



ASSOCIATION OF CLINICAL PSYCHOLOGISTS

Team Formulation

Key Considerations in Mental Health Services

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GUIDANCE

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'The service user should have choice throughout the process. The person needs to feel in control in order for the team formulation to be meaningful and for the process to be successful.'

Adult Mental Health Service Users ResearchNet, Bromley

Executive Summary:

- The practice of team formulation has grown within mental health services, particularly where team-based models of care are necessary to facilitate care pathways such as inpatient, intellectual disability and older adult services.
- While there is overlap, there are also differences between individual formulation, team formulation and team reflective supervision. All seek to enable the service user's understanding of their difficulties to be heard in the team, and people's needs to be central to the care provided.
- Team formulation supports team members to develop a biopsychosocial, non-judgemental understanding of service user's needs and difficulties, enabling compassionate care, and collaborative, strengths-based care planning.
- Service users should be provided with understandable information about team formulation and support to engage in the process of developing a collaborative formulation that can inform the team formulation when they wish to and are able to.
- Where service users do not wish, or are not able, to attend the team formulation meeting in person, feedback from the meeting and ongoing opportunities to engage in developing a shared understanding should be provided.
- Where service users are not able to understand the idea of team formulation and are unable to engage in the meeting, family, carers or other advocates should be sought to put forward their views and wishes.
- Care should be taken to ensure that the cultural context of the service user is included in the team formulation and that culturally informed advocacy is available to support service users.
- Documentation of the team formulation should be co-produced with service users and carers wherever possible. Language used needs to be understandable and compassionate. Where the service user has not been directly involved in developing the team formulation, any documentation should be clearly identified as coming from an indirect, consultative team formulation, and provisional.

- Co-developed and co-led research is needed to build understanding of the impact of team formulation on service users' perceptions of feeling understood, being involved in decisions about care, and on treatment outcomes.
- Further research is also needed on the impact of team formulation on multidisciplinary attitudes, understanding of service users' difficulties and needs, and engagement with service users as partners in their care and treatment.
- As with formulation itself, the ideas in this paper are part of an ongoing, collaborative conversation, and will need amendment over time as understanding and practice evolves.

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1. Introduction

Psychological formulation has been described as a 'core skill' in clinical psychology (DCP, 2011). Formulation is a way of developing a shared understanding that may help an individual to make sense of their difficulties. It explores how difficulties may relate to a range of social, psychological, cultural and biological factors. It looks at how factors may be linked together, or keep things 'stuck', and what might be helpful in moving forwards. Formulation is a collaborative process which aims to 'meet people where they are'; it is continually updated and revised as a shared understanding develops. Guidance on good practice in individual formulation has been developed and remains relevant (DCP, 2011).

The focus of this paper is 'team formulation'. The practice of team formulation has increased in services over recent years (Dexter-Smith, 2015; Johnstone, 2018). Team formulation involves supporting a service user with the Multidisciplinary Team (MDT) involved in their care to develop a collaborative understanding about their mental health and other difficulties, needs and goals. Team formulation draws upon a variety of psychologically informed models, and integrates information about social, biological, cultural and other factors impacting the person.

This paper explores ways in which team formulation overlaps with, but also differs from, team reflective practice, as well as how it aligns with individual formulation. This paper will briefly review the research on team formulation, potential benefits and challenges for clinical practice, service users' perspectives on team formulation, and some of the key issues requiring consideration. Finally, it will offer some initial good practice principles.

The paper has been developed by clinical psychologists, experts by experience and mental health nurses from across a range of services, including adult mental health (AMH), intellectual disability (ID), clinical health, older adult, secure services and children and young people's services (CYPS). Engagement was facilitated with service users in each care pathway to support the development of the principles and the paper. Engagement with people from a diverse range of ethnic and cultural backgrounds was also part of the development process. As with formulation itself, the ideas in this paper are part of an ongoing, collaborative conversation, and will need amendment over time as understanding and practice evolves.

2. What is Team Formulation and What Does the Research Tell Us?

2.1. Definitions of Formulation, Team Formulation and Team Reflective Practice

Psychological formulation has been defined as “a hypothesis about a person's difficulties, which links theory with practice and guides the intervention” (DCP, 2011, p2). Biopsychosocial formulation acknowledges a range of psychological, social, cultural and biological factors impacting on a person, and enables shared agreement about goals, intervention options and ways of managing challenges in creating change. Formulation draws on psychological theory and practice, for example cognitive behavioural therapy (CBT) (Kuyken, Padesky & Dudley 2009) and cognitive analytic therapy (CAT) (Ryle & Kerr, 2020). Different models emphasise different factors or ways of understanding (Johnstone & Dallos, 2014). CBT informed formulation, for example, can focus more on how ways of thinking and behaving may be important, CAT more on relationship patterns; bringing different ‘lenses’ to support understanding.

While practitioners may develop different formulations, the value is in how helpful it is in supporting a shared, compassionate understanding of the person's experience, where their voice is heard, and in identifying ways forward. The ‘5 P's’ model (predisposing factors, precipitating factors, presenting problems, perpetuating factors and protective factors) can be used to support a broad biopsychosocial understanding of difficulties, strengths and what might be helpful (Kuyken et al., 2009). The process of ‘reformulation’ is seen as important to ensure that formulations are adapted in line with the changing understanding and needs of the person (DCP, 2011; Johnstone & Dallos, 2014).

Team formulation is a forum where time is dedicated to supporting the team to use psychologically informed frameworks that take into account social, cultural and biological factors to develop a compassionate understanding of a person's difficulties and needs from multiple perspectives, central to which is the person's history and their way of making sense of experience. This can enable the development of a multidisciplinary intervention plan and may identify ideas which could be helpful to explore further with the service user or family. The summary of ideas can support continuity of care, for example between practitioners, or across services, and the ideas emerging from team formulation are open to revision as understanding evolves over time.

Team formulation may be viewed as having some overlap with, and some distinctions from, team reflective practice. Reflective practice sessions are usually led by a

psychologist, and provide space for teams to consider challenging organisational, systemic or clinical issues. The aim is to promote a shared, compassionate understanding of practitioners' experiences of working with service users, and organisational challenges. This supports practitioners to manage the emotional impact of the work promoting retention and wellbeing, alongside enhancing care quality.

Reflective practice has been seen as valuable in a range of healthcare contexts (Kurtz, 2020), including inpatient mental health (Raphael et al., 2020). Dallimore, Christie and Loades (2016) discuss qualitative feedback from 11 practitioners about a 'Clinical Discussion Group' on an acute inpatient mental health ward. Participants identified the group's value to staff, support in clinical understanding, emotional benefit, and impact on learning and working together as a team. They identify some helpful principles including regularity of the group, clear aims and purpose, and space for emotional expression and validation. This illustrates the overlap between team formulation and more reflective spaces for teams. Some of the differences in the aims of individual formulation, team formulation and team reflective practice are outlined in **Figure 1**.

2.2. Potential Benefits for Service Users, Clinical Practice and Outcomes

Team formulation can take a range of formats and draws on various psychological models or approaches (Short et al., 2019). Geach, Moghaddam and De Boos (2018) in their systematic review of 11 articles, noted varying descriptions of formulation (sharing ideas informally, reflective practice meetings and formulation-focused consultation), with development of a shared understanding as a common factor. This variety makes it difficult to make comparisons. A further systematic review of 10 peer reviewed studies found that team formulation had no distinct definition, with seven studies applying specific psychological theories to team formulation (Short et al., 2019). One review of the literature indicated CBT and CAT are the models most frequently informing the practice (Ghag, Kellett & Ackroyd 2021). The type of clinical setting where research is taking place may also influence the framework used to inform formulation. For example, while acknowledging social and environmental impacts, behavioural principles are used to support development of positive behaviour support plans with teams, most often in intellectual disability services (PBS Coalition UK, 2015).

