'We're able to see the smoke':
Exploring staff experiences of remote cognitive analytic team formulation within a residential learning disability service

SASHA PRIDDY, JO VARELA, JAMES RANDALL

Abstract: Team formulation is increasingly used within health services across the UK to facilitate reflective practice within teams. This research sought to understand staff experiences of team formulation using a cognitive analytic therapy (CAT) model within a residential learning disability (LD) service. The evaluation was conducted in two phases, using a mixed methods approach. In phase one, participants (n=6) were invited to attend a series of team formulation sessions for clients with whom they were directly working. A total of 11 CAT-TF sessions were held, across three clients. Participants completed two evaluative questionnaires following the last formulation session (n=12); there was a 100% response rate on both measures. Phase one analysis informed the development of semi-structured focus group questions (phase two), to further explore participants' (n=4) experiences.

Results across both phases indicated that participants felt CAT-TF sessions facilitated their understanding of the client and of the relational processes within services. This understanding was reported to aid the development of relationships between staff and clients. Remote delivery was experienced positively, with participants suggesting this enabled accessibility and openness within the sessions. These findings indicate there is benefit in practitioners offering CAT as a core model when delivering team formulation groups – particularly with a view to offering these services to organisations which do not have mental health specialists embedded within their teams. The findings of this research

1. Dr Sasha Priddy, clinical psychologist, University of Sheffield, Clinical Psychology Unit, Department of Psychology, University of Sheffield, Cathedral Court, 1 Vicar Lane, SHEFFIELD, United Kingdom, S1 2LT
sasha.priddy@nhs.net

2. Dr Jo Varela, consultant clinical psychologist & CAT practitioner, University of Sheffield

3. Dr James Randall, Health Research Building 1F421, College Lane Campus, University of Hertfordshire
james.randall@nhs.net

aid further development of a CAT-TF structure, particularly within LD services, to support reflective capacity within teams. CAT-TF can be delivered effectively through remote technologies and offered numerous advantages in terms of resource efficiency, accessibility and ethics (e.g. increasing access for staff; allowing greater service-user engagement; providing an means to embed psychological thinking without exhausting resources). In order to be true to CAT, CAT-TF needs to be collaborative in approach – with informed consent and the service-user voice underpinning its delivery.

Introduction

Under the Transforming Care initiative within the UK, there has been a significant shift towards helping people with learning disabilities (LD) to live within the community; in 'homes not hospitals' (Houlden, 2015). This move towards supporting people to return home from hospital units, arose from significant human rights abuses perpetrated by those within 'caring' roles (e.g. Winterbourne view; see Flynn, & Citarella, 2013). In order to meet the care and support needs of people with LD in the community and reduce the risk of any further admissions, care-worker input is often provided to facilitate daily living. Where additional mental health needs are also present, this is often supported through the provision of 'in-reach' from community health teams – whereby specialist services advise, consult and supervise care-worker input.

For staff and professionals fulfilling these roles within LD services, the perceptions that they hold of their client can significantly impact upon the client's experience of services and the quality of their care provision (Russell, 2019). Indeed, people with LD have talked of staff seeing them as 'a different person' once they transitioned back to living at home within their community, rather than being seen as a 'bad' person in hospital (Head, Ellis Caird, Rhodes, & Parkinson, 2018). Having returned home, it was important for these people 'feel safe' and 'happy' in their homes and they viewed staff as having a key role in helping them to feel this way (ibid.). From this, it can be seen that the foundation to effective community health care is to ensure staff are sufficiently trained and supervised to understand and dynamically manage relational and

behavioural difficulties in-line with evidence based clinical models. Within these contexts, psychological consultation has been suggested to benefit staff and clients, through facilitating a consistent team approach across the network (Kerr, Dent-Brown & Parry, 2007).

However, evidence suggests frontline staff working with this client group often feel under-supported and ill-equipped in working with the interplay of psychological, social and physical needs they are presented with (Bromley & Emerson, 1995; Hastings, 1995). Staff burnout and reduced team morale have been found to be influenced by staff feeling unskilled and unsupported in working with such complexity, in addition to the impact of the work itself (Robertson *et al*., 2005; Mills & Rose, 2011). In the face of these challenging environments, Varela and Franks (2019) suggest staff often experience threat-based responses, that eventually become cemented into practice; especially where low levels of support are available. Within these circumstances, staff are likely to fall out of dialogue with clients, as the reciprocal process of commun-ication, and therefore any attempt to understand the client becomes lost (Varela & Franks, 2019).

To provide staff teams with the tools to develop their understanding of clients and provide a coherent team approach, there has been an increasing interest in psychologically informed working with staff groups; such as team formulation and consultation. Team formulation involves a process of collaborative sense-making underpinned by psychological theory, to inform the understanding and approach of staff groups working with a client (Johnstone & Dallos, 2014). The Division of Clinical Psychology (DCP, 2011) propose numerous potential benefits to team formulation, including facilitating consistent interventions, encouraging collaborative working, gathering key information succinctly, generating new ways of thinking, processing staff counter-transference, and increasing staff reflectiveness and empathy. Research suggests whilst the range of models used to provide a framework for team formulation is diverse, CAT is one of the most frequently adopted models; second to the use of cognitive behavioural therapy (Ghag, Kellett & Ackroyd, 2019).

