Submitted in partial fulfilment of the

Lancaster University Doctorate in Clinical Psychology

June 2023

Doctoral Thesis

What works? A grounded theory investigation into the impact of non-psychology staff using Solution-Focused Brief Therapy following brief training

Haakon Juul

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Haakon Juul

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster LA1 4AT

h.juul@lancaster.ac.uk

Word Count

	Main Text	Appendices (inc. tables, references, abstract, footnotes and title pages)	Total
Thesis Abstract	299	0	299
Literature Review	7,998	11,253	19,251
Research Paper	7,989	8,352	16,341
Critical Appraisal	3,999	510	4,509
Ethics Section	5,102	6,981	12,083
Total	25,387	27,096	52,483

Thesis Abstract

The present thesis consists of two sections focusing on investigating and evaluating the role of the clinical psychologist to provide more indirect support in the form of consultation and training respectively. The focus will also be on the experience of staff working in healthcare services in order to extend the extant literature by offering further insight into what works with effective consultation and training.

The systematic review was a meta-ethnographic synthesis of 15 qualitative papers reporting staff members' experiences of consultation provided by clinical psychologists. The review highlighted that staff benefit from consultation that invites them to share and process their unprocessed feelings that are often influenced by working in highly emotive and stressful healthcare environments. It also highlighted the importance of clinical psychologists making sure they establish a trusting relationship with the consultees in order to support them to feel safe enough to engage and benefit optimally from consultation.

A constructivist grounded theory (Charmaz, 2014) was conducted to analyse how 10 multidisciplinary staff working in medical settings perceive and implement Solution-Focused Therapy (SFBT) following brief training. The developed theory highlighted how various personal, interpersonal and systemic factors interact and influence staff members' decision to implement SFBT over the more familiar medical model, which represented a sense of safety and control. Staff reported needing evidence of SFBT being efficient and regular support from the multidisciplinary team in order to feel more motivated and confident to use it, especially in the context of barriers such as time-restricted clinics, service pressures and challenging clients.

The critical appraisal extends the discussion of the project's strengths and limitations and makes additional suggestions for future clinical psychologists and research. It also details

reflections around some of the challenges that came with being a novice meta-ethnographer and grounded theorist and how they were managed throughout the project.

Declaration

This thesis documents research undertaken in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology. The work presented here is my own, except where due reference is made. This thesis has not been submitted for the award of a higher degree elsewhere.

Signature:

Print name: H. Juul

Date: 09/06/2023

Acknowledgements

I would like to thank everyone who participated and supported me throughout this research project. I know that this would not have been possible without you.

I want to thank you Ian for providing me with such consistent support in an often tumultuous and stressful trainee context. This really helped motivate me and keep going when feeling stuck and it has been helpful to know that helpful advice was just an e-mail away.

The same goes for you Jo. I have really appreciated our conversations with your empathy and encouragement as they have been essential in helping me believe in myself more and to believe that this was achievable. They have also played a really important part in making the whole training experience more enjoyable, especially when things have been more difficult in other parts of my life.

I also want to thank my colleagues, whom I see as friends, and the most kind and considerate friends, might I add. The past three years have been challenging and the challenges of the course have often stretched me into new realms I did not even know existed, and that was at times daunting. Having such compassionate, but also outright hilarious, friends has been nothing else but an anchor, and that means a lot to me.

And finally, I want to thank my mum, dad and my sister. I would not even have been on this course if it weren't for you. You have helped me find my inner passion as well as given me tools in how to achieve my goals, this being a significant one. I feel lucky to be part of such a passionate family who fight for what they believe in or to get the most out of life; you have inspired me for as long as I have lived. I miss you, and I love you.

Contents

Chapter 1 : Systematic Review

A meta-ethnographic literature review exploring non-psychology staff experiences of receiving psychological consultation in healthcare services

Haakon Juul

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

To be submitted to Psychology and Psychotherapy: Theory, Research and Practice

All correspondence should be sent to:

Haakon Juul

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster LA1 4AT

h.juul@lancaster.ac.uk

Abstract

Purpose: Psychologists are becoming increasingly more expected to offer consultation to support staff to deliver more effective care in healthcare services. The aim of this systematic review was to explore any themes reported in the literature in greater depth in order to provide novel insights into the underlying mechanisms that contribute to effective consultation. ***Method:*** Six databases were searched using a Highly Sensitive Search Strategy (HSSS), identifying 15 qualitative studies, which were quality-assessed using an adapted version of the CASP checklist. A meta-ethnographic approach was taken when analysing the studies looking at the experience of consultation from the perspectives of multidisciplinary, non-psychology staff. This included nurses, support workers, medical doctors, social workers, occupational therapists and managerial staff. Across the studies, the number of participants ranged from 5-57 with 70% of them being female, and with an age ranging from 18-65. ***Results:*** Six themes were developed highlighting the key aspects that were important to consider for effective consultation. Staff stressed the importance for consultation to help contain their emotional needs, to understand and connect with their clients and to feel their preference for an expert or collaborative approach to be considered. ***Conclusion:*** Recommendations for future clinical psychologists included clarifying the goals of consultation to reduce anxiety, be more accessible and flexible and adapt their language to staff preference in order to facilitate trusting relationships and more effective consultation. Future research should explore staff need and benefit of consultation by comparing experiences across other services and approaches to consultation.

Keywords: Meta-ethnography, psychological consultation, team formulation, multidisciplinary staff, non-psychology staff

Introduction

In the UK, clinical practitioners are increasingly being expected to offer more than direct therapeutic work in order to meet the growing demand for psychologically informed approaches in healthcare services (Onyett, 2007). Psychological consultation is key for providing support to healthcare staff in order to influence and improve the delivery of care to clients. Since the publication of reports by the Management Advisory Services (MAS) (Kuttner, 1989), consultation was considered as a central part of the clinical psychologist's role. The report put forth recommendations suggesting that clinical psychologists should make their knowledge and skills available to other professionals via consultancy. Several years later, these recommendations were formalised as a professional responsibility within the Division of Clinical Psychology Professional Practice Guidelines (DCP, 1995). This sharing of resources has been termed a 'task-sharing strategy' (Hoeft, 2018), and aims to increase therapy accessibility and availability by enabling other non-psychological practitioners to deliver more effective and coordinated psychological interventions.

More recently, consultation has become a central part of the clinical psychologist's role and job plans (Health and Care Professions Council (HCPC), 2011) and is guided by the Good Practice Guidelines published by the DCP (2011). With increased expectation to provide more support to healthcare staff, it is therefore becoming increasingly important that clinical psychologists can provide effective and evidence-based consultation to ensure positive outcomes for staff, clients and the healthcare services as a whole.

However, as the use of consultation in clinical practice has increased, so have the types of and approaches to consultation diversified. This has meant that consultation has increasingly become more of a heterogenous concept, leading to differences in its implementation, making it more difficult to draw evaluative conclusions about its efficacy as

a unitary concept. To compensate for this, there have been several attempts to define, categorise and operationalise consultation to inform research and practice. For instance, Caplan et al. (1994) defined consultation as having two main goals: 1) to improve the consultee's ability to work with a client and to develop the consultee's skills, and 2) to enable more independent problem-solving in future clinical work.

Furthermore, Caplan and colleagues also identified two main types of mental health consultation: client-centred case consultation and consultee-centred case consultation. The former involves co-developing psychological formulations for staff-client therapeutic work. This can be either delivered individually or to a team (DCP, 2011). The latter is recognised as 'team formulation' in the literature and is considered the most widely used form of consultation in services (British Psychological Society (BPS), 2016). Client-centred consultation aims to relate psychological theory to practice (Johnstone & Dallos, 2013) in order to enable greater understanding of the client as well as the client-staff interaction to facilitate improved intervention and support. During consultee-centred consultations on the other hand, the consultant seeks to facilitate development of the clinicians' skills and competencies without directly relating this to therapeutic work with a client (Caplan et al., 1994).

Another attempt to operationalise consultation was produced by Carradice and Bennett (2012), who developed a consultancy framework consisting of three levels, each describing different forms of consultation (see Table 1).The model discriminates between 'direct' and 'indirect' consultation, defining 'direct' as any consultation with the client present. Level 1 corresponds to direct consultation where level 2 and 3 corresponds to indirect consultation. The model also discriminates between formulation work completed with (level 2) or without the team (level 3) with the latter focusing more on organisational factors and dynamics.

Despite the lack of consensus around the operational definition of consultation, there has been a growth in evidence of the benefits of consultation for healthcare practitioners. For instance, findings from small quantitative studies suggested that team formulations can improve staff attitudes toward clients (Berry et al., 2009) and team cohesion (Kellet et al., 2014). In a more recent study, Berry and colleagues (2015) reported a larger and more controlled evaluation of team formulations on inpatient staff using a Randomised Controlled Trial method (RCT). They found that in addition to improved staff attitudes towards patients, patients also expressed feeling less criticised by their key workers and reported overall improvements in staff-patient relationships.

These findings were supported by a recent systematic literature review conducted by Geach and colleagues (2018), who reported findings of improvement in staff understanding and empathy towards clients from their synthesis of five quantitative studies of team formulation. Evidence of this also came from studies looking at consultation provided to individual staff. For instance, Dimaro et al (2014) found that a large proportion of social workers offered individual Cognitive Analytic Consultancy (CAC) considered consultation as having provided them an improved understanding of their clients and had increased their confidence in their competencies.

There has also been a recent accumulation of qualitative research into the benefits of consultation. Overall, a general theme of increased empathy has been found across multiple qualitative studies. For instance, Murphy et al (2013) reported how participants described seeing their service users more as “people” than “patients” after receiving consultation. Other benefits found include enhanced communication skills (Dexter-Smith et al., 2010), more consistent team interventions through formulation-led care plans (Craven-Staines et al., 2010) and positive organisational change (Hickman & Crawford-Docherty, 2010). Finally, a recent meta-synthesis looking at the impact of various types of consultation from the perspective of

healthcare staff reported themes including increased understanding, empathy and job satisfaction (Ghag et al., 2021).

However, research into the use and impact of consultation is still in its infancy and there is still a need to identify the underlying process and mechanisms of consultation that lead to some of the identified benefits in the literature. This was emphasised by the DCP (2011, 2015), who highlighted the scarcity of evidence, particularly in relation to qualitative research, and called for a clearer understanding of the inner workings of consultation. Research into these mechanisms would help maximise the outcomes of consultation for healthcare practitioners and in identifying consistent and standardised guidelines around effective consultation.

Some preliminary research has pointed towards factors that either facilitate or prevent positive consultation outcomes for staff. For instance, a recent systematic review conducted by Bealy et al. (2021) synthesised themes from 16 qualitative studies and found several facilitators to team formulation. They reported that participants found consultations particularly beneficial if the facilitator valued the diversity of experiences of the whole team through validating and including everyone. The reverse of this was reported as a barrier, where group dynamics would in some cases be dominated by only a small proportion of the attendees, leading to negative perceptions of the sessions by some. The review also highlighted the challenges working in a highly emotive and fast-paced service context where competing demands, restricted time and staff burnout were barriers to positive consultation outcomes.

Despite some of the recent attempts to synthesise qualitative research, these studies suffer from some methodological flaws. For instance, Bealy et al. (2021) reported that 56% of their studies were unpublished, grey literature where most of them were doctoral theses.

They also reported including clinical psychologist experiences as a methodological limitation as it meant they were unable to discriminate views from the participators and the facilitators. Moreover, even though Ghag et al. (2021) employed a thematic analysis, their aim was to generate broad conclusions of the outcomes of consultation via triangulation by using the qualitative data to inform the quantitative data, which likely reduced the depth of their analysis. Therefore, there is still a need for further and more in-depth exploration of the underlying factors that might be involved in influencing positive consultation outcomes for healthcare staff.

Based on such a need identified in the literature, the present qualitative review was conducted in order to identify what works with consultation by looking at the most common elements of consultation that healthcare practitioners find helpful or unhelpful. However, in order to justify the benefit of conducting the present review in the context of these recent reviews, three steps were taken. First, a preliminary systematic search of relevant papers was completed in order to identify any significant overlap. This resulted in only one paper overlapping with Bealy and colleagues' review and four with Ghag and colleagues.

Second, unlike previous reviews, grey literature was excluded and instead focused on published, peer-reviewed papers. This was done to 1) avoid an uneven distribution of data to the developed themes due to the varying length of the different reports and 2) obtain an updated qualitative review of published research looking at various types of consultation.

Third, only papers looking at experiences of consultation from the perspectives of healthcare staff were included to ensure results were based on direct experience of the recipients of consultation.

Fourth, unlike Bealy et al. (2021), papers evaluating consultation at level 1b (Carradice & Bennett, 2012) were replaced by any evaluating level 3 to incorporate any

consultation at an organisational level and to further evaluate more ‘indirect’ forms of consultation that clinical psychologist are increasingly becoming more expected to provide for cost-effective purposes.

Finally, this review applied a meta-ethnographic approach with the aim to explore any themes in greater depth by analysing author interpretations and looking more closely at the relationships between the themes... The review provided some novel insights into the underlying mechanisms of consultation and was written in the form of recommendations and will be particularly valuable in providing guidance around what the clinical psychologist would need to consider in order to improve consultation outcomes for staff.

Methods

Search Strategy

A search strategy was developed with the assistance of an expert librarian based on the existing Highly Sensitive Search Strategy (HSSS) (Shaw et al., 2004). The strategy is effective in capturing a wider scope of relevant literature (Flemming & Briggs, 2007). This was considered particularly relevant for this study due to the heterogeneous nature of the literature and the lack of consensus around the operationalisation of consultation.

The search comprised a list of relevant topic-related index tags and search terms that incorporated a proximity search strategy. This strategy was used to enable the researcher more control of the search term order and how closely search terms should be associated. All search terms were then grouped into four separate searches related to 1) psychological consultation 2) staff 3) experiences and 4) qualitative analysis, which were combined as one search (see Table 2).

The search was used through six relevant databases including PsycInfo, MEDLINE, Psycharticles, AMED, PubMed, and Web of Science. The index tags were only available for the former four databases through the EBSCOHost research platform. The search was conducted in April 2022 and was limited to articles published in English between 1999 and 2022. The year limit was set to examine more recent research following a change of strategy to mental health provision in the UK by the National Service Framework for Mental Health (DoH, 1999), emphasising the need for improved multi-professional teamwork and integrated care service provision.

Eligibility Criteria

Inclusion and exclusion criteria were developed prior to the screening process and are detailed in Table 3.

Screening Process

The screening process followed the PRISMA guidelines (Moher et al., 2009) and is illustrated in a PRISMA Flow Diagram (see Figure 1). A total of 3040 papers were title screened against the eligibility criteria. Studies meeting them were identified for full text review. After 28 studies were initially assessed for eligibility, 13 studies were identified for analysis. A further 49 papers were title screened through citation searching from the 13 eligible studies and the two relevant meta-syntheses on this topic (i.e. Bealy et al., 2021; Ghag et al., 2021). This culminated in the inclusion of two additional papers. All 15 included studies are summarised in Table 4. Across the studies, the number of participants ranged from 5-57 (mean 16) with 70% of participants being female, with an age ranging from 18-65. Staff presented with a range of multidisciplinary backgrounds including nurses, support workers, medical doctors, social workers, occupational therapists and managerial staff. Moreover, all studies were conducted in the UK apart from one which was conducted in the United States.

Finally, the studies were conducted across a range of inpatient and community settings including psychiatric rehabilitation, probation, paediatric, social and child care, dementia care and learning disability services.

Study Quality and Appraisal

The Critical Appraisal Skills Programme (CASP, 2017) was used to evaluate the quality of the included papers (see Table 5). The CASP was used for two reasons: 1) suitability for novice researchers, requiring lower levels of research experience in qualitative methods and analysis, and 2) high sensitivity in evaluating the reporting quality of studies (Hannes et al. 2010). However, CASP has been criticised for its limited ability to evaluate the theoretical validity (e.g. reflexivity and credibility) and research conduct of a given study, which is often considered core aspects of the methodological quality of a qualitative study (Hannes et al., 2010). To compensate for this, a recent study (Long et al., 2020) added another question to the checklist taken from the Joanna Briggs Institute appraisal tool (JBI, 2007), which has been argued to have higher sensitivity around theoretical validity (Hannes et al., 2010). Thus, in order to evaluate the reporting quality and theoretical validity of papers in this review, this amended version of the CASP checklist was adopted (see Table 5).

Each item on the CASP scale was rated as either “yes”, “partial” or “no”. A quantitative score was assigned to the 11 questions (Yes: 3, Partial: 2, No: 1), based on Duggleby and colleagues’ approach to quality appraisal of systematic reviews (Duggleby et al., 2010). In this review, papers could achieve a maximum score of 33, which were split into three categories: “Low Quality” (papers scoring equal to or less than 16), “Moderate Quality” (17-25) and “High Quality” (26-33). However, this approach is recognised for prioritising the methodological strength over the conceptual richness of the paper relevant to the review. To compensate for this, a separate categorical score was developed to represent the overall

contribution to the synthesis, including “High”, “Medium” and “Low” (see bottom of Table 3). Therefore, findings from the appraisal were not intended to be used as exclusion criteria, but rather to inform the degree of each paper’s contribution to the analysis. This was based on findings indicating that exclusion of low-quality papers might reduce the richness of the synthesis outcomes and any related themes (Garside, 2014).Studies with lower methodological and/or conceptual ratings will be compared with other papers to evaluate and inform the quality of the synthesis outcomes.

Two random articles of the 15 (13.3%) were subject to inter-rater evaluation by a second investigator to ensure the accuracy of the appraisal. The ratings indicated a high degree of consistency and agreement (75%). Any uncertainties were discussed and resolved to ensure consistent ratings for the remaining articles.

Outcomes of Quality Appraisal

Throughout the appraisal process, it was evident that most articles had a clear purpose, an appropriate methodology, and a suitable conclusion, but lacked a proper description of the sampling strategies and auditability of the analyses (see Table 6). Reporting the sampling strategy was considered particularly pertinent due to the fact that as many as six studies reported potential sampling bias, where participants were likely biased towards positive aspects of consultation. Moreover, five papers were deemed to not have considered the relationship between researcher and participants, which was also considered problematic as many of the clinical psychologists offering the consultation also conducted the interviews. In addition to this, eight papers lacked appropriate consideration and description of their own ontological and epistemological assumptions and biases, meaning that some of the second order interpretations from the authors were considered with caution. This should particularly be considered for one paper (11), which contributed significantly to the conceptual

development, however, demonstrated several methodological limitations and limited credibility.

Two papers met the criteria for poor methodological quality (14, 15). The latter two studies reported limited details around their research methods and lacked rich data for analysis. These papers did not to make any novel contributions to the synthesis, however, did strengthen some themes by demonstrating similar findings across additional services with a range of different healthcare personnel. Thus, the poor quality studies were deemed to make valuable contributions in co-occurrence with higher quality studies (Sandelowski & Barroso, 2002) and did not seem to significantly bias the outcomes of the analysis.

Procedure of the meta-ethnography

This study used a meta-ethnographic approach guided by Noblitt and Hare's (1988) method for synthesising qualitative studies and followed their seven phases of a meta-ethnography. The advantage of this approach over other meta-syntheses is that it can provide novel insights into underlying meanings of the perspectives and experiences expressed by individuals by looking more closely at the relationships between the themes and allowing more space for author interpretation. The first two phases, "Getting Started and "Deciding what is Relevant" have already been described, so only the remaining phases will be explained below.

Phase 3: Reading the studies

During the initial stage of the qualitative analysis, initial and emergent codes and lower order concepts were developed for each paper with corresponding raw data, which was in the form of first order (participant quotes) and second order constructs (author interpretations) (Britten et al., 2002). In order to ensure the context was incorporated into each phase of analysis, a table detailing each paper's context was developed alongside the

corresponding raw data. Throughout the analysis process, I adopted a social constructivist perspective. Only seven papers stated their epistemological stance, however, since all the papers reported the verbatim quotes, it can be assumed that it would fit within a social constructivist framework.

Phase 4: Determining how the studies are related

This phase involved noting salient or frequent concepts regarding the relationships between the papers. This was done by juxtaposing the many codes and concepts for each paper developed in phase three and were used to develop a clustering of higher-order concepts, based on how they related to each other. Higher-order concepts were developed based on this analysis and formed the basis for the reciprocal translation described below. The analysis was an iterative process where some of the concepts were revised when they were reviewed after comparing old with new data.

Phase 5: Translating the studies into one another

During this phase, each concept from each paper was compared with all the other papers to check for commonality (Sattar et al., 2021). This process involved evaluating how each developed higher-order concept contributed to the first and second-order constructs using a constant comparison method. In order to this, the first and second-order constructs from each paper were translated into one document depending on their ability to explain each concept (see Table 7).

Phase 6 and 7: Synthesising translation and expressing the synthesis

The last phase of the analysis involved reading the primary synthesis alongside the reciprocal translations and drawing out the main points from the translations in order to develop third order constructs (see Table 7). The development of third-order constructs were

constantly compared with the translations to make sure it was consistent with the data. This process culminated in the development of six original themes. Each theme was also cross-checked with summaries of first and second-order constructs for each paper to identify how they contributed (see Table 8). Phase 7 ("expressing the synthesis") was achieved through the completion and dissemination of this paper.

Reflexivity and Credibility

The researcher is a Trainee Clinical Psychologist with limitedexperience of delivering consultation, or any specific consultancy models, in clinical practice. Nevertheless, the researcher has personal experiences in delivering supervision and coaching, which arguably overlaps with consultation. It is recognised that this could influence the researcher's interpretations of the original studies. With this in mind, the researcher kept a reflective diary detailing the analysis and process of reflection as well as re-checking codes throughout the analysis to assess any influence of bias. Furthermore, the analysis was conducted under the supervision of a tutor with experience in conducting meta-syntheses of qualitative research.

Results

Six themes were identified across all papers and will be introduced below.

Theme 1: Individual Connection: Broader and Deeper Understanding of Clients

This theme highlighted how consultation helped staff to develop a deeper understanding of their clients by taking a broader perspective when understanding and supporting them (1, 3, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15). Several participants commented on how learning about the clients' life story in combination with psychological theory was essential to generate insight to the "why behind the behaviours" (4, 6), emphasising the

importance of reflecting on the impact of how previous experiences impact current behaviours that challenge (8, 10, 12).

Other papers also highlighted how consultation broadened the staff members' understanding of the individual within a wider context (4, 6, 12). For instance, literature examining consultation in the children's services reported that many participants developed a broader understanding of their clients and their families: "Consideration of complex relationships between all family members" (4).

This broader and deeper understanding was often reported as leading to an increased empathy and compassion for the clients (3, 4, 7, 9, 11, 13). Several papers reported how participants were more able to "put themselves in the shoes" of the clients and relate more to them by recognising their difficult pasts and that they have "a lot going on" (3, 9, 13). This in turn led to more motivation and confidence in implementing strategies and to supporting clients in more person-centred ways that were seen as reflective of best practice (4). For instance, several papers reported participants linking a broader understanding with increased empathy and curiosity toward service users, leading to motivation to spend more time with and increased confidence in interacting with them (4, 9, 11).

Theme 2: Team Togetherness

In several papers, consultation was experienced as giving a sense of team cohesion (1, 4, 5, 9, 12, 14, 15). This was predominately found in consultations that utilised team formulations in healthcare settings with multidisciplinary teams. Staff in such settings valued consultation as a space for staff to engage in a shared problem-solving process where they would "put their minds together" to "solve a jigsaw puzzle" together (1, 12). Staff particularly valued inclusive consultation sessions where everybody's viewpoints, skills and abilities were utilised (12), which reportedly made them feel closer and more understanding

of each other. This would subsequently cause staff, particularly less experienced staff, to feel more confident in their role as part of the team:

> Sometimes I don't feel as good as others, I'm the most less experienced and the last one in, so to speak, so to hear that I was having some of the same ideas as them, I wasn't questioning my judgment as much (1).

Furthermore, it was reported that consultation also helped shape disparate ideas into a "shared understanding", allowing for a more unified approach towards developing more coherent intervention plans, and improving communication, care consistency and confidence in their delivery (1, 5, 9, 12, 14). However, several papers noted that this confidence hinged upon the inclusion of care planning where consultation would consist of clear and concrete plans to use with their clients (4, 5). This would help staff feel like they were "more in control" and confident in order to assist clients that were more difficult to manage:

> Before I was a bit lost, working out how to deal with this person, or I found them a bit dangerous or a bit intimidating…I felt more confident afterwards to be able to interact with that patient and more confident in how I can assist with their care. (9).

Contradicting this, however, some participants did not perceive consultation as needing to be "action-orientated" with the inclusion of structured intervention planning as part the sessions (12). However, this was likely due to the fact that the relevant team already had established regular care plan and care-coordination meetings.

Theme 3: Permission to Feel

The included literature revealed that staff members highly valued consultation as a safe space to reflect and process their feelings (1, 2, 4, 5, 8, 9, 10, 12, 13). For instance, several papers described how staff appreciated how they could "offload without being

scrutinised or managed" (2) and to safely discuss their "possible failings" (1). Several participants also commented on valuing having space to process their feelings during consultation. One such participant summarised this, saying they felt able to cry and to "then talk about those feelings" (2).

Several papers described how this was particularly valued in mental health contexts where such opportunities were sparse (2, 8, 9, 12, 13). Staff described feeling that in their everyday practice they were expected to "uphold a professional demeanour" and would often feel too ashamed to express their own vulnerabilities or failures (2, 8, 9). Taking this further, several papers described how the demanding services often caused staff to feel "emotionally overwhelmed" (13), especially in the absence of sufficient clinical supervision (2), which led to them making blame-based assumptions about their clients: "The ward is so fast-paced and a highly intensive environment, sometimes you just need that space to just, let yourself be heard, because it can be frustrating" (9). Consultation was therefore seen as a way to prevent this by helping them normalise their emotions and reduce self-criticism:

> It's like it gives permission to be thinking about and acknowledging that it is really hard on you and if you've been…getting someone shouting at you or saying things that are unkind to you, that it's quite normal to be feeling that way (9).

Consultation was also experienced as a space for staff to engage in a "sense-making process" of how their own "covert" emotional needs (6, 10) impacted on them and clients, which consequently facilitated increased self-awareness (13). This in turn helped them better regulate and manage their own emotions (4, 5, 9, 13) and made them feel more equipped to deal with difficult situations or dynamics, culminating in an improved therapeutic relationship with clients (5, 9, 13):

> I think what it's made me more do is . . . say ok right this is frustrating, just blurt the frustration out, sort that out in my head and then go back to deal with them differently. It gives you the opportunity to . . . help myself coping in difficult situations (5).

Several papers identified that in order to facilitate such a safe space and motivation to engage in the sessions, consultants needed to offer regular validation, reassurance and non-judgmental feedback that also recognised the consultees' strengths (4, 5, 13).

Theme 4: Consultation Style Preference: The Impact of Work Experience

Multiple papers identified that staff members' length of work experience determined the consultation style they considered to best meet their needs (1, 2, 5, 6, 7, 8, 10, 11, 14, 15). Newer staff reported benefitting more from an expert-led approach (1, 2, 4, 6, 11), expressing a need for more explicit advice and instruction from the consultant (5) to guide them to where they needed to "go next" (1). Conversely, more experienced staff, often expressed frustration and occasionally disdain for an expert-led approach: "Telling me what to do, how dare he?" (10) and others inferred negative intent on the part of the consultant "It's about who's got the loudest voice, wanting to be right or more powerful" (6). Another study suggested that this might be based on the pre-conceptions that more experienced staff might already have due to expecting being told what to do, invoking a sense of resistance: "You're going to get somebody that's going to come in and tell you how to do your job, which you've been doing for nine years!" (1).

Several papers explained this disparity by arguing that less experienced staff had less confidence in their roles and thus presented with a higher need for validation, reassurance and explicit instruction about what they "should be doing" (2, 9, 11). More experienced staff members, on the other hand, were described as having more "established ways of working",

meaning they felt that the team was already working well and were therefore more resistant to expert-led approaches that were perceived as being told what to do (1, 9, 11, 13).

More experienced staff were also described as more resistant to organisational interventions, such as consultation, over time due to higher rates of burnout and chronic stress. It was explained that this was the result of prolonged experiences in emotive and fast-paced services, which caused a reduction in their motivation to invest in consultations sessions (11). Several papers therefore also offered recommendations around identifying and engaging more resistant staff by using motivational interviewing strategies or by affirming staff members' strengths and empowering them to use formulation in their work (1, 11).

Theme 5: Unrealistic Expectations: The Mystery of Psychological Consultation

This sub-theme relates to staff members presenting with an overall uncertainty and confusion around the role of clinical psychology and consultation, leading to unrealistic expectations (1, 2, 6, 7, 9, 10, 11, 13, 15). For instance, several papers reported that staff complained about not knowing the purpose of consultation or what to bring to it (2, 6, 7, 11, 15) and several participants expressed wishing they had been better prepared to get the most out of consultation (4). This was generally more evident for people who had little professional working experience with a clinical psychologist (10), who appeared to expect the clinical psychologist to offer them new insights with little recognition of the requirement of their own contribution to the consultation process: "I expected her to turn the light bulb on" (10), "From a clinical psychologist I would expect them to give… the answers" (6).

There were also expectations that appeared to be based on a strong need for solutions (11, 13). For instance, some participants presented with unrealistically high expectations if they felt that they had exhausted all available strategies and techniques, hoping consultation would provide them with quick solutions to complex problems: "I think sometimes maybe

I'm expecting more than, than you know than is forthcoming, but maybe that's me just being unrealistic, it's that magic wand thing isn't it?" (13). Subsequently, when these unrealistically high expectations were not met, staff would often report experiences of dissatisfaction and disappointment with the consultation, which led to reduced investment in the consultation sessions: "at first you're looking for a quick fix…You think someone's here that can fix it all […]…that's what you hope for I think when they come…But it doesn't seem to be the case" (11).

On the basis of this, several authors emphasised the importance of the consultant disseminating clear information about the purpose of consultation (6, 7, 11, 12, 15).

Theme 6: Building the Consultative Relationship

This theme highlighted the importance of building more of a personal consultant-consultee relationship and connection in order to promote trust and subsequent engagement in the consultation sessions (1, 5, 6, 7, 10, 11, 13). For instance, several papers emphasised the importance of having an informal connection with the clinical psychologist and feeling able to speak with them outside of the consultation space (5, 6, 10, 11): "I've spoken to the consultant many times about different things and I've always been comfortable and confident that I can speak to him about feeling pressured or nervous or anything like that" (7). Based on this, authors of several papers suggested that consultants should initiate informal conversations with their consultees in order to build a sense of familiarity and trust that would facilitate engagement in the consultation sessions (6, 7, 11).

Furthermore, there were also reports of participants forming negative views of the consultant if he/she did not work regularly within the team or service. For instance, several papers described how consultees doubted the consultants' understanding of the clients if they did not work with them directly, and thus were more reluctant to accept their advice and

engage with consultation (5, 7, 9, 11): “I’ve been involved in things and you feel like you’re not able to say or give your opinion because you don’t know these people and you don’t feel comfortable with challenging what they’re saying” (7). This might particularly be the case for consultants who offer consultation externally or as one-off events as they might have to invest more into this or consider building a trusting relationship from the initial point of contact (10).

Conversely, consultants were positively perceived if their approach was informal and collaborative as they would then be considered as “part of the team” and would allow the development of positive relationships based on trust (7). It was argued that this would help create a sense of a safe space where staff could express more sensitive thoughts and experiences and be more open about themselves (7, 10).

Several papers reported that the communication and language skills of a consultant are important to foster a closer working relationship with the consultees (5, 6, 7, 11, 13). More specifically, it was emphasised that consultants should adapt their language to the consultees’ understanding and experience in order to promote positive staff perceptions and attitudes (6): “He can appreciate their talents and…modulate himself down and try to impact on and talk to people at levels that they can understand and respond to” (7).

Several papers also noted that participants appreciated jargon-free and non-scientific language as it fostered a sense of “inclusion and collaborative understanding” between the consultant and consultee (6, 7).

A final factor that was identified as important to establish a good working relationship pertained to the availability, flexibility and responsiveness of the clinical psychologist (5, 7, 11, 13). For instance, staff members commented on needing someone to be readily available to “fall back on” (13) and if they were unable to, they could feel “abandoned” by the clinical

psychologist (5). Finally, it was also reported that the availability of the consultant created a sense of trust and safety, however, would cause frustration if their availability was inconsistent or limited, particularly if relevant situations were perceived as pressing (7).

Discussion

The conducted synthesis of this review culminated in six themes, which will be discussed in turn.

The first theme suggested that staff significantly benefitted from consultation consisting of background information about clients leading to increased empathy and motivation for staff to work more closely with them. This has been reported as a central theme by previous reviews (Ghag et al., 2019; Bealy et al., 2021) and separate empirical research (e.g. Murphy et al., 2013; Hollingworth & Johnstone, 2014). This review, however, also emphasised the importance of consultation including the client's wider context as this was also important for staff to appreciate the individual complexity of a client. This might help "individualise" and normalise the client by contextualising their behaviours and thus counteract reductive conceptualisations of their behaviours being intentional or seen as "problem behaviours" (Farrell et al., 2010), which is often seen in the literature (e.g. Salmon & Manyande, 1996; Markham & Trower, 2003).

The second theme highlighted how staff benefitted from having space for group discussions and shared problem solving to elicit a sense of cohesion with their fellow colleagues. This corresponds with research reporting that group tasks in consultations that allow diverse opinions and experiences facilitate a feeling of everyone contributing (Harrison et al., 2018; Hollingworth & Johnstone, 2014). Similar to connecting with clients, staff also develop empathy towards their colleagues when they share about themselves and their

difficulties in consultation, which has also been found to create a sense of "equality" (Manuel, 2016) and humanisation between them (Kellet et al., 2014). This review added to the literature by highlighting that the consultant should attempt to develop an informal connection with the consultees as this was helpful in supporting staff to share their vulnerabilities, which would help staff feel closer together. This corresponds with research highlighting the importance of professionals in leadership positions to role model healthy interactions as an effective way to influence interactions and relationships formed between others (Holmgren et al., 2018).