There are also differences in how formulation is understood and defined within psychiatry and psychology (Hughes, 2016). Psychiatry tends to focus more on how biological aspects may interact with social factors, leading to the development

Figure 1.

Aims of Individual Formulation, Team Formulation and Team Reflective Practice

Individual Formulation

- Listen to and understand the person's own way of making sense of their experience
- Collaboratively develop an understanding to make sense of the person's difficulties and needs
- Enhance self-compassion
- A process in which the person can feel heard and understood, enhancing the therapeutic relationship
- Offering psychoeducation and informing individual therapeutic work. Shared with others, with consent

Team Formulation

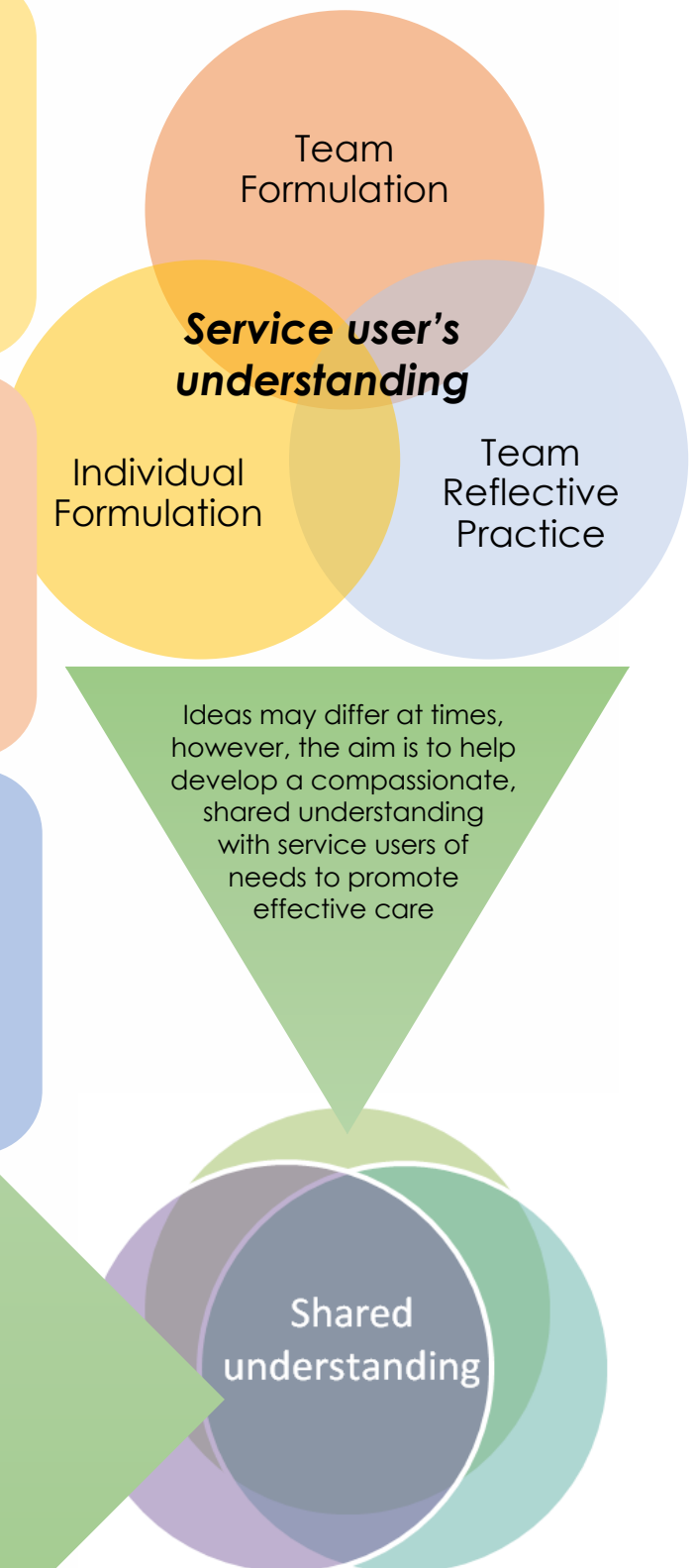
- To develop a compassionate understanding from multiple perspectives, central to which is *the person's history and their way of making sense of experience*
- Support a compassionate understanding of unhelpful repeated patterns and inform potential intervention plans
- Develop ideas to explore further in individual sessions
- Create a summary of ideas to support continuity of care

Team Reflective Practice

- Provide a space for practitioners to reflect on challenges within the care environment and in providing care for service users
- Provide support for practitioners to reflect on and process the emotional impact of their work, alongside developing understanding with reference to *the service user's history and way of making sense* as appropriate, so that they can sustain compassion for themselves and others, holding in mind the needs of the people they

The Practicalities

Individual formulations are co-developed in individual sessions with a psychologist or other team members. Summary diagrams or letters are created and shared with consent. Team formulation happens in meetings usually facilitated by a psychologist, involving the service user directly or indirectly. A summary is produced and shared with the service user and team, noting it is an indirect formulation if there has been no direct service user involvement. Team reflective practice sessions are usually facilitated by a psychologist, with a summary of any action points relating to any service user noted on their care record.



of psychological difficulties which form the criteria for psychiatric diagnosis (Psychdb, 2022). In one qualitative study with 11 psychiatrists, formulation was conceptualised as an addition to diagnosis, triggered by risk, complexity and a need for an enhanced understanding (Mohtashemi, Stevens, Jackson & Weatherhead 2016). Psychiatrists valued collaboration with psychologists in formulation. The DCP (2011) guidelines however define psychological formulation as an alternative, rather than an addition to, functional psychiatric diagnosis. The diversity of ways formulation is conceptualised and used adds to difficulties in evaluating what is helpful for service users and in promoting effective care.

Several potential benefits of team formulation have been noted which are in keeping with those found in individual formulation, such as clarifying understanding about the factors which may be linked to the development and maintenance of a person's difficulties, which in turn can help inform the development of a person-centred intervention plan. The practice has been linked to a range of outcomes including developing a shared understanding of a service user's strengths and difficulties in teams; drawing on knowledge and skills from different clinical backgrounds; generating new ideas to support work with a person; developing an intervention plan; and improving safety management (DCP, 2011; Hollingworth & Johnstone, 2014).

One study, where three sessions of CAT consultancy were provided to individual team members, showed no differences in service user outcomes in comparison to a 'treatment as usual' group; however, there was evidence of a positive change in clinical and team practices over the course of the study (Kellett, Wilbram, Davis & Hardy 2014). Evaluation of the experiences of 12 staff of team formulation using a CAT model within a residential intellectual disability service indicated sessions helped improve understanding of the service user and to develop relationships between staff and service users (Priddy, Varela & Randall, 2021). The authors suggest team formulation can increase access to psychologically informed understanding and reflective capacity in teams where there may be very limited psychology resources.

An evaluation of the effectiveness of 12 team formulation meetings within a community adult mental health team found that staff members' perceptions of 'stuckness' with service users significantly reduced as a result of team formulation (Allen, 2015; unpublished study, cited in Cole, Wood & Spendelow, 2015). In Hartley et al.'s (2016) service evaluation, practitioners identified the purpose of team formulation as understanding and supporting team working and treatment planning. In addition, important areas of focus were coping with challenges or complexity, contributing to making progress and reminding practitioners of the person's journey.

