Psychological consultancy in mental health teams

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Declaration

This thesis has been submitted for the Doctorate in Clinical Psychology at the University of Sheffield. It has not been submitted for any other qualification or to any other academic institution.

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Abstract

Literature Review

Psychological consultation is a common activity in mental health services, but evidence concerning its theoretical grounding, processes, and outcomes are relatively rare. Fifteen mixed method consultation studies were included in the review. Studies were assessed for methodological quality, and found to range from limited to strong. Cognitive behavioural consultation was the main approach used and consultation was most frequently delivered via formulation meetings. Psychological consultation appears to particularly improve staff understanding about clients and consultants should remain visible and accessible to teams. Practical and methodological developments are suggested to the consultation evidence base.

Research Report

This empirical study aimed to measure the effectiveness of cognitive analytic consultancy (CAC) offered within a community team and then to explore the possible mechanisms of change. An A-B with follow-up small *N* case series (*N*=5) design was used that utilised a mixed methodology employing outcome measures and semi-structured interviews. There were significant improvements in client fragmentation, staff competence and emotional exhaustion, and alliance from a client perspective. Potential mechanism of change included the therapists approach, using the sequential diagrammatic reformulation, and acknowledging that difficult processes helped recovery. Further head-to-head trials comparing CAC to other consultation frameworks appears warranted.

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Part One: Literature Review

Staff consultation in mental health services:

A mixed method review of the literature

Abstract

Objectives. Psychological consultation plays an important role in patient wellbeing and staff functioning to allow mental health care to be delivered in an efficient and effective manner. This review aimed to: (1) clarify what models inform the psychological consultation process, (2) define the way psychological therapists offer consultancy, (3) assess the methodological rigour of the consultation evidence base, and (4) define the benefits of psychological consultation to clients, staff, and consultants.

Method. Database searches used the keywords psychol* AND (consult* OR "indirect work" OR "team based formulation" OR "case formulation" OR "case conceptualisation" OR "case consultation"). Focussing on psychological consultation only, this left 15 mixed-methods studies to be included in the review.

Results. Models used for psychological consultation were: cognitive/cognitive-behavioural, cognitive analytic, consultee-driven, graded sequence of stages of consultation, psychoanalytic and undefined models. Consultation was mainly delivered via formulation meetings. The quality of the studies varied from limited to strong. Findings were discussed under the overarching themes: client outcomes, staff outcomes, and consultant factors.

Conclusions. A mixed-methods approach to reviewing the literature was a useful way to inform practitioners and policy makers about psychological consultation practices. Further well controlled and conceived research is required to improve the evidence base.

Practitioner Points

- Psychological consultation improves staff understanding of clients.
- Psychological consultants need to remain visible and accessible to teams.
- MDT-based formulation meetings are a popular way to deliver psychological consultation, but creative methods of delivery (e.g. workshops) are also possible.

Cautions

- Quality assessment of studies could be improved by including assessment of the outcomes measures used in studies.
- Future research needs to publish a model specific protocol, in order that adherence to, or competence in, the consultation model stated can be assessed.

Introduction

Psychological therapists are required to offer more than just direct therapeutic work in order to reach the maximum numbers of clients in health and social care services (Department of Health, 2007). Onyett (2007) argues that sharing psychological ideas (e.g. client formulations) with staff that directly support clients, is one way of delivering psychologically-informed care in an efficient manner. This indirect work can help to support staff to develop their skills, particularly when working with complex clients (Sampson, McCubbin, & Tyrer, 2006). Furthermore, Onyett (2007) stresses the importance of psychological therapists supporting peer consultation processes which give staff time to reflect on clients and their relationships with the client.

