Doctoral Thesis

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Team formulation: A qualitative exploration of service users' views

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Word Counts

	Main Text	Appendices (including tables, figures, and references)	Total
Thesis abstract	170	-	170
Literature review	8000	7298	15,298
Research paper	7983	6171	14,154
Critical appraisal	3962	916	4878
Ethics section	3161	5467	8628
Total	23,276	19,852	43,128

Thesis Abstract

This thesis is comprised of four chapters, including a systematic literature review, empirical research paper, a critical appraisal, and an ethics application section. The systematic literature review offers a meta-synthesis of the published literature exploring service users' experiences of ward rounds in inpatient mental health settings. Five papers were included in the review and the results were synthesised using thematic synthesis. The empirical paper is a qualitative exploration of service users' views of team formulation meetings. A novel methodology was implemented by showing service users a video of a fictional team formulation meeting. Focus group interviews were then used to gather the service users' perspectives and the data was analysed using thematic analysis. The critical appraisal includes a summary of the findings from the empirical paper and systematic literature review, followed by a discussion of the salient aspects across both papers. Methodological considerations are discussed, along with personal reflections of the research process. The fourth section includes the ethics application process of the empirical paper and supporting documents.

Declaration

The present research has been developed and conducted as part of the work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University. The work presented in this thesis is the author's own and has not been submitted to support an application for another degree or other academic reward.

Name: Holly Riches

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Date: 31st August 2022

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Contents

Section One: Systematic Literature Review

Service users' experiences of ward rounds in inpatient mental health settings: A systematic review and thematic synthesis

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Abstract

Purpose: Ward rounds are a routine part of inpatient mental health admissions, acting as a forum for service users and multidisciplinary teams to discuss care and make treatment decisions. Despite the important role ward rounds play in individual's care, there is very limited research exploring service users' experiences of this meeting. Consequently, a meta-synthesis of the current qualitative literature was conducted to answer the research question 'What are service users' experiences of attending ward rounds?'.

Methodology: A systematic search for papers was conducted across six electronic databases. Five papers met the inclusion/exclusion criteria and were analysed using a thematic synthesis approach to generate analytical themes.

Findings: The synthesis produced six analytical themes: (1) *purpose of ward rounds,* (2) *marginalisation of service users,* (3) *the importance of interactions and relationships* (4) *environmental factors,* (5) *experiences of ward rounds are dynamic and changeable,* and (6) *learning to cope and adapt.* The analytical themes can be further understood as part of two overarching themes of *power* and *emotional impact*.

Originality: This is the first thematic synthesis of service users' experiences of ward rounds, thereby building on existing qualitative literature. Future research is needed to further understand service users' experiences of ward rounds and develop guidelines to improve ward round practices.

Keywords: ward rounds, multi-disciplinary team, inpatient mental health, service user experience, thematic synthesis

Inpatient mental health admissions are the most intensive level of psychiatric care. In the United Kingdom (UK) most service users are detained under the Mental Health Act [MHA] (1983, amended 2007), which means that admission is compulsory. The MHA (2007) gives professionals the powers to detain, assess and treat people with a "mental disorder" in the interests of their own safety or the safety of others (Bowen, 2007).

Inpatient services are typically made up of multidisciplinary teams (MDTs) which include a range of professionals working together to support service users. Effective multidisciplinary team working is considered essential in mental health services (Haines et al., 2018). Composition of MDTs can vary dependent on the setting but typically includes psychiatrists, nurses, nursing assistants, occupational therapists, social workers, and clinical psychologists. Service users are allocated a 'named nurse' who is responsible for the coordination and provision of care for that individual, as well being their main point of contact (Mitchell & Strain, 2015).

Ward rounds are one of the central features of hospital practice, in both mental and physical health settings (O'Driscoll et al., 2014). Ward rounds have existed in physical health hospitals since the 18th century (Morgan, 2017) and typically consist of health professionals gathering around the bed of a patient to decide on treatment plans (O'Hare, 2008). In contrast, in psychiatric settings service users usually attend a conference room (Stringer et al., 2016). In both settings, they provide a space where treatment and management decisions around an individual's care can be made as a team (O'Hare, 2008; Fiddler et al., 2010).

Ward rounds are a routine part of inpatient mental health admissions where MDTs meet on a weekly or fortnightly basis (Fiddler et al., 2010). As multi-disciplinary working and communication plays an essential role in inpatient care, ward rounds are often the setting where this can occur (Milner et al., 2008). Generalisation about the function of ward rounds

is difficult since settings and processes can vary (White & Karim, 2005). However, ward rounds typically provide a forum for MDTs to discuss treatment plans, evaluate progress and plan for discharge (Baker, 2005). Attendance of professionals at ward rounds can vary but typically consist of any professionals involved in the service user's care. A survey of 96 consultant psychiatrists found that a median of seven professionals attended the ward round (Hodgson et al., 2005).

Early research into psychiatric ward rounds revealed that some service users reported negative experiences, describing feeling anxious when attending (Armond & Armond, 1985; Foster et al., 1991). More recent studies have reinforced these findings, additionally associating anxiety with the presence of too many people (White & Karim, 2005; Labib & Brownell, 2009). Furthermore, service users have reported finding it difficult to express their feelings (White & Karim, 2005) and not feeling listened to (Labib & Brownell, 2009). Ward rounds provide an ideal opportunity to involve patients in decisions about their care ensuring it meets their preferences and needs (Redley et al., 2019). However, research indicates that the way ward rounds are conducted often reinforces institutional traditions, placing the power with professionals above the service user (White & Karim, 2005). Consultant psychiatrists have reported that ward rounds are a compromise between professional efficiency and patient satisfaction (Hodgson *et al.* 2005). Moreover, Palin (2005) argues that ward rounds tend to serve the interests of professionals rather than service users.

Researchers investigating ward rounds have made suggestions for improvement, including having a scheduled timeslot for the meeting (White & Karim, 2005) and giving service users the option to invite people into the ward round (Baker, 2005). There is currently a limited amount of guidance surrounding how to conduct ward rounds in mental health settings. However, the Highland User Group (1997) have outlined suggestions for improving ward rounds, such as minimising the number of professionals attending. Furthermore, there

are some brief standards for ward rounds outlined in the Royal College of Psychiatrists (RCP) Standards for Acute Inpatient Services (Penfold & Colwill, 2022).

Rationale for the review

National policy and research recognise the positive influence of patient participation in advancing healthcare quality and patient safety (Department of Health, 2011). The RCP additionally sets standards that inpatient services should ask service users and carers for their feedback about their experiences to improve service delivery (Penfold & Colwill, 2022). Despite this, there is limited research into service users' views of ward rounds in inpatient settings. Although ward rounds are a core feature of both physical and mental health hospitals, research into ward rounds has primarily been conducted in physical health settings (Redley et al., 2019). Moreover, research in psychiatric services has typically focused on service users' overall experiences of inpatient admission (Staniszewska et al., 2019), rather than experiences of ward rounds specifically. Where service users' views of ward rounds have been explored this has tended to be conducted using quantitative methods (Armond & Armond, 1985; Foster et al., 1991; White & Karim, 2005; Labib & Brownell, 2009). Surveys and questionnaires have been useful in gathering views from large numbers of service users to understand satisfaction with certain aspects of the ward round. However, these methods use pre-determined and closed ended questions which risk over-simplifying and misinterpreting service users' views. In contrast, qualitative research allows for a more in-depth exploration of the multifaceted aspects of ward rounds. Furthermore, using qualitative methods in healthcare can lead to a better understanding of how to improve quality of care (Pope et al., 2002).

The present literature review aimed to analyse the qualitative literature exploring service users' experiences of ward rounds in inpatient mental health settings. The review used

a thematic synthesis approach (Thomas and Harden, 2008) to synthesise the findings from the articles identified. The primary research question was identified as: What are service users' experiences of attending ward rounds?

Method

Search strategy

Initial scoping searches were conducted to identify the most relevant databases and terminology to be used in the search strategy. Following this, an initial search strategy was implemented using the SPIDER search tool (Cooke e al., 2012). However, the search returned a low number of papers and the author identified that some key papers found in the initial scoping search were missing. Due to the limited amount of literature in this area and to allow for a maximum number of articles in the review a broader search strategy was developed to ensure that all possible relevant papers were captured (Table 1). Two key concepts were identified 1) multi-disciplinary team meetings and 2) qualitative literature, which were combined using the Boolean logic term "AND". Search terms for key concepts were searched for at both title (TI) and abstract (AB) using Boolean logic term "OR". A psychology subject librarian was consulted throughout and helped develop search strategies.

[INSERT TABLE 1]

Data sources

"CINAHL", "MEDLINE", "PsycINFO", "Open Dissertation", "Web of Science" and "Academic Search Ultimate" were searched in June 2022. These databases were thought to be the most suitable for the research topic and most likely to capture as many papers as possible. Due to the limited research in this topic area, a decision was made to search databases that might identify any grey literature.

Inclusion and exclusion criteria

Inclusion criteria were intentionally broad due to a limited number of studies indicated in the initial scoping exercise. For inclusion in the review, papers were required to report on service users' experiences of attending multi-disciplinary team meetings in mental health settings. Therefore, papers which explored service users' experiences of the Care Programme Approach (CPA) where the experiences of meetings specifically could not be separated were excluded. Furthermore, papers needed to present qualitative or mixed method results, and were excluded if they only employed quantitative methodology. For full inclusion and exclusion criteria, see Table 2.

[INSERT TABLE 2]

Study selection

The search strategy yielded 5970 papers of which 3258 were duplicates leaving 2712 papers. After removing duplicates, articles were imported into Rayyan (a systematic literature web-tool), and initial screening of titles and abstracts was undertaken by the first author. Following this, 22 articles were screened at full text against the eligibility criteria and reasons for exclusion were documented. Uncertainties around eligibility were resolved through discussion between the first author and research supervisors. Five articles met the full criteria and were included in the synthesis. The PRISMA flow-chart (Figure 1) shows the details of the screening process.

[INSERT FIGURE 1]

Study Characteristics

Despite the search strategy being designed to be inclusive of all MDT meetings in a variety of setting, all five studies included in this review looked specifically at service users'

experiences of ward rounds in inpatient mental health settings in the UK. Four studies included service users only, however one study interviewed young people and their parents. The decision to include this study was based on service users being interviewed separately, with clear differentiation between quotes in the results. All the studies used interviews and one study also used a Likert scale questionnaire in conjunction with interviews. This study was included on the basis that the qualitative results could be easily separated. Three studies used thematic analysis, one study utilised grounded theory and one study used content analysis to develop themes. Table 3 provides a description of each study's characteristics and an overview of key findings.

[INSERT TABLE 3]

It is important to note that two of the five studies included in this review are classed as grey literature (Bellefontaine & Lee, 2013). One is a doctoral thesis (Ceaser, 2007) and the other is not peer-reviewed (Chapman et al., 2016). After much consideration, with research supervisors, it was decided to include both these studies in the review due to the limited amount of research in this area and the importance of the review. There is some debate about whether it is appropriate to included grey literature in a meta-synthesis (Benzies et al., 2006; Adams et al., 2017). However, it has been argued that grey literature can make important contributions to systematic reviews by providing balanced viewpoints without publication bias (Hopewell et al., 2005).

Quality assessment tool

The Critical Appraisal Skills Programme (CASP) was selected as the most appropriate quality appraisal tool as it is recommended in health-related qualitative evidence syntheses (Long et al., 2020). The CASP covers ten areas, including two initial screening questions identifying unsuitable papers. The remaining questions were scored using a three-

point scoring system developed by Duggleby et al., (2010). The CASP was used to critically reflect on the contribution of each paper and not to exclude studies (Atkins et al., 2008). All studies were independently quality appraised by an external reviewer, to check the consistency of quality decisions made and any disagreements were resolved through discussion. Table 4 outlines the quality appraisal results.

[INSERT TABLE 4]

One concern surrounding the inclusion of grey literature in systematic reviews is that unpublished research is not subject to the same process of review as published articles (Conn et al., 2003). Despite this, the doctoral thesis (Ceaser, 2007) was the highest scoring paper. This may reflect the more comprehensive nature and larger word count of a thesis compared with journal articles. Furthermore, the non-peer reviewed article (Chapman et al., 2016) also scored highly.

Data Extraction

The decision around what classed as data for the review was informed by guidance from the Thomas and Harden (2008) and Noyes et al. (2019) papers and discussions with research supervisors. It was decided the results sections of papers would be included as data, as well as any other parts of the papers which included new results or interpretations. Where a study had data from service users and their parents, only data related to service users was extracted. Similarly, where a study used mixed methods, only the qualitative data was extracted. The data analysis software, NVivo, was used to undertake the analysis.

Analysis

Thomas and Harden's (2008) thematic synthesis method was chosen as it is appropriate for a range of methodologies, and allows flexibility of analysing researchers' conceptualisations in combination with service users' quotes (Shaw, 2012).

Following Thomas and Harden's approach (2008), data analysis was split into three stages: 1) line by line coding of the results 2) organisation of codes into descriptive themes 3) development of analytical themes. In the first stage, data was coded with the primary research question in mind. During stage two, the codes were examined for similarities and differences so they could be grouped into descriptive themes. During this process themes were merged, revised, and re-named in an iterative process. Stage three involved returning to the research question to generate analytical themes by 'going beyond' the content of the original studies to allow for new interpretations to be made. The analysis was primarily undertaken by the first author, however descriptive themes and analytical themes were discussed and adapted with research supervisors. An example of each stage of the analysis, along with excerpts from the transcript is shown in Appendix 1-A.

Results

The synthesis produced six analytical themes: (1) *purpose of ward rounds,* (2) *marginalisation of service users,* (3) *the importance of interactions and relationships* (4) *environmental factors,* (5) *experiences of ward rounds are dynamic and changeable* and (6) *learning to cope and adapt.* Furthermore, the six analytical themes can be understood as part of two overarching themes of *power* and *emotional impact*. Issues surrounding power were closely entwined within each analytical theme, signifying the overwhelming control and influence that professionals hold over service users' experiences. The overarching theme of emotional impact reflects the overwhelming nature of the emotional responses described in service users' accounts of their ward round experiences, with each analytical theme impacting service users' emotions and wellbeing in different ways. A conceptual diagram of the themes was developed (Figure 2) which shows how power had an impact on ward round experiences and consequently this had an emotional impact on service users. Thus, service

users had to learn how to cope and adapt. The overarching themes will be discussed further within each analytical theme.

[INSERT FIGURE 2]

Theme one: Purpose of ward rounds

The ward round process gave service users an opportunity to make requests, hoping these would be approved by the MDT: "Ward rounds were viewed as a forum for requests to be granted or denied" (Chapman et al., 2016, p. 19). In some instances, the process of waiting to find out if requests were approved caused service users to feel anxious and "worry about the news" (Chapman et al., 2016, p. 19). Furthermore, Leese and Fraser (2019) commented: "It was clear that leave requests represented an important element of the MDT meeting for the patients and therefore this was also the basis of some of their anxiety" (p. 164). The importance placed on having requests approved creates a setting where professionals' power over outcomes impacts service users' emotions. Ward rounds also provided service users the opportunity to have their questions answered: "I was able to get information that I may have struggled to get from staff in the week, so I would save up my questions until ward round" (Ceaser, 2007, p. 75).

In addition, service users viewed ward rounds as a place for feedback on their progress: "Nine out of ten residents identified that ward rounds enabled the team to feedback their progress and to give a summary of their behaviour over the previous fortnight." (Chapman et al., 2016, p. 19). Some service users liked this aspect of ward rounds as it allowed them to recognise what had gone well: "Find the ward round good because it gives you the opportunity to understand what you need to do and what you have done well" (Leese & Fraser, 2019, p. 165). However, others felt angry when professionals discussed difficult aspects of their week: "One thing I did hate about the ward round, it made me so mad, was

how they brought up all the crap that had happened during the week, even if it had been dealt with at the time" (Ceaser, 2007, p. 70).

Having a space to be able to talk about longer term plans with their team such as where they would be discharged to was important to service users: "Two residents reported that the meeting allowed them to 'talk about the future' and where they 'want to go', suggesting that the ward round is a chance to discuss future options with regard to moving to another unit or into the community" (Chapman et al., 2016, p. 19). Similarly, Leese and Fraser (2019) state: "Patients discussed the importance of knowing you are [...] 'moving in the right direction' because this informs important decisions about leave and moves to less secure environments" (p. 165). Interestingly, this was aspect of ward rounds was only mentioned by service users who were based in low secure settings, where the length of stay is typically much longer.

Conversely, not all service users knew the purpose of ward rounds: "two service users were unsure of the purpose of the meetings, saying that they were 'not sure of the point of them' and another was left 'wondering about the relevance'" (Chapman et al., 2016, p. 19). In addition, Leese & Fraser (2019) commented: "It was apparent that the patients did not always understand everyone's role in the meeting, including their own" (p. 163).

Theme two: Marginalisation of service users

Experiences of marginalisation were heavily described in service users' accounts, regarding both the processes of the ward round and their experiences within them. Firstly, professionals did not properly explain or prepare service users for the ward round experience: "I think, they mentioned it on the induction day. But just in passing like. I didn't really know what one was to be fair" (Ceaser, 2007, Appendix 14 p. 2). In some cases, the way in which ward rounds were described did not consider the service user's individual needs: "For patient

B, information about the ward round which would have helped ameliorate anxiety was given at a time (and by a means) that did not take account of his mental state at that point". (Cappleman et al., 2015, p. 234). Furthermore, the way professionals presented ward rounds to service users reinforced power dynamics and left them believing attendance at ward rounds was compulsory: "I didn't feel I had a choice about going to the ward rounds then, looking back now I can see how the way it is explained makes you feel you have to go" (Ceaser, 2007, Appendix 14 p. 1). Not feeling prepared for the ward round was associated with feelings of anxiety, worry and even paranoia: "not knowing got me quite anxious about what would happen, I just got more worried really I guess" (Ceaser, 2007, p. 65); "I feel paranoid because I don't know what will be talked about" (Leese & Fraser, 2019, p. 163).

From service users' accounts it was apparent that professionals often held their own discussions prior to the service user attending the meeting: "Patients highlighted how the members of the MDT discuss their care before the patient goes into the meeting" (Leese & Fraser, 2019, p. 166). The knowledge that the team were meeting without them left some service users feeling that decisions had already been made: "Prior to you coming in, they've already made an assessment about how they're going to conduct the ward round" (Wagstaff & Solts, 2003, p. 35). This experience of exclusion was familiar to service users: "it's like most of the things they're behind closed doors" (Cappleman et al., 2015, p. 234). The decision by professionals to exclude service users from attending the whole of their meeting demonstrates the overt nature of the marginalisation of service users and the power professionals hold.

Moreover, professionals would make key decisions about service users' care whilst they were not in the room: "and then they let you know, in your review they let you know 'right we're going to follow this, we're gonna review this" (Cappleman et al., 2015, p. 234). This was particularly frustrating when it related to specific requests they had made "You can

prepare your requests, but I feel it has already been decided before you come in" (Leese & Fraser, 2019, p. 164). Service users felt strongly that they should be able to attend the whole meeting: "We should have open meetings where the patient is present for the whole meeting because they are discussing your care" (Leese & Fraser, 2019, p. 166).