CAT is considered a fundamentally relational model for understanding individuals' experiences, through recognising how internalised relational experiences, termed 'reciprocal roles', come to influence how we engage with the world, other people and with ourselves (Ryle & Kerr, 2020). Although CAT was originally designed as time-limited individual therapy, the application of CAT with teams has become increasingly recognised; for example, the 'Map and Talk' approach (Potter, 2010). The use of CAT

with services has been suggested to enable staff to express and make sense of their reactions to the client, sustain empathy, and maintain a therapeutic approach (Carradice, 2017). Thus, it can be seen that CAT appears to offer a potentially suitable model for working relationally with staff within LD services.

Aims

The service evaluation sought to explore the acceptability of CAT-TF for staff working within a residential LD service that supported people with complex presenting needs and risks, with the view to prevent hospital admission. This research also sought to explore the staff members' experiences of using the groups. Specifically, commissioners of the service also wanted to ascertain whether the project appeared valued by staff and whether its delivery via remote technologies was acceptable. This informed the following aims for the evaluation:

- Explore the acceptability of team formulation for staff;

- Explore staff experiences of the group, including what was considered helpful or unhelpful within the meetings;

- Explore the impact of remotely delivering CAT-TF on staff experiences.

Service context

The service evaluation was conducted within a residential service for clients presenting with significant mental health needs alongside a LD diagnosis. The residential home would often support people who were at risk of hospital admission (with the view to reduce this risk), to mitigate placement breakdown and offer temporary respite, and for periods of assessment in advance of developing a community support package. The residential staff included support workers (n =10) and residential managers (n=4); with additional support provided by external agencies based on client need. This research was conducted during the COVID-19 global pandemic (March 2020 – September 2020), where the UK saw two national 'lockdowns' but residential services continued throughout. In this context, CAT-TF was offered through remote technologies, rather than on site and in person. This provided an additional opportunity to explore the potential benefits or drawbacks of remote delivery.

Team formulation process

For team formulation to take place, informed consent was obtained from the client. To enable this, an easy-read document about CAT-TF and a consent form were developed (Priddy & Varela, in prep.). For each client, three-to-four team formulation sessions were held on a bi-weekly basis; lasting 90 minutes each. Clients were invited to attend their formulation meetings; all clients chose to attend at least one session. Formulation meetings were informed by clinical experience, consultation with the residential home and the steps proposed by Carradice and Bennett (2012). These steps, adapted from Carradice and Bennett (2012), were used to facilitate an effective formulation space (Table 1). All sessions were facilitated by a trainee clinical psychologist, with supervision from a qualified CAT practitioner.

Methods

Design
A mixed methods design was implemented, which occurred in two

Table 1: CAT-TF in a residential LD context – steps adapted from Carradice and Bennett (2012)

Step	Tasks
1. Preparation	● Referral screening ● Seeking consent from service-user (using accessible/easy-read information) ● Preparing the team: process & practical group set up
2. Letting people talk	● Developing empathy and a context to talk freely ● Ensuring that the client's voice is heard and adapting ● Validating relational struggles ● Co-regulation (allowing movement from expressing emotion to reflecting on emotion)
3. Sharing of relational experiences & sharing knowledge of self	● Focussing on how the struggle is embedded in relational dynamics, not necessarily individuals ● Enabling and supporting relational talk ● Drawing out reflections on the self and the selves as relational ● Connecting the selves to the patterns ● Reformulation of team 'stuckness'

4. Funnelling using CAT theory and awareness of ZPD	● Giving observations a name (eg 'that sounds like a dilemma . . .') and supporting elaboration (eg 'because if they do this, or if they do that, what occurs in either situation?' ● Guided questionig to suport identification of target problem procedures, traps, dilemmas, snags, reciprocal roles ● Noticing the relational patterns in the room; using transference and counter-transference, to enrich understandings ● Drawing out the moment, providing examples and scaffolding to extend awareness
5. CAT Mapping	● Drawing out a CAT map together as collaboratively as possible (eg everyone has a pen, or using 'share screen'/ whiteboard features) ● Working to establish and use language and/or images that are co-created by the client and the team to create the CAT map
6. Seeking consensus and further understanding	● Reviewing the CAT map together – what makes most sense and is in-line with the group's expereience ● Taking the map away to revise and return to the group for further review
7. Inviting recognition	● Embedding the invitation of the observing eye ● Tasking the team to actively recognise patterns within the moment ● Collaboratively designing out-of-session ways to recognise and monitor patterns
8. Planning the exits	● Supporrting the development of therapeutic care-plans, rooted in relational ways of understanding/responding ● Developing relational and collaborative ways of managing risk

phases. A validating quantitative data model (Creswell, 2019) was used, whereby quantitative questionnaire findings were validated using content analysis of qualitative questionnaire data (phase one). Findings from phase one informed the second phase of the evaluation, in which a focus group was conducted to further explore participants' experiences of the sessions.

Participants

Inclusion criteria required staff to have attended at least one team formulation meeting and a 2-hour introductory CAT training session. All staff members who met the inclusion criteria participated in phase one (n=6). Participants included three residential workers, a social worker, a team manager and a psychologist; all of whom were white British. Three participants were male, three were female.

Four of the phase one participants also participated in phase two; two participants could not attend due to other commitments. Participants in phase two included three residential workers and one social worker; two participants were male, two were female.

Ethical considerations

Approval was granted from the Research and Development department within the NHS Trust that the project was completed. Participants were informed their data would be anonymised and they could withdraw their data at any time; up until data analysis commenced.