Roberts (1998) refers to 'the consultant in the system' whereby the therapist acts as an objective third person in the typical care dyad (client-staff). The consultant's role is to create a reflective space for staff to observe their interactions with clients and seek alternative perspectives (Onyett, 2007). Reflective opportunities can manage staff stress and burnout (Peterson, Bergstrom, Samuelsson, Asberg, & Nygren, 2008). The reflective space offered by consultation is consistent with the Francis Report (2013) recommendations which state that psychological therapists should support a compassionate organisational culture (Oelofsen, 2014). Psychological consultation can support staff to develop a greater understanding about clients which increases the range of possible ways of helping (Evans, Law, Turner, Rogers, & Cohen, 2011).

Whilst various approaches to psychological consultation have been put forward, this is not to be confused with clinical supervision (Milne & James, 2000; Whitton, Collinson, & Adams, 2013). The difference being that the supervisor is accountable for the supervisees practice, whereas the consultant provides guidance and advice, which the consultee can choose whether to implement or not (Alban & Frankel, 2007). Some

psychological therapists offer consultation formally, such as via reflective practice meetings (e.g. Collins, 2011) or skills level training (e.g. Thompson et al., 2008). Whereas other staff take a more informal approach, such as 'chipping in' with formulations in multidisciplinary team discussions (e.g. Christofides, Johnson, & Musa, 2012). Essentially, formulation provides a link between theory and practice (Johnstone & Dallos, 2013), whereas consultation is the process by which psychological concepts and ideas can be accessed by other professionals (Onyett, 2007). Psychological consultation may draw on a range of clinical models in its delivery (Division of Clinical Psychology, 2010).

Defining Levels of Consultancy

Carradice and Bennett (2012) provide a useful framework, which differentiates levels of consultation by who it is delivered to, and how it is delivered (see Table 1). This review is focal to psychological consultation delivered at levels 1b and 2.

Table 1

Levels of Consultation (based on Carradice & Bennett, 2012)

Levels of work	Nature of work	Impact of work
1a: Direct work	The psychological therapist offers direct therapy to the client and gives feedback to the team working with the client in the form of a formulation. This is not considered consultation.	Can be a time intensive approach, but often required for complex cases (Wellbeing Information, 2017)
1b*: Direct work	The psychological therapist offers time-limited direct work with the client and a member of their team to provide a formulation and/or a care plan that the member of staff (or team) can implement. The psychological therapist is functioning at a consultative level and modelling psychologically-informed approaches to other professionals	Due to the time-limited nature of this level of work, it can influence greater numbers of clients
2*: Indirect work	The psychological therapist offers indirect work to staff member/s to advise and support their work without the client being directly involved	These consultations (e.g. via reflective practice meetings) can potentially influence the greatest number of staff (Caplan & Caplan, 1999)
3: Indirect work	The psychological therapist works at an organisational level, perhaps consulting on service design or interventions to change the culture of a service	Has a secondary benefit of improving care for clients (Onyett, 2007)

Note. *=Levels of consultancy considered in the present review

Study Rationale and Aims

Policy makers and practitioners seek clear guidelines to aid decision-making from systematic reviews (Pearson et al., 2015). There have been no reviews to date which examine what models inform psychological consultation, how it is delivered, assess the quality of the extant literature, or the benefits for clients, staff or psychological consultants. One useful way to address complex questions, is to conduct a mixed-methods systematic review (Pearson et al., 2015). Therefore, this review aimed to:

1. Highlight what models inform psychological therapists consultancy processes across mental health and intellectual difficulties settings, at levels 1b and 2 of the Carradice and Bennett (2012) framework,
2. Define the modes of delivery of psychological consultation,
3. Assess the methodological rigour of the extant literature,
4. Consider the outcomes of consultation for clients, staff, and psychological consultants.

Methodology

Design

The present review did not limit studies by design. Traditionally, heterogeneity was minimised to ensure reliability of review findings (Lorenc et al., 2016). However, the questions being asked about psychological consultation in the present review were complex. Petticrew et al. (2013) argues that incorporating complex review questions and methods can offer a more comprehensive understanding of both the processes and outcomes of interventions. Therefore, this review engaged with this complexity by integrating heterogeneous types of data (quantitative, qualitative and mixed-methods designs).

