line intervention and formulation as a secondary step.

> *"You have to have the diagnosis there so that you can give them the medication and treat them properly, but I think that then the formulation bit just goes one step further, one step deeper which is what's needed to be able to get to know people a little bit better and develop that relationship with them"* Julia.

Despite the distinctions noted by participants, they generally felt that the two concepts need not be separate and could complement each other, although it was not clear how this would work in practice. There was a sense that participants appreciated the inclusive and non-stigmatising approach of formulation, because it felt more positive and empowering, but struggled to consider this as entirely sufficient because it lacked the framework and clear guidelines of diagnosis.

> *"I feel they can be alongside each other, certainly, certainly, I don't think they're separate I think they should be, you know, kind of co-exist really, uh, and interrelate with one another"* Jessica.

4.1.3 Not being stuck in a medical model

Participants appreciated the opportunity to explore a different perspective to the medical model. In contrast to the previous subtheme, this related to the overall framework being

drawn on. Participants thought that clients for whom the typical 'medical model' did not seem to be working would be helped by team formulation. In this way, team formulation was seen as something 'outside of the box', because the staff member felt 'stuck' when their default intervention had not moved the client forward.

Some participants spoke about the distinction between adopting a medical approach or consideration of the person within their wider context; Eleanor elaborated that this was an active choice that the Care Coordinator needed to make. Her use of "something" rather than "someone" indicated that different approaches could be adopted at different times, and is more dependent on the 'problem' at that moment, rather than the individual as a whole.

> *"Sometimes we as care coordinators are sometimes split where we have to sometimes make the choice of are we going to think of, are we going to, you know, medically support something or are we going to psychologically support something"* Eleanor.

A couple of participants felt that the medical model remains helpful, particularly at a time of crisis. This was said with assurance, as if it was a given that when immediate action is required the medical model must be followed. It would seem that when a client is in a 'crisis', with the ensuing uncertainty for Care Coordinators, they seek to find some certainty themselves through the use of the medical model. Because this was only mentioned by a couple of the Mental Health Nurse participants, it is possible that Care Coordinators revert back to their formal training routes, or it might be that during times of stress it is difficult to hold onto other perspectives and formulation presents as too different.

"Uh, particularly when we're managing crisis situation, we tend to stick to, um, the medical kind of side of things really" Jessica.

Participants considered it to be important to question the medical model at times and to think outside of that context, giving them permission to hold a more critical position in relation to the use of medication and to psychosis as 'illness'. Eleanor in particular questioned the rationale for ongoing use of medication and considered a systemic rather than solely individual perspective. This critical position also seemed to be empowering for participants, such a John, as they were able to draw on a range of skills and techniques to support individuals.

"There's a lot more sort of training and techniques that we can use, without being a psych nurse really and looking at medication and looking at symptoms" John.

4.2 The difference is valuable

All participants spoke about finding team formulation helpful. Team formulation was seen as a safe space to find valuable new ways of working, share anxieties and feel listened to, but also a method of self-care.

4.2.1 Broadening perspectives changes practice

This subtheme was characterised by participants' experience that team formulation offered a wider perspective and encouraged thinking about things differently. John spoke about 'a fresh pair of eyes' which seemed to indicate the newness and difference offered by formulation. His comment about widening instead of narrowing was

interesting because it suggested that rather than staying within his mental health nursing background, he was seeking to expand his knowledge and perspective.

> *"It makes you sort of step back a bit I think really. Um, you know, and allow a fresh pair of eyes to sort of be, be on, you know, be looking down a microscope at certain people. Um, and it's like I say, just widening instead of sort of narrowing in your discipline"* John.

Team formulation was considered by some participants to be helpful in finding an appropriate intervention for clients. This expanded the utility of team formulation from being something indirect to aid understanding, to something that can lead to direct action.

> *"You get a different angle, different angle of maybe certain issues that you may be dealing with, so you see different strands as it were. As to, you know, how else you could go"* Edward.

Despite this, there remained a sense that team formulation was not as action-focussed as participants would have liked; detailed in the subtheme 'formulation vs. diagnosis'. Participants identified a positive impact on themselves and other staff members. By considering the person within their context and making sense of their own responses, participants felt that their own practice improved and they developed a more compassionate approach to others.

"I think it gives them a little bit more compassion towards people maybe. You maybe step back and think a little bit more about the person, rather than just thinking they're acting out, or they're attention seeking or whatever, you kind of look further beyond that. So I think it kind of makes the team kind of more compassionate towards people, more understanding of people kind of thing" Julia.

4.2.2 Having your views heard

This subtheme reflected how participants felt confident to have a voice within the team formulation meetings, and that this was different to other MDT forums. There was a sense that participants could not always speak up within other team meetings, or if they did, they might not feel able to be entirely open with their views. There was also something about feeling listened to, and this was something that team formulation meetings provided that other forums did not.

"You do have to have a multidisciplinary approach I suppose. But it's also about having your views heard" Eleanor.

Although everyone acknowledged that the team formulation meetings were a space to share openly, this was not always spoken about as a positive. Gerry felt a sense of frustration when staff members shared their experiences to feel heard, rather than with a view to making direct changes.

"If the person's not going to act upon it and actually use anything from it, it's just a talk shop. And I get very frustrated in talk shops, but sometimes it's like people just want to be heard" Gerry.

4.2.3 Pour out the anxieties

Participants spoke about team formulation meetings being a platform to discuss the impact of clinical work on themselves and a way of containing their own emotions, as individual supervision and team meetings often related to overall caseload management rather than exploration of individual cases and self-reflection. A lot of this was through the offloading of information, but other times it was about developing an understanding of the participant's own limitations and barriers.

"I feel at the end of the [team formulation] somewhat alleviated, because I've been able to pour out the anxieties that I may have myself" Samuel.

Within team formulation, participants spoke about acknowledging difficult emotions; such as feeling frustrated and judgmental. This introduced a self-reflective element to team formulation. To verbalise this interface, between their client's situation and their own reaction, within a team setting seemed important for participants.

"You get a little bit and, you know, we do get judgemental, we do, we're human beings. We say well you know, he's, he's wallowing in self-pity, we can get negative and that's hard to feel" John.

"[Team formulation is] making some sense of it. And making some sense of your own, um, feeling frustrated and the difficulties" Anna.

There was a sense of security from being within the team and not alone; this sense of safety seemed to come from reassurance that participants were not alone in their experiences and associated reactions. That reassurance seemed to make difficult personal reactions feel okay, and was a compassionate response that participants seemed to struggle to give themselves.

> *"I still like to know how people work and see, you know, is it only me who actually feels quite frustrated sometimes, and actually that's when I gain from it, actually no it's not only me, others do as well, and that's okay"* Eleanor.

4.2.4 Looking after ourselves

Experiences of team formulation were largely underpinned by participants' acknowledgement of the importance of the individual self within care delivery. There was a recognition that looking after one's own wellbeing was not self-indulgent, or extra to the role, but rather was fundamental for the effective delivery of care. Sean understood this need for self-care in order to care for others.

> *"Making sure that we look after ourselves, that then enables us to look after our team members and our clients properly"* Sean.

There was an understanding that team formulation provides a vehicle through which self-care can be practiced. Anna felt that making time for team formulation is essential for staff members to be an effective resource for service users.

"We do actually need to make time for this, because this is really, really important. It sort of kind of, um, goes above every, anything that we're doing. If we don't have this, then we can't really work very effectively" Anna.

4.3 Connection within the collective

Some participants indicated that they felt able to approach the psychologist individually to gain a psychological perspective of a case, however there was something within every interview relating to the importance of formulation sessions being shared by the collective. This was considered important because it helped to explain the importance of the 'team' element within team formulation sessions. It is important to note that whilst exploring formulation within a team seemed to be generally positive, the wider experience of working within a team was not without challenges.

Several participants recognised existing strengths within the team. Despite this, there was an indication that team formulation enhanced the team. Jessica seemed to believe that the team was already good at being creative in their approach, and there was a sense that formulation is seen as something different and perhaps more innovative than other approaches. As such, it felt that this was something positive with which to identify, because it inferred that same pioneering image onto the individuals within that team.

"I think we're good as a team actually at looking at things, embracing kind of different approaches, different angles. And I think [team formulation] only helps with that process" Jessica.

Formulation meetings help to strengthen, between team members, the reciprocal relationship of seeking and providing support. Rachael spoke about the importance of providing support to others, so much so that at times she would attend with that sole purpose rather than because her own time or needs permitted it.

> *"Sometimes I'll feel I'm really busy and I'm struggling to go, and I wouldn't go for my own sake, but I feel bad. Though it's not very well represented I feel I should support those people who are there who are presenting"* Rachael.

There were also difficulties of sharing time with the team too. Anna and Sean spoke about difficulties relating to a split within the wider team, and it appeared that 'sub-teams' had been formed. It almost felt that team formulation sessions perpetuated this division by providing a forum that one team accessed and the other did not.

4.3.1 Not being alone

This subtheme related to participant experience of community working as largely isolative. Jessica voiced her perception that everyone worked differently within the team, but without knowledge of how others actually worked this seemed unsubstantiated.

> *"I think we all work quite differently, and it would be difficult to know how other people work having not kind of, we work as lone workers really"* Jessica.

In relation to how staff members view formulation within the team, for some the sessions permitted a practical means through which to access MDT members to

consider risk, rather than relying on solely themselves. Samuel felt that the responsibility of risk could be shared, which seemed to alleviate the burden on the individual and provide some comfort. Interestingly, for Sean, the MDT presence provided a means through which to explore risk management strategies further, but kept the responsibility on the individual himself.

> *"It can be where they're very risky and there's high level of risk and there's a lot of work involved in doing that, and to come and share that and to make sure… The check list really, that you're not just relying on your own check list and your policies and guidelines, you're relying on the experience of your colleagues that may have been through that, you know, previously and can, can hopefully add value or make other suggestions about things that might need to be tried"* Sean.

The nature of sitting in a team forum together was indicated to reduce feelings of isolation and enhance a sense of connection. Sean seemed to think that the purpose of the session was secondary to the process of being with peers.

> *"The nature of community work is that it can be quite isolative, so coming together to talk about anything in any way is better than not doing it at all"* Sean.

However, Anna talked about team formulation specifically providing a collaborative approach to clinical work.

"It just reminds you that it's not just a load that you have to hold yourself. You can share it" Anna.

4.3.2 Learning from others

This subtheme related to the need that participants felt to learn from their peers, and that this was facilitated by team formulation. All participants discussed the importance of learning from others within team formulation. This related to the diversity within the team and the richness and depth of combined experience.

"It's different perspectives. And just peoples', even if it's the same discipline, so even if it's a few nursing in the team, people have worked in different areas" Rachael.

Given this collective experience, participants sought to hear about others' lived experiences with clients. This seemed to add a different dimension to the team formulation sessions; rather than working in the present, hearing previous accounts gave clients some context to what might have worked well or not. This seemed to be with a view to seeking certainty about an approach that would be helpful based on past evidence.

"It also helps to get more, uh, insight and sort of, uh, more, uh, input from other team members, or other care coordinators that might have met with similar situations in the past" Edward.

Most of the participants sought reassurance from peers in order to feel satisfied with the action they were taking with work situations. This came from a sense of feeling unsure about clinical cases, Jessica and Eleanor specifically referenced needing 'reassurance'. Gerry recognised that sometimes other could offer suggestions and advice, and it would indicate that the participant was doing the right thing for that person at that time. Either way there was something important, particularly in times it seemed of difficulty, for participants to feel validated in their struggles and actions.

> *"Where you've got more of a complex client, you might feel a bit more kind of in need of support, reassurance, um, from other members of the team"* Jessica.

> *"You would actually go through all the available knowledge and information and use all the expertise in the room, and still come up with the conclusion that what you were doing was probably the best at the moment"* Gerry.

5 Discussion

The aim of the current study was to explore MDT members' experiences of team formulation within EI. Eleven MDT members were interviewed; interviews were subsequently transcribed and analysed using thematic analysis. The results indicated three main themes: team formulation offers a different perspective; the difference is valuable; and connection within the collective. An overview of the themes and subthemes is provided below and discussed within the context of existing research.

