Exploring Multi-Disciplinary Team (MDT) Experiences of Cognitive Analytic Therapy (CAT) as a Systemic Consultation Tool in an Adult Forensic Service

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Introductory Chapter: Thesis Overview

This thesis consists of two main sections: a narrative review and an empirical paper. Each section, together with how they are linked, is outlined in this Introductory Chapter. An appendix with supporting documents is included.

Chapter One

It is widely acknowledged that staff teams face a number of interpersonal challenges when working with individuals with a diagnosis of personality disorder (IwDPD) which can leave staff feeling inadequate, ineffective, confused, scared, helpless and anxious (Kelly & May, 1982; Nehls, 2000; Risq, 2012; Woollaston & Hixenbaugh, 2008). Emotions can become contagious within a setting if there is a lack of recognition and inadequate processing of emotional reactions from staff to clients (Hinshelwood, 2002). This can inadvertently re-enact early patterns of abuse and staff can become enmeshed in unhealthy, destructive interactions (Meaden & van Marle, 2008), thus negatively impacting upon the care and treatment that this client group receives. Recent guidance has also made a number of recommendations to protect teams against such difficulties associated when working with IwDPD (DOH, 2011a; NIMHE, 2003a, 2009b; NICE, 2009a, 2009b). Based on this guidance, this review has explored the recent literature on using team-based approaches to manage the challenges that staff teams face when working with IwDPD in adult community, in-patient and forensic mental health settings. In particular, the potential contributions of training, formulation and group reflection and supervision have been discussed. Before reviewing the literature, the review discusses the nature, prevalence and aetiology of personality disorder, the types of challenges that mental health teams face when working with this client group and current understandings as to how these challenges are overcome.

The review highlighted the paucity of research exploring these team-based approaches. In general, the literature reviewed was small in scale and the quality was varied. Studies reviewed used different methodologies and there was a lack of outcome measures which showed the impact of the team-based approaches on the challenges that teams face and how this impacts the care that IwDPD receive. The lack of research conducted in secure services was notable, particularly in team formulation, given the high prevalence rates of personality disorder in these sectors and the systemic elements of treating IwDPD.

Establishing staffs' understanding in the above areas is of clinical importance as it will help to identify ways in which relationships between staff, IwDPD and the wider mental health system can be understood and improved. Having a better understanding of IwDPD presentation enables teams to provide more appropriate and therapeutic care and treatment that does not re-enact and reinforce early unhelpful patterns of relating and coping.

Chapter Two

Chapter one highlights the paucity of research exploring the use of formulation and supervision in teams, particularly in forensic services. Given the high prevalence of IwDPD in high secure hospitals (HSHs; Mbatia & Tyrer, 1988; Taylor et al., 1998), the research paper explores the staffs' experiences of Cognitive Analytic Therapy (CAT) as a systemic consultation tool. Through the use of semi-structured interviews with members of the Multi-Disciplinary Team in a HSH, the paper explores staffs' understanding of the forensic patients' behaviour, their clinical presentation and their risk potential. The study also aimed to explore whether using CAT in this way helps them in their management of patients, and how. Furthermore, it aimed to explore whether the CAT consultation process helps consultees to contain their emotional responses when working with these patients. A

discussion of the results follows, with considerations of: the clinical implications of the study; how the results of the study add to the current literature; and future research.

The paper is intended for publication and is written in the style of the journal identified for submission, Journal of Forensic Psychiatry and Psychology. The author guidelines for this journal can be found in Appendix A.

Chapter One: Literature Review

Team-based approaches to managing the challenges of working with individuals with a diagnosis of personality disorder: A narrative review.

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Abstract

Individuals with a diagnosis of personality disorder (IwDPD) have complex needs and are frequent users of the National Health Service (NHS). The guidance for working with this client group highlights the importance of a Multi-Disciplinary Team (MDT) working with the client (National Institute Mental Health England, [NIMHE], 2003a, 2003b; National Institute Clinical Excellence, [NICE], 2009a, 2009b). It is widely acknowledged within the literature that staff teams face a number of interpersonal challenges when working with IwDPD, which can negatively impact upon the care and treatment that this client group receives. Therefore the overall purpose of this article is to review the contributions of team-based approaches to managing the challenges that adult community, in-patient and forensic mental health teams are faced with, when working with this client group. The review highlighted the paucity of research exploring these team-based approaches. In general, the literature reviewed was small in scale and the quality was varied. The review discusses the potential for future research.

Keywords: Personality disorder; formulation; training; group supervision; multi-disciplinary

Background

Before reviewing the literature, this review will briefly discuss the nature, prevalence and aetiology of personality disorder, as well as the types of challenges that staff teams face when working with this client group and current understandings as to how these challenges are overcome.

Personality Disorder

Prevalence. IwDPD experience significant psychological distress which is associated with ways of thinking and feeling about oneself and others (American Psychiatric Association [APA], 2013). This can adversely affect how an individual functions in day-to-day life. According to the Diagnostic and Statistical Manual of Mental Disorders ([DSM-V] APA, 2013) there are ten specific personality disorder categories. Individuals can often have multiple symptoms which belong to more than one diagnostic category (NIMHE, 2003a). Prevalence studies estimate that 10-13% of the general population have a personality disorder diagnosis, which increases to 36-67% within psychiatric hospital populations (NIMHE, 2003a) and 79% in high security hospitals (HSHs; Mbatia & Tyrer, 1988; Taylor et al., 1998). Furthermore, the diagnosis affects between 60-70% of individuals in the prison service (DOH, 2011a). As a result IwDPD who offend are often transferred between NHS secure services and prison services when their symptoms and risk behaviours escalate and reduce.

Aetiology. There are a number of theories that attempt to explain the aetiology of personality disorders. Attachment theory (Ainsworth, 1978; Bowlby, 1969) provides an empirically driven framework to conceptualise personality disorder. Attachment theory considers the emotional and cognitive development and interpersonal relationships that are central to the development of a healthy personality function and disordered personality traits

(Sainsbury, 2011). Here the central premise is that disturbed or insecure attachment models lie at the centre of disordered personality traits (Bowlby, 1977). An attachment relationship refers to the bond between an infant and caregiver(s). Infants are innately motivated to form attachments in order to survive and feel safe from threats in their environment. Infants become 'securely attached' to caregivers who provide them with a 'secure base' (Bowlby, 1988), which in turn requires caregivers to consistently and appropriately notice and respond to the infant's physical and emotional needs (Bowlby, 1969). It is these primary relationships which provide the cognitive and emotional templates, known as internal working models, for how the infant understands their own internal states as well as interpreting interactions with others (Bowlby, 1969). Over time, the securely attached infant learns to manage their emotions and interpersonal behaviour and to recognise the unspoken emotional states of others.

In contrast, caregivers who are consistently emotionally or physically unavailable are not able to attune, notice or sensitively respond to the infant's distress, resulting in the development of an insecure attachment relationship. These experiences can be characterised and exacerbated by abuse and neglect (McGauley & Humphrey, 2003; Sarkar, 2005). Insecurely attached individuals are found to have significant difficulties in: cognitive processing (Grossman, Grossman & Kindler, 2005) which can include rigid patterns of responding (Siegal, 2003); emotional regulation (Schore, 2003); accurately interpreting the thoughts and feelings of others, thus making distorted assumptions about others (Fonagy, 2001); and forming healthy reciprocated relationships with others (Ainsworth, 1989; Bretherton, 1987). These difficulties can result in persistent problematic patterns in interpersonal relations, for example avoidant or dismissing, over-reliant, or a combination of approach and avoidance, and trigger intense states of emotional arousal in response to perceived threats. These kinds of difficulties are characteristic of IwDPD with research

showing high rates of insecure attachment styles in IwDPD (Patrick, Hobson, Castle, Howard & Maughan, 1994; Van Ijzendoorn et al., 1997; Fossati et al., 2003). Consequently, in the face of distress and arousal, IwDPD often have a restricted repertoire of coping skills which can include violence, self-neglect, self-injury, substance misuse, suicide and homicide (Frodi, Dernevik, Sepa, Philipson, & Bragesjo, 2001; van Ijzendoorn et al., 2007). These behaviours mean that this client group are disproportionately involved with mental health services and/or the criminal justice system. These clients have been described as "revolving door" patients (NIMHE, 2003a, p. 13), given their frequent use of services and high financial costs.

As attachment theory is one framework used to understand the development of personality disorders, it is unsurprising that effective interventions draw on attachment theory principles (e.g. Cognitive Analytic Therapy; Ryle, 1990). Given their high use of services, IwDPD interact with a high proportion of staff and therefore there is a greater risk of staff re-enacting unhelpful attachment relationships. However, contact with staff can also provide an opportunity for these individuals to develop healthy, secure attachment relationships with staff as part of their care and treatment. This requires staff to have the capacity to attune to the individual's underlying emotions and fears, to talk about and contain these feelings and to respond appropriately to soothe the individual, for example staff not being drawn in to a rescuing, withholding or punishing enactment (Sainsbury, 2011).

Challenges for Mental Health Staff Teams

How do staff teams feel about personality disorder? Given the frequent use of maladaptive, risky patterns of behaviour, IwDPD often evoke strong emotional reactions and opinions in staff and other clients (Aiyegbusi, 2009; Alwin, 2006; Cox, 1996; Kurtz, 2007). Research across settings, cultures and time has consistently shown that staff describe working with this client group as more challenging than with individuals with other 'diagnoses'

(Alhadeff, 1994; Bland, 2003; Bowers, 2002; Brody & Farber, 1996; Cleary, Siegfried & Walter, 2002; Deans & Meocevic, 2006; Fraser & Gallop, 1993; Gallop et al., 1989; Gallop & Wynn, 1987; Greene & Ugarriza, 1995; James & Cowman, 2007; Lewis & Appleby, 1988; Moran & Mason, 1996; O'Brien & Flöte, 1997; Pavolovich-Danis, 2004; Piccinino, 1990). Mental health staff perceptions, emotions and feelings have been found to be negatively influenced by the diagnosis of personality disorder (Gallop et al., 1989; Langer & Abelson, 1974). The "very sticky label" of personality disorder (NIMHE, 2003a, p. 20) is strongly associated with stigmatising terms such as: 'difficult', 'challenging', 'complex', 'annoying', 'manipulative', 'attention seeking', 'time-wasters', 'violent', 'demanding', 'self-destructive', 'hateful', 'help-rejecting' and 'treatment failures' (Burnham, 1966; Cornfield & Fielding, 1980; Groves, 1978; Hinshelwood, 1999; Koekkoek, Hutschemaekers, van Meijel & Schene, 2011; Koekkoek, van Meijel & Hutschemaekers, 2009; Kuch, Sherman & Curry, 1977; Lewis & Appleby, 1988; Quitkin & Klein, 1967). IwDPD who have offended are faced with a 'double stigma' as staff, in addition to the labels described above, also refer to such individuals as 'prisoners', 'offenders' or 'perpetrators' as they are transferred between prison and mental health services. Such attitudes are likely to negatively affect relationships between staff and IwDPD which in turn is likely to compromise the care that the individual receives (Macdonald, 2003). As such the stigmatising diagnostic label of personality disorder is highly contentious. Although this is an important debate it is beyond the parameters of this review.

Why do staff teams feel this way? The patterns of relating can be understood through processes of transference and countertransference (Moylan, 1994). Transference refers to the feelings, attitudes, defences or fantasies of an individual derived from early relationships which may be re-enacted in the here and now in relationships with others

(Greenson, 1967). The state of mind in which another's feelings are experienced as one's own is referred to as countertransference (Halton, 1998). From these processes, defence mechanisms, such as projective identification (PI) and 'splitting', are used as a way of meeting the individual's emotional needs. PI is the unconscious interpersonal interaction in which an individual projects their intolerable feelings onto the other in such a way that the recipient of the projection unconsciously identifies with these feelings and becomes similarly affected (Halton, 1998). For example an individual projects their guilt from a recent incident of violence, resulting in staff experiencing feelings of guilt, as if it were their own, thus processing these feeling on the individual's behalf. Closely associated with this is the process of 'splitting' (Rubens, 1996); a defence mechanism which aims to keep apart two opposing feelings or thoughts due to difficulties in bringing together both positive and negative qualities of the self and others into a cohesive, realistic whole. For example a staff team can come to represent different, often conflicting, emotional aspects of the client, either 'all good' or 'all bad' with no middle ground. These processes commonly occur together between staff and clients and within the staff team thus increasing the complexity of any one individual's response to emotional milieu.

What happens when the challenges are not recognised? Negative counter-transference can lead to difficult dynamics, such as 'splitting' within teams and often within the institution itself (Gallop, 1985; Greene & Ugarriza, 1995; Piccinino, 1990). This can leave staff feeling inadequate, ineffective, confused, scared, helpless and anxious (Kelly & May, 1982; Nehls, 2000; Risq, 2012; Woollaston & Hixenbaugh, 2008). Dynamics have proved difficult to name (McGrath & Dowling, 2012) as teams are concerned about avoiding and/or creating further conflict (Kurtz & Turner, 2012). Emotions can become contagious within a setting if, for example, there is a lack of recognition and inadequate processing of emotional reactions to clients (Hinshelwood, 2002). If transference and countertransference

are not understood and processed by staff then they may "inadvertently re-enact early patterns of abuse and become enmeshed in unhealthy, destructive interactions" (Meaden & van Marle, 2008, p. 44). This can result in iatrogenic risks, further trauma or relational difficulties brought on unintentionally by something that staff have said or done.

High risk behaviours, which are typical in IwDPD, and strains on staff teams, due to difficult dynamics, can lead to staff burnout (work related stress) (Maslach & Leiter, 1997). Understandably this may result in poor therapeutic alliances: a predictor of a more negative treatment outcome (Koekkoek et al., 2009; Koekkoek et al., 2011; Modestin et al., 1986).

Existing Understandings of How Staff Teams Can Work More Effectively with Personality Disorders

Prior to the NIMHE (2003a) policy, personality disorder was described as a 'diagnosis of exclusion'. The Mental Health Act 1983 (MHA) also stipulated that it was necessary to show that IwDPD were treatable in order to detain them in mental health services. Due to the challenges professionals faced in treating this client group, IwDPD were often 'written off' as untreatable and were not cared for in the same way as clients with other diagnoses (NIMHE, 2003). In 2007, the MHA criteria changed to make service managers responsible for ensuring that appropriate treatment was available. This was seen as a positive shift in treatment for IwDPD. More recently specialist personality disorder services have been developed (Murphy, 2007).

As part of the development of services for IwDPD, the DOH and the National Offender Management Service (NOMS) have more recently developed the Offender Personality Disorder Pathway Programme ([OPDPP] DOH, 2011b). It was recognised that prisons can deliver effective specialist personality disorder treatment services at significantly

lower cost than secure psychiatric hospitals (DOH, 2011b). The aim was to improve public protection and the psychological health of IwDPD by improving practices across the criminal justice system as well as health and social care services (DOH, 2011b).

A key principle of the strategy was that the treatment and management of IwDPD should be psychologically informed, with a focus on relationships and the social context in which this client group live. The immediate objective was to develop model pathways for IwDPD by the end of 2015 (Skett & Goode, 2015). A national evaluation of the OPDPP is in its preliminary stages and is proposed to continue over the next four years (Skett & Goode, 2015). This review will therefore focus on community, in-patient and forensic mental health services, especially as IwDPD remain highly prevalent within these sectors.

The importance of a MDT and a multi-agency approach is now recognised as a necessary condition for those working with IwDPD (DOH, 2011a, 2011b; NIMHE, 2003a; NICE, 2009a, 2009b). The identified benefits of MDT working include: staff teams offering a broader skill base; enhanced staff communication; more efficient use of resources; higher quality decisions and the provision of holistic care (Murphy, 2007). Staff teams can also derive a sense of belonging from an MDT approach which can be helpful at times of stress. Recent guidance has also made a number of recommendations to protect teams against the difficulties associated when working with IwDPD (DOH, 2011a, 2011b; NIMHE, 2003a, 2009b; NICE, 2009a, 2009b). These include: receiving peer support; individual and group supervision; time to reflect and expanding education and training provisions (NIMHE, 2003a). Workforce development underpinned the OPDPP (DOH, 2011) by providing training designed to change attitudes to IwDPD and to develop the skills and confidence of staff when working with this client group (DOH, 2011).

Team formulations have also been identified to contribute to effective MDT working when supporting this client group (DOH, 2011a, 2001b; Division of Clinical Psychology [DCP], 2011). Drawn from theory, a psychological formulation provides a hypothesis about the predisposing, precipitating and perpetuating influences of an individual's psychological, interpersonal, and behavioural difficulties (Johnstone & Dallos, 2014). Team formulations can help to manage the challenges that teams face by increasing staff understanding, empathy and reflectiveness; processing staff countertransference reactions; minimising disagreement and blame; understanding attachment styles in relation to the service as a whole; understanding and managing risk; and challenging negative beliefs about clients (Christofides, Johnstone & Musa, 2012; DCP, 2011). Formulating within teams is also recommended as a way of facilitating cultural change in organisations and teams towards a more psychosocial perspective (Onyett, 2007).

Recent guidance and legislation, on how services can work effectively with IwDPD, has led to an increase in research articles within this area (DOH, 2011a, 2011b; NIMHE, 2003a, 2009b; NICE, 2009a, 2009b). Reviewing this subsequent research is important for increasing our understanding of how mental health teams can manage the challenges of working with IwDPD.

Aims

A literature review was conducted to examine the professional and empirical literature, which has examined the role of team-based approaches to managing the challenges that community, in-patient and forensic mental health teams face when providing care and treatment for IwDPD. The aim of the review was to focus on team approaches based on relevant guidance (DOH, 2011a, 2011b; NIMHE, 2003a, 2003b) which include: training and education, team consultation/ formulation and group supervision. The review also aimed to

synthesise the literature and to build on existing literature and theory (described above) since the recent changes in guidance (e.g. NIMHE, 2003a, 2003b) and legislation (e.g. MHA, 2007). Furthermore, the review aimed to consider the clinical implications of the literature reviewed and to indicate future directions of research.

Method

Design

Narrative reviews offer a broader coverage within a given topic and can provide the reader with background knowledge, evolving concepts and controversies. This type of review also allows for situational choices about the inclusion of evidence (Collins & Fauser, 2005). Narrative reviews can 'integrate' qualitative and quantitative evidence through narrative juxtaposition (i.e. a discussion of diverse forms of evidence side by side). It is less concerned with assessing evidence quality and more focused on gathering relevant information that provides both context and substance to the overall argument (Dixon-Woods, Agarwal, Jones, Young & Sutton, 2005). As such, a narrative approach was seen to be appropriate to provide a comprehensive overview of the application of team-based approaches, which manage the challenges that staff teams face when working with IwDPD in mental health services. A systematic approach to the search was employed to ensure that the review was as thorough and inclusive as possible.

Inclusion Criteria

All literature within community, in-patient and forensic mental health settings describing any aspect of the following roles when working with IwDPD were included: training and education or formulation and consultation or group reflection (e.g. supervision, reflective practice, peer support). This review is limited to articles published from January

2007 onwards to reflect the changes in practices when working with IwDPD within mental health services, primarily the change of the MHA (2007). This means that the review encompasses the most up-to-date research. However, where theories and relevant background information is required, literature outside of these date parameters was accessed and referenced. The reviewed literature was limited to adult populations and publications written in the English language.