Whitton, Small, Lyon, Barker & Akiboh (2016) had feedback from 89 practitioners from a range of disciplines (including nurses, psychiatrists, occupational therapists and support workers), before and after team formulation meetings in a secure intellectual disability service. They identified that team formulation meetings were linked to increased psychological understanding about the service user and their problems, increased empathy towards the service user and increased consistency in the team members' views.

Kramarz, Ling, Mok, Westhead & Riches (2022) analysed feedback from 18 multidisciplinary practitioners from five acute AMH wards. Feedback indicated team formulation supported practitioners to develop a holistic understanding of service users, provided a safe space for discussion about the impact of challenging behaviour, and improved teamwork and communication. Participants also felt this increased ability to identify and support the needs of service users, and improved therapeutic relationships.

A randomised control trial including 85 practitioners in 10 mental health rehabilitation units found team formulation was associated with practitioners feeling less emotionally distanced from service users, and improvements in ward atmosphere (Berry et al., 2016). A thematic analysis of interviews with 57 staff and 20 service users indicated team formulation was associated with improved staff understanding of service users, better team collaboration and increased staff awareness of their own feelings (Berry et al., 2017). Turner, Cleaves and Green (2018) surveyed 28 practitioners working within an assessment and treatment unit for people with intellectual disabilities. Most practitioners felt team formulation meetings helped them gain an understanding of the service user and impacted positively on their work.

A theme of increased empathy for the service user and ability to place them 'at the centre' was evident in one systematic review of 16 studies (Bealey, Bowden & Fisher, 2021). This is in keeping with themes found in a further systematic review of 10 studies regarding the impact of team formulation on the team; "increased knowledge and understanding", "altered perceptions, leading to altered relationships, feelings and behaviours", "space to reflect", "useful when stuck or challenged", "perceived increase in effectiveness" and "improved team working" (Short et al., 2019).

Some systematic reviews of team formulation have indicated that much of the research available is small scale, mostly qualitative, some unpublished (e.g., research theses), and variable in quality, making it difficult to understand relationships between team formulation and experiences or outcomes for service users, the impact on staff, or best-practice implications (Geach et al., 2018; Short et al., 2019; Bealey et al.,

2021). It is also difficult to distinguish the impact of team formulation from other factors influencing care provision, service users' experience of care and outcomes.

Some studies have included team formulation as a core component within a range of interventions. One study for example evaluated a whole team's psychologically informed approach, including individual and team formulation in an AMH inpatient service. The authors found that service users reported significantly reduced levels of distress and significantly increased confidence in self-managing their mental health difficulties (Araci & Clarke, 2017). A further study introduced trauma-informed practice into inpatient wards, with team formulation meetings based on the Power Threat Meaning Framework (Johnstone & Boyle, 2018), along with education, training and supervision in trauma-informed practice. Although the team formulation meetings were not evaluated separately, the approach overall was found to reduce levels of seclusion and restraint (Nikopaschos & Burrell, 2020).

There has been a lack of research focused on service users' perspectives on team formulation, and on its impact on treatment outcomes. One research project in mental health rehabilitation settings linked team formulation to improvements in relationships between service users and staff, patients also reported improvements in ward organisation (Berry et al., 2016). There was also some indication that post-study, service-users' mental health had improved slightly (Positive and Negative Syndrome Scale; Kay, Fiszbein, & Opler, 1987) and functioning was slightly improved (Global Assessment of Functioning; Hall, 1995), however these findings were not statistically significant. Matrunola, Clark, Gumley & Clark (2022) analysed 16 '5 P's' team formulations using the DCP (2011) checklist in an Early Interventions in Psychosis service. They note that service users were not actively involved in the team formulation meeting, although were brought into discussions following the meeting. While formulations suggested explanations for the development of service users' main difficulties, the extent to which the personal meanings of service users and cultural factors were integrated into the formulation was less clear.

Evaluation of team formulation needs to include service user and carer perspectives on how cultural and spiritual needs are sought, respected, and understood. The Patient and Carer Race Equality Framework (2021) has been proposed as a structure to enable organisations to engage with minoritised ethnic communities, to benchmark core competencies and support ongoing collaborative work to improve services (Dyer, 2019). Co-developed and co-led research with experts by experience is essential and would enable greater understanding to support trauma-informed, effective practice in this area.

3. Team Formulation Within an Organisational Context

The approach to team formulation will vary depending upon the individual service user, team and service context. Where care is delivered by a team, for example in inpatient services, there is a need for team members to find ways to work effectively together. Teams have a range of forums where they discuss their understanding of an individual's difficulties and options for enabling change. Team members might discuss a service user's care, for example in referral meetings, care review meetings, or supervision sessions.

Team formulation supports the team to use a biopsychosocial framework to help make sense of what may be happening for an individual and why, enabling communication between team members, and the development of a shared and consistent multidisciplinary intervention plan which promotes effective care and supports continuity of care across services. Team formulation is an approach adopted in adult mental health, older adult, children and young people's services, intellectual disability and clinical health services (Johnstone & Dallos, 2014; Johnstone, 2015). The aim is to improve the quality of care for people, and to promote a more holistic understanding of their needs (Johnstone, 2018).

Team formulation occurs within an organisational context where there is a power imbalance between practitioners and service users, therefore issues of choice, consent and collaboration are complex. Many people, although not all, accessing mental health services have experienced trauma, with the NHS Mental Health Implementation Plan (NHS, 2019) committing to more personalised, trauma-informed mental health service provision. People's experience of distress and of mental health services is influenced by many factors that are interlinked, including discrimination, social class and characteristics protected under the Equality Act 2010 (Race Equality Foundation, 2020; Ebrahim & Wilkinson, 2021). For example, a greater proportion of people from some minoritised ethnic groups experience mental health problems, use mental health services, and are detained under the Mental Health Act than those from 'white' backgrounds (McManus et al., 2016; NHS Digital, 2021).

Health services need to be aware of the potential for re-traumatisation of people accessing support by policies and practices, and to recognise that people providing services may also have experienced trauma, or experience it within their work (SAMSHA, 2014; Sweeney et al., 2016). It is important that processes in mental health services promote physical, psychological and social safety, and that they increase empowerment, shared decision making and treatment choice (Sweeney et al., 2016; NHS, 2019; Kennedy, 2020; NICE, 2021).

Where a person is in a significant state of distress or confusion, or does not want to be involved in a discussion about their care, it is important that the team have ways to make sense of their difficulties and needs, and use this to plan effective interventions (Hartley, 2021). Team formulation provides a supported framework to help meet this need. However, the team's understanding of the service user's experience and needs may not always align with the service user's own ideas; all perspectives need to be heard and valued within the formulation, supporting the development over time of a collaborative shared understanding.

It has been suggested that organisational processes need to promote reflection within the organisational culture, connection and relationships, and be strengths-based (Treisman, 2021). Team reflective practice provides a space for practitioners to reflect on challenges within the organisational environment and in providing care for service users, increasing awareness of individual ways of making sense and responses to the work. This enabling of learning and understanding supports practitioners to sustain compassion for themselves, service users and colleagues, and promotes healthy team functioning. Reflective practice may provide ideas for further exploration with service users directly and collaboratively. While the team may need their thoughts and responses to be understood and contextualised, it will not always be helpful for service users to be aware of these responses (Cole et al., 2015): reflective practice provides space for this.