However, when they were present, service users felt their views were dismissed: "They [MDT] are not interested in what I have to say" (Leese & Fraser, 2019, p. 165), with the interests of staff prioritised over service users: "I trust that staff will do what is in the best interest of the staff" (Leese & Fraser, 2019, p. 167). When attempting to share their perspectives, service users described being dismissed by their team: "I did once have the guts to speak up about a really important matter and it was met with like, okay thanks for that and then went onto the next subject" (Ceaser, 2007, Appendix 14 p. 6). Overall, service users wanted more involvement in ward rounds: "I should have the opportunity to respond to what is being decided" (Leese & Fraser, 2019, p. 166)

The power of the MDT was particularly pertinent to this theme of marginalisation. Professionals were perceived by service users as having authority over how the ward round was conducted, leaving them feeling powerless: "Service users felt that staff held control over ward round processes" (Cappleman et al., 2015, p. 234). Furthermore, there were several unknown factors controlled by the team, including the time of the meeting: "You don't have a set time... if you go and see a doctor or a nurse you always have a set time... I think it's very unprofessional... they just assume you'll be sitting round" (Wagstaff & Solts, 2003, p. 36). Additionally service users described not knowing what was written in ward round documentation: "I think as well you should get like a copy of what they've wrote [sic] (. . .) 'Cos you don't know what they write down and stuff, I reckon they should tell you what they've wrote down" (Cappleman et al., 2015, p. 234). The lack of control over basic

elements such as time of the meeting and documentation reinforced service users' feelings of powerlessness and marginalisation.

Theme Three: The importance of interactions and relationships

The communicative environment of ward rounds was often perceived negatively by service users. Ward rounds were experienced as an interview process, with professionals asking, "probing questions" (Cappleman et al., 2015, p. 234), causing service users to feel under scrutiny: "It feels more like an interrogation than a formal meeting" (Wagstaff & Solts, 2003, p. 35). Professionals' questioning approach reinforced unequal power dynamics: "feel talked at rather than a conversation" (Leese & Fraser, 2019, p. 164) with one service user comparing the experience to the "grand inquisition" (Chapman et al., 2016, p. 19). Service users were aware that the ward round formed part of an assessment of their mental state and were therefore conscious of the impact of what they said: "at first, it's like having to tell these people here, if I tell them I'm having these mad thoughts, they're gonna lock me up forever" (Cappleman et al., 2015, p. 235). The professionals' power to make decisions which affected their lives resulted in service users feeling under pressure to express themselves accurately: "There can be a misinterpretation of what you say [...] and then that gets written down" (Leese & Fraser, 2019, p. 165). The impact of this communicative environment left service users feeling judged: "It's difficult to say I just felt everyone was judging me" (Ceaser, 2007, Appendix 14 p. 4). One service user compared this experience of judgment to their previous interactions with the police: "yeah, it's kind of the feeling where, I don't know if you've ever been stopped by the police but they do that kind of thing, you can feel them looking up and down at you" (Cappleman et al., 2015, p. 235).

Notably, having good relationships and interactions with professionals mitigated some of the negative emotional impact of ward rounds: "Service users stressed the importance of

good relationships with staff and that such relationships had a positive impact on their ward round experiences" (Cappleman et al., 2015, p. 235). Service users described the positive effect of feeling listened to: "Like I say, he listened. That's the main thing. And when you're in... when you're in the kind of situation I'm in at the moment, if people listen to you, it's half the battle, when you've got someone you can talk to, and I felt I could talk to that doctor and he listened." (Cappleman et al., 2015, p. 235). Nurses were identified as the team member that service users felt were on their side: "Some [nursing] staff will fight your corner" (Leese & Fraser, 2019, p. 166). The role of named nurse was identified as key: "The supportive role of the nursing staff was discussed, with some patients suggesting that they would like their named nurse to attend the MDT meeting with them" (Leese & Fraser, 2019, p. 163). However, the importance of these relationships was not always recognised by the MDT, with reports of last-minute changes of personnel: "it's nerve-wracking enough going into your ward review and then at last minute, 'oh yeah by the way, such and such a person isn't coming, this person's coming in'' (Cappleman et al., 2015, p. 235). For service users, having someone support them during the ward round would help to re-balance power dynamics: "If you're close to that member of staff and they're sat at the side of you and if you were both speaking together... Like that would be good. 'Cos you'd feel like somebody's there for you, like, rather than being on your own" (Cappleman et al., 2015, p. 235).

The unclear communication style and language used by professionals also affected service users' experiences of their ward round. Communication and language were not tailored to meet service users' needs: "They use all this, all this jargon, and you know, when your head's up your arse so to speak, you don't take much of it in" (Cappleman et al., 2015, p. 234). Another service user described not understanding the language used: "I don't always understand what is being said because of the language used – I guess it is just part of growing up? I don't understand big words" (Leese & Fraser, 2019, p. 166). Notably, in both instances

the service user turns the professional's failure to communicate clearly into their own failure to understand. Furthermore, the lack of clarity around decision-making resulted in service users feeling unclear about decisions: "There can be conflict between opinions, and nobody explains what is meant by the discussion. Need someone to explain it to you after the ward round." (Leese & Fraser, 2019, p. 167). Some service users suggested they: "need feedback after the event – someone to go over what was discussed and agreed – staff nurse or member of the MDT because it is difficult to remember what is discussed" (Leese & Fraser, 2019, p. 166). Furthermore, the named nurse was identified as being able to support communication: "The role of the named nurse was discussed with a number of patients suggesting that 'their nurse' attending the meeting could support the patient and allow clearer communication about the outcome of any requests or changes in treatment" (Leese and Fraser 2019, p. 167).

Theme four: Environmental factors

The physical environment and set up of ward rounds played an important role in service users' experiences, reinforcing unhelpful power dynamics by creating a situation where service users felt outnumbered and intimidated. Most service users commented negatively on the amount of professionals present: "Some aspects of the ward rounds sucked all the time. Like the ridiculously high number of staff there" (Ceaser, 2007. p. 80); "There were just too many people, I just wanted to talk to one person." Wagstaff and Solts (2003, p. 35). This caused service users to feel intimidated: "I don't like the fact that all of the staff are there staring at me'" (Chapman et al., 2016, p. 19). Service users wanted fewer professionals in their ward round: "When a patient comes in, they should have a smaller group." (Wagstaff & Solts, 2003, p. 35). However, this view was not shared by all service users, with some stating that they were not bothered by the amount of people in the meeting: "I didn't feel intimidated or anything like that" (Wagstaff & Solts, 2003, p. 35).

Interestingly, service users in three of the studies likened the ward round to experiences of the criminal justice system. One participant stated: “Cos my personal experience of walking into a room with loads of people is walking into a courtroom…’Cos they sent me to jail. So, I didn’t have a very good experience of loads of people if you like.’ (Cappleman et al., 2015, p. 235). Another participant stated that the ward rounds felt “like a court room” (Chapman et al., 2016, p. 19). Similarly, another compared it to prison: “It just feels like I am back on the block – where you feel guilty even if you have not done anything wrong” (Leese & Fraser, 2019, p. 165).

The combination of disliking the amount of people present and the formal layout of the room caused service users to feel intimidated: “I find the layout formal and overpowering” (Leese & Fraser, 2019, p. 164); “everyone was sitting there in high chairs’ and ‘they had to get everyone in the same room, so they all sat around, perched.” (Wagstaff & Solts, 2003, p. 36). To address this service users preferred a less threatening layout: “[Seats] better in a circle so I don’t feel that everyone is looking at me” (Leese & Fraser, 2019, p. 164). Service users suggested the environment could be improved with “comfy chairs, flowers and drinks” and “drinks and biscuits available – less formal” (Leese & Fraser, 2019, p. 164).

Theme five: Experiences of ward rounds are dynamic and changeable

Service users’ experiences of ward rounds were not static and could change between weeks and over time. The outcome of the ward round affected how service users experienced it: “When I have progress, I feel all right, when I don’t I feel disappointed” (Wagstaff & Solts, 2003, p. 35). Service users would describe their experience of their ward round more positively if they had requests approved: “[I] find the MDT helpful if you have been behaving – get more leave and move forward” (Leese & Fraser, 2019, p. 165). In contrast

service users would experience the ward rounds negatively if they thought they were not making progress: “Just feel like it today – making no progress – all decisions are already made” (Leese & Fraser, 2019, p. 166). Service users commented on how their perception of how their week had gone would affect whether they wanted to attend or not: “If they have had a good week, they were happy to attend, but if they felt that things had ‘not gone well that week’, they would be anxious due to concerns that staff would speak negatively about them” (Leese & Fraser, 2019, p. 163). Chapman et al. (2019, p. 19) noted that “One respondent even commented that he felt excited about the meetings due to the perception that he could ‘usually get things granted’”. Another participant described the positive effect when professionals commented on how well they were doing: “It was good if I had made progress and I felt I had achieved something, it’s like I felt proud anyway but hearing the staff say I should be proud like gave me permission to and made me feel even prouder and happier” (Ceaser, 2007, Appendix 14 p. 3).

The number of ward rounds service users had attended affected their experience of them. The more familiar they became with the process the easier they became: “After you get over the initial newness of them and get the first few out of the way you just adapt to them. You think oh it’s Wednesday, it’s ward round, it becomes part of the routine, like getting out of bed, you don’t even think about it anymore” (Ceaser, 2007, p. 71). Leese & Fraser (2019) noted: “The level of anxiety expressed by the patients appeared to be linked to their prior experience. Patients who had significant experience of secure care being less anxious: ‘I am used to ward rounds – I have been in a secure hospital for 16 years’” (p. 163). Another participant commented on how, as they got better, the ward round felt more tolerable: “I thought at first I would always find the ward rounds hideous but my views started to change when I started to get better in myself, then they felt more bearable. I felt okay being there. I changed, not the ward rounds” (Ceaser, 2007, p.79).

Theme six: Learning to cope and adapt

Due to the difficult experiences described throughout the themes, service users developed ways of coping and adapting to ward rounds. They acknowledged the ward rounds would not change, therefore they needed to find ways of making the experience more bearable. One strategy was to avoid or ignore the difficult aspects: “During the week most service users attempted to cope with difficulties regarding WR by choosing not to think about them” (Ceaser, 2007, p. 68); “I tend to ignore the people outside - those I don’t know” (Wagstaff & Solts, 2003, p. 35). Furthermore, service users learnt to accept the difficult aspects: “Like the ridiculously high number of staff there, that didn’t change but I think you just get used to it and learn to live with it really” (Ceaser, 2007, p. 80).

Some service users described realising that adapting their behaviour in the week could influence how their ward rounds went: “I knew if I messed about in the week it would get brought up and make it a difficult time so I changed how I behaved in the week to make it easier for me and my folks” (Ceaser, 2007, p. 72). Another service user described a “game playing metaphor” which “resulted in what patient C described as a ‘meet you halfway situation, where if I cooperate with their goals, they’ll offer me incentives’” (Cappleman et al., 2015, p. 235).

Discussion

This systematic review identified five qualitative studies describing service users’ experiences of ward rounds. Thematic synthesis of the results led to the development of six analytical themes, plus two overarching themes. The findings are discussed below in relation to current literature and implications for clinical practice.

Purpose of ward rounds

For service users, ward rounds were described as a forum where they could have questions answered, make requests and ultimately where decisions about their care were made. This is consistent with professionals' descriptions of ward rounds (Milner et al., 2008) and with professional documents (Penfold & Colwill, 2022). The power of professionals was evident within service users' accounts, describing the process of making requests which the team would either approve or reject. The importance placed on having requests approved triggered emotional responses in service users such as anxiety and anticipation. Previous research has shown that service users often feel anxious about attending meetings (White & Karim, 2005; Labib & Brownell, 2009) however, the association with requests had not been identified in questionnaires and surveys. Furthermore, the outcomes of ward rounds can have further emotional consequences if requests are not approved.

Notably, not all service users knew the purpose of ward rounds, and many described feeling unprepared. Milner et al. (2008) found that 54 percent of service users reported they had not received an explanation of the purpose of ward rounds and 37 percent felt they were unprepared. Feeling unprepared was related to feelings of anxiety and worry, due to not knowing what to expect. For some service users, once they had become more familiar with the process of ward rounds, through increased experience of them, anxiety reduced.

Marginalisation of service users

Marginalisation was identified as a major feature of service users' experiences of ward rounds. Service users felt powerless over ward round processes and perceived professionals as having the authority over how they were conducted. Additionally, service users consistently described themselves as being outside the decision-making process, especially being excluded from attending the whole meeting. This fits with findings from Haines et al. (2018) who observed MDT meetings in a forensic hospital and found service

users were only invited to the meeting after all the staff had presented their reports. Moreover, when service users were invited into the meeting, their views and opinions were disregarded, and the professionals' views were prioritised. Similarly, Haines et al. (2018) found that decisions are unequally shaped by professionals, and service users' involvement is marginalised. These findings are consistent with those from Labib and Brownell's (2009) survey which showed service users did not feel listened to during ward rounds and that information was being withheld from them. This correlates with a more general picture of inpatient services; Valenti et al., (2014) found that 92 percent of service users on an inpatient ward reported that they were not involved in decision-making and felt that their rights had been violated.

The National Institute for Health and Care Excellence (NICE) recommends that shared decision making should be routinely implemented with individuals in hospital, including those detained under the Mental Health Act (NICE, 2011). Shared decision-making should include a process whereby different treatment options are fully discussed between service users and professionals, along with the risks and benefits and a decision should be reached together (NICE, 2011). Contrary to NICE guidance, service users in this review described how decisions were made prior to them joining the ward round, leaving them with limited opportunity to share their views and influence decision-making. Shared decision-making has been associated with positive outcomes for individuals with mental health difficulties, including treatment adherence and recovery (Huang et al., 2019). Furthermore, service users interviewed about their experiences of involuntary hospital admissions discussed how shared decision-making enhanced feelings of autonomy and respect (Katsakou & Priebe, 2007). However, this review suggests that shared decision-making is not routine practice within ward rounds in inpatient mental health care. This is consistent with Huang et al.'s (2019) review of shared decision-making practices in severe mental illness. Future

research could pilot a shared decision-making approach to ward rounds which could be evaluated to inform best practice guidelines.

Service users' accounts of marginalisation and exclusion from decision-making further highlight the differentials of power between professionals and service users in ward rounds. Haines et al. (2016) argue that the power dynamics present in decision-making are linked to the knowledge and legal responsibility that psychiatrists hold. Stacey et al. (2016) found that psychiatrists were perceived by both service users and other professionals as holding the most power and responsibility, with all parties acknowledging that decision-making was not shared.

Importance of interactions and relationships

Existing literature has highlighted the importance of the relationship between professionals and service users in inpatient settings (Gilburt et al., 2008; Staniszewska et al., 2019). The current review goes some way to suggesting that the professional-service user relationship is particularly important during interactions in ward rounds. Service users who experienced the ward round as an interrogation, perceived professionals to be intimidating and judgemental, resulting in emotional consequences such as service users feeling scared and fearful. There was a dominant theme throughout service users' accounts of experiencing professionals as powerful. This is consistent with experiences of inpatient services more generally, with service users describing losing their rights and the power to decide for themselves (Katsakou & Priebe, 2007). Furthermore, in this review, some service users likened their experiences of professionals and ward rounds to interactions with authorities such as the police and criminal justice systems.

Conversely, experiencing caring and collaborative interactions with professionals, where service users felt listened to was integral to more positive experiences of ward rounds.

Service users who experienced professionals alongside them and "fighting their corner" felt supported and less powerless. The supportive role was predominately embodied by nursing staff, with service users emphasising the importance of their named nurse being in attendance for support. Previous research has identified that the nurse-service user relationship is critical to service users' perceptions of quality and effectiveness of care (Clark et al., 2009; Walsh & Boyle, 2009). Moreover, nurses believe they have a role as advocates for service users (Haines et al., 2018). Good relationships with professionals have been found to be a facilitator of shared decision-making (Giacco et al., 2018). Moreover, service users with good therapeutic relationships with healthcare professionals are more able to express their needs and preferences and share differing opinions (Huang et al., 2019). To develop good working relationships, professionals need to be mindful of how they use their power within ward rounds. The role of positive relationships should be recognised and capitalised on by professionals, with named nurses taking on responsibilities such as preparing service users for ward rounds and supporting them during and after.

Environmental factors

Concurrent with previous research (White & Karim, 2005; Labib & Brownell, 2009), this review found that the large number of professionals present in ward rounds contributed to anxiety in service users. However, this review goes further in linking the number of professionals attending with feelings of powerlessness for service users. Service users felt outnumbered by professionals in attendance, leaving them feeling intimidated and judged. In general, service users wanted fewer professionals in their meetings.

Additionally, the physical environment of the meeting rooms used for ward rounds was described as formal and unwelcoming. This fits with service users' views of the physical environment on inpatient units more generally (Walsh & Boyle, 2009). Service users wanted

to meet in a more comfortable environment, suggesting changes such as having comfy chairs, drinks and biscuits. Notably, Hodgson et al. (2005) found that in ward rounds where the team had refreshments, only 5 percent of teams offered these to service users, further reinforcing power dynamics. Service users in this review commented on how the layout and seating arrangements in ward rounds felt intimidating and exacerbated unequal power dynamics, with service users preferring seating to be in a circle. The physical environment of ward rounds should be considered to make service users feel more at ease and reduce power dynamics.

Learning to cope and adapt

Service users realised that their ward rounds were not going to change, due to the power and traditions of services and professionals. They therefore described ways in which they adapted to cope with them. This is consistent with service users' experiences of inpatient care, in which service users described having to adapt to the ward, staff and rules (Marklund et al., 2020). Some services users coped by avoidance or learning to accept that ward rounds would not change; others learnt to adapt their behaviour to "play the game" and have an influence over the outcomes of decisions made by their team. Similarly, Hörberg et al. (2012) found that service users on a forensic unit adapted to the demands of staff to gain privileges.

Power

Issues surrounding power were evident throughout service users' narratives of ward rounds. These reflect the exercise of professional and institutional power over service users, supported by the MHA which gives professionals authority to give treatment without consent. Foucault (1983) argues that power is present in all human relationships and where power is exercised, there is also the possibility of resistance. However, in institutions such as mental health units, ordinary free relationships are replaced by formalised processes, such as ward rounds, in which the possibility of resistance is minimised.

Foucault's theory of corrective training (1991) helps to explain how the use of observation of service users in mental health units produces a form of power, where individuals begin to regulate their own behaviour in accordance with what is expected by professionals. This is evident in the narratives of some service users, who discuss how they learnt to adapt their behaviour on the ward in order to have a better experience of ward rounds. However, some service users' also described ways in which they resisted power and use their own agency to play the system to get requests approved. Foucault thus provides us with an important model for thinking about power and consider how both service users' and professionals can use resistance to implement change.

Strengths, limitations, and future research

To the author's knowledge, this is the first systematic review of service users' experiences of ward rounds, thereby building on existing qualitative literature. The use of thematic synthesis enabled this review to 'go beyond' the findings of the included studies to generate analytic themes relevant to the aims of the review (Thomas & Harden, 2008). A clear limitation of this review is the small number of studies included therefore the findings may not be transferable to other contexts. Further research is needed to enhance our understanding of service users' experiences of ward rounds. Additionally, the articles included were all based in UK settings so are not representative of ward rounds outside the UK. It is important to consider why only UK papers were found in the search strategy. The author has considered whether the search strategy was not comprehensive enough to capture papers from other countries, or whether this research has not taken place.

The small number of papers identified for this review emphasises the clear need for further research into service users' experiences of ward rounds, and more generally multi-disciplinary meetings. This review highlights how service users' voices are not only being

marginalised in ward rounds but also in the research literature. The results of the quality appraisal highlighted that future research needs to be more transparent about the relationship between researchers and participants and consider how this may influence findings.

The finding that good relationships with professionals may support positive experiences of ward rounds could be further investigated. The review highlights a discrepancy between the existing guidance of ward rounds (Penfold & Colwill, 2022) and service users' actual experience. It would therefore be important to investigate why guidelines are not being implemented at a clinical level. This could be explored by investigating professionals' views of barriers to improving service users' experiences of ward rounds.