This review also identified different accounts of whether consultation should be structured with more of an action-orientated focus or reflective focus to elicit team cohesion. Papers in this review espousing action-focused approaches have received more support from past research. For instance, staff have reported that the more action-orientated consultations consisting of direct care planning were beneficial in being able to collectively decide ways forward (Eyres & McKay, 2011). However, other staff expressed more need for consultation to be reflective, particularly if they were already provided with regular care plan meetings outside of consultation. It might therefore be that this need depends on what is already provided regularly within the team. Alternatively, it may be that specific intervention planning is more beneficial for staff when working with more complex cases, as has been identified in the literature (Hollingworth & Johnstone, 2014).

With regards to the relevant processes, this review highlighted that the length of consultee experience was important in influencing the consultation experience, which was not identified in previous reviews (Bealy et al., 2021; Ghag et al., 2021). For instance, it was evident that experienced staff would often disengage if the consultant's approach was perceived as non-collaborative or expert-led as they were reluctant to change what was perceived as already working. This is supported by research demonstrating that more

experienced staff are more likely to perceive new interventions as unnecessary (Hassan et al., 2021) or present as more resistant to change due to preferring the "old ways" of working (Blake et al., 2006).

Findings from this review also support research indicating that this resistance is often associated with effects of burnout that comes with working in challenging environments over longer time (Wood et al., 2011).Although Bealy and colleagues reported burnout to be a barrier to consultation, this review extends it by suggesting that this might be a possible link and could point towards future considerations for engaging more resistant staff. Supporting this finding, research literature on burnout has often reported positive correlations between burnout, cynical attitudes and higher resistance to organisational change (Srivastava & Agrawal, 2020). However, due to its correlational nature, this is speculative and thus requires further investigation.

Furthermore, experienced staff also reported negative attitudes towards the consultant as a hierarchical figure when using an expert-led approach. A collaborative approach might therefore be important not just to circumvent reluctance to change but also to prevent "us and them" perceptions that might cause disengagement from consultation. Within the consultation and supervision literature, establishing a sense of "equality" is deemed necessary to prevent such negative attitudes (Manuel, 2016). This sense of equality has been found to be achieved once an informal and personal connection has been formed, leading staff to have more respect for role authority (Fournies, 2007) and are more receptive to constructive feedback (Deprez & Euwerna, 2017). This might be especially important for consultants providing external provision as oppositional attitudes are more easily formed whenever the consultant is not working regularly with the relevant team or service (Thornberg, 2014).

Less experienced staff, on the other hand were found to prefer an expert-led approach due to their reduced confidence and consequently a need for more instruction and guidance. This is supported by research reporting that new employees often experience higher degrees of uncertainty, which they attempt to alleviate by seeking information from credible sources in order to "fit in" by performing as expected (Sias & Wyers, 2001). Unlike previous reviews (Bealy et al., 2021), this review therefore highlights the importance for consultants not to assume a collaborative approach, but to assess the need and preference of staff related to their experience and confidence.

Another finding that differed from previous reviews (Bealy et al., 2021; Ghag et al., 2021) was that many staff formed unrealistically optimistic expectations of consultation. This was found to be related to a lack of understanding the role of psychology and purpose of psychological consultation. This has been reported as more common in primary care and medical services due to a lack of integration between psychological and medical services (Curry & Ham, 2010). Therefore, in such contexts, it might be particularly important for staff to have a clear idea of what should be expected of consultation. This is supported by various studies suggesting that the most positive outcomes would only occur when congruence between the staff members' expected provision and the consultant's actual provision existed (Brown et al., 2005). In line with this, previous research has therefore suggested that the consultant should establish an agreed problem definition between both parties, which has been considered an essential predictor for successful consultation (Kurpuis et al., 1993).

Another novel finding from this review was that most staff considered consultation as mainly having an emotionally supportive function. This was discussed in relation to working in a demanding and highly emotive environment causing staff to be emotionally overwhelmed or burned out. Highlighting the importance of supporting staff emotionally, Geach and colleagues (2019) reported that many of the consultees presented with high levels

of uncontained anxieties and if left unmet, would prevent open discussions and emotional sharing in formulation sessions. They further explained that this reduced staff members' ability to recognise their own contribution to relational dynamics, which is necessary for developing effective clinical formulations and care plans. They, along with this review, highlighted the importance of the consultant taking a non-judgmental approach to help alleviate "covert" feelings that would facilitate self-awareness, psychological resilience and improved self-regulation in order to be more containing towards their clients.

Finally, this review suggested that consultants should be available and responsive in their approach in order to develop more trusting relationships and more effective consultations. It was explained that this might partly be due to the fact that their presence and responsiveness reassured anxieties, particularly when pressure was higher. This corroborates with research demonstrating that work uncertainties and lack of predictability commonly seen in healthcare services are an occupational stressor that cause strain on employees (Schoellbauer et al., 2022). Being provided with a sense of predictability would therefore be important to alleviate stress that might have otherwise impacted on the engagement in consultation (Geach et al., 2019).

Study limitations

The current review has several limitations. First, despite a relatively wide search, it is important to note the review was limited to peer-reviewed articles in the English language, meaning this review might have missed some relevant studies and might be susceptible to publication bias. Furthermore, it was also evident that most of the studies included were structured, client-focused formulation consultations that were delivered to teams based in the UK. Thus, the developed themes and corresponding discussions were mainly relevant to services and professionals in the UK, reducing the overall generalisability of the results.

Moreover, the review also did not cover organisational consultations (Carradice & Bennett's 2012 level 3), and consultee-focused consultation was underrepresented.

Finally, it is worth mentioning that this study relied on citation searching to identify additional relevant papers. This could suggest that despite using a comprehensive search strategy, it is possible that it was missing important keywords to identify relevant papers.

Clinical implications and recommendations for clinical practice

First, and perhaps most important recommendation for clinical psychologists is that they should make themselves available and responsive for staff as much as possible in order to contain staff anxiety and develop trusting relationships. If consultation is provided internally, consultants should consider having an "open door policy" for professional and informal encounters. If provided externally, consultants should communicate clearly what support they can realistically offer.

Second, consultants should engage in expectation management by explicating the purpose and aims of consultation to prevent formations of unrealistic expectations. This might be provided in the form of mutual goal setting discussions at the start of the consultation session to prevent confusion, facilitate team cohesion and to increase collaborative working that could reduce "us and them" perceptions (Geach, 2018).

Third, consultations should liaise with the relevant service to assess the needs of the staff. This includes getting a sense of the current service provision (i.e. care planning) as well as the need for more collaborative or expert led approaches related to staff experience. This might be in the form of liaising with the manager of the team to gauge their needs, which is often recommended for effective training (Kirkpatrick & Kirkpatrick, 2006).

Fourth and finally, consultants should adapt their language to staff need. They should do so by demonstrating an inclusive, normalising and non-judgmental approach using regular positive affirmations to acknowledge the expertise of experienced staff and encourage less experienced staff. Consultants might also benefit from using techniques such as rolling with resistance, which has been found to work well in engaging resistant staff members (Berry et al., 2012).

Research implications and future research

Although some of the findings from this review echoed previous reviews (Bealy et al., 2021; Ghag et al., 2021), several novel contributions were identified that could benefit from further exploration.

First, it was identified that in order for staff to develop an individual connection with their clients, consultation should incorporate the clients' life story and wider context through the lens of psychological theory. However, further qualitative research could explore and compare the impact of different contents, which would give insight into the relative benefits of provision and would subsequently inform what consultants should prioritise. Further qualitative research should also explore the staff members' experiences of the clinical psychologist approach in order to identify what repertoire of skills they should tap into to facilitate a deeper connection with their clients.

Second, the results of this review indicated that staff might have different preferences for consultation being action-oriented or reflection-focused. It was suggested that this likely depends on what provisions are in place within the team or who the staff might be supporting, however, further qualitative research could compare the types of consultation with services that do or do not provide regular care planning meetings to gain further insight into staff preferences and needs.

Finally, the findings of this review indicated that developing an informal and trusting relationship with consultees might be more difficult for a consultant delivering external and one-off consultations. Future qualitative research comparing the staff experience of these different consultation types in relation to building a professional relationship would be beneficial.

Conclusion

This review highlighted that the experience and outcome of consultation is heavily dependent on individual, interpersonal and contextual processes. Staff work experience, lack of knowledge of the clinical psychologist and uncontained anxiety caused by a highly emotive and demanding service contexts should be considered by the consultant when approaching consultation. They should also be available and responsive and use their communication skills to develop trusting relationships with their consultees to facilitate improved engagement.

References

Bealey, R., Bowden, G., & Fisher, P. (2021). A systematic review of team formulations in multidisciplinary teams: Staff views and opinions. *Journal of Humanistic Psychology, 00221678211043002, 1–28*. https://doi.org/10.1177/00221678211043002

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

*Berry, K., Haddock, G., Kellett, S., Awenat, Y., Szpak, K., & Barrowclough, C. (2017). Understanding outcomes in a randomized controlled trial of a ward-based intervention on psychiatric inpatient wards: a qualitative analysis of staff and patient experiences. *Journal of clinical psychology*, *73(10),* 1211-1225.

Berry, K., Haddock, G., Kellett, S., Roberts, C., Drake, R., & Barrowclough, C. (2015). Feasibility of a wardbased psychological intervention to improve staff and patient relationships in psychiatric rehabilitation settings. *British Journal of Clinical Psychology*.

Blake, S. C., Kohler, S., Rask, K., Davis, A., & Naylor, D. V. (2006). Facilitators and barriers to 10 National Quality Forum safe practices. *American Journal of Medical Quality*, *21*(5), 323-334.

Blinkhorn, V., Petalas, M., Walton, M., Carlisle, J., McGuire, F., Kane, S., & Moore, J. (2021). Understanding offender managers' views and experiences of psychological consultations. *European Journal of Probation*, *13(2),* 95-110.

British Psychological Society (2017) Incorporating Attachment Theory into Practice: Clinical Practice Guideline for Clinical Psychologists working with People who have Intellectual Disabilities. Leicester, British Psychological Society.

British Psychological Society/Division of Clinical Psychology (1995). Professional Practice Guidelines. BPS: Leicester.

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

*Brodar, K. E., Leite, R., Marchetti, D., Jaramillo, M., Davis, E., Sanchez, J., Delamater, A., Saab, P., & La Greca, A. M. (2021a). Psychological screening and consultation in a pediatric diabetes clinic: Medical providers' perspectives. Cl*inical Practice in Pediatric Psychology, 10*(2), 164.https://doi.org/10.1037/cpp0000430

Brown, D., Pryzwansky, W. B., & Schulte, A. C. (2005). *Psychological consultation and collaboration: Introduction to theory and practice*. Allyn & Bacon.

Caplan, G., Caplan, R. B., & Erchul, W. P. (1994). Caplanian mental health consultation: Historical background and current status. *Consulting Psychology Journal: Practice and Research*, *46*(4), 2.

Caplan, G. (1970). *The theory and practice of mental health consultation*. New York: Basic Books.

Carradice, A. and Bennett, D. (2012) *Beyond the Psychotherapist's Chair: CAT Consultancy*, ACAT conference presentation, Manchester.

*Clare, R., & Jackson-Blott, K. (2023). Providing psychological consultation within children's social care: a mixed-methods service evaluation. *Journal of Social Work Practice*, *37(1),* 45-62.

Craven-Staines, S. , Dexter-Smith, S. and Li, K. (2010), "*Integrating psychological formulations into older people's services – three years on (part 3): staff perceptions of formulation meetings*", *PSIGE Newsletter* , Vol. 112, pp. 16-22.

Critical Appraisal Skills Programme. (2018). CASP qualitative checklist. Retrieved June 8, 2023, from https://casp-uk.net/images/checklist/documents/CASP-Qualitative-Studies-Checklist/CASP-Qualitative-Checklist-2018_fillable_form.pdf.

Curry, N., & Ham, C. (2010). Clinical and service integration. The route to improve outcomes. *London: The Kings Fund*.

Department of Health. (1999). *National Service Framework for mental health modern standards and service models*. London: DoH

Deprez, J., & Euwema, M. (2017). You can't always get what you want? Leadership expectations of intrapreneurs. *Journal of Managerial Psychology*, 32(6), 430–444.

Dexter-Smith, S. , Hopper, S. and Sharpe, P. (2010), "*Integrating psychological formulations into older people's services – three years on (part 2): evaluation of the formulation training programme*", *PSIGE Newsletter* , Vol. 112, pp. 12-15.

Dimaro, L., Moghaddam, N., & Kyte, Z. (2014). An evaluation of psychological consultation to social workers. *Adoption & Fostering*, *38*(3), 223-237.

Division of Clinical Psychology (2011). Good Practice Guidelines on the use of Psychological Formulation. London: British Psychological Society.

Dixon-Woods, M., Shaw, R. L., Agarwal, S., & Smith, J. A. (2004). The problem of appraising qualitative research. *BMJ Quality & Safety*, *13*(3), 223-225.

*Douglas, J. L., & Benson, S. (2015). Psychological consultation in a paediatric setting: A qualitative analysis of staff experiences of a psychosocial forum. *Clinical child psychology and psychiatry*, *20(3),* 472-485.

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

*Durka, K., & Hacker, T. (2015). The experience of receiving and delivering consultation in a residential childcare setting for looked-after and accommodated children: A sequential exploratory design. *Child Care in Practice*, *21(4),* 392-407.

Epstein, R. M., & Krasner, M. S. (2013). Physician resilience: what it means, why it matters, and how to promote it. *Academic Medicine*, *88*(3), 301-303.

*Evans, K., Law, H., Turner, R. E., Rogers, A., & Cohen, K. (2011). A Pilot Study Evaluating Care Staffs' Perceptions of their Experience of Psychological Consultation within a Mental Health Setting. *Child Care in Practice*, *17(2),* 205-219.

Eyres, S., & McKay, J. (2011). Qualitative evaluation of a case consultation group within a multidisciplinary home treatment team. *Clinical Psychology Forum, 222,* 26-30

Farrell, G. A., Shafiei, T., & Salmon, P. (2010). Facing up to ‘challenging behaviour’: a model for training in staff–client interaction. *Journal of Advanced Nursing*, *66*(7), 1644-1655.

Farrell, G. A., Shafiei, T., & Salmon, P. (2010). Facing up to 'challenging behaviour': a model for training in staff–client interaction. *Journal of Advanced Nursing*, *66(7),* 1644-1655.

Flemming, K., & Briggs, M. (2007). Electronic searching to locate qualitative research: evaluation of three strategies. *Journal of advanced nursing*, *57(1),* 95-100.

Fournies, F. (2007). *Why employees don't do what they're supposed to do and what to do about it.* New York: McGraw-Hill.

Fridrich, A., Jenny, G. J., & Bauer, G. F. (2015). The context, process, and outcome evaluation model for Organisational Health interventions. *BioMed Research International, 2015,* 1–12. https://doi.org/10.1155/2015/414832

Garside, R. (2014). Should we appraise the quality of qualitative research reports for systematic reviews, and if so, how?. *Innovation: The European Journal of Social Science Research*, *27(1),* 67-79.

Geach, N. (2018). *Team Formulation in Practice: A Framework Analysis of Examples From UK Clinical Psychology Practice* [Doctoral dissertation, University of Lincoln]. ProQuest Dissertations & Theses Global.

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

Geach, N., Moghaddam, N. G., & De Boos, D. (2018). A systematic review of team formulation in clinical psychology practice: definition, implementation, and outcomes. *Psychology and Psychotherapy: Theory, Research and Practice*, *91*(2), 186-215.

Ghag, J., Kellett, S., & Ackroyd, K. (2021). Psychological consultancy in mental health services: A systematic review of service, staff, and patient outcomes. *Psychology and Psychotherapy: Theory, Research and Practice*, *94(1),* 141-172.

Hannes, K., Lockwood, C., & Pearson, A. (2010). A comparative analysis of three online appraisal instruments' ability to assess validity in qualitative research. *Qualitative health research*, 20(12), 1736-1743.

Harrison, G., Sellers, E., & Blakeman, M. (2018). Team psychological formulations in assertive outreach teams: Evaluating staff experiences. *British Journal of Mental Health Nursing, 7(2),* 75-80. https://doi.org/10.12968/bjmh.2018.7.2.75

Hassan, T., Bishop, B., Dogar, I., & Galbraith, N. (2021). Frontline Staff Perceptions of the Safewards Model on a Forensic Psychiatric Unit in Canada. *Journal of Pakistan Psychiatric Society*, *18*(3).

Health and Care Professions Council (HCPC). (2011). Standards of proficiency: practitionerpsychologists. London, HCPC

*Hibbert, G., & Frankl, J. (2011). A psychology consultation service for social workers and foster carers in a child and adolescent mental health service. *Educational and Child Psychology*, *28(3),* 63.

Hickman, G., & Crawford-Docherty, A. (2010). Ward C: a formulation-based service development project. *PSIGE Newsletter, 112*, 46-54.

Hoeft, T. J., Fortney, J. C., Patel, V., & Unützer, J. (2018). Task-sharing approaches to improve mental health care in rural and other low-resource settings: a systematic review. *The Journal of rural health*, *34*(1), 48-62.

Hollingworth, P., & Johnstone, L. (2014). Team formulation: What are the staff views? Clinical Psychology Forum, *257(5),* 28-34.

Holmgren, J., Paillard-Borg, S., Saaristo, P., & von Strauss, E. (2019). Nurses' experiences of health concerns, teamwork, leadership and knowledge transfer during an Ebola outbreak in West Africa. *Nursing Open*, *6*(3), 824-833.

Jablin, F. (2001). Organizational entry, assimilation, and disengagement/exit. In F. Jablin and L. Putnam (Eds.), *The new handbook of organizational communication:Advances in theory, research, and methods* (pp. 732-818). Thousand Oaks, CA: Sage.

Joanna Briggs Institute. (2007). clientsMARI: The Joanna Briggs Institute system for the unified management, assessment and review of information. Retrieved from: https://jbi.global/critical-appraisal-tools

Johnstone, L., & Dallos, R. (Eds.). (2013). Formulation in psychology and psychotherapy: Making sense of people's problems (second ed.). London, England: Routledge

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

Kirkpatrick, D., & Kirkpatrick, J. (2006). *Evaluating training programs: The four levels*. Berrett-Koehler Publishers.

*Kramarz, E., Mok, C. L. M., Westhead, M., & Riches, S. (2022). Staff experience of team case formulation to address challenging behaviour on acute psychiatric wards: a mixed-methods study. *Journal of Mental Health*, *32(2),* 412-423.https://doi.org/10.1080/09638237.2021.2022611

Kurpius, D. J., Fuqua, D. R., & Rozecki, T. (1993). The consulting process: A multidimensional approach. *Journal of Counseling & Development*, *71(6),* 601-606.

Kuttner, M. S. (1989). Management advisory services. *Journal of accountancy*, *167*(3), 105.

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1(1)*, 31-42.

Manuel, N. P. (2016). *A grounded theory study of multidisciplinary staff views on participating in team formulation* [Doctoral dissertation, Cardiff University]. ProQuest Dissertations & Theses Global.

Markham, D., & Trower, P. (2003) The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours. *British Journal of Clinical Psychology 42(3),* 243–256.

*Mattan, R., & Isherwood, T. (2009). A grounded theory investigation of consultees' perception and experience of psychological consultation. *Mental Health and Learning Disabilities Research and Practice*, *6(2),* 169-183.

*McKenna, M., Brown, L. J., & Berry, K. (2022). Formulation-led care in care homes: Staff perspectives on this psychological approach to managing behaviour in dementia care. *International Journal of Older People Nursing*, *17*(5), e12465.

*McTiernan, K., Jackman, L., Robinson, L., & Thomas, M. (2021). A thematic analysis of the multidisciplinary team understanding of the 5P team formulation model and its evaluation on a psychosis rehabilitation unit. *Community Mental Health Journal*, *57*, 579-588.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group*, T. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of internal medicine*, *151(4),* 264-269.

Murphy, S. A., Osborne, H., & Smith, I. (2013). Psychological consultation in older adult inpatient settings: A qualitative investigation of the impact on staff's daily practice and the mechanisms of change. *Aging & Mental Health*, *17*(4), 441-448.

Noblit, George W., and R. Dwight Hare. 1988. *Meta-ethnography: Synthesizing Qualitative Studies* (Vol. 11). Newbury Park, CA: Sage.

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

*Radcliffe, K., Carrington, B., & Ward, M. (2020). Exploring offender manager's experiences of psychologically informed consultation on relationships with service users within the offender personality disorder pathway. *Mental Health Review Journal*, *25(4),* 317-328.

Salmon, P., & Manyande, A. (1996) Good patients cope with their pain: postoperative analgesia and nurses' perceptions of their patients' pain. *Pain 68(1),* 63–68.

Sandelowski, M., & Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of nursing scholarship*, *34*(3), 213-219.

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021). Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. *BMC health services research*, *21*, 1-13.

Schoellbauer, J., Sonnentag, S., Prem, R., & Korunka, C. (2022). I'd rather know what to expect… Work unpredictability as contemporary work stressor with detrimental implications for employees' daily wellbeing. *Work & Stress*, *36*(3), 274-291.

Shaw, R. L., Booth, A., Sutton, A. J., Miller, T., Smith, J. A., Young, B., Jones, J. R., & Dixon-Woods, M. (2004). Finding qualitative research: an evaluation of search strategies. *BMC medical research methodology*, *4*, 1-5.

Sias, P. M., & Wyers, T. D. (2001). Employee uncertainty and information-seeking in newly formed expansion organizations. *Management Communication Quarterly*, *14*(4), 549-573.

Sohn, D. (1996). Publication bias and the evaluation of psychotherapy efficacy in reviews of the research literature. *Clinical psychology review*, *16* (2), 147-156.

Srivastava, S., & Agrawal, S. (2020). Resistance to change and turnover intention: a moderated mediation model of burnout and perceived organizational support. *Journal of Organizational Change Management*, *33*(7), 1431-1447.

*Summers, A. (2006). Psychological formulations in psychiatric care: staff views on their impact. *Psychiatric Bulletin*, *30(9),* 341-343.

The British Psychological Society. (2016). Standards for the accreditation of Doctoral programmes in clinical psychology. Retrieved from: https://www.bps.org.uk/accreditation/education-providers

Thornberg, R. (2014). Consultation barriers between teachers and external consultants: A grounded theory of change resistance in school consultation. *Journal of educational and psychological consultation*, *24*(3), 183-210.

*Turner, K., Cleaves, L., & Green, S. (2018). Team formulation in an assessment and treatment unit for individuals with learning disabilities: An evaluation through staff views. *British Journal of Learning Disabilities, 46(4)*, 278-283.

Unadkat, S., Irving Quinn, G., Jones, F. W. and Casares, P. (2015). Staff experiences of formulating within a team setting. Clinical Psychology Forum (Extended Online Edition), 275. pp. 85-88. ISSN 1757-2142.

Wood, S., Stride, C., Threapleton, K., Wearn, E., Nolan, F., Osborn, D., Paul, M., & Johnson, S. (2011). Demands, control, supportive relationships and well-being amongst British mental health workers. *Social Psychiatry and Psychiatric Epidemiology, 46*(10), 1055–1068. https://doi.org/10.1007/s00127-010-0263-6

Table 1

Description of the levels of consultation

Levels of work	Nature of consultation work	Potential organisational impact of consultation
1a: Direct work	The psychological therapist offers direct therapy to the client and gives feedback to the team working with the client in the form of a formulation (with client permission).	Can be a time-intensive approach, but often required for management of complex cases
1b: Direct work	The psychological therapist offers joint time-limited direct work with the client and a member of their team, to provide a formulation and/or a care plan that the client and member of staff (or team) can implement. The psychological therapist is functioning at a consultative level and modelling psychologically informed approaches to other professionals.	Due to the focal and time-limited nature of this level of work, it can influence a high number of clients and staff in the system and is an efficient use of therapists' time
2: Indirect work[a]	The psychological therapist offers indirect work using psychological theory to staff member/s to advise and support their work, without the client being directly involved.	These consultations (e.g., via reflective practice meetings) can potentially influence the approach of a higher number of staff (Caplan & Caplan, 1999) and change the organizational culture of care.
3: Indirect work[a]	The psychological therapist works at an organizational level, perhaps consulting on service design or interventions to change the working practices and culture of a service.	Has a broad and secondary benefit of improving care for clients through macro system change (Onyett, 2007)

Note. [a]Levels of consultancy considered in this review.

Table 2

Table of exact search terms performed

Search Entry No.	Search Query
1	(DE "Consulting Psychology") OR (DE "Professional Consultation")) OR (DE "Professional Supervision")) OR (DE "Practicum Supervision")) OR (DE "Clinical Methods Training")) OR (DE "Community Mental Health Training")) OR (DE "Psychotherapy Training")) OR (DE "Mental Health Inservice Training")) OR (DE "Inservice Training")) OR (DE "Professional Development") OR (DE "On the Job Training")) OR (DE "Paraprofessional Education")) OR (DE "Personnel Training")TI case conceptua* OR case-conceptua* OR case formula* OR case-formula* OR team formula* OR team-formula* OR psychol* N5 (train* OR supervis* OR consult* OR formula*)) OR AB case conceptu* OR case-conceptua* OR case formula* OR case-formula* OR team formula* OR team-formula* OR psychol* N5 (train* OR supervis* OR consult* OR formula*))
2	AND TI (staff* OR personn* OR colleague* OR associate OR team* OR co-worker OR coworker OR "co worker" OR partner* OR worker* OR aide* OR professional*)) OR AB (staff* OR personn* OR colleague* OR associate OR team* OR co-worker OR coworker OR "co worker" OR partner* OR worker* OR aide* OR professional*))
3	AND TI (experienc* OR view* OR impact OR impacted OR influenc* OR change* OR outcome) OR AB (experienc* OR view* OR impact OR impacted or influenc* OR change OR outcome)
4	AND TI (qualita* OR review OR meta-synthesis OR meta synthesis OR ethnograph*) OR AB (qualita* OR review OR meta-synthesis OR meta synthesis OR ethnograph*))

Note. Table containing exact search terms used based on HSSS search strategy for each search entry.

Table 3

Table of inclusion and exclusion criteria for the studies screened

Inclusion Criteria	Exclusion criteria
Papers written in the English language. Peer-reviewed papers. Service evaluations were included if published and peer-reviewed.	Papers that were published/unpublished dissertations, book chapters, doctoral theses, non-peer reviewed reports and any grey literature were excluded from this review. Although it was recognised this would increase the risk of publication bias, it would also likely avoid an uneven distribution of data to the developed themes due to the varying length of the different reports (Sohn, 1996).
Papers using of a qualitative data and analysis design. Mixed-method studies included if the qualitative section is clearly defined.	Papers using quantitative methods only or No clear definition of qualitative approach taken, or analysis used.
Papers exploring experiences of consultation from the perspective of non-specialist healthcare practitioners. Non-specialist was defined as healthcare staff with no formal qualifications in clinical psychology or psychological therapies. Papers including experiences from the perspectives of non-psychology staff and specialists/clients would be included if their experiences could be separated and analysed separately.	Papers exploring experiences from the perspectives of psychological practitioners, clients. This would include papers exploring experiences of non-psychology staff where experiences of specialist/clients that could not be separated. Psychological practitioners included Practitioner Psychologists, psychotherapists or counsellors.

Inclusion Criteria	Exclusion criteria
Papers including psychological practitioners delivering the consultation in a healthcare service.	Papers including consultees or consultants not clearly defined in terms of role.
Papers including consultation that would correspond with level 2 and 3 of Carradice & Bennett's (2012) consultancy model (see Table 2), including individual and team consultation, and consultee- and client-focused consultation.	Papers including "direct" consultation work according to Carradice and Bennet (2012). Studies looking at staff experiences of supervision and coaching were excluded. This was also the case if consultation was delivered together with supervision/coaching, as the recipients' experiences of the different clinical provisions would not be discernable. Papers exploring experiences of training. For the purposes of this review, training was defined as a programme or a workshop offering a structured intervention to staff for educational and teaching purposes in order to learn new skills. For this reason, consultancy or formulation models that were offered through training sessions were excluded.

Table 4

Table of demographic and methodological details of each reviewed study

Author(s) (year)	Participants	Level and Mode of Consultancy	Setting	Psychological Model	Design	Data analysis
1 Berry et al. (2017)	57 healthcare practitioners including nurses and support workers. 38 female and 19 male staff.	Level 2, team case formulation.	Inpatient psychiatric rehabilitation ward, National Health Service (NHS) UK	Case formulation informed by Bio-Psycho-Social (Engel, 1977) and cognitive model (Beck, (1976)	Individual semi-structured interviews (30-90 minutes).	Thematic analysis.
2 Blinkhorn et al. (2021)	23 Offender Managers (OMs). Mean age 46 years. Mean years of working experience was 13.	Level 2, individual consultation from consultation service.	Probation Services North West England.	Relational model based on theories of attachment and trauma theory, focusing on relational dynamics	Focus groups interviews.	Interpretative Phenomenological Analsysis (IPA).
3 Brodar et al. (2021)	Seven healthcare practitioners including five endocronologists and two diabetes educators. One female and five male staff. Age range 30 to 65 years. Work experience ranged from 3 to 25 years.	Level 2, individual consultation from consultation service. Integrated model of psychosocial screening and consultation looking at relationship between stress and diabetes management.	Outpatient paediatric diabetes clinic, South Florida, USA.	Unspecified	Individual semi-structured interviews (32-46 minutes).	Thematic content analysis.

Author(s) (year)	Participants	Level and Mode of Consultancy	Setting	Psychological Model	Design	Data analysis
4 Clare & Jackson-Blott (2022)	15 social workers	Level 2, individual and/or team consultation from external child consultation service. Consultation up to 1.5 hours and write a full summary report from the consultation.	Community social care children services, UK.	Case formulation informed by trauma, systemic and narrative theory.	Mixed design but included qualitative feedback. .	Inductive thematic analysis.
5 Douglas and Benson (2015)	Six healthcare practitioners including paediatricians, nurses and allied health professionals. Had to have attended consultation at least once the past six months.	Team-based consultation – sometimes including formulation. Psychosocial forum/meetings, sometimes involving formulation around client cases, group discussions, planning care and advice	Paediatric gastroenterology MDT team, UK, inpatient hospital	Unspecified	Mixed methods, explanatory, sequential design, focus group interviews.	Thematic analysis.
6 Durka et al. (2015)	15 Looked After and Adopted Children (LAAC) staff. Staff had one year experience of consultation.	Individual consultation through consultation service. Six participants had experience with consultation although the number of sessions and amount of previous consultation experience were not reported.	Residential childcare setting for LAAC in UK	Unspecified	Self-report questionnaire surveys and focus groups ranging 35-55 minutes.	Thematic, semantic and inductive approach.

Author(s) (year)	Participants	Level and Mode of Consultancy	Setting	Psychological Model	Design	Data analysis
7 Evans et al. (2011)	Six healthcare practitioners. Four female and two male staff. Participants had experienced consultation provided by the clinical psychologist, although the number of sessions and amount of previous consultation experience was not recorded.	Consultee-centred model of consultation developed by Caplan (1995) Individual consultation service offered about complex cases.	Residential childcare settings in the NHS, UK	Unspecified	Semi-structured interview.	Thematic analysis.
8 Hibbert and Frankl (2011)	Seven foster carers and seven social workers. Participants had attended a mean of 3.3 and 4.4 consultation meetings previously.	Individual consultation service including psychological formulation about complex cases. Consultation offered to foster carers but also other professionals involved.	Psychology consultation service for Community LAAC service in Children and Adolescent Mental Health Service (CAMHS) for foster carers and social carers in the UK	Formulation informed by attachment theory, solution focused, narrative and behavioural theories	Individual semi-structured interviews via telephone. 10 minutes interviews.	Thematic analysis.
9 Kramarz et al. (2022)	18 multidisciplinary staff including six nurses, three doctors, five occupational therapists, two support workers and two activities coordinators. 13 female and five male staff. Age ranged from 18 to 55. Work experience ranged from less than one year to over 10 years.	Team case formulation. 1 hour fortnightly case formulation sessions.	Five acute psychiatric wards, South London, UK.	Case formulation drawing on Newcastle model, cognitive behavioural theory and third-wave approaches (Acceptance and Commitment Therapy (ACT, Dialectical Behavioural Therapy (DBT)).	Semi structured interviews, 25-45 minutes.	Thematic analysis.

Author(s) (year)	Participants	Level and Mode of Consultancy	Setting	Psychological Model	Design	Data analysis
10. Mattan & Isherwood (2009)	11 healthcare practitioners. Five nurses, two medical doctors, two social workers, one occupational therapist and one behavioural worker. Seven female and four male staff.	Various approaches depending on psychological therapist. Unclear whether internally or externally provided.	Various: LD, health psychology, adult mental health, UK.	Unspecified.	Semi-structured individual interviews, unspecified time.	Grounded theory analysis
11. McKenna et al. (2022)	13 female care staff. Age range from 21 and 63 (mean = 39 years). Work experience ranged from three months to 25 years. All had experience with team formulation within the past year.	Team case formulation. Unclear whether internally or externally provided	Study conducted across five dementia care CMHT facilities, UK.	Case formulation based on Newcastle Model.	Semi-structured individual interviews.	Inductive thematic analysis.
12. McTiernan et al. (2021)	Six healthcare practitioners. Three nurses, one social worker, one psychiatrist and one occupational therapist. Five females and one male. Staff must have attended at least one formulation meeting. The mean number of meetings attended was nine.	Team case formulation. Internally provided.	Psychiatric rehabilitation unit, psychosis service, NHS, UK.	5 Ps model.	Semi structured interviews.	Thematic analysis.