Team formulation requires teams to engage in several actions for it to take place and has been described using an input-process-output model (Short, 2019). In the model the 'inputs' are the factors which may impact on the team's ability to formulate and to develop a formulation together. Input elements include organisational factors in place around the team, such as team characteristics, team knowledge and team knowledge sharing. When these factors are combined with case formulation theory, it is proposed that they enable understanding of the range of factors necessary as a basis for effective team working, which can enhance the quality of team formulation activity. Team conditions provide the inputs into the process of formulating, which then result in 'outputs', for example an MDT plan, and potential changes in team attitudes and functioning (see **Appendix 1**).

4. Emerging Themes with Team Formulation; Consultation with Service Users

Service users, psychologists and other mental health professionals have raised questions about the practice of team formulation following its more widespread use in services. Clare (2022) for example noted concerns about a lack of involvement of

service users in the process of team formulation. Questions have arisen particularly about the best way to inform service users about the practice, to involve service users in a meaningful and person-centred way in the process, and to document and share any outputs from team formulation. Themes around an imbalance of power in mental health systems, and lack of service user involvement in decisions are broader than team formulation but are evident in the concerns raised. These themes echo, for example, those identified in research on people's experience of inpatient mental health care (Tarran-Jones, Summers, Dexter-Smith & Craven-Staines 2019; Wood, Williams, Billings & Johnson 2019).

This section explores some of the themes highlighted in a series of involvement sessions with service users accessing six different care pathways in England and Wales (see **Figure 2**). Comments provided note which care pathway involvement session service users and carers were part of. Care pathways included adult mental health (two separate involvement events, one with 16 service user and carer participants, the other with six service users), intellectual disability (six service users), clinical health (two service users), older adult (three service users, three carers), secure services (one service user), and children and young people's services (four service users and two carers).

Most involvement sessions were facilitated by a member of the team formulation steering group, one was co-facilitated with an expert by experience. One involvement session was facilitated by the Foundation for People with Learning Disabilities. The themes focus on the potential benefits of team formulation; meaningful involvement; indirect involvement and choice; and finally, confidentiality and documentation. The themes were used to review and inform the proposed good practice principles.

4.1. Theme 1. Potential Challenges and Benefits of Team Formulation

Concerns were expressed about the potential benefits of the process being negated if the team involved are unprepared, the quality of facilitation of the meeting is poor and the service user is not involved. Service users and carers

identified potential benefits of team formulation when these factors are well managed in enabling teams to understand their needs and to coordinate care:

'It helps them to work together. I think it is great that they are talking and making sure they are doing the right thing for (the person).'

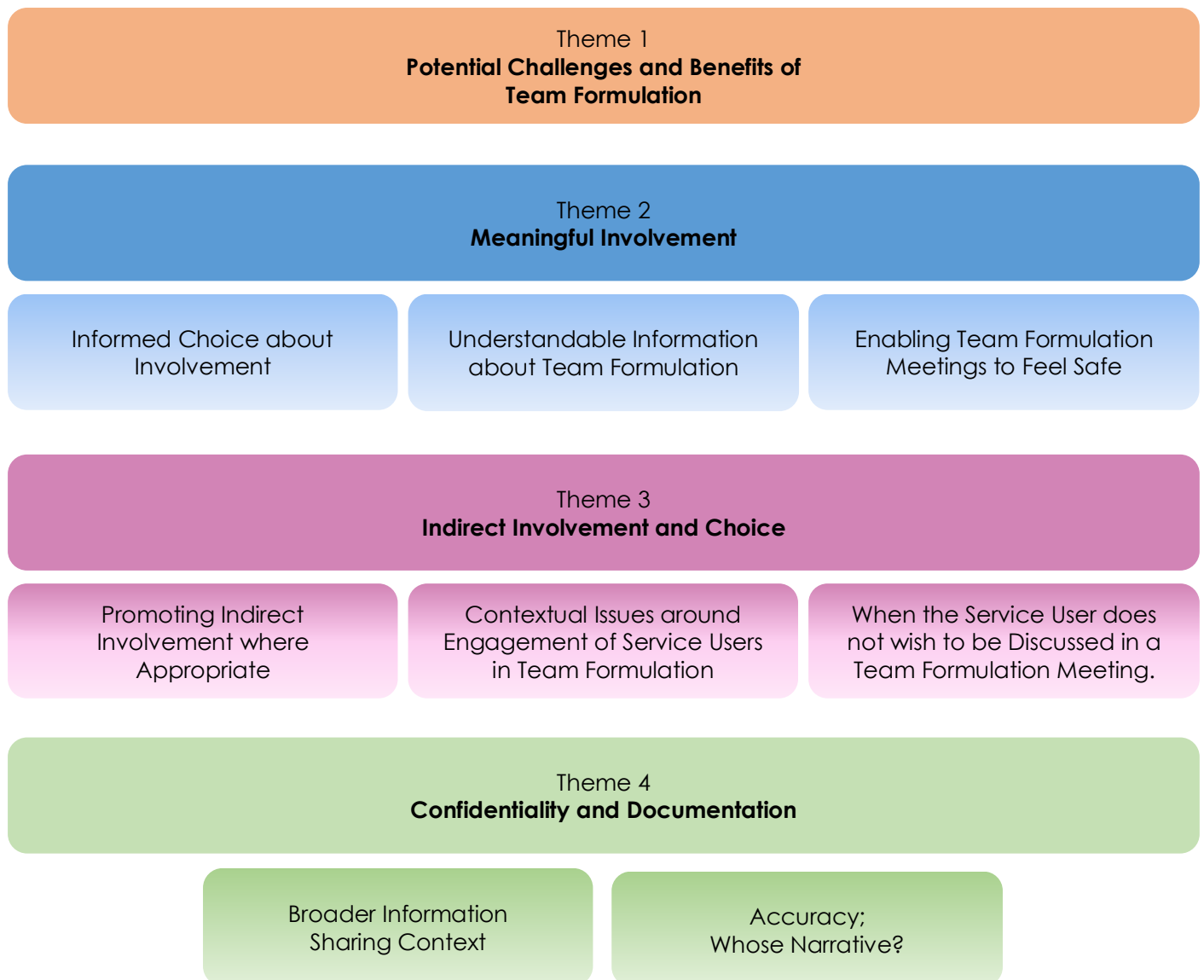
Service Users, Foundation for People with Learning Disabilities

'We recognise the value of teams meeting to reflect on a young person's needs and what might help, given their difficulties, strengths and histories.'

Children & Young People's Inpatient Services, Pennine Care NHS Foundation Trust

Figure 2.

Themes Identified about Team Formulation



4.2. Theme 2. Meaningful Involvement

4.2.1. Informed Choice about Involvement

Service users highlighted the right of individuals to make an informed choice about whether they engage in developing a formulation with the team, acknowledging this may be stressful for some people, and the need for involvement of families and carers

when service users would find this helpful or where due to mental capacity issues they may be unable to take part.

'A full explanation of the context of the meeting is important rather than 'there is a meeting taking place do or don't you wish to attend' so it fully prepares the service user for some of the feelings/issues that may arise'

Adult Mental Health Service Users & Carers CNTW & TEWV Involvement

'Family and carers should be informed about the meeting'

Adult Mental Health Service Users & Carers CNTW & TEWV Involvement

'It might be stressful and should be an individual's choice to attend'

Children & Young People's Inpatient Services, Pennine Care NHS Foundation Trust

Services should seek to meaningfully involve the service user; either in person in a team formulation meeting if they wish to attend, or through enabling the service user's perspectives, views, concerns and wishes to be integrated within the formulation (Hartley, 2021). This is in keeping with the idea of 'nothing about me without me' (DoH, 2012). Service users in one secure inpatient setting, for example, were invited to share their individual formulations in person in a team formulation meeting. This was reported as a positive experience for both service users and staff, enabling service users to take ownership of their narrative and reduced the risk of staff taking on an 'expert' stance (Lewis-Morton, James, Brown & Hider 2015).