Conclusion

This review suggests there are numerous aspects of ward round which are experienced negatively by service users and that guidance around share decision-making and service user involvement are not being implemented. There are currently no professional documents that provide specific guidelines around standards for ward rounds. The establishment of clear guidelines may therefore help to provide a framework for professionals to follow and consequently improve service users' experiences. Furthermore, this review illustrates how the role of power in ward rounds needs to be further understood, in order to be able to make feasible suggestions for change.

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Tables and Figures

Table 1. Final Search Strategy

Key concept	Search terms
Key concept one: multi-disciplinary team meetings	TI (“Multi-disciplin* team meeting*” OR “Multidisciplin* team meeting*” OR “Interprofessional* team meeting*” OR “Interdisciplin*team meeting*” OR “Professional* meeting*” OR “MDT meeting*” OR “Ward round*” OR “Ward review*” OR “Care programme approach” OR “Team discussion*” OR “clinical team meeting*” OR “formulation meeting*”) OR AB (“Multi-disciplin* team meeting*” OR “Multidisciplin* team meeting*” OR “Interprofessional* team meeting*” OR “Interdisciplin*team meeting*” OR “Professional* meeting*” OR “MDT meeting*” OR “Ward round*” OR “Ward review*” OR “Care programme approach” OR “Team discussion*” OR “clinical team meeting*” OR “formulation meeting*”)
	AND
Key concept two: qualitative literature	TI (“Explor*” OR “Experience” OR “Qual*” OR “Grounded theory” OR “Thematic analysis” OR “interview*” OR “focus group*” OR “Involv*” OR “Participat*” OR “View*” OR “Perspective*”) OR AB (“Explor*” OR “Experience” OR “Qual*” OR “Grounded theory” OR “Thematic analysis” OR “interview*” OR “focus group*” OR “Involv*” OR “Participat*” OR “View*” OR “Perspective*”)

Table 2. Inclusion/Exclusion Criteria

Inclusion Criteria	**Exclusion criteria**
1) Qualitative research or mixed-methods where qualitative data could be separated 2) Exploring service users' experiences of multidisciplinary team meetings 3) Mental health setting 4) Adolescents, adults, or older adults 5) Paper available in English language	1) Only quantitative research 2) Professionals or carers experiences of multidisciplinary team meetings 3) Physical health setting

Table 3. Characteristics of studies included in the review

Authors (Year)	**Aim**	**Data collection**	**Method of analysis**	**Sample size**	**Setting**	**Age**	**Gender**	**Themes**
Wagstaff, K., & Solts, B. (2003)	To explore patients' perspectives of ward rounds using qualitative methods	Semi-structured interviews	Content analysis	8	Adult Acute admission ward	18-70	Male (n=5) Female (n=3)	Three main themes and seven subthemes: 1. Internal processes (participants feelings) - Satisfaction with ward round - Negative feelings about ward round - Feelings about the outcome and consequences of ward rounds - Coping with the ward round 2. External processes - Decision making - Communication - Number of people present 3. Practical arrangements

Ceaser, K. J. (2007)	To explore the experiences of ward rounds (WRs) for young people and parents in the context of an inpatient mental health unit	Semi-structured interviews	Grounded Theory	5	Adolescent mental health unit	Young people (age not specified)	Male (n=2) Female (n=3)	One Core category: Adaptation Five main categories: 1. Anticipating 2. Managing immediate impact 3. Seeking understanding 4. Readjusting expectations 5. Further consolidation of experiences
Cappleman, R., Bamford, Z., Dixon, C., & Thomas, H. (2015).	To address the gap in qualitative research examining patients' experiences of ward rounds.	Interviews	Thematic analysis	5	Adult Acute mental health ward	20-49	Male (n=4) Female (n=1)	Three main themes: 1. Not considering patient's emotional state 2. Behind closed doors (wanting more involvement) 3. The importance of relationships One overarching theme: Power and control

Chapman, R., Ingram, N., Collyer, L., & Brifcani, S. (2016)	Explored service user's experiences of attending ward rounds in a forensic rehabilitation setting.	Interviews	Thematic analysis of qualitative data	10	Male Forensic mental health ward	25-70	Male (n=10)	Three main themes: 1. Seeing the purpose and value 2. Perception of the process as being intimidating and anxiety provoking 3. A need for greater involvement from other disciplines
Leese, M., & Fraser, K. (2019)	Understand how patients on a low security personality disorder ward experienced multi-disciplinary team (MDT) meeting	Interviews	Thematic analysis	10	Adult Low secure (Personality disorder)	Not stated	Male (n=10)	Five main themes: 1. The importance of leave applications 2. The formality of the meetings 3. The opportunity to check on progress 4. Decision-making 5. The importance of communication.

Table. 4 Results of CASP

Author (Year)	Q3. Was the research design appropriate to address the aims of the study?	Q4. Was the recruitment strategy appropriate to the aims of the research?	Q5. Was the data collected in a way that addressed the research issue?	Q6. Has the relationship between researcher and participants been adequately considered?	Q7. Have ethical issues been taken into consideration?	Q8. Was the data analysis sufficiently rigorous?	Q9. Is there a clear statement of findings?	Q10. How valuable is the research?	Total
Wagstaff, K., & Solts, B. (2003)	3	2	3	3	2	2	3	3	21
Ceaser, K. J. (2007)	3	2	3	3	2	3	3	3	22
Cappleman, R., Bamford, Z., Dixon, C., & Thomas, H. (2015).	3	3	3	1	2	2	2	3	19

Chapman, R., Ingram, N., Collyer, L., & Brifcani, S. (2016)	3	2	3	2	3	2	2	3	20
Leese, M., & Fraser, K. (2019)	3	2	2	2	2	1	2	2	16

Figure 1. PRISMA flow chart

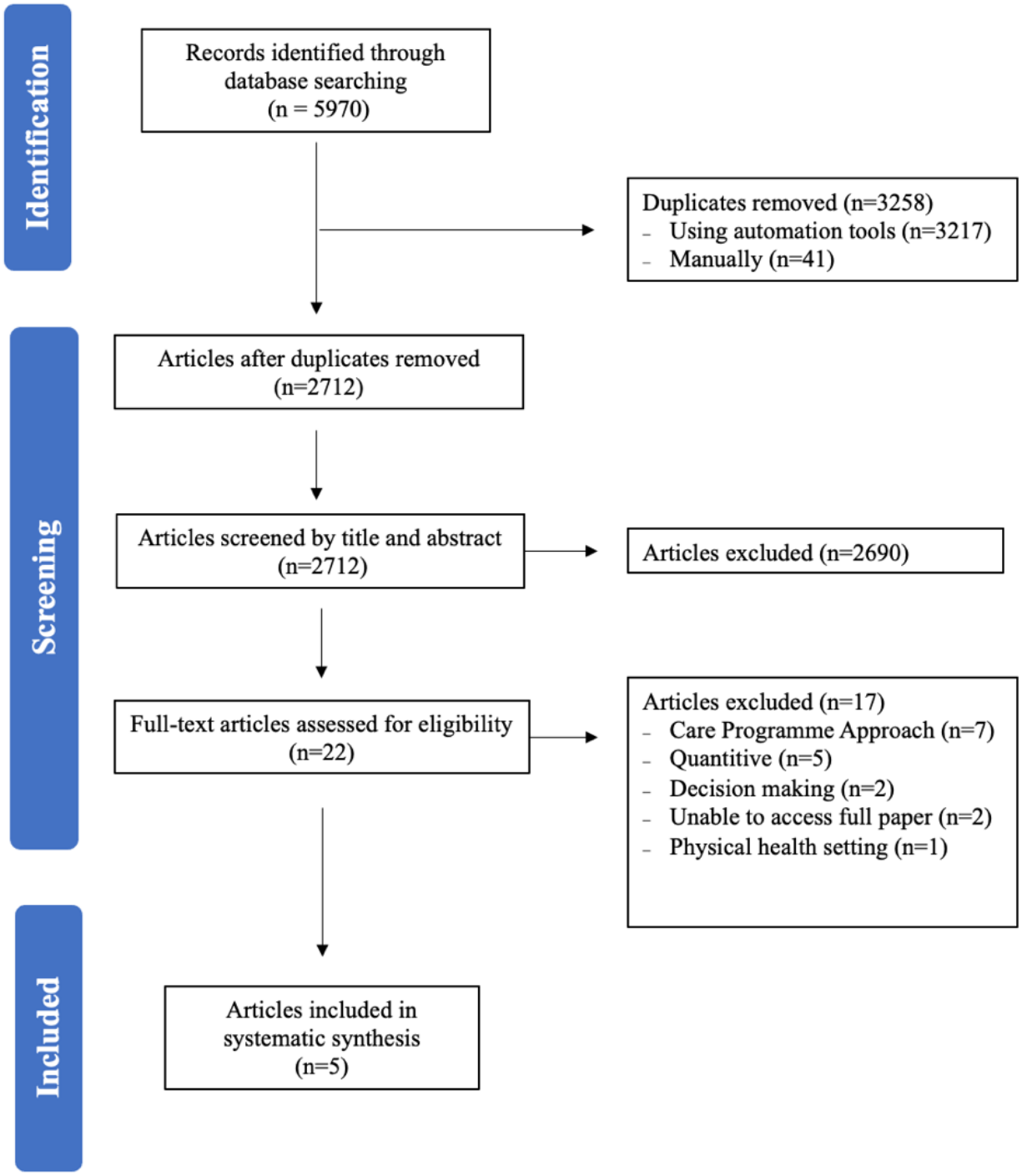
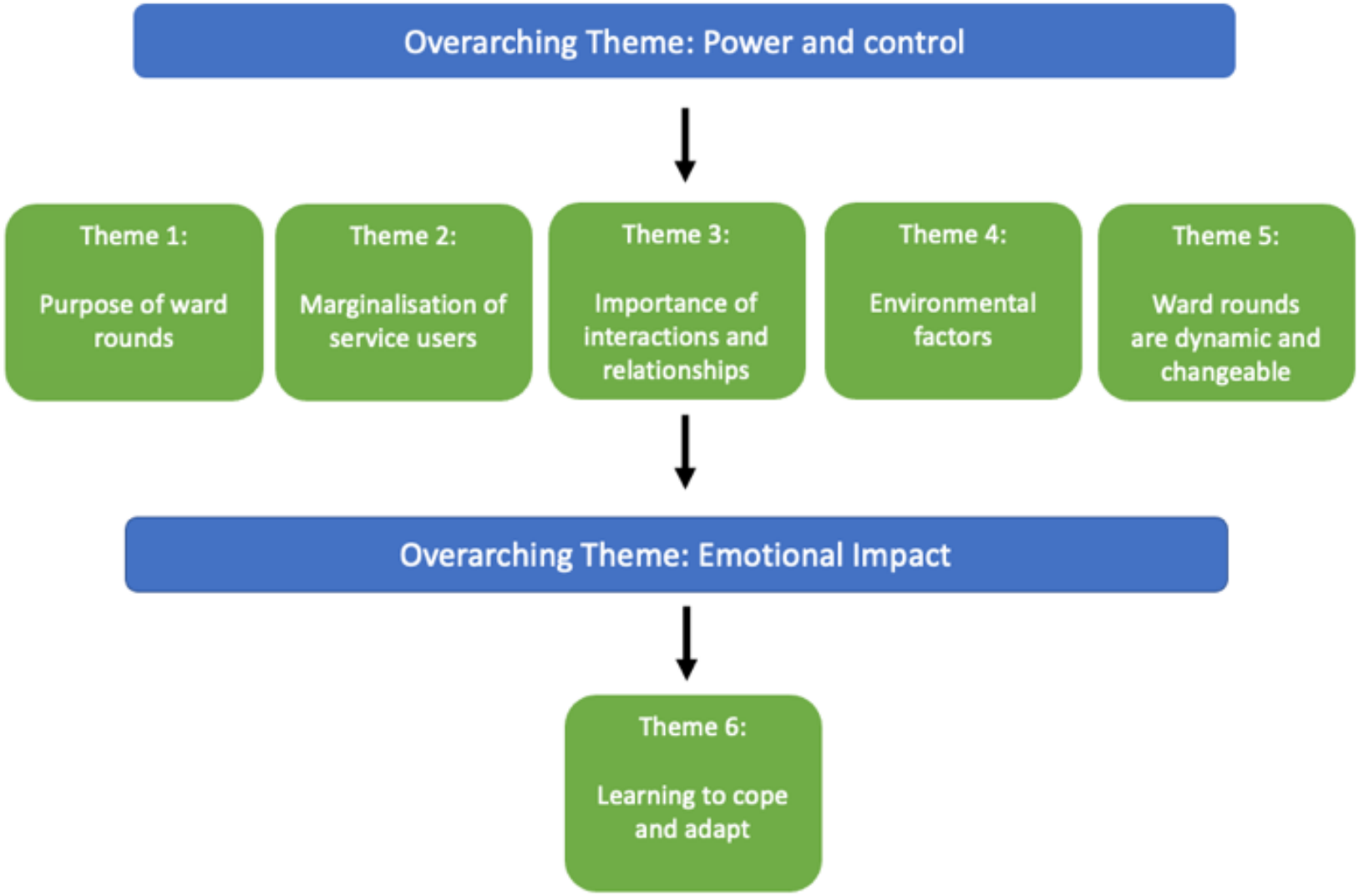


Figure 2. Conceptual diagram of the themes



Appendix 1-A

Example of stages of analysis for theme: "Importance of interactions and relationships"

Transcript	Stage one - Initial codes	Stage two - Descriptive themes	Stage three - Analytical theme
Patient C, who reported unease at 'probing' questions in the ward round	Probing questions	Interrogation of service users	Importance of interactions and relationships
It feels more like an interrogation than a formal meeting	Interrogation		
and another felt that it was like a 'grand inquisition'	Grand inquisition		
feel talked at rather than a conversation	Talked at by professionals		
Participants stressed the importance of good relationships with staff and that such relationships had a positive impact on their ward round experiences.	Good relationships with staff help ward round experience	Importance of relationships	
The nurses were identified as important members of the MDT and it was perceived, that they were on the side of the patient	Nurses' role important		
Some [nursing] staff will fight your corner	Nurses on service users' side		
Like I say, he listened. That's the main thing. And when you're in... when you're in the kind of situation I'm in at the moment, if people listen to you, it's half the battle, when you've got someone you can talk to, and I felt I could talk to that doctor and he listened	Feeling listened too		
The role of the named nurse was discussed with a number of patients suggesting that 'their nurse' attending the meeting could support the patient	Named nurse can support service user	Need for support	
I feel anxious and would like some more support from the [nursing] staff to understand what is to come.	Service user would like support		
Utilise patients' one-to-one time with named nurses so ward rounds can be prepared for	Named nurse could help service users prepare		
If you're close to that member of staff and they're sat at the side of you and if you were both speaking together... Like that would be good. 'Cos you'd feel like somebody's there for you, like, rather than being on your own.	Service users value having support in meeting		

They use all this, all this jargon, and you know, when your head's up your arse so to speak, you don't take much of it in	Jargon language used by professionals	Unclear communication	
The patients suggested that they do not always understand what the decisions mean	Not understanding what decisions mean		
There can be conflict between opinions, and nobody explains what is meant by the discussion. Need someone to explain it to you after the ward round.	Need professionals to explain decisions		
I don't always understand what is being said because of the language used – I guess it is just part of growing up? I don't understand big words	Not understanding language used by processionals		

Appendix 1-B
Guidelines for Authors: Mental Health Review Journal

Before you start

For queries relating to the status of your paper pre decision, please contact the Editor or Journal Editorial Office. For queries post acceptance, please contact the Supplier Project Manager. These details can be found in the Editorial Team section.

Author responsibilities

- Our goal is to provide you with a professional and courteous experience at each stage of the review and publication process. There are also some responsibilities that sit with you as the author. Our expectation is that you will:

- Respond swiftly to any queries during the publication process.
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- Treat communications between you and the journal editor as confidential until an editorial decision has been made.
- Read about our research ethics for authorship. These state that you must:
    - **Include** anyone who has made a substantial and meaningful contribution to the submission (anyone else involved in the paper should be listed in the acknowledgements).
    - **Exclude** anyone who hasn't contributed to the paper, or who has chosen not to be associated with the research.
- If your article involves human participants, you must ensure you have considered whether or not you require ethical approval for your research, and include this information as part of your submission. Find out more about informed consent.

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Our editors and employees work hard to ensure the content we publish is ethically sound. To help us achieve that goal, we closely follow the advice laid out in the guidelines and flowcharts on the COPE (Committee on Publication Ethics) website.

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- Your work should not have been submitted elsewhere and should not be under consideration by any other publication.
- If you have a conflict of interest, you must declare it upon submission; this allows the editor to decide how they would like to proceed. Read about conflict of interest in our research and publishing ethics guidelines.
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- Follow appropriate international and national procedures with respect to data protection, rights to privacy and other ethical considerations, whenever you cite data. For further guidance please refer to our research and publishing ethics guidelines. For an example on how to cite datasets, please refer to the references section below.

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Article length / word count	Articles should be between 4000 and 7000 words in length. This includes all text, for example, the structured abstract, references, all text in tables, and figures and appendices. Please allow 350 words for each figure or table.
Article title	A concisely worded title should be provided.
Author details	The names of all contributing authors should be added to the ScholarOne submission; please list them in the order in which you'd like them to be published. Each contributing author will need their own ScholarOne author account, from which we will extract the following details: • **Author email address** (institutional preferred). • **Author name**. We will reproduce it exactly, so any middle names and/or initials they want featured must be included. • **Author affiliation**. This should be where they were based when the research for the paper was conducted. In multi-authored papers, it's important that ALL authors that have made a significant contribution to the paper are listed. Those who have provided support but have not contributed to the research should be featured in an acknowledgements section. You should never include people who have not contributed to the paper or who don't want to be associated with the research. Read about our research ethics for authorship.
Biographies and acknowledgements	If you want to include these items, save them in a separate Microsoft Word document and upload the file with your submission. Where they are included, a brief professional biography of not more than 100 words should be supplied for each named author.
Research funding	Your article must reference all sources of external research funding in the acknowledgements section. You should describe the role of the funder or financial sponsor in the entire research process, from study design to submission.
Structured abstract	All submissions must include a structured abstract, following the format outlined below.

These four sub-headings and their accompanying explanations must always be included:

- Purpose
- Design/methodology/approach
- Findings
- Originality

The following three sub-headings are optional and can be included, if applicable:

- Research limitations/implications
- Practical implications
- Social implications

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The maximum length of your abstract should be 250 words in total, including keywords and article classification (see the sections below).

Keywords

Your submission should include up to 12 appropriate and short keywords that capture the principal topics of the paper. Our Creating an SEO-friendly manuscript how to guide contains some practical guidance on choosing search-engine friendly keywords.

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During the submission process, you will be asked to select a type for your paper; the options are listed below. If you don't see an exact match, please choose the best fit:

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- Discussion Piece Review
- Practitioner/Policy Paper Review
- Case Study
- Book Review

You will also be asked to select a category for your paper. The options for this are listed below. If you don't see an exact match, please choose the best fit:

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- The construction or testing of a model or framework
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- Papers with a practical focus

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Conceptual paper. Focuses on developing hypotheses and is usually discursive. Covers philosophical discussions and comparative studies of other authors' work and thinking.

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- Electronic figures created in other applications should be supplied in their original formats and should also be either copied and pasted into a blank MS Word document, or submitted as a PDF file.
- All figures should be numbered consecutively with Arabic numerals and have clear captions.
- All photographs should be numbered as Plate 1, 2, 3, etc. and have clear captions.