5.1 Team formulation offers a different perspective

Participants' views around structure varied; some individuals valued a flexible and relaxed approach within the meetings, whereas others valued more structure and formality, therefore finding a medium between these two positions would potentially be quite helpful. Hollingworth & Johnstone (2014) noted that team formulation can take various forms, whether created as reflective-practice groups or 'drop-in' sessions, and whether it was pre-arranged which clients to discuss or there was an open invitation for contributions.

Team formulation was also considered in relation to a diagnostic approach; whilst diagnosis was seen as helpful at times, formulation was considered to encompass more and therefore be more helpful. Interestingly, neither diagnosis nor formulation alone was considered to be sufficient. The findings from the current study mirror the existing literature and demonstrate that 'psychosis' remains a contested area (Coles, 2010). In a critique of the use of a medical framework for mental health difficulties, Boyle (2007) distinguished the medical model as created for the physical body (body parts without language or emotions) and the difficulties of applying this to the complexities of human experience. However, the indication from the current study that formulation alone is not sufficient is in contrast to Bentall's claim that once everything is formulated there would be nothing further needing explanation (Bentall, 2003). Whilst the medical model, and associated diagnostic framework, offers participants certainty it could also be considered as somewhat reductionist; The BPS Division of Clinical Psychology argued that diagnosis 'misses the relational context of problems and the undeniable social causation of many such problems' (BPS, 2012). In contrast, team formulation was viewed in this research as less certain which made it feel less safe during times of crisis. However, staff also reported that its multiplicity permitted the generation of new ideas and a more critical stance.

Team formulation was seen as a way of embracing other ideas, rather than solely following a medical model, however there was a sense that formulation did not offer certainty that the medical model does, and therefore the latter was more helpful during times of 'crisis' when direction and certainty was sought. The notion of 'safe uncertainty' was introduced within the family therapy literature (Mason, 1993) and fits well with the findings from the current study. It explains how staff members seek 'safe certainty', which could be offered by the medical framework and diagnosis, during times of uncertainty and 'crisis'. It seemed that a less certain and more tentative position, such as that offered by formulation, was difficult to hold onto. However, within Mason's model, there is also the concept of 'authoritative doubt' which advocates the importance of balancing professional expertise with a degree of uncertainty. This concept is in keeping with the notion of 'diagnostic uncertainty'; one of the tenets of EI services when they were founded. However this appeared to be neglected during times of pressure and uncertainty.

5.2 The difference is valuable

Participants valued how team formulation enabled different perspectives to be considered within the team, this was spoken about in terms of the widening rather than narrowing of perspective. With the premise that the medical model is the dominant framework, in the current study this meant that participants only really brought cases with which they felt 'stuck', or for whom the medical model did not seem to be working, calling for something different to be tried. In this vein, formulation is offered as an opposite to the medical model, rather than being a more tentative position from which to explore different ideas including diagnosis. A phenomenological study found that when there was a discrepancy between service user's recovery goals and staff views

of the medical model, this provided a struggle for the service user in their unassisted pursuit of recovery (Stovell, et al. 2016). This suggests the importance of being able to hold different understandings of 'psychosis' in order to better support the service user.

The importance of having their own views heard was also a strength attributed to team formulation, and it was indicated that speaking up was not always easy or possible within other forums. These medical ideas seemed to be the default position within the EI teams, and there was a sense that it did not allow for any questioning or space to feel heard. Colombo et al. (2003) found that when service users did not 'buy into' the medical model of mental health difficulties, they felt disempowered and unable to challenge assumptions. This is parallel to how participants reported feeling within other MDT forums, and why they appreciated team formulation because differing views were encouraged.

Participants spoke about some of their anxieties relating to the client group and work, and how these emotions were contained within team formulation sessions. This self-reflection can be considered within the context of 'reflective practice'. Based on the model of reflective practice presented by Schon (1987), Lavender (2003) suggested that reflective practice involves four elements. *Reflection in action* happens during the process itself meaning the individual can think about what has been said and what could be said next. *Reflection on action* occurs after the event with the aim to turn experience into knowledge for future use. *Reflection about impact on others* requires consideration of the perspective of others. *Reflection about the self* encourages the examination of personal experiences and the interface of this with clinical work. Within the current study it was discussed how there was a shift from 'doing' to having the space to stop and reflect, demonstrating a similar process to the model of reflective practice proposed

by Schon (1987). Unadkat (2015) determined that staff members valued the opportunity within team formulation to 'slow down' and consider their clinical cases in more depth. Participants also spoke about team formulation as a useful vehicle for the practice of self-care. Within the current study it was found that team formulation offered a vehicle for self-reflection. Research into the role of compassion in 'psychosis' recovery asserted the importance of staff maintaining a self-reflective position. It indicated the importance of services developing their position as a safe base for service users during times of distress, but acknowledged that this can encourage the development of independence and could only be mediated through ongoing self-reflection (Gumley et al. 2010). Therefore the ongoing practice of self-reflection, such as that facilitated within team formulation, benefits staff members and also impacts on the wellbeing of service users.

Both subthemes of 'pour out the anxieties' and 'looking after ourselves' offer something different to the existing literature on the use of team formulation as a way of understanding and supporting service users, because it indicates that the MDT members involved gain support and comfort from them too.

5.3 Connection within the collective

This theme highlighted the importance of the 'team' aspect within team formulation. All participants spoke about the team working element to their job in a positive way, team formulation was seen as providing an opportunity for increased time spent with colleagues. However, there was talk about colleagues who work differently and do not perhaps value a formulation-based approach; potentially at times the provision of certain forums highlights these differences. Participants recognised that their job role could leave them feeling isolated at times, and that being with colleagues during team formulation was a positive experience. This forum provided an opportunity for shared

responsibility of risk, which seemed important to some participants. A key attribute of team formulation was considered to be the process of learning from other peoples' experiences.

It has been suggested that psychological formulation has the potential to improve working alliances (Wills & Sanders, 1997), and a critical literature review of formulation indicated that the same benefits were assumed to apply to team formulation (Cole, Wood & Spendelow, 2015). There was also expected to be improved communication and teamwork as a result of team formulation (DCP, 2011). Participants within a small-scale qualitative study reported that team formulation "helps the team bond" and "creates team ethos" (Allen, 2015). It has been considered whether some of the noted benefits of team formulation, such as increased contact with the team, pertain more to the process of being within the team rather than the formulation per se, and this has been considered elsewhere (Hollingworth & Johnstone, 2014). If having a space to reflect upon clinical work and team process is important for staff (Onyett, 2007); potentially team formulation sessions would fulfil a need that is otherwise missed within EI services. This meta-theme, and the sub-themes within it, supported the published guidelines on the use of formulation: supporting each other, valuing expertise of other staff, raising team morale, helping to manager risk and increasing reflectiveness (DCP, 2011).

5.4 The role of the Psychologist

The way that psychologists work continues to be under scrutiny and team formulation is a method through which psychologists can hope to influence care indirectly, thus potentially using their time more effectively (Onyett, 2007; British Psychological Society, 2002). Also a thematic analysis of clinical psychologists' experiences of

conducting formulation with MDTs indicated that participants considered team formulation to be beneficial (Christofides, Johnstone & Musa, 2012). Formulation was perceived as helping MDT members to better understand and relate to clients, and to help the MDT make changes. In support of this, the current study indicated that MDT members considered team formulation to be an important influence on their clinical work; an approach that would move away from a perception that formulation is a luxury rather than central to the role.

5.5 Strengths and limitations

The current research analysed accounts from eleven individuals, resulting in a broad range of perspectives. Participant accounts were analysed in detail using a clear and robust methodology. A semi-structured interview was facilitated by the researcher which permitted a broader discussion around the topic and did not restrict any information presented by the participant. The sample comprised a homogenous group and all were in the role of 'Care Coordinator' within EI teams. Demographic information was collected and discussed within analysis, within the confines of anonymity.

In terms of limitations, the research was conducted across two sites, restricting the transferability of findings. Transferability would have been boosted by the recruitment of further participants in the study, however this was limited due to the time constraints of conducting this piece of research. At the interview, seven of the participants explained being able to engage for a limited period of time only. Therefore it is possible that this reduced the amount of information that could potentially have been collected. It is important to recognise that all participants were self-selected, and therefore it is likely that those who were motivated to attend considered it valuable. The research highlighted a gap in the data from MDT members who had chosen not to attend team

formulation meetings within EI. All participants were aware that the researcher was a Trainee Clinical Psychologist and therefore this could have impacted on the largely positive feedback received. However, the researcher did aim to counteract any effects by actively seeking deviant cases through the re-reading of transcripts after initial themes had been generated. Points of difference were actively sought out and discussed between the researcher and a second analyst to enhance credibility (Elliott, Fisher & Rennie, 1999).

5.6 Clinical implications

The current study has several implications for clinical practice and these are drawn directly from the three main themes.

Team formulation offers a different perspective:

- It is known that a divide is created between staff and service users when their views differ (Stovell et al, 2016). Therefore, it is important for the team to hold a tentative position, such as that offered within team formulation, rather than imposing one perspective onto other staff and service users.

The difference is valuable:

- Lavender (2003) encouraged the use of reflective practice within teams for development of individuals and the collective. As such it would be helpful to build space in the team to encourage reflection, self-awareness and expression of emotion.
- Within mental healthcare teams, it was found to be effective when team members were permitted to question or disagree with ideas suggested (Lang,

1982). Therefore, it is suggested that EI teams encourage the opening up rather than closing down of ideas within their team forums and practice.

Connection within the collective:

- Increased contact with colleagues is known to be a factor in reducing occupational stress (Onyett & Smith, 1998). EI teams should provide opportunity for, and encourage, team members to sit together in different forums to encourage connection with others and reduce feelings of isolation.
- It has been established that there is a relationship between occupational stress and manifestations of stress in individuals (Maslach & Jackson, 1986). As such, it is important that staff are encouraged to care for their own wellbeing and to consider the interface between their clinical work and their personal self.

5.7 Future research

There was a notable absence of social workers and medics within the current study. Whilst it was entirely appropriate that they did not participate due to not attending the sessions, it does beg the question why they have not engaged. Potentially with the removal of social care from community mental health teams, the social workers no longer sit within the MDT and do not feel able to, or wish to, attend their activities. Whether psychiatrists see formulation as opposed to their practice of diagnosis is a hypothesis, although fundamentally the process of formulation is to draw on lots of different ideas. Further research could focus on exploring the views of those who do not engage with team formulation. Another group of people who attend the sessions are

unqualified members of staff and, although excluded from the current research project, it would be valuable to consider their perspectives in future research. The impact on practice was not focussed on within the current study; exploring this would be useful in consideration of the future delivery of, and engagement with, team formulation. Team formulation remains a relatively under researched topic area, despite the apparent prevalence of this way of working. Therefore the continued investment for research in this area will be crucial to build the evidence base and develop best practice guidelines.

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Part 3

CRITICAL APPRAISAL

1 Introduction

This critical appraisal offers a reflective account of the research process written with reference to a reflexive journal kept throughout the process. The account will follow the trajectory of the process from the generation of initial ideas, to the development of research methodology, data collection, data analysis and write up. Throughout the account, I will include my thoughts on lessons I have taken away from this process and how I would do things differently in the future. Please see Appendix R for a chronology of the research process.

2 Development of research area

2.1 Pre-training experience

I started clinical training with a range of clinical experience as an Assistant Psychologist and Healthcare Assistant and a feeling of self-confidence regarding my clinical skills. However I had limited experience of research and a limited understanding of the importance of conducting research. The only research experience I had was the dissertation I had undertaken as part of my undergraduate degree. I can recall with this a feeling of 'going through the motions', but I did not consider this work outside of the academic setting. Within my roles to that point I had carried out tasks that I had been told to do, and facilitated groups based on information gathered by others, therefore I had not yet really appraised or conducted research. Due to these reasons, research was the area of clinical training I felt most concerned about, particularly how I would ever reach the insurmountable heights of a doctoral level project.