'The meeting for everyone to come together is very important but not without (the service user) ... support the person to speak about what is important to him and for him. Then the staff can add what they feel is important for him and say what they individually will do'

Service User, Foundation for People with Learning Disabilities

Clare (2022) notes in one inpatient rehabilitation team, service users choose whether to lead on telling their story, co-deliver, or to attend and listen. She suggests that hearing the experience in the individual's words helps the team to make sense of the person's behaviour as 'survival responses' in a more impactful way. The service user rather than the team chooses what to focus on, with questions from the team about what might be helpful for them. In another mental health trust, appropriately trained and supported peer workers co-facilitate team formulation meetings, while a further service invites a peer worker to attend team formulation meetings, to support representation of the service user's perspective (Johnstone, 2022).

4.2.2. Understandable Information about Team Formulation

Service users indicated they and/or their carers should be provided with understandable, accessible information about team formulation, and given support to understand how it might be helpful in their care.

'It needs to be clear about how this (team formulation meeting) differs from other meetings where professionals discuss service users and plan their care.'

Older Adult Carer, Wales

'Why use a word nobody understands (formulation). It's a bad word, find a better word. Maybe person-centred plan'

Service User, Foundation for People with Learning Disabilities

This illustrates how collaboratively identifying an understandable term for formulation, is key.

4.2.3. Enabling Team Formulation Meetings to Feel Safe

Service users identified that it is important the environment is as informal as possible and is organised in a way that helps all involved to feel relaxed, for example with comfortable chairs, rather than around a table. Some inpatient services use the space where team formulation takes place for leisure activities to help people feel comfortable and familiar in the environment.

'Give support before the meeting to help the person understand the purpose of the meeting and emphasise the person's ownership of the team formulation. This could help build trust with the clinician and team.'

Adult Mental Health Service Users ResearchNet, Bromley

'They need to be person centred and invited but need to make it inclusive and make reasonable adjustments to make sure it was a positive experience for all. It can be quite intimidating if I do not know what the meeting is about. Particularly if I am having difficulties with my mental health. Need to make sure the person is prepared in advance and help him to manage his meeting.'

Service User, Foundation for People with Learning Disabilities

The process of developing an individual formulation may be linked to a sense of vulnerability as it touches on sensitive personal topics. Some service users have reported negative experiences of developing an individual formulation (Redhead,

Johnstone, & Nightingale, 2015). It is important in any formulation process that the person feels safe, contained and understood. Similarly, being in the room with team members as part of the process of a team formulation may feel uncomfortable for some service users. In a study in older adult inpatient services, where service users were present as the team developed the formulation, people reported a range of experiences (Tarran-Jones et al, 2019). Some found the process helpful, describing it as an opportunity to make sense of experience and to rebuild a sense of self-agency around moving forwards. Others found it exposing and intimidating, or noted it was difficult to engage with the process and the recommendations that followed. The authors reflect on how different the process of 'making sense of experience' may be in a team rather than individual therapeutic context.

'Safety and sensitivity are essential. The process of team formulation could be retraumatising – "someone's life story being laid bare" – and they are likely to feel very exposed.'

Adult Mental Health Service Users ResearchNet, Bromley

'Making sure service users have had time to develop meaningful and trusting relationships with the staff members involved in the team formulation will hopefully increase how comfortable they feel to be a part of it.'

Expert by Experience, Secure Care Services, CNTW

It is important that team formulation meetings are facilitated in a way which helps manage complex discussions and service users' feelings sensitively (Tarran-Jones et al, 2019). Sufficient time needs to be allocated for the meeting so that service users, carers and advocates have space to be heard and ideas raised about care planning can be discussed fully. Choice for service users around how the plans developed in meetings are carried forward is also important. Service users should be given the opportunity to feedback on both the process of team formulation (e.g., whether the person felt they had adequate information to make the decision to attend or not, had ways of contributing to the meeting if they did not attend, and how sensitively handled the meeting was if they attended) and the content (e.g., the documentation).

4.3. Theme 3. Indirect Involvement and Choice

4.3.1. Ways to Promote Indirect Involvement in the Process of Team Formulation Where Appropriate

Hartley (2021) suggests the way the individual is involved will depend on the context,

form and function of the formulation process and the person's willingness or ability to be directly involved at the time, while always seeking to offer information, choices and collaboration.

'There should be choice (about attending team formulation meetings) where service-users have capacity to make this decision. There may be 'degrees' of involvement that can be negotiated depending on the service-user's individual needs and abilities. Be creative in how service-users can contribute!'

Older Adult Carer, Wales

A number of ways of involving service users in the process of team formulation have been suggested when direct involvement may not be possible. For example, the service user providing information in advance of the meeting and receiving information from it or expressing preferences regarding the content of a formulation. Ingham (2015) illustrates this, describing information from the service user being fed into the team formulation meeting in an ID team, and the outcome of the meeting fed back to them afterwards. Individual formulations, conversations with, and letters to the service user can also be used to involve them in the process if they are not present at the meeting (Johnstone et al, 2015). A CYPs inpatient team reported on the process of feeding back to service users through an optional 'shared understanding' letter to which both they and practitioners contribute (Milson & Phillips, 2015).

4.3.2. Contextual Issues Around Engagement of Service Users in Team Formulation

Some people accessing care and treatment (for example with a severe intellectual disability, dementia, head injury or experiencing extreme distress, severe depression or psychosis), may lack the capacity to understand, agree to, or be involved in a team formulation. In such circumstances it may be in their best interests for a team formulation meeting to take place to enable a holistic, biopsychosocial understanding of their needs, and to inform care planning. The service user's physical presence in a meeting may not be possible or appropriate, for example if they would find it stressful or difficult to understand. However, it may still be possible to find ways to enable the person's voice within the formulation (Rowe & Nevin, 2013). The Mental Health Act 1983: Code of Practice (2015) and the Mental Capacity Act: Code of Practice (2013) outline principles to support decision making in teams around best interests decisions which may be helpful in this context.

'When people are unwell, they sometimes struggle to challenge things they are unhappy with, or to make choices. Advocacy is important'

Adult Mental Health Service Users & Carers CNTW & TEWV Involvement

Involvement of advocates or supporters (family, carers or independent advocates) can help with the process in such circumstances.

'As the family member of a person with dementia, I want to be involved in the discussions about the professionals, as I have relevant information and can contribute to your understanding of the situation. They might not understand what team formulation is, nor might they be able to contribute to the meeting.'

Older Adult Carer, Wales

Working with family members, carers and others important in a person's support network is key with all service user groups. However, with some service user groups (older people or people with intellectual disabilities for example), teams may undertake a greater amount of work with the person's wider system of care, support or care home staff. Family members may be hesitant to share certain concerns or information, or have particular perspectives and patterns of behaviour which can impact on their understanding and responses to situations. The challenge of team formulation in this context is to acknowledge different perspectives, and to enable consensus around a way forwards for the person.

'Some carers may not know or represent the service-user's needs and wishes. Is there a way of ascertaining service-user views on this kind of process ahead of time if they have dementia (e.g., at diagnosis) – some carers have Lasting Power of Attorney for health and wellbeing.'