Measures and materials

Consultation Outcomes Scale (COS)

The COS is a 7-item questionnaire which explores participants' perceptions of the 'outcomes' of formulation and consultation meetings (Fredman, Papadopoulou & Worwood, 2018); for example, 'the consultations have helped improve my relationship with clients'. Each item is rated using a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). For each item, a qualitative response is requested, to enable explanation of the rating.

Consultation Partnership Scale (CPS)

The CPS explores individuals' experiences of 'partnership' within team formulation meetings, across five items (Fredman, Papadopoulou &

Worwood, 2018), namely: 'relationships within the consultation and network', 'goals and topics', 'approach or method', 'group experience' and 'overall experience'. Items are rated on a 5-point Likert scale, anchored by individual statements relating to positive or negative endorsement of the item; higher scores indicate agreement and lower scores indicate disagreement.
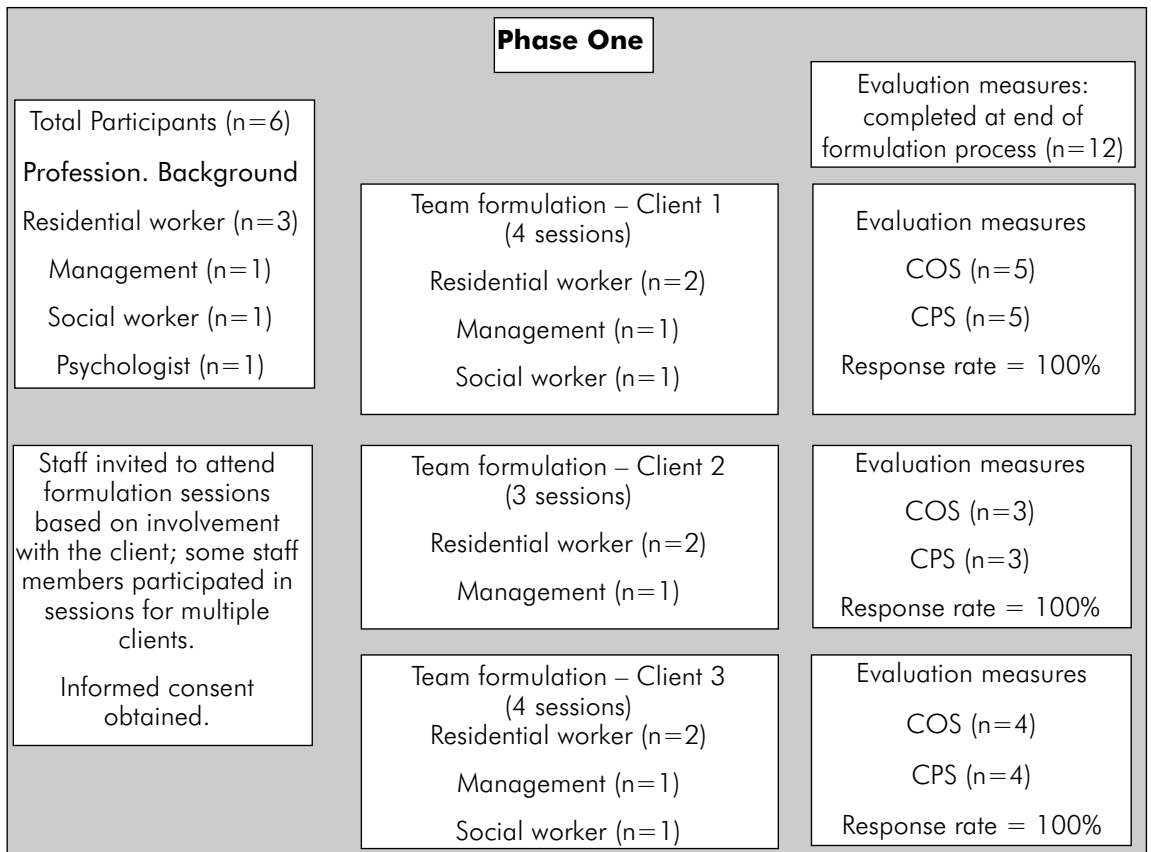
Semi-structured interview schedule
Four semi-structured interview questions were developed, based on the findings of phase one and consultation with the commissioners:

1) In what ways, if any, did team formulation change your understanding and practice?

2) Was there anything within the CAT framework that made it easier to apply your understanding to your practice?

3) What are your perceptions of how the clients responded to team formulation and the use of CAT?

4) Was there anything that happened during the process of team formulation that you found particularly helpful or unhelpful?

Procedure

Informed consent was sought from staff prior to each session using an information sheet and consent form. Following completion of the formulation process for each client, participants completed the COS and CPS measures. These were returned anonymously to the researcher, to reduce risk of bias. Six months after the introduction of the formulation meetings, staff who consented to participating in phase two were invited to attend a two-hour focus group, to further explore their experiences of the sessions. The focus group was recorded using an encrypted device, before being transcribed by the lead researcher and stored securely, according to NHS Trust guidance. For an overview of the service evaluation procedure, see Figure 1.

Phase One

Total Participants (n=6)

Profession. Background

Residential worker (n=3)

Management (n=1)

Social worker (n=1)

Psychologist (n=1)

Staff invited to attend formulation sessions based on involvement with the client; some staff members participated in sessions for multiple clients.

Informed consent obtained.