2.2 Research development and supervision

My initial research idea (around the experiences of people in Intensive Care) did not work out beyond first year. I had a change in supervisors that I was unprepared for and it felt like I had to restart the whole research process again in second year. This felt difficult at times, especially when I was aware that others in my cohort were much further ahead than I was, but I recognised the importance of viewing this as my own research 'journey' and that helped me to maintain motivation.

At this time I was on a second year placement in an Early Intervention service which fit my clinical and research interests. My placement supervisor agreed to offer me

supervision on a new project within this clinical area. Seeing the dominance of the medical model within staff teams supporting those with 'psychosis', and the attempts of others to interject alternative ideas, I decided to focus my research here. When searching databases, I found limited research on team formulation, although this was clearly a growing area of interest (Johnstone & Dallos, 2014). I was aware that the Clinical Psychologist, in EI where I was based, facilitated team formulation sessions which were open to the whole multidisciplinary team (MDT) although I never attended myself (there is further information on my position in relation to the research in section 6 of this critical appraisal).

3 Developing the method

The type of research question that I was interested in dictated the use of a qualitative research method. I was concerned about using a qualitative methodology because I felt that there was an increased scope for me to analyse it incorrectly. Thematic analysis (TA) was a methodology that I had limited knowledge of, having used it for the first time last year for my small scale research project, for which I conducted a very brief analysis of the dominant things people said. I was initially keen to use Interpretative Phenomenological Analysis (IPA) as I knew that this would allow an in-depth exploration of a phenomenon. However the research question was less focused on the phenomenon of psychological formulation or 'psychosis' services, but rather on the associations made by MDT members, for which TA struck me as a way of searching for deeper meaning whilst staying systematic.

A criticism of TA has been that it is too general and simply an 'umbrella term' for numerous qualitative methods (Pistrang & Barker, 2012). However, it has been advocated as an intrinsically discrete methodology (Braun & Clarke, 2006; Joffe, 2011)

and was flexible enough to permit me to make my own decisions about how exactly I would use TA in the current study. I decided to adopt an inductive approach. I was unsure of where I would locate myself in terms of epistemology and valued the flexibility of this choice within TA. I soon realised that on the positivist – constructionist spectrum I aligned myself with the 'critical realist' position. I have placed value in the participant accounts of their experiences and viewed these accounts as a way to 'tap into' their beliefs which belies the element of 'realism'. However I also remained very aware of what I bring as a person and as a psychologist; how this context influenced what participants said and how I interpreted it. I kept a research journal throughout the process so I was able to reflect on this (further details of my own position as a researcher can be found in section 6 of this critical appraisal).

The process of 'setting up' the project, from the ethics forms, research proposals and seeking to gain 'buy in' from others took much longer than I had initially anticipated. If I were to do this again I would be starting from a different point having already been through this process, I would understand some of the tasks involved and plan for this more accurately in terms of planning my time and the research project.

4 Participants and data collection

4.1 Participants

I recruited participants from four separate EI teams across two NHS trusts. I considered endeavouring to recruit from a third trust, but stood by the reasons that I had initially limited recruitment to the two trusts; there were similarities between services and the provision of team formulation. Therefore I was interviewing a homogenous group of individuals, but rather than using a single team or trust, I could be sure that findings were not due to local circumstances; this strengthened the research.

From experience of running these sessions within multidisciplinary teams I am aware that they are not always as well attended as I would have hoped for, and that there has been limited representation from more medically trained colleagues. This was something that I felt unable to impact in terms of recruitment, due to the inclusion and exclusion criteria, however it was definitely a key point for consideration to help contextualise the results.

4.2 Interviews

Making the switch from 'clinician' to 'researcher' was new for me during the research process. This was not a switch that happened easily and I practiced my interviews with several peers prior to conducting a live research interview. This was helpful in building my own confidence with the topic guide, as well as thinking about how I ask questions and how I could be permitted to probe with a further prompt question rather than just reflect back what had been said to me. I really enjoyed the interview process because it was talking about things that both parties seemed interested in, and also the process of curiosity and finding more about people is what really attracts me to the profession.

I noticed early on that I wanted to build a rapport with, and be 'liked' by participants. I was also mindful of a desire to 'sell' psychological formulation to participants. This reminded me of previous encounters with colleagues in MDT meetings and wanting formulation to be seen in a positive light and helpful to others because I really believed it was worthwhile. This was something that I monitored closely within the research process and through the use of my reflective journal. Over the course of the eleven interviews I developed within my role as interviewer and became less pulled into the person I was talking to, but more focussed on what it was they were telling me. I was able to feel secure in the knowledge that my research interviewing skills were

developing, although perhaps not optimum, because the literature around qualitative research skills that suggested it was a 'lifelong endeavour' (Roulston et al, 2008).

I found my own affective responses interesting during the interviews. When participants spoke about how their roles could become quite isolative at times and how team formulation offered a forum for them to feel connected with others I felt empathy for holding them having to hold the risk independently, and for working in an isolative way when I could tell by being sat with them that they were sociable people. This was important as I acknowledged this in my reflective diary and instead of ignoring this felt able to actively use this in the analytic process.

Practical details, such as ensuring that I found a venue, booked rooms and had contact details for the participants were invaluable. I attended team meetings for each of the four teams and explained my research in brief. This helped to advertise the research project, gain familiarity with the physical environment and introduce myself to potential participants.

5 Data analysis

5.1 Transcribing

I had wanted to transcribe all of my interviews myself in order to fully immerse myself in the data. I transcribed the first interview myself and was surprised to learn that this was a very time consuming process. Being unfamiliar to this way of working, I needed to stop and start the recording many times and found it quite a frustrating process. I was glad that I completed data transcription for one interview in order to have that experience of this key part of the research process for myself. However, due to the time constraints of the DClinPsy I felt unable to complete all of the transcription and the employment of a professional service proved very helpful. Due to not transcribing all of

the audio data myself, I was concerned about the level of familiarity I would have with my data as I had planned to immerse myself in the data during transcription. I worked to ensure that I was still very familiar with the data by the following processes prior to formal analysis: conducting each interview myself; listening to audio recordings of each interview in full; checking audio recordings against transcripts.

5.2 Methodology

I have used TA previously on a very small scale research project. Reading and understanding the sheer quantity of data was difficult. I was concerned that the themes I pulled out would be based solely on the questions I asked. I had also considered using IPA for this project, it was attractive due to the small sample size and was a task well suited to the DClinPsy thesis. However the methodology was led by the research question; because I was less interested in the phenomenon of team formulation, but on the associations made by staff members, I knew that TA would maintain a methodical structure but permit me to explore some meaning.

5.3 Data analysis

Describing and reporting what was said seemed safe, but I had major apprehension about making interpretations of the data. It took me some time and struggling with confidence to feel able to find my voice in the analysis. I noticed a fear of taking a position within any of this, but I did. I found that when I was asked questions about my research in supervision and peer supervision I initially was very quiet, but quickly became stronger on my views in relation to research. I felt able to take more of a position and this developed further when I started the analysis process because I noticed my own views and decisions forming and this facilitated making a case during the

'write up' process. This was a process I enjoyed and was one of my favourite parts of the research process.

5.4 Supervision

The supervision that I had with my field supervisor was invaluable in the development of my ideas, particularly throughout the analysis and discussion sections. In the future, I would be clearer from the beginning regarding my own needs and level of support. I would also seek to create a contract between myself and my research supervisors to ensure a clear framework regarding which supervisor would oversee which section, give myself mini-deadlines for sections of the thesis, and set clear expectations for everyone from the outset.

6 Personal position

6.1 'Psychosis'

I was always aware of my own position as quite critical of the diagnostic framework for a set of experiences termed 'psychosis'. Throughout the write-up process I noted the unconscious tendency to use speech marks around 'psychosis' which seemed to signify an acknowledgment of the widely used name for these experiences, without feeling drawn into aligning with the labelling process myself. As such I was mindful to discuss in supervision the themes I generated around 'formulation vs diagnosis' as I was acutely aware of which side I related to. This supervision was helpful in allowing me to bracket off my own ideas and ensure that this theme derived directly from the data rather than solely being my own perspective.

6.2 Early Intervention

I was on placement within one of the EI teams for twelve months in my second year of training. This was really helpful for being aware of the running of team formulation sessions, although I did not attend any of them. This was helpful for me to maintain some distance from potential participants and the research, however highlighted to me the importance of being aware of my position in relation to the research. This is because I was not approaching this from the position of as 'outsider', rather I had been a part of the team which could have impacted my approach towards participants and their responses to me. I did not discuss the research with anyone or approach anyone for recruitment until approximately six months after I had left that placement. This allowed me to feel sufficiently 'removed' from the team and sure that I was limiting my influence based on my placement connection.

One of the participants in the research was someone that I briefly worked with when I offered some short-term psychological therapy to a client of hers. The client only engaged for a couple of sessions, so our paths crossed in a limited way and we did not become aware of much information about each other, or how the other person worked. For this reason I did not exclude this participant from the research because their input was valued, but I used my reflective diary to document how I felt before, during and after the interview with that participant and later, during the analysis, I was mindful about making assumptions based on this relationship. That transcript was one that I discussed in my qualitative peer supervision group and that was helpful to ensure that I was analysing it in a similar way to the others and stayed close to the data itself.

6.3 Burnout

Immersing myself in the field of burnout within mental health staff was interesting for me at a time of increased stress and pressure. As a trainee there is a tendency to feel

within a position of seeking constant validation and a desire to complete all tasks to a high standard. In particular, the process of undertaking this research project was extremely stressful. Reading about burnout and stress allowed me to see myself a little bit more objectively, and to wonder how I would notice when the 'inevitable stress' experienced as a trainee might tip into something unhelpful and impact my job satisfaction or lead me to burnout. It made me think about where I would take any concerns that I had, whether it would be okay to discuss this, or would I be judged critically for finding the training process so tough. I wondered if there is enough of a focus on this during the training phase of careers in mental health, and I suspected not. Further details relating to the future implications of this can be found in section 7 of this critical appraisal.

6.4 Confidence

The training process overall has highlighted for me a journey of the interface between knowledge and confidence. I started training feeling both very confident and knowledgeable but soon realised that there was a lot I did not know, which in turn impacted my confidence. I have now reached a position of feeling at ease with this and not feeling undermined by the gaps in my knowledge, but rather feeling confident enough with my existing expertise.

6.5 Role as a Trainee Clinical Psychologist

Reflecting on the training process overall, I am aware that what I have found most challenging has been the 'juggling' of competing demands: clinical placements, academic work, teaching and the thesis. Not to mention home life, personal relationships and hobbies. I have learned that I have a tendency to become inward-

looking during times of stress; this has impacted my effectiveness and relationships. This awareness helped me to pro-actively make connections with others and stop 'sticking my head in the sand'. The development of strong relationships has been fundamental to my 'survival' over the three years of the course, and I am sure that the development of good working relationships with colleagues will be key to a successful future career. This has helped me to build my own resilience and self-awareness, in the long term I feel that this will stand me in good stead against the stresses of work in the public sector and potential for burnout.

7 Implications and future focus

7.1 Why read my research?

Within the 'thesis guidelines' the question of why someone should bother to read my research struck a chord with me. Whilst I was concerned about not being 'academic' myself, I do thrive within the clinical environment and recognise that the two are not always mutually exclusive; the work of someone I might perceive as 'academic' shapes how I practice clinically. I approached my thesis very much from the position of a clinician and therefore wanted it to be something interesting and accessible to other clinicians. Formulation is the cornerstone of clinical psychology training, and often one of the key skills that is touted, therefore paying attention to how other disciplines understand this process is extremely important, as is thinking about how we can best use our skills and how we can look after ourselves, and others, at work.