Exclusion Criteria

Although prison settings are relevant to IwDPD, the OPDPP (DOH, 2011a) is highly specialist and is still being evaluated (Skett & Goode, 2015). Therefore due to the constraints of the review, literature which was not contextualised within in-patient, community or forensic mental health settings was excluded (e.g. generic health services and prisons). This was to retain a focus within mental health services and mental health staff. Furthermore, it was felt that the teams, systems and cultures outside of mental health services may be different and therefore may warrant a review in their own right.

Search Strategy

The literature was searched using the following on line search engines; PsycINFO, Web of Science and Scopus. A mind map was created to identify key words (Shaw, 2012) and controlled vocabulary (i.e. MESH headings) were used, which include: ‘personality disorders’ or ‘difficult patient*’ or ‘difficult client*’ or ‘complex patient*’ or ‘complex client*’ or ‘problem patient*’ or ‘problem client*’ or ‘challenging patient*’ or ‘challenging client*’ AND ‘community mental health services’ or ‘patient care team’ or ‘hospitals, psychiatric’ or ‘mental health services’ or ‘secur* hospital*’ AND ‘interprofessional relations’ or ‘psychoanalytic theory’ or ‘case conceptualis*ation’ or ‘clinical supervision’ or

'reflective practice' or 'consultation' or 'training' or 'formulation' or 'patient care planning' or 'interdisciplinary communication'.

Following the removal of duplicates, 16 journal articles and 4 book chapters were identified and included in the results. References were checked for additional sources.

Structure

Based on the findings of the review, the results are separated into three main sections which include: training, formulation and group reflection and supervision. Within each of these sections relevant background information will be discussed in order to provide the reader with a context in which to consider the results. The results of the search will then be discussed in terms of strengths and limitations, clinical implications and the potential for future research. The review ends with a concluding section.

Results

Table 1 summarises the papers found in the search.

Insert Table 1 Here

Training

Background information. Research has suggested that between 29% (Clearly, Siegfried & Walter, 2002) and 56% (Deans & Meocevic, 2006) of psychiatric nurses perceived themselves as lacking in personality disorder training and struggle to conceptualise the diagnosis within a psychological framework (Moran & Mason, 1996). Core professional training differs widely across mental health professional groups and there is a paucity of

training which meets the demands for all levels of staff (NIMHE, 2003b). Therefore, it is recommended by the NIMHE (2003a) that personality disorder training is team focused, supported and valued by the organisation, as well as tailored to meet the specific requirements of the service. Furthermore, it is suggested that training should have active service user involvement.

Search results. The importance of training and education within teams was evident throughout the literature reviewed. Data collected from experienced clinicians working with IwDPD in the community identified the provision of staff training as the main area for improving services (Fanaian, Lewis & Grenyer, 2013).

The literature reviewed emphasised that training should develop staff's core competencies by providing education in relation to aetiology, key symptoms, the treatment of personality disorder and the long-term nature of the condition (Murphy & McVey, 2007). Radically different views can lead to conflicting interventions, inconsistent approaches to treatment and splits within teams (Murphy, 2007; Murphy & McVey, 2007; Sneath, 2007) which can then lead to unhelpful re-enactments between staff and IwDPD. This can be minimised by increasing staff teams' psychological understanding of an IwDPD's difficulties by focusing on emotional regulation, distorted thinking and the feelings about self and others, for example how behaviours such as self-harm and violence may be a way of eliciting care or getting their needs met (Sneath, 2007), which can impact on their relationships and how this may influence staff responses (Murphy & McVey, 2007).

An introduction to what constitutes inappropriate interactions and how to maintain professional boundaries was also highlighted as being a core aspect of training (Moore, 2012). This kind of training is likely to make staff feel more competent, less personally attacked and to increase their tolerance when interacting with such clients (Murphy &

McVey, 2007). Whilst this should indirectly reduce negativity towards this client group, it is also argued that training should directly address staff team attitudes and beliefs concerning personality disorder diagnosis, including treatability and willingness to work with IwDPD (NICE, 2009a).

The nationally recognised personality disorder knowledge and understanding framework training ([KUF] Institute of Mental Health, 2013) encompasses all of the above areas in a three-day training course comprising of six modules. Personality disorder is conceptualised through the theoretical framework provided by schema therapy (Young & Klosko, 1993) and explores how to work more effectively as individuals and as organisations with this client group. In addition, the KUF training (Institute of Mental Health, 2013) explores common misconceptions and stigma associated with the label of personality disorder and is co-produced and co-facilitated by experts with lived experience of the diagnosis (EBEs) and experts by occupation (EBOs).

Two studies (Davies, Sampson, Beesley, Smith & Baldwin, 2014; Lamph et al., 2014) have evaluated the impact of this training (combined N = 343). Data was collected at pre-, post- and three-month follow up and measured staff members' (1) understanding of the diagnosis; (2) capability efficacy, referring to subjective confidence in ability to work with IwDPD; and (3) emotional reaction, referring to levels of positive emotional reaction to the diagnosis (as measured by the Personality Disorder- Knowledge Attitude and Skills Questionnaire; PD-KASQ; Bolton et al., 2010). In both studies, pre- and post- training evaluation indicated a significant improvement in all three factors. There was a significant improvement in staff understanding from pre-training compared to three months after training in both studies. However, whilst it is positive that staff, with diverse experience and job roles, understanding of personality disorder improved across both studies, other findings indicate that the training did not improve their confidence or their emotional reaction in working with

this client group. These findings contradict what might be expected as a result of training for those working with this client group. Furthermore, Lamph et al. (2014) found that there was a significant reduction in scores between post-training and follow-up on all three factors indicating limited durability of the training.

In both studies response rates at follow-up were significantly reduced. As a result this research has obvious limitations and therefore further investigation is warranted. These studies highlight the limitations of a three day training course in teaching staff teams to manage the interpersonal challenges that IwDPD present. This is unsurprising given the complexity of the interpersonal challenges common in IwDPD. Clearly there is a need for ongoing training, supervision and support for KUF trained staff who continue to work with this client group (Davies et al., 2014). Positively, both studies provide evidence that staff valued training which is co-facilitated by EBEs and EBOs (Davies et al., 2014) although the methodology used to explore this was limited. Further formal investigation of the EBEs role in training and other team-based approaches is warranted (Davies et al., 2014) to explore how and why their role is valuable in overcoming the challenges when working with this particular client group.

Training in a coherent treatment model that is understood across the MDT is recommended to guide and embed interventions, including staff-client interactions, and increase consistency across the team (McManus & Fahy, 2008; Murphy, 2007). This coherence has been explored in three studies which use a Cognitive Analytic Therapy (CAT) training package. CAT is a time-limited, multi-model approach which combines ideas from Personal Construct Theory (Kelly, 1995) and Object Relations (Greenberg & Mitchell, 1983). It is a relational approach which involves working with our relationships with ourselves, others and the world by trying to attune to the people we relate to (Lloyd & Potter, 2014). Similar to other multi-model formulations, CAT formulation can be regarded as a fluid

dynamic process, at the heart of which is the co-construction of the therapeutic relationship. Furthermore, CAT formulations are developed in collaboration with the patient, therapist and often the wider system (i.e. staff team). Furthermore in accordance with best practice guidance CAT formulation allows the patient to locate personal meaning within wider systemic, organisational and societal contexts (DCP, 2011). CAT provides a coherent model of the development and maintenance of presenting difficulties represented in a diagrammatic formulation (Ryle & Kerr, 2002). CAT has been used with staff teams as it allows for reflection on how interpersonal difficulties affect and are affected by systemic considerations as opposed to being purely intrapsychic.

CAT, as a conceptual framework for working with personality disorder (Jones, Annesley & Gilley, 2012) within the community (Thompson et al., 2008) and within in-patient settings (Caruso et al., 2013), has been found to have a number of positive outcomes. The common components in CAT-informed training packages included: an introduction to the model and key principles; the role of formulation; systemic and group dynamic factors associated with CAT; (Caruso et al., 2013; Jones et al., 2012; Thompson et al., 2008) and the role of group supervision following training in order to support staff to work effectively with clients (Caruso et al., 2013; Thompson et al., 2008).

The CAT training packages led to improvements in: team cohesion; team functioning; clinical confidence and how staff from a range of disciplines would approach their individual clinical work (Caruso et al., 2013; Jones et al., 2012; Thompson et al., 2008). Staff perceived themselves as being more integrated and open to social relationships within the team (Caruso et al., 2013). For example, they felt that the training enhanced personal support within the team through the use of positive team cultures such as shared language (Thompson et al., 2008). The training enabled staff to work with clients they had previously perceived as challenging, as the model instilled hope (Thompson et al., 2008), increased their levels of

tolerance and challenged them to reflect on their own responses to clients (Jones et al., 2012). Caruso et al. (2013) found significant changes, including a lower level of emotional response and a higher level of effectiveness and confidence in clinical work in staff one-month after training. Staff teams were less likely to respond in unhelpful ways and re-enact difficult early life experiences, thus improving the care that IwDPD received.

It was suggested that the structured approach of CAT enabled teams to understand relational problems and enact a lower level of emotional response, as well as a higher level of effectiveness and confidence in clinical work (Caruso et al., 2013). Consistent with other literature reviewed (Sneath, 2007), the 'whole-team' approach was considered to be an important aspect in enhancing staff roles and generating team cohesion (Thompson et al., 2008). The role of CAT formulation will be discussed later in the review.

Whilst findings from CAT studies have some promising implications, they constitute small scale investigations (maximum N = 28; Jones et al., 2012) which use different methodologies and measurement tools. Furthermore, the training packages had multiple components making it difficult to ascertain the 'active ingredient' of learning (e.g. theoretical knowledge gained or the experiential aspects of the reformulation). It is unclear whether improved staff attitudes towards personality disorder diagnosis resulted in improved practice as there was no direct measure of client outcomes. Although Caruso et al. (2013) found that there was an improvement in the quality of the staff-client relationship (one-month follow up), the measure used (Service Engagement Scale [SES] Tait, Birchwood & Trower, 2002) is not a validated measure. Furthermore, in practice, adherence to the treatment model can be difficult due to the clients' propensity to expose splitting within the team (Sneath, 2007); however, this was not explored. Clearly, there is a value in further systematic evaluation of

the role of CAT informed training packages. Whilst training is one team-based approach, another aspect is formulation.

Formulation

Background information. Formulation can be used to explain difficulties to both the individual and the team, and is also a tool which can aid the development of meaningful relationships between staff and clients (Aviram, Brodsky & Stanley, 2006). More recently, there has been a growing interest in the use of systemic formulations that conceptualise team transferences. Approaches such as contextual reformulation in CAT (Ryle & Kerr, 2002) are used to help the staff team care for the individual. Formulation is used to change the way in which the team relates to and works with the individual and to prevent the staff team or system re-enacting problematic relationships or experiences which brought the individual into mental health services (Carradice, 2004). The process of developing team formulations can be done in consultation with the staff team, which may be directly involved in developing the formulation by reflecting on countertransference feelings (Lieper, 2006). This approach is commonly used when the team feel 'stuck' or if there is a lack of progress (Christofides, et al., 2012; Ryle & Kerr, 2002). Alternatively, the formulation may be developed with the individual and shared with the staff team afterwards.

Despite interest in individual case formulation, the evidence for the role and usage of formulations being linked with improved outcomes is both limited and conflicting (Bieling & Kuyken, 2003; Chadwich, Williams & MacKenzie, 2003; Godoy & Hayes, 2011) across populations and settings, particularly within forensic services (Sturmey & McMurran, 2011). Most of the available evidence, in terms of reliability, usefulness and the effect on teams and outcomes is lacking (DCP, 2011). However, staff involved in using formulation in a team

setting not specific to IwDPD have been predominantly positive (Christofides, et al., 2012; Hood, Johnstone & Christofides, 2013; Summers, 2006).

Search results. Newman-Taylor and Sambrook (2012) used a cognitive-interpersonal approach (Safran & Segal, 1996) to formulate team problems and negative staff beliefs in an in-patient setting. The cognitive-interpersonal model proposes that an individual's beliefs about other people will not only influence their own behaviour, but exert an effect on others (i.e. a 'pull') which is likely to lead the other person to act in such a way that the schema, the thoughts and beliefs and the relationships between them, is reinforced and confirmed. For example, staff made negative attributions about the function of clients' behaviour and held negative beliefs, such as feeling uncared for by management and feeling unsafe in their working environment. This elicited staff behaviours that exacerbated poor care practices including avoidance and inconsistent care planning. The team formulation highlighted how clients responded reciprocally to staff behaviours, using extreme expressions of distress to communicate unmet needs, which subsequently confirmed staff's negative beliefs and contributed to staff burnout (Newman-Taylor & Sambrook, 2012).

As proposed by Johnson and Paley (2013), the cognitive-interpersonal team formulation led to further team intervention to improve management and team working (Newman-Taylor & Sambrook, 2012). Post-intervention findings using the Maslach Burnout Inventory (MBI; Maslach, Jackson & Leiter, 1996) showed an improvement in emotional exhaustion, depersonalisation and personal accomplishment in staff. This is surprising given that incidents of physical assaults on staff, property damage and racial abuse increased post-intervention. The multiple interventions, including training, following the formulation preclude the identification of a causal mechanism for the reductions in staff burnout and some risk behaviours.

As the Newman-Taylor and Sambrook (2012) study was a naturalistic study, there are a number of factors which may have compromised the findings, for example staff turnover during the study meant that a matched comparison could not be completed. Furthermore, there was no direct measure of the impact of the formulation on staff-client relationships or change in staff's beliefs. In light of these design limitations it is difficult to ascertain if the interpersonal problems associated with working with this client group were addressed through a cognitive-interpersonal approach to team formulation. Further research exploring the staff team's experience of team formulation, more specifically how they felt this impacted on their work with IwDPD, would be valuable in the future.

Carradice (2012) used a five-session CAT consultation model to work jointly with staff from a community mental health team to develop a formulation. The formulation included therapist and service dynamics as a way of understanding the maintenance of the IwDPD's difficulties and patterns of coping. The aim of the consultancy was to guide care planning. Moreover it aimed to help staff to understand their reactions through the formulation and to consider alternative ways of relating through modelling new ways of interacting with IwDPD. The consultant worked together with staff and the IwDPD but also worked with the staff member alone before and after each session.

Positive findings from the five session CAT consultancy were found (Carrdice, 2012). Staff and IwDPD reported that the CAT tools, the here and now approach and the internalisation of the diagrammatic formulation instilled hope and raised awareness of alternative ways of relating. Staff reported that their understanding of the IwDPD's presentation improved and they therefore had more clarity about how to help the IwDPD. Staff felt more confident and motivated and more able to engage with this client group. Importantly, staff felt that they could apply their knowledge to working with other IwDPD. However, these findings are based on a single case study using a measure which was not

validated. Given the early stages of using CAT in this way with this client group, it is unclear if and how this model will help to manage the challenges that teams face. Therefore further systematic research is required.

As part of the CAT training packages, staff experienced elements of CAT formulation. Staff developed formulations for IwDPD they were working with (Caruso et al., 2013). They personally experienced the process of formulation so they could appreciate how it would feel from the client's perspective (Thompson et al., 2008) and they focused on the concept of RRs which is a central feature of CAT reformulation (Jones et al., 2012). Although there was no explicit evaluation of the role of CAT formulation, the results (which have been discussed within the training section of this review) proved promising. The development of a shared, common language using CAT facilitated clinical discussion was perceived to improve team cohesion (Caruso et al., 2013; Jones et al., 2012; Thompson et al., 2008). Specifically, the CAT training package gave staff a framework for team case discussions of IwDPD they perceived as challenging. Reflecting on ways to relate to this client group may help reduce the likelihood of splitting and help-rejecting from IwDPD. As previously highlighted, it is difficult to define which component of the CAT training package led to the positive outcomes. However, further research to establish if and why CAT formulations, used in teams through consultation, can help to overcome the challenges of working with this client group would be valuable.

Group Reflection and Supervision

Background information. Group reflection and supervision have a vital role as a containing relationship which can counteract the challenges staff face when working with this client group (NICE, 2009b). For example, group reflection and supervision can assist staff in

managing anxiety and dealing with conflict (NIMHE, 2003a). Previous research has suggested that clinical supervision has important benefits for teams working with IwDPD including: reducing stress, burnout and sickness absence (Winstanley, 1999); providing an opportunity to reflect on practice (Jones, 2006); minimising or alleviating the negative consequences of working with behaviours perceived as challenging (Bland & Rossen, 2005); developing clinical knowledge and competence (Gallagher, 2006) and improving client care (Alleyne & Jumaa, 2007).

Search results. The process of reflecting is defined as "the opposite of operating mindlessly in response to problem behaviour" (Moore, 2012, p. 52). In teams, reflecting is widely recommended and is a common theme in the literature reviewed. Whilst operating through different forums such as staff support, clinical supervision, reflective practice (Johnston & Paley, 2013; Moore, 2012), case consultation groups ([CCGs] Eyres & McKay, 2011) and peer supervision, the literature reviewed suggests that supporting staff who work with IwDPD through supervision is critical "to safe and effective clinical practice" (Sneath, 2007, p. 288).

Typically, supervision involves staff meeting in a group to discuss their feelings towards IwDPD. The process of reflection aims to enable staff teams to remain calm whilst interacting with IwDPD and to use their responses therapeutically (Friedman, 2008) thus minimising damaging re-enactments. The presence of a variety of attitudes towards IwDPD and paying attention to team dynamics within these forums improves self-efficacy, staff communication and should lead to a shared understanding of the inevitable interpersonal and inter-professional tensions that emerge when working with this client group (Daykin & Gordon, 2011).

In an evaluation of CCGs conducted in a community Home Treatment Team (HTT), staff (N = 11) from a wide range of disciplines described how the forum provided containment for anxiety and tensions within the team, enabling them to talk about their feelings; "We all kind of open up, we talk about our frustrations… it kind of de-stresses for that hour" (Eyres & McKay, 2011, p. 27). This type of intervention could help to minimise staff 'acting out' these feelings and becoming burnt-out. However, there was no exploration as to how such containment impacted on staffs' clinical practice, in particular the way they interacted with IwDPD. Furthermore, findings suggested that there were sustainability issues: "but then you have to go out there again in the front line and you're facing the same problems" (Eyres & McKay, 2011, p. 27). Therefore it is unclear if this forum was helpful in managing challenges that staff face when working IwDPD.

It is suggested that supervision can include a formative (lifelong learning and professional development) normative (concerned with good practice standards) and restorative (a place for support, shared understanding and acknowledgement of impacts) function (Daykin & Gordon, 2011; Moore, 2012). Whilst the majority of the literature reviewed focuses on the latter – for example promoting the use of psychodynamic ideas of transference, countertransference and projective identification – Daykin and Gordon (2011) use a "systemic multi-level approach" (p. 206) within a HSH, to ensure that the staff's needs are met at different levels. This involved providing a number of group supervision forums including: supervision for unqualified nurses; MDT supervision; and incident debriefing.