Team formulation – Client 1
(4 sessions)

Residential worker (n=2)

Management (n=1)

Social worker (n=1)

Team formulation – Client 2
(3 sessions)

Residential worker (n=2)

Management (n=1)

Team formulation – Client 3
(4 sessions)
Residential worker (n=2)

Management (n=1)

Social worker (n=1)

Evaluation measures: completed at end of formulation process (n=12)

Evaluation measures

COS (n=5)

CPS (n=5)

Response rate = 100%

Evaluation measures

COS (n=3)

CPS (n=3)

Response rate = 100%

Evaluation measures

COS (n=4)

CPS (n=4)

Response rate = 100%

Phase Two

Participants from phase one (n=6) invited to attended focus group. Two participants were unable to attend; resulting in four participants for phase two.

Participants (n=4)

Professional background

Residential wonder (n=3)

Social worker (n=1)

Response rate = 67%

Figure 1. Project overview

Analysis

Quantitative Analysis
Based on the aims of the project and due to the small sample size, descriptive analysis was used on the quantitative data collected on the COS and CPS measures.

Qualitative Analysis
Qualitative data from phase one and two was analysed using content analysis, which involves systematic investigation of written verbal or visual information through identifying, coding and categorising patterns within the data (Elo & Kynäs, 2008; Patton, 1990). To complete the analysis, the researcher followed Schreier's (2012) content analysis model, which involved the following process:

>1) *Conceptualising.* The researcher repeatedly examined the data, to note patterns of similarity and difference, and identify concepts that appeared relevant.

>2) *Defining categories.* Similar concepts were grouped into categories; according to their shared features.

>3) *Developing categories.* The researcher introduced a structure to the coding frame through deciding upon main categories and subcategories.

Reliability procedures were implemented using Hill, Thompson and Williams (1997, as cited in Priester *et al*., 2008) consensual qualitative research model. An independent clinical psychologist, who was not part of the research team, second coded the data. Coders discussed discrepancies until they reached agreement on categorising 95% of the items. This process was repeated two weeks later, until coders reached consensus on all themes and subthemes.

Results

Quantitative Results
Twelve questionnaires were available for analysis. Based on the small sample size, raw data has been presented; as opposed to percentages. Responses on the COS scale illustrate that participants strongly agreed with four items on the measure (Figure 2). These items included: 'my hopes and goals for the consultation were met', 'the consultation has

given me new understanding/changed my thinking to help address the issues brought', 'the consultation had helped me learn new skills/ideas to address the issues brought', and 'the consultation has improved my relationship with clients'.

Figure 2. Quantitative COS data
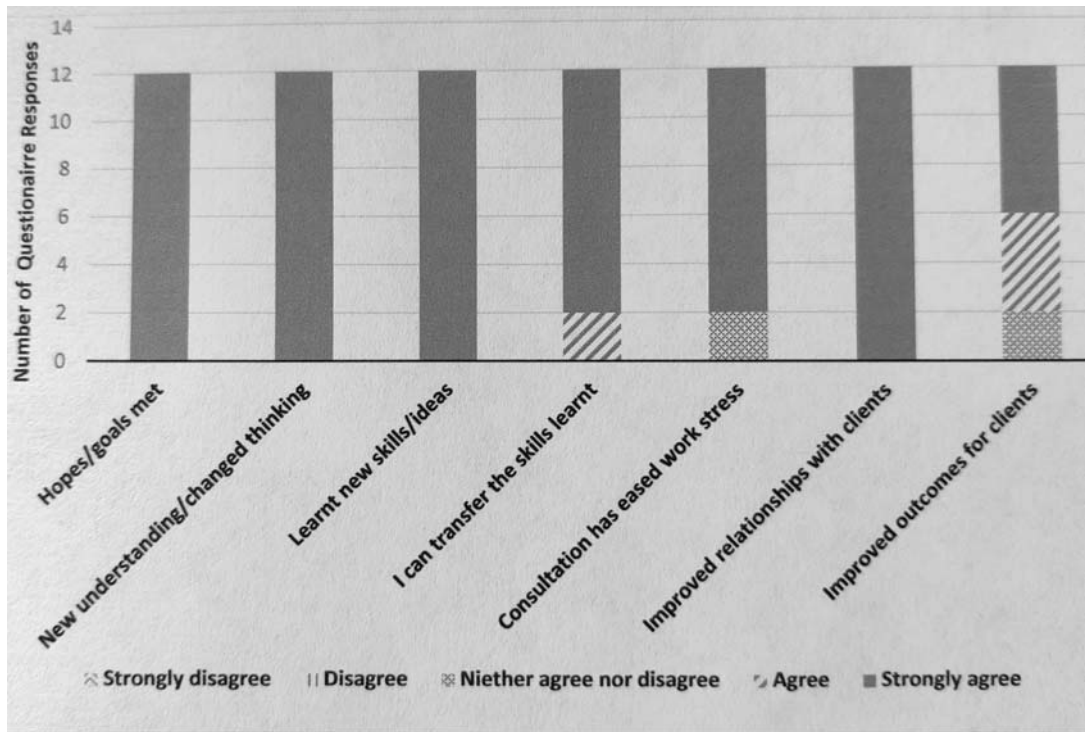
In response to the 'I can transfer the skills I've learnt' item, two respondents indicated 'agree', whilst 10 indicated 'strongly agree'. On the item 'team formulation had reduced work-related stress and/or increased my confidence', two respondents indicated 'neither agree nor disagree', 10 responses 'strongly agreed' with this statement. On the final item, 'the consultation will lead to improved outcomes' for the client, there were six responses for 'strongly agree', four for 'agree', and two for 'neither agreed nor disagree'.