Search Strategy

Literature searches were conducted using bibliographic databases PsycINFO (for papers between 1806 – March Week 1 2017), Scopus and Web of Science Core Collection (between 1900 – 2017). Google Scholar was also accessed in an attempt to find any grey literature and unpublished studies. To identify studies not captured in the electronic searches, ancestry searching from the reference lists of the articles was conducted to find original source information. No start date parameters were set to

ensure all relevant studies were captured. Searches were conducted using the guidance of a systematic research strategy (Higgins & Green, 2011) based on the search string psychol* AND (consult* OR "indirect work" OR "team based formulation" OR "case formulation" OR "case conceptualisation" OR "case consultation" OR “reflective practice”) NOT (sport* OR school OR coach* OR police). The keywords were searched for in the title and abstract fields. Results were combined in EndNote Basic and duplicates removed. The remaining studies were screened in two stages. Firstly, titles and abstracts were read to eliminate clearly irrelevant studies. Secondly, full-texts were read where it was not clear whether studies met the eligibility criteria. This search strategy is shown in Figure 1.

Eligibility Criteria

Studies must have used a guiding psychotherapeutic model (i.e. psychotherapy, cognitive analytic therapy, analytic consultancy, cognitive behavioural therapy, analytic, dynamic and counselling) and this was to avoid including any other discipline offering consultation (e.g. medical). Consultation needed to have been delivered at levels 1b and 2 of the Carradice & Bennett (2012) model. Papers that included other levels of consultation (1a and 3) were included as long as they discussed the above levels. Studies were required to have a minimum of a hypothesis/research question, were required to have full text available and be published in English. Finally, studies were not limited by study design. Studies were excluded if they focussed on: regular supervision rather than consultancy; offered consultation to other psychological therapists; were in the areas of sports, educational, coaching or police psychology; only focussed on level 1a or 3; or were not primary research.