Author(s) (year)	Participants	Level and Mode of Consultancy	Setting	Psychological Model	Design	Data analysis
13. Radcliffe et al. (2020)	Five female OMs. All had engaged in at least three consultations previously. Work experience ranged from 11-15 years.	Individual consultation service with case formulation. Established consultation service, staff had experienced at least 3 consultations Externally provided.	National Probation Service, UK	Case formulation based on a relational model drawing on attachment theory and trauma-based therapy.	Semi structured interviews.	IPA.
14. Summers (2006)	25 staff, nine nurses, 11 support workers, two doctors and one occupational therapist, social worker and drama therapist.	Team case formulation. Bi-weekly Formulation meetings up to 90 minutes. Internally provided.	High-dependency rehabilitation service, UK.	Case formulation based on cognitive behavioural or object relations theoretical framework.	Semi-structured interviews.	Grounded theory-based methodology, iterative approach.
15. Turner et al. (2018)	28 healthcare practitioners including nursing, managerial and care support staff	Team case formulation - model outlined by Lake (2008). Weekly team formulations, 40 minutes, clinical cases. The team formulation model outlined by Lake (2008). Internally provided.	Inpatient assessment and treatment facility for Learning Disabilities, UK.	Unspecified.	Mixed design. Open-ended questionnaire	Not reported.

Table 5

Questions contained within the CASP qualitative checklist

Question (Q)
Q1: Was there a clear statement of the aims of the research?
Q2: Is a qualitative methodology appropriate?
Q3: Was the research design appropriate to address the aims of the research?
Q4: Are the study's theoretical underpinnings (e.g. ontological /epistemological assumptions; guiding theoretical framework(s)) clear, consistent and conceptually coherent?[a]
Q5: Was the recruitment strategy appropriate to the aims of the research?
Q6: Was the data collected in a way that addressed the research issue?
Q7: Has the relationship between researcher and participants been adequately considered?
Q8: Have ethical issues been taken into consideration?
Q9: Was the data analysis sufficiently rigorous?
Q10: Is there a clear statement of findings?
Q11: How valuable is the research?

Note. [a]Additional criterion incorporated to the CASP checklist

Table 6

Table of outcomes of the CASP quality appraisal tool

Questions	Berry et al (2017)	Blinkhorn et al. (2021)	Brodar et al. (2021)	Clare & Jackson-Blott (2022)	Douglas et al (2015)	Durka et al (2015)	Evans et al (2011)	Hibbert & Frankl (2011)	Kramarz et al (2022)	Mattan & Isherwood (2009)	McKenna et al (2022)	McTiernan et al (2021)	Radcliffe et al (2020)	Summers (2006)	Turner et al (2018)
CASP Score Question 1	3	3	3	3	3	3	3	3	3	3	3	3	3	2	2
CASP Score Question 2	3	3	3	3	3	3	3	3	3	2	3	3	3	3	3
CASP Score Question 3	3	2	3	3	2	2	3	3	3	2	3	3	3	2	1
CASP Score Question 4[a]	3	3	1	1	2	1	1	1	2	1	2	2	3	1	1
CASP Score Question 5	1	1	1	1	3	1	1	1	3	2	3	3	3	1	1
CASP Score Question 6	2	3	3	3	3	3	3	3	3	2	3	3	3	1	1
CASP Score Question 7	3	1	1	3	3	3	3	1	3	1	3	3	3	1	1
CASP Score Question 8	3	1	3	3	3	3	3	1	3	1	3	3	1	1	2
CASP Score Question 9	3	2	2	2	2	3	3	2	3	2	3	3	3	1	1

Questions	Berry et al (2017)	Blinkhorn et al. (2021)	Brodar et al. (2021)	Clare & Jackson-Blott (2022)	Douglas et al (2015)	Durka et al (2015)	Evans et al (2011)	Hibbert & Frankl (2011)	Kramarz et al (2022)	Mattan & Isherwood (2009)	McKenna et al (2022)	McTiernan et al (2021)	Radcliffe et al (2020)	Summers (2006)	Turner et al (2018)
CASP Score Question 10	3	3	3	2	3	3	3	3	3	2	3	3	3	1	1
CASP Score Question 11	3	2	1	3	3	3	3	2	3	2	3	3	2	1	1
Total Score (out of 33)	30	24	24	27	30	28	29	23	32	18	32	32	30	15	15
Method-ological Rating	HQ	MQ	MQ	HQ	HQ	HQ	HQ	MQ	HQ	MQ	HQ	HQ	HQ	LQ	LQ
Concept-ual Rating	H	M	L	M	H	H	H	L	H	H	H	H	H	L	L

Note. Critical Appraisal Skills Programme (CASP). 3 = Criteria met; 2 = Criteria partially met; 1 = Criteria not met. [a]Additional criterion incorporated to the CASP checklist.

Table 7

Data analysis of first, second and third order translations

Concept	first Order Construct (participant quotes)	second Order Construct (author interpretation)	3rd Order Construct (interpretative summary)
A need for time and space to think and feel	"I was quite closed off, whereas now I tend to find that I am more open, more acknowledging my own feelings" (1).	Staff were more aware of relationships and more open to feelings related to relationships leading to emotional awareness and reflection (1).	Healthcare staff work in challenging and fast-paced environments where they often miss opportunities and a safe space to reflect on their every-day experiences and how they respond to challenges. Consultation is appreciated as a non-judgmental and containing space to allow staff to express their vulnerabilities. This gives them more of an ability to contain their own emotions in challenging situations or when working with staff presenting with behaviours that challenge.
	"There are some evoked difficult feelings but having the objectivity in the room makes you feel safe with the service" (2).	Benefits of consultation could be summarised as relating more to a supportive and psychologically containing role of the service, rather than more applied and clinical aspects. This is a significant finding that points to the perceived main benefits of consultation relating to emotional support functions (e.g. personal support, validation) (2)	
	'In one consultation I got emotional, but then to talk about the feelings and why I felt like that, and why and whether remove from case, but I didn't "(2).		
	"You sometimes forget in your role and you need to take a step back and see what has formed – and it does not happen often" (2).		
	'You get to be able to take a step back and consider new ways of working" (4).		
	"I could sort out my frustration in my head and go back to deal with them differently" (5).	Staff found it helpful to express feelings and feeling valued which made them more effective with patients (5).	
	"It does allow you…an opportunity to just say 'this person stresses me out'… showing vulnerability is rarely something you're capable of doing…so to have the opportunity to do that in a way that is just socially sanctioned can be helpful, because otherwise you have to just uphold a very professional demeanour and that can be quite exhausting" (10).	Benefits such as providing a safe space for staff to discuss and contextualise their emotional reactions to the behaviour, inadvertent reinforcement of certain behaviours, and staff feeling heard and supported are likely to be critical to good service provision for service users, and thus indirectly improve care (10).	

Table 8

Table of how the first and second order data contribute to each theme

Theme	Berry et al. (2017)	Blinkhorn et al. (2021)	Brodar et al. (2021)	Clare & Jackson-Blott (2022)	Douglas et al. (2015)
Individual Connection: Broader and Deeper Understanding	✓ Deeper understanding of clients led to increased empathy and reduced criticism of them.	X	✓ More holistic understanding after consultation and staff noticing SU concerns otherwise missed. Also promoted empathy and approaching clients more aware.	✓ Enriched understanding leading to more curiosity leading to empathy, more motivation to engage, confidence, higher resilience and less burnout. Broader and deeper understanding using psychology models fitting systemic thinking of social workers improving best practice.	✓ More of a holistic understanding and some felt more sensitive to psychological issues of patients.
Team Togetherness	✓ Shared understanding improved team working and included less experienced staff, which improved team member wellbeing and quality of care.	X	X	X	✓ Benefitted from team formulations having a broad range of professionals as it increased a more holistic perspective and enhanced problem-solving.

Theme	Durka et al. (2015)	Evans et al. (2011)	Hibbert & Frankl (2011)	Kramarz et al. (2022)	Mattan & Isherwood (2009)
Individual Connection: Broader and Deeper Understanding	✓ Increased understanding of context and behaviours, enabling holistic views, increased empathy and supportive care.	✓ Linking theoretical concepts to the histories and backgrounds of the young people enabled staff to gain an understanding of the young people as individuals rather than just the challenging behaviours they were displaying.	✓ Greater understanding fostered confidence around behavioural management and better relationship with child and prevented negative dynamics.	✓ Thinking more deeply about their needs and developing more informed care plans. Staff also reported finding more meaning in their work, due to gaining a broader understanding of service users.	X
Team Togetherness	✓ Consultation seen as a way of developing links between the different services	X	X	✓ Formulating as a team helped staff to develop a shared understanding of clients based on different professional views. Listening to other staff brought them closer together, made them feel less alone and more like part of a team. Agreeing upon a single care plan has improved consistency of care delivery.	X

Theme	McKenna et al. (2022)	McTiernan et al. (2021)	Radcliffe et al. (2020)	Summers (2006)	Turner et al. (2018)
Individual Connection: Broader and Deeper Understanding	✓ Team formulation provided them a more holistic perspective and understanding of subjective experience which facilitated person-centred attitudes and increased quality of care.	✓ Broadened knowledge and deeper understanding of patient.	✓ Staff felt consultation provided them a chance to connect with patients through a new understanding of them. Described it as opening up their minds and perspectives and seeing the whole picture. Helped them become less drawn into dynamics due to having understanding of alternative approaches.	✓ Improved understanding which helped achieve better staff patient relationships and staff satisfaction.	✓ Consultation as an opportunity to think about and identify with service user personally and creating new ideas on how to work with them.
Team Togetherness	✓ Reported staff got a sense of team cohesion through shared understanding.	✓ Consultation reinforced team support and working by being inclusive of all team members.	X	✓ Improved team working through inclusive practice and everyone having their say. Staff felt valued through the way they brought together people and ideas, combining different information and perspectives.	✓ Increased team working mentioned but not explored or discussed.

Theme	Berry et al. (2017)	Blinkhorn et al. (2021)	Brodar et al. (2021)	Clare & Jackson-Blott (2022)	Douglas et al. (2015)
Permission to Feel	✓ More self-awareness of own feelings increasing capacity and reducing burnout.	✓ Appreciating reflective space and feeling validated, reassured and contained in an otherwise stressful and uncontained environment that lacks such opportunities.	X	✓ Consultation as safe to space to reflect and be validated leading to increased self awareness and emotional regulation.	✓ Airing difficult emotions leading to more effective strategies when supporting challenging clients. More confident by affirming what they were doing.
Consultation Style Preference: the Impact of Work Experience	✓ Staff having an established way of working more resistant to expert-led approaches. Experienced staff benefitting from collaborative approach to overcome initial resistance.	✓ Participant requesting more joint work arguably due to resistance to power dynamic and requiring more of an egalitarian and collaborative approach.	X	X	✓ Less experienced wanting more teaching.

Theme	Durka et al. (2015)	Evans et al. (2011)	Hibbert & Frankl (2011)	Kramarz et al. (2022)	Mattan & Isherwood (2009)
Permission to Feel	✓ Feeling listened to in consultation and feeling reassured.	✓ Consultation allowed self-validation and reduced self-criticism	✓ Emotional support, felt listened to, validated concerns, and felt contained making them able to contain their clients.	✓ Safe space to contextualise their emotions and support their own wellbeing in stressful environments, leading to increased clinical confidence and job satisfaction as well as prevention of reinforcing negative relational dynamics.	✓ Described staff need for feeling safe to explore unconscious needs associated with uncertainty and vulnerability. Emphasised importance of consultation affirming this need in a non-judgemental way. When affirmed, it relieved staff from self-criticism and increased emotional resilience and confidence.
Consultation Style Preference: the Impact of Work Experience	✓ Staff who desired a prescriptive approach also benefitted less which was attributed to unrealistic expectations of psychologist.	✓ Importance of collaborative and equal approach to increase engagement.	X	X	✓ Some consultees expecting advice and expectations around the 'expert' consultant. Experienced staff seeking affirmation for their own knowledge and expertise. Requirement of the psychologist being flexible and adaptive to the audience.

Theme	McKenna et al. (2022)	McTiernan et al. (2021)	Radcliffe et al. (2020)	Summers (2006)	Turner et al. (2018)
Permission to Feel	✓ Emphasised importance of staff feeling heard and valued by psychologist.	✓ Described team formulation as a rare and precious opportunity to think, reflect air things.	✓ Feeling they got permission to think about their own emotional responses in an otherwise fire-fighting context. Consultation seen as space to process emotions, described as a container to help deal with difficult feelings and situations. Leads to confidence in challenging dynamics and increases alliance.	✓ Felt listened to and encouraged to think creatively. Described as a space to think where formulation brings unconscious pathology into consciousness and can prevent team splitting in highly emotive environments.	X
Consultation Style Preference: the Impact of Work Experience	✓ Experienced care staff reported that formulation did not aid their understanding compared to their less experienced counterparts. Experienced staff perceiving expert-led consultants negatively as not having attained the perspective of residents.	X	X	✓ Experienced staff often held their own views with strong conviction. Some perceiving psychology and reflective space as pop psychology and wanting to be right and more powerful.	✓ Negative attitude related to psychology not working with clients regularly.

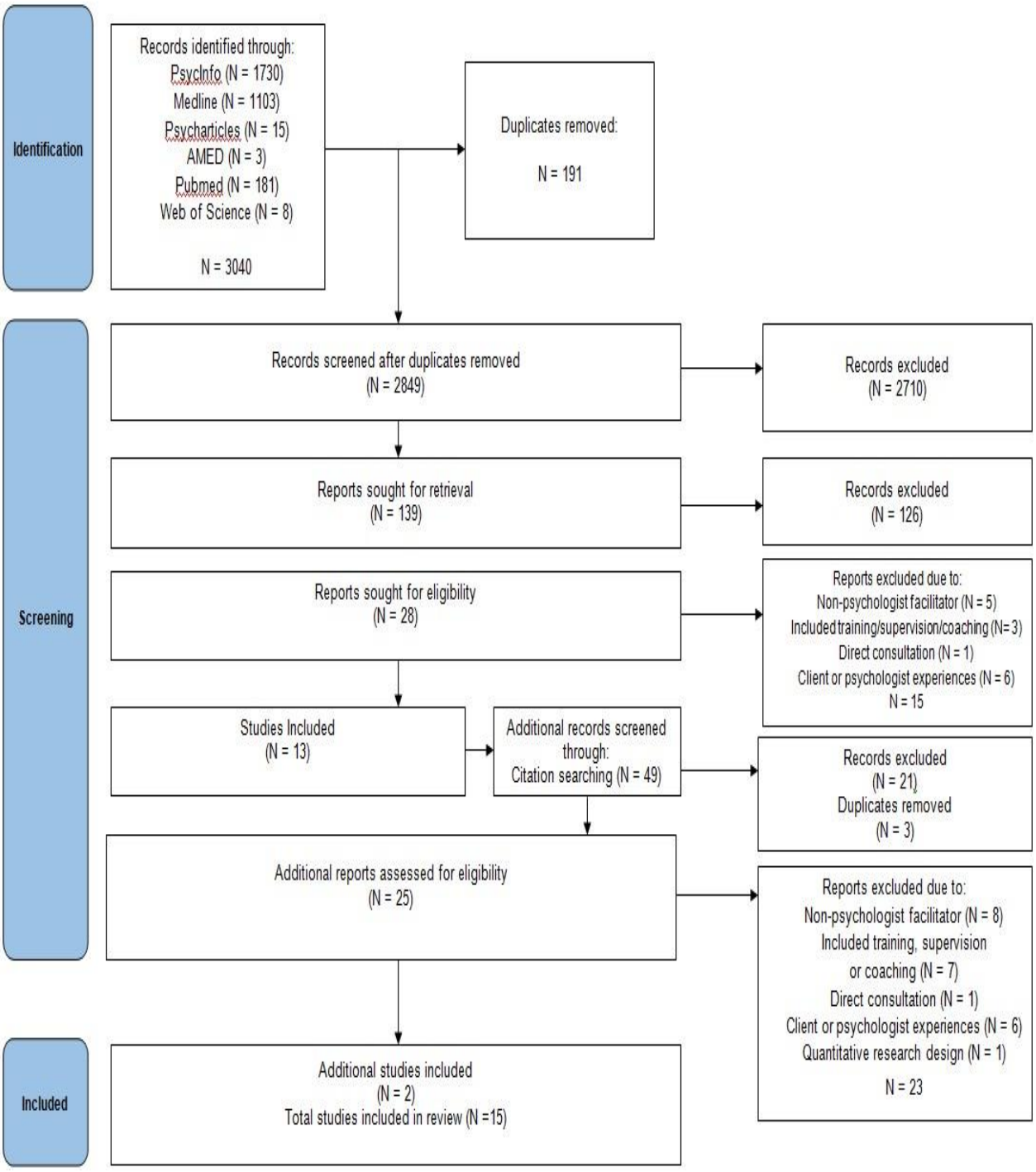
Theme	Berry et al. (2017)	Blinkhorn et al. (2021)	Brodar et al. (2021)	Clare & Jackson-Blott (2022)	Douglas et al. (2015)
Unrealistic Expectations: the Mystery of Psychological Consultation	✓ Initial anxiety around not understanding what psychology does and reluctant to share difficulties with psychologist.	X	X	✓ Staff wanting clearer purpose and structure of consultation. Recommending future consultation to ensure expectations align with the support offered to prevent confusion and unrealistic expectations.	X
Building the Consultative Relationship	✓ Importance of building informal relationship to overcome initial anxiety around psychologist.	✓ Expressed difficulty and frustration around unresponsive and unavailable consultants.	X	X	✓ Staff found the ready availability of a clinical psychologist extremely helpful.

Theme	Durka et al. (2015)	Evans et al. (2011)	Hibbert & Frankl (2011)	Kramarz et al. (2022)	Mattan & Isherwood (2009)
Unrealistic Expectations: the Mystery of Psychological Consultation	✓ Absence of shared understanding of role and purpose led to frustration and anxiety. Also led to unrealistic expectations and disappointment if not met.	✓ Participants explained that not understanding what a psychologist could offer created a sense of uncertainty around the process of consultation and could cause unrealistic expectations.	X	X	✓ Uncertainty around the psychologists' remit leading to expectations of psychologist miraculously finds a 'cure' for the presenting issues.
Building the Consultative Relationship	✓ Importance of availability of psychologist to feel supported. Emphasising benefits of jargon free language to promote inclusion and safe space. Helped to develop positive relationship which decided perception of consultation.	✓ Psychologist needing effective interpersonal skills including informal, jargon-free language and regular availability to develop positive relationship.	X	X	✓ Informality of consultation played a part in facilitating safety, containment and engagement. Important for consultant to use skills to enable a positive working atmosphere from the start. Accessibility and availability important in establishing a relaxed and safe relationship.

Theme	McKenna et al. (2022)	McTiernan et al. (2021)	Radcliffe et al. (2020)	Summers (2006)	Turner et al. (2018)
Unrealistic Expectations: the Mystery of Psychological Consultation	✓ If staff do not understand the purpose or the nature of the formulation developed, they are unlikely to appreciate the value of it. High and unmet expectations led to disappointment which strengthened beliefs that nothing could be done	X	✓ Some staff demonstrating unrealistic expectations of consultation, expecting a magic wand and quick fix.	X	✓ Recommended giving formulation meetings clearer aims and more practical outcomes to prevent unrealistic expectations.
Building the Consultative Relationship	✓ Good working relationship between team and psychologist countered power dynamic. Psychologist as role modelling good team interaction?	X	✓ Importance of psychologist being the container, needing regularity and accessibility to build trusting relationship – having someone to 'fall back on'.	X	X

Figure 1

PRISMA Diagram



Appendix 1-A

Author Guidelines for Publication

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological and social processes that underlie the development and improvement of psychological problems and mental wellbeing, including:

• theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
• behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
• psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

- systematic reviews following replicable protocols and established methods of synthesis
- qualitative and other research which applies rigorous methods
- high quality analogue studies where the findings have direct relevance to clinical models or practice.

Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

PAPTRAP AUTHOR GUIDELINES

Sections

1. SUBMISSION

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

New submissions should be made via the **Research Exchange submission portal**. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our FAQs or contact **submissionhelp@wiley.com**.

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

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **https://authorservices.wiley.com/statements/data-protection-policy.html**.

Preprint policy:

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

2. AIMS AND SCOPE

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological and social processes that underlie the development and improvement of psychological problems and mental wellbeing, including:

• theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
• behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
• psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

- systematic reviews following replicable protocols and established methods of synthesis
- qualitative and other research which applies rigorous methods
- high quality analogue studies where the findings have direct relevance to clinical models or practice.

Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

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

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

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

Word limits for specific article types are as follows:

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

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

Please refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

Brief-Report COVID-19

For a limited time, the *Psychology and Psychotherapy: Theory, Research and Practice* are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal's main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured

(according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the authors. Appendices are included in the word limit; however online supporting information is not included.

4. PREPARING THE SUBMISSION

Free Format Submission

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

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (if you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

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

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

To submit, login at **https://wiley.atyponrex.com/journal/PAPT** and create a new submission. Follow the submission steps as required and submit the manuscript.

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

Revised Manuscript Submission

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

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

Parts of the Manuscript

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

Title Page

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

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our **Author Services** site.

Abstract

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

Keywords

Please provide appropriate keywords.

Acknowledgments

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

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

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

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the LaTex Main Document should be uploaded as a "LaTeX Supplementary File."

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.
- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Acknowledgments;
- Abstract structured (intro/methods/results/conclusion);
- Up to seven keywords;
- Practitioner Points Authors will need to provide 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;

- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below);
- Statement of Contribution.

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

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

References

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

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡,

§, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

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

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

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

Supporting Information

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

Click here for Wiley's FAQs on supporting information.

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

General Style Points

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

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

Wiley Author Resources

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

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

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

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double-anonymous) peer review. Please ensure that any information which may reveal author identity is anonymized in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, please read **the terms and conditions of submission** and the **declaration of competing interests**.

We aim to provide authors with a first decision within 90 days of submission.

Further information about the process of peer review and production can be found in '**What happens to my paper?**' Appeals are handled according to the **procedure recommended by COPE**. Wiley's policy on the confidentiality of the review process is **available here**.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)
- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **https://www.crossref.org/services/funder-registry/**

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

"Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed (APA Ethics Code Standard 8.12a, Publication Credit). Authorship encompasses, therefore, not only those who do the actual writing but also those who have made substantial scientific contributions to a study. Substantial professional contributions may include formulating the problem or hypothesis, structuring the experimental design, organizing and conducting the statistical analysis, interpreting the results, or writing a major portion of the paper. Those who so contribute are listed in the byline." (p.18)

Data Sharing and Data Accessibility Policy

Psychology and Psychotherapy: Theory, Research and Practice recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

It is not necessary to make data publicly available at the point of submission, but an active link must be included in the final accepted manuscript. For authors who have pre-registered studies, please use the Registered Report link in the Author Guidelines.

In some cases, despite the authors' best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or laws, or the nature of data gathered. In such cases, authors must inform the editors at the time of submission. It is understood that in some cases access will be provided under restrictions to protect confidential or proprietary information. Editors may grant exceptions to data access requirements provided authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

Finally, if submitting authors have any questions about the data sharing policy, please access the **FAQs** for additional detail.

Open Research initiatives.

Recognizing the importance of research transparency and data sharing to cumulative research, *Psychology and Psychotherapy: Theory, Research and Practice* encourages the following Open Research practices.

Sharing of data, materials, research instruments and their accessibility. Psychology and Psychotherapy: Theory, Research and Practice encourages authors to share the data, materials, research instruments, and other artifacts supporting the results in their study by archiving them in an appropriate public repository. Qualifying public, open-access repositories are committed to preserving data, materials, and/or registered analysis plans and keeping them publicly accessible via the web into perpetuity. Examples include the Open Science Framework (OSF) and the various Dataverse networks. Hundreds of other qualifying data/materials repositories are listed at the Registry of Research Data Repositories (**http://www.re3data.org**). Personal websites and most departmental websites do not qualify as repositories.

Publication Ethics

Authors are reminded that *Psychology and Psychotherapy: Theory, Research and Practice* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). The Journal generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**). Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county.

Note this journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley's Top 10 Publishing Ethics Tips for Authors **here**. Wiley's Publication Ethics Guidelines can be found **here**.

ORCID

As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. This takes around 2 minutes to complete. **Find more information here.**

6. AUTHOR LICENSING

WALS + standard CTA/ELA and/or Open Access for hybrid titles

You may choose to publish under the terms of the journal's standard copyright agreement, or Open Access under the terms of a Creative Commons License.
Standard **re-use and licensing rights** vary by journal. Note that **certain funders** mandate a particular type of CC license be used. This journal uses the CC-BY/CC-BY-NC/CC-BY-NC-ND **Creative Commons License**.
Self-Archiving Definitions and Policies: Note that the journal's standard copyright agreement allows for **self-archiving** of different versions of the article under specific conditions.

BPS members and open access: if the corresponding author of an accepted article is a Graduate or Chartered member of the BPS, the Society will cover will cover 100% of the APC allowing the article to be published as open access and freely available.

7. PUBLICATION PROCESS AFTER ACCEPTANCE

Accepted Article Received in Production

When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with **Wiley Author Services**. The author will be asked to sign a publication license at this point.

Proofs

Once the paper is typeset, the author will receive an email notification with full instructions on how to provide proof corrections.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process – authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt of first proof.

Early View

The journal offers rapid publication via Wiley's Early View service. **Early View** (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Before we can publish an article, we require a signed license (authors should login or register with **Wiley Author Services**). Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

8. POST PUBLICATION

Access and Sharing

When the article is published online:

- The author receives an email alert (if requested).
- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receivea publication alert and free online access to the article.

Promoting the Article

To find out how to best promote an article, click **here**.

Wiley Editing Services offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

Measuring the Impact of an Article

Wiley also helps authors measure the impact of their research through specialist partnerships with **Kudos** and **Altmetric**.

9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (**papt@wiley.com**) or phone +44 (0) 116 252 9504.

Doctorate in Clinical Psychology | Lancaster University

Chapter 2 : Research Paper

What works? A Grounded theory investigation of training non-psychology staff in using Solution-Focused Brief Therapy

Haakon Juul

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

To be submitted to Psychology and Psychotherapy: Theory, Research and Practice

All correspondence should be sent to:

Haakon Juul

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster LA1 4AT

h.juul@lancaster.ac.uk

Abstract

Objective: As part of a task-sharing strategy, clinical psychologists are becoming increasingly expected to offer therapy training for staff to be more psychologically minded and equipped in order to increase access and provision of psychological support for clients. The current study explored how 10 staff working in healthcare settings experienced brief Solution-Focused Brief Therapy (SFBT) training and how they used it after. ***Methods:*** A constructivist grounded theory (GT) approach was used to generate a model based on the participants' reflections after the training. ***Results:*** Staff shared how they felt they needed evidence of SFBT working in order to believe that learning a new model would be worth the required investment. They also shared benefitting from realistic role-modelling that was relevant to their context to be particularly convincing as well as regular support from their peers and multidisciplinary meetings. Participants also shared some barriers to use SFBT in practice including time-restricted clinics, service pressures and challenging clients.

Conclusion: The model describes a complex dynamic between personal, interpersonal and systemic factors that influenced the staff members' individual decision to abandon the more familiar medical model that represented a sense of comfort and safety. The study includes recommendations around how clinical psychologists can address the identified facilitators and barriers to facilitate more effective training programmes and training transfer.

Keywords: Grounded theory, Solution-Focused Brief Therapy, brief therapy training, multidisciplinary staff, non-psychology staff, medical settings

Introduction

Mental health needs are a growing concern. For instance, in the UK, records indicate increased prevalence of common mental health disorders for people aged 16-64 by 20 % between 1993 and 2015 (McManus et al., 2016). This puts more pressure on healthcare services, which consequently increases the risk of unmet needs. These unmet needs are particularly evident in medical settings in the UK such as inpatient settings, which demonstrate poor access to psychologically informed care (Schizophrenia Commission, 2012), and primary care services, where between only 1 and 40% of patients with psychosocial issues receive adequate treatment for these (World Health Organization, 2015).

A large proportion of patients in UK primary care services present with chronic or otherwise debilitating health symptoms with no known medical cure (Hartman et al., 2013). Individuals presenting with such symptoms, such as diabetes and chronic pain, often benefit significantly from psychosocial support in order to facilitate motivation to use behavioural management strategies that help improve psychological wellbeing (Mental Health Taskforce, 2016). Despite this, however, the majority of these patients are often only offered medical treatment (Mind, 2011) due to psychosocial difficulties not being reported or identified in medical appointments (Negri et al., 2021). These unmet needs have been recognised as being caused by a fragmented healthcare system and there has therefore been a call for improved integration between mental and physical health services to address these issues.

One approach to facilitate this has been to adapt the role of clinical psychologists to prioritise consultation, supervision and training to increase the availability of psychological support within and across services. Since the late 1980s, it has been argued that clinical psychology staff should expand on their roles from being predominately direct therapy providers to provide more indirect staff support as this would sit well with their competencies

(Kuttner, 1989; Onyett, 2007). This strategy has been referred to as task-sharing (Hoeft et al., 2018), and aims to increase availability of psychological support by redistributing resources from specialist psychological practitioners to non-specialist, non-psychological healthcare professionals. More specifically, the role of the clinical psychologist would be to focus on providing public mental health leadership (Xiong et al., 2019) in the form of providing training, supervision and consultation to healthcare professionals to deliver more effective and coordinated psychological interventions in primary and community care settings.

One way clinical psychologists can facilitate task-sharing is by providing therapy training to non-psychology staff. However, in order for therapy training to be effective in medical settings, it is important to identify a model that suits this unique context (Blount, 2003). Researchers have argued that psychological interventions that can demonstrate effectiveness while also incorporating brevity to meet the patient's physical abilities and time constraints would be ideal (Cunningham, 2009; Olfson et al., 2013; Zhang et al., 2018)

Thankfully, due to past efforts and empirical investigations, several brief, evidence-based therapies exist today. This effort was initiated by an increase of empirical research assessing the outcomes of psychotherapy in the 1980s. During this time, longer-term therapies, stemming predominately from psychoanalytic traditions, were compared with shorter forms of therapy in terms of impact (Lambert & Bergin 2013, pp. 3-5). Overall, the consensus was that the time-limited therapies were found to demonstrate comparable outcomes to long-term therapies (Howard et al., 1986). Since then, there has been an exponential growth in empirical evaluations of various therapy forms. For instance, in the UK, this was largely influenced by national attempts to increase access of psychological therapy through increased funding of therapy provision (Onyett, 2007) where policy makers were searching for cost-effective therapy models for common mental health problems.

Ultimately, this led to a shift towards developing condensed, evidence-based treatments with an average of only 6-10 sessions.

Supporting the idea of task-sharing, a recent accumulation of evidence has demonstrated that non-psychology staff can deliver therapy successfully using a range of brief therapy models, even after brief training. Some of this evidence comes from randomised controlled trials (RCTs) that have reported outcomes for healthcare staff delivery to be comparable to specialist staff, even after training of only two days. These include Brief Cognitive Behavioural Therapy (BCBT) (Cape et al., 2010; Cully et al., 2017), Behavioural Activation (Ekers et al., 2013) and Motivational Interviewing (Carroll et al., 2006; Bennett et al., 2007).

Another such model is Solution Focused Brief Therapy (SFBT), which has also been implemented by a variety of non-psychology staff (e.g. Hosany et al., 2007; Simm et al., 2013; Kim et al., 2017). SFBT, a family therapy model that was developed in the 1980s, is a short-term, goal-oriented approach that that aims to build solutions by tapping into the clients' own resources and strengths in order to support the client to achieve and sustain desired behavioural change (de Shazer et al., 1986; Trepper et al., 2006).By identifying what already works for the client, the approach does not require an in-depth exploration of the past use of comprehensive psychological formulations in order to understand the problem. The clinician can therefore support the client to be the expert using questioning techniques to identify exceptions of their difficulties that lead to lasting and adaptive solutions (Iveson, 2002). The model has amassed a considerable evidence-base demonstrating recurrent positive outcomes for a range of clients with various presentations (Gingerich & Peterson, 2013; Franklin, 2015; Kim et al., 2019).

In addition to the evidence-base around therapy outcomes, SFBT has also been proposed as a model that is particularly applicable for healthcare practitioners. This is based on arguments that it requires little previous knowledge of psychology or therapy, suggesting it would require less time to implement in practice, making it more cost-effective (Hosany et al., 2007). This has been supported by qualitative studies reporting the model as being easy to understand and implement (Bowles, 2001; Smith & Macduff, 2017) as well as flexible for use on inpatient wards such as during on-call shifts (Blayney et al., 2014).

SFBT has also been adopted in medical settings such as stroke and pain services (Simm et al., 2013; Simm & Barker, 2018), diabetes management services and other health management services (Kim, 2007; Gingerich & Peterson, 2013). The model has been espoused as particularly useful for services offering support for individuals with long-term conditions that cannot be 'fixed' (Bray, 2009) as the strength-based approach facilitates motivation and independence necessary for on-going self-management.

Another reason for its applicability to medical settings relates to the model's ethos coinciding with the gradual policy shift away from the more traditional deficiency-focused (or 'fixing') treatment approach towards more recognition of client choice and empowerment. This was particularly emphasised in the 'expert patient strategy' outlined by the Department of Health (2001) in the UK proposing that 'knowledge and experience held by patients has been for too long an untapped resource'.