Data from the CPS measure indicated positive experiences of partnership across all five domains (i.e. participants provided a score of 5 across all items).

Table 2 Summary of qualitative findings for phase one

Theme	Subtheme
Outcomes for client: this theme related to participants reflections on how team formulation had impacted the client (either directly or indirectly	Improving care provision: this subtheme contained comments from staff relating to how clients would be positively impacted up by the team formulation process
	Building relationships: two participants described a positive influence of team formulation on improving therapeutic relationships
Outcomes for staff: this theme contained four subthemes, which reflected different outcomes of team formulation for staff in relation to their personal and professional development	Increased confidence: Three participants reported increased confidence in themselves or their practice as a result of attending the team formulation
	Changing practice: Two participants provided reflections which detailed ways in which the team formulation would inform their practice
	New understanding: this was the most frequently reported subtheme, with participants reflecting a sense of new understanding of the client based on their participant in team formulation
	Transferable skills: Four participants contributed to this subtheme, indicating that the skills they felt they had developed were transferable to other areas of their work
Facilitator role: this theme reflected comments relating to the characteristics of the facilitator role that were experienced as helpful	No subthemes

Qualitative results

Questionnaire data

The content analysis indicated the presence of three themes, for which a brief summary is provided:

1) Outcomes for staff: participants reported increased feelings of confidence, greater understanding of clients, changes to their practice and the development of transferable skills.

2) Outcomes for clients: team formulation was perceived as facilitating improvements in the care offered to clients and enhancing client-staff relationships.

3) Facilitator role: this theme reflected the perceived role of the facilitator and helpful aspects of their approach; such as introducing ideas using psychological theory.

Examples	Frequency
'I think the consultation enabled a positive outcome for the client by giving direction for the care team, providing consistency, improving emotional well-being, ensuring the client's needs are being met, encourage development of C2's skills when care planning, and supporting the client to achieve their outcomes.'	3
'The consultation has helped improve our relationship with them, we know more about their background. We will continue to learn and build on our skills.'	2
'This has improved overall confidence in working with the client, as I can now have confidence in support planning and my advice to support staff, as this is underpinned by psychological theory.'	3
'We are now able to create an evidence-based care plan which will support the client's emotional well-being.'	2
'I now have a better understanding of what C2 is trying to communicate, and how they are communicating this to us.'	12
'Skills I learnt in these sessions are invaluable. Thinking about reciprocal roles is transferable to all clients.'	4
'The facilitator offered ideas and put together a really useful flow chart of behaviours and explored current responses and exit strategies for times of heightened anxiety.'	3

These themes informed the semi-structured interview schedule for phase two, alongside the quantitative findings. All themes, subthemes, and the frequency they occurred within the data is presented in Table 2.

Focus group data
Content analysis of the focus group data yielded five overarching themes: 1) new insights and understanding, 2) the tools of CAT, 3) growing relationships, 4) creating safe and (remotely) accessible spaces, and 5) recognising patterns and unhelpful responses. All major themes and subthemes are listed in Table 3. Samples of the data have been included, to maintain the richness of the data (Elo & Kyngäs, 2008).

Table 3
Phase two content analysis: main themes, subthemes and frequencies

Themes	Subthemes	Frequency
New insights & understandings	Understanding client	10
	Understanding self	4
	New understanding changes practice	5
	Subtotal	19 (30.16% of total)
The tools of CAT	Using the map	8
	The map provides a plan	5
	Understanding complex ideas	3
	Subtotal	16 (25.4% of total)
Growing relationships	Relationship enables dialogue	4
	Understanding builds relationships	3
	Developing cohesion	4
	Subtotal	11 (17.46% of total)
Creating safe & (remotely) accessible spaces	The benefits of remote sessions	5
	Creating a safe space to share knowledge	4
	Subtotal	9 (14.29% of total)

Theme 1: New insights and understanding

Within this theme, participants described team formulation as developing their understanding of clients, themselves and the team; which, in turn, facilitated changes in their practice.

Understanding the client

The process of team formulation was experienced as an opportunity to understand the client 'beyond the surface':

> 'You can just understand them so much more. . . and you realise there is a reason behind every action that they do. . . just because we don't know everything, there's still got to be a reason somewhere.'

> 'It's like our understanding goes beyond the surface now, we're actually seeing what's going on.'

Participants noted that this understanding was enabled through new insights into the client's historical experiences:

> 'I just think it's such a holistic approach, looking at his past, his current presentation, and why we see these things. . .'

Understanding the self

Participants also reported that engaging in self-formulation using CAT allowed them to consider the relational interplay between them and the client:

> 'Because I have my own CAT map in my head now, I can understand why I respond in certain ways [to clients].'

This understanding extended to reflecting upon themselves within the context of the team:

> 'It's made us think about how we work, and we all take on specific roles. . . I almost feel like 'dad' at times in the building. . . we take on roles of brother, sister, mates and stuff, and I think that's something that we've learnt. . . we can transfer the CAT stuff on to each other, and look at each other as a team.'

Your understanding changes your practice

For all of the participants, comments were made relating to how their new understanding had changed their practice:

> 'Understanding the way he's working, made me realise I can support him better. . . knowing that information, it's like having a separate bag of tools that you can pull out to use with somebody.'

Theme 2: The tools of CAT

Elements of CAT were perceived as offering an accessible framework for understanding 'sophisticated' ideas.