7.2 Building on this research

As discussed within the body of the research report, I am interested in supporting staff for them to work more effectively within their roles and improve their wellbeing. I

strongly believe that we should care for those who we need to care for others. The findings around the importance of self-care struck me as being interesting within the context of my literature review regarding burnout within mental health professionals. I have reflected on how, in my role as a qualified Clinical Psychologist, I can support my colleagues in a bid to maintain their wellbeing and the efficacy of the team. This will be through the provision of team formulation sessions, offering reflective space and encouraging the holding onto of tentative positions within the team.

There is also self-compassion to think about too. This is an important tool to counteract burnout and improve wellbeing; inside and outside of the work environment. As a psychologist, as a person, I am determined to think about how I can support myself as well as my colleagues.

I was particularly interested in the finding from the research that staff members seek certainty, especially during times of crisis. Often as psychologists we purposefully hold a tentative position and I had previously considered this to be helpful, however after conducting this research I reconsidered that this may not always be the case. Whilst this will not necessarily influence my direct practice, it has undoubtedly added to rich reflections since. For example, whilst I have not been able to offer 'safe certainty' such as that sought from the medical framework, I have sought to explore the notion of 'authoritative doubt' with staff in my own clinical area (Mason, 1993).

7.3 Clinical Psychologists in research

Engagement with this research process has pushed me to consider the importance of continued investment in research as a qualified psychologist. This is fundamental to Psychology's position beyond direct therapeutic services. As someone who started this process because it was mandatory, this position surprised me initially, however it is

because I have found it to be important in the development of core skills. Permitting adding to the literature as well as taking from it, as we generally work within an 'evidence-based practice' framework.

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Appendix A: Publication identified for submission of literature review.

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· Review your submission (in HTML and PDF format) before sending to the Journal. Click the 'Submit' button when you are finished reviewing.

3.3 Manuscript Files Accepted

The text file must be anonymous, and must contain the entire manuscript including abstract, keywords, text, references, tables, and figure legends, but *no* embedded figures. Figure tags should be included in the file. The title page will be uploaded as a separate file from the main text to avoid identification of the author during the review process, and should contain title, short title, author names, qualifications, affiliations, and highlight the corresponding author details and email, and any acknowledgments. The text should be double spaced on A4 (or nearest equivalent) with wide margins (5cm/1in), leaving the right hand margin unjustified and turning the hyphenation off. Use tabs, not spaces, to separate the data in tables and ensure all pages are clearly numbered. Manuscripts should be formatted as described below.

Manuscripts should be uploaded as Word documents or Rich Text Format (.rft) files (not write-protected) and not as PDFs, plus separate figure files. GIF, JPEG, PICT or Bitmap files are acceptable for submission, but only high-resolution TIF or EPS files are suitable for printing. The files will be automatically converted to HTML and PDF on upload and will be used for the review process.

A covering letter/e-mail must also be included with each submission stating, on behalf of all the authors, that the work has not been published and is not being considered for publication elsewhere. It should also confirm the contact details and e-mail address of the correspondence author, in case there is a problem with the electronic file. All papers will then be peer-reviewed. Authors should ensure they keep an up-to-date copy of their paper for reference.

3.4 Blinded Review

Before peer review, all manuscripts are screened by the editors for their suitability for publication in the journal on the basis that they meet the criteria laid out in the Aims and Scope. Papers that pass the initial screening are assigned to an Editor and double-blind peer reviewed. The names of the reviewers will thus not be disclosed to the author submitting a paper and the name(s) of the author(s) will not be disclosed to the reviewers.

To allow double-blinded review, please upload your main manuscript and title page as separate files.

Exception to the double-blind rule
The editorial team requires that all clinical trials are registered in a publicly accessible registry. Registration of systematic reviews and observational studies is also actively encouraged. Reviewers are encouraged to check protocols as part of the review process and consequently

will be able to identify authors names and organisational affiliations. Registered studies will therefore be subject to single blind review (i.e. the reviewer may be aware of the name and affiliation of the author but reviewers will remain anonymous). The registration number should be supplied in the main body of the paper for example the methods section and can be obtained retrospectively. The title page should also be included in paper.

3.5 Suspension of Submission Mid-way in the Submission Process

You may suspend a submission at any phase before clicking the 'Submit' button and save it to submit later. The manuscript can then be located under 'Unsubmitted Manuscripts' and you can click on 'Continue Submission' to continue your submission when you choose to.

3.6 E-mail Confirmation of Submission

After submission you will receive an e-mail to confirm receipt of your manuscript. If you do not receive the confirmation e-mail after 24 hours, please check your e-mail address carefully in the system. If the e-mail address is correct please contact your IT department. The error may be caused by spam filtering software on your e-mail server. Also, the e-mails should be received if the IT department adds our e-mail server (uranus.scholarone.com) to their whitelist.

3.7 Manuscript Status

You can access ScholarOne Manuscripts any time to check your Author Centre for the status of your manuscript. The Journal will inform you by e-mail once a decision has been made.

3.8 Submission of Revised Manuscripts

Revised manuscripts must be uploaded within 1 month of authors being notified of conditional acceptance pending satisfactory revision. Locate your manuscript under 'Manuscripts with Decisions' and click on 'Submit a Revision' to submit your revised manuscript. Please remember to delete any old files uploaded when you upload your revised manuscript. Please also remember to upload your manuscript document separate from your title page. Any changes made to the new manuscript should be highlighted in red and not as track changes. You should also upload a file which outlines how you responded to the reviewers' comments.

4. MANUSCRIPT TYPES

Research and review papers:

The journal welcomes methodologically, ethically and theoretically rigorous original research (primary or secondary) which adds new knowledge to the field and advances the development of policy and practice in psychiatric and mental health nursing. We will consider research papers of up to 5,000 words and review papers of up to 7,000 words. The decision on the final word count rests solely with the Editor and Associate Editors.

Consumer and practitioner narratives:

As part of its mission to facilitate the translation of research into psychiatric and mental health nursing practice and give space to practitioner and consumer perspectives, *JPMHN* aims to engage with and be relevant to all those who are involved in the development of mental health knowledge, policy and practice. The journal therefore welcomes consumer and practitioner narratives which have the potential to improve mental health nursing practice and/or advance knowledge.

The narrative can be authored by a single person concerning their own experience, or jointly, for example, one person relating their own experience and another person providing context and analysis. In either case, the paper should contextualise the experience with reference to relevant literature (in the arts and/or the sciences) and answer the following questions: how does this experience fit within the context of the literature and how does it inform other consumers, practitioners or researchers?

Joint authors of consumer narratives should ensure that there is a genuine and equal collaboration, and that the contextualisation and analysis avoids any interpretation of someone else's experience that has not been validated with that person.

This section will be subject to full double blind peer review. Papers must contribute to theoretical, conceptual, or methodological knowledge, and/or practice development. There is no need to provide an abstract, however an accessible summary is required (See MANUSCRIPT FORMAT AND STRUCTURE section 5.2). No more than 10 references are allowed. We will consider papers of up to 5000 words. The decision on the final word count rests solely with the Editor and Associate Editors.

Letters to the Editor

Purpose

• To provide readers of the journal with a mechanism for submitting comments, questions or criticisms about published articles as well as brief reports and commentary unrelated to previously published articles.
• To respond to a paper recently printed in the Journal.
• To share an alternate point of view to a paper recently published in the Journal.
• To draw readers' attention to new evidence or other issues relevant to the Journal aims.
• To comment on newly released guidelines / legislation changes / significant reports.

Guidelines

• Keep your points simple and focused;
• Avoid personal comments about the authors;
• Provide evidence to support your position;
• You need to reference the points you make in the same way you would in a research paper.
• Correspondence may be edited for length and grammatical correctness. Authors will be asked to approve editorial chances prior to publication.
• Letters responding to articles published in the JPMHN will normally only be considered if they are submitted within six months of the papers online publication date. We will inform authors if a letter relating to their paper (if it is published in the JPMHN) is going to be published and give them the opportunity to respond. Authors of papers discussed in correspondence will be given an opportunity to respond (normally in the same issue) in which the original correspondence appears.

Essays and Debates in Mental Health

Purpose

• To explore a contemporary topic relevant to mental health nursing practice/service user care.
• To provide a rigorously developed theoretical perspective on a topic relevant to the Journal aims.

Guidelines

• A scholarly paper providing a new perspective, debating a contemporary issue, or introducing innovative practices:
    o Presented as a well-structured argument/ scholarly exploration delivered in a coherent and systematic style.
    o Clearly related to the aims of the Journal.

- o A broad understanding of relevant literature is demonstrated.
- o Well-developed integration of ideas and concepts.

• The topic should be of international relevance and be written in clearly expressed English.
• There is no need to include an accessible summary or abstract, however, authors should provide and introductory paragraph which sets out the purpose of the article.
• Word length between 3-5,000 words.

5. MANUSCRIPT FORMAT AND STRUCTURE

5.1 Format

Language: The language of publication is English. Authors for whom English is a second language must have their manuscript professionally edited by an English speaking person before submission to make sure the English is of high quality. It is preferred that manuscripts are professionally edited. Visit our site to learn about the options. Please note that using the Wiley English Language Editing Service does not guarantee that your paper will be accepted by this journal.

5.2 Structure

All original studies and reviews of the evidence submitted to Journal of Psychiatric and Mental Health Nursing should include:

Relevance Statement: Only papers relevant to mental health nursing practice will be considered for publication in the Journal of Psychiatric and Mental Health Nursing. We require that corresponding authors submit a statement that-in 100 words or fewer, sets out the relevance of the work to mental health nursing practice. If authors do not convince the Editor in Chief of this, the work will not be considered for publication.

Title page: This should give: the title of the article, the names and initials of each author, their qualifications, the department and institution to which the work should be attributed, the name, address, and telephone numbers of the author for correspondence, and a short title of 40 characters or less if the paper title exceeds this limit, and any Acknowledgments.

Abstract: The abstract should be less than 200 words in length and should be followed by six keywords in alphabetical order for indexing purposes. You should as far as possible use the following structure for research papers: Introduction; Aim/Question; Method; Results; Discussion; Implications for Practice. For consumer and practitioner narratives this should be: Introduction; Aim; Methods (if applicable); Thesis; Implications for Practice

Optimizing Your Abstract for Search Engines

Many readers looking for information online will use search engines such as Google, Yahoo or similar. By optimizing your paper for search engines, you will increase the chance of someone finding it. This in turn will make it more likely to be viewed and/or cited in another work. We have compiled these guidelines to enable you to maximize the web-friendliness of the most public part of your paper.

Accessible summary: In keeping with the aims and scope of *JPMHN* authors are required to include an easy-to-read summary of their papers as part of their submission. This is in the spirit of making research findings more accessible to non-academics, including users of mental health services, carers and voluntary organisations. It should also make scanning the Journal contents easier for all readers. The Accessible Summary should be structured under the following

headings, with 1-2 bullet points under each:
- What is known on the subject
- What this paper adds to existing knowledge
- What are the implications for practice

Authors are asked to:
• Limit the summary to less than 250 words in total
• Express ideas in straightforward language
• Explain the importance of the paper's findings for a non-specialist audience.

Main text: This should begin on a separate page. Authors should follow established guidelines for their study design where these exist/apply:
• Randomised controlled trials: CONSORT checklist and flow diagram
• Non-randomised controlled trials: TREND checklist
• Observational research: STROBE checklists
• Systematic review and meta-analyses: PRISMA checklist and flow diagram
• Qualitative studies: COREQ checklist
• Quality improvement: SQUIRE checklist

Where there are no established guidelines for the study design, please use the same headings as the abstract.

Abbreviations should be written in full at the beginning of a sentence. Footnotes should be avoided. Spellings should conform to those used in the Concise Oxford Dictionary. SI units should be used throughout and authors should refer to Units, Symbols and Abbreviations published by the Royal Society of Medicine.

Information on CONSORT:
Journal of Psychiatric & Mental Health Nursing requires a completed CONSORT 2010 checklist and flow diagram as a condition of submission when reporting the results of a randomized trial. Templates for these can be found here or on the CONSORT website which also describes several CONSORT checklist extensions for different designs and types of data beyond two group parallel trials. At minimum, your article should report the content addressed by each item of the checklist. Meeting these basic reporting requirements will greatly improve the value of your trial report and may enhance its chances for eventual publication.