Findings from implementing the systemic multi-level approach (Daykin &Gordon, 2011) indicated that group supervision for unqualified nurses had poor attendance overall; however, there were some regular attendees who reportedly gave positive feedback. Unsurprisingly, this group had the least developed supervision systems prior to the implementation of this approach despite them having a significant impact on the therapeutic

milieu (Daykin & Gordon, 2011). MDT supervision was integrated into existing meeting processes and, as other literature recommends (Crawford, Adedeji, Price & Rutter, 2010; Moore, 2012) had an external facilitator. The MDT exposed staff to the perspectives and approaches of other disciplines and improved their understanding of different roles, therefore minimising the risk of splitting. Incident debriefs focused on helping the team to process distressing information related to a difficult team event from the behaviours of an IwDPD. The importance of encouraging individual and group reflection in a sensitive way was highlighted in this forum in order to avoid the creation of a blame culture. However, there was little outcome evidence on how the team managed the challenges they faced when working with IwDPD. Although there appears to be some positive outcomes for a systemic multi-level approach in a HSH (Daykin & Gordon, 2011), further research is required to explore the effect of this approach on the clinical care provided by the staff team.

The space for reflection may be particularly pertinent for staff members in an in-patient setting, as they are more likely to face provocation due to the frequency of contact and the nature and severity of the challenging, often risky behaviours of IwDPD. Furthermore, there is the expectation that in-patient staff will provide a constant acceptable standard of care and maintain a therapeutic atmosphere on the ward (& Cochrane, 2013). Staff working in these services, particularly support workers, often have less opportunity for ‘safe space’ and time away from IwDPD to ‘self-reflect’.

Since boundaries define relationships and roles, it is unsurprising that there needs to be a focus upon boundaries early in the supervision process in order to provide the team with containment and safety (Daykin & Gordon, 2011; Moore, 2012). The facilitator is deemed important in setting and maintaining the boundaries (Johnston & Paley, 2013) as well as attending to the actions and reactions of individuals and the team as a whole. An external facilitator who can offer external perspectives on the treatment system to safeguard against

boundary violations and harmful practices is recommended (Crawford et al., 2010; Daykin & Gordon, 2011; Moore, 2012).

The value of group reflection is a common theme in the literature reviewed which focuses on training and team formulation (Davies et al., 2014; Caruso et al., 2013; Jones et al., 2012; Newman-Taylor & Sambrook, 2012; Thompson et al., 2008). Despite this recognition, Thorndycraft and McCabe (2008) eloquently state,

> Little or no account seems to be given to the risks of contamination from working with mental disorder… it is frequently stated by professionals that the nature of the work is actually not the problem. It is the widespread minimizing – or even denial – of the need for appropriate resources for the processing and working through the potentially damaging emotional residues of engaging in such work, particularly under very stressful conditions (pg. 170).

This view is supported by Newman-Taylor and Sambrook (2012) who suggest that group supervision is not being implemented as standard practice for staff when working with IwDPD. Thompson et al. (2008) also suggest that staff value group supervision but fear that it could be removed at any time. Often organisational demands and situational factors mean that consistent and ongoing supervision is difficult to facilitate (Daykin & Gordon, 2011; Thompson et al., 2008; Thorndycraft & McCabe, 2008). Daykin and Gordon (2011) suggest that there is a culture within some services, such as HSHs, whereby staff avoid supervision by blaming external factors, for example reduced staffing numbers, due to the perception that supervision is a 'tick box' exercise. The ambivalence and the avoidance of group supervision by staff may mirror some of the defences common in this client group. One way of addressing these barriers is to provide training around what supervision is/is not (Daykin &

Gordon, 2011). Exploring these potentially mirroring dynamics in future research would be valuable in establishing how this barrier is overcome.

Discussion

Although there are some positive findings, the evidence base for the role of training (including KUF and CAT training) as a team-based approach to managing the challenges that mental health teams face when working with IwDPD is limited. This is due to the paucity of studies as well as the quality of existing studies, which often lack appropriate control groups, have limited follow up data, use small sample sizes and inappropriate measures. Based on the literature reviewed, training packages for staff teams working with IwDPD should have, as a minimum: a clear ring-fenced funding for development and delivery with outcome monitoring; a positive culture within the organisation that values this type of training by providing finance, time and co-facilitation where clients are seen as 'equal' partners; effective clinical leadership; a coherent model for understanding behaviour (e.g. schema, CAT); and continuous 'on the job' support (Davies et al., 2014). In addition, whilst it may be expected that training would be useful for teams which are burnt-out, training may have the potential to exacerbate some negative beliefs within the staff teams (Moore, 2012).

The literature reviewed has explored the role of formulation using a CAT approach. CAT formulations (known as reformulations) focus on 'reciprocal roles' (RRs), which conceptualise patterns of problematic relationships that an individual develop in childhood, for example the abusing parent-to-abused child. Similar to internal working models of attachment theory (Ainsworth, 1989) these RRs are templates for future relationships with others, including staff. The client's RR patterns are likely to be re-enacted with staff teams (Ryle & Kerr, 2002). This principle enables the IwDPD and the staff team to relate to being in any of these roles, for example staff or clients re-enacting the abusing parent role.

Therefore relational difficulties can lie within the staff team, system or institution (Ryle & Kerr, 2002). This can help teams to reflect on and respond to difficult interactions with IwDPD in a more helpful way.

Despite recommendations (DOH, 2011b; DCP, 2011), there is a clear paucity of research exploring the use of formulation in teams who work with IwDPD. Furthermore, it is worth noting that there were no studies conducted within forensic services. Whilst the findings of the literature reviewed have some promising implications, the studies are small, use different methodologies and different outcome measures and therefore are unable to be directly compared. Given the systemic elements of treating this client group the lack of research in the use of systemic formulation is surprising. However, what is common in the literature reviewed is that team formulations are multi-model and take into account team transferences. Research exploring team formulation is limited. This should be an area for future research to focus upon.

In comparison to training, where IwDPD may be largely seen as a whole group with shared difficulties, formulation has the potential to capture the individual needs of each IwDPD and also of the staff team. Therefore, future research could employ a qualitative methodology to explore the individual, yet potentially shared experiences that staff report as a result of complex transference and countertransference processes when working with this client group. Another team-based approach which can explore transference and countertransference processes is forums for group reflection and supervision.

Whilst forums for reflection come at a financial cost to services in terms of reduction in time spent with clients, there is evidence to suggest that they may benefit the service through reducing burnout and helping maintain an effective team (Crawford et al., 2010). Irrespective of the forum, the importance of creating an emotional and physical ‘safe place’

to foster mentalisation and emotional containment is a critical part of working with this client group. However, despite recommendations (DOH, 2011a; NICE, 2009a, 2009b; NIMHE, 2003a), only a few studies have explored the use of group supervision in mental health teams who work with IwDPD. Furthermore, these studies are small, use different methodologies and do not use outcome measures and cannot be directly compared. Future research would benefit from addressing these methodological issues.

Conclusion

It is widely acknowledged that staff teams face a number of interpersonal challenges when working with IwDPD, which can leave staff feeling inadequate, ineffective, confused, scared, helpless and anxious (Kelly & May, 1982; Nehls, 2000; Risq, 2012; Woollaston & Hixenbaugh, 2008). Emotions can become contagious within a setting if there is a lack of recognition and inadequate processing of emotional reactions from staff to clients (Hinshelwood, 2002). This can inadvertently re-enact early patterns of abuse and staff can become enmeshed in unhealthy, destructive interactions (Meaden & van Marle, 2008), thus negatively impacting upon the care and treatment that this client group receives. Recent guidance has also made a number of recommendations to protect teams against the difficulties associated with working with IwDPD (DOH, 2011a; NIMHE, 2003a, 2009b; NICE, 2009a, 2009b). Based on this guidance, this review has explored the recent literature on using team-based approaches to manage the challenges that staff teams face when working with IwDPD in adult community, in-patient and forensic mental health settings. In particular, the potential contributions of training, formulation and group reflection have been discussed.

This review highlighted the paucity of research exploring these team-based approaches. In general, the literature reviewed was small in scale and the quality was varied. Studies used different methodologies and there was a lack of outcome measures, which

showed the impact of the team-based approaches on the challenges that teams face and how this impacts the care that IwDPD receive. The lack of research conducted in secure services is notable, particularly in team formulation, given the high prevalence rates of personality disorder in these sectors. Therefore future research may wish to concentrate on this sector.

The disparity of research around training, against the sparse research in formulation and group reflection, is clear. It is likely that this is because the outcomes of training programmes (i.e. increase in knowledge) are tangible and therefore can be easily measured. In contrast group supervision and formulation involve more complex interpersonal processes, which potentially pose difficulties to researchers aiming to measure these components as well as identifying the active components of change.

The literature reviewed demonstrated that training alone was not sufficient in managing the challenges that mental health teams face when working with IwDPD and that further 'on the job' support, such as supervision, was required. However, the literature reviewed recommended that training for mental health teams working with IwDPD should have as a minimum: a clear ring-fenced funding for development and delivery with outcome monitoring; a positive culture within the organisation that values this type of training by providing finance, time and co-facilitation where clients are seen as 'equal' partners; effective clinical leadership; a coherent model for understanding behaviour (e.g. schema, CAT); and continuous 'on the job' support (Davies et al., 2014).

Furthermore, the review highlighted that the use of team formulation is under-researched despite the systemic elements of treating IwDPD. Based on the literature reviewed, there was limited exploration of how team formulation impacted on mental health teams' understanding of IwDPD behaviour and how this impacted on staffs' ability to manage this through their relationship with IwDPD.

CAT as a conceptual framework for working with personality disorder (Jones, Annesley & Gilley, 2012) within the community (Thompson et al., 2008) and within in-patient settings (Caruso et al., 2013) was found to have a number of positive outcomes including improvements in: team cohesion; team functioning; clinical confidence and how staff from a range of disciplines would approach their individual clinical work (Caruso et al., 2013; Jones et al., 2012; Thompson et al., 2008). Given that the CAT training packages incorporate team formulation, of which team transference is a key principle, there would be value in undertaking further research. Therefore, qualitative approaches may be more suitable in the first instance to enable exploration of staffs' experiences of formulation. In particular, to explore the individual, yet potentially shared, experiences that staff have as a result of complex transference and countertransference processes.

Additionally, the review highlighted the importance of creating an emotional and physical 'safe place' for emotional containment and reflection. However, the review highlighted gaps in the research. Future research should explore the potential barriers to implementing supervision groups in order to overcome these. In addition to this, future research may wish to explore how group supervision forums can be used as a process for developing or sharing formulations, given some of the similarities in processes which require staff to reflect on 'the self' (Dallos & Steadman, 2014).

It is possible that that an integration of all of the above team approaches would provide such support, however, due to the paucity of research in team formulation and group reflection, there is a clear need for more evaluative research to be conducted in these areas. The dearth of research in this area may reflect some parallel processes occurring between the challenges of working with this client group and research in this field. The difficulties in researching team approaches may be overwhelming for clinicians working in this field, who are arguably well placed to conduct research, whilst they also try to contain the

overwhelming feelings that IwDPD can evoke. However, this results in a 'vicious cycle', whilst teams are still faced with challenges and the care of IwDPD is negatively affected.

Establishing staffs' understanding in the above areas is of clinical importance, as it will help to identify ways in which relationships between staff, IwDPD and the wider mental health system can be understood and improved. Having a better understanding of IwDPD presentation enables teams to provide more appropriate and therapeutic care and treatment that does not re-enact and reinforce early unhelpful patterns of relating and coping.

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Table 1.

Authors	Study type	Purpose/ aim	Main findings/ themes
Sneath (2007)	Book chapter	To discuss the issues and challenges for the clinical profession treating personality disorder	Preparing and developing staff by identifying training needs. Knowledge is required across the staff group and there is a discussion about how to overcome practical difficulties in the delivery of training. Issues for supervision. Maximising informal support opportunities.
Fanaian, Lewis & Grenyer (2013)	Qualitative study	To explore the views of mental health clinicians (*N*=60) with expertise in personality disorders on how mainstream services can improve the services provided to people with a diagnosis of personality disorder.	The most common themes included: - More training and education for health professionals and carers - Better support through supervision and leadership Others identified: - More consistent patient-centred, collaborative recovery approach - Changed attitudes to decrease stigma
Murphy & McVey (2007)	Book chapter	Explores the difficulties that staff experience in treating individuals with personality disorder. Summaries action that can be taken to develop a service for the client group.	Staff to possess a psychological understanding of personality disorder; good emotional regulation skills; capacity for self-reflection.
Davies, Sampson, Beesley, Smith & Baldwin (2014)	Service evaluation	To audit the Knowledge and Understanding Framework a 3-day nationally devised personality disorder training programme for staff (*N* = 162).	Results immediately post-training suggest an improvement in levels of understanding and capability efficacy and a reduction in negative emotional reactions. Indications from a 3-month follow-up suggest that while understanding and emotional reaction improved, capability efficacy regresses back to pre-training levels.
Lamph et al. (2014)	Service evaluation	To evaluate the effectiveness of mixed multi-agency Knowledge and Understanding Framework delivery over a 12-month period. To establish the effectiveness of the training to staff (*N*= 136).	Results immediately post-training an improvement in understanding and capabilities efficacy and a reduction in negative emotional reactions. Indications from a 3-month follow-up suggest that while understanding improved, there was no significant change in capabilities and pre- to post-training scores decreased.
Johnson & Paley (2013)	Case study	Reflections on facilitating reflective practice groups in adult community mental health teams and 3 acute in-patient wards.	-Differences between reflective practice, case discussion and formulation groups -Practicalities of facilitating the group -The importance of the role of the facilitator

Carradice (2012)	Article: Case study	To describe the steps of 'five-session Cognitive Analytic Therapy' consultancy in a community mental health team and discussion preliminary findings.	Staff members feel they gain understanding of the client's presentation, clarity about how to help clients and that they feel more contained, have increased confidence, motivation and ability to engage with the client. They also report that they have more focus to their work and are able to apply the experience to other clients.
Steinberg & Cochrane (2013)	Article: Case studies	The focus is on dealing with staff transference and countertransference manifestations.	Staff members should reflect on their experiences with patients and will therefore be less likely to respond with adverse behavioural reactions.
Jones, Annesley & Gilley (2012)	Service evaluation	To evaluate a 2-day introductory training course on Cognitive Analytic Therapy.	- Made staff feel more positive and more confident about working with this client group - Challenged them to think about their own responses to clients - Increased tolerance and understanding and perceived that it would impact on their work - Gave them a new understanding which has potential for contributions to MDT discussions, informing care plans - Should be mandatory
Thorndycraft & McCabe (2008)	Article: Case studies	1) To highlight the importance of a regular reflecting space for team dynamics & their own mental health 2) To discuss the role of facilitator 3) To propose a model of "Team Development & Reflective Practice Groups"	- Providing a containing safe space- physically and emotionally - Assessment - clarify what the group task will & will not be - Boundaries and confidentiality. - Practical issues
Crawford, Adedeji, Price & Rutter (2010)	Service evaluation	1) To examine levels of burnout among staff working in community-based services for personality disorder. 2) To explore the factors that add to or lower the risk of burnout among people in such services & what steps services took to try & support their staff.	- The role of whole-team supervision was one of three themes which were important for avoiding staff burn-out - Importance of external supervision by someone independent of the team - Importance of willingness to engage in reflective practice.

Newman-Taylor & Sambrook (2012)	Exploratory and naturalistic study in a clinical setting.	1) To explore the value of the cognitive-interpersonal model in formulating key staff-service user relationships 2) To determine whether such an approach would yield useful team-based intervention in a 16-bedded in-patient service for adults.	The team formulation was effective in making sense of interactions contributing to the maintenance of challenging behaviours and staff burn-out, and in deriving systemic interventions likely to effect change and guide service planning. Preliminary data indicated that staff burn-out and incidents of challenging behaviour reduced over time.
McManus & Fahy (2008)	Review article	To review the aspects of epidemiology, diagnosis, clinical presentation, assessment and management.	Training- emphasis on the consistency of the therapeutic model among all staff dealing with client (no details). Supervision is important for maintaining a clear therapeutic agenda and in supporting staff in what may be challenging and emotionally draining work.
Moore (2012)	Review article	To summarise personality disorder and its impact on staff and the role of supervision	Training: - Opportunities to learn about core competencies. - Contents of training packages: empathy & understanding; transference and countertransference reactions; how to set & maintain boundaries; and knowledge of the service. Post-qualification training- complex interpersonal therapeutic skills. Support: - The role of supervision in maintain optimal working alliances - Different types of supervision: group approaches including reflective practice; peer supervision; learning from incidents. - Boundary violations
Friedman (2008)	Chapter: Two case studies	Reviews & discusses the issues and controversies related to the hospitalisation of suicidal patients with BPD. It highlights the challenges faced by staff team and patients.	- Ongoing education for staff - Awareness of t treatments including emotional regulation - Staff support should involve helping them become attuned to their own emotional responses to patients to enable staff to remain calm and to use their own responses purposefully and therapeutically.
Caruso, Biancosino, Marmai, Kerr & Grassi (2013)	Quantitative study	To evaluate if a Cognitive Analytic Therapy -based training intervention directed at mental health staff (*N*=12) dealing with complex psychiatric cases in a residential facility, had an impact on reducing stress and improving group cohesion and quality of work with "difficult" psychiatric patients.	Training had a positive impact on mental health staff across areas. More specifically on burn out, professional-patient relationship and team cohesion.

Thompson, Donnison, Warnock-Parkes, Turpin, Turner & Kerr (2008)	Qualitative study	To explore community mental health teams (*N*=4) experiences of receiving an innovative introductory level training in Cognitive Analytic Therapy. CMHT staff (*N* = 12) were interviewed following completion.	- Team cohesion including improved functioning, communication and confidence. Group supervision deemed important in this process but concern that this would not continue. - Individual clinical confidence- frequent use of CAT model. Training had informed their clinical work, to contain their anxieties about working with this client group.
Eyres & McKay (2011)	Qualitative evaluation	In a home treatment team what was helpful about case consultation groups (CCGs)? What did staff consider needed changing about the CCGs? (*N*= 11)	Five broad themes emerged: - Collaboration- improving team cohesion - Containment- to share and normalise difficult feelings when working with patients - Psychologists' Role- to provide explicit strategies, teaching and suggestions - Psychological mindedness- considering social, economic and psychological factors which impact on patient's mental state - Disruption/ inconsistency- erratic attendance impacted on benefits of group
Daykin & Gordon (2011)	Book chapter	To focus on how the supervisory needs of multidisciplinary staff working in the context of a high secure hospital are met. To explore the different supervisory systems that were established and their underpinning rationale.	A supervisory philosophy which adopts a systemic multi-level approach focused on 6 main areas: - Profession-specific, one-to-one supervision - Supervision groups for unqualified nurses - Therapy-focused supervision - Multidisciplinary team supervision - Incident debriefing - Team-focused formulation
Murphy (2007)	Book chapter	To discuss effective transdisciplinary teamworking when working with IwDPD.	- Staff training when preparing for a team and orienting new staff - Some shared knowledge

Chapter Two: Research Paper

Exploring Multi-Disciplinary Team (MDT) Experiences of Cognitive Analytic Therapy (CAT) as a Systemic Consultation Tool in an Adult Forensic Service

Word Count: 12,850

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Abstract

Background: Following the growing emphasis on the use of psychological consultation and the use of Cognitive Analytic Therapy (CAT) as a consultation tool, this qualitative study explored staff members' experiences of using CAT as a systemic consultation tool. *Method:* Interviews were conducted with nine members of the Multi-Disciplinary Team in a High Secure Hospital and the data analysed using thematic analysis from a social constructionist perspective. *Results:* Emerging themes of CAT as consultation tool included the availability and accessibility, the genuine value and mirroring enlightenment. *Conclusion:* The study demonstrates how genuine value within the system sits at the heart of accessibility and availability of CAT as a systemic consultation tool and the mirroring enlightenment of staff and patients. Implications for clinical practice are also discussed.