Using the map

Participants reported benefits of using a visual diagram (i.e. a sequential diagrammatic reformulation) to encapsulate the formulation and recognised this as aiding the recognition process:

> 'I think the client can understand their patterns better through the map. . . especially [client]. . . she really understood the little circles that she could go in, she'd say to us, 'oh, well I'm here. . . I need to find the exit to get out of that circle', so she genuinely took it on. . . because she was telling us where she was.'

Two participants spoke about the map providing a mechanism to hold the formulation over time:

'I think it's good that we have it down on paper, so that when they move on, they don't have to go through everything again. . . it's just there, and we can carry on working in that way.'

Understanding complex ideas
Participants described experiencing the CAT model as providing an accessible framework for understanding complex ideas:

'As a format, I think it's lovely. . . because it looks at past, present, and allows us to push them into their future and change. . . in what feels like very simplistic way. . . but is actually a very sophisticated model of analysis and psychological intervention.'

Theme 3: Growing relationships

Participants perceived their new understanding as enabling staff-client relationships to grow, which was suggested to facilitate dialogue within the relationship.

Understanding builds relationships
This subtheme reflected participants' perceptions of how their understanding of clients led to developments within the therapeutic relationship:

'The knock-on effect of doing this, and understanding more about him means that the relationship has grown, it's amazing. . . it's been beautiful to walk on this journey.'

This was described as a two-way process, whereby understanding the client facilitated participants' professional development, to allow staff to facilitate personal development for the client:

'With some of the residents we really didn't connect with them, but now we've got really good relationships, and I think part of that is a knock-on effect from this process, because we think bigger. . . around how have they got to be where they are, what's gone on for them. . . it allows you to develop. . . and that develops them. . . which is really nice, because it's a two-way process.'

Building the relationships enables dialogue
This subtheme captured participants' subsequent experiences of dialogue with clients based on their improved relationship:

'I saw [client] and [staff]'s relationship grow. . . because [they] opened up, talked about her experience, which let you guys in even more.'

'He must feel comfortable around me now, he's able to say how he feels. . . it made me feel quite proud'

Relationships with the team

Participants spoke about feeling stronger as a team based on the skills they had developed throughout the process:

'Skills that we've got now have helped make the team stronger, and they are able to support in a better way.'

In turn, the development of skills and strategies were described as enabling a more cohesive staff approach:

'It's given us lots of strategies that we can be consistent with. . . and I think with this client group, consistency is really important.'

'It's given us direction as a team, which is a really beautiful thing. . .'

Participants felt that engaging in a CAT-based training generated a new outlook for the team and reported a desire for more of these opportunities:

'It gave the whole team a different outlook and a different view. . . so I wish we could've done more of that sharing as a group remotely.'

Theme 4: Creating safe and (remotely) accessible spaces

This theme related to participants' experiences of engaging in team formulation via video-call platforms and being able to establish a safe space.

The impact of engaging remotely

Participants reported benefits of engaging in the sessions via video call, for both themselves and the clients, despite initial reservations:

'[client] is so scared of meeting new people. . . and actually. . . it's worked really well. . . because I thought, 'how is this gonna work?'

. . . and I honestly thought. . . 'how can we do psychology type meetings over the internet?'. . . and it's worked amazingly.'

Some participants felt clients appeared to find it easier to 'open up' over video call:

'Being behind a screen probably allowed her to open up and little bit more than she would've done in person. . . it's a safe space, she knows where she is. . . I think having the screen maybe gave them more confidence to open up.'

Remote engagement was seen as increasing the accessibility of the team; which could be helpful, whilst also making work feel more stressful:

'I think we've all been more accessible. . . which makes the job more stressful. . . but it's also really helpful, because you're just at the end of a video-call.'

Creating a safe space to share knowledge
Participants described the meetings as a safe space where curiosity, uncertainty and knowledge could be shared:

'I feel like we could all be really honest, in saying in the sessions, 'I don't know, can someone help me?' It did feel like a safe space. . . where we could say we don't know the answers, but we can figure it out together.'

Theme 5: Recognising client patterns and staff responses

Within this theme, participants described being able to actively recognise enactments.

Recognising patterns in the client
Within this subtheme, staff described recognising enactments of reciprocal roles or problematic patterns from the CAT map:

'When they say 'I'm going to go get stoned, and you won't like me then' . . . I was able to be like, ah okay, that's your past experience, that's your parent speaking. . . and then they turn into 'child' [client], the victim bit, and being able to identify that is really useful.'

The ability to recognise enactments was seen as providing staff with the opportunity to intervene earlier, before situations escalated:

> 'We used to just all get in there and just firefight, and now, we don't firefight, because actually, we're able to see the smoke. . . so we can intervene quicker'

Recognising unhelpful responses
Within this subtheme, participants contributed comments which related to reflecting on their actions and how these impact upon relational dynamics:

> 'I think sometimes I try and rescue, and now I realise that can ignite the fire even more.'

Some participants extended these reflections beyond themselves, to recognise unhelpful responses within the team and initiate conversations about revising relational patterns.

Discussion

Delivering CAT-TF to residential services is an appropriate, effective and resource efficient way of ensuring that people with LD have access to staff who are able to deliver care informed by theoretical and evidence-based models of care, as an alternative to hospital admission. This research evidences that its delivery is both acceptable and feasible, and indicates that those participating experience CAT-TF positively and as helpful for their practice. In particular, team formulation sessions enabled staff to develop their understanding of clients, themselves and the team. In turn, this facilitated the positive development of relationships between the staff team and clients. This process is encapsulated in the below figure for illustrative purposes. CAT-TF appears to be a well-matched service offer to meet the relational needs of people with LD who have moved out of hospital or face other significant transitions (as voiced within Head *et al*., 2018).