Tables

Tables should be typed and submitted in a separate file to the main body of the article. The position of each table should be clearly labelled in the main body of the article with corresponding labels clearly shown in the table file. Tables should be numbered consecutively in Roman numerals (e.g. I, II, etc.).

Give each table a brief title. Ensure that any superscripts or asterisks are shown next to the relevant items and have explanations displayed as footnotes to the table, figure or plate.

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- Page numbers should always be written out in full, e.g. 175-179, not 175-9.
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e.g. Wilde, S. and Cox, C. (2008), "Principal factors contributing to the competitiveness of tourism destinations at varying stages of development", in

	Richardson, S., Fredline, L., Patiar A., & Ternel, M. (Ed.s), *CAUTHE 2008: Where the 'bloody hell' are we?*, Griffith University, Gold Coast, Qld, pp.115-118.
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	Title of encyclopaedia (year), "title of entry", volume, edition, title of encyclopaedia, publisher, place of publication, page numbers.
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	Surname, initials (year), "article title", *newspaper*, date, page numbers.
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There are a number of key steps you should follow to ensure a smooth and trouble-free submission.

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Before submitting your work, it is your responsibility to check that the manuscript is complete, grammatically correct, and without spelling or typographical errors. A few other important points:

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- Does your manuscript comply with our research and publishing ethics guidelines?
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Section Two: Empirical Paper

Team formulation: A qualitative exploration of service users' views

Holly Riches

Doctorate in Clinical Psychology

Division of Health Research

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Prepared for: Mental Health Review Journal

Abstract

Purpose: Team formulation is a practice recommended when working within multi-disciplinary teams to develop a shared understanding of a service user. However, much of the current research has focused on staff and team outcomes and the perspective of service users is noticeably absent. Furthermore, consideration of whether service users should be involved in team formulations has been a topic of debate. This research therefore aimed to gain service users views on team formulation meetings and explore how this practice could be improved.

Methodology: Nine participants watched a fictional video vignette of a team formulation meeting, and their views were explored across three focus group interviews. The data was analysed using thematic analysis to develop themes.

Findings: Four core themes were developed: (1) *purpose of the meeting*, (2) *factors that support or impede the meeting*, (3) *the dilemma of service user involvement* and (4) *suggestions for moving forwards*. Service users acknowledged the dilemma between involving service users whilst equally acknowledging the advantages of professionals having a space to talk. Participants made suggestions of how the meetings could be improved and how service users voice could be better incorporated into team formulation meetings.

Originality: The present study is the first of its kind to directly explore service users' perspectives of team formulation by showing participants a video vignette of a team formulation meeting. Further research is needed to understand service users' views of team formulation meetings and explore how they can be meaningfully involved.

Keywords: team formulation, service users' views, service user involvement, mental health,

Formulation

Formulation is widely recognised as a core skill for psychologists and is specified as a key competence in the Health and Care Professions Council's (HCPC) standards of proficiency for practitioner psychologists (HCPC, 2015). There is no universal definition of formulation. However, the Division of Clinical Psychology (DCP) defines psychological formulation as "a hypothesis about a person's difficulties, which links theory with practice and guides the intervention" (DCP, 2011, p. 2). Johnstone (2018) describes formulation as a collaborative process between a clinician and service user, where the practitioner draws on their knowledge of theory, psychological models, and research, whilst the service user is the expert in their own experiences. Formulation seeks to make sense of a person's difficulties holistically by understanding how the difficulties arose and are maintained within the individual's life context, alongside acknowledging the person's strengths.

Team formulation

The BPS emphasise the importance of psychologists working within multi-disciplinary teams (MDTs) to encourage psychological thinking and improve outcomes for service users (Onyett, 2007). Team formulation is a rapidly expanding practice which promotes this way of working. Furthermore, it is recommended in numerous professional documents (DCP, 2011; HCPC, 2015). In this approach, a facilitator supports a group of staff to develop a shared formulation to understand the service user's difficulties and inform care planning (Hollingworth & Johnstone, 2014). In many settings, supporting individuals with mental health difficulties involves various professionals who interact with each other to provide care. Team formulation meetings can therefore be helpful to ensure there is a shared understanding between professionals of how to support the service user (Hartley, 2021). Supporting individuals in extreme distress can raise challenging feelings in teams such as

anger, stuckness and hopelessness (Johnstone, 2014). Having spaces for staff to explore their emotional responses can support staff to maintain positive regard and respect for service users, which is necessary for effective care (Hartley, 2021). The DCP (2011) suggest a range of benefits of team formulation, including but not limited to: promoting team working, encouraging psychosocial ways of thinking, changing culture in teams, and reducing negative staff perceptions of service users. Consequently, the DCP (2011) state that in team formulation the team become the primary client, not the service user.

Service user involvement and team formulation

Team formulation is a relatively new practice, consequently the evidence base is still emerging. Previous research has mainly focused on staff and team outcomes and the perspective of service users is noticeably absent. In a systematic literature review examining outcomes of team formulation (Geach et al., 2018), only one of the eight studies reviewed sought data from service users directly (Berry et al., 2016). Additionally, Geach et al., (2018) concluded that there is no strong evidence of change for service users following team formulation. It is unsurprising however, that there is less evidence for service user outcomes given the team is identified as the primary client in professional documents (DCP, 2011).

Discussions about whether service users should be involved in team formulations has been a topic of debate (Cole et al., 2015). This dilemma is recognised in the DCP guidelines (2011) which acknowledges that team formulation meetings are often used when staff are stuck or have counter-transference feelings about a service user, where it would not be helpful for the service user to be present. Consequently, the guidelines suggest that “the team formulation may, therefore, not be shared with the service user in its entirety” (DCP, 2011, p. 21). Moreover, several psychologists have acknowledged the tension around excluding

service users from team formulation meetings (Lewis-Morton et al., 2015; Wood, 2018; Stratton & Tan; 2019; Hartley, 2021).

Involving service users in their own care and treatment is at the centre of mental health policy initiatives, aimed at improving quality of care (Department of Health, 2011; NICE, 2011). Research has shown that involving individuals with mental health difficulties in their care has been associated with positive outcomes, including increased autonomy, improved communication and positive experiences of their care and staff (Millar et al., 2015). However, to date, only two studies have investigated team formulation meetings where the service user has been in attendance. In one case study, a service user and her team discussed their experiences of developing a co-produced team formulation (Lewis-Morton et al., 2017). The team described how co-production led to an enhanced collaborative understanding of the service user's difficulties and allowed the service user to take an active and leading role in her own care and risk assessments. The authors acknowledged the challenges associated with co-production, including anxiety and hesitancy from the team, and described how the process took time and trust. McKeown et al. (2020) also reported some encouraging findings in Secure Children's Homes, that suggest staff's knowledge, motivation, confidence, and satisfaction with the treatment plan is improved after attending a team formulation where the young person is present and actively participating.

Despite some early evidence suggesting there could be benefits to involving service users in team formulation (Lewis-Morton et al., 2017; McKeown et al., 2020), the practice is fundamentally set up to support the team rather than the service user (DCP, 2011). This has led not only to the exclusion of service users from the team formulation process but also exclusion of their voice from the evidence base. Involving service users in team formulation meetings has been identified as a challenge for professionals and services (Lewis-Morton et al., 2017). However, the alternative is that by excluding them, service users feel "done too"

and disempowered. This raises the question how mental health services and psychologists can involve service users meaningfully in team formulation. A first step in addressing this is to explore service users' views of team formulation meetings in a bid to understand ways in which team formulation practice could be improved.

Consequently, the aim of this study was to understand service users' views of the use of team formulations. The study was designed to answer the following research questions:

- What are service users' views of team formulation meetings?
- What are service users' thoughts on how team formulation meetings could be improved?

Ontology and epistemology

A critical realist position has been adopted for this research, which distinguishes between the world and our experience of it (Bhaskar, 2016). Critical realists assume that, at an ontological level, an objective reality can exist theoretically, and that this reality is shaped by structures and rules. Our knowledge of this reality is filtered through our perspectives and experiences. At an epistemological level, the aim of social research is to try to understand the structures that underpin reality, as filtered through our perceptions of it (Gorski, 2013). Critical realism encourages us to understand and address macro-level context on a social, political, and historical level and consider how power is enacted (Fletcher, 2017). This is important to consider in mental health settings where there are complex social, political, legal and contextual factors (McMurran et al., 2013). Additionally, critical realist research frequently makes recommendations which could result in changes to existing structures or policies (Haigh et al., 2019). In critical realist research participants' contributions can challenge existing theory and policies, making a critical realist perspective useful for change-orientated research (Fletcher, 2017). This epistemological position

therefore provides a framework for this research to understand the way service users' perceive team formulation and consider any recommendations for change (Alderson, 2021).

Method

Ethics

Ethical approval for the study was provided by Lancaster University Faculty of Health and Medicine Research Ethics Committee. Full documentation of the ethics application is contained within section four of this thesis.

Design

A qualitative design was chosen, given the uniqueness of the focus of the research. As far as the researcher is aware, no previous research has looked at service users' views of team formulation meetings. This research project was therefore exploratory, and a novel design and methodology was used to explore the subject matter. Due to the nature of team formulation meetings, service users are usually excluded, thus they are unlikely to understand what a team formulation meeting is. Hence, to gain service users' views of team formulation meetings, participants first needed to be made aware of the concept. To enable this, a team formulation meeting was replicated by creating a video vignette of a fictional team formulation meeting. Vignettes are a valuable tool for exploring individuals' perceptions of specific situations and are useful when studying sensitive topic areas which may not be assessable though other means (Barter and Renold, 1999). While written vignettes are most common, video vignettes have been used in qualitative research (Cohen & Strayer, 1996; Eskelinen & Caswell, 2006; Jiwa & Meng, 2013). The video vignette was thus used as a tool to enable participants to understand what happens in a team formulation, to generate discussions about their use and to allow participants to reflect on their own responses to what they saw.

Focus group interviews were chosen, as they are recommended when researching a topic that has not been studied previously (Kite and Phongsavan, 2017). They allow for the analysis of opinion in greater depth through discussion, which is of particular importance in exploratory research (Frey & Fontana, 1993). Moreover, focus groups are an ideal method for research in which the goal is to give a voice to participants from marginalised populations (Davis, 2016), hence in line with the critical realist epistemology.

Thematic analysis was used to analyse the data (Braun and Clarke, 2006). Given this research is exploratory, thematic analysis is a useful method for examining differing perspectives, highlighting similarities and differences, and generating novel insights (Clarke et al., 2015). Furthermore, thematic analysis is a flexible approach which can be applied to a variety of qualitative methods and epistemological stances (Braun & Clarke, 2014).

Participants

Nine participants took part in the study, across three focus groups. Eleven individuals were recruited however two individuals did not attend the focus groups at the allotted times. All participants self-identified as having long term mental health difficulties. Table 1 provides an overview of participant demographics. Certain details have been withheld to support anonymity.

[INSERT TABLE 1]

Context

This research was conducted during the COVID-19 pandemic and consequently the research project was conducted solely online. This decision was made to protect the health and safety of both the researcher and participants and ensure that no public health measures were breached.

Procedure

Recruitment

Participants were recruited using an advert (Appendix 4-B) which was disseminated on social media platforms, through service user groups and charities. Inclusion and exclusion criteria are presented in Table 2 and was designed to be broad and inclusive.

[INSERT TABLE 2]

Individuals who contacted the researcher were provided with information packs about the study, including the participant information sheet (Appendix 4-C) and consent form (Appendix 4-D). They were encouraged to have a phone call with the chief researcher to ask any questions. Individuals who maintained interest in the project were asked to either return the signed consent form via email or consent was taken via a phone call with the chief researcher which was audio-recorded. Once participants had consented, they were sent a Microsoft Form via email and asked to complete demographic information and record their availability for attending a focus group. Arrangements were then made to conduct the focus groups at a time convenient to participants

Materials

A short video vignette of a fictional team formulation meeting was created to be used as part of the focus groups. The video was created by the chief researcher in collaboration with three research supervisors, two of whom are clinical psychologists who have experience of team formulation meetings. First, a written vignette about a fictional service user called ‘Kelly’ was produced (Appendix 4-E). The vignette aimed to cover a range of presenting difficulties that might be seen in mental health services; representing an individual who might typically be discussed at a team formulation meeting. Four mental health professionals agreed improvise a fictional team formulation meeting. They were all provided with the written

vignette and asked to use this information as the basis of the improvised conversation. Team formulation meetings are often led by a clinical psychologist (Johnstone, 2018) therefore a clinical psychologist, who regularly facilitates team formulation meetings, was chosen to lead the fictional meeting. The other three mental health professionals took on roles of different members of an MDT: mental health nurse, key worker and social worker. The video was pre-recorded on Microsoft teams and then edited to form a 17-minute video.

Data collection

Once participants had been assigned to a focus group, they were sent an invitation to a Microsoft Teams link and asked to accept to confirm attendance. The day before the focus group participants were sent a reminder email and a link to the video vignette and were asked to watch the video once before the focus group.

An interview guide (Appendix 4-F) was developed for the focus groups which was designed to facilitate conversations about the video vignette. The interview guide started by asking participants to introduce themselves, they were then reminded of their rights as participants and information about confidentiality and group rules was shared. The video vignette was then introduced by the chief researcher and was played for a second time to participants using the share screen function on Microsoft Teams. Following this, the chief researcher then followed the interview guide which included an opening question followed by specific and free probes and a final wrap-up question (Morgan, 2002). The focus group interviews lasted between 45-56 minutes and were recorded using the recording function contained within Microsoft Teams.

Data Analysis

Braun and Clarke's (2006) six stages of thematic analysis were followed to provide a clear structure for the analysis. As the research was exploratory, an inductive approach to

thematic analysis was chosen, as this approach works well with unknown data with open-ended questions (Clarke et al., 2015). In inductive analysis the researcher develops themes from the data without trying to fit it into preconceived ideas or frameworks (Braun and Clarke, 2006).

First, recordings from the focus groups were transcribed verbatim and then read several times by the chief researcher to familiarise themselves with the data and initial ideas were noted. Transcripts were then coded line-by-line. An example of a coded extract is provided in Appendix 2-A. All codes were then typed into a table and printed onto different coloured paper, representing one of the three focus groups. A common criticism of coding is that context is lost (Bryman, 2016), therefore each printed code included page and line numbers so that the transcript could be referred to when needed. Codes were then cut out and collated with similar codes and then codes were sorted into potential themes (Appendix 2-B). Post-it notes were used to write brief descriptions of initial themes and an initial thematic map was created and refined during supervision discussions (Braun and Clarke, 2006).

Reflexivity and quality of analysis

Consistent with critical realism, it is important to acknowledge the impact of the researcher's biases, beliefs, and personal experiences in relation to the research. This is consistent with Braun and Clarke's (2021) reflexive approach to thematic analysis. The authors describe the reflexive process as "a disciplined practice of critically interrogating what we do, how and why we do it and the impacts and influences of this on our research" (Braun & Clarke, 2021, p.5). The researcher used supervision and a reflective journal (King, 2010) to consider the personal and contextual aspects of the process. The researcher reflected on their personal identity throughout data collection and analysis, as well as their context as a trainee clinical psychologist who uses team formulation in their clinical practice. This helped the researcher to step back from the research, putting aside assumptions to observe the data

(Barker et al., 2015). Reflexive practice has been established as one method of ensuring rigor and quality in research (Dodgson, 2019). To further ensure the quality of the analysis, an academic supervisor experienced in qualitative analysis, coded a section of the analysis at step two (Braun and Clarke, 2006), which was compared with the researcher's own codes to check the quality of coding. The research team were involved in step four and five of analysis (Braun and Clarke, 2006) to ensure that thematic development was true to the data (Yardley, 2017).

Results

Four core themes were developed from the focus groups: (1) *purpose of the meeting,* (2) *factors that support or impede the meeting, (3) the dilemma of service user involvement* and (4) *suggestions for moving forwards*. Core themes were broken down further into 14 subthemes which are presented in Table 3. The themes are illustrated in a conceptual diagram to demonstrate the relationships between themes (Figure 1).

[INSERT TABLE 3]

[INSERT FIGURE 1]

Theme 1: Purpose of the meeting

1.1 Team working together to help service user

The team formulation meeting was viewed by participants as a space for the team to meet to help the service user: "They're having a meeting to try and work out what's best for her" (F1P1). Participants felt that the team's intention was to work together as a team in the interests of the service user: "The meeting was to try and help her in some respects and, you know, like all parties working together for her best interest" (F2P4). Participants recognised that the professionals were attempting to think about how they could move forwards from

feeling stuck: “They were all kind of acknowledging that they were stuck and thinking what other options are there? What can we do differently?” (F3P1). Participants appreciated that the team were attempting to help, although some questioned whether the process of helping was flawed: “They're trying to help her, even if it's slightly misguided, but at least they are attempting to do it” (F2P4).

1.2 Understanding the service user

The participants observed how the team thought about the service user’s past and current experiences in combination with their own views, to help understand the service user’s perspective. They described observing the team generating hypothesises to try to understand how the service user feels: “I quite liked how they didn't state things as facts if they weren't quite sure, so it was, you know, assumptions, but in the best way possible to kind of say, ‘I imagine she feels like this’” (F3P2). However, it was discussed that this could have been explored in more depth: “They did consider how the service user might be feeling but I think there could have been more exploration around that” (F3P1). Some participants thought the professionals were not successful in understanding the service user because they did not know enough about them: “They just weren't able to do that work were they, because they didn't know Kelly enough” (F1P3). Overall, participants believed it was beneficial for the professionals to spend time understanding the service user, but they would have liked this to have been done on a deeper level.

1.3 Generate ideas

The meeting was seen as a forum which helped professionals to generate ideas for moving forwards. Participants believed the meeting worked well as a space to discuss ideas and come up with a plan for how to help: “I thought it worked quite well as a kind of an airing ideas around” (F3P1). This consequently helped the meeting to have a purpose:

"Ultimately they did manage to come to some kind of decision about the next steps, so I guess it had a purpose" (F3P2). Moreover, participants commented on how the professionals were able to use the understanding they had developed to think about what the service user needs: "One of them said, but she needs a friend. She needs someone and just maybe the fact they recognised that you know was good" (F1P1). The meeting was recognised as an opportunity for all voices in the team to be heard and to make suggestions for supporting the service user: "The psychologist was trying to formulate a care package for her and the content of all these different voices being put together, to give her an idea of a way forward".

1.4 Psychologist's role

According to participants the psychologist's role was key in enabling the meeting to function and have a purpose: "having the one person the psychologist, sort of chair it and then gather ideas from everyone helped so that it wasn't just sort of a random conversation, like it had a purpose and she moved it through" (F3P2). Participants described how the psychologist enabled the team to understand the service user and generate ideas by bringing together information from different professionals to formulate an understanding of the service user: "She was trying to find out what she could get from the social worker the CPN and the key worker to formulate her own view about how to move forward in this case" (F2P2). Furthermore, the psychologist role was vital in helping the team to consider ideas for moving forwards: "I think the whole point was the psychologist running it, to see a pathway forward" (F2P4).

The psychologist was perceived by some participants to be encouraging the MDT to be more empathic and compassionate. However, they felt that some members of the team were unwilling to engage with a more empathic way of thinking: "and I think that's what the psychologist were trying to do, trying to get them to, you know, be more compassionate, but

they weren't forthright" (F2P1). Similarly, another participant observed the psychologist asking useful questions but felt that some professionals didn't respond in a helpful way: "I think she tried to ask the right questions as well. Even though some of them were answered wrong. But you know, I think she asked a lot of the right questions" (F2P4).