5.3 References

Please ensure that references in the text exactly match those in the manuscript's reference list. If editing sections of text please ensure that any references that are affected are amended accordingly in the reference list.

In the text, cite the authors' names followed by the date of publication e.g., Bowers & Thompson (2013). Where there are three or more authors, the first authors name followed by *et al*. will suffice, e.g. Kennard *et al*. (2012). Where more than one reference is cited they should be listed in chronological order. Authors should use the examples given below for referencing style. References to personal communications or unpublished results should be in the text only i.e. (A.C. Bowers & J.M. Thompson pers. comm.) or (A.C. Bowers unpublished results).

The editor and publisher recommend that citation of online published papers and other material should be done via a DOI (digital object identifier), which all reputable online published material should have - see www.doi.org/ for more information. If an author cites anything which does not have a DOI they run the risk of the cited material not being traceable.

5.4 Tables, Figures and Figure Legends

Figures and tables should be numbered consecutively and their positions indicated clearly in the text. Each should have an appropriate caption or legend that clearly describes it. In the full-text online edition of the journal, figure legends may be truncated in abbreviated links to the full screen version. Therefore, the first 100 characters of any legend should inform the reader of key aspects of the figure. Illustrations should be referred to in the text, e.g. as Fig. 1, Fig. 2, etc., in order of appearance.

Preparation of Electronic Figures for Publication

Although low quality images are adequate for review purposes, print publication requires high quality images to prevent the final product being blurred or fuzzy. Submit EPS (line art) or TIFF (halftone/photographs) files only. MS PowerPoint and Word Graphics are unsuitable for printed pictures. Do not use pixel-oriented programmes. Scans (TIFF only) should have a resolution of at least 300 dpi (halftone) or 600 to 1200 dpi (line drawings) in relation to the reproduction size (see below). Please submit the data for figures in black and white or submit a Colour Work Agreement Form (see Colour Charges below). EPS files should be saved with fonts embedded (and with a TIFF preview if possible).

For scanned images, the scanning resolution (at final image size) should be as follows to ensure good reproduction: line art: >600 dpi; halftones (including gel photographs): >300 dpi; figures containing both halftone and line images: >600 dpi.

Further information can be obtained at Wiley's guidelines for figures

Check your electronic artwork before submitting it:
http://authorservices.wiley.com/bauthor/eachecklist.asp

6. AFTER ACCEPTANCE

Upon acceptance of a paper for publication, the manuscript will be forwarded to the Production Editor who is responsible for the production of the journal.

6.1 Proof Corrections

The corresponding author will receive an e-mail alert containing a link to a website. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site.

Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following website: www.adobe.com/products/acrobat/readstep2.html . This will enable the file to be opened, read on screen, and printed out in order for any corrections to be added. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available; in your absence, please arrange for a colleague to access your e-mail to retrieve the proofs.

Proofs must be returned to the typesetter at charliehuang@toppanleefung.com within three days of receipt. Please note that if you have registered for production tracking e-mail alerts in Author Services, there will be no e-mail for the proof corrections received stage

Appendix B: Search terms and combinations across each database.

PsycINFO	Psychiatric Nurses (MM) OR "community mental health" AND Occupational Stress (MM) (includes burnout; stress; work-life balance etc) OR Compassion Fatigue (MM) OR "secondary trauma" OR Distress (MM) OR Job Satisfaction (MM) OR "Resilience (psychological)" (MM). Limits: Peer reviewed; English language.	21,613 40,704 Total when combined with AND = 364 Limits applied: **262**
Web of Science Core Collections	"psychiatric nurs*" OR "community mental health" AND "burnout" OR "compassion fatigue" OR "stress" OR "distress" OR "job satisfaction" OR "resilience" OR "secondary trauma" OR "wellbeing" Limits: Articles; English language.	6,775 1,409,548 AND= 673 Limits: **597**
Medline	Psychiatric Nursing/ OR Community Mental Health Services/ AND Burnout, Professional/ OR Job Satisfaction/ OR Compassion Fatigue/ OR Resilience, Psychological/ OR Stress, Psychological/ "secondary trauma" OR "wellbeing" Limits: English language; Journal Articles.	32,411 129,529 1,112 Limits: **958**

Key: MM= major concept; /=concept 'exploded'; ""=exact term searched; otherwise, heading searched.

Appendix C: Reasons for excluding papers.

Author and year	Title	Reason for exclusion
Billings et al. (2003)	Assertive outreach teams in London: staff experiences and perceptions.	The study focussed on all clinical staff and did not separate out responses from nursing.
Brooker et al. (1999)	Evaluating clinical outcome and staff morale in a rehabilitation team for people with serious mental health problems.	The setting was a 24 hours care facility rather than community working.
Buunk et al. (2001)	Affect generated by social comparisons among nurses high and low in burnout.	The study focussed on nurses in hospital settings, rather than the community.
Burnard et al. (2000)	Community mental health nurses in Wales: self-reported stressors and coping strategies.	The study did not utilise quantitative methodology.
Cao et al. (2015).	Effect of professional self-concept on burnout among community health nurses in Chengdu, China: the mediator role of organisational commitment.	The sample comprised community nurses working in physical, rather than mental, health.
Coffey (1999)		The paper focussed on a forensic population, so no data on community mental health nurses provided.
Dolan (1987)	The relationship between burnout and job satisfaction in nurses.	The study made comparisons between two groups of participants, so no data on community mental health nurses provided.
Edwards et al. (2000)	Stressors, moderators and stress outcomes: findings from the All-Wales Community Mental Health Nurse Study.	Reported the scores for All Wales stress study, but no further analysis was undertaken.
Fothergill et al. (2000)	Self-esteem in community mental health nurses: findings from the all-Wales stress study.	This paper was part of a larger study, two paper for which are included in the current review. The analysis within this paper focussed on self-esteem rather than stress or burnout, therefore was omitted from the current review.
Happell et al. (2003)	Burnout and job satisfaction:	The study included nurses

	A comparative study of psychiatric nurses from forensic and a mainstream mental health service.	from across sectors and settings, including inpatient, so data for community nurses was not available.
Green et al. (2013)	Transformational Leadership Moderates the Relationship Between Emotional Exhaustion and Turnover Intention Among Community Mental Health Providers	The focus of the study was in programs rather than individuals.
Hamaideh (2011)	Burnout, social support, and job satisfaction among Jordanian mental health nurses.	It is unclear whether the sample is solely community based mental health nurses, or whether the sample also comprises inpatient staff, but "ward type" was referenced.
Hamaideh (2012)	Occupational stress, social support and quality of life among Jordanian mental health nurses	It is unclear whether the sample is solely community based mental health nurses, or whether the sample also comprises inpatient staff.
Hanrahan et al. (2010)	Relationship between Psychiatric Nurse Work Environments and Nurse Burnout in Acute Care General Hospitals.	The sample comprised psychiatric nurses working in inpatient units; community mental health nurses were not included.
Johnson et al. (2012)	Morale in the English mental health workforce: questionnaire survey.	No separation of teams or settings so the data was pooled; data for community mental health nursing was not presented separately.
Kilfedder et al. (2001)	Burnout in psychiatric nursing.	The pooled data included participants in the hospital and community settings; data for community mental health nursing was not presented separately.
Lasalvia et al. (2009)	Influence of perceived organisational factors on job burnout: survey of community mental health staff.	The sample was community mental health staff as a whole; data was not presented separately for CMHNs.
Levert, Lucas & Ortlepp (2000)	Burnout in psychiatric nurses: Contributions of the work environment and a Sense of Coherence.	The sample comprised of psychiatric nurses from inpatient units; there was no data for community nurses.
Mann & Cowburn (2005)	Emotional labour and stress within mental health nursing.	The focus was on nurses working in inpatient units, rather than community.
Nelson et al. (2009)	Satisfaction and burnout among staff of crisis	The study focussed on the MDT as a whole, data for

	resolution, assertive outreach and community mental health teams.	nursing was not presented separately.
Onyett (1997)	Job satisfaction and burnout.	Analysis was on the differences between different professional disciplines.
Parry-Jones (1998)	Stress and job satisfaction among social workers, community nurses and community psychiatric nurses: implications for the care management model.	The sample of CPNs within the study were taken from across mental health, learning disabilities and older peoples services. The focus of the study was on comparisons between CPNs and other disciplines.
Pompili (2006)	Hopelessness and suicide risk emerge in psychiatric nurses suffering from burnout and using specific defense mechanisms.	Nurses were recruited from across a range of public and private clinics, therefore it was unclear where the 'psychiatric nurse' sample came from.
Prosser (1996)	Mental Health, 'Burnout' and Job Satisfaction among Hospital and Community-Based Mental Health Staff.	The study was about MDTs as a whole and the data was pooled: data for nursing was not presented separately.
Prosser (1997)	Perceived sources of work stress and satisfaction among hospital and community mental health staff, and their relation to mental health, burnout and job satisfaction.	The study was about MDTs and the data was pooled: data for nursing was not presented separately.
Prosser et al. (1999)	Mental health, ``burnout'' and job satisfaction in a longitudinal study of mental health staff.	The paper considered MDTs as a whole and the data was pooled: data for nursing was not presented separately.
Salyers & Bond (2001)	An Exploratory Analysis of Racial Factors in Staff Burnout Among Assertive Community Treatment Workers.	The study did not just use nursing staff, but rather a range of staff within the single category of "case managers"; data for nursing was not presented separately.
Singh, Cross & Jackson (2015)	Staff Burnout - a Comparative Study of Metropolitan and Rural Mental Health Nurses within Australia	Did not separate out the hospital-based and community nurses.
Sullivan (1993)	Occupational stress in psychiatric nursing.	The sample solely comprised psychiatric nurses working in inpatient settings, and not the community.
Thomsen (1999)	Individual and organizational well-being in psychiatric	Did not separate out the clinic-based and community

	nursing: a cross-cultural study.	nurses.
Wykes et al. (1997)	Stress in community care teams: will it affect the sustainability of community care?	The focus was on MDTs and the data was pooled; data for nursing was not presented separately.
Webster & Hackett (1999)	Burnout and leadership in community mental health systems.	The focus was the entire MDT and data was pooled; data for nursing was not presented separately.
Ward & Cowman (2007)	Job satisfaction in psychiatric nursing.	The focus of the study was to compare community and inpatient mental health nurses, and the data was pooled; data for nursing was not presented separately.
Yada et al. (2014).	Differences in job stress experienced by female and male Japanese psychiatric nurses	The sample was taken from nurses in hospital settings.

Appendix D: PRISMA flowchart of the search process.

Process	No. of papers left at each stage.
Scoping literature search to identify area and help form question.	
↓	
Systematic literature search using the databases and search terms listed in Appendix A.	1,817
↓	
326 duplicate papers were excluded.	1,491
↓	
Titles of 1,491 papers were screened. Any titles not meeting the inclusion criteria were excluded.	131
↓	
Abstracts of 131 papers were read. Any abstracts not meeting the inclusion criteria were excluded.	32
↓	
Reference lists were checked for additional papers	34
↓	
All articles sourced from the library at the University of Leicester.	
↓	
34 papers were read in full. Any articles that did not meet the full inclusion criteria were excluded.	9
↓	
Quality appraisal and data extraction.	

Appendix E: Downs and Black data extraction form (revised).

Data Extraction Form

Authors and year	
Study Title	
Journal	
Study design	
Participants	*N*: *Age*: *Sex:* *Ethnicity*:
Other demographic information collected	
Setting	
Method of recruitment of participants	
Aim of study	
Constructs measured e.g. burnout	
Person measuring/reporting e.g self report	
Measures used	
Are outcome tools validated	
Participation rate	
Missing data reported?	
Statistical Analysis e.g correlational/ regression	
Significant burnout findings	
Non-significant burnout findings	
Limitations/ strengths of study	
Other comments	

Appendix F: Thompson and McCabe quality appraisal criteria.