Finally, qualitative researchers have also reported that healthcare practitioners found that the SFBT model generally fit well with their personal and professional values (Bowles, 2001; Smith & Macduff, 2017; Smith, 2010). This finding of a personal "fit", or so-called "allegiance" (Wampold, 2001) with the model has been replicated in other qualitative SFBT research (e.g. Cunanan & McCollum, 2006; Stark et al., 2018) and has been suggested to be a

potential factor for the success behind SFBT training and implementation for healthcare practitioners.

However, despite some promising results from research, a variety of barriers have also been reported that appear to prevent people from implementing SFBT in practice. Many of these barriers are similar to those found in the general literature around successful implementation of skills after training. Kirkpatrick and Kirkpatrick (2006) identified four levels at which the training could be evaluated including: a) trainee satisfaction; (b) knowledge gain; (c) transfer of skills to practice; and (d) the effect of the training on outcomes. Of these four factors, training tends to be less successful around the transference of skills into practice where studies have demonstrated that staff apply as little as 10-30% of the training content in practice (Nielsen & Shepherd, 2022). The same problem is seen within the therapy training literature indicating that many staff fail to use techniques and strategies, despite demonstrating high rates of satisfaction and learning (e.g. Jahr, 1998; Milne et al., 2000). Several barriers to training transfer have been identified including lack of organisational policies and support, lack of time in clinics, lack of supervision and the trainees' perceived applicability of a model to their client group and their perceived ability to use it (e.g. Seko et al., 2020; Nielsen & Shepherd, 2022).

Although these factors have been identified for SFBT training including lack of organisational support, time and supervision (Hosany, 2007; Smith, 2010; Smith, 2011), other additional barriers have also been identified. These include managerial pressure to apply problem-focused models (Smith, 2011), lack of confidence in using strength-based approaches (Simm et al., 2011) and negative attitudes towards the model being formed after seeing it being used rigidly (Cunanan & McCollum, 2006). Furthermore, findings indicate that implementation is low even in the presence of reported high affiliation with SFBT or

motivation to apply techniques in practice (Cunanan & McCollum, 2006), suggesting that these more external barriers play an important part in preventing SFBT implementation.

In order for training to be more effective, a more thorough understanding of what factors are at play and how they interact in determining successful and unsuccessful implementation of SFBT in practice is needed. This will be particularly helpful as healthcare organisations can then develop more tailored training methods that can be adapted to different staff experiences in order to maximise the training effects in the long-term (Volet, 2013). Furthermore, it could also help measure the specific 'dosage' of support required to further inform cost-effective provision.

The aim of this study was therefore to apply a constructivist grounded theory approach to explore the process of how the identified barriers and facilitators might interact and unfold following training of non-psychology staff working in medical settings, and how this interaction might influence their implementation of SFBT. Furthermore, these processes were explored in the context of brief training programmes (defined as 40 hours or less (Stark et al., 2018; Smith, 2011)) provided by clinical psychologists. This was in order to further contribute to the evidence-base around the clinical psychologists' role of task-sharing by increasing staff skills and psychological mindedness through brief, post-graduation training programmes for continuous professional development (CPD) purposes. Finally, the researcher of the study also aimed to identify novel recommendations for future clinical psychologists delivering SFBT training to inform future best practice (Solution Focused brief Therapy Association (SFBTA), 2012).

Methods

Participants

10 healthcare staff working in National Health Services (NHS) services in the UK participated in the present study. Demographic and training details are included in Table 1.

Eligibility Criteria

Eligibility criteria were developed prior to recruitment and are detailed in Table 2.

Recruitment Procedure

Potential participants were sent e-mails with information about the project including a participant information sheet, a consent form and an opt-in sheet (see Appendix 4) by an appointed point of contact working for the NHS Trust that provided the training. Those who wished to participate were asked to contact the trainee researcher directly or by returning an opt-in form. 65 potential participants were initially invited via an e-mail list of which two agreed to participate. Following this, a further 23 participants were approached individually via e-mail by the appointed point of contact, of which another eight participants agreed to participate. It is unclear what the proportional overlap is between these two stages of recruitment and therefore no specific number of approached participants can be provided. However, it can be stated that a range between 65 and 88 participants were approached with a total of 10 participants who agreed to participate.

The recruitment was conducted in three phases: An initial round of data collection where three participants were interviewed followed by a further three participants and a final four with data analysis conducted in between each phase. All interviews were conducted by the main researcher via a virtual platform where they were also recorded.

Purposive recruitment was used to allow the researcher the necessary flexibility to identify the most relevant participants that were suited to inform the qualitative research questions of this study. The criteria used to identify the relevant sample were based on a maximum variation sampling approach to capture a wide range of perspectives of the various relevant staff receiving psychological training. Factors considered for this included work role, employment status, psychology training, duration of training, clinical experience after SFBT training and experience of supervision.

Furthermore, a survey was developed to aid the recruitment and theoretical sampling that took place at the end of each analysis stage (see Appendix 4).However, due to limitations around recruitment the use of this was restricted. Despite this, however, one participant was purposively recruited based on their supervision experience to cover a wider range of experiences. Theoretical sufficiency was deemed to be achieved after 10 interviews and further recruitment was discontinued (Dey, 1999, p. 257; Corbin & Strauss, 2015).

Data Collection

Data was collected from semi-structured interviews that lasted from 50 to 110 minutes. The interviews were informed by an interview schedule that was developed to guide questions relevant to the research question in an attempt to obtain rich data (see Appendix 4). The interviews were video recorded and the recordings were automatically transferred to a secure online server where they were transcribed and anonymised.

Design & Analysis

The data were transcribed in verbatim and analysed using constructivist grounded theory approach (Glaser & Strauss, 1973; Charmaz, 2014). The approach was applied due to its suitability around generating a new theory that can encompass and array of factors and processes that are relatively poorly understood in the literature (Charmaz, 2014). It was

analysed iteratively using a constant comparative method to continuously compare emergent data in order to develop a theory around the research question (Charmaz, 2014). Analysis included line-by-line coding of the transcripts followed by focused coding, which were based on more salient information relating to the research question (Charmaz, 2014).

Once initial and focused codes were completed for all 10 interviews, conceptual codes were developed, which formed the basis of developing preliminary theoretical categories. Once all theoretical categories were formed, a process model of the participants' experience of SFBT training was developed.

The analysis process was aided by ongoing memo- writing and free-writing throughout (Charmaz, 2014) (See Appendix 3). Furthermore, quotes were also used throughout the analysis and drafting of the results to keep the model grounded in the data. The constant comparison method was applied by looking for similarities and differences between the codes and categories of all interviews throughout the analysis process (Charmaz, 2014).

Finally, the study adopted a constructivist approach, assuming that theories do not exist to be discovered but are constructed through the research process (Charmaz, 2014). Therefore, the grounded theory from the study is regarded as interpretative representation, not an objective 'truth'. This way, the researcher's own biases and interpretations will have impacted on the outcomes of this research project, as this is unavoidable despite any efforts to reduce any bias (Charmaz, 2014).

Ethical Permission

Ethical permission was granted from the Faculty of Health and Medicine Ethics Committee at Lancaster University as well as the UK, NHS Health Research Authority (HRA). Permission was also granted from the Trust's local Research and Development department that was involved in conducting this research project (see Appendix 4).

Reflexivity and Credibility

Charmaz (2006; 2014) argues for the recognition of the active role of the researcher within research when taking a subjectivist epistemological stance. Thus, it is important for the researcher to acknowledge their position in relation to the data (Yardley, 2015). The researcher is a trainee clinical psychologist with no previous clinical or research experience around SFBT. Furthermore, reading of any relevant literature around the project was minimised until the data was collected, in line with guidance for conducting GT. However, prior to the analysis, the researcher had attended two introductory teaching sessions as part of the training programme and as such had a relatively basic conceptual understanding of the SFBT theory, ethos and practice. With this in mind, the researcher utilised a reflective diary, documenting any assumptions or reflections relating to the research throughout the project. The research was conducted under the supervision of a tutor with experience of qualitative research. With this, the initial interview was reviewed to guide future interviews and the coding was checked to ensure coherence.

Results

As part of the analysis, a model of SFBT implementation in clinical practice was developed (see Figure 1). In the figure a successful process of implementation is depicted by the diagonal arrow. The analysis indicated that this optimal trajectory is seen as depending on the interaction between four separate elements consisting of: 1) a core category consisting of two opposing mental states 2) a sub-category of four internal experiential states 3) 13 themes of facilitators and barriers and 4) three chronological stages of the journey to implement SFBT. These elements together describe the process of how participants are pulled into or pushed away from implementing SFBT and will be introduced in their respective order.

Core Category: The Two States of Mind

This category describes two states of mind that participants were in throughout the process of using SFBT in practice. The first category, "Comfort Zone", can be seen at the bottom of the diagram, and relates to state of mind that has been described by participants as "comfortable" and "familiar" and being "where your experience lies" (Participant 4, 7). All participants described the comfort zone as being associated with using a "medical model" that they were familiar from their training and gave them a sense control when using it. Participants described that since the goals of the medical approach would often contrast that of SFBT, using one would often exclude the other. The second category, found at the top, just below the four stages, is the "Brave Zone". Being in this state of mind was often described with a feeling of "discomfort" but with a willingness to learn something new, therefore often referred to as a "sacrifice" worth the effort: "so it's not comfortable for me at that moment in time, but… I still feel that it's worth doing because it can make a difference where other things haven't made a difference" (Participant 7).

Participants described various aspects of their working environment that acted as factors that either pulled them into using the medical rather than the SFBT model or vice versa. This push and pull dynamic is represented as the upwards and downwards arrows (see Figure 1) and are affected by the four internal states, which will be introduced next.

Sub-Category: The Four Internal States of Processing

This sub-category describes four internal states of processing (illustrated as the smaller coloured circles in the larger circle on the arrow) that are involved in determining the outcome of the SFBT learning process. These are: 1) Interest, indicated as I (orange), which relates to an interest in the SFBT model and training, 2) Motivation (M, green), which relates to the intent to act upon stated interest, whether it would be motivation to attend or engage in

the training or motivation to use SFBT in clinical practice, 3) Belief in SFBT (B, red) which relates to how much the participants believe that SFBT is an effective, useful and applicable model and 4) Confidence (C, blue) which relates to the participants' perceived ability to implement SFBT in practice.

Although a careful analysis of the data indicated that all four factors were directly involved in explaining the relationship between various influences and SFBT implementation, it did not suggest that they were all needed to ensure it. For instance, several participants described times when they experienced minimal confidence but still made attempts to use SFBT, e.g.: "I think when we first started our confidence and knowledge of it was a bit ropey…but we were motivated to give it a go" (Participant 3).

Therefore, these factors should mainly be understood as a combination of multiple partial mediating variables that together directly alter the degree of SFBT implementation, including the frequency and quality. The factors should also be interpreted as having a degree of influential strength dependent on the facilitators and barriers which will be discussed in the next section.

The Three Stages of the Journey to use SFBT

This part of the model depicts the process of SFBT learning in a chronological fashion, starting from when participants heard about SFBT to "today", where participants had been using the model for up to several years. The stages are pre-training, during, and post-training (see top of Figure 1). Each stage included relevant themes (located above or below the circle to signify facilitators (above) and barriers (below)) that influenced the states of processing, which then influenced the next stage. For instance, an overall positive experience of SFBT in the pre-training stage (e.g. high interest and motivation and positive belief) would likely facilitate training attendance, engagement and an overall positive training experience, which

again would likely facilitate the process of implementing SFBT in practice. Some of the themes influenced each other, which was either illustrated with black arrows (indicating causal links) or lines (indicating correlation). Finally, the themes were colour-coded signifying which of the four internal states they influenced.

Stage 1: Pre-training

The first stage, along with the second, should be considered as a preparatory stage that influences the outcome of later SFBT implementation.

Barriers.

Role Clash. This theme describes how participants' medical training conflicted with the SFBT and required a significant level of investment to unlearn the medical approach in order to implement SFBT: "It's really difficult. You've been doing something for 40 years and you suddenly (have) to change an entire way of running a clinic" (Participant 5).

It was also described that the investment required a change from their typical professional language they were accustomed to, which caused discomfort: "I might use some of the phrases, but then I'd be uncomfortable using it because it's not what I normally say or not part of my normal language" (Participant 5).

Facilitators.

Connecting with SFBT. This theme describes how participants formed a personal connection with the SFBT model. There were two main causes of such connection: 1) SFBT as a much-needed alternative approach in their role and 2) a personal fit to individual values.

With regards to the first cause, several participants described a sense of relief that there was an alternative model to the medical approach for supporting clients with long-term complications:

> It (SFBT) gives you a more positive approach to something that potentially has been weighing you down because you can't fix it, you can't make it better… you can't do it in Diabetes, you can't fix - we can't make it better, but we can find techniques to make it better (Participant 4).

They further described feeling that the medical model was too problem-focused, which they considered unhelpful to clients and often led to a sense of feeling "drained", "demoralised" or "guilty". SFBT became a "solution" to this (Participant 4) and another described a sense of desperation for anything to help support their clients as they had "nothing else" (Participant 3), which facilitated motivation to try the SFBT approach.

Some participants were motivated to use SFBT through a personal connection where they described a sense of yearning for more empathy and feelings that were lacking in the medical approach and felt relieved that there was a recognised approach that incorporated this:

> This (SFBT) is what I've been looking for… I want to be able to address them in this way. I have a platform that says that this is a recognized way of doing things. I'm not just chit-chatting, I'm doing so much more than that. I think that was something I was very motivated by (Participant 7).

Witnessing Successful SFBT Practice. Several participants commented on the utility of observing colleagues use SFBT in practice prior to the training. They described how this provided them evidence of SFBT and how seeing certain "success stories" kept them going, despite causing them discomfort and investment:

> Because I know that it works, I've seen it work. I still feel that it's worth doing because it can make a difference where other things haven't made a difference. I suppose it gives me the motivation, doesn't it, to go on and keep thinking of that young man…(Interview 9).

They also described the reputation of SFBT from trusted colleagues or team narratives as evidence of the credibility of SFBT, which motivated them to attend the training:

> They talked really positively at how they found that (training), they were already starting to implement or make changes within the team so it was already here and it was already talked about and I was really interested in attending the training myself (Participant 8).

Finally, the reverse was also found, demonstrating how the absence of proof reinforced feelings of scepticism around the validity and applicability of SFBT (see Absence of Successful SFBT Practice in Figure 1).

Stage 2: During Training

Barriers.

Negative Pre-conceptions. This theme is based on the sceptical preconceptions about SFBT that participants brought into the training. This was mainly related to doubts about the applicability in a medical context and their own ability to use it as non-psychological practitioners. For instance, one mentioned how the training challenged their pre-conceptions:

> It was really useful in demonstrating that it doesn't have to be this huge intervention, that you have to be the world's best psychologist to use it and it can be quite adaptable depending on… the time that you might have (Participant 6).

Facilitators.

Role Modelling through Role-Plays. Participants described the approach of the trainers in discussions and role-plays as being an important facilitator for motivation to engage in training and in giving future confidence to implement SFBT.

Participants reported that the trainers often provided the role-playing client space and time and in debrief discussions, highlighted the importance of silence as a tool to allow the client to lead and feel listened to. It also helped reassure participants: “And I picked up…from the training, all from watching the way he (clinical psychologist) works…that silence is OK and it’s OK to take a minute and OK to not rush in with the next question” (Participant 8).

Realistic Practice Opportunities. Most participants emphasised the importance of practical opportunities in training to feel more interested and engaged during the training. Several participants particularly appreciated the opportunity to bring in examples from their own professional practice in role-plays and scenarios, making them more relatable, which reinforced a sense of trust in the psychologist and the SFBT being more applicable to their client population and service context:

> I don’t think you can do solution focused (training) by giving someone “here’s a card and you play this person now”. I think you have to relate because you gotta go into your own feelings. I think you’ve got to relate it to something (in) real life (Participant 4).

Stage 3: After Training

Barriers.

Problem-Oriented Clients. Participants often stated that clients themselves were often a barrier to the confidence of implementing SFBT.

For instance, participants described how they often felt pulled into using a medical approach whenever a client was focused on an immediate problem and requested a “quick fix”. Participants would in this case resort to use more of a medically, expert-led led approach:

> We said “What do they want?” And the response was just “not to have epilepsy” and then you go “well, what else” or try and redirect the conversation and she’ll just came back to “I just don’t wanna have epilepsy”. And she was just so focused on it and we couldn’t get to anywhere else (Participant 3).

Lack of Time and Opportunity. This theme relates to the participants’ perceptions and experiences of insufficient time and opportunities to use SFBT affecting their motivation and confidence.

With regards to time, most participants described how SFBT requires more time than the medical model due to the need for exploration. For instance, one participant mentioned how initial conversations require more time for “personal information” about the client to develop “good rapport” (Participant 6). As the staff were often contracted to provide 20-30-minute clinics, such a required time investment meant that explorative conversations were often disrupted, requiring more follow-up sessions. Coupled with staff reporting such conversations being more difficult to return to as well as other competing demands, they would often miss opportunities to explore the clients’ “main” difficulties through the use of SFBT (Participant 7).

Moreover, SFBT was also perceived as needing more time for clients to feel comfortable in taking the lead in conversations. For instance, one participant mentioned how clients themselves go out of their own “comfort zone”, in this case referring to the challenge of doing something new. This then required clinicians to “draw them out” in conversations, which was time consuming: “I’m asking people to step out of their comfort zone for a lot of things and come into my world try something different” (Participant 7).

Finally, it was mentioned that the participants’ needed more time at the start as they were not yet confident with the use of question and other SFBT techniques. This was described as

being exacerbated by a lack of opportunity: “At the start it was very shaky, forgetting the key questions…and forgetting where to… direct it and that’s still there because we don’t practice it every day, we don’t even practice it every week” (Participant 3).

Unrealistic Expectations of SFBT. This theme relates to several assumptions and expectations that were formed about SFBT after training based on the pre-conceptions developed before and during training. It was evident that participants had formed different ideas of what SFBT entails and thus also expectations of what they should be able to offer. For instance, several participants wanted their clients to identify comprehensive goals by the end of an initial 20-30-minute session. Participants with this understanding of SFBT were more likely to resort to a medical approach of “fixing” by providing advice or education rather than supporting the client to lead their own conversations due to time constraints. They also appeared more likely to conclude that SFBT was a context-dependent “tool” that in these cases was “not working” (Participant 5).

Service Pressures. The final barrier relates to the external pressures in healthcare services. For instance, several participants talked about how their services’ performance goals often pulled participants into the comfort zone by shifting the team’s focus and reducing individual motivation:

> So it’s very easy to get drawn into pushing your patients for your own or the Trust’s gain…when we’re published in that National Audit, “where do we sit, what number are we in the country?”. So I think it’s more the target that drives you to go back to your medical model (Participant 4).

Facilitators.

Proactive Pursuit of Support. This theme related to how participants who were more connected with SFBT pre-training were later more proactive and motivated to find ways to

improve their SFBT learning despite external challenges. For instance, several participants described that they had proactively requested a supervisor (Participant 7), sought advice from staff members more experienced in SFBT (Participants 1, 2 and 7), or established discussion groups with their colleagues (Participants 1, 3, 4 and 9).

Support Networks. This theme describes how supervisors, colleagues and the teams supported staff to use SFBT.

One of the main contributions of the support network was around providing staff regular "reminders" after training in order to maintain confidence and prevent depletion over time. Participants identified that regular team MDTs and supervision were particularly helpful in providing them a reminder of what they were already doing, which helped them feel reassured and more confident: "The supervision or the MDT…make me feel a little bit more confident, that little boost to know that something's worked…or something's going OK and just makes us all feel a little bit better I suppose" (Interview 8).

The MDTs were particularly appreciated as it provided a sense of collective purpose and a sense of "doing it together" as a team (Participant 8) but also a sense of continuity by discussing SFBT cases regularly and develop more confidence: "I think even just speaking together as a team, bouncing off ideas sort of one that thing that's worked for one patient, you might sit there and think…"oh, yeah, that might work for them" (Participant 9).

Staff also reported they benefitted the most when MDTs were delivered in an SFBT way by also focusing on what the staff members were doing well:

> I like the way we do that "pleased to notice" because sometimes I think you can get bogged down with what's not going well and you forget to focus on the things that have been good… It will give you a "right, ok, I'm prepared to give that a go". (Participant 4)

Realistic Expectations of SFBT. In contrast to unrealistic expectations, realistic expectations helped staff form more realistic goals and acted like a buffer against systemic barriers and challenges by making them more confident. Findings indicated that such expectations were facilitated by supportive teams as well as good role modelling from the training.

Discussion

This study was able to construct a model which suggested that transitioning from a medical, problem-orientated approach to a strength-based approach was challenging for all staff. This echoes previous research reporting that staff often struggle with the required shift in their mindset, language and approach (Simm, 2011; Cunanan & McCollum, 2006),often finding themselves slipping back into the approach they are more familiar with (Smith, 2011). Going further, however, this study suggested that this was due to the medical approach representing a sense of safety, where transitioning was perceived to involve many 'sacrifices' and a sense of loss. For participants, the sacrifice was in the form of the confidence that came with the skills associated with a familiar approach. This was therefore perceived as a high price to pay and would affect their interest, motivation and confidence to engage in the training and their use of SFBT.

These results could be understood in the context of 'Conservation of Resources' theory (Hobfoll, 1989), which suggests that the motivation to prevent the loss of resources is greater than the potential gain of new resources. This suggests that in order for staff to be motivated throughout and following the training, they need to be 'convinced' that the transition towards using SFBT will be worth the loss of confidence and the cost of the required investment. Staff reported needing 'proof', such as in the form of seeing it work in

practice, in order to feel motivated to attend and engage in the SFBT training. This could be interpreted in line with research suggesting that some staff present with initial scepticism about SFBT, perceiving it as 'naïve' as it does not appreciate the complexity of the client's problem and past (Cunanan & McCollum, 2006). Seeing SFBT successfully work in practice was considered as important evidence on the contrary. This overlaps with findings in the SFBT training literature suggesting that observing successful implementation was experienced as a "aha!" moment, which was suggested as important in facilitating future investment in the model (Stark et al., 2018). It might also be that observing and engaging in role-plays that were more "realistic" also functioned as an "aha" moment that facilitated belief in the model.

Another scepticism of SFBT seemed to be related to the staff members' own ability to use SFBT. Perceived self-efficacy has been found to correlate highly with skill-transfer and has been suggested as playing an important role in facilitating implementation following training (Blume et al., 2010). The findings of this study suggested that the trainer's role-modelling of SFBT implementation via role-plays was effective in increasing self-efficacy. The importance of role-play and live demonstrations has previously been highlighted (Cunanan & McCollum, 2006; Stark et al., 2018), however, there has been a lack of research demonstrating how staff benefit from it. This study demonstrated that staff present with various negative pre-conceptions about their ability to deliver therapy, and if left unchallenged, unrealistic expectations would be formed of what they were supposed to offer. These unrealistic expectations would then likely lead to negative conclusions about the perceived utility of the model. This study therefore highlighted that the trainer's demonstration provided them a realistic idea of what an SFBT intervention would normally look like and thus countered any unrealistic expectations. For instance, one of the aspects of the demonstrations was the use of silence and helped staff challenge ideas of always having

to have the answers in situations. This is supported by research recommending clear goal setting as part of any training in order to have a clear vision of what is expected of them (Suleiman et al., 2017). This in turn would improve self-efficacy by believing that their SFBT-related goals are more achievable and thus be more willing to invest (Lambright, 2010).

Another important finding from this study was around the personal connection with the SFBT model. Although connecting with SFBT's ethos has been regularly reported among nurses (Bowles et al., 2001; Wand, 2010; Stark et al., 2018) and has been suggested as a possible factor in relation to training transfer (Cunanan & McCollum, 2006), this study provides a novel explanation of how it might contribute to SFBT implementation. Findings suggested that the staff members who connected with the SFBT model were more likely to proactively seek ways to increase and improve their use of it in future practice. This was predominately in the form of seeking support from their individual colleagues, teams or supervisors. Furthermore, this was particularly apparent for staff members who did not already have regular clinical supervision. This suggests that establishing a connection and believing in the efficacy of SFBT could be an important buffer against common barriers reported in the literature, particularly around lack of supervision and managerial support (Smith, 2011; Stark et al., 2018).

With regards to barriers, this study highlighted that the restrictions of time in healthcare settings can negatively impact the implementation SFBT. This has also been reported by other researchers in the field (e.g. Smith, 2011), however, the findings of this study provided further insight into how this might occur. For instance, participants in this study reported two aspects of a SFBT conversation to be time-consuming, including 1) asking questions about clients' lives outside the medical problem and 2) supporting the client to lead the conversation. This was particularly the case with the latter point as this contrasted the

medical ‘fixing’ approach where the clinician would often take the lead in providing advice and education. They reported that at the start, when confidence was low, using question techniques to guide the client was difficult and even more so with many of their clients who were also unfamiliar and uncomfortable with this way of conversing, requiring more time for clinicians to ‘draw them’ into such a conversational dynamic.

Furthermore, if these experienced difficulties were combined with unrealistic expectations of the outcomes of a session, they were more likely to conclude that the model itself was not applicable to these situations. Somewhat ironically, however, this study suggested that supporting staff to use silence as a tool might help them achieve SFBT goals more quickly through facilitating realistic expectations and increasing self-efficacy. This study therefore suggests that although time can be a barrier in itself, it is highly dependent on the staff members’ expectations, pre-conceptions and confidence that need to be considered during and after the training.

Fortunately, however, this study identified various facilitators that could counteract some of these systemic barriers. The main finding is the importance of staff being provided with regular reminders and reassurances in order to maintain their use of SFBT post-training. Clinical supervision, peer support and multidisciplinary team meetings all served the same function in this regard. In the context of this, clinical supervision was therefore not reported as an essential component of training transfer, which contrasts with research indicating the opposite (Hosany, 2007; Ferraz & Wellman, 2009). Instead, this study highlighted the importance of a supportive SFBT culture where staff could engage in regular solution-focused-informed multidisciplinary teams, which would often facilitate informal and formal conversations about clients in a solution-focused way.

Furthermore, participants also reported benefitting from reflecting on positive changes noticed in their own personal and professional lives, which encouraged them to engage in more strength-based thinking more naturally. In these contexts, staff were often able to ask others questions about clinical cases, hear other people's experiences and receive feedback around their own progression using SFBT. This gave them the confirmation they needed to feel more confident to continue using SFBT in practice. Several studies have indicated that a solution-focused friendly environment is conducive to SFBT training transfer, reporting that it provides staff regular opportunities for sharing ideas through a shared language (Cunanan & McCollum, 2006; Seko et al., 2021). It might therefore be that in the presence of such supportive teams, clinical supervision might be less of a necessity for SFBT training transfer, possibly suggesting that team-based supervision might be a more cost-effective investment.

Study Limitations

The sample in this study was relatively homogenous which might have limited the reliability and transferability of the data. More theoretical sampling may also have generated data from a wider pool of staff experience. For instance, most of the staff in this study were female specialist nurses and therefore lacked representation of gender as well as other professionals who have been trained in this way. There was also a considerable degree of variation between the training programmes the staff attended. Therefore, the study could have benefitted from more demographic information on the participants and training programmes such as years of work experience, number of attendees and nature and style of the training. Furthermore, a large proportion of the participants also worked in services that had already embraced a shift towards more strength-based and solution-focused thinking, meaning they were likely more receptive to the training than staff in other healthcare services. Moreover, due to the resource limitations that accompany a student doctorate, this research project was

not able to include a second analyst, effectively limiting its interpretative validity and credibility.

Clinical Implications and recommendations for clinical practice

Several recommendations were identified for clinical psychologists when providing brief SFBT training in healthcare and medical services. First, clinical psychologists should ensure that live demonstrations and role-plays are specific to the relevant service and client group (Seko et al., 2021) by incorporating challenges of using SFBT in time-restricted clinics and risk-related conversations. It might be helpful for staff members to bring in their own cases for discussion and role-plays as well as facilitate group discussions around common challenges. Furthermore, clinical psychologists should consider their demonstrations to consist of "imperfections", such as silence, to increase self-efficacy and challenge unrealistic expectations.

Second, clinical psychologists should consider the importance of staff observing successful interventions using SFBT. Optimally, staff would be able to observe a trained SFBT practitioner delivering SFBT pre-training in order to facilitate motivation to attend and engagement in the training. However, as this might not always be practically feasible, the clinical psychologist might need to consider including video demonstrations of successful interventions in the training in order to provide staff with a sense of evidence that SFBT is worth their investment.

Third and finally, clinical psychologists working within a MDT should invest time and effort in building a solution-focused friendly environment (Stark et al., 2018). This could be facilitated by ensuring that newcomers are provided SFBT training and shadow opportunities of SFBT in practice. They should also consider facilitating regular MDT meetings as group supervision of SFBT, providing staff opportunities to discuss and reflect

upon cases where using SFBT principles have been attempted. In this study, staff also benefitted from MDTs that invited them to notice what was going well, which is echoed by the SFBTA practice guidelines around identifying "what they are already doing that is working" (SFBTA, 2012). It is likely that the strength-focused meetings further facilitates strength-based thinking and subsequent implementation, and is therefore recommended for future practice.

Research implications and future research

This was to the author's knowledge the first study to explore the experiences of medical staff receiving brief SFBT training using a grounded theory approach. Although some of the results from this study echoed the findings from previous studies (Cunanan & McCollum, 2006; Smith, 2011; Stark et al., 2018; Seko et al., 2021), several novel contributions were identified that could benefit from further exploration.

First, several factors were identified that facilitated a sense of interest and motivation to attend the SFBT training. However, in order to develop deeper insight into the factors that might be involved in this decision-making process, further qualitative research interviewing staff who decided not to attend the training would be beneficial. Being able to more accurately identify why staff choose not to attend SFBT training might be particularly important for clinical psychologists attempting to build more solution-focused friendly teams and service cultures.

Second, this study indicated that one-to-one clinical supervision sessions might not be essential in maintaining training transfer for all staff within a context of a solution-focused environment offering regular solution-focused MDTs. Future research would benefit from exploring this concept further by comparing staff experiences with and without supervision in healthcare environments.

Third, this study replicated previous research in suggesting that individual connection with the SFBT ethos was important to facilitate further implementation. Although this study was the first to attempt explaining how the connection led to training transfer, the data of this study could not explain how it was developed. Future qualitative research should look into how this connection could be beneficial in order to support future clinical psychologists to tailor their training programmes to individual or group-based preferences and manage various team dynamics better. This could be explored by comparing the experiences of staff with different personality profiles (e.g. using the Big Five Inventory (BFI) (John et al., 1991)) and professional roles.

Conclusion

This Grounded Theory study suggests that healthcare staff require to be convinced of the SFBT's utility and their ability to implement it before they would transition out of using the medical model. Psychologists would need to ensure that trainees observed demonstrations of successful implementation of the model before training in order to facilitate motivation to attend and engage in training. They should also role model realistic SFBT implementation that is relevant to the specific service to negate unrealistic expectations. Finally, they should invest time to develop solution-focused friendly environments to counter harmful impact caused by a range of systemic barriers in order to facilitate long-term confidence and training transfer.

References

Baron, R. M., & Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of personality and social psychology*, *51*(6), 1173.

Bennett, G. A., Moore, J., Vaughan, T., Rouse, L., Gibbins, J. A., Thomas, P., & Gower, P. (2007). Strengthening motivational interviewing skills following initial training: A randomized trial of workplace-based reflective practice. *Addictive Behaviors, 32*, 2963–2975.

Blayney, S., Crowe, A., & Bray, D. (2014). Survival as medical registrar on call: remember the doughnut. *Clinical medicine*, *14*(5), 506.

Blount, A. (2003). Integrated primary care: Organizing the evidence. Families, Systems & Health, 21, 121–134.

Blume, B. D., Ford, J. K., Baldwin, T. T., & Huang, J. L. (2010). Transfer of training: A meta-analytic review. *Journal of management*, *36*(4), 1065-1105.

Bowles, N., Mackintosh, C., & Torn, A. (2001). Nurses' communication skills: an evaluation of the impact of solution-focused communication training. *Journal of Advanced Nursing, 36*(3), 347-354. doi:10.1046/j.1365-2648.2001.01979.x

Bray, D. (2009). Patient-centred care, Darzi and solution focused approaches. *Clinical Psychology Forum*, 19, 41–5

Cape, J., Whittington, C., Buszewicz, M., Wallace, P., & Underwood, L. (2010). Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression. *BMC medicine*, *8*(1), 1-13.

Carey, T. A., & Spratt, M. B. (2009). When is enough enough? Structuring the organization of treatment to maximize patient choice and control. *The Cognitive Behaviour Therapist*, *2*(3), 211-226.

Carroll, K. M., Ball, S. A., Nich, C., Martino, S., Frankforter, T. L., Farentinos, C., Kunkel, L. E., Mikulich-Gilbertson, S. K., Morgenstern, J., Obert, J. L., Polcin, D., Snead, N., Woody, G. E. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81*, 301–312

Charmaz, K. (2014). *Constructing grounded theory* (second ed.). Thousand Oaks, CA: Sage.

Charmaz, K., & Thornberg, R. (2021). The pursuit of quality in grounded theory. *Qualitative research in psychology*, *18*(3), 305-327.

Charmaz, K., (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London: SAGE Publications.

Corbin, J., & strauss, A. L. (2015). *Basics of qualitative research: techniques and procedures for developing grounded theory*. SAGE PUBLICATIONS.

Cully, J. A., Stanley, M. A., Petersen, N. J., Hundt, N. E., Kauth, M. R., Naik, A. D., et al. (2017). Delivery of brief cognitive behavioral therapy for medically ill patients in primary care: A pragmatic randomized clinical trial. *Journal of General Internal Medicine, 32(*9), 1014–1024.

Cunanan, E. D., & McCollum, E. E. (2006). What works when learning solution-focused brief therapy: A qualitative study of trainees' experiences. *Journal of family psychotherapy*, *17*(1), 49-65.