Theme 2: Factors that support or impede the meeting

2.1 Knowledge of the service user

Participants acknowledged that there was a reasonable understanding of the service user, however, they felt that the meeting highlighted gaps in their knowledge. Some professionals did not know the service user very well, which participants felt impeded the meeting: "two of the people just didn't know very well at all. So how, you know how on earth are they going to be able to make a valuable contribution to the meeting" (F1P3). Participants observed that some professionals relied on notes to be reminded of the service user's history and some questions were left unanswered because the team didn't know enough about the service user. Participants felt that the professionals should have been better prepared for the meeting: "I think they could have done a bit more background stuff 'cause they all admitted that they were working with limited knowledge…they should have been better prepared" (F1P1).

Some professional in the meeting had never met the service user. "He's in a meeting about someone he hasn't met with before and is just reading a couple of notes, so I find that he's basically not gonna be any use" (F3P2). Consequently, participants questioned the rationale for having professionals in a meeting who do not know the service user: "He said that he hasn't met her yet… why is he even in the meeting?" (F2P2). Some participants reflected on how this may be outside of the team's control: "I guess staff do turnover at different times so yeah that's not ideal but yeah I get when it happens" (F3P1).

The participants agreed that the team need to make an effort to get to know the service user: “Just because one thing doesn't work doesn't mean you give up. You need to keep going until you find a connection” (F2P4). They thought that this would help with the process of the meeting and increase the likelihood of service users engaging.

2.2 Professionals’ engagement

Overall, participants felt that the professionals were considerate and discussed the service user in a respectful way: “I was kind of on the lookout for like if they were gonna use kind of really alienating stigmatising language, but I thought they seemed… interested in supporting the person, and yeah, talked about her positively” (F3P1). However, participants noticed differences in attitudes and behaviour. They identified how some professionals displayed compassion and looked interested in the meeting: “She was very empathic, and you could see that she was really trying to help” (F3P2), whereas they perceived some of the professionals’ body language and facial expressions indicated that they were disinterested: “He just didn't seem interested, not in the slightest bit” (F2P1). They commented on how professionals’ interpersonal skills and body language would be especially important if the service user was present: “The point, in particular, I found quite difficult was just their facial expressions… and if the service user was there then she would have perceived those things too and found that again quite challenging” (F3P2). Furthermore, participants felt the service user would have been frustrated if they had been attending or been able to watch the video: “I think if Kelly could watch that video. If Kelly existed and she could watch that video. I think should be quite annoyed at what she seen” (F2P2).

2.3 Importance of action plan

The importance of professionals setting an action plan at the end of the meeting was highlighted by participants. They observed that some actions for moving forward were

generated: “there were some actions to follow up on to kind of to help to move things forwards” (F3P2). However, participants thought that the action plan was unclear, and the meeting was left unresolved: “A lot of information was taken on board, but it seemed like no decision was actually concluded about what was going to be the move forward for her” (F2P4). Participants expected tasks would have been clearly allocated to different professionals at the end of the meeting with deadlines for them to abide by: “There wasn’t a clear action plan. Like you know, roughly a timeline of couple of weeks or a month… how quickly you gonna report back about that to the psychologist and then what happens from that?” (F3P2). Participants thought a written action plan would hold professionals accountable for the tasks they had committed to. Participants also wanted next steps to be communicated with the service user “making sure any sort of yeah, next steps, particularly in terms of communicating next steps to the client are transparent and in writing as well” (F3P1).

2.4 Lack of service user voice

Lack of service user voice was identified by all participants as a key drawback of the meeting: “They were talking about her and not to her” (P2P4). They commented on how this impacted on being able to view the service user as a real person: “I felt like they sort of talked about her, but I didn't get any sense of Kelly as a person… without her input it's just like she's being talked about, but she doesn't seem to feel real as a person” (F1P1). This meant that the service user’s views and perspectives were not represented accurately. Furthermore, the lack of advocacy or someone speaking on behalf of the service user was noted: “There was just the lack of, someone speaking for her fighting for her rights, because that's evidently what she needs” (F2P4).

Participants reflected on their own experiences of not being involved in meetings about them and commented on how this is usual practice: “It’s always been a discussion without the person being there, as long as I've been around services, it's always been like that.” (F1P2). Some participants wondered whether the service user wasn’t invited because the professionals did not want or value their input: “They just didn’t want her input or her contribution” (F2P3). Other participants questioned whether power imbalances meant professionals had even considered inviting the service user: “I think for some people it might not even occur to them to invite a service user 'cause there's still this kind of us and them culture.” (F3P1).

Participants were strongly in favour of the service user being able to have a voice in the meeting. Some felt that the service user should always be present: “It’s a pretty pointless meeting if the service user isn't there. They've got to be there” (F1P3). Whereas others felt that it would be enough to have the service user’s views shared in the meeting.

Theme 3: The Dilemma – “It’s tricky”

The dilemma between involving service users in team formulation meetings whilst equally acknowledging the advantages of professionals having a space to talk was discussed.

3.1 Benefits of service user involvement

A range of benefits of service user involvement were identified by participants, for both the service user and the team. These included getting to know the person better: “It would have been an opportunity if she had been in the meeting for them to get to know her a little bit more” (F1P3) and being able to gain a better understanding of the issues facing them: “to form a true picture of somebody, they need to be there in the room with you, discussing their issues, maybe giving some explanation” (F1P1).

Furthermore, questions hypothesised about during the meeting could have been answered by the service user: “When they were sort of supposing, ‘I wonder what things are like when it was going better’, like she would be able to answer those questions” (F3P1). It was believed service user attendance would allow the service user to express themselves and the team would have a better understanding of their needs: “You would have a much better indication of what's going on in Kelly's mind and what she wants in her life, if she’s present” (F1P1). Moreover, participants thought this would help the progression of the meeting: “There are definitely moments in there where the patient could have offered quite a bit of information that would have helped to move it along” (F3P2). Service user involvement would allow the team to listen to the service users’ ideas and suggestions: “They just need to listen to people…just be patient with her and she will tell you exactly what it is she needs from you for her to get better… the answers will come from Kelly” (F2P4). Ultimately participants argued that service user involvement would allow the team and service user to work alongside and make decisions together: “There could be room to kind of problem solve together” (F3P2).

3.2 Space for professionals to “hash it out”

When watching the video vignette, some participants also identified benefits of professionals having a space without the service user. This included allowing the team to share their thoughts openly in a way they might be unable to do if the service user was present: “So that they can say things they might not want to in front of Kelly” (F1P3). Participants recognised this was especially important if the team were feeling stuck with how to move forwards:

> “There is a place for professionals just talking to kind of like, yeah, to kind of hash it out, like what are we going to do?... Like the service user not being there, kind of

> allows for the sort of free flow of ideas. Like if they're at a stuck point, perhaps you need to be able to sort of hypothesize stuff like if the service user was there, they might not have raised" (F3P1).

Participants discussed how this space would allow professionals to arrive at a quicker understanding of the issues, which in turn would help the service user: "Being able to have those conversations and just be able get to the point and get through what you need to get through, to be able to help the patient" (F3P2). These viewpoints were not represented by all participants, with some participants believing that the service user should always be present.

Theme 4: Suggestions for moving forward

Participants made suggestions of how to move forwards from the dilemma of service user involvement and made recommendations for how team formulation meetings could be improved.

4.1 Service user choice

It was argued that the service user should have a choice about their involvement in team formulation meetings. Participants commented on how the choice to attend is often taken out of the service user's hands as they are uninformed meetings are happening: "Because ultimately, you haven't got much choice. It sounds like the choice has been taken out of her hands and she's not there" (F1P2). Thus, most participants argued service users should be informed about the meeting and offered the opportunity to attend if they wish: "Being able to offer that at least to patients, if it is possible for them to come, and then they get to make that decision for themselves" (F3P2).

4.2 Safe space for service users to attend

Participants strongly believed that if service users choose to attend, certain aspects of the meeting would need to be addressed to make the space feel safe.

Service user's needs. Participants highlighted the team would need to consider the type of support the service user might need to attend: "If she is able to attend the meeting, she should be given whatever support she needs to get her there and to get through it" (F1P1). Trusting relationships were identified as being integral to creating a safe space for service users to share their personal history with professionals: "If she's not built up a rapport with the professional, she may not feel comfortable going into detail about what happened when she was a child, so that would be really difficult as well" (F3P1). It was felt that therapeutic relationships would need to be established before conducting team formulation meetings: "They might need to gain her trust before holding meeting" (F2P4). Furthermore, participants suggested that service users should be prepared for their role in the meeting: "Work should be done prior to the meeting to prepare her for what's coming…I think if you practised in the sessions with the CPN, doing mock run up to the meeting or what might be discussed" (F2P4).

Power imbalance. The power imbalance between service user and professionals was identified as a barrier to participation of the service user: "I think she would have felt quite attacked by having four different people versus her" (F3P2). Participants commented on the emotional impact of attending a meeting without any support; suggesting service users should have the opportunity for someone to support them in the meeting:

> "Maybe give her the chance to bring someone whether to meeting if she got, you know a peer support, you know somebody outside of the professional circle because it could be intimidating to be faced with four professionals, it's an imbalance, so she should be supported" (F1P1).

Environment. Participants also emphasised the importance of creating a relaxed environment for service users to feel comfortable to attend: “You'd have to make it as informal as possible. For it to be less threatening and less imposing” (F2P4). Suggestions included meeting around a circular table: “Sitting in a circle feels important, cause yeah, the idea of turning up to like an interview panel of professionals” (F3P1) and providing tea and biscuits:

> I don't know if this is just Fantasyland, but if there was like a kettle in the room and it's like you come in and have a of cup of tea, you can sit down and… it just kind of felt like we're all here to talk about this, 'cause we're all interested in helping you, that might have a different vibe (F3P1).

Furthermore, it was believed that allowing the service user to choose a place to hold the meeting would be beneficial: “If you know, meeting in Kelly's home works, or… wherever Kelly felt comfortable and could relax and actually relate to them, that would be the optimum” (F1P1).

4.3 Creative service user involvement

Participants felt strongly that the service user voice should be represented in the meeting, even if they chose not to attend. They wanted professionals to be more creative in involving service users meaningfully in the process: “All the potential ways to involve people, it's not always about them being in the room” (F3P2); “I think to make it a more effective process, it needs to be much more creative and flexible” (F1P1). Suggestions included having a 1:1 session before the meeting to share their perspective or making a written or recorded statement that could be shared in the meeting: “You know whether it's a recorded message, wants to write a letter, or whichever way, or whether she wants somebody

else to be in that meeting, specifically on her behalf. Just as much effort as possible to involve that person" (F1P3).

4.4 "Keep the client as a human in mind"

Regardless of whether the service user is present or not, professionals should keep service users in mind and remember that they are "dealing with human beings, made of flesh and bones and they should be treated with love and tender care." (F2P2). Participants noted this was particularly important when service users are in the room, as they will be sensitive to professionals' language and facial expressions. However, it was important for participants that professionals communicate in a respectful way, even when the service user is absent:

> "It's important to always keep the client as a human in mind, so it's like it's like they're in the room, even though they're not in the room, and I think the most important thing for them to continue to see the human" (F3P1).

Discussion

The present study is the first of its kind to directly explore service users' perspectives of team formulation by showing participants a video vignette. Focus group discussions produced four main themes and 14 subthemes. The relationship between themes is presented in a conceptual diagram (Figure 1). Firstly, participants described their understanding of the purpose and aims of the meeting. The diagram illustrates how the psychologist's role was key in ensuring purpose by supporting the team to understand the service user and encouraging them to generate new ideas and ways of working. Following on from this, participants identified factors they felt would either support or impede the success of these meetings. The lack of service user voice was identified as a key drawback of team formulation meetings and the diagram shows how this led to a discussion around the tension between service user

involvement and the need for professionals to have a separate space. As a result of this dilemma, participants made suggestions of how team formulation meetings could be improved to address the lack of service user voice. The theme "keep the client as a human in mind" is illustrated in intersecting circles to emphasise the importance of professionals holding the service user in mind, regardless of whether they attend the meeting or not. The findings are discussed further in relation to current literature and implications for clinical practice.

Functions of team formulation

The findings indicate that participants' understanding of the function of team formulation meetings is relatively consistent with the existing evidence base. Service evaluations have found staff teams report an increased understanding of service users following team formulation meetings (Turner et al., 2018; Stratton & Tan 2019). Additionally, some papers report how psychologists believe this new understanding has an impact on staff's compassion and empathy for service users (Christofides, 2012; Wood, 2018). However, from watching the video, participants identified that some professionals were less engaged and less willing to adopt a more compassionate understanding of the service user. Furthermore, participants commented on how the lack of knowledge of the service user impeded the team formulation process. A survey of clinical psychologists' accounts of team formulation implementation concluded that limited engagement from staff and lack of psychological understanding obstructs the team formulation process (Geach et al., 2019). In contrast, good knowledge of the service user and the team's openness to psychological approaches supported team formulation (Geach et al., 2019). The psychologist's role was acknowledged by participants as important in facilitating the meeting. This is consistent with a thematic synthesis of staff views of team formulation which found

that staff members attributed the success of the meeting to the role of the facilitator (Bealey et al., 2021).

Generating ideas for moving forwards was identified as an important function of team formulation meeting. Moreover, participants identified the absence of an action plan as a limitation. Several studies report that staff describe discussing new ideas in team formulation meetings and consequently make changes to their clinical practice (Summers 2006; Beardmore & Elford, 2016; Turner et al., 2018). However, over half of staff on an inpatient ward suggested that the meeting did not result in a strategy for moving forwards (Dallimore et al., 2016). Furthermore, Wood (2018) highlighted discrepancies in psychologists' reports of action planning. Inconsistencies across the literature could be indicative of differences in facilitators' approaches to team formulation. This study emphasises the need for facilitators of team formulation meetings to prioritise the development of a clear action plan at the end of meetings.

Service user involvement

Current conventional practice excludes service users from team formulation meetings. However, this study has highlighted the need for service user involvement in team formulation to be reconsidered in both clinical practice and on a broader professional level. Participants recognised the challenges associated with involving service users, however they emphasised that service user involvement should be encouraged, whether this be directly or indirectly. The key principle of "keep the client as a human in mind" was strongly evident, stressing the importance of professionals discussing service users in a respectful way regardless of whether they are in attendance or not. This is concurrent with a policy document from the King's Fund titled 'Seeing the person in the patient' (Goodrich & Cornwell, 2008).

Furthermore, participants commented on the lack of service user voice in the video and discussed the benefits of service user involvement. The primary benefit being that involvement could lead to a better informed and more accurate formulation and thus more effective care plans. This echoes findings from Lewis-Morton et al. (2017) and McKeown et al. (2020) who also reported some encouraging findings; suggesting involving service users in team formulation meetings is not only possible but can have positive outcomes for both staff and service users. Despite the proposed benefits, the challenges of service user involvement in team formulation have been the subject of discussion by several authors (Cole et al. 2015). This tension was identified by some participants who commented on the advantages of service user involvement, as well the benefits of a separate space for professionals to "hash it out". Staff have reported benefiting from a space where they felt listened to and reflect on their practice (Unadkat et al., 2015; Dallimore et al., 2016; Whitton et al., 2016). In addition, psychologists have commented on the benefits of allowing staff a "space to think" without service users being present (Christofides et al., 2012).

Some solutions to this dilemma have been proposed by psychologists, such as meeting with service users beforehand to incorporate their views (Wood, 2018) or writing a summary letter to the service user following the meeting (Milson and Phillips, 2015). This is concurrent with participants' views, who also suggested a range of creative ways that service users can be involved in team formulation meetings. However, some participants deemed these suggestions as an alternative only if service users have chosen not to attend. This tension needs further consideration by psychologists and professional bodies such as the DCP, to address how to involve service users in team formulation meetings, as well as maintaining reflective spaces for staff teams.

Participants noted several factors would need to be considered for service users to feel safe to attend team formulation meetings. Participants commented on the need to address

power dynamics, environmental factors, and service users' individual needs. Similar views have been expressed by service users sharing their experiences of attending MDT meetings (Haines et al., 2018; Leese & Fraser, 2019). Facilitators of team formulation meetings should therefore carefully consider how to support a service user to attend. This could be achieved by having a 1:1 session with the service user prior to their formulation meeting to consider their preferences and needs.

Strengths and limitations

This study provides an initial contribution to understanding service users' views on team formulation meetings. The novelty of the methodology, using a fictional video vignette, allowed service users' views to be explored in a safe and containing way. However, definitions and implementation of team formulation can vary massively (Short et al., 2017; Geach et al., 2018), therefore the short fictional video used in this study will not be transferable to different team formulation practices. The novelty of the methodology will be discussed further in the Critical Appraisal Section.

Despite the online element of the focus groups, recruitment was challenging, and two participants did not attend the focus group, resulting in a small sample size. Furthermore, the study's findings are limited to a white British sample and therefore may not be representative of individuals with different demographics.

Future research

This study explored service users' views of a fictional team formulation. However, it would be beneficial for future research to explore service users' experiences of attending team formulation meetings. McKeown et al. (2020) developed a framework for involving young people in formulation meetings however they did not explore service users' experiences of this. Future research could follow a similar framework and conduct interviews

with service users to explore their experiences of attending team formulation. It will be important for future research to also explore professionals' views of having service users present in team formulations to understand any challenges they perceive and discuss ways to overcome these.

Conclusion

This paper utilised a novel approach to explore service users' views of team formulation meetings. The findings highlighted the dilemma between involving service users whilst equally acknowledging the advantages of professionals having a space to talk. Suggestions of how team formulation meetings could incorporate service users' voices into team formulation meetings were made. A key challenge to service user participation in team formulation meeting, and consequently research, is that it is not in line with current guidance (DCP, 2011). Guidelines therefore need to be reviewed to consider how team formulation meetings can continue to provide a forum for staff teams, whilst also encouraging service user involvement. Research exploring service users and professionals' views and experiences of collaborative team formulation meetings could be used to inform the development of these professional guidelines.