Keywords: Cognitive Analytic Therapy (CAT); consultation; forensic; high secure hospital; thematic analysis

Introduction

There are three high secure hospitals (HSHs) within England which provide in-patient care and treatment in conditions of maximum security (Hamilton, 2010). Patients admitted to a HSH are subject to detention under the Mental Health Act (MHA) 2007 and are deemed to be a grave and immediate danger to themselves or others (Annesley & Sheldon, 2012). Previously known as 'special hospitals', HSHs are considered to be distinct from other secure hospitals, in terms of the limited number of sites, their physical security, the patients' profiles and the treatments offered (Sarkar, 2005; Stowell-Smith, 2006). For the purposes of this paper, the terms 'patient' and 'forensic patient' will be used interchangeably, in accordance with the other literature, to encompass the range of terms used to describe this client group.

The physical security of HSHs – the high perimeter fence, locked wards, staff carrying security alarms and constant surveillance – means that there are a plethora of policies and procedures to follow (Ireland & Snowden, 2002). With a heightened focus on physical and procedural security, there is the risk of less emphasis being placed on relational security (Hamilton, 2010), which is the detailed knowledge of the patients, their backgrounds and the reasons behind their admission. The high level of security in these environments can be construed as controlling. Indeed, synthesising the dialectic of care versus security represents a constant challenge for staff working in this environment (Hamilton, 2010; Sarkar, 2005). Good relational security involves maintaining appropriate relationship boundaries. This requires all staff to be aware of what they say and do, and how this could be interpreted by others, which means being prepared to examine one's feelings (Department of Health [DOH], 2010).

Good relational security is challenging given the presentation of patients in HSHs. They have complex psychopathology and have committed violent and aggressive acts

towards others and themselves. Patients are often labelled as 'disturbed' and 'dangerous' (Sarkar, 2005), have been given multiple diagnoses and have high levels of co-morbidity (McGauley & Humphrey, 2003). Prevalence studies estimate that 79% of individuals in HSHs have a diagnosis of personality disorder (Mbatia & Tyrer, 1988; Taylor et al., 1998), of which, anti-social, narcissistic and paranoid personality disorders are common (Sheldon & Krishnan, 2009). Irrespective of diagnosis, common among forensic patients are experiences of abandonment, loss and deprivation and a childhood and/or early adulthood characterised by abuse and neglect (McGauley & Humphrey, 2003; Sarkar, 2005). Consequently, in the face of distress and arousal, forensic patients have restricted repertoires of coping skills, such as violence, self-harm and substance misuse (Frodi, Dernevik, Sepa, Philipson, & Bragesjo, 2001; van Ijzendoorn et al., 2007).

The secure environment places great demands on patients' and staffs' emotional and physical resources (Jeffcote & Travers, 2004). The challenging behaviour and the risks that patients pose mean that staff teams can struggle to view patients as both a perpetrator and a victim. The patients evoke strong feelings in staff and other patients of both rejection and concern, but are known to undermine or sabotage attempts of help due to their early experiences, often characterised by mistrust, abuse and abandonment. The inconsistency and rapid change in their moods can leave staff feeling confused, scared and helpless and leads to difficult dynamics, such as splitting and collusion within teams and often within the institution itself. Furthermore, research has shown that staff teams who work with complex and challenging patients tend to be inadequately resourced (Kerr, 1999) which contributes to splits in staff teams (Ryle & Kerr, 2002). As a result, staff often adopt defensive ways of coping in their work with patients (Hinshelwood, 1994) borne out of fear which is heightened in HSHs (Cox, 1996). This can lead to adverse care practices (Withers, 2008) such as abuse and neglect, which institutions are at risk of colluding with (McGauley & Humphrey, 2003).

The problems with the structure and therapeutic milieu of services and the impact on staff teams and patients is widely acknowledged,

> the nature and quality of the relationships we find and create around us can have a profound effect, not just on the efficient, smooth running of any enterprise, but also on how we feel – whether we thrive or struggle (Royal College of Psychiatrists [RCP], 2013, p. 3).

To thrive in secure services is a greater challenge based on the relational difficulties described above. This is further compounded by patients having to negotiate and manage up to 180 staff relationships within one year of being in secure services (Aitken & McDonnell, 2006) which is likely to compromise good relational security but also evoke feelings of abandonment in the patient. As a result, secure systems, and in particular HSHs, operate in fragmented ways. This means that continuity and collaborative approaches to care are imperative – albeit difficult to achieve in light of the above. All of these challenges can re-enact the early experiences of the patients, for example neglect and abuse, and contribute to, and maintain, their already complex psychopathology. This then perpetuates the challenges that the staff teams working in this environment face, thus creating a self-fulfilling prophecy.

Given the emphasis on the relational aspects of care, it is unsurprising that establishing quality services which foster productive relationships and promote good mental health have recently become high on the agenda through the Enabling Environments standards (RCP, 2013). Among the ten standards, the importance of the nature and quality of relationships and boundaries are highlighted. Furthermore, the reduction of restrictive practices, for example the use of restraint and seclusion, has recently become a focus of attention (DOH, 2014). This is relevant to forensic patients as they are at high risk of

restrictive and abusive practices, given that staff may adopt 'self-protecting' defensive care practices as described above.

The Role of Forensic Psychotherapy

The application of psychodynamic and psychoanalytical principles, commonly referred to as forensic psychotherapy, in understanding the treatment and management of forensic patients has increased over recent years and continues to be a developing speciality (McGauley & Humphrey, 2003; Norton & McGauley, 2000). Current practice in the United Kingdom (UK) applies these principles to working individually with forensic patients and also to the complex dynamics of the staff teams and institutions working with these patients (McGauley & Humphrey, 2003). These principles can be applied in assessment, formulation and intervention through direct clinical work (individual or small groups); through supervision of others; in team forums, for example clinical meetings and case conferences; and in consultation. However, the provision for forensic psychotherapy is sparse within secure services, particularly within HSHs given its specialism (McGauley & Humphrey, 2003). This means that only a small number of patients are seen on an individual basis, creating delays and inconsistencies in care, which adds to the existing challenges of secure services highlighted in previous paragraphs.

One common practice in secure services which aims to target the limited resources is the role of consultation. Consultation or 'institutional supervision' (McGauley & Humphrey, 2003) can operate at three levels: supervision of clinical work with patients; assisting staff to understand patients in the context of the ward in which they live and their interactions with staff and other patients; and addressing how patients' psychopathologies unconsciously influence the system in which they are treated, at ward level and within the wider institution. The latter two levels aim to understand how the patient's psychopathology is enacted and

incorporated in to certain aspects of how the institution functions. One of the benefits of consultation on these levels is that it can highlight the conflicts within the system and between staff, for example in boundaries of care and security as described earlier. However, McGauley and Humphrey (2003) rightly note that in order for consultation at these levels to be effective, it needs to be available to all staff members at all levels within the institution, from support workers to management and executives.

Cognitive Analytic Therapy (CAT)

One form of psychotherapy used in forensic settings is Cognitive Analytic Therapy (CAT). CAT is a time-limited, integrated approach which combines ideas from Personal Construct Theory (Kelly, 1995) and Object Relations (Greenberg & Mitchell, 1983). CAT is a relational approach which involves working with our relationships with ourselves, others and the world by trying to attune to the people we are with (Lloyd & Potter, 2014).

A central feature of CAT is to collaboratively develop the reformulation in a non-collusive therapeutic relationship (Ryle & Kerr, 2002). Reformulation is based on the premise that individuals have their own understanding of their experiences and problems. In order to elicit change, there needs to be a full understanding of the route of the problem and how it is maintained. In CAT this is facilitated by key features known as Reciprocal Roles (RRs) and Reciprocal Role Procedures (RRPs).

Reciprocal roles (RRs) refer to the pattern of relating to others which are internalised from an early age, for example the parent-to-child roles. An individual internalises both roles in childhood and carries them throughout life (Ryle & Kerr, 2002). When an individual takes up one of the roles, then the other whom he/she is relating to feels compelled to take up the other role (Denman, 2001) creating a self-to-other role, for example the abusing father-to-abused child. RRs also refer to the way in which a person relates to his or herself, known as

the self-to-self role. The benefit of CAT is that it captures the RRs which can manifest within the therapeutic relationship and the setting/system in which the patient is being treated, for example, the abusing therapist-to-abused patient. Ryle (1979) proposes that people have a repertoire of RRs which are flexible and adaptive, but that this is likely to be restricted in those with psychological disorders.

Reciprocal Role Procedures (RRPs) are the interactive patterns of intention, feeling, thinking, action and response or consequence that keep us in particular reciprocal role positions – and thus, explain how a patient's problems are maintained.

The understanding of RRs and RRPs is transformed into a more exploratory and helpful form through the therapeutic relationship and are presented in a Sequential Diagrammatic Reformulation ([SDR] see Appendix B for an example). The SDR is a diagram of words or pictures describing RRs with arrows illustrate the multi-modal nature of procedures how procedures maintain distress and how key procedures relate to each other. Moreover, the SDR offers a visual description of the relationships between self-other, other-self and self-self the client's presenting problems and the system around them. The SDR has value in being a self-monitoring tool for tracking the RRPs as well as guiding intervention, illustrated by 'exits' (i.e. positive and viable alternatives to unhelpful procedures) in the diagram.

CAT in Forensic Settings

Empirical research in CAT is in its infancy. Nevertheless, research to date has shown CAT to be an effective approach in the treatment of a variety of clinical populations (Clarke & Llewelyn, 1994; Cowmeadow, 1994; Denman, 1995), particularly those with more complex presentations, including the treatment of personality disorders (Clarke, Thomas & James, 2013; Ryle, 1997; Ryle & Marlowe, 1995) and within the forensic population

(Pollock, 1996; Pollock, 1997; Pollock, 2001a, 2001b; Pollock & Kear-Colwell, 1994; Pollock & Belshaw, 1998). CAT is provided across secure services within the UK (Mitzman, 2010) and there is a growing body of practice-based evidence within forensic settings (e.g. Pollock, Stowell-Smith & Göpfert, 2006).

CAT for forensic patients highlights the relational component of the offender-to-victim roles, for example the exploiting/manipulating offender to the exploited/duped victim. These roles can also conceptualise societal beliefs which view crime and offending from opposing positions, for example guilty/innocent (Stowell-Smith, 2006). The aim of using CAT with this client group is for the offence committed to be understood as the outcome of patterns of thinking, perceiving, feeling, relating and acting, which are able to be changed (Pollock & Stowell-Smith, 2006). Understanding offending in this way has proved to be helpful, not only to individual patients, but also to staff working with them both in terms of day-to-day interactions (Cox, 1976; Dunn & Parry, 1997) and wider risk management (Pollock, 1996, 1997; Pollock & Kear-Colwell, 1994) which will be discussed below.

CAT and Risk Assessment

It is proposed that CAT can contribute to risk assessment – in accordance with the DOH (2007) best practice principles – through the emphasis on transparency and collaboration in developing, using and sharing the SDR with patients, staff teams and external agencies (Kirkland & Baron, 2014; Shannon, 2009). It is proposed that a patient's absence during the risk assessment process is likely to contextually re-enact RRs which are characteristic of their past experiences, such as control, neglect and exclusion, thus perpetuating the patient's psychopathology (Shannon, 2009).

Another benefit of using CAT in risk assessment is having the understanding of the patient's intra-personal experiences (Mitzman, 2010; Shannon, 2009). The dynamic and

relational nature of the patient's risk of harming themselves and others is identified by exploring the patient's RR repertoire (Pollock, 2006). The RRPs provide a way of formulating the nature, the likelihood, severity and imminence of the offending behaviour (Hart, Kropp, Laws, 2003; Pollock & Stowell-Smith, 2006; Shannon, 2009). More specifically, these procedures identify real or perceived triggers, which are likely to shift the patient into an intolerable state, and which likely actions the patient will take (Shannon, 2009).

The SDR is seen as a risk management tool to recognise risk patterns and use the 'exits' to prevent patients from re-enacting their RRPs, thus preventing risk of harm to themselves and others. The exits in the SDR will help to identify any future interventions and treatment needs that will help to minimise risk and to improve public protection (Shannon, 2009).

Using CAT Systemically

The dysfunctional relationship between the patient and the mental health system has also been explored using dissociated RRs, which outline processes such as splitting and idealisation (Dunn & Parry, 1997; Kerr, 1999). Like Walsh (1996), Stowell-Smith (2006) proposes that the HSH could also be deemed a 'harmful work environment' for both staff and patients which has a "series of defensively dissociated, psychological states that hang together in a fragmented way" (p. 73). These states include: separateness and exclusion, claustrophobic dependency, and control and emotional numbness. Stowell-Smith (2006) describes this distinctness as being 'separateness' and 'exclusion' from the macro level for example the concentration of HSHs in to only three sites in England, to the micro level for example the characteristics of the client group. With the mirroring complexities of the forensic patient and the secure system, care can be fragmented and the likelihood of re-

enacting RRPs is high. Therefore it is unsurprising that over recent years CAT has been applied to indirect ways of working (Carradice, 2012; Caruso et al, 2013; Kellettt, Wilbram, Davis & Hardy, 2014; Nicholson & Carradice, 2002).

CAT coherently conceptualises the parallel processes occurring between staff and organisations in relation to the patient through the SDR, which is referred to as a 'contextual reformulation' (Kerr, 1999; Ryle & Kerr, 2002). Ryle (2002) argues that the use of contextual reformulations may "enable staff to respond therapeutically rather than simply react to such patients" (p. 202) thus minimising the likelihood of staff adopting defensive, abusive care practices. Furthermore, "understanding the importance of the setting and context, and their relationship to the internal vulnerability associated with different personality traits, staff will find it easier to recognise risk and will be in a better position to manage it" (Reid & Thorne, 2007, p. 8).

Using CAT in Consultation. Ryle and Kerr (2002) outline the benefits of using reformulation through consultation with a staff team when a patient is too ill or too 'stuck' to participate themselves (see Appendix B for an example of CAT SDR in consultation). Furthermore, sharing or collaboratively developing reformulations with staff teams and also to wider systems helps staff teams to understand the person in context and to provide a more consistent and coherent understanding (Aitken & McDonnell, 2006). It allows staff and patients to make sense of previously challenging and confusing behaviours (Walsh, 1996) allowing staff to respond in more adaptive, helpful ways. The use of CAT in consultation can also help to predict the transference and counter transference reactions (Dunn & Parry, 1997) and contain staff anxieties about future behaviours (Kerr, 1999; Ryle & Kerr, 2002). It can therefore protect against 'splitting' and fragmentation of the team (Mitzman, 2010). In turn, this can improve the care that a patient receives.

Research conducted in non-forensic settings has demonstrated how developing a CAT reformulation with patients in consultation with the staff team has assisted with increasing the understanding of the patient's difficulties, has gone on to inform care planning (Carradice, 2012; Dunn & Parry, 1997; Kellett et al., 2014), has enhanced team work, and made positive changes to the staffs' clinical approach, for example giving them more direction and enabling them to behaving and thinking differently (Kellett et al., 2014).

Research using CAT consultation in forensic settings is in its infancy, but it is promising. A case study in female forensic settings found that after sharing an SDR with the staff team, staff members had shifted their perceptions of the female as 'psychiatric patient' and 'arsonist' (i.e. offender) to a more holistic view of being a woman with children (Aitken & McDonnell, 2006).

Hamilton (2010) found that sharing the contextual reformulation in consultations with staff teams was useful for reflecting on how their personal patterns of relating could elicit a response from another. This was conceptualised in the RRs within the SDR, for example the controlling/withholding/judging/safe staff team to the controlled/ judged/ neglected/ scared/ angry patient. This process was helpful for ward staff as it simplified the complex process of relational boundary management as they could monitor boundary shifts and violations by reflecting on which role they were at risk of re-enacting (Hamilton, 2010). Professionals need to hold a balanced and informed view of the patient to enable true risk assessment, risk management and therapeutic care. However, some of the ward staff found the reformulation complex and difficult to comprehend, which poses questions about how this could then be used in clinical practices (Hamilton, 2010).

Sharing reformulations with staff from multi-agencies has shown to help with developing a shared language (Kirkland & Bowland, 2014). This is likely to help staff relate

to patients in a more consistent, empathic, non-stigmatising and non-blaming way, thus preventing splitting in staff teams and improving patient care.

Limitations of CAT in a Forensic Setting

Annesley and Sheldon (2012) found a number of specific challenges that CAT clinicians face when using CAT within HSHs. CAT clinicians highlighted concerns around therapy, and therapeutic relationships more specifically; staff perceived clinicians to be "over-involved" and "overly-rescuing" (p. 127). Similar to other literature (Hamilton, 2010; Stowell-Smith, 2006) challenges related to the HSH culture, environment and organisational dynamics were found. More specifically, CAT clinicians experienced the organisation as wanting to control disciplines. Undeveloped skills in staff in terms of them being able to self-reflection, balance care and control, and understand patients' risk and patients' ability to change were raised as concerns.

Annesley and Sheldon (2012) described CAT as a "double-edge sword" in HSHs (p. 135) as CAT clinicians saw huge value in using the approach with patients and staff teams within forensic settings, but identified difficulties with staff in their efforts to use CAT and integrate CAT within this setting. Clinicians identified obstacles in embedding CAT into team working and into the culture of the HSHs, as well as in sharing formulations and making CAT principles accessible to others. Clinicians hypothesised that some of these difficulties were related to the focus on emotional connectedness. This threatened staff members' coping strategies for working in that environment which included cutting off emotionally. Other challenges which clinicians encountered in using this approach included the stages, structure and tools used in CAT. Despite the challenges, clinicians noted positives about CAT, including the way patients and professionals respond to the approach, in that it is

engaging and often provides understanding and relief of the push-pull and offender-to-victim roles in forensic services.

Aims

As highlighted by Pollock (2006) the effectiveness of CAT and its expansion into other areas of forensic work is essential. Despite CAT being utilised in practice within forensic services as a systemic consultation tool, there remains paucity in the research investigating this, particularly the experiences of the consultees. The present study will aim to address the gap in the literature by exploring individual staff members' (consultees) experiences of receiving consultation within a HSH in order to develop the CAT reformulation and/or to share the reformulation which has been previously developed. Given the challenges faced within HSHs and the proposed benefits of using CAT with offenders as discussed above, this study also aims to explore whether using CAT as a systemic consultation tool increases consultees' understanding of the forensic patients' behaviour, their clinical presentation and their risk potential. The study also aims to explore whether using CAT in this way helps them in their management of patients, and how. Furthermore, it aims to explore whether the CAT consultation process helps consultees to contain their emotional responses when working with these patients.

Establishing staff understanding in the above areas is of clinical importance as it will help to identify ways in which relationships between staff, patients and the wider system can be understood and improved. Having a better understanding of patients' presentation enables the care team to provide more appropriate and therapeutic care and treatment that does not re-enact and reinforce early RRs and unhelpful patterns of relating and coping. Staff play a crucial role in the treatment as they 're-parent' by modelling more appropriate interactions, through developing insight in the moment and by providing alternative, more appropriate,

ways of coping. This research also has the potential to inform training needs and the delivery of psychology services within forensic services and thus the delivery of care to patients.

Staff understanding of CAT as a systemic consultation tool will be explored in interviews and analysed using a thematic analysis from a social constructionist perspective. The aim is to tease out the relevant and prevalent themes in attempting to understand staff insight into their experiences and the underlying influence and attitudes that impact on staff beliefs about CAT as a systemic consultation within a HSH.