Older Adult Carer, Wales

4.3.3. When the Service User Does Not Wish to be Discussed in a Team Formulation Meeting

Some service users felt that a team formulation should not go ahead if the person would prefer it not to. There were a variety of views from service users, carers and practitioners on this issue. Service users noted the power inherent within mental health services, and difficulty trusting service providers and teams, at times linked to past experiences of not feeling understood or supported by services.

'I don't think a team formulation meeting should go ahead if the service user doesn't want this to happen'

Adult Mental Health Service Users & Carers CNTW & TEWV Involvement

How teams navigate issues of consent, collaboration and choice will depend on the setting, the functions of the service and the wishes of the individual service user. In

some settings (e.g., inpatient services) a team-based way of working is essential, with practitioner-based team discussions taking place daily to facilitate effective, timely care. As noted earlier, team reflective practice and individual supervision is also required for practitioners to think about their experience of caring for service users and the organisational context in which they work, supporting processing of difficult interactions and events in ways which enable them to maintain compassionate, caring responses.

The process of team formulation has some overlap in enabling a compassionate understanding to support care, however, may differ in using psychologically informed frameworks explicitly to enable understanding of an individual service user's experiences and needs, and how this relates to care planning. Psychological frameworks used in formulation are intended to enable compassionate, non-judgemental ways of understanding difficulties in developing relationships or understanding behaviour patterns. The aim is to help teams to provide care in ways that enable service users to feel understood and able to trust the team, and to help prevent iatrogenic harm. However, the way team formulation is carried out will impact on how understood service users feel, and some service users have experienced the process as unhelpful or harmful.

It is important that each service states whether a team formulation will go ahead if a service user would prefer it not to happen, and provides a clear rationale about their practice. Where team formulations go ahead in these circumstances, the reasons for this need to be explained to the service user, and continued support provided to listen to their concerns, and to resolve them as far as possible. This may include for example, agreement about confidentiality of sensitive information, limits to how widely the emerging ideas are shared, the person's wishes being noted in their care record, understanding of the concerns in the context of the person's life experience and documentation identified as an indirect, consultative provisional team formulation.

4.4. Theme 4. Confidentiality and Documentation

4.4.1. The Broader Information-Sharing Context in Which Team Formulation Is Situated

While this is a broader issue than team formulation, service users may not have been made aware that sensitive personal information shared with one professional could be placed in a shared care record, accessible to the wider team involved in their care. Service users have noted in the context of team formulation that this can leave

people lacking control over who can access sensitive personal information. This is particularly an issue with electronic healthcare record systems where most staff within for example an inpatient mental health team could legitimately access a service user's care record as part of providing care and interventions. This could become more distressing for service users as information is shared across NHS trusts and with other organisations (NHS, 2021). Service users should have clear information about how information they share will be stored and used.

'While it's important to acknowledge trauma, some service users might have experienced a lot of trauma and seeing that written on paper could be traumatic in itself. There should be an emphasis on the service user having control over the information that is shared and the wording.'

Expert by Experience, Secure Care Services, CNTW

4.4.2. The Accuracy of a Team Formulation – Whose Narrative?

It has been noted that the usefulness and acceptability of formulation is founded on the personal meaning that it has for the individual, in the context of their experiences.

'Having a summary of your own formulation that is easy to access at all times would be very beneficial. Sometimes it's very easy to lose sight of your own personal goals when you're feeling poorly or if it's been a long time since you accessed help.'

Adult Mental Health Service Users & Carers CNTW & TEWV Involvement

'It's important to be informed before team formulations happen, for any ideas that we didn't co-develop to be clearly labelled as the team's ideas and for us to know how information is shared more generally within the team. We want to have an opportunity to develop an individual shared understanding when we are ready to.'

Children & Young People's Inpatient Services, Pennine Care NHS Foundation Trust

There are concerns about the accuracy and validity of an understanding developed if a service user is not directly involved in the team formulation meeting or the process through providing information to the meeting and reviewing information from it, and the potential for harm if practitioners' perspectives about a service user's difficulties are imposed, contrary to the service user's own views. The content of the formulation summary needs to be agreed with the service user wherever possible. The language used in formulations needs to reflect the person's understanding and language; professional language may feel disconnected from their experience or imposing a particular way of making sense. Where it is not possible to agree the content with the

person, it is important any documentation is clearly identified as such (for example as team consultation or an indirect, provisional team formulation).

'Having written documents in accessible language, easy read formats, is important, no jargon – a document for the service-user and the family as much as for professionals.'

Older Adult Carer, Wales

'Co-developing formulations needs to take account of people's ability to understand ideas and information. My son is autistic and it would need to be accessible.'

Adult Mental Health Service Users & Carers CNTW & TEWV Involvement

The need for mental health services to understand the cultural and spiritual context of people's mental health issues, particularly in crisis, and for support to be adapted is clear (Mental Health Foundation, 2021). Disconnection from the person's cultural context can be re-traumatising; the language used, and information provided by people from minoritised ethnic groups can be misunderstood if the team is not aware of the cultural context. Team formulation therefore needs to be culturally and spiritually informed so that the service user's perspective is understood and an appropriate approach to care is taken. This requires collaboration in the formulation so that the voice of the person is heard. Where people are not able to engage with this directly, advocates and cultural advisors can help. The need for culturally appropriate advocacy is noted within the Reforming the Mental Health Act White Paper.

'Professionals should check back with the service user about whether their understanding/formulation is correct; inaccurate information (about me) could have informed later understandings and potentially, professional decisions.'

Adult Mental Health Service Users & Carers CNTW & TEWV Involvement

Formulation is always provisional and understanding changes over time. It is important organisational processes and care pathways enable ongoing collaborative re-understanding over time, alongside appropriate updating of documentation.

'Things can change over time, especially in context of dementia or where there are physical health difficulties too. Sometimes people only feel 'ready' to share information after some time has passed – need to build relationships and make sense of own experiences. Work with psychology can be helpful in moving things forward.'

Older Adult Carer, Wales

5. Challenges of Team Formulation Practice From a Practitioner Perspective

Several challenges have been identified in the implementation of team formulation, including competing demands on staff time, having sufficient staff and allocated time for discussion, team distress, managing different roles and the sharing of information (Hartley et al., 2016; Berry et al., 2017; Geach, Moghaddam, & De Boos, 2019; Bealey et al., 2021). Staff and service users may feel anxiety about attending meetings, sharing feelings openly, and fear criticism (Johnstone et al., 2015; Berry et al., 2017). Sensitivity and care are needed to introduce team formulation in this context (Johnstone et al., 2015; Dexter-Smith, 2015). Support from all professionals in the team is important for the process to be effective (Casares & Johnstone, 2015; Dexter-Smith, 2015). It is also important to ensure that team formulations are valued from a managerial level to ensure staff have a dedicated time to participate (Berry et al., 2017; Bealey et al., 2021). Hymers, Dagnan & Ingram (2021) analysed feedback from eight clinicians in an ID service, and found team formulation was hindered by poor communication and inconsistent staff attendance, but enhanced by collaborative working.

Facilitation of team formulation meetings can be challenging, especially where the team has a range of differing views (Johnstone & Dallos, 2014). The role of the facilitator in team formulation is to use psychologically informed theory to enable the development of an understanding of the service user's difficulties and identify potential ways forwards, to manage group processes around differences of opinion, to promote reflection, clarify and summarise. In team reflective practice, again the facilitator is drawing on psychological understanding to support reflection in the team about the challenges they may be experiencing in working with individual service users, in the team itself and the broader context of the service. Both of these types of team-based support require a high level of psychological knowledge and skill which may influence the quality of the process and outcomes.