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Tables and Figures

Table 1. Participants demographics

Identification number	Age range	Gender	Ethnicity
P1F1	55-64	Male	White British
P2F1	35-44	Male	White British
P3F1	55-64	Male	White British
P4F1	55-64	Female	White British
P1F2	65-74	Female	White British
P2F2	45-54	Male	White British
P3F2	55-64	Male	White British
P1F3	25-34	Female	White British
P2F3	25-34	Female	White British

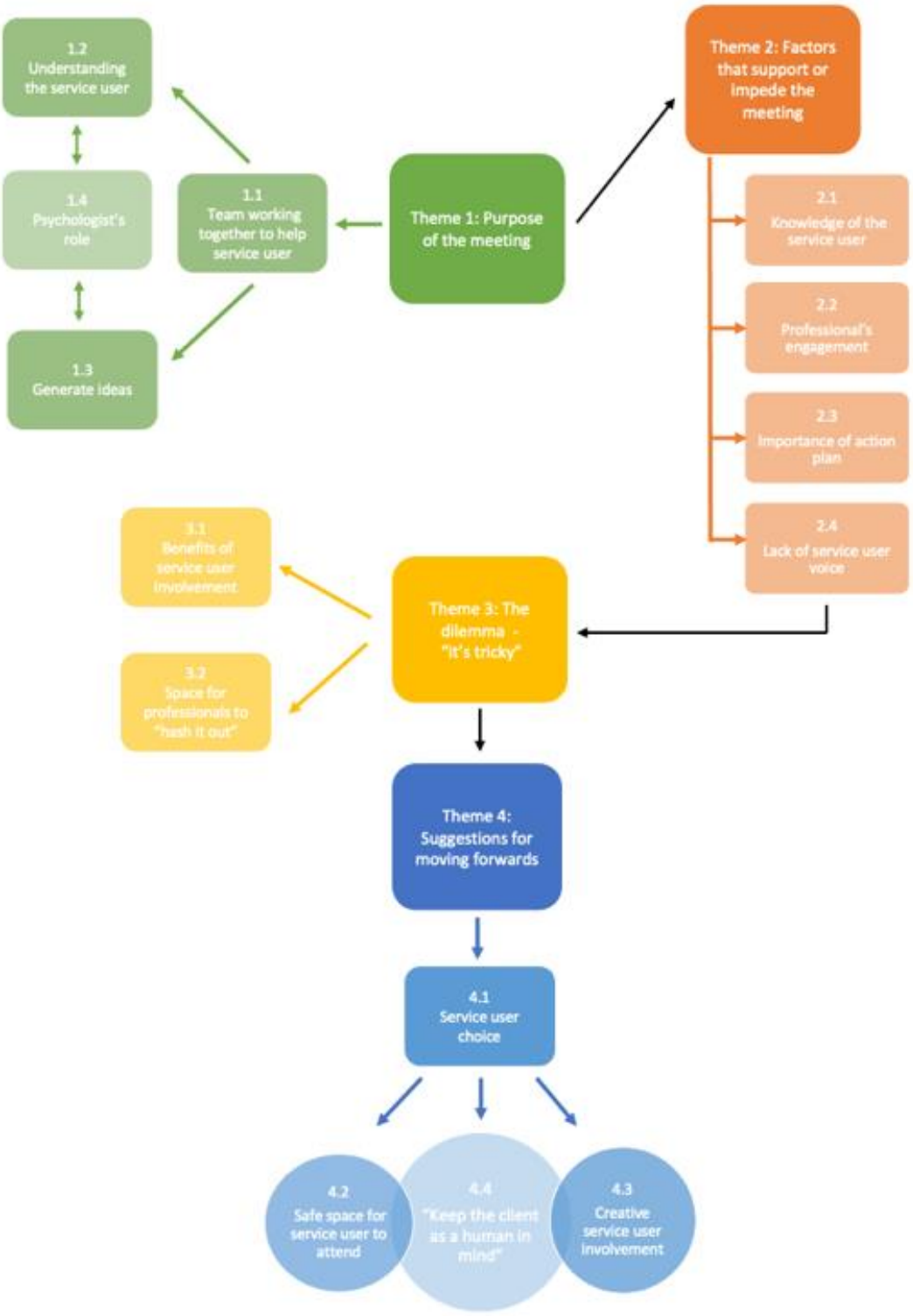
Table 2. Inclusion/Exclusion criteria

Inclusion Criteria	Exclusion criteria
1) Adults (18 or over) 2) Identify as someone who has long term mental health difficulties 3) Currently living in the UK 4) English speaking 5) Has access to use of Microsoft Teams	1) Currently accessing crisis support for their mental heath

Table 3. Summary of themes and subthemes

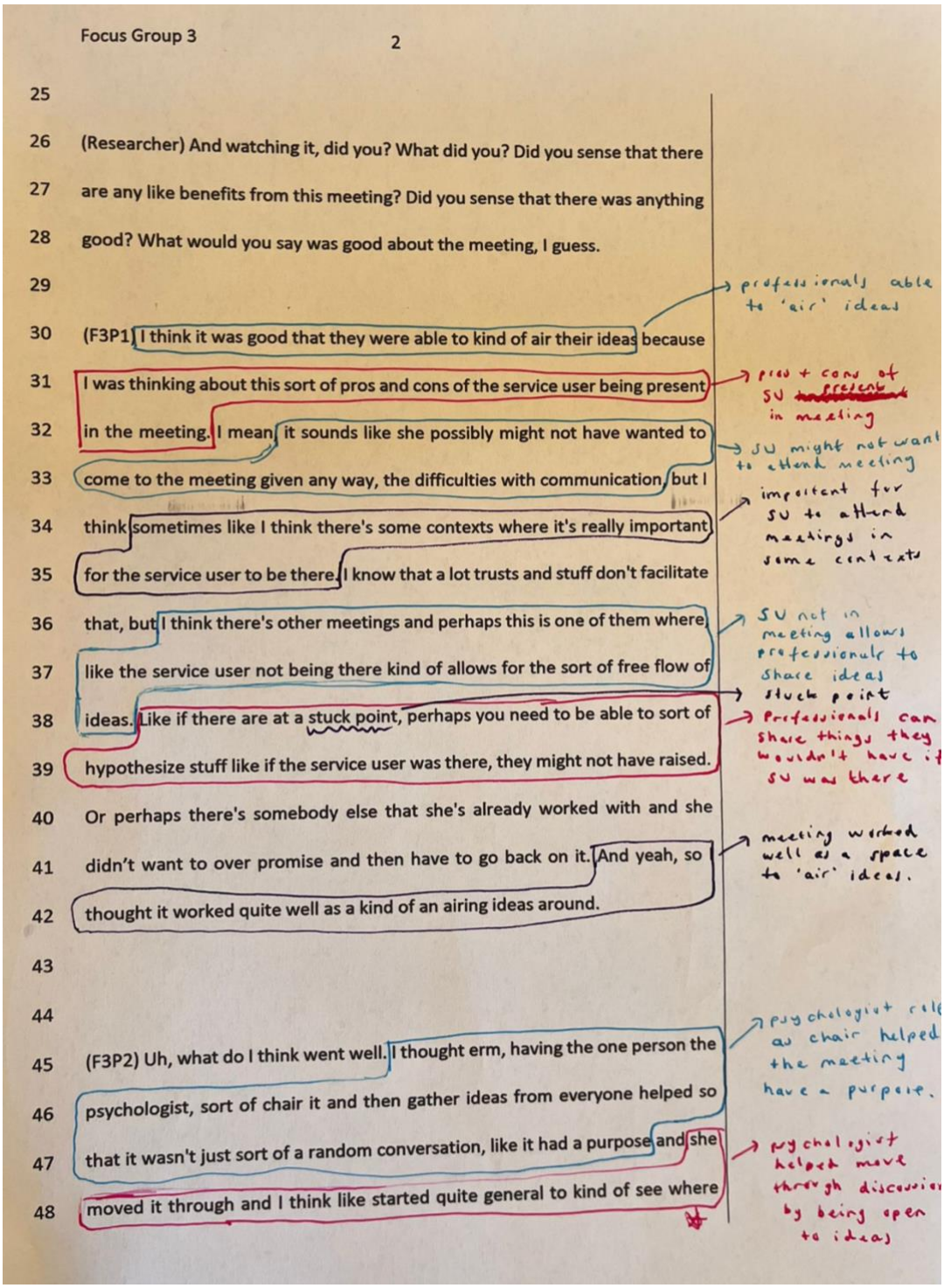
Themes	**Subthemes**
Theme 1: Purpose of the meeting	1.1 Working together to help the service user
	1.2 Understanding the service user
	1.3 Generate ideas
	1.4 Psychologists role
Theme 2: Factors that support or impede the meeting	2.1 Knowledge of the service user
	2.2 Professional's engagement
	2.3 Importance of action plan
	2.4 Lack of service user voice
Theme 3: The dilemma – "It's tricky"	3.1 Benefits of service user involvement
	3.2 Space for professionals to "hash it out"
Theme 4: Suggestions for moving forward	4.1 Service user choice
	4.2 Safe space for service user to attend
	4.3 Creative service user involvement
	4.4 "Keep the client as human in mind"

Figure 1. Conceptual diagram of the themes



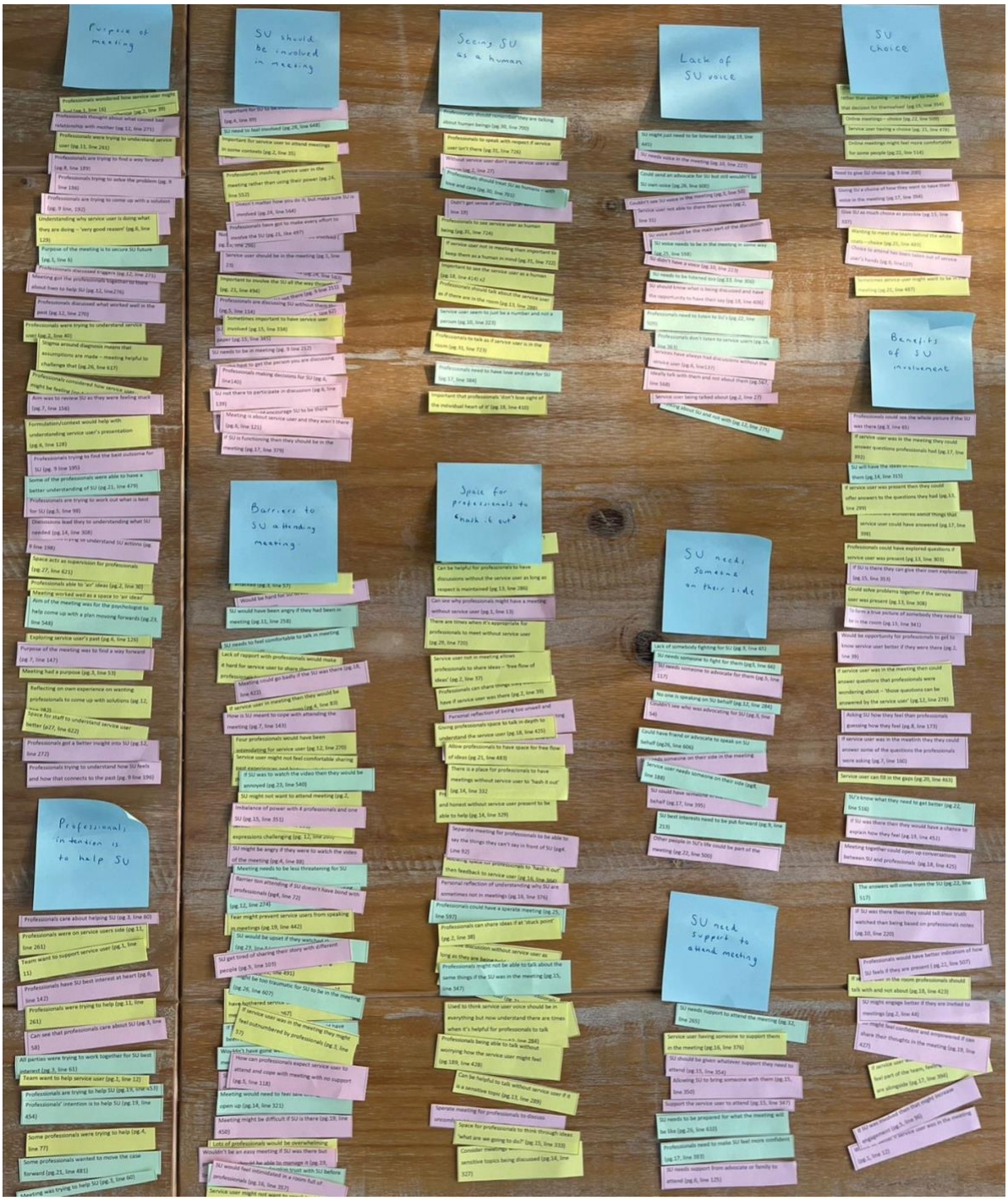
Appendix 2-A

Example of coded extract



Appendix 2-B

Organising themes



Appendix 2-C
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Article title	A concisely worded title should be provided.
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These four sub-headings and their accompanying explanations must always be included:

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Section Three: Critical Review

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Critical appraisal

This critical appraisal will provide an overview of the findings from the empirical paper and systematic literature review, including a discussion of the salient aspects across both papers. Methodological considerations will be discussed at more length considering the strengths and limitations of the work. Finally, some personal reflections are included.

Summary and overview of findings

The systematic literature review aimed to develop an understanding of how service users experience ward rounds on inpatient mental health wards. The review included a total of five studies, four studies explored ward rounds in adult settings and one study was an adolescent unit. A meta-synthesis approach was selected to answer the research question and papers were analysed using thematic synthesis (Thomas and Harden, 2008). Six analytical themes were developed: (1) *purpose of ward rounds*, (2) *marginalisation of service users*, (3) *the importance of interactions and relationships* (4) *environmental factors reinforce power dynamics*, (5) *experiences of ward rounds are dynamic and changeable* and (6) *learning to cope and adapt*. Furthermore, two overarching themes of *power* and *emotional impact* were identified. The findings revealed that there are many elements of ward rounds that are experienced negatively by service users. Service users described processes that exclude and marginalise them, as well as describing how the interaction styles of professionals and the physical environment can reinforce feelings of powerlessness. In contrast, positive relationships and interactions with professionals were integral to more positive experiences of ward rounds. The review suggests that current guidelines and recommendations for ward rounds are not being implemented consistently and that more work needs to be carried out to improve service users' experiences of ward rounds.

The empirical paper utilised a qualitative approach to explore service users' views of team formulation meetings. Nine participants watched a video vignette of a team formulation meeting, and their views were explored using focus group interviews. The data was analysed using thematic analysis (Braun and Clarke, 2006) and four core themes were developed: (1) *purpose of the meeting*, (2) *factors that support or impede the meeting*, (3) *the dilemma of service user involvement* and (4) *suggestions for moving forwards*. The findings revealed factors that participants thought would either support or impede a successful team formulation meeting. Furthermore, the dilemma between involving service users whilst equally acknowledging the advantages of professionals having a space to talk was discussed. Finally, participants made suggestions of how the meetings could be improved and how service users' voices could be better incorporated into team formulation meetings. The study highlighted that there needs to be more consideration of how team formulation meetings are implemented to ensure that service users' voices are at the centre of their care.

Links Between the Systematic Review and Empirical Paper

Ward rounds and team formulation meetings are both meetings that take place within MDTs in mental health settings. Ward rounds provide an arena where treatment and management decisions around an individual's care can be made as a team in inpatient settings (Fiddler et al., 2010). Whereas team formulation meetings are a space where a group of staff develop a shared formulation to understand the service user's difficulties and inform care planning (Hollingworth & Johnstone, 2014). In contrast to ward rounds, team formulation meetings can take place in a variety of mental health settings.

During the process of writing the two papers, it was evident that there were salient themes which appeared across both papers. Firstly, there was a strong theme of marginalisation of service users' voices. The World Health Organisation (WHO) state that

experiences of stigma, exclusion and marginalisation are all too common for individuals with mental health difficulties (Drew et al, 2010). This thesis suggests that the marginalisation of service users continues within mental health systems. The literature review showed that service users repeatedly described not being involved for the whole duration of their ward round. Furthermore, in the empirical paper participants felt that the service user's voice was missing from the team formulation meeting. It is apparent in both team formulation meetings and ward rounds, that professionals hold the power to decide if or when service users are included in meetings about them. Across both papers it was clear that service users have a strong desire to be involved in meetings and discussions about them. This is echoed by the "nothing about us, without us" mantra first coined by the disability rights movement which has since been adopted by other marginalised groups, including individuals with mental health difficulties (Charlton, 1998). NHS England have made a commitment to improve involvement of service users in their care (NHS England, 2017) which has been further supported by the NHS long term plan (NHS England, 2019). However, despite this, it appears that this is still not the reality in either ward rounds or team formulation meetings. This thesis highlights the challenges associated with involving service users in meetings about them in systems where very real power hierarchies exist. At present, guidelines and reports from professional bodies do not appear to be enough to challenge the current status quo in mental health systems. Stacey et al. (2016) argues that until the role of professional groups is understood in the context of power, a practical implementation of shared decision-making will be illusory.

This thesis has highlighted the importance of the physical environment and therapeutic relationships in supporting service users to attend meetings within MDTs. Across both papers service users wanted the environment to be less threatening and intimidating. Furthermore, the number of professionals involved in meetings contributes to service users

feeling outnumbered and powerless. This was strongly associated with issues surrounding the unequal power dynamics that exist between professionals and service users. Notably, the presence of a professional who has a good relationship with the service user was suggested as important in creating a safe and supportive environment for service users to attend meetings. Similarly, Borg and Kristiansen (2004) found that service users with mental health difficulties valued relationships with professionals who conveyed hope, shared power and were available when needed.

The most notable difference between the two papers is that service users wanted to be involved in the whole of their ward round, however for team formulation, some participants talked of the benefits of allowing professionals a space to talk without the service user present. I have wondered whether the purpose of these two meetings may play a part in how important it is to service users to be involved. The key role of ward rounds is to discuss service users care and make key decisions about their treatment (Fiddler et al., 2010). In contrast, team formulations are about teams developing a shared understanding of a service user and to generate ideas as a team of how to work with the individual (Hollingworth & Johnstone, 2014). It is not surprising therefore that service users have a stronger desire to be involved in ward rounds, where decisions about them are made. It is however important to note that this was not the view of all participants, with some individuals arguing that service users should have the opportunity to be involved in any meeting that is about them. Future research could investigate this difference further and explore this hypothesis.

Methodological considerations

Systematic literature review

The systematic literature review is the first of its kind in offering a synthesis of the published qualitative studies on service users experiences of ward rounds. Furthermore, the

thematic synthesis approach allowed the review to 'go beyond' original findings to generate analytical themes (Thomas and Harden, 2008). However, despite the strengths of the originality of the review, there are clear methodological elements that need consideration. Firstly, the number of papers included in the review was small, resulting in findings which are not necessarily transferable. Furthermore, the inclusion of two papers which are classed as grey literature is contentious and had to be considered within supervision. However, being aware of the limited number of papers identified it was believed important to include them given that the topic was an under-researched area. Hopewell et al. (2005) argue that grey literature can make important contributions to systematic reviews by offering balanced viewpoints without publication bias. The decision to include these papers, was also supported by the scores on the CASP.

Service user involvement is essential in mental health services (WHO, 2005; NICE, 2011). However, the lack of papers identified for the review, highlights the absence of service users' views in the literature and the further marginalisation of their voice. Research has shown that service user involvement is more likely at an individual level than in the planning, delivery, and management of mental health services (Storm, et al., 2011a; Kortteisto et al., 2018). This may go some way to explaining the limited research into service users' experiences of ward rounds in inpatient settings. Notably, Storm et al., (2011b) have found that an intervention program can be useful in increasing service user involvement in inpatient mental health services.

Moreover, recruiting participants to mental health research can be challenging as ethics committees tend to require professional involvement before supporting research (Bucci et al., 2015). It is notable that four out of the five studies included in the literature review were service evaluations conducted by professionals within the service the research took.

This may also explain the lack of published research and is consistent with evidence that suggests recruitment in health services can be hindered by clinicians who 'gatekeep' access to participants (McFadyen & Rankin, 2016). Grey literature is commonly overlooked in conventional literature reviews, however given the challenges faced in recruiting in mental health setting, service evaluations may prove valuable in contributing to understanding service users' experiences of ward rounds.

Empirical paper

The novelty of the methodology used in the empirical paper to investigate service users' views on team formulation meetings has its strengths and limitations. As discussed, service users are often excluded from team formulation meetings therefore the idea of using a fictional video vignette was developed to make service users aware of the concept of team formulation meetings. Vignettes are a valuable tool when studying sensitive topic areas which may not be assessable though other means (Barter and Renold, 1999). This allowed service users' views to be explored in a safe and containing way. The development of a fictional video was imperative in avoiding confidentiality issues which would arise if using videos of real team formulation meetings. However, it could be argued that the fictional video may not be representative of real-life meetings. Furthermore, a decision was made to keep the video a shorter length, to keep participants engaged and not lose interest in the video. However, typical team formulation meetings would last at least an hour and therefore the shorter version may not be representative of what would be discussed over a longer period of time.