For the purposes of this study, the term consultation is based on McGauley and Humphrey (2003). It refers to a process in which the aim was to assist staff to understand patients in the context of the ward and the institution in which they are being treated, and their interaction with other patients and with staff; also addressing how patients' psychopathologies unconsciously influence the system in which they are treated, on the ward and institutional level. This includes forums such as care team meetings, reflective practice and case discussions where there was one leading 'consultant'.

Method

Design

Data were collected (N = 9) using a semi-structured interview (Appendix C). A qualitative methodology was used as this is capable of providing a rich and complex understanding of the data (Braun & Clarke, 2006), "whilst categorising and organising the subtleties of everyday social phenomena in a meaningful way" (Krauss, 2005, p. 766).

Thematic analysis was chosen as it is a method for identifying, analysing and reporting patterns (themes) within and across the data at the manifest level (i.e. a descriptive

account of the data but no comments or theories as to why or how) and also interprets themes across the data at latent levels (i.e. an underlying theme that influences an individual's experience of using CAT as a systemic consultation tool). The flexibility of thematic analysis enables it to be compatible with the social constructionist framework, which is a primary concern of this study.

Social constructionism is a theoretical orientation for which there is no one single description. Based on Gergen (1985), Burr (2003) suggests that a social constructionist approach is one which has its foundations in one or more of four key assumptions. One assumption pertinent to this study is that our knowledge is sustained by social processes; people construct and share knowledge between each other through social interaction, particularly language.

Therefore, a thematic analysis from a social constructionist perspective is taken. A data-driven approach is used for the analysis where understanding and knowledge of the study topic is deconstructed. However, meaning is viewed as being co-created by the participants and the researcher (Ciclitira, Starr, Marzano, Brunswick & Costa, 2012) by interacting with each other's constructions through the interview schedule. The interview schedule includes others' co-constructions of meaning as it is based on existing literature. This approach will examine the extent to which meanings and experiences are the effects of a range of discourses operating within the society of the work place (Braun & Clarke, 2006); in this case a HSH, and where historical and cultural issues are considered.

Participants

A sample of 21 staff members were identified as being eligible to participate. In total, ten participants opted in and nine were interviewed. One participant did not attend the scheduled interview and did not respond to follow up correspondence. Participants were

recruited from one HSH. All participants had a professional qualification and had at least one experience of a CAT-informed consultation within the last six years.

Insert table 1 here

Procedure

Ethical approval. A research proposal was submitted to the Research Committee of the Division of Clinical Psychology at the University of Liverpool in September 2012 and approval was gained in October 2012 (Appendix D), followed by the University's intention to sponsor in September 2013. Ethical approval was granted from both a local Research Ethics Committee in July 2013 (Reference 13/NE/0241) and a local NHS Trust Research Governance Committee in August 2013 (Appendix E).

Interview Schedule. The semi-structured interview was developed as a guide to allow for a number of areas to be covered, but to also enable a natural exploration of the topic area. Pre-determined questions and prompts facilitated a wide and consistent coverage of material that previous literature had highlighted as being potentially important in using CAT systemically, but also permitted detailed and personal accounts of staff experiences. The semi-structured interview schedule was developed by the researcher and was refined over time through consultation at the HSH patient steering group and with colleagues experienced in CAT consultation. The interview schedule was also piloted with a colleague who had experience of using CAT in consultation.

Selection and recruitment. Supervisors of this research used a psychology service data base to identify potential participants. Staff members were selected on the basis of

having been involved in at least one CAT consultation, either by contributing to the development of a reformulation, or by the reformulation being shared with them in a consultation session within the last six years. The six year time frame was on the basis that this is the average in-patient stay within this particular HSH. Staff members were notified about the study via e-mail, and the participant information sheet (Appendix F) and opt-in sheet (Appendix G) was included. The supervisors were asked not to select participants according to any preconceived ideas, for example, staff members they suspected might favour CAT as a model. All staff disciplines were approached in order to gain a wide cross-section of participants and different staff discourses.

Those wishing to take part completed the opt-in sheet which they returned to the researcher. On receipt of the opt-in sheet, contact with the participant was made by telephone or email and a convenient time to meet was arranged.

At this meeting the participant information sheet was discussed and any questions were answered. Interviews were scheduled after receiving the participant's consent, and continuing consent was explained. Interviews were booked at least 24 hours after the meeting in order to allow participants time to opt out of the study. Participants were given the option to meet in a private room within the HSH walls, or outside of the HSH walls but still on site. All participants chose to complete all meetings and interviews within the HSH walls. All participants completed a consent form (Appendix H).

Interview Process. The interviews ranged between 33 minutes and 62 minutes and took place between February 2014 and April 2014. Consent was re-addressed before and after the interview and the limits of confidentiality were explained. Participants had already been informed that interviews would be recorded using a digital recording device and they were informed of the transcribing and storage process. Participants were also informed that

they could stop the interview at any time. Time was given to discuss any concerns and to answer questions. Participants were asked to complete a demographic sheet (Appendix I) before the researcher followed a semi-structured interview schedule. All nine participants consented for their interviews to be included. None of the participants chose to terminate the study or sought support following the study.

Analytic Procedure. The six steps of thematic analysis as outlined by Braun & Clarke (2006) were followed.

Transcriptions. Due to security restrictions, all nine interviews were transcribed within the HSH by administration staff employed by the trust. Participants were given an identifying number and their names did not appear on any audio files or transcripts. Any identifying information about staff or patients was also changed to ensure complete anonymisation.

Familiarisation with the Data. The researcher familiarised herself with the data by reading through the transcripts and listening to all interviews and checking them for accuracy. Once all the corrections were made to the transcripts, the researcher listened to the interviews again a number of times before making initial notes on the transcripts (Appendix J) and noted any interesting points the interviewee made. This process was completed for all nine transcripts.

Generating Initial and Higher Order Codes. The data was considered line by line or in small paragraphs. Initial codes were taken directly from the data and the content of what the participant had said. Higher order codes were then generated which could still be either at manifest or latent level, but were of a higher level of interpretation.

Defining initial codes was done systematically across the entire data set which generated a list of initial codes. During this process, it is key to code for as many potential themes, to code data inclusively in order to maintain the context, and to consider codes for as many different themes as they are relevant. Extracts may be coded once, or numerous times. Within each transcript there may be patterns emerging, which conceptualise the data and relationships between the patterns, or accounts which "depart from the dominant story" (Braun & Clarke, 2006, p. 89).

Higher order codes were typed up and given a reference, linking them to the transcript that they came from. This was completed for every code and then printed off and cut out. This enabled the researcher to connect with the data visually, and to cluster and develop themes (Appendix K).

Searching for Themes. Visual thematic maps were developed to enable the researcher to start thinking about the relationship between codes and themes and the different levels of themes within them (Braun & Clarke, 2006). A number of initial thematic maps were drawn out and reviewed until they represented a coherent fit with the data (Appendix L).

Reviewing Themes. The themes were refined, which involved combining or separating themes until the data within the themes cohered together in a meaningful way which answered the research questions posed (Braun & Clarke, 2006).

Themes were then revised at two levels. Firstly, the themes were reviewed at the level of the coded data extracts, which required returning to the original coded transcripts for each theme. At times, when the themes did not form a coherent pattern, then the theme had to be reworked and a new theme was created, and data were moved to another theme or the data were discarded from the analysis. Secondly, the validity of individual themes in relation

to the entire data set was considered. This was achieved by re-reading the entire data set to ascertain whether the thematic map accurately reflected the meanings evident in the data set as a whole (Braun & Clarke, 2006). The map was refined until it provided a true and accurate reflection and representation of the meanings across the entire data set. This process continued throughout the analysis and write-up of the study.

After developing a final thematic map of the data, the themes were defined and further refined. From this a narrative for each theme and how this fits with the overall narrative of the broader data was developed. The final map and write-up of the analysis can be found in the results section.

Reflexivity. Throughout the research process, the researcher kept a reflective journal which noted their own expectations, thoughts and feelings about the research. Ways in which they may have influenced the data gathered or the interactions with the participants was also considered.

Validation of the Analysis. Several transcripts were checked by two supervisors to ensure a fit between the actual data extracts and the initial and higher order codes. The supervisors also checked the higher order codes within themes and sub-themes, in order to see if the themes remained true to the data.

Results

Analysis of the nine transcripts revealed three main themes: ‘Availability and Accessibility’, ‘Genuine Value’ and ‘Mirrored Enlightenment’. Each theme consists of two sub-themes (Figure 1), which will be illustrated using quotes from the transcripts.

Insert figure 1 here

Whilst discrete from each other, the three themes were seen to tell a narrative through links with each other. Whilst the availability and accessibility was seen to influence the value, genuine value was also seen to influence the availability and accessibility of the CAT consultation process, which reinforces its value and thus influences mirrored enlightenment.

Theme 1: Availability and Accessibility

This theme discusses how physically available and intellectually accessible the CAT consultations were. Two sub-themes comprise this theme: breaking down barriers and embedding into practice. The sub-themes reinforce each other and both influence, and are influenced by, the main theme.

Breaking down barriers. Staff believed that the sharing of the SDR in the consultation gave them a more cohesive understanding of patients' problems: "it just pulled it together and conceptualised it instead of it all being so fragmented like it was … made it more coherent" (P1. 6. 295-300).

Staff further noted that through the consultation process the clinical team were able to develop a shared language with the patient, which in turn helped them to communicate more effectively with the patient and to deal with difficult dynamics: "that strength of being able to use how he describes and what he recognises in himself, it's really helped to, you know, bring down the barriers and we're all able to get over those hurdles when they come up" (P1. 4. 177-179).

While staff found the SDRs useful, they also viewed them as complicated. Some viewed this complexity as reflecting the multi-faceted nature of the patient's presentation and therefore accepted it: "It can get quite complicated but I guess that reflects the reality … Well the reality of complicated personalities …" (P2. 3. 115-126).

However, some staff reported that the complexity of the SDRs made them intellectually inaccessible and therefore they were unable to change their care practices unless interpreted and 'broken down' by a psychologist:

> … because it is complex people get a little bit overwhelmed when they go out and they carry on with their care and they know that they might still be doing something that is not helpful, but they are not actually sure what they could do differently (P3. 6. 260-268).

"It needs to be shared properly because, like I say, if a diagram's simple, it wouldn't need to be explained…" (P1. 17. 813-821).

The timing and pace of the CAT consultation was an important issue in the process of making the information more accessible and therefore useful in the understanding and management of the patient and the planning of future care:

> Fairly earlier on in an individual's treatment is the best way […] it can be quite helpful really because it gives you a better understanding … of that patient's problems at a relatively early stage … of their admission so kind of informs a debate about further therapeutic interventions from thereon … (P9. 1. 24-45).

Embedding into practice. Staff spoke of how the understanding they gained from the consultation could be embedded in to clinical practice: "there's value in having the reflective

team discussion […] for me it is about how that is embedded in routine care changes" (P3. 6. 246-247).

The SDR was seen as a vehicle for making a wealth of information easily accessible. For some, having the SDR physically available helped to embed staff knowledge of patients' presentation and their risk potential, which led them to make changes to their care, including risk management strategies:

> Sometimes large reports, people don't have the time or say they haven't got the time to read them. So I think the SDRs […] it's a summary of the patient's risk and how they feel, how they perceive others and it also enables staff to look at exit strategies that they can adopt when a patient might be feeling a certain way (P4. 7. 327-331).

For others there appeared to be a distinction between the 'thinking' of the consultation process and the active, practical 'doing' of translating ideas in to practice. Therefore, others wanted the management strategies to be integrated into familiar, well-utilised documentation in order to increase accessibility, and facilitate multi-disciplinary management of the patient's presentation:

> The aim of those consultation meetings or reflective practice meetings should be to value the SDR and the work that has gone in to it but to get the views of everybody around, well what do we actually need to do practically now and how could we incorporate that in to their care plan so that everybody is doing at least one or two things differently and let's measure the impact on that patient (P3. 5. 210-215).

Staff felt that information would be lost through the patients' and staff's journey through the hospital. Embedding the documentation and the consultation process in to

practice and having it physically available was viewed as helping with the maintenance of knowledge and care:

> The problem that you are going to have in the hospital is maintenance … staff re-visiting the SDR because once it's done it's great but then as time goes on it's about having that visible, having that there you know for discussions during handovers, during reflective practice (P4. 4. 190-193).

It was evident that for some staff the consultation had helped them to embed their understanding in to practice by reflecting on dynamics in their everyday clinical practice: "it gave me permission to actually say erm in the session with him, 'what is happening here?'[…] because I knew that he'd [the patient] had that experience [of CAT] and he wouldn't find that too much" (P1. 14. 686-704).

The consultation process had made staff more proactive in obtaining information for other patients which was not readily accessible: "it has made me a bit more actively seek information […] like CAT information hasn't always been readily available to people" (P7. 12. 590-591).

The availability and accessibility of the consultation process was seen to influence the value of this process.

Theme 2: Genuine Value

The second theme which emerged from the analysis consists of two sub-themes: cultures and utility. The cultures within the HSH appeared to influence the perceived utility of the CAT consultations, and more generally the role of psychological thinking, which reinforced the value of the consultations.

Cultures. An understanding of the ward and organisational milieu was gained from discussions with staff. They described issues around difficult dynamics, politics, unspoken attitudes and 'taboo' cultures which filtered down from an organisational level to the individual level. There appeared to be tension within the system which created a split within the organisation, creating an 'us and them' culture. Some staff valued the 'masculine', controlling, physical aspects of care and under-valued the 'feminine', psychological understanding. Staff also perceived the system to be in a state of denial about these issues. The laughter in the extract below also highlights the tension.

> We can be a very invalidating environment can't we? (laughs) […] but it's a very male environment… so as a woman, as, as a female member of staff I probably see things differently (laughs) than a male member of staff (laughs). Obviously different than a patient but … there's something about the environment that's quite err macho […] So the formulation will be the fluffy stuff … Er, whereas, and no criticism of this group of people…the [team] are the 'rufty tufty' stuff cos they're doing physical activity. There's value in that but sometimes I think the fluffy stuff (laughs) … there's less value in it. So the system, I think sometimes sends that message out to both staff and patients as well … we're all not honest enough to accept that that's what happened … I think within the organisation it's, it's almost like a state of denial.[…] And it's kind of a widely accepted term within the hospital … It's a little bit more … than a joke (laughs) … It's like almost fundamental to people's thinking (P5. 14. 680-725).

The 'us and them' culture was also apparent in the politics between different professionalisms. Staff perceived there to be a lack of genuine value in the wider role of psychology, and that to be valued within the system it would require a more directive

approach to making recommendations for care. This was captured when staff were talking about consulting with the medical staff during ward rounds:

> People start switching off after 15 minutes because it's not helping them…Unless there's like right, this is what you are going to do with this patient from now on… (laughter) but obviously we don't do that do we in psychology? It's much more subtle and it's much more nuance to say you know and also you don't want to be telling people what to do… (P6. 9. 399-408).

Specifically within the profession of psychology there were comparisons between theoretical orientations and the value of models, giving the sense of sub-cultures:

> Whilst the formulation may be fairly similar at times to my own formulation around CBT [Cognitive Behavioural Therapy], what I like is that it [CAT] creates other opportunities, particularly round, like I say exits and some of the core pain and things like that which errm really quite helped to look at why the person is reacting in that way (P3. 2. 61-64).

The physical environment of the HSH and the system around it are seen as a therapeutic barrier for patients learning new skills. At the same time, the environment and system act as a physical and emotional container for staff, patients and the system:

> We can't test … things out in the normal situations so we have to take every opportunity that we can to create errm a situation that might be similar … However, the system has another mechanism to keep them safe so it contains them. So while we are containing them […] it is not easy to develop new skills (P3. 9. 350-359).

Utility. The genuine value of the consultations was apparent when staff discussed how interesting and useful the model is for the patients that they work with: "A lot of them

have got attachment issues, and I think CAT gives you a really useful way of looking at that" (P5. 14. 674-675).

Staff believed the consultations were beneficial to everyone as they have seen an improvement in the staff-patient relationship: *"*I'd definitely like more input in to it, definitely feel it's something that is definitely beneficial to everyone, patient, staff and the whole relationship and obviously to help them recover" (P7. 14. 681-683).

Staff also saw an improvement in their ability to understand and manage risk:

> Looking at formulation with him, when you look at the key indicators for the index offence, which was his offence why he was brought here, erm it helped to understand the emotional responses that he has to certain situations that can actually increase risk (P8. 2. 62-65).

It was understood that not all staff in the HSH had been involved in a consultation or had been active within the process. This was viewed as being a missed opportunity, as consultations were valued for gaining a different perspective in to the patients' presentations and for bringing about a change in care practices. It appeared that in absence of the consultation, formulations were not utilised:

> maybe everyone should have the opportunity … to understand it an' I think that is what you know the previous psychologist […]done […]however not everyone is always […] forthcoming with the information so since she left you know I have not seen any formulations since then. It is quite important that people do see these finished formulations an' it just doesn't become a, you know, a meaningless exercise [...] So it definitely is gonna shape how we deal with our patients (P7. 13. 611-620).

The consultation process facilitated multi-disciplinary contribution to patient care. Staff valued the consultations as they gave them a 'voice' which they saw as being supportive and empowering. This appeared particularly important for non-qualified staff who, without the consultation process, would not have had this opportunity:

> It's encouraged debate, it's encouraged opinion, especially from people that may not be qualified staff. It gives people a voice so everyone's had an input an' a discussion about it. You know maybe we've adapted things from it to help how we deal with our patients and their management so it has definitely helped as a group […] people, you know, not thinking they have a say, not feeling […] that it is their place or they have anything credible or valuable sort of to bring, so it has encouraged everyone to have an opinion no matter what their role is (P7. 13. 627-639).

However, some staff felt that the utility of the SDR was dependent upon the forum it was being shared in. A forum where there was a shared sense of value with participants enabled everyone to have a voice and for there be a valued outcome:

> at the CPA [Care Programme Approach meeting] was probably more useful […]than doing it in a care team 'cos the commissioner was at the CPA … So the commissioner could see all sides of this patient and was prepared to support the idea of him moving on. (P6. 6. 266-274).

This theme links back to the first theme, as genuine value was also seen to influence the availability and accessibility of the CAT consultation process which in turn reinforces its value. The final theme is built upon these preceding themes, as where there was availability, accessibility and genuine value, there was also mirrored enlightenment.

Theme 3: Mirrored Enlightenment

The final theme is made up of two sub-themes: parallels and enabling. Staff discussed paralleled processes between them, the patient and the system following the CAT consultations, which enabled them to have a sound, open-minded understanding of these processes.

Parallels. Through the consultation process there was a paralleled process of enlightenment – the patient, individual staff and the staff team developed insight about the patient's presentation and the contextual issues alongside each other:

> In terms of that process of developing the SDR in therapy and then that being shared with us helped us to understand what he feels is the problems as well, which actually was the same… And we're all thinking he had no insight when actually he does. (P1. 5. 235-241).