Cunningham, P. J. (2009). Beyond parity: Primary are physicians' perspectives on access to mental health care. Health Affairs, 28, 490–501.

De Shazer, S., Berg, I. K., Lipchik, E. V. E., Nunnally, E., Molnar, A., Gingerich, W., & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. *Family process*, *25*(2), 207-221.

Department of Health. (2001). *The Expert Patient: A New Approach To Chronic Disease Management In The 2first Century Stationery Office*: London, NHS, England.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative enquiry*. Academic Press.

Duff, A. J., & Bryon, M. (2005). Consultation with paediatric teams. *Clinical child psychology and psychiatry*, *10*(1), 102-111.

Ebrahimi, H., Hassankhani, H., Negarandeh, R., Azizi, A., & Gillespie, M. (2016). Barriers to support for new graduated nurses in clinical settings: A qualitative study. *Nurse education today*, *37*, 184-188.

Ekers, D. M., Dawson, M. S., & Bailey, E. (2013). Dissemination of behavioural activation for depression to mental health nurses: training evaluation and benchmarked clinical outcomes. *Journal of Psychiatric and Mental Health Nursing*, *20*(2), 186-192.

Ferraz, H., & Wellman, N. (2009). Fostering a culture of engagement: an evaluation of a 2-day training in solution-focused brief therapy for mental health workers. *Journal of psychiatric and mental health nursing*, *16*(4), 326-334.

Forrester, D., Westlake, D., Killian, M., Antonopoulou, V., McCann, M., Thurnham, A., Thomas, R., Waits, C., Whittaker, C., & Hutchison, D. (2018). A randomized controlled trial of training in motivational interviewing for child protection. *Children and Youth Services Review, 88*, 180–190. https://doi.org/10.1016/j.childyouth.2018.02.014

Franklin, C. (2015). An update on strengths based, solution-focused brief therapy. *Health & Social Work, 40*(2), 73-76.

Franklin, C. (2015). An update on strengths-based, solution-focused brief therapy. *Health & social work*, *40*(2), 73-76.

Gingerich, W. J., & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice*, *23*(3), 266-283.

Gingerich, W. J., & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice*, *23*(3), 266-283.

Glaser, B. G., & Strauss, A. L. (1973). *The discovery of grounded theory: Strategies for qualitative research* (5th ed.). Chicago, IL: Aldine Publishing Company.

Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American psychologist*, *44*(3), 513.

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose–effect relationship in psychotherapy. *American psychologist*, *41*(2), 159.

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose–effect relationship in psychotherapy. *American psychologist*, *41*(2), 159.

Iveson, C. (2002). Solution-focused brief therapy. *Advances in psychiatric treatment*, *8*(2), 149-156.

Jahr, E. (1998). Current issues in staff training. *Research in developmental disabilities*, *19*(1), 73-87.

John, O. P., Donahue, E. M., & Kentle, R. L. (1991). Big five inventory. *Journal of Personality and Social Psychology*. Technical report, University of California, Berkeley.

Kerr, K., Oram, J., Tinson, H., & Shum, D. (2017). Health care workers' experiences of aggression. *Archives of psychiatric nursing*, *31*(5), 457-462.

Kim, J. S. (2007). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. Research on Social Work Practice, 18(2), 107–116.

Kim, J. S., Kelly, M. S., & Franklin, C. (2017). *Solution-focused brief therapy in schools* (second ed.). New York, NY: Oxford University Press.

Kim, J., Jordan, S. S., Franklin, C., & Froerer, A. (2019). Is solution-focused brief therapy evidence-based? An update 10 years later. *Families in Society*, *100*(2), 127-138.

Kirkpatrick, D., & Kirkpatrick, J. (2006). *Evaluating training programs: The four levels*. Berrett-Koehler Publishers.

Lambert, M. J., & Bergin, A. E. (2013). *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*. John Wiley & Sons, Incorporated.

Lambright, K. T. (2010). An update of a classic: Applying expectancy theory to understand contracted provider motivation. Administration & Society, 42(4), 375–403.

McManus, S., Bebbington, P. E., Jenkins, R., & Brugha, T. (2016). *Mental health and wellbeing in England: the adult psychiatric morbidity survey 2014*. NHS digital.

Mental Health Taskforce (2016). *The five year forward view for mental health. A report from the independent Mental Health Taskforce to the NHS in England*. Leeds: NHS England. Retrieved June 8, 2023, from www.england.nhs.uk/mentalhealth/taskforce/.

Milne, D., Gorenski, O., Westerman, C., Leek, C., & Keegan, D. (2000). What does it take to transfer training?. *Psychiatric Rehabilitation Skills*, *4*(2), 259-281.

MIND (2011). Listening to Experience: An Independent Inquiry into Acute and Crisis Mental Healthcare. London: MIND.

Negri, A., Zamin, C., Parisi, G., Paladino, A., & Andreoli, G. (2021). Analysis of General Practitioners' Attitudes and Beliefs about Psychological Intervention and the Medicine-Psychology Relationship in Primary Care: Toward a New Comprehensive Approach to Primary Health Care. In *Healthcare, 9*(5), 613).

Nielsen, K., & Shepherd, R. (2022). Understanding the outcomes of training to improve employee mental health: A novel framework for training transfer and effectiveness evaluation. *Work & Stress*, *36*(4), 377-391.

Nylund, D., & Corsiglia, V. (1994). Becoming solution-focused forced in brief therapy: Remembering something important we already know. *Journal of Systemic Therapies, 13*, 5-12

Oster, S. (2015). Solution-Focused approach in a team working with social welfare benefits in social service. *InterAction-The Journal of Solution Focus in Organisations*, *7*(1), 7-23.

olde Hartman, T. C., Woutersen-Koch, H., & Van der Horst, H. E. (2013). Medically unexplained symptoms: evidence, guidelines, and beyond. *British Journal of General Practice*, *63*(617), 625-626.

Olfson, M., Blanco, C., Wang, S., & Greenhill, L. (2013). Trends in office-based treatment of adults with stimulants in the United States. *Journal of Clinical Psychiatry, 74,* 43–50.

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

Schizophrenia Commission (2012). The Abandoned Illness: A Report from the Schizophrenia Commission. Rethink Mental Illness: London.

Seko, Y., King, G., Keenan, S., Maxwell, J., Oh, A., & Curran, C. J. (2021). Perceived impacts of solution-focused coaching training for pediatric rehabilitation practitioners: A qualitative evaluation. *Physical & Occupational Therapy in Pediatrics*, *41*(4), 340-354.

Simm, R. (2013). The role of occupational therapists in supporting psychological wellbeing after stroke using a solution-focused psychological approach to mood assessment. *British Journal of Occupational Therapy*, *76*(11), 503-506.

Simm, R., & Barker, C. (2018). Five years of a community pain service solution-focused pain management programme: extended data and reflections. *British Journal of Pain*, *12*(2), 113-121.

Simm, R., Hastie, L., & Weymouth, E. (2011). Is training in solution-focused working useful to community matrons?. *British Journal of Community Nursing*, *16*(12), 598-603.

Simm, R., Iddon, J., & Barker, C. (2014). A community pain service solution-focused pain management programme: delivery and preliminary outcome data. *British Journal of Pain*, *8*(1), 49-56.

Smith, I. C. (2011). A qualitative investigation into the effects of brief training in solution-focused therapy in a social work team. *Psychology and Psychotherapy: Theory, Research and Practice*, *84*(3), 335-348.

Smith, S. (2010). A preliminary analysis of narratives on the impact of training in solution-focused therapy expressed by students having completed a 6-month training course. *Journal of Psychiatric and Mental Health Nursing*, *17*(2), 105-110.

Smith, S., & Macduff, C. (2017). A thematic analysis of the experience of UK mental health nurses who have trained in Solution Focused Brief Therapy. *Journal of psychiatric and mental health nursing*, *24*(2-3), 105-113.

Solution-Focused Brief Therapy Association. (2012). *SFBTA position paper on training.* Unpublished manuscript. Retrieved June 8, 2023, from https://irp-cdn.multiscreensite.com/f39d2222/files/uploaded/SFBTA_Training_Position_Paper_9_July_2012.pdf

Solution-Focused Brief Therapy Association. (2013). *Solution-focused treatment manual.* Unpublished manuscript. Retrieved June 8, 2023, from https://www.sfbta.org/resources/manuals/

Stark, M. D., Kim, J. S., & Lehmann, P. (2018). Solution-Focused Brief Therapy Training: What's Useful When Training Is Brief?. *Journal of Systemic Therapies*, *37*(2), 44-63.

Suleiman, W., Dassanayake, M. S., & Othman, A. E. A. (2017). Mediation of transfer motivation on the relationship between supervisor support, peer support and transfer of training. *International Journal of Business and Society, 18*(3), 605–617.

Trepper, T. S., Dolan, Y., McCollum, E. E., & Nelson, T. (2006). Steve De Shazer and the future of solution-focused therapy. *Journal of Marital and Family Therapy*, *32*(2), 133-139.

Volet, S. (2013). Extending, broadening and rethinking existing research on transfer of training. *Educational Research Review, 8(1)*, 90–95. https://doi.org/10.1016/j.edurev.2012.11.005

Wampold, B. E. (2001). *The great psychotherapy debate. Models, methods, and findings*. Mahaw, NJ: Lawrence Erlbaum.

Wand, T. (2010). Mental health nursing from a solution focused perspective. *International Journal of Mental Health Nursing*, *19*(3), 210-219.

Wang, C., Wang, C., Wang, J., Yu, N. X., Tang, Y., Liu, Z., & Chen, T. (2022). Effectiveness of Solution-Focused Group Counseling on Depression and Cognition Among Chinese Older Adults: A Cluster Randomized Controlled Trial. *Research on Social Work Practice*, *0*(0). https://doi.org/10.1177/10497315221119991

Wheeler, J. (2001). A helping hand: Solution-focused brief therapy and child and adolescent mental health. *Clinical Child Psychology and Psychiatry, 6*, 293–306.

World Health Organization. (2015). *World health statistics 2015*. World Health Organization.

Xiong, T., Wozney, L., Olthuis, J., Rathore, S. S., & McGrath, P. J. D. A. (2019). A scoping review of the role and training of paraprofessionals delivering psychological interventions for adults with post-traumatic stress disorder. *Journal of Depression and Anxiety, 8*(3), 2167. https://doi.org/10.35248/2167-1044. 19.8.342

Yardley, L. (2015). Demonstrating validity in qualitative psychology. *Qualitative psychology: A practical guide to research methods*, *3*, 257-273.

Zhang, A., Franklin, C., Currin-McCulloch, J., Park, S., & Kim, J. (2018). The effectiveness of strength-based, solution-focused brief therapy in medical settings: a systematic review and meta-analysis of randomized controlled trials. *Journal of behavioral medicine*, *41*, 139-151.

Table 1.

Demographical and training-related information of participants included in the study

Nr	Gender	Age	Title/Role	Service	Year/month of most recent training	Duration of most recent training course	Nr of completed training courses	Virtual or F2F training	Optional vs. required attendance	Formal clinical supervision (Y/N)
1	Female	57	Specialist Nurse	Frailty Service NHS	Jan 2021	Two days	1	Virtual	Opted in	N
2	Female	62	Specialist Nurse	Chronic Pain NHS	Sept 2022	Two days	1	F2F	Opted in	N Some informal supervision by clinical psychologist
3	Male	29	Specialist Nurse	Paediatric Service NHS	Sept 2022	Two days	1	F2F	Opted in	N
4	Female	46	Specialist Nurse	Diabetes Service NHS	Sept 2022	Two days	2	F2F	Opted in	N Some informal supervision by clinical psychologist
5	Female	49	Consultant Endocrin-ologist	Paediatric Service NHS	2019	Two days	3-4	F2F	Required	Y SFBT specific for several years, on-going

Nr	Gender	Age	Title/Role	Service	Year/month of most recent training	Duration of most recent training course	Nr of completed SFBT training courses	Virtual or F2F training	Optional vs. required attendance	Formal Clinical Supervision (Y/N)
6	Female	33	Specialist Mental Health Nurse	Psychological Intervention Service NHS	Sept 2022	Two days	1	F2F	Required (mandatory)	Y Non-SFBT supervision for several sessions over 6 months
7	Female	54	Research Nurse	Paediatric Service NHS	2014	Two days	1	F2F	Opted in	Y 4 SFBT sessions 2 years after training. Informal supervision provided in a 6-month period.
8	Female	35	Specialist Nurse	Paediatric Service NHS	2021	Two days	1	Virtual	Required (induction)	Y 4 SFBT sessions 2 years after training. Informal supervision provided in a 6-month period.
9	Female	37	Specialist Nurse	Paediatric Service NHS	2021	Two days	2	Virtual	Required (induction)	N
10	Female	48	Rehab-ilitation Assistant	Chronic Pain Service NHS	2021	Two days	1	Virtual	Required (induction)	N

Note: Further data around the participants such as years of experience, ethnicity and use of SFBT were not collected. Moreover, data around training programmes such as number of attendees and nature and style of the training were not collected or not categorisable from the interviews.

Table 2.

Inclusion and exclusion criteria for potential participants

Inclusion Criteria	Exclusion criteria
Potential participants with no formal experience of applying psychological therapy in practice prior to receiving SFBT training were included.	Potential participants with accredited qualifications or apprenticeships in clinical psychology (i.e. Practitioner Psychologist, Psychological Wellbeing Practitioner, Children's Wellbeing Practitioner, Educational Mental Health Practitioner, Clinical Associate in Psychology, Clinical Associate in Clinical Psychology), counselling or coaching prior to receiving SFBT training were excluded.
Potential participants who were provided training by qualified Clinical Psychologists were included and prioritised in this study. This was in order to further contribute to the evidence-base around the clinical psychologists' role of task-sharing. However, if there were an insufficient number of clinical psychologist trainers, the following trainers would also be accepted: 1. Trainee Clinical Psychologist or Assistant Psychologist delivering training under	Potential participants who were provided training by non-qualified professionals or without supervision or jointly delivered by a Clinical Psychologist were excluded. Non-qualified in this case referred to staff with no formal post-graduate qualification in a given profession (e.g. support worker, assistant).

supervision of a Clinical Psychologist. 2. Qualified non-psychology healthcare professionals delivering jointly or in collaboration with a Clinical Psychologist. Qualified in this case referred to staff with formal qualification in a given profession equivalent to or higher than a level 6 of the Framework for Higher Education Qualifications (FHEQ) within the UK National Qualifications Framework (NQF)(e.g., mental health nurses, social workers, medical doctors). No specific criteria around the trainer's SFBT experience were set.

Potential participants who attended training programmes that were40 hours or less were considered brief (Stark et al., 2018; Smith, 2011) and were thus included. This number also corresponds to the minimum annual Continuous Professional Development (CPD) requirement for maintaining relevant skills in practice (CISI CPD Policy, 2020). Potential participants who attended brief, follow-up training programmes repeatedly

Potential participants who attended training programmes that were designed to exceed 40 hours were excluded.

over time were still included despite exceeding a total of 40 hours of SFBT training attendance. This was due to the fact that the training programmes were still designed to be brief, which this study sought to investigate the impact of.

Potential participants with more than 3 months clinical experience after their first SFBT course were included. This was to ensure that staff had sufficient opportunities to attempt implementing SFBT following training.

Potential participants with less than 3 months clinical experience after their first SFBT course were excluded.

Table 3

Example of memo writing and field notes

Interview 2
Felt more confident in this review than last one, but did also feel there were some tentativeness from them around the negatives around the training and I'm wondering how much of that could be because the trainer hey had is my field supervisor. I think it was really helpful to re-iterate confidentiality and limits of it and how they could be completely honest. I think in future interviews I will re-iterate this in the introduction and how their experience (whether good or bad) would be just as relevant as it would tell us what works and doesn't (i.e. it would help regardless). This interview had some interesting reflections around the power of the service and how the any in the service focus could cause a shift in the mindset? Talked about how they felt their contractual obligations and prioritisations meant that SFT and 'exploration' was perceived as difficult to implement at times. Could maybe explore more in future interviews. Mentioned SFT as a tool as did interview 1. Non-psychology staff using SFT as a tool and need assessment skills of whether to use SFT or not as it is not applicable in all situations (and often falls outside the trained scenarios) – beneficial for training around when to use it and when not to? Might be again a difference between therapists and non-psychology staffpsychology staff– they cannot use it as a whole framework, partially because they would need many other techniques/skills but also because it might not suit the situation? Also, a clinical psychologist might not fully understand the non-specialist role and obligations and thus might be a communication barrier between the facilitator and trainee -> context of supervision being essential for psychologically trained trainees -> might be

recommendations around

Interview 2

discussing and working closely with the service managers and also the trainees. Also talking about importance of scenarios like with interview 1, would need to explore further to see if it is appreciated – avoid biased questions around this in the future – discuss in supervision, particularly difference between being biased vs. reaching theoretical saturation and using theoretical sampling to explore more of what is emergent from data. Might be possible that this might relate to future recommendations for training, how training needs to be more relevant and 'relatable' and also to communicate certain barriers for using therapy in general – dedicating a session of 'what are some barriers to prevent you from using SFT?

Non-psychology staff experience very different situations than therapists doing the sessions: nurses might respond to an urgent crisis – the expected role is not to offer therapy in this context. They then need to assess whether it would be helpful or well received. For therapists, clients often come to them and expect therapeutic input -> expectation important – theme from 2 as well -> another difference is therefore that patients coming to see a nurse do expect invasive physiological procedures but not invasive psychological procedures (e.g. questions) -> this is a huge difference.

Something around the problem having to be acknowledged first before SFT work can be done – if fixated on the problem – how can one get to the strengths? Looking for strengths and resources require a broader perspective and search – a story that contains other elements than one is used to. A child who has a medical diagnosis as well as a continuous physiological trigger would likely fixate -> potential barrier for people with little experience.
Something about patients identifying their own goals – not advice, 'doing it themselves' ->

why is this important? Also, it was mentioned that this does not always work – why? when is

Interview 2

advice, recommendations and providing solutions/answers more useful – is this outside of the SFT framework? How do people perceive something as advice and solutions vs giving people a chance to identify it themselves – is there anything that stops staff from helping clients realising it -> it was mentioned that time and some form of 'fixation' (their word) on a problem or not knowing their own goals. What about this is challenging?

Remembering that the interviews are about identifying what the trainees got from the training – this includes how they understood SFT. It could be discussed then how this understanding led to other consequences, such as how it was used or motivation etc. Their understanding of SFT and how to use it is possibly quite important.

Also seems like first impressions and reputations had an impact on interest and motivation to attend and engage in the training -> but does it have any further impact beyond this? Does it act as a buffer against poor or mediocre training or enhancing the positive experience? How much and what other factors might be involved?

Upon reflection, I think I could have asked more questions around the causes of the changes they experienced – too much focus on what the changes were and could be helpful to consider more around this in future interviews.

Table 4

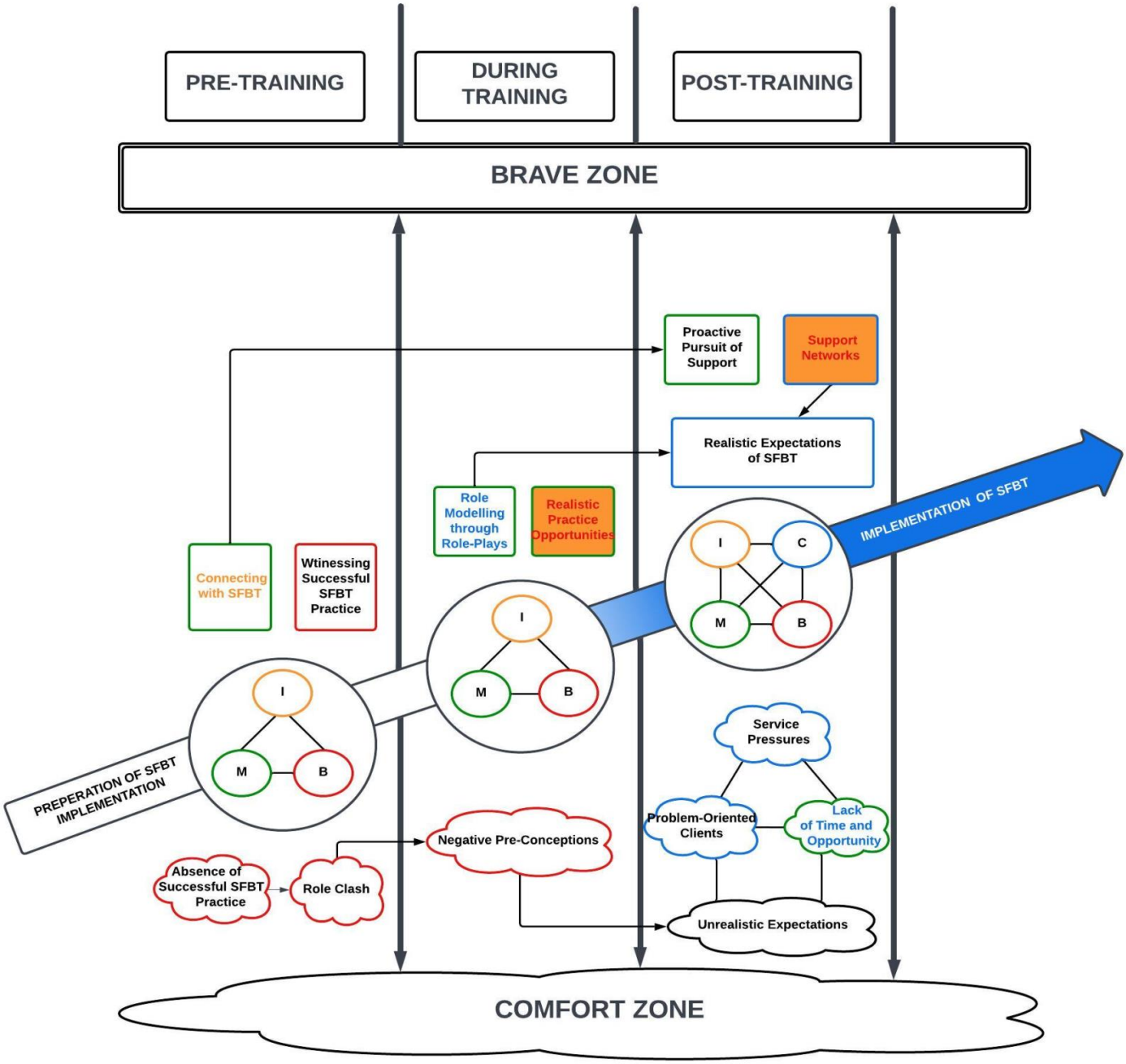
Example of how model was developed from quotes, codes, memos and theoretical categories

Participant	Data (Quotes)	Initial Codes	Focused Codes	Theoretical Codes	Memos/Notes
Interview 3	P: So the diabetes team was using it and they were quite encouraging, which *redacted* (trainer) works in. And then our *redacted* (Consultant Doctor) they are a big advocate for it. So they got into before *redacted* (trainer) even came here. They run a clinic once a week with children who come to A&E with mental health problems regularly and stuff like that. And they use solution focus in their conversations to talk with these families and stuff. So we've already got that kind of stuff going on here, yeah, which gives you a good insight. But then	Separate team being encouraging for them to use it Consultant doctor also advocating for it who also used it regularly. Feeling that other teams and colleagues using it gives the team insight about the model Trainer as an advocate as well Feeling this helped them understand how SFT would be beneficial prior to the training	Teams giving them insight into benefits of SFT before training	Positive reputation acts like evidence for people to feel more interested, which motivates them and facilitates an increased willingness to invest	Wonder if this in a way is the start of the formation of a relationship with the model or the ethos of the model where basically this represents the first impression. I am curious then about how impactful this actually is – is this shared with other staff. Will be interesting to keep in mind in future interviews but important to keep mind open as it might not be important or an influential factor for some people at all (or somewhere in between).

	also we've got - obviously, *redacted* (trainer) working here was also as a big advocate for it. So we're quite lucky in what we already had in terms of understanding how it's going to be beneficial, I suppose.				

Figure 1

Figure illustrating a chronological process model of SFBT implementation following brief training



Note. Keys: I= Interest, M=Motivation, B=Belief, C=Confidence, SFBT= Solution Focused brief Therapy. Some themes influenced more than one experiential state. This was delineated by colouring the text, background and the contours of any given box. No themes influenced all four states and thus a fourth colour coded element was not needed.

Appendix 2-A

Author Guidelines for Publication

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological and social processes that underlie the development and improvement of psychological problems and mental wellbeing, including:

• theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
• behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
• psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

- systematic reviews following replicable protocols and established methods of synthesis
- qualitative and other research which applies rigorous methods
- high quality analogue studies where the findings have direct relevance to clinical models or practice.

Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

PAPTRAP AUTHOR GUIDELINES

Sections

1. SUBMISSION

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

New submissions should be made via the **Research Exchange submission portal**. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our FAQs or contact **submissionhelp@wiley.com**.

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

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **https://authorservices.wiley.com/statements/data-protection-policy.html**.

Preprint policy:

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

2. AIMS AND SCOPE

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological and social processes that underlie the development and improvement of psychological problems and mental wellbeing, including:

• theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
• behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
• psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

- systematic reviews following replicable protocols and established methods of synthesis
- qualitative and other research which applies rigorous methods
- high quality analogue studies where the findings have direct relevance to clinical models or practice.

Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

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

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

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

Word limits for specific article types are as follows:

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

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

Please refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

Brief-Report COVID-19

For a limited time, the *Psychology and Psychotherapy: Theory, Research and Practice* are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal's main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured

(according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the authors. Appendices are included in the word limit; however online supporting information is not included.

4. PREPARING THE SUBMISSION

Free Format Submission

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

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (if you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

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

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

To submit, login at **https://wiley.atyponrex.com/journal/PAPT** and create a new submission. Follow the submission steps as required and submit the manuscript.

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

Revised Manuscript Submission

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

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

Parts of the Manuscript

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

Title Page

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

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our **Author Services** site.

Abstract

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

Keywords

Please provide appropriate keywords.

Acknowledgments

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

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

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

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the LaTex Main Document should be uploaded as a "LaTeX Supplementary File."

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.
- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Acknowledgments;
- Abstract structured (intro/methods/results/conclusion);
- Up to seven keywords;
- Practitioner Points Authors will need to provide 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;

- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below);
- Statement of Contribution.

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

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

References

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

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡,

§, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

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

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

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

Supporting Information

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

Click here for Wiley's FAQs on supporting information.

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

General Style Points

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

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

Wiley Author Resources

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

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

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

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double-anonymous) peer review. Please ensure that any information which may reveal author identity is anonymized in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, please read **the terms and conditions of submission** and the **declaration of competing interests**.

We aim to provide authors with a first decision within 90 days of submission.

Further information about the process of peer review and production can be found in '**What happens to my paper?**' Appeals are handled according to the **procedure recommended by COPE**. Wiley's policy on the confidentiality of the review process is **available here**.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)
- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **https://www.crossref.org/services/funder-registry/**

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

"Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed (APA Ethics Code Standard 8.12a, Publication Credit). Authorship encompasses, therefore, not only those who do the actual writing but also those who have made substantial scientific contributions to a study. Substantial professional contributions may include formulating the problem or hypothesis, structuring the experimental design, organizing and conducting the statistical analysis, interpreting the results, or writing a major portion of the paper. Those who so contribute are listed in the byline." (p.18)

Data Sharing and Data Accessibility Policy

Psychology and Psychotherapy: Theory, Research and Practice recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

It is not necessary to make data publicly available at the point of submission, but an active link must be included in the final accepted manuscript. For authors who have pre-registered studies, please use the Registered Report link in the Author Guidelines.

In some cases, despite the authors' best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or laws, or the nature of data gathered. In such cases, authors must inform the editors at the time of submission. It is understood that in some cases access will be provided under restrictions to protect confidential or proprietary information. Editors may grant exceptions to data access requirements provided authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

Finally, if submitting authors have any questions about the data sharing policy, please access the **FAQs** for additional detail.

Open Research initiatives.

Recognizing the importance of research transparency and data sharing to cumulative research, *Psychology and Psychotherapy: Theory, Research and Practice* encourages the following Open Research practices.

Sharing of data, materials, research instruments and their accessibility. Psychology and Psychotherapy: Theory, Research and Practice encourages authors to share the data, materials, research instruments, and other artifacts supporting the results in their study by archiving them in an appropriate public repository. Qualifying public, open-access repositories are committed to preserving data, materials, and/or registered analysis plans and keeping them publicly accessible via the web into perpetuity. Examples include the Open Science Framework (OSF) and the various Dataverse networks. Hundreds of other qualifying data/materials repositories are listed at the Registry of Research Data Repositories (**http://www.re3data.org**). Personal websites and most departmental websites do not qualify as repositories.

Publication Ethics

Authors are reminded that *Psychology and Psychotherapy: Theory, Research and Practice* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). The Journal generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**). Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county.

Note this journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley's Top 10 Publishing Ethics Tips for Authors **here**. Wiley's Publication Ethics Guidelines can be found **here**.

ORCID

As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. This takes around 2 minutes to complete. **Find more information here.**

6. AUTHOR LICENSING

WALS + standard CTA/ELA and/or Open Access for hybrid titles

You may choose to publish under the terms of the journal's standard copyright agreement, or Open Access under the terms of a Creative Commons License.
Standard **re-use and licensing rights** vary by journal. Note that **certain funders** mandate a particular type of CC license be used. This journal uses the CC-BY/CC-BY-NC/CC-BY-NC-ND **Creative Commons License**.
Self-Archiving Definitions and Policies: Note that the journal's standard copyright agreement allows for **self-archiving** of different versions of the article under specific conditions.

BPS members and open access: if the corresponding author of an accepted article is a Graduate or Chartered member of the BPS, the Society will cover will cover 100% of the APC allowing the article to be published as open access and freely available.

7. PUBLICATION PROCESS AFTER ACCEPTANCE

Accepted Article Received in Production

When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with **Wiley Author Services**. The author will be asked to sign a publication license at this point.

Proofs

Once the paper is typeset, the author will receive an email notification with full instructions on how to provide proof corrections.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process – authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt of first proof.

Early View

The journal offers rapid publication via Wiley's Early View service. **Early View** (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Before we can publish an article, we require a signed license (authors should login or register with **Wiley Author Services**). Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

8. POST PUBLICATION

Access and Sharing

When the article is published online:

- The author receives an email alert (if requested).
- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receivea publication alert and free online access to the article.

Promoting the Article

To find out how to best promote an article, click **here**.

Wiley Editing Services offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

Measuring the Impact of an Article

Wiley also helps authors measure the impact of their research through specialist partnerships with **Kudos** and **Altmetric**.

9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (**papt@wiley.com**) or phone +44 (0) 116 252 9504.

Doctorate in Clinical Psychology | Lancaster University

Chapter 3 : Critical Appraisal

Haakon Juul

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Haakon Juul

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster LA1 4AT

h.juul@lancaster.ac.uk

Critical Appraisal

Introduction

This thesis focused on the role of the clinical psychologist and the increasing expectation and responsibility to provide more indirect support to other multidisciplinary staff working in healthcare services. The literature review provides a systematic meta-ethnographic review of healthcare staff experiences of consultation provided by clinical psychologists. The review highlighted that clinical psychologists need to provide an emotionally containing space, have clear aims for the consultation, and adapt communication towards the consultees' experience, expectations and needs in order to develop trusting relationships. Particular emphasis was also put on the importance of clinical psychologists making themselves available and flexible in order to contain some of the staff members' uncertainties and anxieties that could otherwise lead to unhelpful clinician-client interactions.

Using a Grounded Theory approach, the research chapter presents a theory of how staff experience brief training in SFBT delivered by clinical psychologists. The study identified that clinical psychologists should take into account how staff bring previous experiences, pre-conceptions and expectations into the training. This is because they were found to impact future training transfer by affecting the staff members' belief in whether learning a new approach would be worth their investment. The study highlighted that clinical psychologists should provide live demonstrations of SFBT that are realistically tailored towards the specific service context, as this was found to be particularly helpful in supporting staff to use SFBT more regularly. Findings also indicated that trainers should build a solution-focused friendly environment in order to maximise adoption of the approach. This was particularly emphasised as participants often reported their peers and the team as important buffers against other systemic barriers that would otherwise cause confidence in and motivation to

use SFBT to wane over time. It was suggested that offering immediate training for newcomers as well as regular solution-focused –informed MDTs could be helpful in facilitating a supportive and encouraging team culture.

Strengths, Limitations and future considerations

Overall, the study meets the criteria produced by Charmaz (2014, p. 337-338) as requirements for a constructivist Grounded Theory research study: credibility, originality, resonance and usefulness. However, several limitations of the study were also noted. Strengths and limitations of the study will therefore be explicated using these criteria as an evaluative framework and guide throughout.

First, in terms of credibility, the data gathered are sufficient to support the claims made by the model (Charmaz, 2014). The data are based on in-depth interviews averaging around 90 minutes where analysis is based on systematic comparisons between themes and categories. This was sufficient for me to form an intimate familiarity with the data, which allowed me to identify links between the data and my arguments. The produced outcome of the analysis should also consist of enough evidence for readers to be able to refute or challenge any of such links that I have formed.

One limitation relates to the number of participants. This based on some of the literature suggesting how theoretical saturation is unlikely met by 10 participants where more participants would be necessary for saturating the constructed categories. However, the concept of saturation has been refuted by some, where the concept of theoretical sufficiency has been proposed instead. This concept supports the idea of the researcher having more flexibility to decide when they have enough data to develop strong categories that are sufficiently credible. Charmaz (2014) supports the latter approach due to the benefits of flexibility and the lack of clarity around theoretical saturation and argues that it can instead

lead to superficial analysis. To evaluate whether enough data have been collected for a comprehensive analysis, Charmaz recommended that the researcher carefully review, and possibly recode, the data to see if new leads, concepts or theories are formed. This evaluative procedure was administered throughout each level of the coding processes and no further leads were identified during the last stage of analysis.