It is important to consider that the use of the video vignette meant that participants were only exposed to one type of team formulation meeting. Literature reviews of team formulations have concluded that there is currently no standardised definition of team

formulation and descriptions across the literature are inconsistent (Short et al., 2017; Geach et al., 2018). Additionally, clinical psychologists' accounts of team formulation implementation, revealed four types of team formulation: case review, formulating behaviour experienced as challenging, formulating the staff-service user relationship, and formulating with the service-user perspective (Geach et al., 2019). Furthermore, Christofides et al. (2012) found clinical psychologists described their use of formulation as an informal process, rather than a standalone case formulation meeting. Both practice-based accounts and descriptions in the literature illustrate a variety of ways team formulation is defined and implemented. The implications of these inconsistencies must be considered when interpretating the findings of this study, as using consistent terminology in research is imperative when comparing findings across studies (Hill et al., 2012). Service context, the facilitator's professional training and the psychological theories and models used will affect different practitioners' implementation of team formulation. Therefore, the results will not be representative of all types of team formulation meetings. Future research could replicate the study design with different styles of team formulation meetings to investigate if results are replicated or different. Moreover, the team formulation quality rating scale (TPQS) could also be used as a way of measuring consistency and quality of team formulation meetings (Bucci et al., 2021).

Although this research has gone some way to understanding service users' views of team formulation meetings and giving service users a voice in the literature, I have reflected that more could have been done to involve service users in the design and implementation of the research. It has been argued that research needs to go further, in the involvement of service users, to achieve a shift in the balance of power from being subjects to partners (Happell & Roper et al., 2007). This means service users themselves being engaged in the whole research process including study design, recruitment analysing, and dissemination of findings (Szmukler et al., 2011). Furthermore, there is evidence to suggest that service user

involvement in research increases the likelihood of research leading to action, as findings are more likely to influence service delivery (Staley, 2009). Service user involvement in this thesis would have been challenging due to strict time constraints and the lack of funding available to compensate service users for their contributions. This could have led to involvement being tokenistic and exploitative. Future research exploring team formulation meetings should consider how to include active service user involvement in projects which can lead to benefits for both the service users involved and services (Minogue et al., 2005).

Reflections of the research process

Selection of research topic

Prior to starting the DClinPsy course I spent almost four years working in mental health inpatient settings as a both a support worker and assistant psychologist. I worked in a variety of different settings including CAMHS acute wards, locked rehab and forensic low secure wards. During this time, I experienced the multifaceted nature of working in inpatient settings. I worked with individuals with complex presentations, who were often either in crisis admissions or had long and enduring mental health difficulties that had kept them in hospitals for significant amounts of time. My personal experiences of working as a support worker, exposed me to the emotional and relational challenges of working in such environments. Furthermore, as an assistant psychologist I experienced the difficulties in engaging service users in psychological interventions. Team formulation meetings were a practice I experienced as both as support worker and assistant psychologist. As a support worker, I valued the space as somewhere I could share my emotional responses to working with complex individuals and have my feelings validated. As an assistant psychologist I saw team formulation meetings as an opportunity to develop a shared understanding of service users' presentation with staff and have psychological input into individuals care who may not

be engaging in 1:1 therapy. These experiences made me want to understand more about team formulation meetings and therefore became the starting point for my empirical thesis.

Whilst conducting an initial scope of the existing literature of team formulation meetings, I came across a paper which presented a case study of how a service user and her team discussed developing a co-produced team formulation (Lewis-Morton et al., 2017). This was a concept I had not come across before, as all my experiences of team formulation meetings had been without the service user present. As I explored further into the literature base, I noticed there was a sparsity of literature that described team formulation meetings which involved service users. Furthermore, other than the case study, there was no other research exploring service users' views of team formulation meetings. An initial idea that was explored for the empirical paper was to interview service users who had experience of team formulation, however, due to COVID-19 pandemic, it was not possible to gain NHS ethics approval. As a result, I had to explore more creative ideas of how to gain service users views of team formulation meetings. The final study was developed through numerous discussions with my research supervisors about how to approach the study in a creative way. The result is a novel but important research project, which is the first of its kind.

The topic for the systematic literature review, emerged from an aspiration to understand how service users experience meetings where numerous professionals are present. As I was unable to gain service users views of attending team formulation meetings, I considered that MDT meetings were a similar forum that service users would have experienced. When completing initial scoping for the literature review, I was surprised to find that the literature exploring service users' experiences of more broad team meetings was very sparse. Moreover, once I had completed the systematic literature search, the only papers which fitted the inclusion criteria were exploring service users' views of ward rounds on

inpatient settings. Despite the limited number of papers available, I thought it was important that service users' experiences were explored, given the significance of these meetings for their care. In addition, I also had a personal interest in service users' experiences of ward rounds given my experiences in inpatient settings and having attended countless ward rounds as a member of the MDT.

Reflexivity

In line with critical realism, it is important to recognise the way in which the researcher's context could have influenced the research. This was particularly important given that the topic was based within an area which was a clinical interest of mine. Furthermore, I was on third-year placement, which was based across three inpatient wards, during the time when I completed most of the write up of this thesis. It was therefore imperative to acknowledge the impact of my own biases, beliefs, and personal experiences in relation to the research process.

The reflexive process has been described as "a researcher's conscious and deliberate effort to be attuned to one's own reactions to respondents and to the way in which the research account is constructed" (Berger, 2015, p.221). I therefore made a conscious effort to be reflective throughout the process of designing, implementing, and writing the thesis. Firstly, I engaged in discussions with my research supervisors at different stages of the research, to help me consider my assumptions and personal beliefs (Chan et al., 2013). In addition, I used a reflective journal (King, 2010) during both my literature review and empirical paper to consider my personal experiences and identity throughout the data collection and analysis process. Furthermore, for my empirical paper I followed Braun and Clarke's (2019) reflexive approach to thematic analysis.

I recognised it was particularly important to consider my role as a professional who had both attended and co-facilitated team formulation meetings whilst completing my empirical paper. I acknowledged that I had my own experiences and beliefs about the benefits and limitations of the practice. I was aware that team formulation is a practice conducted mainly by clinical psychologists and I was conscious there was a possibility for me to be protective of the practice. It was therefore crucial that I remained neutral and open to opinions that may have differed from my own. In addition, I was conscious of my role as a trainee clinical psychologist during the focus group interviews. The participants were aware from my advert and the participant information sheets that I was a trainee psychologist completing the research as part of my doctoral thesis. It is essential to consider how this may have impacted on participants ability to be honest during the interviews. To address this, I included a speech at the start of all focus groups to encourage honesty and that differing opinions were welcomed.

Furthermore, during my third-year placement I attended several ward rounds where I both observed and personally experienced unhelpful power dynamics. I was therefore conscious of not only service users' experiences of power within ward rounds, but also my own experiences of feeling powerless and dismissed. During the literature review I was therefore aware that I held assumptions that service users might discuss power in their narratives of ward rounds. In order to avoid putting my own narrative onto service users' experiences I was mindful when coding data that fitted with my narrative of power and took time when coding these excerpts. The reflective diary and discussions with my supervisors additionally helped me to take a step back and put aside my assumptions to observe and interpret the data impartially (Barker et al., 2015). This helped ensure that the theme of power was derived from the data and not from my own experiences.

Personal reflections

Completing this research has had a profound impact on my professional identity and practice as a clinical psychologist. It has helped me to consider and question my practice in relation to team formulation meetings and reflect on my role within powerful systems that marginalise service users. In particular, the research has prompted me to reflect on my own dilemmas around excluding service users from team formulation meetings. Prior to conducting the thesis, I viewed team formulation meetings as an effective space for teams to better understand service users and explore their emotional responses. I observed how these spaces enabled staff to have more compassionate understanding of service users and reflect on how their interactions may be contributing to unhelpful patterns of relating. However, I have since been able to consider the ethical dilemmas surrounding not involving service users in team formulation meetings.

On completing the analysis for the literature review I found myself feeling angry about the exclusion of service users from ward rounds. However, on reflection I questioned what the difference was between excluding service users from ward rounds than from team formulation meetings. I had previously justified excluding service users as I had witnessed the positive effect this had on staff and subsequently on service user care. However, on reflection this positioned me as the powerful professional who 'knows best'. I have used supervision to reflect on my own dilemmas around involving service users and have found it helpful to acknowledge that I don't have to have all the answers. Being aware of this tension alone, will prompt me to be more reflective and considered when making decisions about how and when to include service users in team formulation meetings.

I was pleased that there were important ideas generated from the empirical paper around how to creatively involve service users in team formulation. I plan to take these ideas

forward into my clinical practice once qualified and to be more creative about how to include service users' voices in team formulation meetings. Furthermore, I found the theme of "keep the client as a human in mind" very poignant and it is a quote I aim to hold in mind throughout my career. I believe it will be helpful to share this with staff teams when holding meetings without service users to encourage professionals to be respectful and see the human in the people we work with. Finally, I aspire to continue to reflect on my role within powerful systems and continue to work towards facilitating a shift in power differentials in mental health services.

Conclusion

Due to the limited amount of research exploring service users' perspectives of ward rounds and team formulation meetings, it is important that further exploratory and qualitative research is carried out to gain their views. It is vital that we listen to the service users' narratives with the aim of developing our understanding as well as finding ways to improve service delivery. Both papers have highlighted how service users are excluded and marginalised from meetings about them. Careful consideration and guidance around how team formulation and ward rounds practices are implemented is required to ensure that service users rights to involvement in their care are upheld.

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Section Four: Ethics Documentation

Holly Riches

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Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Title of Project: Team formulation: A qualitative exploration of service user's views

Name of applicant/researcher: Holly Riches

ACP ID number (if applicable)*: n/a **Funding source (if applicable):** n/a

Grant code (if applicable): n/a

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM:

Student on Doctorate in Clinical Psychology

2. Contact information for applicant:

E-mail: h.riches@lancaster.ac.uk **Telephone**: [redacted]

Address: [redacted]

3. **Names and appointments of all members of the research team (including degree where applicable)**

Holly Riches, Student on DClinPsy

Dr Suzanne Hodge, Division of Health Research, Lancaster University

Dr Anna Daiches, Faculty of Health and Medicine, Lancaster University.

Dr Anna Duxbury, Faculty of Health and Medicine, Lancaster University.

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant:

Dr Suzanne Hodge

Dr Anna Daiches

Dr Anna Duxbury

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:

Dr Suzanne Hodge, Division of Health Research, Lancaster University

Dr Anna Daiches, Faculty of Health and Medicine, Lancaster University.

Dr Anna Duxbury, Faculty of Health and Medicine, Lancaster University.

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms'

4c. If yes, where relevant has permission / agreement been secured from the website moderator?

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users?

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain?

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

This study aims to gain experts by experience (EbE) views of team formulations. Team formulation is an approach used in mental health settings where a professional supports a group of staff to understand a service user's difficulties. The literature around team formulation is growing, however this has mostly focused on staff views and staff outcomes. This study is interested in EbE views as their voice is currently missing from the research. This study will recruit individuals who identify as having long term mental health difficulties. The study will take a qualitative approach, using focus groups. At the beginning of the focus groups, participants will be shown a short video of a fictional team formulation. They will then be asked questions to facilitate discussions about their views of this practice. In addition, questions will encourage participants to think about how this practice could be changed. The data collected will be analysed using thematic analysis.

2. **Anticipated project dates (month and year only**)

Start date: March 2021 End date: March 2022

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

Individuals living in the UK who are over 18 years old and identify as having long term mental health difficulties. No limits on maximum age or gender. Participants will need to be English speaking due to limited funding for interpreters.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Participants will be recruited using social media adverts on platforms such as Twitter and Facebook. Service user groups and charities, for example National Survivor User Network, will be asked to circulate the advert via their mailing lists and newsletters. Contact information of the researcher will be included on adverts so that anyone interested in participating can contact the researcher for further information. Individuals who contact the researcher will be provided with information packs about the study, including the participant information sheet, expression of interest form and consent forms. If potential participants maintain their interest, the researcher will organise a time to go through the participant information sheet with them and obtain informed consent.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Focus group interviews has been chosen as the method of data collection, which are recommended when researching a topic that has not been studied previously. Grundy et al (2016) found that discussions in groups have led to findings that would not have emerged in one-to-one discussions. It is therefore proposed that group discussions will generate novel insights and ideas which may result in recommendations for the use of team formulations in mental health services. Synchronous online focus groups using audio and video conference technology will be utilised. Research has found that the level of discussion and the quality of the data obtained was similar to that found in face-to-face groups (Kite & Phongsavan, 2017).

Thematic analysis has been chosen as the method of analysis as this study is researching individuals' views and opinions. There are no studies which have directly explored service users' views of team formulation and therefore this research is exploratory. Braun and Clarke (2006) have argued that thematic analysis is a useful method for examining differing perspectives, highlighting similarities and differences, and generating novel insights.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

The chief researcher will comply with the EU General Data Protection Regulation (GDPR) and the UK Data Protection Act (2018) in order to ensure that personal data is kept confidential. All data will be kept electronically on the secure, encrypted Lancaster university drive and password protected. Assignment ID numbers allocated to participants will be saved separate from the demographic data and from the transcripts of audio files to ensure confidentiality. Recordings will be transcribed using the researcher's personal laptop via the University's Virtual Private Network (VPN). Transcripts will be anonymised, removing any identifiable information like names, places or organisations. Sections of recording might be played to the academic supervisor however in these instances, recordings will be listened to in a private space.

All data will be stored on the researcher's secure university drive until the successful examination of the thesis project is complete. Following this, all files will then be transferred via the University's secure file transfer software to the DClinPsy Research Coordinator. Files will be saved in password-protected file space on the university server where they will be stored for 10 years after the study has finished. At the end of this time, they will be permanently deleted. Confidential, personal data will be destroyed after the study is complete.

7. Will audio or video recording take place? ☐ **no** ☒ **audio** ☒ **video**

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

Focus groups will be audio and video recorded using the Microsoft Teams recording function and a voice recorder as back up. If the Microsoft Teams recording has been successful, then the voice recording will be deleted immediately. Recordings will not be encrypted but they will be transferred onto the secure, encrypted Lancaster university drive as soon as possible and then deleted from portable devices.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Recordings will be stored on the researcher's secure university drive until the successful examination of the thesis project is complete. Following this, recordings will be deleted.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder.

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE? The data will be stored by the DClinPsy Research Coordinator for 10 years after the study has finished. At the end of this time, they will be permanently deleted.

8b. Are there any restrictions on sharing your data?

Responses to requests for access to the data will be made on a case by case basis. However, because this is a small scale, qualitative study, it is not appropriate for the data to be made freely available.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

Individuals who contact the researcher will be provided with information packs about the study, including the participant information sheet, expression of interest form and consent forms. If potential participants maintain their interest, the researcher will organise a time to go through the participant information sheet with them and obtain informed consent. As this study will be completed virtually, consent will either be audio recorded via telephone/Microsoft Teams or consent via email will be treated as an electronic signature.

10. What discomfort (including psychological e.g. distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

Minimal risks are associated with taking part in this study. It is unlikely that sensitive information will be discussed, as the study focuses on asking participants opinions of team formulation and will not ask questions of their personal experiences. Participants however may choose to share personal information which could cause distress to themselves or other participants. At the start of the focus group participants will be made aware that they can ask for a short break or withdraw from the discussion at any time. If a participant becomes distressed during the focus group, the researcher will offer to pause the group. During a break the researcher will talk privately to any participant who may be experiencing distress and discuss how best to proceed. Participant information sheets will also include resources and contact details of places they can access support.

Participants are welcome to withdraw from the study at any time before the focus group begins, but will not be able to withdraw their contribution to the discussion once recording has started. Participants will have two weeks to withdraw their permission for their data to be included in the write up. Participants will be made aware of this in the participant information sheets and will be reminded again at the start of the focus group.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

There are minimal risks for the researcher in this study. As all research will take place virtually there are no foreseen risks regarding the researcher's safety. It is unlikely that focus groups will cause any distress to the researcher, however if the researcher felt affected by anything discussed they will bring this to supervision.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There may be no direct benefits to participants in this study.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

There will be no incentives or expenses paid to participants.

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Assignment ID numbers allocated to participants will be saved separate from the demographic data and from the transcripts of audio files to ensure confidentiality. Transcripts will be anonymised, removing any identifiable information such as names, places or organisations. Quotes from participants will be used in the thesis submission and any publications. Participants will be made aware of this and informed that every effort will be made to ensure participants remain anonymous. Participant assignment numbers will be used instead of names.

Participants will be made aware of the limits of confidentiality in participant information sheets and will be reminded at the beginning of focus groups. Issues surrounding confidentiality may arise during focus groups as we will not be able to guarantee that other participants will follow confidentiality procedures. However, participants will not be asked to share any personal information during discussions. The researcher we will set up ground rules at the beginning of sessions to encourage confidentiality between participants. The researcher will also encourage participants to set up profile on Microsoft Teams that only show their first names. Participants will also be made aware in the participant information sheet that they cannot record and/or share a recording of the focus group.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

No involvement planned.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

Findings from this research will be written up and submitted as part of a thesis submission. Results of the research may also be submitted for publication in academic and professional journals.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

n/a

SECTION FOUR: signature

Applicant electronic signature: Holly Riches Date: 13/12/2020

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☐

Project Supervisor name (if applicable): Suzanne Hodge Date application discussed 15/12/20

Submission Guidance

1. Submit your FHMREC application by email to Becky Case (fhmresearchsupport@lancaster.ac.uk) as two separate documents:
    i. **FHMREC application form.**
    Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*
    ii. **Supporting materials.**
    Collate the following materials for your study, if relevant, into a single word document:
        a. Your full research proposal (background, literature review, methodology/methods, ethical considerations).
        b. Advertising materials (posters, e-mails)
        c. Letters/emails of invitation to participate
        d. Participant information sheets
        e. Consent forms
        f. Questionnaires, surveys, demographic sheets
        g. Interview schedules, interview question guides, focus group scripts
        h. Debriefing sheets, resource lists

    Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:
    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:

a. existing documents/data only;
b. the evaluation of an existing project with no direct contact with human participants;
c. service evaluations.

3. **<u>You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application</u>**

Appendix 4-A
Research Protocol

Research Title: Team formulation: A qualitative exploration of service users views

Applicant

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Introduction

Formulation is widely recognised as a core skill for psychologists and is specified in the Health and Care Professions Council's (HCPC) standards of proficiency for practitioner psychologists (HCPC, 2015). There is no universal definition of formulation. However, the Division of Clinical Psychology (DCP), a subdivision of the British Psychological Society (BPS), defines psychological formulation as "a hypothesis about a person's difficulties, which links theory with practice and guides the intervention" (DCP, 2011, p. 2).

The BPS emphasise the importance of psychologists working within multi-disciplinary teams (MDT) to encourage psychological thinking and improve outcomes (Onyett, 2007). A rapidly expanding practice promoting this method of working is team formulation. In this approach, a facilitator supports a group of staff to develop a shared formulation to understand the service user's difficulties and inform care planning (Hollingworth & Johnstone, 2014). Team Formulation has grown in popularity over the last 10 years (Johnstone, 2018), particularly in the United Kingdom and is explicitly recommended in professional documents. The DCP (2011) states that "clinical psychologists should be… formulating within multi-disciplinary teams and organisations" (DCP, 2011, p. 5). Team formulation has a role in psychologists' commitment to work, not only with individuals but also at the team, service and organisational level (Johnstone, 2018). The DCP (2011) suggests a range of functions and benefits of team formulation, including but not limited to: encouraging team working, promoting psychosocial ways of thinking, reducing negative staff perceptions of service users and changing culture in teams.

Service user involvement is increasingly being recognised as a crucial part of mental health service delivery. In a case study, where a service user and her team discussed their experiences of developing a co-produced formulation on an inpatient ward, the authors

concluded that there were a number of benefits to involving the service user in team formulation (Lewis-Morton et al., 2017). This included an increased understanding for the team and sense of empowerment for the service user. The authors also acknowledged the challenges associated with co-production in the context of a team.