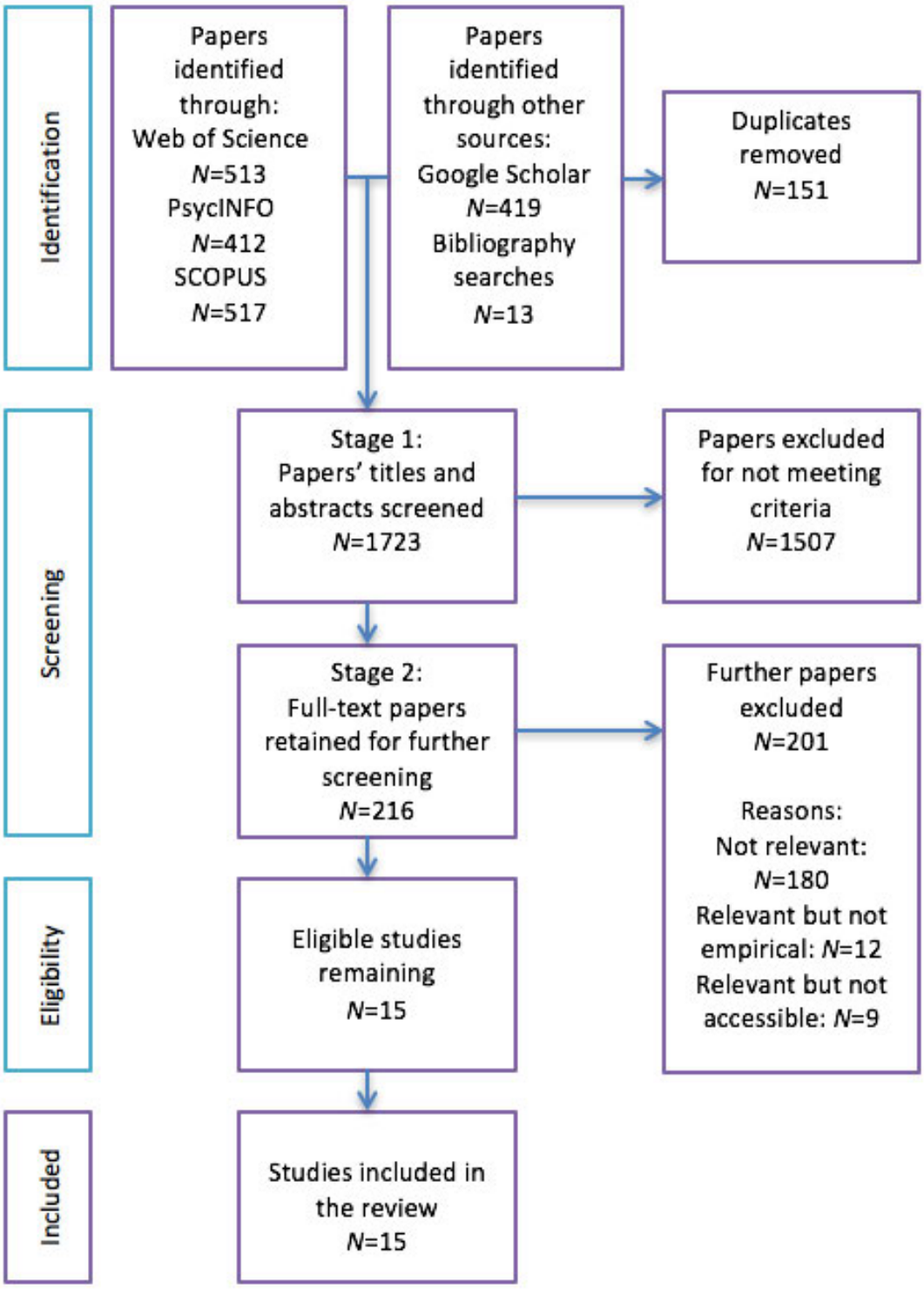

Figure 1. PRISMA flow diagram of the study selection strategy

Quality Ratings

Each included study was scored using the QualSyst quality ratings checklist (Kmet, Lee, & Cook, 2004). QualSyst provides quality assessment criteria to evaluate both quantitative and qualitative primary research papers and are appropriate for literature reviews across broad-based study designs (Kmet et al., 2004).

The quantitative checklist contains 14 criteria (see Appendix A) that equate to 28 total possible points. Each criterion is allocated two points when met, one point when partially met and no points if not met. These are summed together to create a total sum. There is also an option for not applicable (NA) where the total number of NA's multiplied by two, generates a total possible sum. The final summary score is calculated by dividing the total sum by the total possible sum. Kmet et al. (2004) suggested a cut off score of >0.75 as the threshold for allowing studies to be included in reviews. However, Lee, Packer, Tang, and Girdler (2008) used this tool to define the quality of papers as: strong (>0.80), good (0.71-0.79), adequate (0.50-0.70) and limited (<0.50). Lee et al.'s (2008) method of assessing quality was appropriate for the present review because it focused on the assessment of the quality of the studies rather than using a threshold for including papers.

The qualitative checklist contains 10 criteria (see Appendix B) that equate to 20 total possible points. Each criterion is allocated two points when met or one point when partially met. The final score is calculated by dividing the total points achieved by 20. Kmet et al. (2004) suggested a threshold of >0.55 for the inclusion of qualitative studies based on strong inter-rater agreement (100%) when they developed the tool. However, the present review will define qualitative studies using Lee et al.'s (2008) criteria above.

To enhance reliability, three papers were randomly selected (one from each methodology; quantitative, qualitative, and mixed methods) and second rated by an

independent assessor (a trainee clinical psychologist). Cohen's kappa was used to assess interrater reliability (McHugh, 2012). Due to inter-rater reliability being strong ($\kappa = .82$, 94% agreement; McHugh, 2012), it was not felt necessary to co-rate any further papers.