Resonance is another domain used to evaluate quality of a constructivist Grounded Theory study (Charmaz, 2014). This principle emphasises that any constructed concepts or categories as a result of the analysis should directly represent the participants experiences (Charmaz & Thornberg, 2021). To facilitate this, I spent considerable time reviewing and comparing the data at each level of abstraction. This process particularly involved comparing higher- with lower-order abstractions in order to ensure that the conceptual model was emergent from the staff narratives. Despite this, however, the data could have been strengthened by using member-checking as an evaluate procedure to explore further resonance with the participants (Motulsky, 2021). This would also have improved the credibility of the findings by evaluating the accuracy of the analysis and conclusions made.

Furthermore, with regards to resonance, this study would have benefitted from conducting follow-up interviews (Charmaz, 2014). This would have provided staff more time and space to reflect on their original interview and for them and me to discuss and interpret my initial analysis. It would also have been beneficial to clarify any potential misunderstandings or missed opportunities that were identified after the initial interview.

With regards to originality, the current study offers novel insights into the efficacy of SFBT training by being the first Grounded Theory study to develop a comprehensive process model to predict SFBT training transfer over time. One of the key contributions from this study was that it provided a psychological explanation of how staff decide to invest in using SFBT

following a brief training programme. More specifically, it demonstrated that staff weighs up the costs and benefits in order to conclude whether an investment is worth it, as well as pointing towards important factors that influence this internal appraisal process.

For instance, staff seemed to feel that transitioning from a medical model to SFBT cost them a sense of safety by sacrificing the control they felt they had when using a familiar approach. This explanation can be a useful theoretical framework for future exploration of more resistant staff who might be more resistant to change (Berry et al., 2012). This original finding could also add to the usefulness criteria of Grounded Theory (Charmaz, 2014) by being practically useful to the every-day lives of staff by supporting clinical psychologists to be better able to engage more resistant staff by assessing their individual needs and processes. It is also interesting that this finding overlaps with the findings of the systematic review, proposing that experienced and more resistant staff might benefit from being approached differently by the clinical psychologist in order to facilitate engagement and motivation.

It is important, however, not to see these individual experiences of 'safety' in isolation, but within the context of the healthcare environment. In the results, many participants reported feeling that the systemic pressures from the service and external teams caused them to be pulled into their comfort zone and back into 'safety'. These findings speak to the many challenges that healthcare staff face at work and corresponds with the literature where staff often report experiencing high rates of burnout and chronic stress (Wood et al., 2011). It also corresponds with research that indicates that burnout and resistance to change are positively correlated (Srivastava & Agrawal, 2020), suggesting that staff are less inclined to invest in new ways of working when they present with high levels of chronic stress. However, the literature does not provide clear indications as to why this might be. This study provides a model of how they perceive learning of new approaches as a sacrifice of resources that induces a sense of anxiety and discomfort. In the light of these findings, it might be that a

stressful context changes their cost-benefit perception by increasing anxiety and thus making them less willing to make sacrifices and more in need for control that is associated with a sense of safety and comfort.

Furthermore, these studies often report that this is closely associated with feelings of anxiety, particularly in services where their clients present with behaviours that challenge or risk (Skirrow & Hatton, 2007). This also supports the usefulness domain, which can be understood as the evaluation of the transferability of the findings (Charmaz, 2014). In this case, these original findings suggest ways of future practice that could support the every-day work lives of staff working in challenging and emotive environments. It also points towards the need and benefit for clinical psychologists to be more closely integrated with healthcare services by providing opportunities for staff to feel safe and encouraged to make adaptive changes for the sake of improved care for their clients. Although this is often the role of a manager in a given service, a clinical psychologist could offer additional insight around the staff members' experiences and needs at work through formulation as well as highlight strategies to meet these needs.

Another novel finding related to this was that supervision might play less of an essential role in encouraging staff to develop more confidence in using newly learned skills and approaches than previously suggested (e.g. Hosany, 2007; Ferraz and Wellman, 2009; Rakovshik et al., 2016). It might be that once SF-friendly environments are established, staff obtain their need for encouragement and support from their peers instead, in order to feel safe enough to enter the 'brave space' to try out new approaches. The results do not suggest that clinical supervision offered on an individual basis is not helpful, but does question the benefit relative to the support provided by peers and teams. It might be that following a brief-training programme, staff mainly obtain a new mindset rather than confidence in using specific techniques, as suggested by Smith (2011), which is better facilitated by the team culture.

Developing an SFBT culture with regular reminders being provided through SF-informed MDTs and peer-support might be particularly helpful in facilitating such a mindset. This sits well with research that indicates that the more aspects of an environment that are informed in a therapeutic way, the more likely people will naturally think and behave accordingly (Street, 1997). This is not to say, however, that would replace the role of clinical supervision in relation to quality of assurance of practice or governance, however, it might suggest that the investment from the clinical psychologist into disseminating supportive functions over to the team might be a more cost-effective way for non-psychology staff to develop therapeutic skills following brief therapy training programmes.

It might also be the case that if a particular service expects staff to be able to use a comprehensive set of SFBT techniques that individual supervision might be more of a requirement. It might also be particularly useful for staff who might be more resistant to the model or struggling with the transition process from using the medical model as suggested by this study. These findings therefore highlight new avenues for research, where comparing the benefit of supervision in various team settings might be particularly helpful to provide further insight into what level of support is needed for what benefits which could ultimately improve the cost-effectiveness related to service expenditure.

These findings also add to the usefulness domain by highlighting how clinical psychologists can be more involved in making changes to staff members' work lives. Psychologists possess many competencies that make them particularly equipped to develop improved services and team dynamics (Health and Care Professions Council, 2011). In this sense they should work more closely with managers to integrate new staff into the team as well as facilitate regular team sessions in order to facilitate a cooperative culture, which is recommended in the literature (Kirkpatrick & Kirkpatrick, 2006). This interestingly overlaps with the findings from the systematic review, suggesting clinical psychologists should be more visible and

responsive in order to facilitate a sense of safety and togetherness. Psychologists could then develop some other staff to become 'mini-supervisors' or mentors with more SFBT experience who might support those with less and might relieve the clinical psychologist more of costly clinical supervision that are often provided on an individual basis.

A final finding that contributes to the study's originality was the emphasis on the need for brief training programmes to consider the processes involved in long-term change and maintenance of training transfer. For instance, several staff expressed needing regular reminders and reassurances that they were on the right track over long periods of time. Some participants also suggested their use of SFBT would plateau over time if this was not provided. Considering this was expressed both by staff who had completed training relatively recently and also after several years, suggested that staff need on-going support in order to maintain training transfer.

However, this raises a question whether there is a threshold where on-going support is less needed for staff feel confident and motivated enough to continue applying it independently. The findings in this study allude to the fact that training transfer is heavily influenced by their support network. However, this study also pointed towards how role confidence and connection with the SFBT model helped them implement SFBT in spite of poor support networks. Research has also supported how staff use SFBT even outside their professional roles (Smith, 2011), suggesting a certain change has occurred even outside the direct influence of the healthcare environment.

What is unclear, however, is what changes that staff have gained remain and what changes are lost in the long term and what factors causes them to wane over time. This study has identified several factors that clinical psychologists should be mindful of, however, points towards future research into long-term change after training. This is supported by the general

training transfer literature, arguing that there is a gap in our understanding of how training transfer is maintained, arguing that it evolves over time due to its complex dynamic between individual and context factors (Nielsen & Shepherd, 2020; Blume et al., 2019). Several recent studies have attempted to describe what the process might look like after three months (Virgili, 2015), but further studies are needed to elucidate the processes following this. As suggested by our study around role confidence, it might be that staff who have worked in services for years might demonstrate a different training transfer 'evolution' than staff working in services for only several months. Further qualitative investigations of long-term impact of brief training would be helpful to elucidate this further.

My Position in the Research Process and Personal Reflections

As a novice grounded theorist, considerable time and conscious effort was spent to ensure that I was sufficiently mindful of my philosophical positioning throughout the research project. A social constructivist stance was adopted in line with Charmaz's version of Grounded Theory (Charmaz, 2014). Constructivism as an epistemological stance challenges the idea of "truth" to be objectively measurable, and instead maintains that we are all active participants in the construction of meaning that are influenced by our own history and cultural contexts (Mills et al., 2006). As a research paradigm, constructivism emphasises the subjective interrelationship between the researcher and the participant where they are both involved in the construction of meaning (Pidgeon & Henwood, 1997). Therefore, the researcher is not seen as an objective observer, as the traditional Grounded Theory approach would suggest (Glaser & Strauss, 1967), and has to consider how the researcher might contribute to the co-construction process when interpreting the subjective experiences of the participants. The approach also differs from Glaser and Strauss' version in that the preparation for a Grounded Theory study allows more review of literature as long as any pre-conceived knowledge is managed throughout the analysis process. Throughout the project I

was mindful of my contribution in the data collection and analysis process as well as the preparation stage. This allowed me to make efforts to mitigate any influence of bias or assumptions that could have affected the results. I have described my process with regards to this below.

In relation to the preparation of the study, developing a research question using a Grounded Theory approach was challenging at first. This is because Grounded Theory generally discourages reviewing the literature before the data is collected in order to prevent pre-conceptions being formed that would otherwise interfere with construction of novel and emergent theories (Dunne, 2011; Giles et al., 2013). However, it is also appreciated that some time is needed to review the literature for the purposes of addressing the gap in knowledge in the SFBT training literature (Charmaz, 2014). This was particularly the case for me as I had limited knowledge of SFBT, especially with regards to the academic literature. I believe this was an advantage throughout my process as it meant that I had very few pre-conceived perceptions and knowledge about the topic. However, it still meant that I had to be careful when learning about the literature and I was initially uncertain about how much preparation was "enough" and what was "too much". Several strategies were applied to support myself throughout this process.

First, in order to identify how to approach the literature, I searched for academic papers that had discussed this issue and had developed recommendations around this process, specifically for a constructivistic Grounded Theory (Deering & Williams, 2020). This helped me identify the second strategy, which was to ensure a level of reflexivity at this stage, using a diary to write down any pre-conceived ideas I had about the topic. Third, the threat of bias was regularly discussed in supervision. In one particular supervision session for instance, one question that I considered including in the interview schedule was discussed and subsequently amended. The question related to the connection with the SFBT ethos and its

impact on SFBT use, which was identified coming from the literature (e.g. Cunanan and McCollum, 2006) and following the discussion was amended to fit more of a general exploration of the clients' experience of SFBT. This also leads to the fourth and final point of how I ensured that the semi-structured interview schedule was made deliberately broad in order to prevent any biased questions during the interviews.

Throughout the data collection process several challenges came up that related to the consideration of my philosophical stance. Being a novice in conducting research interviews, one of the initial challenges for me was around balancing my use of therapeutic skills, such as building rapport, and interview skills, such as asking more direct and efficient questions that would likely obtain in-depth answers with limited scaffolding. In my first interview, I noticed I spent considerable time supporting the person to feel comfortable. I also noticed my questions were often long, with me either describing the purpose of my questions, or using psychotherapeutic techniques such as active listening to demonstrate my understanding of their experience. Although this likely did improve the participant's comfort, I recognised that summarising my understanding could be more leading and induce more demand characteristics. I also noticed it cost more time, and thus could limit the amount of information I could obtain from an interviewee. Finally, I recognised that longer questions could often be less clear and could cause the participant to answer only parts of the question.

On the basis of these reflections, I was then searching for ways to maximise the data I could obtain from any given interview. Two processes were helpful in improving my interview skills. The first process was discussing this in supervision. In one of the sessions, we reviewed the recording of the interview and discussed parts of it that could have benefitted from improvement. From this discussion, we identified some question techniques that could be helpful in obtaining more information with less explanation. One such technique stems from SFBT and involves asking the participant "what difference makes the difference?"

During the interviews, this also helped me condense my questions to focus on the most important aspects of the participants' experiences of training, which helped the interviews become more efficient.

The second process that improved my interview skills was related to a coaching class that I attended as an optional module during my training. In these sessions, we would practise "cleaning up" questions in order to facilitate efficient reflective thinking. This was particularly helpful during the earlier stages as it also directed me to research around clean language (Grove & Panzer, 1989) as a coaching skill and how it could be applied to phenomenological interviewing and data coding (Linder-Pelz & Lawley, 2015, p. 161-173). What was particularly helpful was to discuss how to avoid asking too direct or too indirect questions. It was interesting that the former questioning approach was sometimes perceived as feeling "rude", causing us, as the interviewers or coaches, to feel we would be testing the recipient of the questions. These reflective and practice sessions not only helped me ask more efficient questions, they also supported me to adapt my approach to different inter-personal dynamics in order to maximise information from the interviews.

Another adaptation I made was around how I introduced and explained the purpose of the interview. Based on the interviews discussed so far, I ensured adding more reassurances around the questions and the general intent behind including that the interviews were not intended to 'test' their knowledge about SFBT. Another change was added after the second interview had expressed frustration with the trainer who was my field supervisor. In this case I reiterated the nature of confidentiality and the purpose of the interviews being to develop improved training programmes in the future. In future interviews I made sure to emphasise that any negative experiences were just as valuable and welcome as well reiterated confidentiality if there were any concerns around conflict of interest.

Finally, with regards to the interview as well as the analysis process, memo-writing and diaries were used throughout to capture my own experiences and thus also biases that could affect the data collection and analysis. One particular aspect of this was that was helpful was using field notes or "spontaneous memoing" based on Glaser's prime rule (Glaser, 1992, p. 83). This was helpful not only to prevent loss of ideas but also to note my own experience of interpersonal dynamics that could affect my interpretation of the subjective narrative of the participants. For instance, through my notes I noticed I developed an empathy for staff working in challenging contexts and their desperate need for 'answers' and support, which the SFBT model represented for many of them. I also noticed that SFBT had an overall positive narrative which I recognised impacted me and my perception. This was particularly interesting as I did not have a strong relationship with the model prior to the project. Later on, however, when I interviewed participants who had more of a critical view of SFBT, I noticed a sense of contrast and even a sense of frustration. This was particularly due to the fact that such criticism accompanied opinions around supporting clients that I personally disagreed with. However, due to recognising this change of my own perception, it was easier for me to remain curious and explore how these staff had formed such perceptions including considering what was perhaps missing for them.

Final Reflections

The process of conducting a meta-ethnography and a Grounded Theory study as a novice came with several challenges as well as opportunities for learning. Reflecting upon my philosophical disposition was relevant for both studies and gave me new insight as well as practice in how to increase my self-awareness of my own influence and contribution to every stage of the project. It was also a good opportunity to closely consider the match between the aims of my study, methodology chosen and my philosophical disposition.

It was also interesting to see overlaps between my two studies, suggesting that staff 'safety' must be particularly appreciated in order to encourage any change in challenging and emotive healthcare contexts. It also pointed towards the importance of the clinical psychologist providing some form of emotional containment in their indirect work with staff, whether it be consultation, training or supervision. For me, this finding corresponds with my own personal experiences of working as a trainee in emotive environments where the team dynamic is essential in providing a sense of safety. It has also inspired me as a future clinical psychologist to consider the impact of the work that we do in a new light and to invest more time and effort into developing and supporting systems around the staff in healthcare services.

References

Berry, K., Barrowclough, C., Innes, C., Fitzgerald, M., Hartley, S., & Haddock, G. (2012). A description and evaluation of a challenging behaviour workshop. *Journal of Mental Health, 21*, 478-484.

Blume, B. D., Ford, J. K., Surface, E. A., & Olenick, J. (2019). A dynamic model of training transfer. *Human Resource Management Review*, *29*(2), 270-283.

Charmaz, K. (2014). *Constructing grounded theory* (second ed.). Thousand Oaks, CA: Sage.

Charmaz, K., & Thornberg, R. (2021). The pursuit of quality in grounded theory. *Qualitative research in psychology*, *18*(3), 305-327.

Deering, K., & Williams, J. (2020). Approaches to reviewing the literature in grounded theory: a framework. *Nurse Researcher*, *28*(4), 9–15.

Dunne, C. (2011). The place of the literature review in grounded theory research. *International Journal of Social Research Methodology, 14*(2), 111-124. https://10.1080/13645579.2010.494930

Giles, T., King, L., & De Lacey, S. (2013). The timing of the literature review in grounded theory research: an open mind versus an empty head. *Advances in nursing science*, *36*(2), E29-E40.

Glaser, B. G., Strauss, A. L. (1967). *The discovery of grounded theory*. Aldine, New York.

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emerging versus forcing*. Mill Valley, CA: Sociology Press.

Grove, D. J., & Panzer, B. I. (1989). *Resolving traumatic memories: Metaphors and symbols in psychotherapy*. New York: Irvington Publishers Inc.

Health and Care Professions Council (HCPC). (2011). *Standards of proficiency: practitioner psychologists*. London, HCPC.

Kirkpatrick, D., & Kirkpatrick, J. (2006). *Evaluating training programs: The four levels*. Berrett-Koehler Publishers.

Linder-Pelz, S., & Lawley, J. (2015). Using Clean Language to explore the subjectivity of coachees' experience and outcomes. *International Coaching Psychology Review*, *10*(2), 161-174.

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International journal of qualitative methods*, *5*(1), 25-35.

Motulsky, S. L. (2021). Is member checking the gold standard of quality in qualitative research?. *Qualitative Psychology*, *8*(3), 389.

Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.), Doing qualitative analysis in psychology (pp. 245-273). Hove, UK: Psychology Press.

Rakovshik, S., McManus, F., Vazquez-Montes, M., Muse, Kate & Ougrin, D. (2016). Is Supervision Necessary? Examining the Effects of Internet Based CBT Training With and Without Supervision. *Journal of Consulting and Clinical Psychology, 84* (3), 191-199.

Skirrow, P., & Hatton, C. (2007). 'Burnout' amongst direct care workers in services for adults with intellectual disabilities: a systematic review of research findings and initial normative data. *Journal of Applied Research in Intellectual Disabilities*, *20*(2), 131-144.

Srivastava, S., & Agrawal, S. (2020). Resistance to change and turnover intention: a moderated mediation model of burnout and perceived organizational support. *Journal of Organizational Change Management*, *33*(7), 1431-1447.

Street, E. (1997). Family therapy training research–an updating review. *Journal of Family therapy*, *19*(1), 89-111.

Virgili, M. (2015). Mindfulness-based interventions reduce psychological distress in working adults: Meta-analysis of intervention studies. *Mindfulness, 6(2)*, 326–337. https://doi.org/10. 1007/s12671-013-0264-0

Wood, S., Stride, C., Threapleton, K., Wearn, E., Nolan, F., Osborn, D., Paul, M., & Johnson, S. (2011). Demands, control, supportive relationships and well-being amongst British mental health workers. *Social Psychiatry and Psychiatric Epidemiology, 46*(10), 1055–1068. https://doi.org/10.1007/s00127-010-0263-6

Chapter 4 : Ethics Section

Haakon Juul

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Haakon Juul

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster LA1 4AT

h.juul@lancaster.ac.uk

Lancaster University Ethics Application (FHMREC)

Faculty of Health and Medicine Research Ethics Committee (FHMREC) at Lancaster University

Title of Project: Impact of training non-psychology staff in using Solution-Focused Therapy in clinical practice

Name of applicant/researcher: Haakon Juul

ACP ID number (if applicable)*: **Funding source (if applicable):** Lancaster University

Grant code (if applicable):

***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 Trainee Clinical Psychologist

2. Contact information for applicant:

E-mail: h.juul@lancaster.ac.uk **Telephone**: 07478757021

Address: Clinical Psychology, Div. Of Health Research, Lancaster University Lancaster, LA1 4YG

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

Dr. Ian Smith, Consultant Clinical Psychologist, Research Director, Senior Lecturer at Lancaster University, supervisor

Redacted (Field supervisor)

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-t PG**, 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. Ian Smith

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**: Research Director, Senior Lecturer at Lancaster University, DclinPsy

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' n o

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

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? n o

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? n o

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? yes

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):

Solution-Focused Brief Therapy (SFBT) is a short-term, goal-oriented approach stemming from family therapy traditions that aims to build solutions by tapping into the clients' own resources and strengths in order to support the client to achieve and sustain desired behavioural change (de Shazer et al., 1986; Trepper et al., 2006). SFBT has recently garnered evidence as an effective alternative model to traditional biomedical models (Kim et al., 2019). There is also evidence that SFBT has been successfully applied by professionals without formal training in psychological therapy, however, the extent of successful application appears to vary. There is research indicating which factors influence this variance, such as agreement with the therapy philosophy, organisational culture and training style/provision, but it is unclear how they interact.

To inform future training, this study will be looking at the impact of training people who are not therapists/clinical psychologists in using SFBT within ***Redacted***. I will apply a Grounded Theory analysis to data gathered from qualitative semi-structured interviews to investigate

how trainees form views/attitudes towards SFBT following training, and how this interacts with other organisational and training factors to influence their use of the model/techniques in clinical practice.

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

Start date: 01/2022 End date 03/2023

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):

The aim will be to up to 12 (age range 18+) male and female professional non-therapist staff. Potential participants will include any staff who has undergone a brief (maximum 5 days of training) Solution Focused Brief Therapy (SFBT) training course delivered or co-delivered by a clinical clinical psychologist within ***Redacted***. Participants will be excluded if they have any formal training or accreditation in psychological therapy or have received SFBT training courses lasting more than 5 days. No further exclusion criteria have been set.

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 (e.g. adverts, flyers, posters).

Potential participants will be identified via previous training registers held by ***Redacted*** where which brief SFT training courses have already been completed. Recruitment will likely include participants from recent and older training courses provided by the service. Several training courses have been identified to recruit from, including a future 2-day training course in December 2021 consisting of 15-20 non-psychology staff, a 2-day training course completed in April/May 2021 to 15 non-psychology staff, and another 2-day training course delivered in January 2021 where approximately 15-20 staff members were trained. Which training groups that will be recruited from will depend on the success of recruitment with regards to required sample size and theoretical saturation. Earlier training courses from 2020 would also be available to recruit from if needed.

Recruitment packs, including participant information sheet, will be sent to a member of the healthcare service, who will then send this to a point of contact to request interested participants to partake in this study. The point of contact will then pass on this information and any potential participant will then be provided my direct contact details to contact me directly. This way, I will not be able to identify personal information of participants until they choose to partake in my study out of their own volition.

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

Data collection

Data will be in the form of approximately one hour long semi-structured, face-to-face, phone or virtual interviews, which will be transcribed by me from audio- or video-recordings. The interviews will be informed by previous research related to training of non-psychology staff and possibly by input from staff trained by ***Redacted***. As I will apply a constant comparative method/analysis through Grounded Theory approach, some aspects of the interview might be altered based on newly coded data in order to inform/build a theory.

I will also include two sets of questionnaires: 1) demographic information related to their profession, previous training and overall years of experience. These questions are the basis of to my inclusion/exclusion criteria and relevant information to my question around non-professionals' experience of psychological training. And 2) simple scaling questions (e.g. in the form of Likert scales) around their pre- and post-training agreement with the philosophy of SFT, their perceived benefits from training and the frequency of using SFT techniques in clinical practice following training. These questions are useful to capture important factors identified in previous research and can also inform/specify recruitment, as interviewing participants with different views could help further enrich the data, depending on participant recruitment and saturation.

Analysis

I will analyse the qualitative data from the interviews using a Grounded Theory approach with a social constructionist epistemology. I will apply line by line coding of the transcribed data initially to obtain rich data and then apply focused coding, based on research question and theory development. Constant comparative method will also be applied throughout all stages of the analysis, looking for differences/similarities between the interviews and codes. The process will be aided by on-going memo-writing and free-writing.

No statistical analysis required of the quantitative data as it will only be used to guide recruitment and subsequent analysis, and not as empirical evidence.

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.

All data, including audio/video recordings and any identifiable information of participants, will be stored on the university's password protected server on my university laptop which can be accessed from my and thus there will be no need to transport the data on USB sticks. All documents will be password protected and personal data will be kept separate from supporting data and will only be connected via use of codes (e.g. pseudonyms). I will be the custodian of the data during the duration of the project but will also be accessible to my academic supervisor until the end of my project. Following completion of the project, the data will continue to be stored on a secure university server for up to 10 years in accordance with standard guidance. A research co-ordinator at Lancaster University will be appointed custodian for the data for this time period and will be responsible for storing and deleting data, following my completion of my course.

The interview will be recorded on a digital recorder. Following each interview, the recordings will be transferred on to the university's secure server and deleted off the recorder. Direct quotations from the interviews will be used but will be anonymised and reported under pseudonyms. Opt-in forms will be destroyed once the information is no longer required. Consent forms will be scanned into electronic forms and kept on the secure server, but paper versions will then be destroyed.

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.

Documents that contain identifiable data will be password protected and stored on a secure University server. The laptop that will used throughout the project is provided through the university DclinPsy programme and is password protected and will continue to be throughout the project.

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

Digital recordings will be deleted once the data has been transcribed and the research project has completed. The digital recordings will not be kept beyond publication.

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?

Following completion of the project, the data will continue to be stored on a secure university server for up to 10 years in accordance with standard university procedures. The custodian of the data will be a newly appointed chief investigator (a research staff member at the Lancaster University) and will be responsible for storing and deleting data, following completion of my course.

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

All personal data will be kept confidential and will only be accessible to the chief investigator. However, with regards to supporting data, there is a small risk that participants can be identified, even after full anonymisation, due to the small sample size. Therefore, the data will not be shared due to the risk of anonymity being breached.

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?

Written consent will be obtained via a consent form, which will be sent to potential participants from a point of contact who will receive this from a staff member at ***Redacted*** who will again receive this from me. This will be offered a few weeks prior to recruitment. The consent form includes information relating to confidentiality, anonymity, right to withdraw, purpose of project etc (with the Participation Information Sheet). At the start of the first interview, potential participants if will be asked if they understood the contents of the recruitment pack, including consent, and will also be offered to ask any questions about this.

However, due to the small sample size, even after full anonymisation there is a small risk that participants can be identified.

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.

I am not anticipating any significant risks from this project. Participants will be informed that they may withdraw from the project at any time.

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).

As I may work where there are few or no people present, the Lancashire Trust's (LSCFT) Lone Worker policy will be followed.

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 benefit to participation in this study. However, there may be benefits to policy makers or management of services around effective delivery of training in psychological therapies in the relevant healthcare services.

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

No incentives or payments will be made 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.

All steps to ensure participants' anonymity will be taken throughout the duration of the project. Any identifiable information will be removed from the interview transcript and will be replaced by pseudonyms, which I will do myself. All data will be stored on the university's secure server and each individual document will be password protected. Personal and supporting data will be stored as separate files in separate locations within the same secure

server and be linked via codes (e.g. pseudonyms) to avoid reliance on personal data once they have been stored.

However, as direct quotations will likely be reported in the final product, confidentiality cannot be guaranteed, but will, as mentioned, be anonymised. Also, due to the small sample size, even after full anonymisation there is a small risk that participants can be identified. Therefore, data will not be shared due to risk of breach of anonymity.

As will likely be interviewed using video-conferencing, I will either use the University's WebEx or Microsoft Team system as these are the most secure. If using Microsoft Teams, participants will be informed of the fact that the internet is not secure and will be offered the option of withdrawing from the research. This information has also been included in the Participant Information Sheet.

Confidentiality will only be breached if there are any reports of significant risk to the person or others. I will have contact details of a member of staff from ***Redacted***if any risk issues arise including safeguarding concerns or worrying aspects of clinical practice. Should any participants reveal any information that indicates worrying work practices this shall be shared with the field supervisor and/or my research supervisor, both of whom are clinical clinical psychologists. If there are any imminent safeguarding concerns or risk to safety, appropriate people will be notified to ensure the risk is minimised. All participants will be made aware of this safeguarding measure prior to interviews.

Confidentiality of participation will be minimised through virtual interviews but cannot be guaranteed if interviews are on the premises. Point of contact would be aware of the participants' participation.

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

N/A

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

Plans for dissemination will primarily be an academic submission in the form of doctoral thesis. Results of the research will be submitted for publication in an academic journal. Dissemination plans also include providing feedback to ***Redacted*** that provided the

training. This will be in the form of providing the service the doctoral thesis, where results may also be presented in meetings, relevant conferences and/or training events.

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?

Whistle-blow procedure related to reports of worrying aspects of clinical practice as mentioned above. Should any participants reveal any information that indicates worrying work practices, this will be shared with the field supervisor, but may also be discussed with my research supervisor. All participants will be made aware of this safeguarding measure prior to interviews.

COVID-19 Contingency Plan: This project has been made deliberately flexible to allow alternative ways of recruitment and data collection in the event that I, my research colleagues or study participants either contract the Coronavirus or are affected by the pandemic to the point of impacting on the planned project procedures. This includes the use of video-conferencing instead of face-to-face sessions for interviews, data and materials to be sent online and minimal to no access to fieldwork sites if necessary for safety purposes.

SECTION FOUR: signature

Applicant electronic signature: Haakon Juul Date 29/11/2021

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): Dr. Ian Smith Date application discussed 02/11/2021

Submission Guidance

1. **Submit your FHMREC application <u>by email</u> 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 mark up>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>

Lancaster University Ethics Application ACP Governance Checklist

ACP Governance checklist ***ACP ref:*** *Click here to enter text.*

Introduction

Please complete all sections (1 to 4) below. If none of the self-assessment items apply to the project then you do not need to complete any additional LU ethics forms.

Further information is available from the Research a Support Office website.

Note: The appropriate ethics forms must be submitted and authorised to ensure that the project is covered by the university insurance policy and complies with the terms of the funding bodies.

Name: Haakon Juul **Department**: DClinPsy, Lancaster University

Title of Project: Impact of Training Non-psychology staff in Using Solution-Focused Therapy **Supervisor** (if applicable): Dr. Ian Smith

Section 1A: Self-assessment

1.1 Does your research project involve any of the following?

a. Human participants (including all types of interviews, questionnaires, focus groups, records relating to humans, use of internet or other secondary data, observation etc)

b. Animals - the term animals shall be taken to include any non-human vertebrates, cephalopods or decapod crustaceans.

c. Risk to members of the research team e.g. lone working, travel to areas where researchers may be at risk, risk of emotional distress

d. Human cells or tissues other than those established in laboratory cultures

e. Risk to the environment

f. Conflict of interest

g. Research or a funding source that could be considered controversial

h. Any other ethical considerations

Section 1A response: X Yes - complete Section 1B

☐ No - proceed to Section 2

Section 1B: Ethical review

If your research involves any of the items listed in section 1A further ethical review will be required. Please use this section to provide further information on the ethical considerations involved and the ethics committee that will review the research.

If your research is not being reviewed by an NHS Research Ethics Committee, any other external ethics committee or one of the Lancaster University local ethics committees (e.g Psychology Department Ethics Committee, Faculty of Health and Medicine Research Ethics Committee) then it will be considered by the University Research Ethics Committee (UREC).

UREC offers an expedited short form review for more straightforward projects and more in depth review by the full committee for projects that raise more complex issues. Further information is available from the Research Support Office website; if you are unsure of the approval route to use for your project please contact the Research Ethics Officer for advice.

Ethical approval is not required at the time the proposal is submitted, but please remember to allow sufficient time for the review process if it is awarded. The ethical review process can accommodate phased applications, multiple applications and generic applications (e.g. for a suite of projects), where appropriate; the Research Ethics Officer will advise on the most suitable method according to the specific circumstances.

1.2 Please indicate which item(s) listed in section 1A apply to this project (use the appropriate letter(s), e.g a,c,f)

Items: a, c

1.3 Please indicate which committee(s) you anticipate submitting the application to:

☐NHS ethics committee

☐Other external committee

☐LU FST REC

X LU FHM REC. As research participants will include NHS staff, I will also seek Health Research Authority (HRA) approval

☐LU FASS & LUMS REC

☐AWERB (animals)

1.4 If item (d) in section 1A (human cells or tissues other than those established in laboratory cultures) applies to your project - please confirm that you will comply with the relevant aspects of the Human Tissue Act (See here: https://www.hta.gov.uk)

☐Confirmed

Section 2: Project Information
This information in this section is required by the Research Support Office (RSO) to expedite your proposal and/or award

2.1 If a statement of institutional commitment is required by the funder (such as a letter of support from the VC or PVC Research), please indicate below and liaise with RSO as soon as possible.

☐Statement of institutional commitment required

Please note: If match funding is required please inform RSO (if you have not already done so). It is the PI's responsibility to notify their HoD that match funding is required before the costing is submitted for approval.

2.2 If the establishment of a research ethics committee is required as part of your collaboration, please indicate below. (This is a requirement for some large-scale European Commission funded projects, for example.)

☐Establishment of a research ethics committee required

2.3 If the research involves either the nuclear industry or an aircraft or the aircraft industry (other than for transport), please provide details below. This information is required by the university insurers.

Section 2 notes: Click here to enter text.

Section 3: Guidance

The following information is intended as a prompt and to provide guidance on where to find further information. Where appropriate consider addressing these points in the proposal.

- If relevant, guidance on data protection issues can be obtained from the Data Protection Officer - see Data Protection website
- If relevant, guidance on the Freedom of Information Act can be obtained from the FOI Officer - see FOI website
- The University's Research Data Policy can be downloaded here
- The health and safety requirements of each research project must be considered, further information is available from the Safety Office website
- If any of the research team will be working with an NHS Trust, consider who will be named as the Sponsor (if applicable) and seek agreement in principle. Contact the Research Ethics Officer for further information
- If you are involved in any other activities that may result in a conflict of interest with this research, please contact the Head of Research Services (ext. 94905)
- If any of the intellectual property to be used in the research belongs to a third party (e.g. the funder of previous work you have conducted in this field), please contact the Intellectual Property Development Manager (ext. 93298)
- If you intend to make a prototype or file a patent application on an invention that

relates in some way to the area of research in this proposal, please contact the Intellectual Property Development Manager (ext. 93298)
- If your work involves animals you will need authorisation from the University Secretary and may need to submit an application to AWERB, please contact the University Secretary for further details
- Online Research Integrity training is available for staff and students here along with a Research Integrity self-assessment exercise.