6. Evaluating the Quality of Team Formulation

As noted, the quality of psychologically-informed formulation may be influenced by the skills, experience and supervision of the practitioner, and is likely to impact on outcomes. A review of case formulation measures indicated that no tool has been evaluated across a range of clinical settings, and further research is needed to increase the reliability and validity of measures (Bucci, French & Berry, 2016). There are similar issues in relation to evaluation measures for team formulation. The Good

Practice Checklist (DCP, 2011) applies to both individual and team formulation and includes the items: 'Is respectful of the service user/team's view of what is accurate/helpful'; and 'Constructs the formulation collaboratively with service user/team'.

The Team Formulation Quality Rating Scale (Bucci, Hartley, Knott, Berry & Raphael, 2021) was developed to support the delivery of team formulation in clinical practice, with good content and face validity, good internal consistency and inter-rater reliability consistent with individual case formulation quality measures. However, neither this scale nor the Formulation Session Reflection Tool (Marshall & Craven-Staines, 2015), address the issue of direct engagement with service users in the process. The Team Formulation Quality Measure from an inpatient team (Central and North West London NHS Foundation Trust) is based on the assumption that service users will not be present in the room, and includes an item on sharing feedback with service users.

The Consultation Outcomes Scale and Consultation Partnership Scale explore professionals' perceptions of the outcomes of formulation meetings, and the impact on their sense of partnership with service users, but again not the service user's perceptions (Fredman, Papadopoulou & Worwood, 2018). The '5 P's + Plan Quality Guide' (CNTW, 2021), checks for service user involvement in developing the formulation and choosing between intervention options, however there is no data on reliability and validity. The practitioner leading the team formulation needs to have standards in mind to guide the process as well as the outcomes and documentation. This is an area where measures that put service users' and carers' experience of the process and outcomes of team formulation are of central importance but lacking. Further evaluation on the perceived usefulness of the formulation developed with service users and teams is essential.

'There should be demonstrable outcomes and it should be made clear how this will be monitored and checked. Both how useful it is for the staff and how useful it is for service-users/carers should be evaluated. ("Could be as simple as asking")'

Older Adult Carer, Wales

There also needs to be further evaluation of the skills necessary to facilitate team formulation sensitively and effectively, given the combination of formulation, group facilitation and consultation skills required. Training and supervision needs could be clarified to support effective practice. Crucially, evaluation that centres the views and needs of those who use service (e.g., as experts by experience inspectors or auditors) would be welcomed, alongside qualitative evaluations that explore service users' experience of working with teams who utilise team formulation processes.

7. Good Practice Principles

The following principles are proposed to guide teams around the process and documentation of team formulation. Asking a number of questions as a team can be helpful, (see **Appendix 2** for ideas).

'The principles are respectful, person-centred and focussed on the whole person. They convey a welcome sense of colleagues working together and sharing information and knowledge. Flexibility, according to the patient's needs, will be important in applying these principles'

Clinical Health Service Users, Liverpool University Hospitals, NHS Foundation Trust

7.1. The Process of Team Formulation

- Provide service users with information explaining what team formulation is, how it can be helpful, and how they can engage with the process. This should note the organisational policy around confidentiality of care records and information sharing.
- Wherever possible, formulations co-produced with service users individually should inform a team formulation and ensure the meeting is focused on what is important to the person.
- It should be the service user's choice whether they attend a team formulation meeting. It is important queries and worries are discussed prior to the meeting, for example information the service user may not wish to be disclosed, how they can be supported to put forward their views and what they want to prioritise.
- Information to be discussed, for example assessment information, should be available to practitioners and the service user before the meeting. It is usually not appropriate to focus on sensitive information in the meeting.
- Care should be taken to support everyone attending to feel respected, for example practitioners and service users arriving at the same time to a team formulation meeting, the setting being as comfortable as possible, people being introduced, and their role made clear.
- Where service users do not wish to attend the team formulation meeting in person, they should be aware when it is taking place. They, and where

appropriate their families and carers, should be engaged as meaningfully as possible with the process, for example providing information for the meeting and receiving feedback from it.

- Where service users are not able to understand the team formulation process or to engage in the meeting, family, carers or other advocates should be sought to support the input of their views and wishes.
- Culturally informed advocates should be sought to support service users and families from minoritised communities, and to inform the understanding developed in team formulation.
- Organisations should monitor the quality of team formulations, in collaboration with service users, and the impact of the team formulation process on care, particularly how involved service users feel in decisions around their care. Care should be taken to ensure involvement of service users from minoritised communities in evaluation processes.
- Team formulation should be facilitated by a qualified mental health practitioner with specific skills in psychological models of understanding disability and mental health issues, sociological and cultural factors, and expertise in facilitating groups. Training and supervision should be provided for practitioners facilitating team formulation meetings.
- Team formulations are always provisional and need to be updated collaboratively as more information is available and understanding evolves.

7.2. Team Formulation Documentation

- Where the service user has not been directly involved in developing the team formulation, any documentation should be clearly identified as coming from an indirect team formulation, and provisional.
- Goals, care plan suggestions and safety management recommendations coming from a team formulation meeting should be agreed with the service user whenever possible and documented in the care record.
- Team formulation both overlaps with and differs from team reflective practice. Any actions relating to the care and treatment of individual service users from reflective practice meetings should be recorded in the

person's care record, but not the detail of the discussion.

- Team formulations should use language that is understandable and compassionate.
- Team formulations should respect the service user's wishes about confidentiality and sensitive information. Where the service user disagrees with an aspect of the formulation their view should be clearly documented.

8. Future Directions

While it has been advocated that team formulation should be implemented to improve quality of care in inpatient settings (Berry et al., 2017), it is vital that research is co-produced with people with lived experience of a range of services and focuses on understanding service users' and carers' experience of team formulation, alongside the impact of team formulation on outcomes (Berry et al., 2017; Turner et al., 2018). There is also a need for more detailed guidance on ways to involve service users in the process, and to feedback on the process to help clarify what works well in practice. The Open Narrative System provides a framework to support the process of enabling trauma-informed care and may be of value here (Trauma Informed Community of Action, 2021).

'Monitoring the quality of team formulation should be done in partnership with service users'

Children & Young People's Inpatient Services, Pennine Care NHS Foundation Trust

A range of psychological models have been used to inform the structure of team formulation, and there will be positive aspects related to the characteristics of different models. Greater specification in the variety of team formulation practices and focus on key processes may enable a clearer understanding of relationships with outcomes (for example the impact on care planning), and implications for best practice (Geach, Moghaddam, & De Boos, 2018; Geach, Moghaddam, & De Boos, 2019). It has also been argued that a conceptual framework encompassing team inputs, processes and outputs in team formulation practice may help identify the factors with key positive impacts (Short et al., 2019). However, this is an area where practice-based evidence is important in exploration of the positive impacts of different models of team formulation in different service contexts and care pathways. Furthermore, it is important that research is undertaken to explore the interaction between the skills of the facilitator and the process and outcomes of formulation for service users, carers and teams.

'This approach is more person-centred but it is important that there are 'checks and balances' to make sure it is a helpful process'

Older Adult Carer, Wales

9. Summary

The practice of team formulation has grown within services, particularly where team-based models of care are necessary such as inpatient, intellectual disability and older adult services. Team formulation can support team members to develop a biopsychosocial understanding of service users' needs and difficulties, enabling compassionate care, effective interventions and collaborative care planning. It can promote non-judgemental, caring interactions with service users, and trauma informed, strengths-based care. However, it is a complex, multi-functional process operating in a system within which service users often have little power.