1) Reporting	Do studies provide a clear description of aims, outcomes, characteristics of patients, findings and actual probability values?	(Total/5)
2) External validity	Are those patients asked to participate in the study representative of the entire population from which they were recruited? Patients would be representative if they consisted of the entire source population, an unselected sample of consecutive patients, or a random sample	(Total/1)
3) Internal validity	Are the statistical tests used to measure the outcomes appropriate? Are both adherence and alliance/communication measures validated and reliable? Was there adequate adjustment for confounding in the analyses from which the findings were drawn?	(Total/3)
4) Study design	To what extent can the study identify causality? Scores differentiate between cross sectional, prospective/longitudinal and experimental designs	(Total/2)

Appendix G: Ethical approval

University of Leicester

University Ethics Sub-Committee for Psychology

24/11/2015

Ethics Reference: 3229-js732-neuroscience,psychologyandbehaviour

TO:
Name of Researcher Applicant: Jennifer Sica
Department: Psychology
Research Project Title: Multidisciplinary team membersâ€™ experiences of team formulation: A thematic analysis.

Dear Jennifer Sica,

RE: Ethics review of Research Study application

The University Ethics Sub-Committee for Psychology has reviewed and discussed the above application.

1. Ethical opinion

The Sub-Committee grants ethical approval to the above research project on the basis described in the application form and supporting documentation, subject to the conditions specified below.

2. Summary of ethics review discussion

The Committee noted the following issues:
I approve this application

3. General conditions of the ethical approval

The ethics approval is subject to the following general conditions being met prior to the start of the project:

As the Principal Investigator, you are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Research Code of Conduct and the University's Research Ethics Policy.

If relevant, management permission or approval (gate keeper role) must be obtained from host organisation prior to the start of the study at the site concerned.

Research & Development
Investigating the Future, Today

Leicestershire Partnership NHS
NHS Trust

A University Teaching Trust

Research & Development
Swithland House
352 London Road
Leicester
LE2 2PL

[redacted]

Fax: 0116 295 8311
Web: www.leicspt.nhs.uk

DC/JS/PSYC0752/191056

14th December 2015

Miss Jennifer Sica
c/o University of Leicester
104 Regent Road
Leicester
LE1 7LT

Dear Jennifer Sica

RE: Multidisciplinary team members' experiences of team formulation: A thematic analysis.

Study Codes:			
Local Trust Reference:	PSYC0752	IRAS ID:	191056
CSP Reference:	N/A	Portfolio ID:	N/A
Study Sponsor:	Leicestershire Partnership NHS Trust		

I am happy to confirm that Leicestershire Partnership NHS Trust is able to undertake the duties of SPONSOR in relation to the above-named study. This study is primarily being conducted for "educational purposes" in pursuit of a Clinical Psychology Doctorate, and therefore primary supervisory responsibility rests with University of Leicester staff as part of a delegated responsibility from the main Sponsor.

This sponsorship approval is subject to the accuracy of the following information:

Study Summary			
Chief Investigator (Supervisor):	Dr Noelle Robertson		
Principal Investigator (Local):	Miss Jennifer Sica		
Other Investigators (Local):	Dr Jon Crossley		
Indemnity Provider:	Leicestershire Partnership (NHS Indemnity)	Start Date (Local)	16/12/2015
NIHR Portfolio:	No	End Date (Local)	23/09/2016
Student Project	Yes	Target Recruitment	15 (Staff Only)
Funding Source:	N/A	Amount:	N/A
Local NHS Support Costs:	N/A		
Clinical Sites	[redacted]		

I hope the project goes well, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Kind regards

Dr. Dave Clarke [Operational Lead: Research & Development]

C.C. To whom it may concern.

Northamptonshire Healthcare NHS
NHS Foundation Trust

Research and Development
Carey Block
ST Mary's hospital Kettering,
Northamptonshire
NN15 6XR

Direct Di[redacted]

5th January 2016

Miss Jennifer Sica
c/o University of Leicester
104 Regent Road
Leicester
LE1 7LT

Dear Miss Sica

I am pleased to confirm that with effect from the date of this letter, the above study now has Trust Research & Development permission. You can now commence your research activities in Northamptonshire Healthcare NHS Foundation Trust in accordance to the agreed protocol and the Research Governance Framework.

Title	Multidisciplinary team members' experiences of team formulation: A thematic analysis.
NHFT Ref:	R261
Start date	05/01/2016 **End date: 23/09/2016**

If you have any questions regarding this, or other research you wish to undertake in the Trust, please contact this office. We wish you every success with your research.

Please be aware that any changes after approval may constitute an amendment. The process of approval for amendments should be followed. Failure to do so may invalidate the approval of the study at this trust

Yours sincerely

Leanne Holman

Research and Development Manager

Appendix H: Participant information sheet

Version 2

University of Leicester

PARTICIPANT INFORMATION

You are being invited to take part in a research study. In order to help you decide whether you would like to participate or not, please take time to read the following information carefully.

Multidisciplinary team members' experiences of team formulation: A thematic analysis.

What is the purpose of the study?

Clinical psychologists use psychological formulation as a framework to understand cases and these ideas are often shared with multidisciplinary colleagues. The study aims to explore the how non-psychology professionals describe their experience of psychological formulation within specialist teams for first-episode psychosis. The study is being conducted as part of the researcher's Doctoral Degree in Clinical Psychology at the University of Leicester.

Why have I been invited to take part?

You have been approached to take part in the study, as you are a mental health professional who routinely works in a specialist team for first-episode psychosis. I am interested in hearing about the experiences of currently practicing professionals who have had direct contact with people experiencing psychosis and their families whilst engaging with psychological formulation from a clinical psychologist.

Do I have to take part?

Participation in the study is entirely voluntary. If you do agree to take part, you can withdraw at any time prior to and during the interview. You may also withdraw up to one month following the interview. You will not be asked to provide a reason for your withdrawal from the study.

What are the disadvantages and the benefits?

It is possible, though unlikely, that the issues talked about in the interview may be difficult for you. Following the interview you will be advised of how to seek support should you need to. There will be no financial gains for taking part in the study but you will be reimbursed for any travel expenses.

What is involved?

If you choose to take part in the study you will be asked to read and sign a consent form stating that you agree to participate. You will then be invited to attend a one-to-one interview at a mutually convenient time and place. The researcher will ask questions relating to your experiences of psychological

formulation. It is expected that the interview will last approximately 60 minutes. The interview will be audio recorded.

What happens to the information?

Everything that you say within the interview will remain confidential.

Each participant's data will be assigned a numerical code which will be used to link the consent form and audio recording to the anonymised interview transcript. Data will be kept in locked filing cabinets and on password-protected computers.

All interviews will be anonymised during transcription. As this is a qualitative study, some direct quotations from participants will be used in the final write up of the research but will not include any identifiable information (e.g. names) and may only be accompanied by basic demographic information (e.g. gender or bracketed ranges for 'years since qualification').

Any information regarding the specific service a participant works in, service structure, trust policies or any other information with the potential to affect anonymity will be modified in a manner that protects anonymity whilst maintaining the integrity of the data. Only the researcher, research supervisor and University of Leicester examiners will have access to the completed interview transcripts.

The recordings and transcripts will be destroyed within five years, as per University of Leicester protocol. Confidentiality will be discussed prior to commencing the interview and will only be broken in the unlikely event of serious concern about the safety of yourself or others.

Who has reviewed the study?

The current study was approved by the University of Leicester research ethics committee. The Research and Development department within the Leicestershire Partnership NHS Trust has also reviewed and agreed to sponsor the study.

Contact details

Thank you for taking the time to read this leaflet. The contact details of the researcher are included below.

Principal researcher

Jennifer Sica (Trainee Clinical Psychologist)

Email: js732@le.ac.uk

Phone: 0116 223 1639

Address: University of Leicester, Clinical Psychology, 104 Regent Road, Leicester, LE1 7LT.

Appendix I: Participant consent form.

Version 2

University of Leicester

PARTICIPANT CONSENT FORM

BACKGROUND INFORMATION

Title: Multidisciplinary team members' experiences of team formulation: A thematic analysis.

Researchers: Jennifer Sica, University of Leicester, School of Clinical Psychology.

Purpose of data collection: Doctoral research project.

Details of Participation:
CONSENT STATEMENT

1. I understand that my participation is voluntary and that I may withdraw from the research at any time up until one month after my interview without giving any reason.

2. I am aware of what my participation will involve.

3. I have had the opportunity to ask questions.

4. I understand that other researchers involved in the research project will have access to the anonymised data, following all of the restrictions placed on the project in terms of confidentiality

5. My data will be kept securely for a period of at least five years after the appearance of any associated publications.

6. I understand that brief interview excerpts, in the form of anonymised quotations, will be used in the final write-up of the project.

7. The overall findings may be submitted for publication in a scientific journal, or presented at scientific conferences.

8. This study will take approximately twelve months to complete.

I am giving my consent for data to be used for the outlined purposes of the present study

All questions that I have about the research have been satisfactorily answered.

I agree to participate.

Participant's signature: _____

Participant's name (please print): _____

Date: _____

If you would like to receive a summary of the results when the study is complete please provide your email address: _____

If you have further questions about this study, you may contact ***researcher's name and contact information***. This study was reviewed by the University of Leicester Psychology Research Ethics Committee (PREC). You may contact the Chair of PREC Professor Mark Lansdale at ml195@le.ac.uk if you have any questions or concerns regarding the ethics of this project.

Please note that this form will be kept separately from your data

Appendix J: Interview topic guide.

Version 2

University of Leicester

TOPIC GUIDE

Initial Questions

How long have you worked within the Early Intervention team?

What is your professional discipline?

How long have you been in this role?

Have you trained in a psychological therapy? Or training in psychological formulation?

Formulation

Have the formulations been helpful? How?

What's been less helpful? How?

How could things have been different? What do you think that would be like?

What type of client have you brought to the meeting? Why?

Who have you not brought to the meeting? Why?

Difference

What have you been able to do with the ideas gained within the meeting? With the client? With families? With the team? What was that like? How has that been different to what you might have done?

How has formulation been different to other ideas, such as diagnosis?

How have you felt about that as a professional? Similar or different to previous stance? Do the two sit together or separately?

What has the impact of that been?

Team

What is it like to have these meetings as part of an MDT? For you? For the team?

Why have you attended these meetings? What motivates you?

Structure

Has it been helpful to have something written down or the process of discussion itself? What about that has been helpful?

What can you tell me about the role the psychologist takes within the meeting? What is that like?

What can you tell me about the different ideas or models that are drawn on? Are some of these more helpful than others? Were some of these known to you before these meetings? Are there psychological ideas you have learned from the meetings?

Appendix K: Researcher's epistemological position.