Analysis

The analysis took place in two sections. First, studies were grouped by the model of consultation they employed. Data related to the mode of consultation were extracted and quality scores reported. This process addressed the first three aims of the review. Second, the review synthesised findings by clustering conceptually similar outcomes related to clients, staff, and psychological consultants, using thematic analysis (Braun & Clarke, 2006). This involved extracting quantitative results from the quantitative and mixed methods studies, which formed the basis of a template for the qualitative studies. Qualitative themes from the qualitative and mixed methods studies were extracted literally (to preserve meaning) and added to the template based on conceptually similar results. Through an iterative process of clustering around main themes and subthemes, a table of synthesised results from the studies was generated. A minimum of two studies were required to generate a subtheme.

This process allowed a combined picture to emerge from the outcomes of the studies. The value of each theme could then be assessed on the quality of the studies and whether the various findings contradict or confirm each other. Where findings were confirmatory, themes were coded whether they broadly agreed and added depth (i.e. "confirmatory: convergent and expansion") or findings broadly agreed and added breadth (i.e. "confirmatory: convergent and complementary"). This process addressed the fourth aim of the review. To enhance reliability of the codes, a trainee clinical psychologist second rated the convergence codes.

Results

A total of 1874 studies were retrieved. Duplicates were removed, resulting in 1723 studies for Stage 1 screening of titles and abstracts against the inclusion criteria. Once obviously inappropriate studies were removed, 216 papers were retained for Stage 2 reading of the full-texts against the inclusion criteria. This resulted in *N*=15 eligible studies that were quality assessed (Kmet et al., 2004). The score sheet (including second rater scores) can be seen in Appendix C. Included studies and summary scores are presented in Table 2. Studies are clustered by model of consultation used and consisted of cognitive/cognitive behavioural (*N*=5), cognitive analytic therapy/consultancy (*N*=2), consultee-driven consultation (*N*=3), graded sequence of stages of consultation (*N*=1), psychoanalytic/ attachment theory/object relations (*N*=2) and undefined models (*N*=4). Two studies used more than one type of consultation approach. Four studies had a quantitative design, seven had a qualitative design and four studies had a mixed design. The sample sizes of the studies ranged from 1 to 89 (*M* = 28.6). All of the studies measured consultation at level 2 of the Carradice and Bennett (2012) framework, except for two, which also worked at level 1b (Kellett, Wilbram, Davis, & Hardy, 2014; Prior, Stirling, Shepherd, & Stirrat, 2003).

Table 2.

List of Included Studies, Clustered by Model of Psychological Consultation

Author(s)	Design	Sample size	Setting	Mode of consultancy	Explicitly named model	Level(s) of work	QualSyst summary score
Cognitive/Cognitive-behavioural							
*Berry, Barrowclough, & Wearden (2009)	Quantitative: Pre and post outcome measures	*N*=7 (client) *N*=30 (staff)	Psychiatric rehabilitation unit	Team-based (nurses and support workers) formulation meetings on ward at handover time	Used a mixed theoretical model approach of Becks (1976) Cognitive Model, CAT and attachment theory	Level 2	.95 (strong)
Berry, Haddock, Kellett, Roberts, Drake, & Barrowclough (2015)	Quantitative: Randomised single-blind cluster, comparing TAU with intervention	*N*=36 (client) *N*=74 (staff)	Long stay psychiatric ward	MDT-based formulation meetings on ward. 24 one-hour sessions over 6 months	Beck's (1976) Cognitive Model	Level 2	.96 (strong)
Craven-Staines, Dexter-Smith & Li (2010)	Qualitative: Thematic analysis	*N*=20 (staff)	Older adult inpatient and community	MDT-based formulation meetings over 2 services on ward/team office, either weekly or twice weekly, both for 1 and half hours each.	Roseberry Park Model/ Cognitive Behavioural Therapy Model	Level 2	.85 (strong)
Ingham (2011)	Quantitative: Case study Pre and post staff outcome measures	*N*=1 (client) *N*=7 (staff)	Intellectual difficulties service	Team-based (care staff) formulation via two 3-hour workshops	Workshops used a 5-problem area's framework (Dudley & Kuyken, 2006) to develop a psychosocial case formulation	Level 2	.94 (strong)
*Summers (2006)	Qualitative: Grounded theory	*N*=25 (staff)	High dependency rehabilitation	MDT-based formulation meetings on ward, fortnightly	Developed either CBT or Object Relations formulations	Level 2	.8 (strong)