There was an increase in staff's ability to reflect on the enactments between themselves, the patient and the system, from the past to the here and now. More specifically, staff were able to think about their feelings in relation to the enactments and they were enlightened on how this influenced staff-patient relationships, team dynamics and patient care:

> people [staff] saw, they've either became a punishing father or like a comforting mother … which they tolerated more, which was a real big split as well between the staff [team], so I think it was useful when we, we reflected on that various relationship […] he [the patient] like, makes you feel special as well…and we all like that don't we (laughs)[…], but then with other people he's really kind of hostile and abusive and

> aggressive and, so he, he definitely causes splits in teams […] It's just that being a little bit more tolerant…And not to criticise one another (P5. 19. 899-940).

The ability to reflect on enactments also extended outside of the HSH to the personal lives of some staff: "Sometimes that makes you even start thinking about non-work related stuff really, relationships with other individuals out of work and you kind of start drawing up these kind of reciprocal roles and sequences…" (P9. 7. 390-400).

A shared increase in insight led to an improvement in the staff-patient relationship which was perceived from both perspectives: "he was able to open up more and come and see me about it…But it definitely improved the relationship I had with him" (P7. 2. 94-102).

The consultation process also gave the staff and the patients a shared sense of empowerment and hope: "from a patient's perspective it can be quite empowering for them as well erm because it helps them to share their emotions and feelings…with others…" (P8. 1. 23- 28).

Enabling. The consultation process enabled staff to see the patient from different perspectives:

> I was able to like just put myself in the patient's shoes for the moment, looking at CAT and looking at it from the patient's perspective rather than my own all of the time, and how the patient might be feeling an' CAT brought that to the table. (P7. 9. 402-405).

The staff team were able to gain a deeper, more empathic understanding about the patient's life experiences and how this influenced their patterns of behaviour and risk potential. Staff were also able to reflect on their own difficult feelings in relation to the patient's risk and how these feelings impacted on patient care and risk management:

> when a new admission comes along and we are trying to understand why someone behaves the way they do, then we are about to move forward, so bringing any patient out of long term segregation that have a propensity for extreme violence, it's going to cause anxieties and may be a bit of resistance…with the staff […] However, when this was presented at reflective practice, it enabled staff to gain, I felt, a further understanding and empathy…on why the patient behaves the way he does…and why sometimes his risks of violence are linked to previous experiences in his life. *(*P4. 2. 52-73).

The consultation helped staff to think about different ways to manage difficult dynamics and risk. More specifically, an increased understanding through the sharing of the formulation led to positive changes; it enabled progressive, empathic and non-restrictive care:

> A patient becomes really irate and historically you would put hands on which would exacerbate the situation, but because we have an awareness of his formulation, we just ride it out, yeah, just through effective de-escalation … Probably longer than what we would have done in the past because of an awareness of his formulation … And he … broke down in tears and we were able to manage it without the use of control and restraint and segregation. (P4. 2. 86-99).

Discussion

Overview of the Study

This research study aimed to explore staff experiences of using Cognitive Analytic Therapy (CAT) as a systemic consultation tool. The aim was to tease out the relevant and prevalent themes by attempting to understand staff's insights in to their experiences, and the

underlying influence and attitudes that impact on staff beliefs about CAT as a systemic consultation within a HSH. This was explored using transcripts of interviews and was analysed using thematic analysis from a social constructionist perspective (Braun & Clarke, 2006). From the data three main themes were constructed: 'availability and accessibility', 'genuine value' and 'mirrored enlightenment'. The thematic map (Figure 1) illustrated the three themes with their sub-themes and quotes from the transcripts were used to support the analysis. The three themes were seen as telling a narrative through the way they made links with each other. Genuine value was seen as being at the heart of availability and accessibility and mirrored enlightenment. The results indicate that aims of the study have been met.

Summary of Results

The availability and accessibility of the consultations is understood as a polarised yet parallel process. Staff were polarised in their descriptions of consultations as either being accessible or not. The availability and accessibility of the consultation process enabled the breaking down of barriers for staff, which helped them to embed their understanding in to practice. In turn, this helped to break down the barriers in the staff-patient relationship. On the other hand, staff discussed ways in which embedding psychological understanding from a CAT perspective in to practice helped to break down the barriers within the staff team and in the staff-patient relationship. It is from the theme 'availability and accessibility' that the theme 'genuine value' is built.

Staff described some organisational and individual factors within the HSH which influence the genuine value of the CAT consultations. It appears that staff perceive there to be a number of cultures which underpin the attitudes and beliefs about the utility of CAT consultations, and more widely the role of psychology, within the HSH. The cultures and the perceived utility of the consultation contribute to, and maintain, the split between those who

genuinely value the 'fluffy' formulation and consultations, and those who value the 'macho' and physical approach. When consultations were accessible, they gave staff a valued opportunity to contribute to patient care. Linking back to the first theme, it appears that when consultations are more available and accessible, they are genuinely valued, which in turn makes them more available and accessible. Where there is genuine value, there is 'mirrored enlightenment'.

The consultation process enabled staff, patients and the system to have a more informed and open-minded understanding of the individual and contextual issues which were reflected within the patients' SDRs. This included a deeper understanding of how past life experiences have led to unhelpful behaviours, which include staff-patient dynamics and risk issues, in the here and now. It appears that this paralleled understanding has enabled staff to work with patients in implementing less restrictive and more empathic ways of managing these unhelpful behaviours, thus improving patient care.

Therefore, whilst the three themes are seen as separate from each other, they also tell a narrative through making links with each other. Whilst the availability and accessibility was seen to influence the value, genuine value was also seen to influence the availability and accessibility of the CAT consultation process, which reinforces its value and thus influences mirrored enlightenment.

Comparison of Present Study to Previous Findings

Availability and accessibility. Previous literature has highlighted the importance of providing a more consistent and coherent understanding of the person in the context in which they are being treated (Aitken & McDonnell, 2006). Staff believed that the consultations had provided them with this understanding. More specifically, they described how the SDR was

a vehicle for collating a vast amount of information, but also for embedding their understanding in to practice.

The current study supports the assumption that the practice of CAT enables the patient to tell their story using their own language which enhances insight (Mitzman, 2010). In this particular study, staff were able to use the patients' language to break down barriers in communication in the staff-patient relationship and to deal with difficult dynamics.

However, similar to Hamilton (2010), some of the staff found the SDRs which were discussed in consultation too complex and difficult to comprehend. As a result, staff felt that there were some difficulties in embedding the formulation and the 'exits' in to practice. This was also found to be the perceptions of the CAT practitioners working in HSHs (Annesley & Sheldon, 2012). If SDRs are so complex that they become inaccessible then staff may become dependent upon consultations to explain them. However, if consultations also become inaccessible to some staff then the clinical value of using this model is questionable. The suggestions made by staff to make the consultations more accessible are consistent with previous research (Aitken & McDonell, 2006; Annesley & Sheldon, 2012) which proposes that there need to be additional considerations to make the sharing of the SDR accessible, for example, making language less complex.

Mitzman (2010) suggests that CAT assessments are routinely offered within forensic services and it is usual practice for the assessing clinician to continue to consult with the ward and staff team as a means of further exploring and developing the SDR. Furthermore, it is proposed that the SDR tool is intended to 'travel' with the patient throughout their journey through secure services. Results from this study suggest that this may not be occurring consistently across the HSHs, or that staff are unclear of this process. Staff raised specific concerns that information would be lost when patients moved wards, or when the

psychologist is no longer involved. Moreover, it is suggested that consultation must be available to staff at all levels (McGauley & Humphrey, 2003), which staff did not believe to be the case. In this study, collaborative working with the MDT was highlighted as a way to embed staff knowledge and understanding in to practice. This barrier may be due to limited resources within the HSH, including the lack of CAT trained practitioners and the depleting number of clinical psychologists who, although not CAT trained, may have had some experience of CAT as part of their core training, and therefore are well suited to help facilitate this consultation process.

Previous research has found that developing a CAT reformulation in consultation with staff has gone on to inform care planning (Carradice, 2012; Dunn & Parry, 1997). Annesley and Sheldon (2012) also reported that CAT clinicians in HSHs were inputting CAT formulations in to care planning. However, this study made recommendations for this process to occur earlier in the patients' care pathway, and for it to be more explicit by information being integrated in to patients' care plans.

Genuine value. Previous literature in forensic settings suggests that staff can defend against fear, which is heightened in HSHs (Cox, 1996) due to the level of risk and complex presentation, by adopting a 'tough' and controlling attitude (McGauley & Humphrey, 2003), but that consultation from a psychotherapy approach can highlight this and other conflicts within the system (McGauley & Humphrey, 2003). The current study identified themes consistent with these ideas. Staff described opposing cultures within the system which generated splits across the hospital and politics between professionalisms. More specifically, staff spoke of a split within the HSH which they described as 'macho verses fluffy'. Interestingly this was a term used in the study by Annesley and Sheldon (2012), who found that there was a negative perception of CAT therapists and the idea that formulation is "fluffy" (p. 127).

The roles of staff could be applied to Hamilton's (2010) contextual reformulation. Staff perceived as 'fluffy' may be perceived by the 'macho' staff as enacting the role of 'the pacifier', which is conceptualised in the RR by protecting/ accepting/ indulging/ safe-to-depended/ accepted/ indulged/ scared/ resentful. On the other hand, the 'fluffy' staff perceive the 'macho' staff to be re-enacting the role of the 'security guard', which is conceptualised in the RR by controlling/ with-holding/ judging/ safe-to-controlled/ judged/ neglected/ scared/ angry. Similarly, Stowell-Smith (2006) proposed that HSH was characterised by control and emotional numbness, which was apparent in this study when staff described their perceptions that the physical, masculine approach was valued, which mirrors detached styles of coping.

Staff involved in the study described the consultations as being a valued opportunity. This contrasts with previous research which suggests a lack of value in CAT, as therapy observers behaved inappropriately in sessions, for example falling asleep (Annesley & Sheldon, 2012). However, it was also clear from this study that there was a split within the hospital and other professionals may not have held the same beliefs about its value. It was understood that although staff perceived it to be a valued opportunity, the practice was not routine, and as a result not all staff have been involved in consultations across the hospital. It is unclear as to why this is the case. However, it is possible that this is due to a lack of resources both in terms of the psychologists/therapists to facilitate the consultations and staff being available to attend. This is consistent with literature which suggests that forensic psychotherapy is sparse within services (McGauley & Humphrey, 2003).

In a similar way to Kirkland and Baron (2014), staff spoke about the consultations as giving them a 'voice' and how these were represented in the SDR. In this study this appeared to be a more generic input and concerns, rather than a specific emphasis on voicing risk concerns.

Mirrored enlightenment. The current study identified that the consultations enabled staff to implement non-restrictive, more empathic care. Consistent with the literature (Cox, 1976; Dunn & Parry, 1997), staff knowledge from the consultation enabled them to 'ride out' the distress which patients were experiencing, and to contain them emotionally by using de-escalation techniques rather than physical restraint. This provides evidence of positive and proactive care as outlined in the DOH policy (2014). Furthermore, these findings support the idea that 'exits' can prevent patients from re-enacting their RRPs and prevent risk of potential harm to others (Shannon, 2009). The harm in this instance refers to staff or other patients if the patient has been violent, or to staff and the patient during restraint. Similarly the current study provides evidence to support the literature, which suggests that CAT reformulations can be used to contribute to risk assessment and forecast risk potential (Kirkland & Baron, 2014; Mitzman, 2010; Pollock, 1996, 1997; Pollock & Kear-Colwell, 1994; Shannon, 2009).

There was some evidence to suggest that following the consultation, staff had a deeper understanding of the patient both in terms of their past life experience and how this related to their risks. This knowledge is integral to good relational security (DOH, 2010). These findings differ to the perceptions that CAT therapists had of staff understanding of risk in HSHs (Annesley & Sheldon, 2012).

Consistent with the literature around CAT in forensic settings (Pollock, 1997), staff were able to see the patient from a different perspective and to gain a different understanding about the patient's life experiences and how this influences their current behaviour and risk. Staff began to see the patient's offending behaviour more relationally by reflecting on the patient's early life experiences, which then enabled them to understand why the patient had been trapped in the patterns of offending behaviour.

Although CAT was compared to other models and there was some perceived lack of value from other professionals, there was evidence to suggest that staff involved in the consultation found it valuable. Staff wanted more involvement in consultations as they found them to be interesting and useful. More specifically, staff noted improvements in the patients' presentation, which mirrors the positive findings of previous research in exploring the use of CAT within HSHs (Annesley & Sheldon, 2012).

Overall, this theme provides support for the idea that through enlightenment, staff and patients are able to make changes to their care. Staff were able to 're-parent' through reflection and by adopting less restrictive practices. This also makes for a more enabling environment which fosters productive relationships (RCP, 2013).

CAT and multi-model formulation

CAT can be seen an example of multi-model formulation as it combines ideas from Personal Construct Theory (Kelly, 1995) and Object Relations (Greenberg & Mitchell, 1983). Similar to other multi-model formulations, CAT formulation can be regarded as a fluid dynamic process, at the heart of which is the co-construction of the therapeutic relationship. Furthermore, CAT formulations are developed in collaboration with the patient, therapist and often the wider system (i.e. staff team). Furthermore in accordance with best practice guidance CAT formulation allows the patient to locate personal meaning within wider systemic, organisational and societal contexts (DCP, 2011).

Compared to other multi-model formulations, for example CBT, one of CAT's strengths is that it explicitly combines systemic/relational components (Object Relations Theory; Greenberg, 1983) and intra-psychic approaches (Personal Construct Theory; Kelly, 1995) (Dallos & Stedmon, 2014). Moreover, CAT illustrates how an individual's intrapersonal procedures are derived from the internalization of key interpersonal patterns

typically characterised by early parenting relationships (Ryle, 2012). In theory this means that it is more accessible for staff teams to understand the intrapersonal pattern of an individual, referred to as the self-to-self reciprocal roles, by highlighting the interpersonal patterns, referred to as the self-to-other reciprocal roles. Therefore, the difference between CAT and CBT approaches to team formulation is that CAT conceptualizes and maps the relationships between the team and the patient as a re-enactment of ways of relating learnt in childhood. This concept is supported by the results of this study, more specifically the sub-theme parallels, where staff were able to reflect on enactments between themselves, the patient and the system, from the past to the here and now. However, the results from this study also suggest that the complexity of the language used within consultations may have been a barrier in making the links between the interpersonal and intrapersonal patterns. A comparative study of multi-model formulations may be useful to consider in future research.

Reflexivity

As the researcher, I have brought to this research my own constructions and beliefs about using CAT as a systemic consultation tool in HSHs. Prior to completing this study I had experience of working in settings where CAT was being used systemically, but I had not been directly involved in the consultations. I had heard positive comments about the systemic use of CAT through informal conversations with professionals within the psychology teams. My own professional values of being a psychologist working in in-patient services had also influenced my thinking. More specifically, I thought that working systemically could only be viewed as positive and that others would also think in this way. Therefore I feel that at the onset of this study I had not fully considered factors such as the culture within institutions.

Reflecting on my research, I am now more mindful of how staff are influenced and constrained by the unspoken cultures of institutions, and how fundamentally this influences the care that patients receive. This raises new questions about how to change a culture which is perceived to be in a state of denial. In true CAT style, cultures in the institution need to be recognised in order for them to be revised. The motivation to consider this is borne from the discussions in my research that if you make contextual issues more available and accessible then this may led to genuine value and enlightenment. These points will resonate with me throughout my career.

Methodological Considerations

Design. Thematic analysis from a social constructionist perspective was used to analyse semi-structured interviews. A social constructionist framework met the aims of the study as it allows the "objectivity-talk" of the researcher to become part of the discourse and regards objectivity as impossibility (Burr, 2003, p. 171). Language constructs our reality and therefore themes were derived from that very language used to express staffs' reality and lived experience. A social constructionist perspective can be used with other qualitative methods of analysis (Burr, 2003), for example discourse analysis (DA) or interpretative phenomenological analysis (IPA). However, one of the assumptions of DA is that it focuses in detail on sentence structure and assumes that "any order of detail in text and talk is consequential for interaction" (Potter, 1997, p. 158). Therefore using this method would lose the detail of how constructions are generated overall. IPA places more of an emphasis on understanding an individual's personal world, and as the current study is more interested in exploring themes within a group and culture, a thematic analysis was deemed to be a more appropriate method of analysis.

Due to the broad nature of the research aims, this study chose to explore all forums of CAT consultations. Furthermore, it did not distinguish between those SDRs shared within the consultation and those developed within the consultation. This was also partly due to the way that the service captures their information. Given that there was some discussion within the theme of 'genuine value' that the utility of the consultation depended on the forum, these distinctions may have been interesting to consider. Although the narrative of the participants describes some positive changes, the qualitative design does not allow for a direct measure of outcome on patient care which is a key issue in NHS service delivery. The chain of process from team consultancy, to changes in staff behaviour, to change in patient behaviour is a complex process (Kellett, Wilbram, Davis & Hardy, 2014) and therefore careful consideration of this would be required in future research.

Interviews. All of the interviews were conducted within a short period of time and therefore only captured the constructions of the staff who participated at that period of time. It should be noted that the organisation had undergone many structural changes; in particular, the psychology service had been reconfigured. Throughout the research process it was noted that staff informally commented on how overwhelmed staff were with their work. Therefore, it should be acknowledged that a study at a different period of time may have revealed different findings.

Sample. All staff from various disciplines who had been involved in CAT consultations in the past six years had been invited to take part in the study. Recruiting a large sample for this study proved difficult and there were no non-qualified participants that opted in to the study. This was reflective of the organisational changes described above. For support workers there are the added pressures of being 'front-line' staff, where non-clinical duties such as research interviews would not be deemed as essential to attend. This study did not explore the differences between disciplines and gender as this may have made staff

identifiable. Furthermore, the aim was to have an understanding of the shared experiences. Participants were asked to opt in to the study which may have potentially biased the data to some extent as it could be argued that they may have seen some value in the consultation in order to be motivated to participate.

Validation. Validation occurred through two supervisors checking transcripts, codes being checked for consistency and interpretation, and thematic maps being checked to ensure that they related back to relevant codes. However, further validation could have been achieved by presenting findings back to the participants. This had been planned, but due to the time constraints of the study this was unable to be done in time for the writing of this report. The findings will be disseminated to the service and the local NHS Trust Research and Governance Committee in a report, and feedback will be considered prior to publication.

Clinical Implications

By gaining a deeper understanding of staff experiences of using CAT as a systemic consultation tool, this study has uncovered a number of areas that need to be addressed in the organisation, from a macro to a micro level.

Given that staff felt that the system was in a state of denial of the contextual issues it would be important to address this. Not addressing these dynamics could be understood as an under-involvement in care and a boundary crossing in the therapeutic environment (Hamilton, 2010) which then compromises patient care. It can be argued that it would be beneficial and therapeutic to name the organisational dynamics within a contextual reformulation, in a similar way to other literature (Hamilton, 2010; Stowell-Smith, 2006) and share this with all staff, from HSH executives and managers to support workers (McGauley & Humphrey, 2003). The recognition of unspoken cultures, such as the splitting between professionalisms, may be the first step in addressing the boundary crossings, breaking down

the barriers between staff and increasing the genuine value of different approaches and professionalisms. In the same was as when working with patients, this should be done in a collaborative, transparent way. The following discussion points could be incorporated in to the 'exits' of the contextual reformulation to minimise the re-enactments.

There may be some benefits in revisiting care pathways within the HSH in order to address staff views that a CAT reformulation and consultation would be more helpful at the beginning of the care pathway.