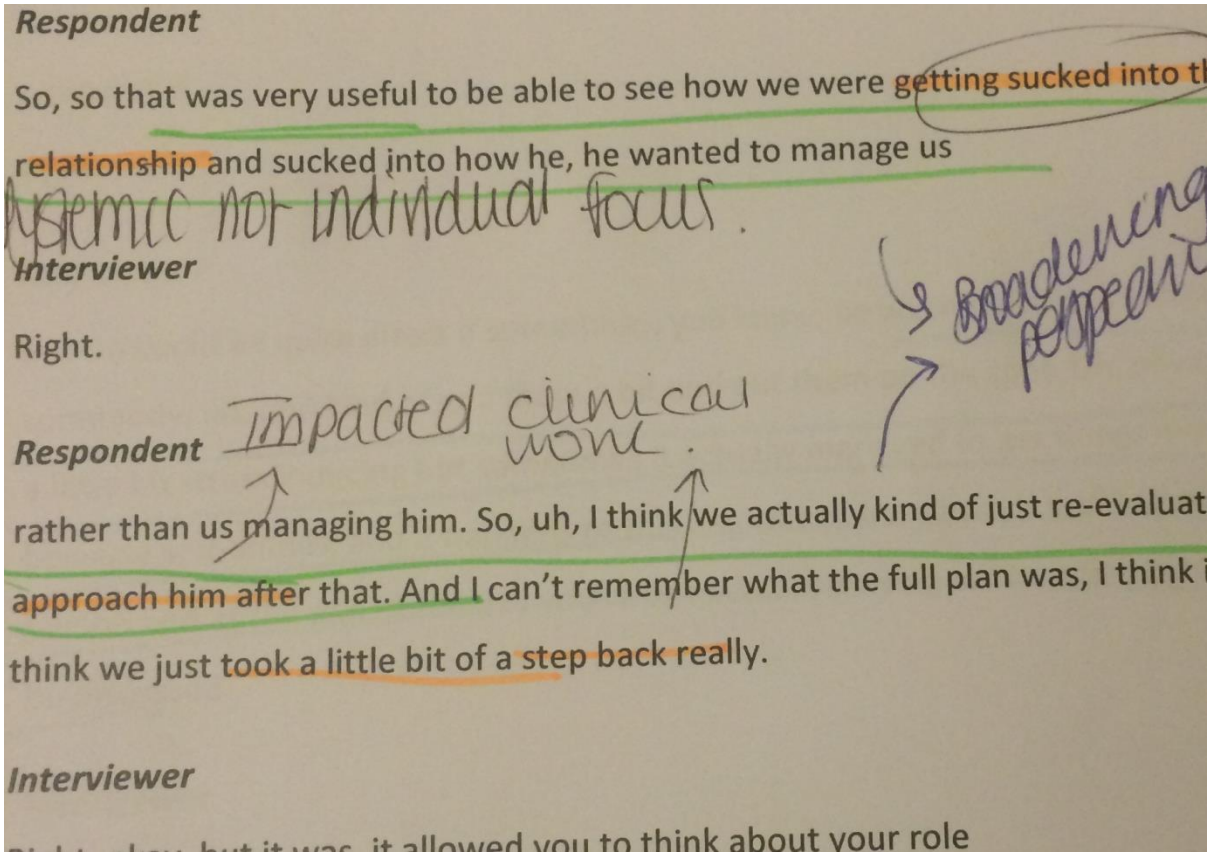
Epistemologically, the researcher assumed a critical realist position; acknowledging that observable phenomena is constructed through pre-existing mechanisms and concurrent sense-making by the individual. This position also allowed the researcher to acknowledge their own active role within the research process, rather than claiming a detached and objective position.

In the present study this translated to an awareness of the external forces on the MDT members (service structure and clinical guidelines) as well as the construction of their own reality through language, attitudes and beliefs. Bergin and Wells (2010) argued that adopting a critical realist position facilitates a deeper understanding of the data through consideration of the 'real', 'actual' and 'empirical' elements.

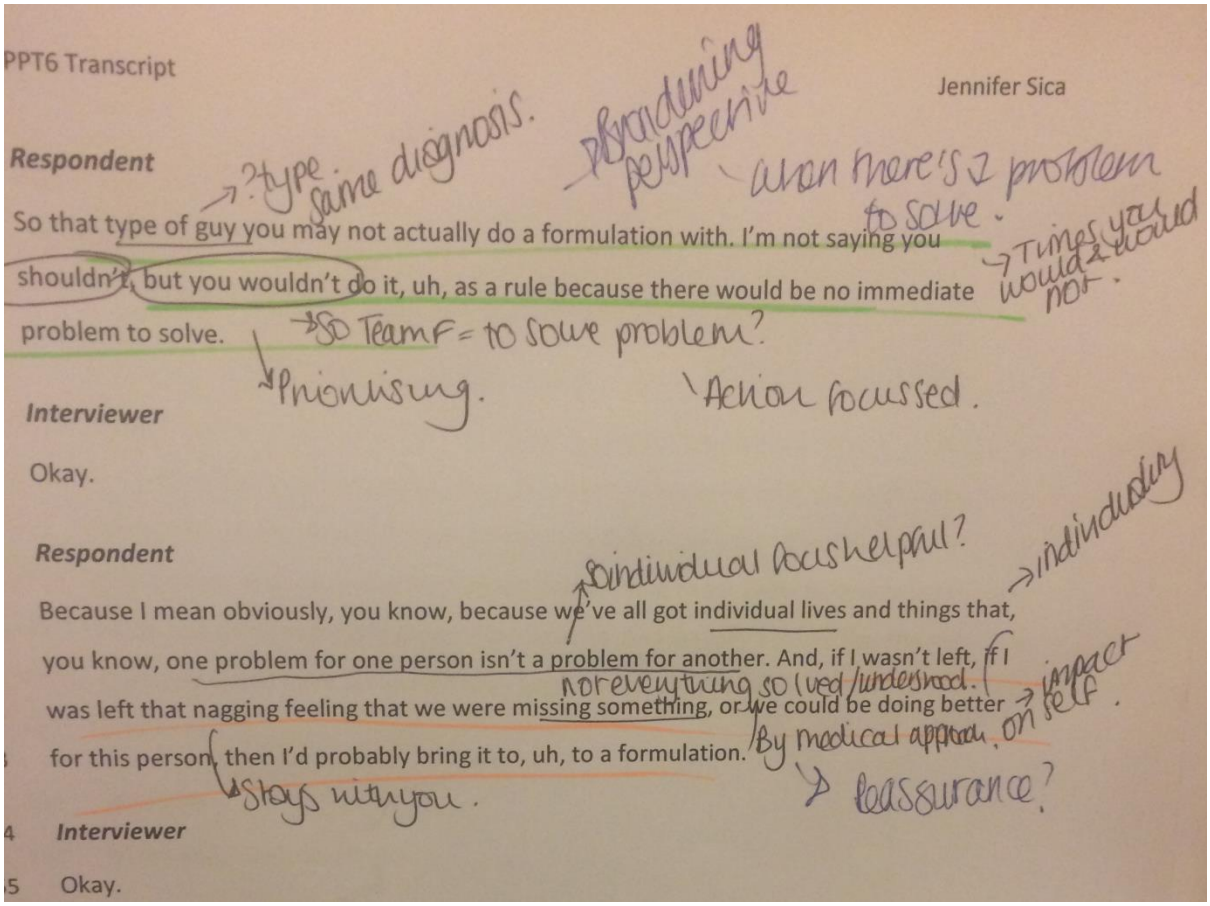
References

Bergin, M., Wells, J.S.G. & Owen, S. (2010). Relating realist meta theory to issues of gender and mental health. Journal of Psychiatric and Mental Health Nursing, 17 (5), 442-451.

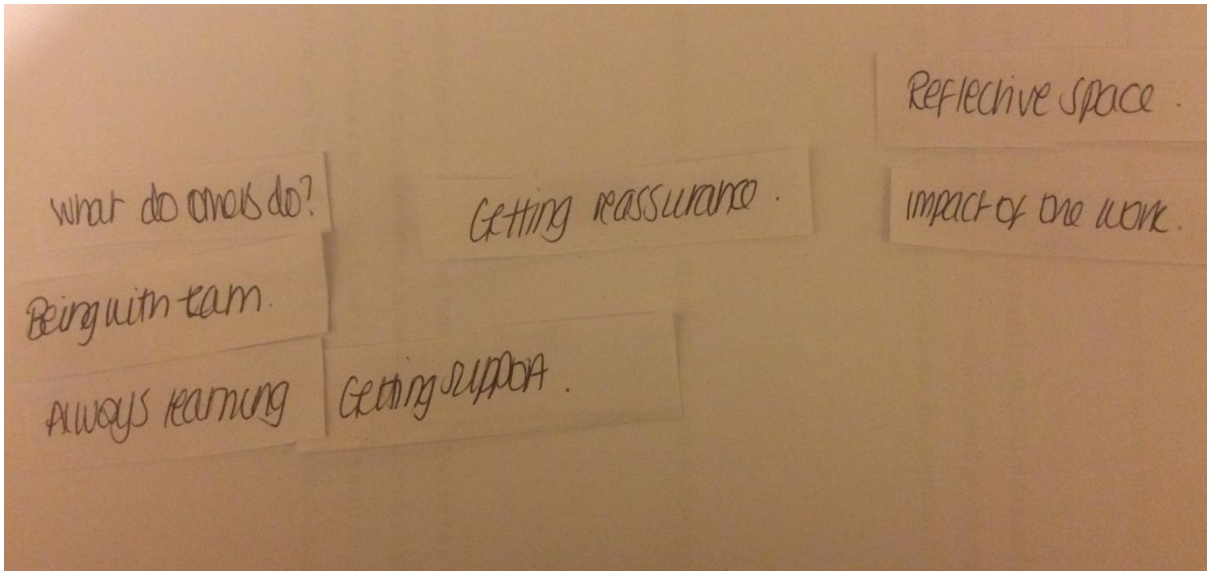
Appendix L: Thematic analysis – initial impressions noted.



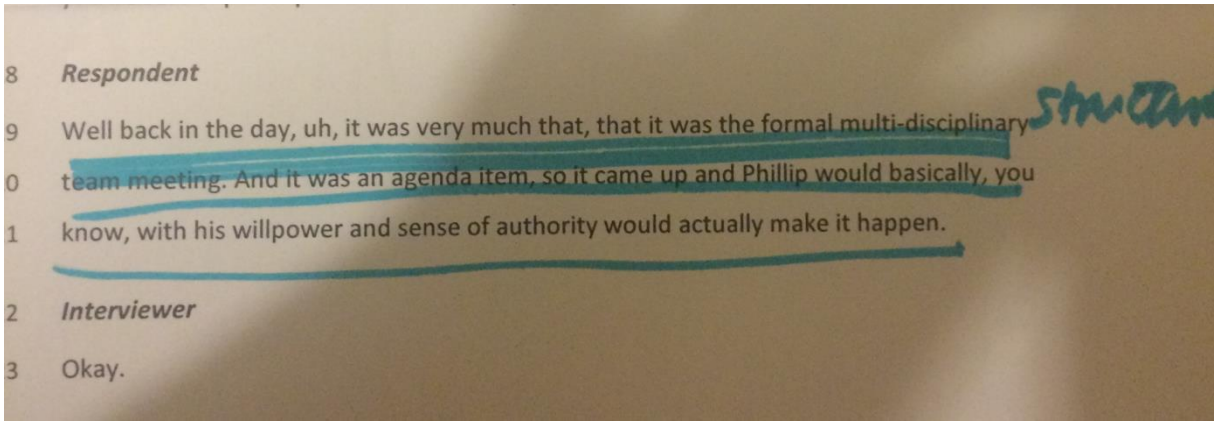
Appendix M: Thematic analysis – Coding.



Appendix N: Thematic analysis – Generating themes.



Appendix O: Thematic analysis – Reviewing themes.