This research also sought to explore the potentially helpful and unhelpful elements of team formulation for staff. The findings indicated numerous valued aspects of this approach, particularly the benefits of the CAT 'map'; which appeared to be appreciated for its ability to increase

accessibility to relational understandings, and provide a single document to 'hold' the developed understanding both figuratively and literally. Overall, these findings suggest that the 'tools' of CAT add helpful components to team formulation.

This research also provided the opportunity to consider the impact of remote delivery (i.e. through video-call platforms). Remote delivery of CAT-TF appeared to increase accessibility and flexibility, with more staff attending than had been anecdotally observed within similar projects – this included staff members who attended despite not necessarily being 'on shift' or attending whilst being based elsewhere (though no comparison data was collected). The formal evaluation indicated that staff did not feel inhibited by using remote technology to engage in sessions, with some staff describing the use of video-call technology as having a positive impact on accessibility and 'openness' within sessions. As such, there are clear benefits from remote delivery of CAT-TF.

Clinical and research implications

Based on this research, there are a number of clinical and research implications:

1. CAT-TF is acceptable/feasible, and appears to facilitate relationally-informed, ethical and safe practice within residential services.

> CAT-TF appears to facilitate understanding, dialogue, and relational aspects of care for staff and clients who do not have specialist mental health training within residential settings. Although there is a need for further research, this research clearly demonstrates it is experienced as acceptable and useful by staff. As such, this research provides a good evaluative basis for further commissioning for such groups.

2. CAT-TF offers a user-friendly approach to facilitate reflective practice, with useful steps and stages.

> It is recommended that the formulation framework outlined by Carradice and Bennett (2012) or adaptations, such as our described process, continue to be used; as this provides necessary 'steps' to reach a visual CAT formulation.

3. Remote delivery of CAT-TF is acceptable, feasible and advantageous.

> The use of remote technologies to facilitate CAT-TF was considered acceptable by participants and appeared to facilitate regular and

fuller attendance. Remote delivery did not appear to negatively impact the experience and quality of these sessions for staff. Therefore, the use of video call platforms is recommended where appropriate.

4. Informed consent from service-users is a fundamental milestone in delivering CAT-TF and speaks to the ethos of collaboration at the heart of CAT.

To the authors' knowledge, no other easy-read team formulation and consent forms have been produced for CAT-TF (and possibly for Team Formulation more widely). Easy-read materials are vital if CAT-TF is to embody CAT principles and values, such as collaboration. Therefore, this study uniquely contributes to the betterment of CAT-TF processes when working within the context of learning disabilities and residential care through setting the precedents for this. We are preparing a manuscript in order to make these materials available for wider user (Priddy & Valera, *in prep*.). Please contact the lead author for a copy in the meantime.

The process of CAT team formulation

See Priddy, Varela & Randall (2021) for further discussion
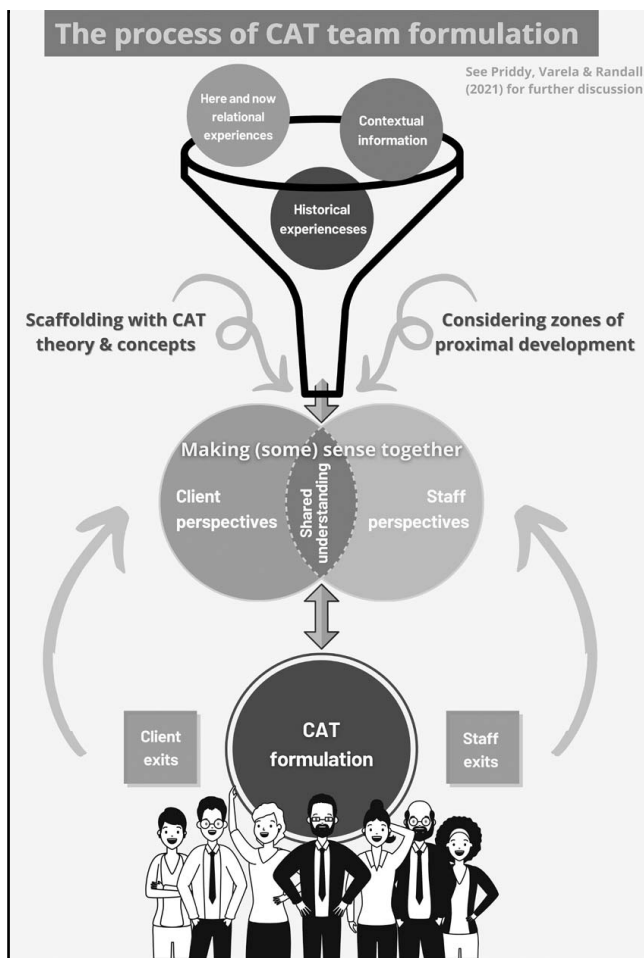
Conclusion

We believe that CAT is uniquely placed to cater to the multi-faceted constraints of individualised thinking; freeing up teams to take the relational seriously, and thus help unstick themselves from unhelpful repetition and re-enactments. CAT-TF is an acceptable, feasible, and resource efficient process for supporting psychologically informed

thinking and formulation informed decision making within contexts that support people with complex health and relational needs. Further research to explore client outcomes and experiences of CAT-TF is needed to further inform the implementation of CAT-TF within services. □