As part of the care pathway, training for members of staff from all disciplines at various levels around the role of CAT will be important, as previously recommended by Annesley and Sheldon (2012). This may be part of a wider piece of training which focuses on therapeutic relationships with patients, relational security and boundaries. This will provide them with the opportunity to increase their understanding about psychological models, including CAT and the benefits that it has for staff and patients, for example increasing understanding, forecasting risk and enabling more empathic, less restrictive and progressive care. It is important that this training takes in to account the participants' zone of proximal development (ZPD) in order for it to be accessible. This may involve making language clearer by translating CAT specific terminology; this may be a role for the Association of CAT (ACAT) (Annesley & Sheldon, 2012) in conjunction with staff and patients who have been involved in CAT. Hopefully, this will lead to a more consistent view within HSHs about the value of psychology, more specifically CAT consultations, and will help to break down the barriers of the unspoken cultures.

Ideally, the care pathways would involve the role of systemic consultation as routine practice across HSHs. This would provide opportunities for staff to feel valued by having a 'voice' in the development of formulations and recommendations for interventions. This

would serve as another way to maintain and increase understanding through the patient and staff journey through HSHs.

Work-related stress is a common symptom of working with this complex and hard-to-help client group. The consultation process would help staff to feel supported, as it acknowledges and increases understanding of the emotional stresses within the team. These are often a result of the complex dynamics between staff, patients and the system. As outlined in this study, this enlightenment enables a less restrictive, more therapeutic environment which will have a positive impact on staff and patient well-being (RCP, 2013).

Staff involved in facilitating consultations may wish to think about making the consultations more accessible to staff. Firstly, as highlighted with training, it is important to ensure that the information is in line with the staff's ZPDs. Secondly, this should be done over a period of time and at a pace which suits staff and patient needs. Thirdly, information needs to be consistently integrated in to familiar documents such as care plans in a clear and simple way which may require further consultation with the Multi-Disciplinary Team (MDT). Caution should be taken to ensure that this does not replace regular consultations. As highlighted by the DOH (2010), a thorough detailed knowledge of the patient's history is required for good relational security. Based on the findings from this study, and once the recommendations are implemented, then this can be achieved through systemic CAT consultation.

All of this requires the investment of staff time. Therefore there needs to be recognition from a higher level of the importance of psychological approaches to patient and staff well-being. In an ideal world, this would require more staff in all disciplines; psychologists and therapists to deliver the training and more ward-based staff to enable staff to attend training and consultation. However, in light of the current economic climate this

may not be realistic. Alternatives may involve protected time for all ward-based staff to attend training and consultations. There may also need to be a shift in what the trusts and services consider to be 'mandatory' in order to facilitate more psychologically based training. Whilst the hospital provides some mandatory training at induction around boundaries, the training would benefit from being underpinned by the CAT model. Furthermore mandatory training would be an opportunity to introduce a psychological understanding of the HSH, moreover, to introduce the contextual reformulation. This mirrors staffs' ideas that consultation and reformulation should be available at the beginning of patients' care pathways; in this respect the trust induction is the beginning of the staff pathway to the HSH. Additional training would then increase and maintain staff understanding. On-line training should also be considered in order to make this more accessible for staff.

Future Research

CAT is in the National Institute of Clinical Excellence (NICE, 2009) guidance for the treatment of borderline personality disorder; a diagnosis prevalent in the forensic population. However, the NICE research evidence base does not apply adequately to the many patients who present with multiple or complex difficulties such as those in forensic services. As highlighted, empirical research in CAT is in its infancy and it is widely acknowledged that this is an area that needs addressing. This is particularly pertinent for forensic patients who present with multiple or complex difficulties and co-morbidity with mental illness.

Further exploration of the use of CAT in consultation is warranted in other forensic services as existing literature (Stowell-Smith, 2006) suggests that HSHs categorically differ from other levels of security. In addition to this, it would be important to conduct a follow-up study once the above clinical implications are addressed. Given the importance of measuring outcomes, it is also recommended that future research considers the use of

outcome measures to measure both patient changes and also changes in staff and their practice, for example staffs' attitudes and beliefs.

This study is one part of two studies conducted within the same HSH at similar times. The other study by Croft (2014) explored how CAT and the SDR had influenced participants' constructions of risk and risk management. The findings complement each other in that CAT and CAT SDRs were found to facilitate patient engagement in acknowledging, understanding and managing their risks. Combining the two studies will hopefully add to the existing evidence base for the use of CAT with the forensic population, and more specifically provide evidence for the systemic use of CAT within HSHs.

Conclusion

In summary, this study explored the experiences of staff in CAT being used as a systemic consultation tool in a HSH. Specifically, the study aimed to explore whether the CAT consultations impacted on staffs' understanding of patients' clinical presentation, the patients' behaviour, the clinical management of patients, the patients' risk and the relational and systemic elements of working with forensic patients. Results suggested that there are a number of factors which influence staffs 'experiences and their understanding. Genuine value in the CAT model, the consultation process and more generally in psychological approaches appeared to be at the heart of making consultations more available and accessible, both physically and intellectually. When the consultations were accessible and available on both levels, they appeared to be genuinely valued. This appeared to lead to mirrored enlightenment for the staff, patients and the system which in turn creates therapeutic relationships and environments and enables positive changes to patient care and staff experiences.

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Table 1. Participant demographic information

Participant	Gender	Job Title
1	Female	Psychologist
2	Male	Social Worker
3	Male	Therapist
4	Male	Nurse
5	Female	Nurse
6	Male	Psychologist
7	Male	Nurse
8	Female	Social Worker
9	Male	Psychiatrist

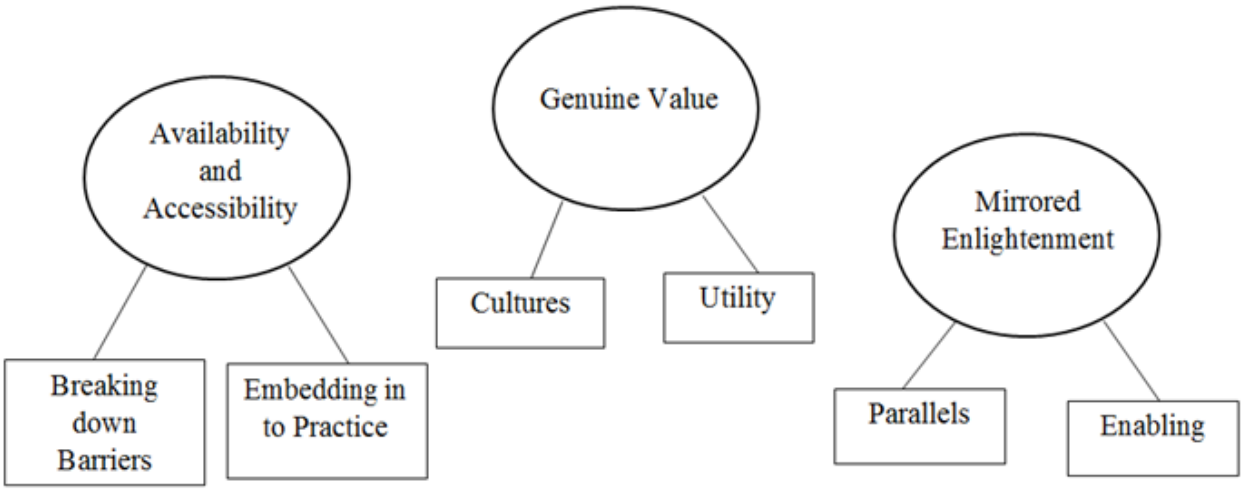


Figure 1. Final thematic map showing final three themes, each with two sub-themes.

Appendix A

Author Guidelines

Taylor & Francis
Author Services

Advice to authors on preparing a manuscript for
The Journal of Forensic Psychiatry and Psychology

NB: Please follow any specific instructions for authors provided by the Editor of the journal

Font: Times New Roman, 12 point. Use margins of at least 2.5 cm (1 inch).

Title: Bold, type the first word and proper nouns only in capital letters. Any sub-title should follow a colon and every word should be lower case (except proper nouns).

Authors' names: Give the names of all contributing authors on the title page exactly as you wish them to appear in the published article.

Affiliations: List the affiliation of each author (department, university, city, country).

Correspondence details: Please provide an institutional email address for the corresponding author. Full postal details are also needed by the publisher, but will not necessarily be published.

Anonymity for peer review: Ensure your identity and that of your co-authors is not revealed in the text of your article or in your manuscript files when submitting the manuscript for review. Advice on anonymizing your manuscript is available here.

Abstract: Indicate the abstract paragraph with a heading or by reducing the font size. Advice on writing abstracts is available here.

Keywords: Please provide three to six keywords to help readers find your article. Advice on selecting suitable keywords is available here.

Headings: Please indicate the level of the section headings in your article:

- First-level headings (e.g. Introduction, Conclusion) should be in bold, with an initial capital for each main word.
- Second-level headings should be in bold italics, with an initial capital letter for each main word.
- Third-level headings should be in italics, with an initial capital letter for each main word.
- Fourth-level headings should also be in italics, at the beginning of a paragraph, with only the first word capitalized (except proper nouns). The text follows immediately after a full stop (full point) or other punctuation mark.

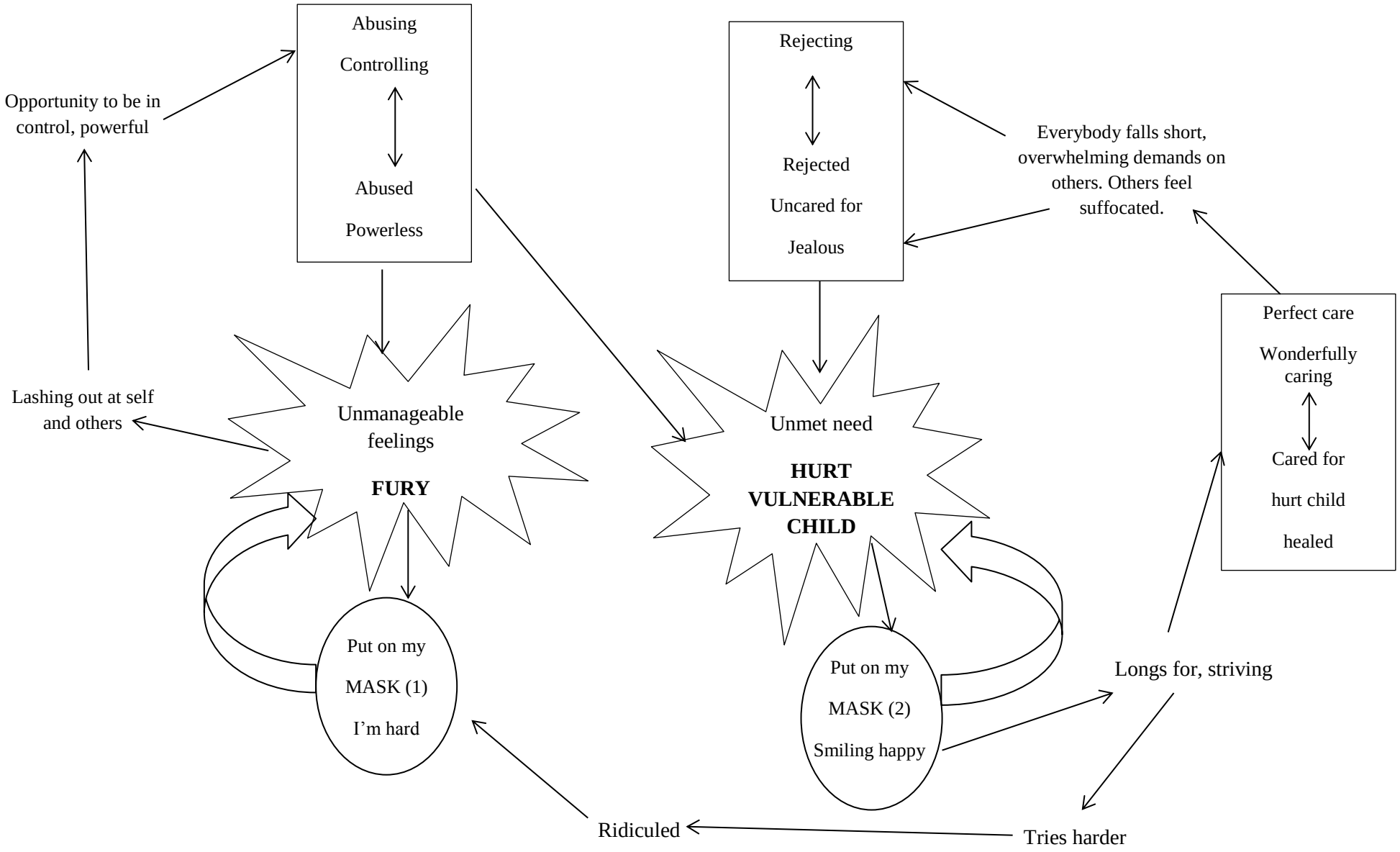
Tables and figures: Indicate in the text where the tables and figures should appear, for example by inserting [Table 1 near here]. The actual tables and figures should be supplied either at the end of the text or in a separate file as requested by the Editor. Ensure you have permission to use any figures you are reproducing from another source. Advice on artwork is available here.

Running heads and **received dates** are not required when submitting a manuscript for review.

If your article is accepted for publication, it will be copy-edited and typeset in the correct style for the journal.

If you have any queries, please contact us at authorqueries@tandf.co.uk, mentioning the full title of the journal you are interested in, or see our Author Services homepage.

Appendix B: Example CAT Sequential Diagrammatic Reformulation (Lloyd & Clayton, 2014)



Appendix C

Interview Schedule

Title of Research Project: Exploring Multi-Disciplinary Team (MDT) Experiences of Cognitive Analytic Therapy (CAT) as a Systemic Consultation Tool in an Adult Forensic Service.

Introduction (NOT audio-recorded: approx. 10 minutes)

Thank you for participating

Explain procedure for interview (time frame, audio-recording, process etc.)

Completion of consent form & demographics sheet

Any questions?

Interview (Audio-recording begins)

Interviewer says:

"Thank you for agreeing to take part in this study. We have approximately one hour today to discuss how a Cognitive Analytic Therapy approach (which is also referred to as CAT) is used in patient case discussions to develop a sequential diagrammatic reformulation (an SDR) or as it is sometimes referred to, a formulation. I would like to gain an understanding of your experiences and perceptions of being involved in such discussion. I have a number of questions which will cover a number of areas. I am interested in finding out what your understanding is of patient's behaviour, their clinical presentation, their risk and the relational aspects of working with patients following your experience of being involved in CAT case discussions. I would like to find out what you think and what comes to mind when we discuss these issues and so the direction of our discussions will be led according to this. If for any reason you prefer not to answer any of the questions then please do not hesitate to say so and we can move on. Throughout the interview please try to refrain from using any identifiable information about staff or patients."

A) STAFF OVERALL EXPERIENCES

1. Can you tell me about your experience(s) of CAT when used in patient case discussions.

Prompts: What is your understanding of CAT? What do you like about it? What have you found useful? What have you found challenging?

B) PATIENT'S BEHAVIOUR& CLINICAL PRESENTATION

2. Based on your experience of CAT so far, has that helped you to understand the patient's presentation and if so how? It may be helpful to describe your understanding of a patient's behaviour before the case discussion compared to afterwards.

   Prompt: Is there anything more you would like to add about_____?

3. Do you think the formulation has helped you understand how the patient copes and why they cope in that way?

4. Given some of the difficult/challenging behaviours you may have seen at ward level, has the formulation changed the way you understand or think about that? If so how?

   Prompt: For example why they may use self-harm or violence?

C) RISK

5. In what ways has the CAT case discussions and/or SDR/formulation helped you to think about the patient's risk to themselves?

6. In what ways has the CAT case discussions and/or SDR/reformulation helped you to think about risk to others?

   Prompt: Risk to staff or other patients

D) CLINICAL MANAGEMENT

7. Based on your experience of CAT case discussion and SDR/formulation has this helped you with the management of the patient's behaviour and if so how?

8. What are your thoughts about the use of CAT and managing the patient's risk to themselves and/or others?

   Prompt: For example managing their risk of self-harm, managing their risk of violence

E) RELATIONAL ASPECTS

9. In what ways has the CAT case discussion and SDR/formulation helped you to think about relationships between the patient and others?

   Prompt: Relationship between patient and staff, patient and family, patient and victim

10. Has the CAT case discussion and/or SDR/formulation made you think differently about your working role from a relational perspective?

11. Is there anything that you have found personally helpful for working with a patient? You may want to think about a specific case and discuss in relation to this. Please remember not to use identifiable information.

    Prompt: Is there anything else you would like to add about_____?

F) FUTURE

12. Is there anything which you have taken from the CAT case discussions of the SDR/reformulation which you would find helpful for working with future patients?

13. What are your thoughts about the use CAT case discussions and SDR/reformulations with future patients?

    Prompts: prediction of future risk, ways of relating with other patients

G) REFLECTION OF INTERVIEW

14. Is there anything that you would like to discuss further or anything that we have not discussed that you would like to?

    Ending (NOT audio-recorded: approx 5 minutes)

    Check for any concerns raised by interview

    Discuss the remaining research process

    Any questions

    Thank again for participation

Appendix D

University of Liverpool Research Approval

D.Clin.Psychology Programme
Division of Clinical Psychology
Whelan Building, Quadrangle
Brownlow Hill
LIVERPOOL
L69 3GB

Tel: 0151 794 5530/5534/5877
Fax: 0151 794 5537
www.liv.ac.uk/dclinpsychol

10th October, 2012

Lianne Franks
Clinical Psychology Trainee
Doctorate of Clinical Psychology Doctorate Programme
University of Liverpool
L69 3GB

RE: EXPLORING MULTI-DISCIPLINARY TEAM (MDT) EXPERIENCES OF COGNITIVE ANALYTIC THERAPY (CAT) AS A SYSTEMATIC CONSULTATION TOOL IN AN ADULT FORENSIC SERVICE

Trainee: Lianne Franks
Supervisors: James Reilly, Elisabeth Hansen, Tanya Peterson

Dear Lianne,

Thank you for your response to the reviewers' comments of your research proposal submitted to the D.Clin.Psychol. Research Review Committee (no letter date, signatures dated 02/10/12 and 03/10/12).

I can now confirm that your amended proposal (no version, dated 05/10/12) meet the requirements of the committee and have been approved by the Year 1 Committee Chair.

Please take this Chairs Action decision as ***final*** approval from the committee.

You may now progress to the next stages of your research.

I wish you well with your research project.

Dr Catrin Eames
Chair Year 1 D.Clin.Psychol. Research Review Committee.

Appendix E

NHS Research Ethics Committee Approval

NHS
Health Research Authority
NRES Committee North East - Newcastle & North Tyneside 1
Room 002
TEDCO Business Centre
Viking Business Park
Jarrow
Tyne & Wear
NE32 3DT

Telephone: 0191 4283563

8 August 2013

Miss Lianne Franks
Trainee Clinical Psychologist
Division of Clinical Psychology
Whelan Building
University of Liverpool
Brownlow Hill
Liverpool
L69 3GB

Dear Miss Franks

Study title:	**Exploring Multi-Disciplinary Team (MDT) Experiences of Cognitive Analytic Therapy (CAT) as a Systemic Consultation Tool in an Adult Forensic Service**
REC reference:	**13/NE/0241**
Protocol number:	**UoL000913**
IRAS project ID:	**123588**

The Proportionate Review Sub-committee of the NRES Committee North East - Newcastle & North Tyneside 1 reviewed the above application on 7 August 2013.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Gillian Mayer, nrescommittee.northeast-newcastleandnorthtyneside1@nhs.net.