3.1 I confirm that I have noted the information provided in section 3 above and will act on those items which are relevant to my project.

X Confirmed

Section 4a: Statement Part 1

4.1 I confirm that while preparing this application I asked for and received advice from the following people (minimum 2 colleagues who are not closely involved with the proposal i.e. excluding staff named on the proposal)

Names: The thesis proposal and application was reviewed by the DclinPsy research team at Lancaster University.

Section 4b: Statement Part 2

4.2I understand that as Principal Investigator I have overall responsibility for the financial and ethical management of the project and confirm the following:

- I have read the Code of Practice, Research Ethics at Lancaster: a code of practice and I am willing to abide by it in relation to the current proposal
- I have completed the ISS Information Security training and passed the assessment
- I will manage the project in an ethically appropriate manner according to: (a) the subject matter involved; (b) the code of practice of the relevant funding body; and (c) the Code of Practice and Procedures of the university.
- On behalf of the institution I accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- On behalf of the institution I accept responsibility for the project in relation to the observance of the rules for the exploitation of intellectual property.
- I will give all staff and students involved in the project guidance on the good practice and ethical standards expected in the project in accordance with the university Code of Practice. (Online Research Integrity training is available for staff and students here.)
- I will take steps to ensure that no students or staff involved in the project will be exposed to inappropriate situations.

X Confirmed

Please note: If you are not able to confirm the statement above please contact Faculty Research Ethics Officer and provide an explanation

Applicant

Name: Haakon Juul Date: 05/11/2021 Signature: Haakon Juul

***Supervisor (if applicable):**

Name: Dr. Ian Smith

**I declare that I have reviewed this application, and discussed it with the applicant as appropriate. I am happy for this application to proceed to ethical review.*

Head of Department
(or delegated representative)

Name: Bill Sellwood

Please return this form to your Faculty Research Ethics Officer

Appendix 4-A

Approval from Faculty of Health and Medicine Research Ethics Committee (FHMREC)

FHM Research Ethics

To: Juul, Haakon (Postgraduate Researcher) <h.juul@lancaster.ac.uk>

Cc:

FHM Research Ethics
Thu 2022-03-10 1:41 PM

Approval of a new application

Subject: Ethics approval FHMREC ref: FHMREC21049

Dear Juul,

Thank you for submitting your research ethics application for the above project for review. The application has been reviewed by members of the FHM Research Ethics Committee and I can confirm that approval has been granted for this 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 via this email address (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 on fhmresearchsupport@lancaster.ac.uk if you have any queries or require further information.

Best wishes,
Annie

Annie Beauchamp | Research Ethics Officer (FST/FHM)
Research and Enterprise Services | Lancaster University
Contact me on Microsoft Teams (for enquiries not related to REC applications)

Appendix 4-B

Health Research Authority Approval Letter

Dr. Ian Smith
Research Director, Senior Lecturer, Consultant Clinical Psychologist
Lancaster University, LSCFT NHS Foundation Trust
Clinical Psychology
Div. Of Health Research
Lancaster University
LA1 4YG

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

Study title:	**What works? A Grounded Theory investigation into the impact of training non-psychology staff using Solution-Focused Brief Therapy.**
IRAS project ID:	**305874**
Protocol number:	**n/a**
REC reference:	**22/HRA/2073**
Sponsor	**Lancaster University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland. If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The "*After HRA Approval – guidance for sponsors and investigators*" document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- • Registration of Research
- • Notifying amendments
- • Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **305874**. Please quote this on all correspondence.

Yours sincerely,

Amber Slack

Approvals Specialist

Email:
approvals@hr
a.nhs.uk

Appendix 4-C

Local Research and Development (R&D) Approval

From: *redacted*
Sent: 17 June 2022 15:59
To: 'i.smith@lancaster.ac.uk' <i.smith@lancaster.ac.uk>; 'h.juul@lancaster.ac.uk'
Cc: *redacted* <sponsorship@lancaster.ac.uk>
Subject: FW: Smith - Haakon - are you happy for me to sign and scan loa

Dear Dr Smith

Confirmation of Capacity and Capability

Trust ref	2022/23
Chief Investigator	Dr Ian Smith
Student [if not CI]	Mr Haakon Juul
Full title	What works - A Grounded Theory investigation into the impact of training non-psychology staff using Solution-Focused Brief Therapy
IRAS	305874
REC Ref:	n/a – staff only study
HRA approval	25/05/2022
Sponsor	Lancaster University
End date	31/03/2023
Type of Study	Non Portfolio – Study involving qualitative methods only

This email confirms that *redacted* has the capacity and capability to deliver the study within the Trust.

Please find attached the Organisation Information Document signed and dated on behalf of the trust.

redacted has kindly agreed to support this study.

The trust has not agreed a specific recruitment target, however, it will aim to help you recruit as many as possible.

Due to COVID19 restrictions, If your study involves direct contact with service users/staff,/carers, you must liaise with the Divisional service contacts and follow their advice which will be based on the latest Divisional guidelines regarding any planned face-to-face contacts or visiting.

The trust agrees to start this study on Friday, 17th June, 2022.

This support is subject to the research team adhering to all statements in the IRAS application. In order to securely protect participant information and comply with Data Protection Act legislation it is vital that any personal identifiable information is held as per IRAS application. Dropbox accounts should never be used to store personal information as they do not provide adequate security and are hosted outside the European Union. Any

potential data breach must be reported immediately to the Trust. If you are unsure about using, storing or sharing information please contact the R&D team in the first instance on 0151 471 2638 for advice.

Amendments
Please note it is the CI's responsibility to ensure the R&D department is informed in a timely manner when amendments have been submitted and provided with a summary of the amendment and any updated documentation. For information regarding how to notify the trust of any amendments to your study please refer to the amendments guidance found on the HRA website: https://www.hra.nhs.uk/approvals-amendments/amending-approval

Annual monitoring
The trust asks research teams to provide annual updates for all open studies at year end (3first March). Please find attached the trust's monitoring form for completion and return.

Event reporting
You are reminded you must report any adverse event or incident whether or not you feel it is serious, quoting the study reference number. This requirement is in addition to informing the Chairman of the relevant Research Ethics Committee.

Extension
If you require any extension to the project, please inform the department. For further information regarding notification of amendments, please visit: http://www.hra.nhs.uk/research-community/during-your-research-project/amendments.

Publication
The Trust supports the publication and dissemination of study results to relevant wider audiences but requests that this be completed in a timely manner. Whilst the Trust appreciates that the time taken to analyse results and write up findings for publication can be lengthy, we request this is completed within 2 years of the end of data collection. This allows for a real time and current representation of the service which is imperative given the continuous aim of striving for *redacted* aspires to.

redacted can provide support to *Trust members* when they undertake research, evaluations or QI projects to encourage publication of your findings. Trust staff, service users and carers carrying out research commissioned by the trust or staff carrying out research for educational purposes can contact the team at *redacted* to find out how they can help you.

We look forward to working with you to successfully deliver this study.

If you wish to discuss further, please do not hesitate to contact myself or Karen.

Kind regards,

redacted
Tel: *redacted*
Email: *redacted*

Kind regards
redacted

Tel: *redacted*
redacted

The NHS Constitution pledge to all patients:
"to inform you of research studies in which you may be eligible to participate"

Appendix 4-D

Research Protocol

Project Title: Impact of training non-psychology staff in using Solution Focused Therapy

Trainee Clinical Psychologist: Haakon Juul

Research Supervisor: Dr. Ian Smith, Research Director, Senior Lecturer in Health Research, Division of Health Research, Doctorate in Clinical Psychology, Lancaster University, Lancaster

Field Supervisor: *redacted*

Introduction

Over the last few decades, strength-based approaches have gradually become more of a prominent alternative approach to the biomedical model for mental health difficulties. One such approach is Solution-Focused Therapy (SFBT), which is has been described as a short-term, goal-oriented approach that that aims to build solutions by tapping into the clients' own resources and strengths in order to support the client to achieve and sustain desired behavioural change (de Shazer et al., 1986; Trepper et al., 2006). The therapy was developed in the early 1980s and originally stemmed from a systemic family therapy tradition. However, the therapy has since expanded its use to other client groups and services and has accumulated a significant evidence-base for a range of mental health difficulties (Kim et al., 2008; Kim et al., 2019). It has also been found to be a rather flexible model, as in addition to specialist staff, non-psychology staff (i.e. with no formal training in psychological therapies) have also been successfully trained in using the model with evidence of positive outcomes (Kim et al., 2019). For instance, various qualitative reports from the perspective of non-psychology staff indicate that SFT is easy to understand and use, and generally fit with their

own personal values, as well as enhancing their professional identity (e.g. Bowles, 2001; Smith & Macduff, 2017; Smith, 2010). This personal fit, or allegiance, has been suggested to be an important factor to facilitate implementation of therapy techniques in clinical practice following training (Wampold, 2001), which has also been found for SFT (Cunanan & McCollum, 2006; Stark et al., 2014). Being able to identify an effective but also 'user-friendly' and suitable model for non-psychology staff that does not require costly and lengthy training programmes might be particularly useful as it could facilitate preventative, psychological treatments to be more widely available. This could ultimately help reduce the constraints on specialist services and effectively avoiding a 'bottleneck effect' (i.e. long waiting lists for specialist intervention) seen in mental health service provision today.

However, despite some promising results indicating SFT as an effective and flexible model to be used by non-psychology staff following brief training, research points towards various barriers that prevent the implementation of SFT techniques and principles in practice. These barriers include 1) organisational factors and culture, including lack of support from management or managerial and service pressure to apply problem-focused models (Smith, 2011), 2) training factors and provision, including lack of supervision (Smith, 2011; Hosany, 2007), and 3) personal factors, including lack of confidence and difficulty with not thinking in problem-focused ways (Simm et al., 2011), as well as disagreement with the positive and optimistic nature of the model (e.g. calling it "solution-forced") (Cunanan & McCollum, 2006). Furthermore, findings indicate that implementation is low even in the presence of reported high affiliation with SFT or intent/motivation to apply techniques in practice (Cunanan & McCollum, 2006), suggesting that these barriers play an important part in mediating the impact of brief SFT training. Despite these findings, however, details of how these factors interact are still poorly understood.

Therefore, a more thorough understanding of what factors are involved and how they interact in determining successful implementation of SFT techniques is needed. Further insight into this interaction could help guide healthcare organisations to develop more tailored training programmes that are more adaptive to individual staff perceptions and service contexts. This could then facilitate motivation, intent and opportunities to implement techniques in clinical practice and ultimately improve treatment outcomes for service users. Therefore, the aim of this study is to explore the process of how some of the internal factors (i.e. personal factors) and external factors (i.e. organisational and training factors) might interact and unfold following training of non-psychology staff, and how this interaction impacts SFT implementation.

Participants

Potential participants in the present study will encompass individuals who are employed NHS staff members who have completed a brief Solution Focused Therapy (SFT) training course (which will include how to apply SFT techniques/principles in clinical practice) provided by qualified professionals at the *redacted* physical health service. The participants will be recruited from different training courses held at different time points throughout 2020 and 2021 by the *redacted*, however, which courses will depend on the recruitment outcomes. Approximately 12 participants will be recruited. This is an approximate upper figure and it is likely to be in the range of 8-12. Recruitment will stop once theoretical sufficiency is considered to be achieved. However, due to time constraints of the project, recruitment will not exceed 12 participants even if saturation has not been reached. According to previous research using similar methodology, however, 12 participants have been demonstrated as sufficient to achieve theoretical sufficiency (e.g. Corbin & Strauss, 2015; Thickle et al., 2014).

With regards to exclusion criteria, participants should be non-therapists, and therefore should not have any formal qualification or accreditation in psychological therapies. Furthermore, staff offered training that has exceeded more than 5 full days will also be excluded. Finally, although there are no specific age restrictions, participants need to be of adult age (18+).

Design & Analysis

The project will be a qualitative design, with data being collected through semi-structured interviews. The data will be analysed using adapted Grounded Theory (GT) methodology (Charmaz, 2006; Charmaz, 2014). In accordance with Grounded Theory approach to data, the analysis will be an iterative process, with data being analysed throughout data collection, and will be using a constant comparative method to continuously compare emergent data in order to develop a theory around the research question (Charmaz, 2014). Based on this, the analysis, along with recruitment, will take place over multiple stages. In the initial recruitment stage, a few participants will be interviewed and their recordings will be transcribed and analysed by the main researcher to look for emerging themes across the interviews. Following this, the questioning within the subsequent interviews will be more focused on eliciting viewpoints and perspectives around the areas and emerging themes from the initial interviews. This study will adopt a constructivist approach that assumes that theories do not exist to be discovered but are constructed through the research process (Charmaz, 2006). Therefore, the grounded theory from the study is regarded as interpretative representation, not an objective ‘truth’.

Grounded theory is well suited to this project as it will enable the researcher to develop a theoretical model of how non-psychology staff form views of Solution Focused Therapy following training and how this interacts with organisational, personal and training factors that lead to implementation of the therapy model in clinical practice.

Materials

A semi-structured interview schedule has been developed. It includes planned interview questions as well as prompts to help the flow of the interview, though not all questions may be asked (see Sample Interview Schedule/Topic Guide). In addition, two brief screening questionnaires have been developed to be used in the study (see Screening Surveys). One screening questionnaire will contain standard questions around demographics including previous professions, education and training (formal and informal). The second screening questionnaire will include simple scaling questions around the participants' views of the training and the SFT model as well as implementation of the model following training. Both are aimed to aid the selection of relevant participants as well as subsequent analysis of data, where no quantitative analysis will be required.

Procedure

Potential participants will be identified via previous training registers held by the *redacted* where which training courses were conducted. Recruitment packs will be sent to a member of the healthcare service, who will then send this to point of contact to request interested participants to partake in this study. The point of contact person will then pass on recruitment packs to any potential participants who have previously completed SFT training via the *redacted*. Participants will then be provided contact details of the researcher in order to contact researcher directly. The recruitment pack will contain the participant information sheet, which will include information around consent, right to withdrawal, confidentiality and anonymity. Once participants have expressed interest in participating in the study, the time and date of the interview will be agreed between the researcher and participant. If necessary for reasons of convenience or participant preference, interviews will be face-to-face, and will be held at the *redacted* in pre-booked rooms. Otherwise, the interviews will be held

virtually via video conferencing, where potential participants will be provided a link to access the interview.

On the day of the interview, the participants will have the opportunity to ask any questions around the information in the recruitment packs provided previously. The researcher will again inform them of their right to consent and withdrawal before asking the participants to sign the consent form. The recruitment packs will also include opt-in forms to take home and will be able to opt-in to the study at their own time frame. The interviews are expected to last about an hour and will be digitally recorded. Following the interviews, the participant will be asked if they would consent to be interviewed a second time if required, however, they would be informed that this is voluntary.

Practical issues

Data handling and storage

All data, including transcripts of the interviews will be anonymised by the chief investigator/main researcher who will act as custodian of the data. All identifiable information will be changed or anonymised through the use of pseudonyms and stored on a secure encrypted server and the relevant documents will also be password protected. Following each interview, the recordings will be transferred on to the university's secure server and deleted off the audio or video recorder. Data accessed from the researcher's home and thus there will be no need to transport the data on USB sticks. Data in paper format, including consent forms and opt-in forms, will be scanned into electronic forms and kept on the secure server, but paper versions will then destroyed.

Personal data will be permanently deleted from the secure server following completion of the project, however, supporting data (including consent forms) will be kept stored on the secure server in accordance with Data Protection Act (1988; 2018) and Freedom of information Act

(2000). A research staff member from the Lancaster University will be allocated as new data custodian for data stored after completion of the project.

As the researcher may be conducting interviews in places where there are not many people around, or may conduct home visits, the employing trust's (LSCFT NHS Foundation Trust) lone worker and home visit policy will be followed.

Logistics of practicalities

Room bookings will be liaised with the field supervisor of the main researcher at the *redacted* if required. Considering the current impact of the on-going pandemic, however, it is likely that interviews will be facilitated using video-conferencing where virtual platforms such as the University's WebEx system or Microsoft Teams will be used. Recording of the interviews will through using a tape recorder provided by the University or Microsoft Teams.

Costs and equipment

A digital recorder, postage paid envelopes and mobile telephone can be supplied by the university. Photocopying or printing costs will be met by the university.

Ethical concerns

Although there are no anticipated risks associated with the interview or research project, participants will be reminded that they have a right to withdraw from the study at any time. Any distress will be managed in the immediacy by the researcher. The researcher will have contact details of a member of staff from the *redacted* if any risk issues arise including safeguarding concerns or worrying aspects of clinical practice. Should any participants reveal any information that indicates worrying work practices this shall be shared with the field supervisor and/or the research supervisor, both of whom are clinical psychologists. If there are any imminent safeguarding concerns or risk to safety, appropriate people will be notified to ensure the risk is minimised.All participants will be made aware of this safeguarding

measure prior to interviews. If there are any imminent safeguarding concerns or risk to safety, appropriate people or authorities will be notified to ensure the risk is minimised.

Timescale

ACTIVITY	**DATE**
Submit ethics proposal to FHMREC committee and IRAS	November 2021
Send recruitment packs to potential participants and start recruitment	February 2021
On-going recruitment	February - July 2022
Data analysis	March – September 2022
First draft of research paper	June 2022
Second draft of research paper	November 2022
Submit thesis	March 2023
Submit papers for publication	June 2023
If accepted, submit final accepted manuscript to research coordinator	September 2023

References

Bowles, N., Mackintosh, C., & Torn, A. (2001). Nurses' communication skills: an evaluation of the impact of solution-focused communication training. *Journal of Advanced Nursing, 36*(3), 347-354. doi:10.1046/j.1365-2648.2001.01979.x

Chambers, M., Gillard, S., Turner, K., & Borschmann, R. (2013). Evaluation of an educational practice development programme for staff working in mental health inpatient environments. *Journal of Psychiatric and Mental Health Nursing, 20*(4), 362-373. doi:10.1111/j.1365-2850.2012.01964.x

Cunanan, E. D., & McCollum, E. E. (2006). What works when learning solution-focused brief therapy: A qualitative study of trainees' experiences. *Journal of family psychotherapy*, *17*(1), 49-65.

Hosany, Z., Wellman, N., & Lowe, T. (2007). Fostering a culture of engagement: A pilot study of the outcomes of training mental health nurses working in two UK acute admission units in brief solution-focused therapy techniques. *Journal of Psychiatric and Mental Health Nursing, 14*(7), 688-695. doi:10.1111/j.1365-2850.2007.01161.x

Hsu, W.-S., Lin, H.-J., Sun, S.-T.M., & Chen, H.-J. (2017). The training effects of solution-focused brief counseling on telephone-counseling volunteers in Taiwan. *Journal of Family Psychotherapy, 28*(4), 285-302. doi:10.1080/08975353.2017.1297066, and comorbid depression. *Cognitive and Behavioral Practice*, *21*(4), 416-431.

Kim, J., Jordan, S. S., Franklin, C., &Froerer, A. (2019). Is solution-focused brief therapy evidence-based? An update 10 years later. *Families in Society*, *100*(2), 127-138.

Simm, R., Hastie, L., & Weymouth, E. (2011). Is training in solution-focused working useful to community matrons?. *British journal of community nursing*, *16*(12), 598-603.

Smith, S. (2010). A preliminary analysis of narratives on the impact of training in solution-focused therapy expressed by students having completed a 6-month training course. *Journal of Psychiatric and Mental Health Nursing*, *17*(2), 105-110.

Smith, I. C. (2011).A qualitative investigation into the effects of brief training in solution-focused therapy in a social work team. *Psychology and Psychotherapy: Theory, Research and Practice, 84*(3), 335-348. doi:10.1111/j.2044-8341.2010.02000.x

Smith, S., & Macduff, C. (2017). A thematic analysis of the experience of UK mental health nurses who have trained in Solution Focused Brief Therapy. *Journal of Psychiatric and Mental Health Nursing, 24*(2-3), 105-113. doi:10.1111/jpm.12365

Stark, M. D., & Bruhn, R. (2014). Practicum student experiences of solution-focused supervision: A pilot study. Retrieved from: http://www.counseling.org/knowledge-center/vistas

Wampold, B. E. (2001). The great psychotherapy debate: Models, methods, and findings. Lawrence Erlbaum Associates Publishers. *Mahwah, NJ.*

Appendix 4-E

Participant Information Sheet

Study Title: Impact of Training Non-therapists in Using Solution-Focused Therapy

My name is Haakon Juul and I am conducting this research as a student on the Clinical Psychology Doctorate programme (DClinPsy) at Lancaster University, Lancaster, United Kingdom, who is also the sponsor for this project.

What is the study about?
This study will be looking at the impact of training non-therapist staff to use Solution-Focused Brief Therapy (SFBT) in their clinical work. SFBT is a short-term therapy that aims to build solutions by focusing on the clients' own resources and strengths in order to support them to obtain their desired behavioural change (de Shazer, 1986). By interviewing the staff, I am hoping to get information about different factors that might influence how SFBT techniques and principles are used in clinical work, which may then be used to inform and improve future psychological therapy training.

Why have I been approached?
You have been approached because we want to talk to people who have previously undergone brief training in SFBT offered by the *redacted*.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part.

What are my choices about how my information is used if I take part?
You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we will not be able to let you see or change the data we hold about you.

What will I be asked to do if I take part?
If you decide you would like to take part, please email me at h.juul@lancaster.ac.uk or complete and return the opt-in letter provided in this pack. We can then arrange a convenient time and place to meet for an interview. The interview will last for about 1 hour and can be arranged to be face-to-face, online or by phone, depending on your preference. If the interview is agreed to take place online via video-conferencing, please note that the internet cannot be guaranteed to be a completely secure means of communication. Further details of the meeting arrangement will be agreed once you have expressed interest in participating in the study and completed and returned the forms included in the pack that you were provided (two brief surveys and a consent form). To return the forms, please send them to the above secure e-mail address. The forms will then be saved and stored on a secure and encrypted online University server. Any e-mail traces will be deleted once stored.

In the interview you will be asked questions about some of your thoughts and reflections around your previous SFBT training, how you feel it has or has not changed your practice and why you think this might be. There may be an option for a second interview. If you agree

to this, I will likely ask more focused questions around some of the themes or content from the initial interview. The interview will be digitally recorded.

How will we use information about you?
We will need to use information from you for this research project. This information will include your initials, name and contact details. People will use this information to do the research or to check your records to make sure the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that minimises the possibility that anyone could work out that you took part in the study.

Will my data be Identifiable?
All personal information you provide will be treated confidentially and all information collected from the interview will be anonymised. Some of your anonymous comments may be used in the final write-up of the research, which may be published in a scientific journal. The data collected for this study will be stored securely and only my research supervisor and I, as the doctoral student researcher conducting this study, will have access to this data.

- The transcribed files from the digital recordings will be stored on a secure online server at Lancaster University and will be encrypted, so that no-one other than my research supervisor and I will be able to access them during the duration of the project. Following completion of the project, all transcription files will continue to be stored on the Lancaster University secure server for 10 years and will be managed by a research co-ordinator at the University during this time. My research supervisor will also be able to access data during this time.
- Any online copies of forms or questionnaires containing identifying information will be password protected and deleted after completion of the project.
- Any hard copies of forms or questionnaires will be scanned and transferred to a secure online server at Lancaster University and will be password protected. Following this, any original hard copies will be destroyed.
- 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, are at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

Finally, it is worth noting that the Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study (see below for contact details of doctoral student).

Where can you find out more about how your information is used?
You can find out more information about how we use your information:

- at www.lancaster.ac.uk/research/data-protection for further information about how Lancaster University processes personal data for research purposes and your data rights
- at www.hra.nhs.uk/information-about-patients/
- by asking one from the research team, which in this case would be me, the doctoral student researcher, by sending an e-mail to h.juul@lancaster.ac.uk

What will happen to the results?
The results will be summarised and reported as a thesis as part of my clinical psychology training at Lancaster University, and will be submitted for publication in an academic or professional journal. The results of my research will also be shared with the services that provided the training and took part in the study and may be also be disseminated via relevant conferences and/or training events.

Are there any risks?
There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher 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 for you 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 and the NHS Health Research Authority.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact myself as the doctoral student researcher conducting this study:

Haakon Juul
Trainee Clinical Psychologist
h.juul@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 Bill Sellwood
Programme Director
Doctorate in Clinical Psychology
Division of Health Research
Furness Building
Lancaster University
LA1 4YG

If you wish to speak to someone outside of the Clinical Psychology 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

If you feel worried or upset after the interview, please talk to your line manager, or someone within the service that you feel comfortable talking with. If this is not possible, you could also contact one of the resources listed below.

- Your local
- For anonymous support contact the Samaritans
- Confidential support for people experiencing feelings of distress or despair. Phone: 08457 90 90 90 (24-hour helpline)

Website: www.samaritans.org.uk

Appendix 4-F

Participant Consent Form

Title of Project: Impact of Training Non-therapists in Using Solution-Focused Therapy

Before you consent to participating in the study we ask that you read the participant information sheet and initial each box below if you agree. You can choose whether you want to complete and send this consent form in writing or digitally. Contact details can be found on the opt-in form within this pack. If you have any questions or queries before signing the consent form please speak to the doctoral student researcher, Haakon Juul, or any of the people identified on the participant information sheet.

Please tick each statement:

I confirm that I have read the information sheet V and fully understand what is expected of me within this study. ☐

I confirm that I have been able to ask questions about the study and these answered in a way that I understand and am happy with. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time up until publication without giving any reason. However, I also understand that it may not be possible to withdraw all of my data from the study after the interview, as it may have been pooled with data from other participants at this point, though every attempt will be made to extract my data. ☐

When in the interview, I understand that I can also refuse to answer a question and ask to stop taking part at any time without having to give an explanation. ☐

I understand that my interview will be audio or video recorded and then made into an anonymised written transcript. ☐

I understand that audio/video recordings will be kept until the research project has been completed. ☐

I understand some anonymised quotes and information from my interview may be used in reports and academic papers as well as relevant conferences and/or training events. ☐

I understand any information I give, apart from anonymised quotes referred to above, will remain confidential and unless it is thought that there is a risk of harm to myself or others, in which case the doctoral student researcher conducting the interviews will need to share this information with his field supervisor and/or research supervisor, both of whom are qualified clinical psychologists. ☐

I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has been completed. ☐

I consent to take part in the above study.

Name of Participant _____

Signature _____

Date (day/month/year) _____

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Name of Researcher taking consent_____

Signature_____

Date (day/month/year)_____

One copy of this form will be given to the participant and the original will be scanned and kept by the doctoral student researcher as a file on a secure server at Lancaster University.

Appendix 4-G

Semi-structured Interview Schedule

The schedule may be changed based on feedback following the initial interviews. Other questions may be asked in the interview if more detail or clarification is required. Additionally, due to the method of analysis, potential subsequent set of interviews may follow a different schedule, based on themes that develop from the initial interviews.

Topic 1: Training

- What was your overall experience with the training?
  - What did you like the most about it?
  - What did you like the least about it?
  - What do you think worked/did not work – most or least helpful?
  - What would you change about the training to improve it and why?
- You indicated in the survey that the training was good/less good – why?
  - Did the training help you feel motivated/confident using SFBT and if so, how?

Topic 2: SFBT

- What are your thoughts of SFBT and what it is trying to achieve?
- You indicated in the survey that you liked/disliked the SFBT model, what do you like/dislike?
- Is there anything about the SFBT model you particularly agree or disagree with? If so, what and why?
- What were your first impressions of the SFBT and what is it now?
  - If it changed, why do you think so? And what helped change your view?
- Do you feel SFBT fits your role or not?
  - Why or why not?

Topic 3: Using SFBT

- What was helpful or unhelpful to help you use of SFBT in your practice?
  - Were there any barriers to you using it in your practice? Anything mentioned already about your view of SFBT, the training, the workplace, anything else?
  - If so, how would you it impacted on your use of SFBT?
  - Anything with SFBT that were easier/harder to use in practice than others and why? Techniques, principles or general approach?
- How did you use SFBT at the start and what were the initial challenges vs. how you used it later and what were the later challenges if any?
- Do you think your view of SFBT had an impact on how or whether you would use it in practice?
- Do you have any experience using any other therapy modalities?
  - If so, what were the challenges applying this model compared with SFBT?
  - What did you like/dislike about this model compared with SFBT?

Topic 4: Change

- Do you think that the SFBT training changed you and/or your clinical work/approach?
  - If not, why?
  - In what way? Prompts: personal and professional identity, ways of working, approach to staff or clients, skills and competencies, perception and attitudes.
  - How did the change start and progress?
  - What helped this change throughout?
  - Was this change easy or difficult – why/why not?
  - Were there any times change was harder – why?
  - What did you think and what do you think now about this change?
  - Would you describe these changes as important to you?
- Do you think the training and the process after training changed anything else?
  - Prompts: changes to workplace, clients or staff?
- Specific moments during or after training you realised any change?
  - Yes, when and what was this point?
  - No, then how did it happen? If it was gradual, how did you know change had occurred?
- Was there anything about the training that changed your view of SFBT?
  - Did you change your view of SFBT over time, why or why not?

Topic 5: Potential follow-up questions

- What was that like? How did/does it feel?
- How did/does that impact on you?
- Why was that important?
- What do you mean by…?
- Can you say anymore about that?

Appendix 4-H

Participant Screening Surveys

Please see and complete the two surveys below: a demographic survey and a survey containing statements about the Solution-Focused Brief Therapy (SFBT) training you have completed previously.

Demographic Survey

Please answer each question with information you are comfortable with. Each Yes/No question can be responded by highlighting the correct response or writing the correct response next to it.

- How old are you?

  _____

  What is your current occupation?

  _____

  What service do you currently work in?

  _____

  Have you completed or are you currently completing training to be a qualified or accredited psychological therapist/counsellor (e.g. psychotherapist, counsellor, clinical psychologist, forensic psychologist)?

  Yes/No

- If you have or are currently completing training in psychological therapy/counselling, but are not accredited or qualified therapist/counsellor, please state either your highest

level of training (e.g. Level 3 diploma in counselling) or which year you are in your postgraduate education (e.g. first year DClinPsy).

_____

Have you attended any additional SFBT training courses before the most recent one you attended? Yes/No

- If yes to the above, how many?

_____

Have you attended any training courses in other psychological therapies before (e.g. Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), psychodynamic therapy, etc.)?

Yes/No

- If yes to the above, which one(s)?

_____

SFBT Training Survey

Please rate the extent you agree/disagree with each statement by ticking or putting an 'X' in the appropriate box next to each statement.

Statement:	Strongly Disagree	Disagree	Somewhat Disagree	Undecided	Somewhat Agree	Agree	Strongly Agree
I thought the SFBT training was of good quality							
I came from the training feeling motivated using							

SFBT in my work							
I came from the training feeling confident using SFBT in my work							
I like the SFBT model							
I sometimes find it difficult to use SFBT in my work							
I use SFBT regularly in my work							
SFBT training changed my practice in a good way							

Appendix 4-I

Covering Letter

Dear Potential Participant,

My name is Haakon Juul and I am a doctoral student in clinical psychology at the University of Lancaster. I am currently conducting a study where I will be looking at the impact of training non-therapist staff in Solution-Focused Brief Therapy (SFBT) and what has been helpful or unhelpful when using Solution-Focused therapy in clinical work after training. You have been given this pack as you have previously completed a training course in SFBT offered by the clinical psychology team at *redacted*, and I would be very interested in hearing your experience.

Within the pack you will find a participant information sheet which explains a bit more about the research project as well as two brief surveys, a consent form and an opt-in form with a postage paid envelope. If you are interested in taking part in the study then you can either e-mail me directly or fill in your details on the opt-in form and post it to me (see contact details in participant information sheet). I will then contact you to answer any questions and arrange a time we can meet.

Thank you for taking your time to read this letter.

Yours sincerely,

Haakon Juul

Trainee Clinical Psychologist

Lancaster University

Appendix 4-J

Integrated Research Application System (IRAS) Application Form

IRASProject Filter

WelcometotheIntegratedResearchApplicationSystem

Please enter a short title for this project (maximum70characters) Impact of training non-psychology staff in using Solution-Focused Therapy

1.Is your project research?

(●) ( )

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

2.Selectonecategoryfromthe list below:

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

( ) Clinical trial of an investigational medicinal product

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

( ) investigation or other study in a medical device

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

( ) Basic science study involving procedures with human participants

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

(●) Study involving qualitative methods only

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

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

( ) Research tissue bank

( ) Research database

( )

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

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

[✓] England

a) Does the study involve the use of any ionizing radiation? ○Yes ◉No

b)Will you be taking new human tissue samples(or other human biological samples)? ○Yes ◉No

c)Will you be using existing human tissue samples (or other human biological samples)? ○Yes ◉No

☐ Scotland Wales
☐ Northern Ireland
☐

3a.Inwhich countryoftheUKwilltheleadNHSR&Dofficebe located:

◉ England
○ Scotland
○ Wales
○ N Ireland
○

4.Which applications do you require?

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

Mostresearchprojects requirereviewbya RECwithinthe UKHealthDepartments' Research EthicsService.Is your study exempt from REC revie

◉ Yes ○ o

4b.Please confi hereason(s) y thepr ctdoes require re ewby aREC hin theU alth Departments Re rch Ethics Service:

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

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

◉ Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out the research e.g. NHS support costs) for this study provided by a NIHR Biomedical Research Centre (BRC), NIHR Applied Research Collaboration (ARC), NIHR Patient Safety Translational Research Centre (PSTRC), or an NIHR Medtech and In Vitro Diagnostic Co-operative (MIC) in all study sites?