There are challenges in navigating issues of meaningful collaboration and information sharing in ways that support people's trust in services and teams, and the good team functioning necessary for effective care. Service users should be supported to engage in the process of developing a collaborative formulation, and in providing information into and being given feedback from team formulation meetings if they do not wish, or are not able, to attend in person. When a service user is unable to fully engage with the process due to cognitive impairment or their mental health and distress, psychologically informed team formulation can help the team work sensitively with the person, drawing on a range of information and biopsychosocial approaches to develop the care plan.

Where the service provides team-based care, the team is required to develop their understanding of the person's needs and difficulties, through a range of discussions and meetings, and this understanding informs the care plan. The biopsychosocial framework underpinning team formulation can help practitioners to develop, as collaboratively as possible, a trauma-informed, compassionate, non-judgemental understanding of the person's difficulties and needs which enables the team to respond in ways that support service users to feel understood and able to trust in the team.

Where a team formulation goes ahead when the service user would prefer it not to, for the reasons outlined, why this is happening needs to be explained to the person in an open and honest way, and continued support provided to listen to their concerns and understand them in the context of their life experience, and to work in ways which help to promote psychological safety. Outcomes from the meeting should be

shared as openly as possible with the service user, and continued support provided to help the person create a narrative where their voice can be heard.

Co-developed and co-led research is needed to build understanding of the impact of team formulation on service users' perceptions of feeling understood, involved in care plans and decisions about interventions, and on treatment outcomes. Further research is also needed on the impact of team formulation on MDT attitudes, understanding of service users' difficulties and needs, and engagement with service users as partners in their care and treatment. In enabling services to be trauma informed, it is important to focus on the process or 'journey' (Treisman, 2021) rather than the 'destination', increasing our understanding of and responsiveness to people's needs together. As with formulation itself, the ideas in this document are just one step in an ongoing conversation about how the process of team formulation is implemented, experienced and evaluated. The authors welcome contributions to and collaborations in that process, and hope that all those utilising team formulation will adopt the same open, compassionate stance.

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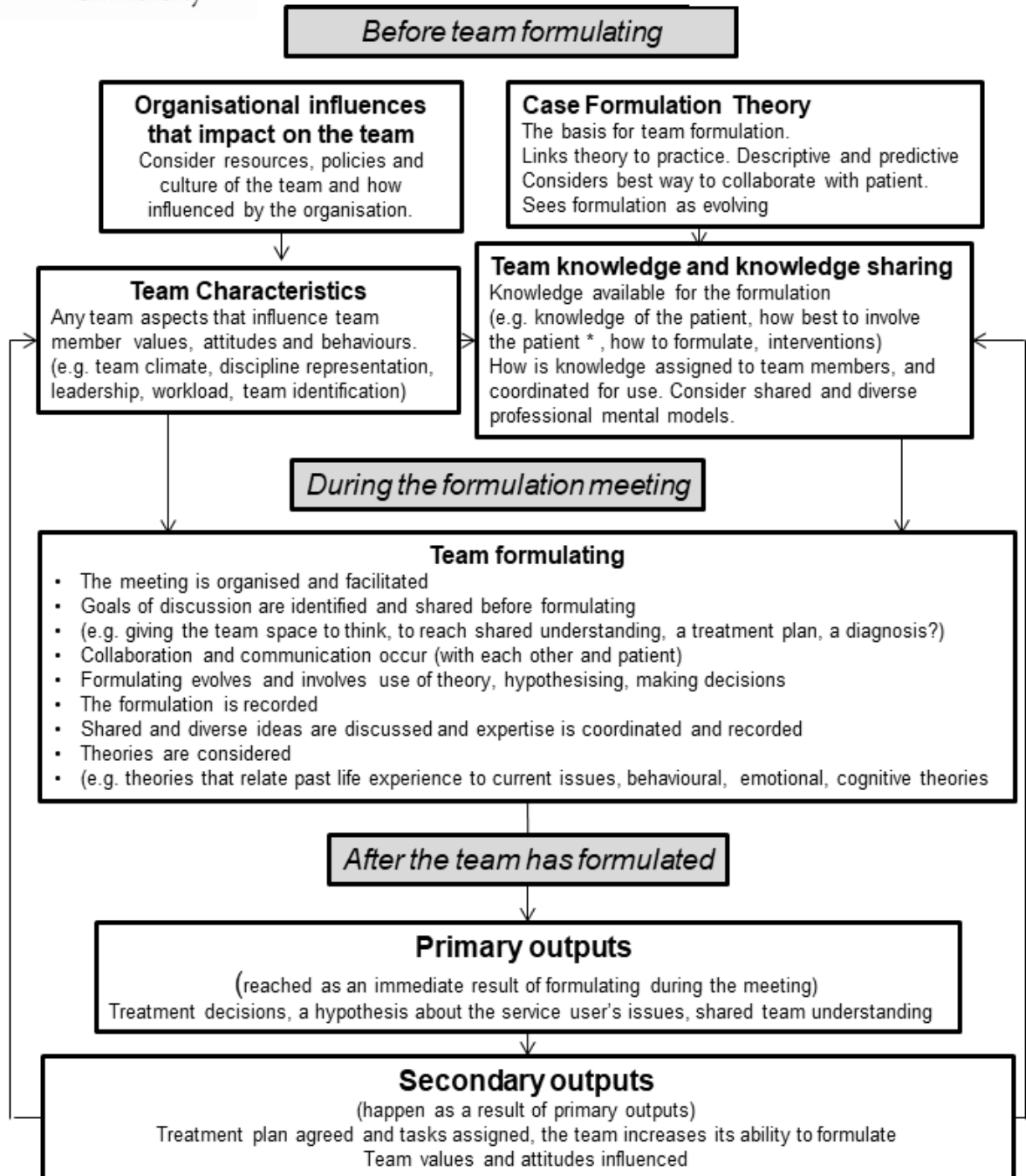
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Appendix 1: The Team Formulation Model, Short (2019)



The Team Formulation Model (Short, 2019)



*The team should carefully consider how patients are involved in their formulation. Studies show that service users can find the formulation distressing. Co-production should be planned and considered. Collaborative conversations can take place before the formulation meeting. Formulating should be collaborative where possible, but considerations of harm to the service user must be considered and formulating can be about space to think for the team.

Appendix 2: What do Teams Need to Think About in Enabling Team Formulation?

1. How have we shared information about team formulation practices with those who use our services and how have we checked this is accessible and understandable?
2. How have we enabled collaboration and inclusion in team formulation processes?
3. If applicable, what is our rationale for facilitating team formulation in the service user's absence and how have we communicated this?
4. How have we prepared for the team formulation discussion in order to ensure that accurate and person-centred information about the person is included and their views and perspectives are heard?
5. How have we ensured that our team formulation honours the social and cultural context of the individual?
6. Is the team formulation facilitated by someone with competence in psychological theories, models and group process? Is the person acting from an empathic and compassionate values base?
7. How is the summary of the team formulation stored and shared and is this commensurate with the information provided to the service user and the nature of their involvement?
8. Do we have opportunities for the co-creation or collaborative individual formulation and how is this integrated into and informed by team formulation processes?
9. What are our processes for reformulating and ensuring team formulation is seen as tentative, and iterative?
10. How do we evaluate the quality of team formulation collaboratively with people who use services?
11. What processes do we have for continuing to develop and improve team formulation processes collaboratively with people with lived experience?



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