Ethical opinion

The sub-committee raised the following issues and you responded accordingly as follows, as student investigator –

1. Storage arrangements for data/recordings – confirmation was requested that all data/recordings will be stored on security protected computers within the research site. It is not appropriate to store data on portable laptops as this is not a very secure method of storing data.

   You confirmed that all data/recordings will be stored as password protected files on password protected computers within the high secure hospital.

2. It was advised that the clinicians who are acting as gatekeepers make the first approach to participants.

You confirmed that Dr Tanya Petersen and Dr Elisabeth Hansen (academic supervisors and clinicians at Ashworth Hospital) have agreed to approach participants in the first instance.

3. Given the context of the research, it was noted that there should be a strategy in place for managing disclosures that may give rise to concern – this would also need to be suitably noted in the information sheet.

   You clarified that you will notify and discuss any disclosures regarding patients at the hospital with the academic supervisors of the study (Dr Tanya Petersen and Dr Elisabeth Hansen). The supervisors will then inform the patient's Responsible Clinician. The patient's clinical team will decide how to take this further. All decisions will be made in line with Mersey Care Policies and Procedures. You provided a revised information sheet accordingly (version 4 / 5.8.13).

The sub-committee was satisfied with the responses given to the issues raised and revised documentation.

On behalf of the Committee, the sub-committee gave a **Favourable** ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt

and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved were:

Document	*Version*	*Date*
Covering Letter		28 July 2013
Evidence of insurance or indemnity	Marsh Ltd	02 August 2012
Interview Schedules/Topic Guides	3	31 May 2013
Investigator CV		31 October 2012
Letter from Sponsor	UoL000913 L. Carter	2 November 2012
Other: Student CV - Lianne Franks		
Other: Supervisor CV - Dr Tanya Petersen		
Other: Supervisor CV- Dr Elizabeth Hansen		
Other: Application to REC letter from Sponsor	UoL000913	25 July 2013
Other: Participants Demographics Sheet	2	31 May 2013
Other: Participant Opt-In Sheet	1	31 October 2012
Participant Consent Form	2	31 May 2013
Protocol	2	01 October 2012
REC application	(IRAS 3.5)	23 July 2013
Other: Response letter	L Franks	05 August 2013
Participant Information Sheet	4	05 August 2013

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of

changes in reporting requirements or procedures.

Feedback

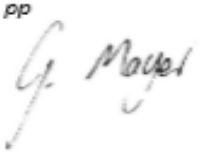
You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
information is available at National Research Ethics Service website > After Review

13/NE/0241	Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely
pp



Dr Simon Woods
Vice Chair

Email: nrescommittee.northeast-newcastleandnorthtyneside1@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

'After ethical review – guidance for researchers'

Copy to: Dr James Reilly - Consultant Clinical Psychologist, University of Liverpoo

Mr Alex Astor – Research Support Office, University of Liverpool

Mrs Pauline Parker – R&D Office, Mersey Care NHS Trust

Appendix F

Participant Information Sheet

Title of Research Project: Exploring Multi-Disciplinary Team (MDT) Experiences of Cognitive Analytic Therapy (CAT) as a Systemic Consultation Tool in an Adult Forensic Service.

Researcher: Lianne Franks (Trainee Clinical Psychologist)

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask if you would like more information or if there is anything that you do not understand. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to. Thank you for reading this.

What is the purpose of the study?

The purpose of this study is to try to understand your personal experiences and perceptions of being involved in clients' case discussions where Cognitive Analytic Therapy (CAT) has been used to develop a sequential diagrammatic reformulation (SDR) or formulation. The clinical implications of this research would be to identify if CAT increases staff understanding of i) patients' behaviour, ii) the clinical presentation of the patient, iii) the clinical management of the patient, iv) the patient's risk and v) relational aspects of working with the patients and other patients. Data would be gathered through interviews lasting approximately between 45-60 minutes. These interviews would be audio-recorded and transcribed for data analysis. It is estimated that the data collection for this study will be completed by November 2013.

Why have I been chosen to take part?

You have been chosen to take part as you are a member of the multi-disciplinary team (MDT) in which CAT case discussions for clients have been facilitated. All members of the MDT will be invited to take part.

Do I have to take part?

Participation in this study is voluntary and you are free to withdraw at any time without explanation and without incurring any disadvantage.

What will happen if I take part?

I will be the main researcher for this study and I am on placement at the service but I have no managerial responsibilities to the staff and/or patients at the hospital. If you agree to take part in the study you will be required to complete the attached opt-in form and return via e-mail or in the provided envelope. Not all of the people who opt-in to this research may need to be interviewed as the study requires a variety of staff from different disciplines/ professions to be involved. All people who opt-in to the study will be contacted (via telephone or e-mail). If you are chosen to take part I would contact you to arrange a convenient time to discuss the research with you, provide you with the opportunity to ask any questions and if you agree to take part in the study you will be asked to complete a consent form (see attached 'consent form'). The participant and I would then conduct the interview or we could arrange an alternative time so that you could have more time to think about whether or not you would like to participate. Interviews would be audio-recorded and would last between 45-60 minutes in which time we would discuss your experience in case discussions involving CAT SDR's/ formulations. As part of the interview you will be asked to complete a 'demographics sheet' which includes questions about your job-title and experience. There will be an opportunity at the end of the interview for you to ask any questions and this will not be audio-recorded. Once all of the interviews have taken place,

they are then transcribed in to written format ready for analysis. All transcriptions are anonymous and pseudonyms will be used for both your details and any client information which may be discussed. All information collected throughout the study will be stored securely by a password and/or in a locked filling cabinet which only my supervisor and I have access to.

Are there any risks in taking part?

There are no expected adverse effects from participating in this study. However, for those who wish to discuss any issues you can contact Dr James Reilly, University of Liverpool on 0151 794 5534 or j.reilly@liverpool.ac.uk. Alternatively you can contact Dr Elisabeth Hansen or Dr Tanya Petersen (Clinical Psychologists) at Ashworth Hospital on 0151 471 2213.

Are there any benefits in taking part?

It is hoped that this research will help to inform the way services deliver case discussions in the future.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Dr James Reilly at The University of Liverpool on 0151 794 5534 or j.reilly@liverpool.ac.uk and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer on 0151 794 8290 (ethics@liv.ac.uk). When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Will my participation be kept confidential?

If you were to participate in this research you will be asked to use non-identifiable information when discussing clients and colleagues in order to preserve anonymity. Everything you discuss would remain confidential and your place of work will not be informed should you choose to participate (or not participate), unless however you were to disclose something that would put yourself or someone else at harm or in danger. If this were to happen, then I would try to discuss my concerns with you and advise you to discuss further with your line manager or supervisor. I would also have a responsibility to discuss my concerns with my supervisor who would advise me on what to do next. All identifiable information would be removed so that anyone you discuss cannot be identified. All information gathered from the research will be stored in password protected documents and/or in a locked filing cabinet by Dr James Reilly at The University of Liverpool. Only my supervisors and I will have access to this information. All audio-recordings will be destroyed after they have been transcribed; however, paper transcripts will be stored securely at The Division of Clinical Psychology, University of Liverpool for five years before being destroyed.

What will happen to the results of the study?

The results will be submitted to the University of Liverpool as part of the named researcher gaining her Doctorate in Clinical Psychology. Although some direct quotes from the interviews may be used within the results, participants will not be identifiable. It is hoped that the research will be published in an appropriate journal. Participants of the study are able to contact the researcher(s) after completion of the study to discuss the findings if they wish.

What will happen if I want to stop taking part?

If you choose to participate in the study then you can withdraw from the study at any time, without explanation and without any effect to your employment. Any information you give up to the time of withdrawal may be used, if you are happy for this to be done. Otherwise you may request that they are destroyed and no further use is made of them. However, once the data is anonymised and analysis has begun your data will not be able to be able to be identified and therefore your information cannot be withdrawn from the study.

Who can I contact if I have further questions?

If you would like to contact the researcher to discuss any aspect of the research please leave a message with the secretary at the University of Liverpool on 0151 794 5530 with your name and contact details. Alternatively, you can contact me via e-mail on lianne.franks@liverpool.ac.uk.

THANK YOU FOR TAKING THE TIME TO CONSIDER TAKING PART IN THIS RESEARCH STUDY.

Appendix G

Opt-in Sheet

Title of Research Project: Exploring Multi-Disciplinary Team (MDT) Experiences of Cognitive Analytic Therapy (CAT) as a Systemic Consultation Tool in an Adult Forensic Service.

Researcher: Lianne Franks (Trainee Clinical Psychologist)

If you have read and understand the information sheet and would like to participate in the study then please complete the sheet below and return to: Lianne.Franks@liverpool.ac.uk or alternatively, please return it in the envelope provided. I will then contact you via your preferred method to arrange a suitable time to visit you to discuss the study, complete the consent forms and to conduct the interview should you wish to participate.

Please complete all fields using BLOCK CAPITALS

Name:_____

Job Title: _____

Ward/Base: _____

CONTACT DETAILS: (please choose preferred method of contact)

☐ **Telephone Number:** _____

☐ **E-mail address:** _____

☐ **Other:** _____

THANK YOU FOR PROVISIONALLY AGREEING TO PARTICIPATE IN THIS STUDY

Appendix H

Consent Form

UNIVERSITY OF LIVERPOOL

Title of Research Project: "Exploring Multi-Disciplinary Team (MDT) Experiences of Cognitive Analytic Therapy (CAT) as a Systemic Consultation Tool in an Adult Forensic Service"

Researcher: Lianne Franks (Trainee Clinical Psychologist)

	PLEASE INITIAL BOX
1. I confirm that I have read and have understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights/ job being affected.	☐
3. I consent to the interview being audio-recorded.	☐
4. I consent to the audio-recording being transcribed.	☐
5. I consent to direct quotes being used from the transcripts in the write up of this study but understand that my name or other identifiable information will NOT be used.	☐
6. I understand that all the information gathered in this study will be confidential as all data will be anonymised.	☐
7. I understand that once the data is collected is anonymised and analysis begins I will not be able to withdraw at this point.	☐
8. I understand that all information, audio-recordings and transcripts will be kept in locked filing cabinets but stored separately at the Division of Clinical Psychology, University of Liverpool and that only the researcher and study supervisors will have access to these. The data will be kept for 10 years and then destroyed.	☐
9. I agree to take part in the above study.	☐

Participant Name	Date	Signature
_____	_____	_____
Researcher Name	Date	Signature
_____	_____	_____

Lead Researcher: Lianne Franks (Trainee Clinical Psychologist) University of Liverpool, Division of Clinical Psychology, Whelan Building, Brownlow Hill, Liverpool, L69 3GB. Tel: 0151 794 5534. E-mail: Lianne.Franks@liverpool.ac.uk

Chief Investigator (supervisor): Dr James Reilly. University of Liverpool, Division of Clinical Psychology, Whelan Building, Brownlow Hill, Liverpool, L69 3GB/ Tel: 0151 794 5534. j.reilly@liverpool.ac.uk

Appendix I

Demographic Sheet

UNIVERSITY OF LIVERPOOL

Title of Research Project: Exploring Multi-Disciplinary Team (MDT) Experiences of Cognitive Analytic Therapy (CAT) as a Systemic Consultation Tool in an Adult Forensic Service.

Researcher: Lianne Franks (Trainee Clinical Psychologist)

PARTICIPANT ID NUMBER:_____

CHECK FOR CONSENT FORM COMPLETED? YES/NO (delete as appropriate)

Please complete the following sheet using BLOCK CAPITALS:

SEX: Male ☐ Female ☐ *(please tick)*

What is your job title?_____

What service(s) do you work in?_____

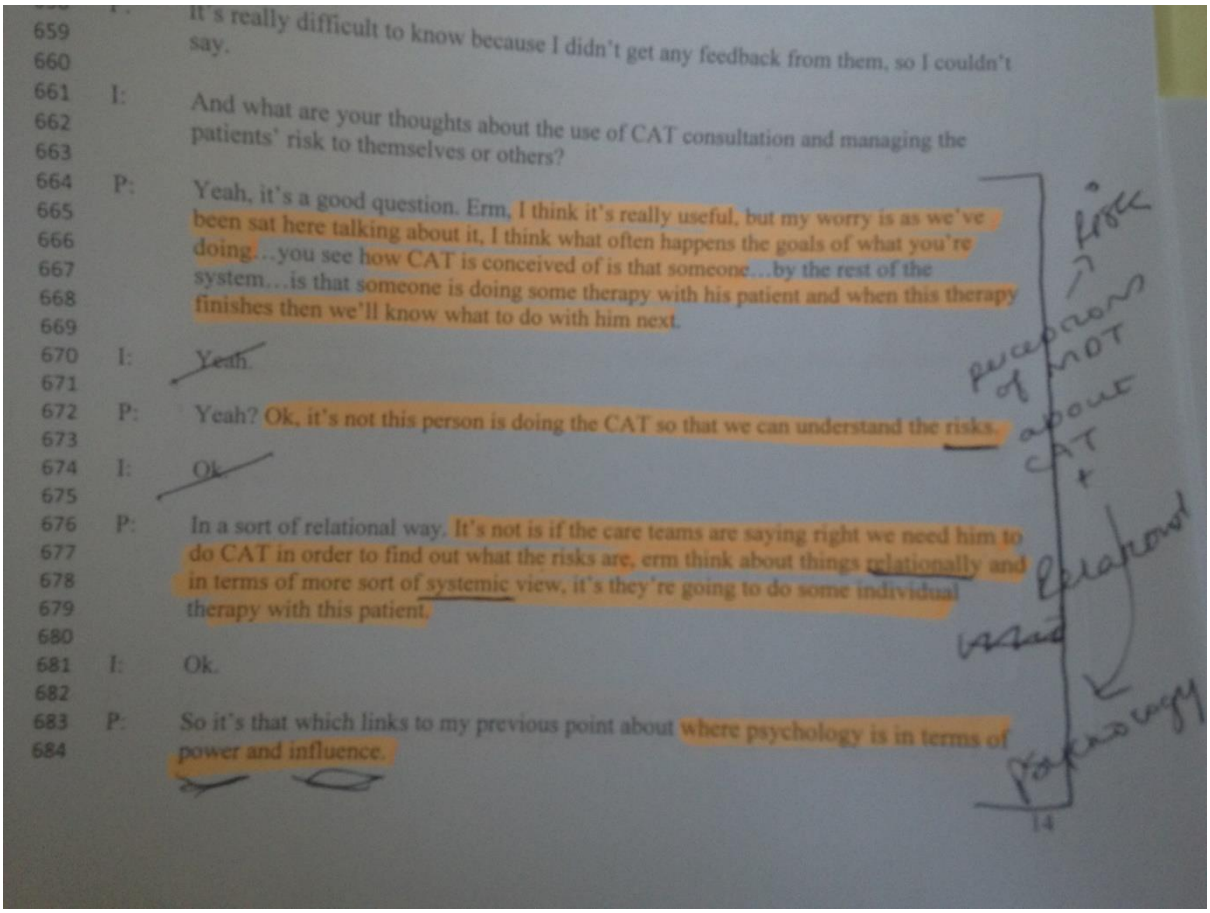
Have you been involved in discussions of patient's problems where a Cognitive Analytic Therapy (CAT) model has been used in the last 6 years? *(please tick)*

☐ Yes ☐ No

THANK YOU FOR COMPLETING AND AGREEING TO PARTICIPATE IN THIS STUDY

Appendix J

Annotated Excerpt from Transcripts



659 It's really difficult to know because I didn't get any feedback from them, so I couldn't
660 say.
661 I: And what are your thoughts about the use of CAT consultation and managing the
662 patients' risk to themselves or others?
663
664 P: Yeah, it's a good question. Erm, I think it's really useful, but my worry is as we've
665 been sat here talking about it, I think what often happens the goals of what you're
666 doing…you see how CAT is conceived of is that someone…by the rest of the
667 system…is that someone is doing some therapy with his patient and when this therapy
668 finishes then we'll know what to do with him next.
669
670 I: Yeah.
671
672 P: Yeah? Ok, it's not this person is doing the CAT so that we can understand the risks.
673
674 I: Ok.
675
676 P: In a sort of relational way. It's not is if the care teams are saying right we need him to
677 do CAT in order to find out what the risks are, erm think about things relationally and
678 in terms of more sort of systemic view, it's they're going to do some individual
679 therapy with this patient.
680
681 I: Ok.
682
683 P: So it's that which links to my previous point about where psychology is in terms of
684 power and influence.

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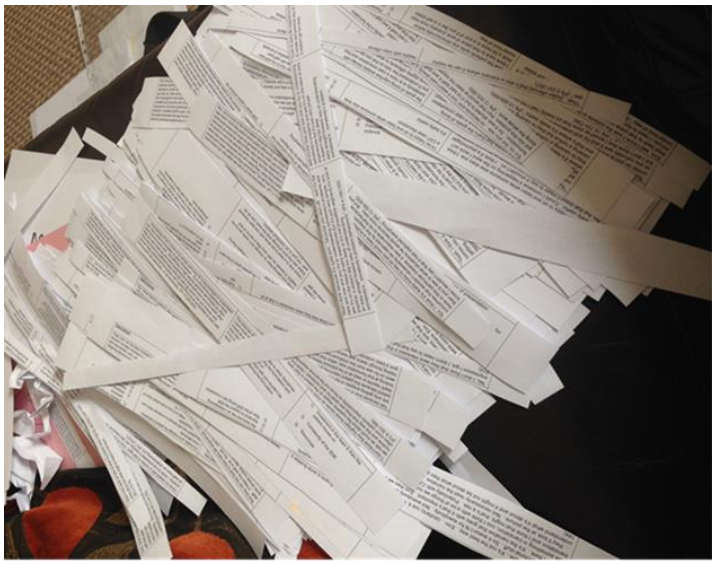
Appendix K

Example of Initial and Higher Order Codes and Clustering Themes

Data Extract	**Initial Codes**	**Higher Codes**
Is it the rubbishing…is it the rubbishing cycle kicking in, and he is now able to respond to that instead of us getting into a real sort of you know head…erm loggerheads with him…We're able to say and they're his terms (P1.4.167-173)	Staff asking the patient about the cycles Responding to staff rather than getting in to loggerheads Using the patients terms Language	1) Using the patients language terms 2) Patient responding to staff using the SDR with the patient
So that, you know that strength of being able to use how he describes and what he recognises in himself, it's really helped to you know bring down the barriers and we're all able to get over those hurdles when they come up 'cos they do come, but we're able to all use the terms that he feels comfortable with to get past those barriers. Does that make sense? (P1.4.177-181)	Strength of being able to use the terms the patient feels comfortable with Helped to bring down the barriers Able to get over those hurdles Language	1) Using the terms the patient feels comfortable with 2) Brings down the barriers and getting over the hurdles
I think not necessarily different to what I thought, but it helped me to see it clearer because he was… his presentation's quite difficult, when you're working with him it's quite frustrating and the CAT therapist was saying that as well you know, and she was able to label it with him, erm, which helped me to work with him better by recognising where that all comes from. (P1.4.195-199)	It's helped me to see clearer CAT therapist able to label the frustration with him His presentation is quite difficult Work better with the patient by recognising where that all comes from	1) Helped staff to see clearer 2) Feelings of the staff team 3) Working better with the patient by recognising where it all comes from



Appendix L

Initial Thematic Map