Please see information button for further details.

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

○ Yes ◉ No

Please see information button for further details.

○ Yes ◉ No

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

IfyouselectyestothisquestioninformationfromyourIRASsubmissionwillautomatically besharedwiththeNIHR CRN.

SubmissionofaPortfolioApplicationForm(PAF)isnolongerrequired.

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

○ Yes ◉ No

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

○ Yes ◉

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

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

○ Yes ◉ No

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

◉ Yes ○ No

Please describe briefly the involvement of the student(s):

The doctoral student will be the main researcher and their research supervisor will be the chief investigator.

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

◉ Yes ○ No

10.Willthis researchbe financially supported by the UnitedStates DepartmentofHealthandHumanServicesorany of its divisions, agencies or programs?

11.Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project

○ Yes ◉ No

(includingidentificationofpotential participants)?

◯ Yes ◉ No

Chapter 5 IntegratedResearchApplicationSystem

ApplicationFormforResearchinvolvingqualitativemethodsonly

IRASForm(projectinformation)

Pleaserefer totheE-Submission andChecklisttabs for instructionsonsubmittingthis application.

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

Pleasedefine anyterms oracronyms that might notbe familartolay reviewers ofthe application.

Shorttitleandversionnumber: (maximum70 characters -thiswill be inserted as headeronallforms) Impact of training non-psychology staff in using Solution Focused Therapy

Pleasecompl[illegible]these d[illegible]ilsafteryo[illegible]ave b[illegible]edthe RECapplic[illegible]ionfor review.

RECName:
22/HRA/207

RECRefere[illegible]eNumbe[illegible]:
Non-RECStudies:England

Submi[illegible]on date:
13/05/2022

PART A: Core study information

1.ADMINISTRATIVEDETAILS

A2-1.Educationalprojects

A1.Fulltitleoftheresearch:

What works? A Grounded Theory investigation into the impact of training non-psychology staff using Solution-Focused Brief Therapy

Academicsupervisor1

Name and contact details o facademic supervisor(s):

	TitleForename/InitialsSurname
	Dr.Ian Smith
Address	Clinical Psychology
	Div.OfHealthResearch
	Lancaster University LA1
PostCode	4YG
E-mail	i.smith@lancaster.ac.uk
Telephone	

Pleasestatewhichacademic supervisor(s)has responsibilityfor whichstudent(s):

Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are

Student(s)	Academicsupervisor(s)

A copy of a current CV for the student and the academic supervisor (maximum2 pages of A4) must be submitted with the application.

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

- ○ Student
- ◉ Academic supervisor
- ○ Other

A3-1.ChiefInvestigator:

	TitleForename/InitialsSurname
	Dr.Ian Smith
Post	ResearchDirector,SeniorLecturer,ConsultantClinicalPsychologist
Qualifications	DclinPsyMAinSolutionFocusedBriefTherapy
ORCID ID	
Employer	LancasterUniversity/LSCFTNHSFoundationTrust Clinical Psychology
	Div.OfHealthResearch
Post Code	LancasterUniversity,LA1 4YG
WorkE-mail	i.smith@lancaster.ac.uk
* PersonalE-mail	
Work Telephone	
* Personal Telephone/Mobile	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*

Acopy of a current CV (maximum2 pages of A4) forthe Chief Investigatormustbesubmitted with the application.

A4.Whoisthe contactonbehalfofthe sponsorforall correspondencerelating toapplicationsforthis project?

Thiscontactwill receivecopies ofallcorrespondencefromRECandHRA/R&Dreviewersthat issent tothe CI.

	TitleForename/InitialsSurname
	MsBecky Gordon
Address	HeadofResearch Quality andPolicy
	LancasterUniversity
	Lancaster
PostCode	LA1 4YT
E-mail	sponsorship@lancaster.ac.uk
Telephone	0000000
Fax	0000000

A5-1.Researchreferencenumbers.*Pleasegiveanyrelevantreferencesforyour study:*

Applicant's/organisation's own referencenumber,e.g.R& D(if available):	n/a
Sponsor's/protocolnumber:	n/a
Protocol Version:	1
ProtocolDate:	11/10/2021
Funder's referencenumber (enterthereferencenumber orstatenot Project	
website: n/a	

Ref.NumberDescription	Reference Number
n/a	n/a

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

A5-2.Isthis applicationlinkedto apreviousstudyoranothercurrent application?

◯ Yes ◉ No

Please givebrief details and reference numbers.

2.OVERVIEW OF RESEARCH

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

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

This project will be looking at the impact of training people who are not therapists using Solution Focused Brief Therapy (SFBT) within *redacted*. It will apply a Grounded Theory (GT) analysis to data from qualitative semi-structured interviews to investigate how trainees form views/attitudes towards the SFBT philosophy following training and howthis interacts with their use of SFBT. It will also explore barriers that might prevent successful implementation of the model in clinical practice, and thus will explore the relationship between internal and external factors and how this dynamic predicts implementation of SFBT in practice.

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

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

Potentialparticipants will be able towithdrawfromthestudy at any pointthroughout the process of theproject. Ifthis

were to be the case, every effort to remove their data from the results will be made. However, due to the type of analysis this may not always be possible after the results have been analysed (e.g. for instance the final results and conclusions). Potential participant will be made aware of this in the participant information sheet and consent form.

At the start of each interview, the participant will be offered an opportunity ask any questions around the participant information sheet, consent form or any other details about the project, which will then be answered. They will also be reminded of their right to withdraw. At the interview, the participant will be asked to sign a consent formto demonstrate that they are providing informed consent, if they have not already done so.

All steps will be taken to ensure anonymity throughout the duration of the project. Any identifiable information will be removed from the interview transcript and will be replaced by pseudonyms. All data will be stored on the university's secure server where documents will be password protected. All personal data will be kept confidential and will only be accessible to the chief investigator and doctoral student researcher. However, with regards to supporting data, there is a small risk that participants can be identified, even after full anonymisation, due to the small sample size. Therefore, data will not be shared due to risk of breach of anonymity.

Any digital recordings will be transferred to the secure service and deleted fromthe digital recorder. The recordings will also be deleted once the data has been transcribed and the research project has completed and/or published. Digital recordings will not be kept beyond project completion or publication.

Confidentiality will only be breached if there are any reports of significant risk to the person or others. The doctoral student researcher leading the project will have contact details of a member of staff from the *redacted* if any risk issues arise including safeguarding concerns or worrying aspects of clinical practice. Should any participants reveal any information that indicates worrying work practices, this shall be shared with the field supervisor and/or the research supervisor of the doctoral student researcher, both of whom are clinical psychologists. If there are any imminent safeguarding concerns or risk to safety, appropriate people will be notified to ensure the risk is minimised. All participants will be made aware of this safeguarding measure prior to interviews.

3.PURPOSEANDDESIGNOFTHERESEARCH

A7.Selecttheappropriatemethodology description forthisresearch.*Pleasetick allthat apply*:

- ☐
- ☐ Caseseries/casenotereview Case
- ☐ control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐
- ☐ Database analysis Epidemiology Feasibility/pilotstudy Laboratory study Metanalysis Qualitative researc
- ☐ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☑
- ☑ Other (please specify).
- ☐ Nothing further to add.
- ☐

A10.Whatisthe principalresearchquestion/objective?*Please putthisinlanguage comprehensibletoalay person.*

The principal objective for this project is to develop an understanding and a theory of the process of change following SFBT training, looking at what factors influenced the non-psychology staff who were trained to apply SFBT techniques in their clinical work.

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

N/A

A12.Whatisthe scientific justification for the research?*Pleaseput thisinlanguagecomprehensible toalay person.*

Over the last few decades, strength-based approaches have gradually become a popular, alternative approach to the biomedical model for mental health difficulties. Solution-Focused Brief Therapy (SFBT) has gained evidence as an effective, but also cost-effective, strength-based approach used in treating a range of mental health difficulties (Kimet al., 2008; Kim et al., 2019). It has also been found to be a flexible model, as in addition to therapists, non-therapists have also been successfully trained in using the model with evidence of positive outcomes (Kim et al., 2019). For instance, many qualitative reports show that the SFBT model are easy to understand and use, and generally fit with their own personal values, as well as enhancing their professional identity (Bowles, 2001; Smith, 2010; Smith & Macduff, 2017). This personal fit, or 'allegiance' (Wampold, 2001), with the model has been reported in qualitative SFBT research (e.g. Smith, 2010; Bowles et al., 2001), and has been suggested to be important for the success behind SFBT training and use. Being able to identify an effective but also 'user-friendly' model for non-therapists that does not require costly and lengthy training programmes might be particularly useful as it could make psychological treatments more widely available. This could ultimately help reduce the constraints on specialist services and effectively avoid a 'bottleneck effect' (i.e. long waiting lists for specialist treatment) seen in mental health service provision today.

However, despite some promising results from research, there has also been reported variety of barriers that appears to stop people from using SFBT in practice. Some examples of barriers reported include; lack of supervision, managerial and service pressure to use problem-focused models, lack of confidence, difficulty with not thinking in problem-focused ways, as well as some disagreeing with the positive and optimistic nature of the model (e.g. Cunanan&McCollum,2006;Smith,2011).

Therefore, a more detailed understanding of what factors are involved and how they interact in determining successful use of SFBT techniques is needed. Further insight into this interaction could help guide healthcare organisations to develop more tailored training programmes that are more adaptive to individual staff perceptions and service contexts. This could then help increase motivation, intent and opportunities to use techniques in clinical practice and ultimately improve treatment outcomes for clients. Therefore, the aim of this study is to explore the process of how some of the internal factors (i.e. personal factors) and external factors (i.e. organisational and training factors) might interact and unfold following training for non-psychology staff, and how this interaction impacts use of SFBT.

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

Data will be obtained from about one hour long semi-structured interviews with a variety of non-therapists trained in SFBT by the *redacted*. Potential participants will be contacted by a staff memberfrom*redacted*(field supervisorof doctoral student researcher)by sending out e-mails viaan e-mail list of potential participants that has been provided by a point of contact who will then ask anyone interested to participate. Each potential participant will be sent a recruitment pack, which will all include a participant informationsheet,consentformandtwosurveys.Participantswillbeabletoaskquestionsaroundanydocumentseitheratthe start of the interview or by contacting the doctoral student researcher directly. Contact information will be provided in the participant information sheet.

The aim is to recruit up to 12 participants from SFBT training courses offered by the *redacted* at different time points in 2021, as well as 2020 if needed. The number of training courses to recruit from will depend on the recruitment outcome. A number of around 12 participants is considered a realistic number based on the number of applicable staff, and should be sufficient to achieve theoretical saturation.

The project will be a qualitative design, with data being collected through semi-structured interviews. The data will be analysed using adapted Grounded Theory methodology (Charmaz, 2006; Charmaz, 2014). In accordance with Grounded Theory approach to data, the analysis will be an iterative process, with data being analysed throughout data collection where
a constant comparative method will be used to continuously compare new data in order to develop a theory around the research question (Charmaz, 2014). Based on this, the analysis, along with recruitment, will take place over multiple stages. Intheinitialrecruitment stage,afew participantswillbeinterviewed andtheir recordingswill betranscribed and analysed by the doctoral student researcher to look for emerging themes across the interviews. Following this, the questioning within the subsequent interviews will be more focused on eliciting viewpoints and perspectives around theareasand emerging themesfromthe initialinterviews.

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

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

Givedetails ofinvolvement,orifnone please justifytheabsenceofinvolvement.

As this is a project investigating staff experiences, staff members have been approached and consulted with regards to the design of project materials including participant information sheets.

4.RISKSANDETHICALISSUES

RESEARCHPARTICIPANTS

A 15.What is the sample group or cohort to be studied in this research?

- [ ] Selectall at apply:
- [ ]
- [ ] Blood
- [ ] Cancer
- [ ] Cardiova ular
- [ ] CongenitalDisorders
- [ ] DementiasandNeurodegenerativeDiseases Diabetes
- [ ] Ear
- [x] Eye
- [ ] GenericHealthRelevance Infection
- [ ] InflammatoryandImmuneSystem
- [ ] Injuries and Accidents
- [ ] Mental Health
- [ ] MetabolicandEndocrine
- [ ] Musculoskeletal
- [ ] Neurological
- [ ] OralandGastrointestinal
- [ ] Paediatrics
- [ ] Renal and
- [ ] UrogenitalReproductiveHealthand
- [ ] Childbirth Respiratory
- [ ] Skin
- [ ] Stroke

Gender:	Maleandfemaleparticipants
Lower age limit:18	Years
Upperagelimit:1000	Years

A17-1.Pleaselisttheprincipalinclusioncriteria(listthemostimportant,max5000characters).

The participants should be employed professionals that have completed a brief training course in Solution Focused Therapy including how to apply techniques/principles in clinical practice. Training should be completed at least in part by qualified professionals

A17-2.Pleaselisttheprincipalexclusioncriteria(listthemostimportant,max5000 characters).

The participants should not have any formal qualification or accreditation in psychological therapy. Staff offered training that has exceeded more than 5 full days of training will be excluded

RESEARCHPROCEDURES,RISKSANDBENEFITS

A18. Give details ofallnon-clinicalintervention(s)orprocedure(s)thatwillbereceived byparticipants aspartofthe research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Pleasecompletethecolumnsforeachintervention/procedureas follows:

1. Total number of interventions/procedures to be received byeach participant as part of theresearch protocol
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine
3. Average timetakenperintervention/procedure(minutes,hoursor days)
4. Details ofwhowill conductthe intervention/procedure,and wherethe itwill take place.

Intervention or procedure				
Answering any questions from participants regarding recruitment pack documents and signing consent form	1	N/A	10	The doctoral student researcher will ask for consentprior tothe interviewifnotalready given via the recruitment pack.
Interview	1-2	N/A	60-90	Thedoctoralstudentresearcherwillconductthe interview
Debrief	1	N/A	5	Thedoctoralstudentresearcherwill debriefthe participant following the interview

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

It is estimated that the participant will be in the study about 60 (up to 90) minutes for the interview and approximately 6 weeks between interviews, if there are second interviews.

A22.Whatarethepotentialrisksandburdensforresearchparticipantsandhowwillyouminimisethem?

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

Although therearenoanticipated risks associated with the interviewor researchproject,participants willbe reminded that they have a right to withdraw from the study at any time. Any distress will be managed in the immediacy by the doctoral student researcher. The researcher will have contact details of a member of staff from *redacted*

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

○ ◉

A24.Whatisthepotentialforbenefittoresearch participants?

No anticipated benefits forparticipantsin this study.

A26.Whatarethepotentialrisksfortheresearchersthemselves?*(ifany)*

The doctoral student researcher may be conducting interviews in places where there are not many people around, or may conduct home visits (although steps will be taken to minimise the need for conducting home visits). Therefore, the employing *redacted* and the University's (Lancaster University) lone worker policy will be followed.

RECRUITMENTANDINFORMEDCONSENT

In this sectionwe ask youtodescribe the recruitmentprocedures forthe study.Pleasegive separate details for different study groups where appropriate.

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

Potential participants will be identified by a point of contact from previous training registers held by *redacted* where which training courses were conducted.

At the start of the recruitment process the doctoral student researcher will provide inclusion criteria as well as recruitment packs for potential participants to the *redacted* who is also the fieldsupervisor tothedoctoralstudent researcher. Asan appointedpointof contact, they will then send this information to any potential participants identified on the training registers and will then request interested participants to partake in this study. Theye will then pass on this information to the potential participants who will also be provided contact details of the doctoral student researcher and will then be able to contact them directly if interested in partaking in the study. This is to avoid that any information from the training registers are passed on to the doctoral student researcher.

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

◉ Yes ○ No

Please givedetailsbelow:

As stated above, for this project, the appointed point of contact at the*redacted* will screen registers and send invites to potential participants. Therefore, the doctoral student researcher will not review nor have access to any identifiable personal details of participants until after they have expressed interest in partaking in the study out of their own volition. The potential participants in this study will involve professional staff and not service users or patients.

A27-3. Describe what measures will be taken to ensure there is no breach of any duty of confidentiality owed to patients, service users or any other person in the process of identifying potential participants.*Indicate what steps have been or will be taken to inform patients and service users of the potential use of their records for this purpose. Describe the arrangements to ensure that the wishes of patients and service users regarding access to their records are respected.*

Pleaseconsultthe guidancenotes onthistopic.

As above, the doctoral student reseracher nor the chief investigator will have access to staff records containing identifiable information. Consent forms and information about the project, including information about informed consent and right to withdraw from the study will be provided to the potential participant prior to any contact being established between the doctoral student researacher and potential participant. This way, the doctoral student researcher and chief investigator will not

A27-4. Will researchers or individuals other than the direct care team have access to identifiable personal information of any potential participants?

○ Yes ◉ No

A28.Willanyparticipantsberecruitedbypublicitythroughposters,leaflets,advertsorwebsites?

○ Yes ◉ No

A29.Howandbywhomwillpotentialparticipantsfirstbeapproached?

As stated above, for this project, the appointed point of contact at the *redacted* will send invites to the potential participants and request participation in the study along with the recruitment packs, all via e-mail. In the e-mail, the point of contact will request any interested participant to contact the doctoral student researcher directly, where the recruitment packs contains the relevant contact information of the doctoral student researcher. Once contact is established, the doctoral student researcher will request the potential participant to complete the consent form and screening surveys and for them to be sent back to the doctoral student researcher. Once the documents have been completed, the doctoral student researcher will then confirm their participation in the study and will propose a time for an interview.

A30-1.Willyouobtaininformedconsentfromoronbehalfofresearchparticipants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (e.g. written information sheet, videos, or interactive material).

Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section

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

At the start of the interview, participants will be provided an opportunity to ask any questions about the content of the recruitment pack including the consent form. The researcher will then ask the participant to sign the consent form, if they have not already done so.

Pleaseenclose acopy ofthe informationsheet(s)andconsentform(s).

A30-2.Willyourecordinformedconsent(oradvicefromconsultees)in writing?

◉ Yes ○ No

A31.Howlongwillyouallowpotentialparticipantstodecidewhetherornottotakepart?

Participants will be given opt-in forms to take home and will be able to opt-in their own time frame up until the recruitment target has been met or the recruitment process has been closed as they would not be able to take part after this point.

A33-1.Whatarrangementshave beenmade forpersons whomightnot adequately understandverbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Participants will be staff who are required to speak proficient English for employment purposes, so it is not expected that an

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

- ○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- ○ Theparticipant wouldbewithdrawnfromthe study.Identifiable dataortissuealready collectedwithconsentwould be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- ○ The participant wouldcontinue tobeincluded inthestudy.
- ◉ Not applicable– informed consent will not be sought from any participants in this research.

  Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

Due to the nature of the demographic and population of participants involved in this study, capacity will be assumed as there would be no reasons or evidence to assume otherwise and therefore will not be monitored proactively. However, should it come to the attention of the doctoral student researcher that there has been a loss of capacity, he will consult with the research and field supervisor at the earliest opportunity to minimise any consequences around ongoing participation.

CONFIDENTIALITY

In this section, p onal data m s anyd relatin a participanty oc d potentially dentifie d. Itincludes p donymised data capable of being ked to a part ant th ique code num er.

Storageanduseofpersonal aduringth udy

A36. Will yoube undertakinganyof thefollowing activitiesatanystage (includingin the identificationofpotential participants)?*(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☐ Electronic transferby magnetic oropticalmedia,emailorcomputernetworks
- ☐ Sharing of personal data with other organisations
- ☑ Export of personal data outside the EEA
- ☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☑ Publication ofdata thatmightallowidentificationofindividuals
- ☑ Use of audio/visual recording devices
- ☐ Storageofpersonaldata on any ofthefollowing:
  - ☐ Manual files (includes paper or film) NHS computers
  - ☑ Social Care Service computers
  - ☐ Home or other personal computers
  - University computers
  - Private company computers
  - Laptop computers

Further details:

All data will be stored on a University approved and secure cloud server, which can be accessed from the researcher's home and thus there will be no need to transport the data on USB sticks. All documents will be password protectedand any identifiable data (e.g. consent forms) will be stored separately to research data. The interview will be recorded on a digital recorder. Following each interview the recordings will be transferred on to the university's secure serverand deleted off the recorder. Direct quotations from the interviews will be used, but will be anonymised and reported under pseudonyms. Opt-in forms will be destroyed once the information is no longer required. Consent forms will be scanned into electronic forms and kept on the secure server, but paper versions will then destroyed.

A37.Pleasedescribethephysicalsecurityarrangementsforstorageofpersonaldataduringthestudy?

Physicalcopiesof consentformsandother formswith personaldatawill be scannedinto electronicformsand kept on the secure server. No paper versions will be stored during the study as they will be destroyed after they have been scanned.

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

The transcripts of the interviews will be anonymised and pseudonyms will be used for all participants. All identifiable information will be changed or anonymised and stored on a secure server. Documents will be password protected.

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

As interested participants directly contact the doctoral student researcher, they will have access to the participants' personal data for the duration of the project until completion/publication. Personal data will be permanently deleted from the secure server following completion of the project.

Storageandu ofdataafterth dofth tudy

A41.Wherewi data generated byth dy beana dandby whom?

Thedata will betranscribedandanalysedbythe doctoral studentresearcherwith support fromacademicsupervisor. Field supervisor from *redacted* will also support in the analysis process. The data gathering process will mainly be completed via video-conferencing from the doctoral student researcher's home, where data will be transferred and stored on a secure server approved by the University. If requested or deemed necessary, the data gathering process may take place at the *redacted*, which will be liaised with the field supervisor. The analysisprocess will be completed at the doctoral student researcher's home or at Lancaster University, where any data will be accessed via the secure server.

A42.Who willhave controlofandactasthecustodianforthedata generatedby the study?

	TitleForename/InitialsSurname
	Mr.Haakon Juul
Post	TraineeClinicalPsychologist
Qualifications	BSc, Psychology
Work Address	DoctorateinClinicalPsychology
	LancasterUniversity
	Lancaster
PostCode	LA1 4YG
Work Email	
	h.juul@lancaster.ac.uk
Work Telephone	07478757021

A43.Howlong willpersonaldatabestoredoraccessed afterthestudyhas ended?

- ◉
- ○ Lessthan3months 3 –
- ○ 6 months
- ○
- ○ 6–12 months
- 12months–3years
- Over3years

A44.Forhowlongwillyoustoreresearchdatageneratedbythe study?

Years:10
Months:0

A45. Please givedetailsof thelongtermarrangementsforstorage ofresearchdata afterthe study has ended.*Say where data will be stored, who will have access and the arrangements to ensure security.*

The recordings will be deleted by the doctoral student researcher researcher once examination of the academic assignment has been completed. The DClinPsy administration team will be responsible for the storage and deletion of data once the researcher have completed my course on September 1st 2023. The data will be transferred electronically using a secure method to secure electronic server in accordance with the university guidelines and data protection act.

INCENTIVESANDPAYMENTS

A46. Will research participants receive any payments, reimbursement ofexpenses orany other benefitsorincentives for taking part in this research?

○ Yes ◉ No

A47. Will individualresearchers receiveany personal payment overand above normalsalary, oranyotherbenefits or incentives, for taking part in this research?

○ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial,share holding, personal relationshipetc.)inthe organisations sponsoringorfunding the research thatmay give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATIONOFOTHERPROFESSIONALS

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

○ Yes ◉ No

IfYes,please encloseacopy oftheinformation sheet/letterfortheGP/healthprofessional withaversionnumberand date.

PUBLICATIONANDDISSEMINATION

A50.Willtheresearchberegisteredonapublicdatabase?

◯ Yes ◉ No

Please givedetails, orjustify ifnotregisteringtheresearch.

N/A

Registration of researchstudies is encouraged whereverpossible.

You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish

A51.Howdoyouintendtoreportanddisseminatetheresultsofthestudy?*Tickas appropriate:*

- ☑ Peer reviewed scientific journals
- ☐ Internal report
- ☐
- ☑ Conference presentation
- ☑ Publication on website
- ☐ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study by Independent Steering Committee on behalf of all investigators
- ☑

No plans to report or disseminate the results

Other (please specify)

A52. Ifyouwill beusingidentifiable personal data,howwill you ensurethatanonymity willbe maintained when publishing the results?

Alldata will beanonymisedand identifyinginformationremoved.Pseudonymswill be used.

A53.Howandwhenwillyouinformparticipantsofthestudyresults?

If therewillbe noarrangements in placeto informparticipants pleasejustifythis.

5.ScientificandStatistical Review

A54.Howhasthescientificqualityoftheresearchbeenassessed?*Tickasappropriate:*

- ☐ Independent external review
- ☐ Review within a company
- ☐
- ☑ Review within a multi−centre research group
- ☑ Review within the Chief Investigator's institution or host organisation

☑ Review within the research team

☐ Review by educational supervisor Other

Justify and describe the review process and outcome. If the reviewhas been undertaken but not seen by the researcher, give details of the body which has undertaken the review:

The research has been proposed to the Lancaster University Clinical Psychology Doctoral Training Programme research team who have approved the study pending ethical approval from Lancaster University Faculty of Health and Medicine Research

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

A59. What is the sample size fortheresearch?*Howmany participants/samples/data recordsdoyou plan to study in total? If there is more than one group, please give further details below.*

Total UKsample size:	12
Totalinternationalsamplesize(includingUK):	12
TotalinEuropeanEconomicArea:	0

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

Recruitment will stop once theoretical sufficiency is considered to be achieved. However due to time constraints of the project, recruitment will not exceed 12 participants even if saturation has not been reached. According to previous research using similar methodology, however, 12 participants has been demonstrated as sufficient to achieve theoretical sufficiency (e.g. Corbin & Strauss, 2015; Tickle et al., 2014).

A62. Please describe the methods ofanalysis(statistical orotherappropriate methods,e.g.forqualitativeresearch)by which the data will be evaluated to meet the study objectives.

The data will be analysed using Grounded Theory (Charmaz, 2014; Charmaz, 2006). The analysis is an iterative process of interviewing, analysing and developing theory throughout. Through a constant comparative method, the theory will then be rooted in the data and come from the experiences of the participants rather from an already established theory. The outcome will therefore be a bottom-up developed theory about the process of how non-specialist staff (with no formal training in psychological therapy) apply SFBT techniques/principles following SFBT training in healthcare services and what influences this process.

6.MANAGEMENTOFTHERESEARCH

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

	TitleForename/InitialsSurname
Post	*redacted*
Qualifications	*redacted
Employer	*redacted*
	redacted

	*redacted
PostCode	*redacted*
Telephone	*redacted*
FaxMobile	
Work Email	

	TitleForename/InitialsSurname Mr.Haakon Juul
Post	TraineeClinicalPsychologist BSc
Qualifications	Psychology
Employer	LancasterUniversity/LSCFTNHSFoundationTrust
WorkAddress	Doctorate in Clinical Psychology LancasterUniversity Lancaster LA14YG
PostCode	
Telephone	07478757021
FaxMobile	juulhaakon@gmail.com

A64.Details of Sponsor(s)

A64-1.Sponsor

LeadSponsor

Status:
- ○ NHSorHSCcareorganisation
- ◉ Academic
- ○
- ○ Pharmaceuticalindustry
- ○ Medical device industry
- ○ Local Authority
- ○ Othersocialcare provider (including voluntary sector orprivate

Commercialstatus: Non-Commercial

IfOther,please specify:

Contactperson

NameoforganisationLancasterUniversity Given name	Becky
Familyname	Gordon
Address	HeadofResearch Quality andPolicy
Town/city	LancasterUniversity

Telephone 01524592981
Fax
sponsorship@lancaster.ac.uk

Legal representative for clinical investigation of medical device (studies involving Northern Ireland only) *Clinical Investigations of Medical Devices that take place in Northern Ireland must have a legal representative of the sponsor that is based in Northern Ireland or the EU*

Contactperson

Nameoforganisation Given name

Familyname
Address
Town/city Post code

A65. Has exte l fundingforth esearc cured?

Pleasetickatleast onecheckbox.

☐ Fundingsecuredfromone ormorefunders
☑ External funding applicationtoone ormore funders inprogress No application for external funding will be made

◉
○
○
W attypeofresearchprojectisthis?
○ Standaloneproject
○ Projectthatispartofaprogrammegrant Project that is part of a Centre grant

A66. Has responsibility foranyspecific research activities orprocedures beendelegated toa subcontractor(other than a co-sponsor listed in A64-1) ?*Please give details of subcontractors if applicable.*

○ Yes ◉ No

A67. Has this orasimilarapplicationbeen previouslyrejectedby aResearchEthics Committee in theUKoranother country?

○ Yes ◉ No

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

A68-1.Givedetailsofthelead NHS R&Dcontactforthis research:

	Title Forename/Initials Surname
	redacted *redacted*
Organisation	*redacted*
Address	*redacted*
	redacted
Post Code	*redacted*
WorkEmail	*redacted*
Telephone	
Fax	*redacted*

*Details can be obtainedfromthe *redacted**

A69-1.Howlong youexp the study t t inth K?

Planned sta ate: 29/10/2
Plannedendd e:31/03/202
Total duratio
Years: 1Months:5Days:3

A71-1.Isthisstudy?

- ◉
- ○ Singlecentre Multicentre

A71-2.Wherewilltheresearchtakeplace?*(Tickasappropriate)*

- ☑ England
- ☐ Scotland
- ☐ Wales
- ☐ NorthernIreland
- ☐ OthercountriesinEuropeanEconomicArea

TotalUKsitesinstudy

DoesthistrialinvolvecountriesoutsidetheEU?

Yes	No
○	◉

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

☑ NHS organisations in England NHS 1

☐ organisations in Wales

☐ NHSorganisationsinScotland

☐ HSCorganisationsinNorthernIreland GP

☐ practices in England

☐ GP practices in Wales

☐ GPpracticesinScotland

☐ GPpractices in Northern Ireland

☐ Jointhealth andsocialcare agencies(eg community mental health teams)

☐ Local authorities Phase

☐ 1 trial units

☐ Prisonestablishments

☐ Probation areas

☐ Independent(privateorvoluntarysector) organisations

TotalUKsites in study: 1

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

○ Yes ◉

A74.Whatarrangementsareinplaceformonitoringandauditingtheconductoftheresearch?

Research supervisor and field supervisor will be involved in the on-going monitoring and auditing of the research. When completed it will also be submitted as part of my doctoral training programme where it will be evaluated and marked

A76.Insurance/indemnitytomeetpotentiallegal liabilities

***Note:** inthisquestiontoNHSindemnity schemesinclude equivalentschemes provided by Health and Social Care (HSC) in Northern Ireland*

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

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

☐ NHS indemnity scheme will apply (NHS sponsors only)

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

Pleaseencloseacopyofrelevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s)oremployer(s)forharm toparticipants arisingfromthedesign ofthe research?*Please tick box(es)as applicable.*

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

☐

☑ NHSindemnity scheme will apply (protocolauthors with NHS contractsonly) Other

insurance or indemnity arrangements will apply (give details below)

Pleaseencloseacopyofrelevant documents.

A76-3.Whatarrangementswill be made forinsurance and/ orindemnityto meetthe potentiallegal liability of investigators/collaborators arising from harm to participants in theconduct of the research?

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

☑

☐ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only) Research includes non-NHS sites (give details of insurance/indemnity arrangements for these sites below)

Pleaseencloseacopyofrelevant documents.

A78.Couldtheresearchleadtothedevelopmentofanewproduct/processorthegenerationofintellectualproperty?

○ ◉ ○

PARTC:Overviewofresearchsites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites.

For further information please refer to guidance.

Investigator identifier	Researchsite	InvestigatorName	
IN1	◉ NHS/HSCSite ○ Non-NHS/HSCSite	Forename Middlename Familyname Email Qualification (MD...) Country	Haakon Juul h.juul@lancaster.ac.uk BSC,Psychology United Kingdom
	Organisation name: *redacted* Address: *redacted* *redacted* PostCode Country		
IN2	○ NHS/HSCSite ○ Non-NHS/HSCSite	Forename Middlename Familyname Email Qualification (MD...) Country	

PARTD:Declarations

D1.DeclarationbyChiefInvestigator

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

    - Willbe heldby the REC (where applicable)untilatleast3 years afterthe end of the study; and byNHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managersofreviewbodies, orthe appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointedtoundertake accreditation ofRECs (whereapplicable).
    - Will be subject to the provisions of the Freedomof Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sentbyemail to RECmembers.

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

Contactpointforpublication*(NotapplicableforR&DForms)*

HRAwouldliketo includea contactpointwith the publishedsummary of thestudy forthosewishing to seek further

information.We wouldbegrateful if youwouldindicateone of the contact points below.

- (●) ChiefInvestigator Sponsor
- ( ) Studyco-ordinator Student
- ( ) Other–pleasegivedetails
- ( ) None
- ( )

Access toapplicationfortraining purposes*(Notapplicable forR&DForms) Optional – please tick as appropriate:*

- [x] Iwouldbe contentformembersofotherRECsto haveaccesstotheinformationintheapplicationinconfidence

Thissectionwassi delectro allyby DrIa ithon 05/2022 15:25.

JobTitle/Post: Rese Direc

Organisation: Lanc erUniv ty

Email: i th@lancas .ac.uk

D2.Declarationbythesponsor'srepresentative

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

Iconfirm that:

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

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

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

This section was signed electronically by An authorised approver at sponsorship@lancaster.ac.uk on 12/05/2022 14:53.

Job Title/Post:	ActingHeadofResearchQuality&Policy
Organisation:	Lancaster University
Email:	c.odonnell@lancaster.ac.uk

D3.Declarationforstudentprojectsbyacademicsupervisor(s)

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

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

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

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

Academicsupervisor1

JobTitle/Post:	Research Director
Organisation:	LancasterUniversity
Email:	i.smith@lancaster.ac.uk