REFERENCES

Bromley, J., & Emerson, E. (1995). Beliefs and emotional reactions of care staff working with people with challenging behaviour. *Journal of Intellectual Disability Research*, *39*(4), 341–352. https://doi.org/10.1111/j.1365-2788.1995.tb00526.x

Carradice, A., & Bennett, D. (2012, July 5-7). *Beyond the psychotherapists chair: CAT consultancy, contextual reformulation and CAT's vision for psychologically informed case management'* [Conference session]. Association of Cognitive Analytic Therapy Conference, Manchester, United Kingdom. https://www.acat.me.uk/page/annual+conference+programme

Carradice, A. (2017). *Supervising CAT consultancy in mental health teams.* In D. Pickvance, (Ed.), *Cognitive Analytic Supervision* (pp. 229-241). London: Routledge. https://doi.org/10.4324/9781315716145

Creswell, J. (2019). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Sage Publication. https://doi.org/10.1002/nha3.20258

Division of Clinical Psychology. (2011). *Good Practice Guidelines on the Use of Psychological Formulation.* British Psychological Society, Leicester.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of advanced nursing*, *62*(1), 107-115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Flynn, M., & Citarella, V. (2013). Winterbourne View Hospital: a glimpse of the legacy. *The Journal of Adult Protection*, 15(4): 173-181. https://doi.org/10.1108/JAP-06-2013-0023.

Fredman, G., Papadopoulou, A., & Worwood, E. (Eds.). (2018). *Collaborative consultation in mental health: Guidelines*

for the new consultant. Routledge. https://doi.org/10.4324/ 9781315696652

Ghag, J., Kellett, S., & Ackroyd, K. (2019). Psychological consultancy in mental health services: A systematic review of service, staff, and patient outcomes. *Psychology and Psychotherapy: Theory, Research and Practice*. Article e12264. http://doi:10.1111/ papt.12264

Hastings, R. P. (1995). Understanding factors that influence staff responses to challenging behaviours: An exploratory interview study. *Mental Handicap Research, 8,* 296–320. https://doi.org/ 10.1111/j.1468-3148.1995.tb00163.x

Head, A., Ellis Caird, H., Rhodes, L., & Parkinson, K. (2018). Transforming identities through Transforming Care: How people with learning disabilities experience moving out of hospital. British Journal of Learning Disabilities, 46(1), 64-70.

Houlden, A. (2015). Building the right support: A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. NHS England.

Johnstone, L., & Dallos, R. (2014). *Formulation in psychology and psychotherapy: Making sense of people's problems* (2nd ed.). Routledge. https://doi.org/10.1192/bjp.191.5.465a

Kerr, I., Dent-Brown, K., & Parry, G. (2007). Psychotherapy and mental health teams. *International Review of Psychiatry,19*(1), 63–80. https://doi.org/10.1080/09540260601109380

Mills, S., & Rose, J. (2011). The relationship between challenging behaviour, burnout and cognitive variables in staff working with people who have intellectual disabilities. *Journal of Intellectual Disabilities Research, 55*(9), 844-857. https://doi.org/10.1111/ j.1365-2788.2011.01438.x

Patton, M. (1990). *Qualitative evaluation and research methods* (2nd ed.). Sage. https://doi.org/10.1002/nur.4770140111

Potter, S. (2010). Words with arrows – the benefits of mapping whilst talking.–*Reformulation, 34*, 37-45.–https://www.acat.me.uk/ reformulation.php?issue_id=3&article_id=46

Priester, P., Jones, J., Jackson-Bailey, C., Jana-Masri, A., Jordan, E., & Metz, A. (2008). An analysis of content and instructional strategies in multicultural counselling courses. *Journal of Multicultural Counselling and Development, 36*(1), 29–39. https://doi.org/10.1002/j.2161-1912.2008.tb00067.x

Robertson, J., Hatton, C., Felce, D., Meek, A., Carr, D., Knapp, M., Hallam, A., Emerson, E., Pinkney, L., Caesar, E., & Lowe, K. M. (2005). Staff stress and morale in community-based settings for people with intellectual disabilities and challenging behaviour: A brief report. *Journal of Applied Research in Intellectual Disabilities, 18*(3), 271–7. https://doi.org/10.1111/j.1468-3148.2005.00233.x

Russell, R. (2019). *You're Changing the Pattern': Using Cognitive Analytic Team Formulation to Help Care Staff Working with People with Intellectual Disabilities Understand and Manage Challenging Behaviour* [Doctoral dissertation, Royal Holloway, University of London]. Royal Holloway University Depository. https://pure.royalholloway.ac.uk/portal/en/publications/youre-changing-the-pattern-using-cognitive-analytic-team-formulation-to-help-care-staff-working-with-people-with-intellectual-disabilities-understand-and-manage-challenging-behaviour(e98e194d-ac14-4148-b050-00dd372f9cbc).html

Ryle, A., & Kerr, I. B. (2020). *Introducing Cognitive Analytic Therapy: Principles and Practice of a Relational Approach to Mental Health* (2nd ed.). John Wiley & Sons. https://doi:10.1002/9781119375210

Schreier, M. (2012). *Qualitative content analysis in practice.* London; Sage publications.

Varela, J., & Franks, L. (2019). Responding not reacting to challenging behaviour: A reformulation approach. In J. Lloyd, & R. Pollard, R. (Eds), *Cognitive Analytic Therapy and the Politics of Mental Health* (pp. 129-143). Routledge. https://doi.org/10.4324/9780203728857