However, despite this, service user perspectives are noticeably absent from the majority of literature evaluating team formulation. Unsurprisingly, given that team formulation is a direct intervention with staff and teams, there is also less evidence for service user outcomes. The literature suggests that service users are also frequently excluded in the development of team formulation. Qualitative papers interviewing psychologists about team formulation showed that some practitioners discussed their dilemmas of involving service users (Lewis-Morton et al., 2015; Wood, 2016; Stratton & Tan, 2019). Some described solutions such as meeting with service users beforehand to incorporate their views (Wood, 2016) or encouraging service users to share their formulation with the team (Lewis-Morton et al., 2015).

Research conducted by the New Economics Foundation, found that the co-production of services and the idea of doing "with" rather than doing "to" or "for" supports better recovery outcomes for service users (Slay and Stephens, 2013). Despite this there are two main ways in which service users' voices are currently neglected in team formulations. Firstly, the DCP guidelines (2011) identify the team as the primary client and state that the developed formulation may not be shared with the service user in its entirety. Consequently, service users are often excluded from attending team formulations. Secondly, there is a lack of service user perspective in the research exploring team formulation. This therefore raises questions about how mental health services, can address the need for meaningful service user involvement when DCP guidelines appear to exclude service users from a practice such as team formulations.

The proposed study therefore aims to understand Expert by Experience (EbE) views of the use of team formulations, as their voice is currently missing from the literature base. The study aims to understand EbE views on the use of team formulation as well as gaining any suggestions for how team formulation could be different. It is hoped that by gaining EbE unique perspectives this research could suggest changes to address any identified issues.

Method

Design

Focus group interviews have been chosen as the method of data collection, which are recommended when researching a topic that has not been studied previously. As opposed to interviews, focus groups use group interactions to elicit detailed responses which are shaped by social cues and the participant's own beliefs and perceptions (Kite & Phongsavan, 2017). Focus groups allow for the analysis of opinion in greater depth through interaction and discussion, which is of particular importance in exploratory research (Frey & Fontana, 1993). Grundy et al (2016) found that discussions in focus groups have led to findings that would not have emerged in one-to-one discussions. Krueger (2009) describes how collective sense is developed in groups, which can echo how new ways of working are naturally explored in the workplace. It is therefore proposed that group discussions will generate novel insights and ideas which can result in recommendations for the use of team formulations in mental health services.

Due to existing public health measures related to the COVID-19 pandemic, synchronous online focus groups using audio and video conference technology will be utilised. This will protect the health and safety of both the researcher and participants and ensure that no public health measures are breached. Web conferencing technology provides a good alternative to face-to-face focus groups as rich data can still be achieved as participants

can both see and hear each other (Tuttas, 2015). Research has found that the level of discussion and the quality of the data obtained from online focus groups was similar to that found in face-to-face groups (Kite & Phongsavan, 2017). Online focus groups will also be beneficial in increasing the target population as participants will not be as limited by geographical location (Tuttas, 2015). However, online focus groups will unfortunately exclude individuals who do not have access to technology to support its use.

Participants

Inclusion criteria:

- Adults (18 or over)
- Identify as someone who has long term mental health challenges
- Currently living in the United Kingdom
- English speaking
- Have access to a laptop/computer that supports the use of Microsoft Teams

Exclusion criteria:

- Currently accessing crisis support for mental health

The number of focus groups that are needed to sufficiently address the research questions is often difficult to predetermine (Morgan, 1997). Fern (2001) suggests that researchers should conduct at least two focus groups and conduct further groups until saturation is achieved, in general this requires between two and four focus group interviews. Morgan (1997) advises to determine a target number of groups at the planning stage but have flexibility if more groups are needed. Research literature recommends that focus groups should consist of six to twelve participants, however smaller groups of four participants is

reasonable when focusing on unique perspectives (Fern, 2001). There appears to be no theoretical literature relating to group size for online focus groups, however Kite and Phongsavan (2017) recommend having fewer participants than face-to-face groups.

The researcher will aim to recruit between 12–18 individuals for this study. This will comprise of a minimum of two focus groups, with the potential for up to three focus groups. Attrition rates for online focus groups is understood to be higher than traditional focus groups and has been reported in a number of studies (Tuttas, 2015). The study will therefore aim to recruit six participants per group which will account for attrition rates and reduce the chances of any group having less than four participants.

Focus groups will last approximately one hour and be facilitated by the chief researcher. Participants will be shown a short video vignette of a fictional team formulation meeting and then asked questions to facilitate a discussion. The video will be pre-recorded on Microsoft Teams using professionals who will improvise a team formulation based on a fictional vignette (Appendix A). An interview guide (Appendix B) has been developed for the focus groups which has been informed by the research question. The interview guide includes an introduction, opening question, specific and free probes and a wrap-up question (Morgan, 2002).

Focus groups are an ideal method for critical types of research in which the goal is to give voice to participants from marginalised populations (Davis, 2017). The researcher has therefore chosen to adopt a critical realist position for this study. Critical realists believe that the way we understand the world is influenced by our perspectives and experiences and therefore can only be understood by considering the structures that underpin it (Fletcher, 2017). Critical realism encourages us to understand and address macro-level context on a social, political and historical level and consider how power is enacted (Fletcher, 2017).

These will all be relevant when trying to understand EbE perspectives of a forum that is used by professionals in mental health contexts. In addition, critical realist research often makes recommendations which could result in changes to existing structures or policies (Haigh et al., 2019). In critical realism research participants' contributions can challenge existing theory and policies which makes a critical realist perspective useful for change-orientated research (Fletcher, 2017). It is hoped that by gaining service users' perspectives of team formulation this research could suggest changes to address any identified issues.

Thematic Analysis (TA) has been chosen as the method of analysis. There are currently no studies which have directly explored service users' views of team formulation and therefore this research is exploratory. Braun and Clarke (2006) propose that TA is a useful method for examining differing perspectives, highlighting similarities and differences, and generating novel insights. Furthermore, TA is a flexible approach which can be applied to a variety of qualitative methods and epistemological stances (Braun & Clarke, 2006). This therefore makes it a suitable for critical realist research and is a suitable analytical tool for focus groups.

Materials

Interview schedule, technology for use of Microsoft teams, audio recorder, transcription equipment.

Procedure

Participants will be recruited using an advert (Appendix C) which will be put on social media platforms such as Twitter and Facebook. Service user groups and charities, for example National Survivor User Network, will be asked to circulate the advert via their mailing lists and newsletters. Contact information of the researcher will be included on adverts so that anyone interested in participating can contact the researcher for further

information. Individuals who contact the researcher will be provided with information packs about the study, including the participant information sheet (Appendix D) and consent form (Appendix E). If potential participants maintain their interest, the researcher will organise a time to go through the participant information sheet with them and obtain informed consent. Participants will also be asked if they have the necessary equipment and skills to participate in an online group. Where possible support will be offered to help participants feel confident in using Microsoft Teams. As this study will be completed virtually, consent will either be audio recorded via telephone/Microsoft Teams or consent via email will be treated as an electronic signature.

After informed consent has been obtained, participants will be given a participant identification number and will be sent a form to complete with demographic data. Participants will also be asked to record days and times they would be available to attend a focus group. Once the study has recruited enough participants for at least two focus groups, participants will be allocated to focus groups and informed of the date and time of this. They will be asked to confirm that they can attend by accepting a Microsoft Teams invite. A week before the focus group participants will be invited to meet briefly with the researcher to test out the software and have an opportunity to ask any questions. Participants will also be sent a reminder email a few days before the focus group.

Participants will be asked to join the Microsoft Teams meeting 10 minutes before the scheduled start time to allow for informal chat between group members and to ensure that the focus group starts on time. The focus group will begin with an introduction which will include a reminder of confidentiality expectations and their right to withdraw consent from the study. Participants will be reminded that they cannot withdraw their contribution after the group has taken place but will have two weeks to withdraw their permission for their data to be included in the write up. Participants will also be reminded that the focus group will be

recorded and will be told when this begins. They will be informed that they can turn their microphone and video off and on at any time in order to have a break from active participation or to maintain their privacy. Following introductions, the group will then be shown the video vignette and the researcher will proceed to follow the interview guide.

When the group has finished, participants will be thanked for their involvement and informed that they will be contacted offering them a summary of the themes arising from the analysis for their comments. It will be made clear that they do not have to provide feedback.

Proposed Analysis

A Thematic Analysis (TA) approach as outlined by Braun and Clarke (2006) will be used to analyse and code the data retrieved from focus groups, following the six phases proposed. Firstly, the researcher will familiarise themselves with the content of the data by transcribing the data, re-reading the data and noting initial ideas. Initial codes will then be assigned and then drawn together to form potential themes. Themes will then be checked and refined in supervision and through feedback from participants. Any assumptions held by the researcher or decisions made during the analysis will be recorded in a reflective journal and discussed in supervision (Braun & Clarke, 2013).

Practical Issues

Data transfer and storage

The chief researcher will be compliant with the EU General Data Protection Regulation (GDPR) and the UK Data Protection Act (2018) in order to ensure that personal data is kept confidential. To ensure confidentiality assignment ID numbers allocated to participants will be saved separate from the demographic data and from the transcripts of audio files. All confidential and personal data of participants will be destroyed after the study is complete.

Microsoft Teams software will be used to record online focus groups. This platform has been chosen as Lancaster University has full access to security features that include encryption of data. Microsoft Teams also allows for the researcher to be the only member of the groups to record and access the discussion. A digital voice recorder will also be used to record the focus groups as a back-up. Audio recordings of consent will be recorded through Microsoft Teams or using a digital voice recorder. All recordings will be uploaded onto University secure services and deleted from the device or application and saved as password protected files onto encrypted University servers. Consent given through email electronic signatures will be saved as password protected documents onto encrypted University servers. Once the researcher has submitted the thesis and completed the course, all data will be deleted off the chief researcher's devices. The Doctorate in Psychology programme will then store the data for 10 years and will be responsible for storing and deleting the data.

Recruitment

Due to the specific inclusion and exclusion criteria for this study, it has been foreseen that there may be difficulties with recruitment. However, as focus groups will be conducted online, individuals living anywhere in the United Kingdom will be able to take part in the study, which will increase the target population. The researcher will be pro-active in advertising the study on social media and ask administrators of closed groups to circulate adverts. The researcher will be flexible when organising focus groups and will maintain good communication with participants to reduce the chances of attrition.

Ethical Issues

Confidentiality

Participants will be made aware of the limits of confidentiality in participant information sheets and will be reminded at the beginning of focus groups. Issues surrounding confidentiality may arise during focus groups as we will not be able to guarantee that other participants will follow confidentiality procedures. However, participants will not be asked to share any personal information during discussions. The researcher we will set up ground rules at the beginning of sessions to encourage confidentiality between participants. The researcher will also encourage participants to set up profile on Microsoft Teams that only show their first names.

Risk to participants

Minimal risks are associated with taking part in this study. It is unlikely that sensitive information will be discussed, as the study focuses on asking participants opinions of team formulation and will not ask questions of their personal experiences. Participants however may choose to share personal information which could cause distress to themselves or other participants. At the start of the focus group participants will be made aware that they can ask for a short break or withdraw from the discussion at any time. If a participant becomes distressed during the focus group, the researcher will offer to pause the group. During a break the researcher will talk privately to any participant who may be experiencing distress and discuss how best to proceed. Participant information sheets will also include resources and contact details of places they can access support.

Risk to researcher

There are minimal risks for the researcher in this study. As all research will take place virtually there are no foreseen risks regarding the researcher's safety. It is unlikely that focus groups will cause any distress to the researcher, however if the researcher felt affected by anything discussed they will bring this to supervision.

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Appendix 4-B

Lancaster University

Experts by experience views of team meetings in mental health settings

Can you help?

- Are you 18 years or over and live in the UK?
- Do you identify as someone who has **long term mental health challenges**?
- Would you be interested in taking part in a study looking at how mental health professionals discuss and try to understand individuals with mental health difficulties?

What does it involve?

This study will be an **online focus group** which is likely to **last up to an hour**. We are interested in gaining expert by experience views on how mental health professionals may discuss individuals receiving support for their mental health. The focus group will involve you discussing and sharing your views with other individuals.

Participation in this study is voluntary. If you would like more information about taking part please email Holly Riches at **h.riches@lancaster.ac.uk**. You will then be sent a Participation Information Sheet which will give you more information about the study and you will have the opportunity to ask any questions you might have.

This research is being conducted as part of a Clinical Psychology Doctorate at Lancaster University and has been approved by the Lancaster University Faculty of Health and Medicine Research Ethics Committee.

Appendix 4-C

Participant Information Sheet

Team formulations: A qualitative exploration of experts by experience views

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

My name is Holly Riches and I am conducting this research as a student in the Clinical Psychology Doctorate at Lancaster University, United Kingdom.

What is the study about?

Mental health professionals sometimes hold team meetings where they discuss a service user to better understand their difficulties and think about ways they can help. This practice is sometime called 'Team formulation'. The purpose of this study is to find out what people who have experienced mental health difficulties think of this practice. It is hoped that this research will support future developments in how mental health professionals use team formulation.

Why have I been approached?

You have been approached because the study requires information from people who identify as having long term mental health difficulties. It is important that experts by experience views on mental health practices are understood so that professionals can reflect on their practice using the views of the individuals accessing the service.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. You can also decide to take part and then change your mind.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to join an online focus group which will take place using Microsoft Teams. There will be up to 6 other participants in the group. You will be shown a short video of an example of a Team Formulation meeting which is based on a fictional person. You will then be asked some questions about your views about the video. The discussion will be video, and audio recorded and transcribed to form data which will be analysed and written up a part of a thesis.

Will my data be Identifiable?

The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data.

- Video recordings will be destroyed and/or deleted once the project has been submitted for publication/examined.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.
- At the end of the study, data will be kept securely by Lancaster University for ten years. At the end of this period, they will be destroyed.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, but your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from your interview responses.
- There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to my supervisor about this. Where possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported in a thesis and may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress after the focus group you are encouraged to let me know and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher

Holly Riches on h.riches@lancaster.ac.uk. You can also contact the research supervisor Dr Suzanne Hodge on s.hodge@lancaster.ac.uk.

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Ian Smith
Research Director
Division of Health Research
Faculty of Health and Medicine
Health Innovation One
Sir John Fisher Drive, Lancaster University
Lancaster, LA1 4AT
Tel: 01524 592 282
Email: i.smith@lancaster.ac.uk

If you wish to speak to someone outside of the Lancaster Doctorate Programme, you may also contact:

Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress

It is not anticipated that taking part in this research will cause distress. However, should you feel distressed as a result of taking part you can contact:

- The Samaritans if you feel you need to talk to someone you can phone their free 24-hour helpline on 116 123 or visit their website www.samaritans.org

- You can contact Mind on the following number: 0300 123 3393, or by email on: info@mind.org.uk or by text message on: 86463

Appendix 4-D

Consent Form

Study Title: Team formulations: A qualitative exploration of experts by experience views

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Holly Riches.

	Initial each statement
I confirm that I have had the opportunity to ask any questions and to have them answered.	
I understand that my interview will be video recorded and then made into an anonymised written transcript.	
I understand that video recordings will be kept until the research project has been examined.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.	
I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published. All reasonable steps will be taken to protect the anonymity of the participants involved in this project	
I consent to information and quotations from my interview being used in reports, conferences and training events.	
I understand that the researcher will discuss data with their supervisor as needed.	
I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the chief investigator will need to share this information with their research supervisor.	
I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.	
I consent to take part in the above study.	

Name of Participant _____Signature_____ Date_____

Name of Researcher _____ Signature_____ Date_____

Appendix 4-E

Vignette for Team Formulation Recording

Background information

Kelly was brought up by her mother and father in North Manchester. Her father was an alcoholic and was violent towards both Kelly and her mum. Kelly's mum experienced depression and found it difficult to meet Kelly's basic needs. Social care were involved with the family for a period but the family did not find them helpful or supportive. Kelly eventually moved into the care of her grandparents at the age of 8 years old through an informal arrangement. Kelly had irregular contact with her mum and her father passed away when she was 10 years old.

Kelly experienced prolonged bullying at school and as a result she often truanted and began drinking and using drugs at 14 years old. At 16, Kelly began self-harming as a way of coping with difficult experiences. Kelly's grandparents referred her to CAMHS, however Kelly only attended a few appointments and as a result she was discharged from the service. Kelly's school did not offer her any additional support and she left school with few qualifications.

At 18, Kelly moved out of her grandparents' house and moved in with an older boyfriend who was physically abusive and controlling. Kelly experienced a number of violent relationships between the ages of 18-25 and moved between different addresses regularly. Kelly met Ben when she was 26 years old and they got married and had two children together. They had a stable relationship and there was no violence. After the birth of their first child, Kelly's mum began having more regular contact with Kelly and her grandchildren. Kelly and her mum's relationship however remained strained.

Current situation

Kelly is currently 34 years old and her children are now 5 and 8 years old. Six months ago, Ben told Kelly that he has been having an affair and he moved out of the house to be with another woman. Since that point Ben has had sporadic contact with the children and has not offered Kelly any financial support. Kelly has not been able to afford the rent on the property alone and her landlord has been threatening her with legal action. Kelly's alcohol consumption has increased, and she has started self-harming again and voicing suicidal thoughts. Kelly was seen by the crisis team and was put under the care of CMHT 3 months ago.

Kelly had begun to develop a good relationship with her key worker; however, they recently left the team unexpectedly. Kelly has been allocated a new key worker, but she is currently refusing to see them. Last week Kelly was issued with a legal notice to vacate her property. Kelly's social worker is encouraging Kelly to move in with her mother, however she is refusing this as an option. Her social worker has informed Kelly that there is a chance that her children may be taken into care if she does not have somewhere to live. Their relationship has broken down as a result of this conversation and Kelly has been asking for a new social worker. Kelly's team feel that she is not engaging with the support they are offering her and they feel stuck as to how to move forwards.

Appendix 4-F

Interview Guide

Introduction

- **Welcome**
  - Introduce discussion leader
  - Encourage participants to introduce themselves

- **Guidelines for session**
  - Participants rights
  - Recording of session
  - No right or wrong answers, only differing points of view
  - You don't need to agree but you must listen respectfully as others share their views
  - Keeping confidentiality

Focus group begins

- **Explanation of procedure**
  - My role as moderator will be to guide the discussion talk to each other
  - Explain process of showing a short video and that discussion will follow

Play video

- **Opening question**
  - What are your initial thoughts about this meeting?

- **Specific probes**
  - What do you think the purpose of this meeting is?
  - Do you think there are any benefits of this meeting, if so what?
  - Do you think there are any limitations of this meeting, if so what?
  - If Kelly was watching this meeting how do you think she would feel?
  - Do you think anything could be done to improve these meeting? If so, what?
  - What's your thoughts about service users attending these meetings? In what sense would this change the meeting?

- **Free probes examples**
  - Anything else?'
  - Does anyone have a different thought?

- **Ending question**
  - When we write up our report of this group, what should we pay attention to? What is one important point that you think we should pay attention to?"

Appendix 4-E

Ethics Approval Letter

Applicant: Holly Riches
Supervisor: Dr Suzanne Hodge, Dr Anna Daiches, Dr Anna Duxbury
Department: DHR
FHMREC Reference: FHMREC21014

04 October 2021

Re: FHMREC21014
Team formulation: A qualitative exploration of experts by experience views

Dear Holly,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

T. Morley

Tom Morley,
Research Ethics Officer, Secretary to FHMREC.