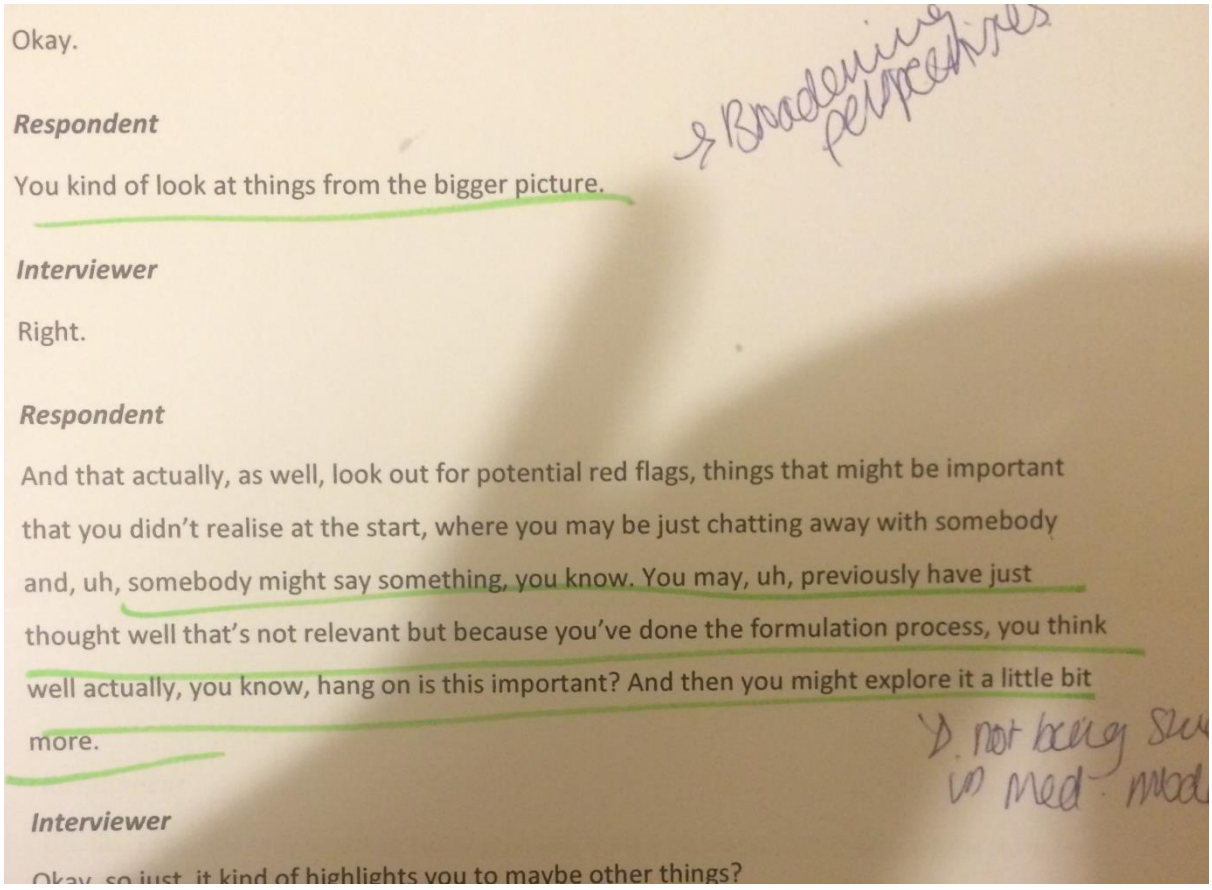


Respondent

Well back in the day, uh, it was very much that, that it was the formal multi-disciplinary team meeting. And it was an agenda item, so it came up and Phillip would basically, you know, with his willpower and sense of authority would actually make it happen.

Interviewer

Okay.



Okay.

Respondent

You kind of look at things from the bigger picture.

Interviewer

Right.

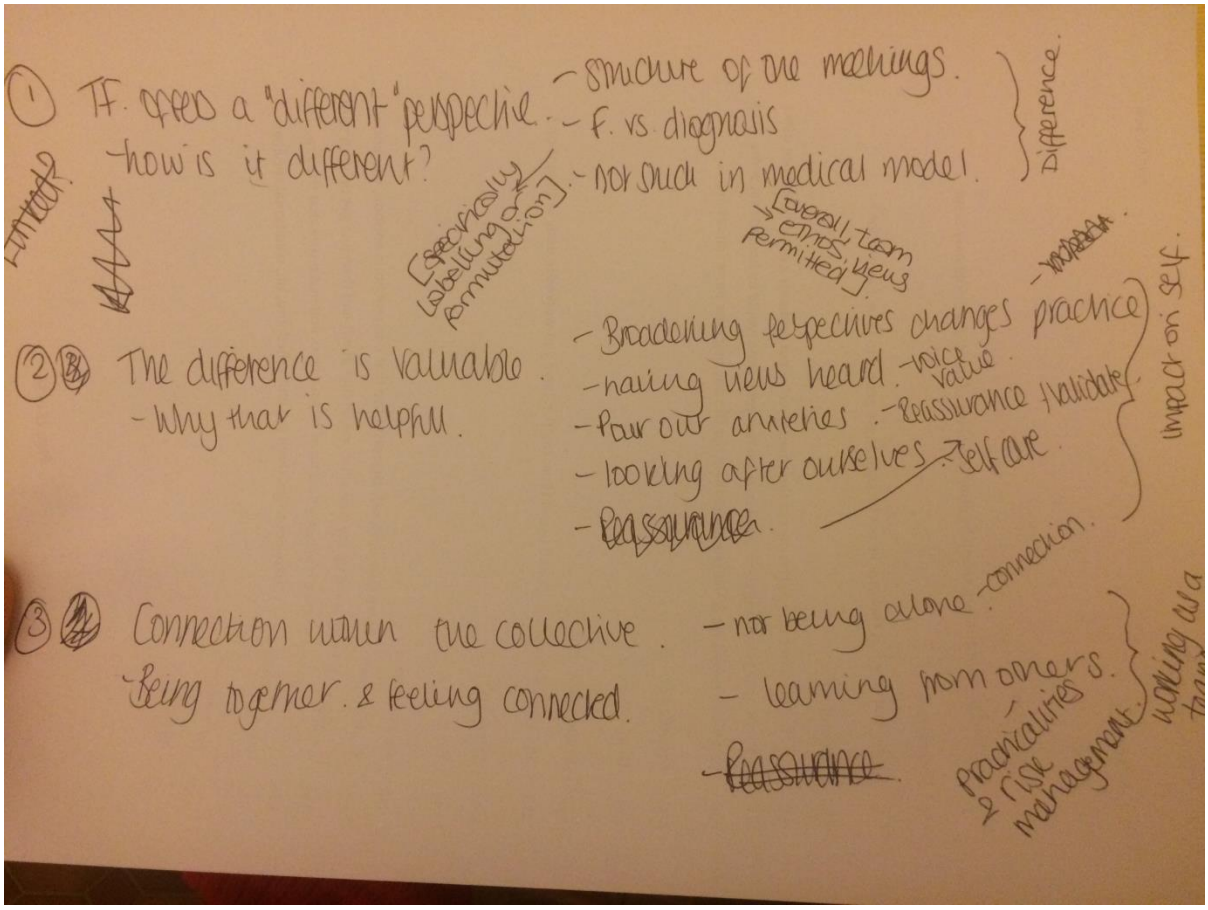
Respondent

And that actually, as well, look out for potential red flags, things that might be important that you didn't realise at the start, where you may be just chatting away with somebody and, uh, somebody might say something, you know. You may, uh, previously have just thought well that's not relevant but because you've done the formulation process, you think well actually, you know, hang on is this important? And then you might explore it a little bit more.

Interviewer

Okay, so just, it kind of highlights you to maybe other things?

Appendix P: Thematic analysis – Theme comparisons.



Appendix Q: Additional quotes in relation to themes.

Additional supporting quotations for the theme 'Team formulation offers a different perspective'.

Theme	Quote	Participant
Structure	"It's quite easy to drift off and then realise you've not formulated anything. So it does, you're aware of the time I suppose and how much you've got to fit in".	Rachael
	"I think it's quite flexible which is what's kind of positive about it"	Jessica
	"As long as it remains an open session as it is now... as long as it is not like a teaching session"	Edward
	"I could put an hour in my diary to sit and reflect but I would feel uncomfortable and I would likely or not, um, end up prioritising something else"	Anna
Formulation vs. diagnosis	"People in our team have similar diagnoses anyway so it feels slightly insignificant but it'd be looking much more about… what's the impact on someone rather than the diagnosis or its symptoms"	Rachael
	"With diagnosis you are saying, uh, what is your problem, what is your illness, we are looking at finding, we are looking at somebody more as, as, as a patient… whereas for formulation you are more or less saying what has brought you here"	Edward
	"I think you miss that bit about understanding someone a little bit deeper, or maybe why they've got that diagnosis, that kind of thing"	Julia
Not being stuck in a medical model	"We're trying to embrace a, uh, differential diagnosis kind of approach. You know, we always look at things again, like I said before, in a holistic way"	Jessica
	"whilst I feel there is a place for medicine, uh, in treating somebody, I also feel there is, uh, therapies that we need to bring in"	Samuel
	"Sometimes priority's given to the medical model and I can understand that, especially if someone's in a crisis… but sometimes I think a lot of focus is put on the medication, rather than the person themselves"	Eleanor

Additional supporting quotations for the theme 'The difference is valuable'.

Subtheme	Quote	Participant
Broadening perspectives changes practice	"It actually helps you to look towards actually a shared problem that you can actually work with somebody with"	Gerry

	"When we're assessing, um, we can have those sort of ideas and those formulations I suppose at the back of our mind"	Eleanor
	"It was just able to actually look at a problem from a different perspective"	Gerry
	"Certainly others have for me, things they've said have opened up other possibilities and ask yourself, um, it makes you ask some questions about, um, your own practice and your own attitudes and relationships with your clients"	Sean
	"Different ways of thinking, viewing problems and needs and therefore that impact the, what interventions you might then offer in the future"	Jessica
Having your views heard	"It's when you need to think maybe a bit out loud and I find that helpful when you can talk to other people and bounce ideas off of people, a different way of thinking, that kind of thing"	Julia
	"It's a different type of team meeting, because it feels like you can talk, and be op- be honest… I don't think I speak about that much at meetings really compared to these"	Gemma
	"It feels nice actually, um, that we can be heard"	Anna
Pour out the anxieties	"It's because they take a lot of your time, they drain you physically and mentally and, uh, you also on, uh, specially someone who is very much a high suicidal sort of risk, you're always almost thinking about what will they do next"	Edward
	"I feel at the end of the [team formulation] somewhat alleviated, because I've been about to pour out the anxieties that I may have myself"	Samuel
	"Quite often staff will come and it will be a chance to vent"	Julia
	"An opportunity actually to, um, get it off your chest, to talk about it. I mean that's actually really helpful sometimes"	Jessica
Looking after ourselves	"Sometimes you can actually feel quite drained, you know, that you're a resource as well and you're not being actually used properly"	Eleanor
	"If you were that busy… that says to me there's a higher need to be able to come and do this stuff, where you get together and you talk and you share and support one another. Rather than continue to try and battle on in a way that's not getting you anywhere"	Sean
	"We do actually need to make time for	Anna

	this, because this is really, really important. It sort of kind of, um, goes above every, anything that we're doing. If we don't have this, then we can't really work very effectively"	

Additional supporting quotations for the theme 'Connection within the collective'.

Theme	Quote	Participant
Connection within the collective	"I think it's good for the team. A, an opportunity to sit together in a different setting. Um, and discuss things with a different formulation in the background really"	Jessica
	"The process of talking within the team is useful because it gets your ideas kind of sparking, or other people will be thinking about things in a different way to you, and that will be really helpful"	Julia
	"I find it a forum not just for support but also to, uh, look at interaction with other teams, uh team members and get to know one another a bit better"	Jessica
Not being alone	"Sometimes it can be quite isolated, can't it?"	Eleanor
	"You're sharing the risk as well, the team. If there's a decision to be made, it's like a multi-disciplinary team meeting, you know, making the decision as opposed to me making the decision about this particular individual"	Samuel
	"It just reminds you that it's not just a load that you have to hold yourself. You can share it"	Anna
	"Sometimes you just need that reassurance to say actually, do you know what, I'm not doing a bad job, that's fine, we'll continue"	Eleanor
Learning from others	"this is like a forum where you get different ideas and different views from other people"	Samuel
	"And maybe just a reminder sometimes as well, because you tend to drift along. So a reminder of tools you could use with people"	Rachael
	"Sometimes it's interesting to hear about what other people's experiences of working with clients are, and sort of knowing what other people are doing is really good"	Gemma

Appendix R: Chronology of the research process.

Process / milestone	**Approximate date**
New research supervisor appointed.	April 2015
Generation of ideas and scoping exercises.	April 2015 – August 2015
Submission of research proposal for internal review.	September 2015
University Ethics process	November 2015
NHS R&D approval – multi Trust	December 2015
Systematic literature review.	December 2015 – May 2016.
Data collection	February 2016 – May 2016
Analysis	May 2016
Write up of project	June 2016 – August 2016
Submission of thesis	August 2016
Viva preparation	September - October 2016