Table 2. (continued)

List of Included Studies, Clustered by Model of Psychological Consultation

Author(s)	Design	Sample size	Setting	Mode of consultancy	Explicitly named model	Level(s) of work	QualSyst summary score
Cognitive/Cognitive-behavioural (continued)							
Murphy, Osbourne, & Smith (2013)	Qualitative (exploratory): thematic analysis	*N*=10 (staff)	Mental health and dementia care wards	MDT training package (3-day) including formulation plus weekly formulation consultation sessions	Dexter-Smith (2007)	Level 2	.75 (good)
Wainwright & Bergin (2010)	Qualitative (service evaluation): pre and post interviews using content analysis	*N*=5 (staff) x2 interviews each	Acute older adult inpatient mental health ward	MDT formulation meetings (max 3 sessions per client) lasting 1 hour	Cognitive behavioural formulations	Level 2	.75 (good)
Cognitive Analytic Therapy/consultancy							
Kellett, Wilbram, Davis, & Hardy (2014) Also see Berry et al. (2009)	Mixed methods: RCT + 3-month follow-up	*N*=10 (clients in CAC) *N*=10 (clients in TAU) *N*=7 (staff pre) *N*=8 (staff post)	AOT	Working with individual staff + MDT + 2 day training inc. reformulation + 3-month consultation	Carradice (2013) CAT consultation model	Level 1b and 2	.8 (strong; qual) .95 (strong; quant)

Table 2. (continued)

List of Included Studies, Clustered by Model of Psychological Consultation

Author(s)	Design	Sample size	Setting	Mode of consultancy	Explicitly named model	Level(s) of work	QualSyst summary score
Consultee-driven consultancy							
Dimaro, Moghaddam, & Kyte (2014)	Mixed methods: questionnaires and focus groups	*N*=48 (staff questionnaires) *N*=9 (staff focus group)	Social Care: Looked after children	As required, individual consultee-driven assessments, formulations and interventions	Consultee-centred model of consultation developed by Caplan (1970) and outlined by Golding (2004)	Level 2	.75 (good; qual) .59 (adequate; quant)
Evans, Law, Turner, Rogers, & Cohen (2011)	Qualitative: Thematic Analysis	*N*=6 (staff)	Specialist residential care for young people	As required, individual and group consultation	Consultee-centred model of consultation developed by Caplan (1995)	Level 2	.75 (good)
Graded sequence of stages of consultation							
Prior, Stirling, Shepherd, & Stirrat (2003)	Mixed methods: Frequency comparisons and qualitative feedback	*N*=6 (staff) discussing *N*=18 (clients)	Child services with health visitors	Case discussion Weekly, 1-hour groups over 6 months	Own model	Level 1b and 2	.5 (adequate; qual) .33 (limited; quant)

Table 2. (continued)

List of Included Studies, Clustered by Model of Psychological Consultation

Author(s)	Design	Sample size	Setting	Mode of consultancy	Explicitly named model	Level(s) of work	QualSyst summary score
Undefined model							
Clark & Chuan (2016)	Quantitative: Recall rates measured, descriptive findings presented only	*N*=10 (staff)	Probation officers working with personality disorder	Case discussion and training based on knowledge & understanding framework, monthly	Not specified	Level 2	.82 (strong)
Douglas & Benson (2015)	Qualitative: thematic analysis	*N*=6 (staff)	Paediatric gastroenterology	MDT psychosocial forums, weekly	Not specified	Level 2	1 (strong)
Mattan & Isherwood (2009)	Qualitative: grounded theory	*N*= 11 (staff)	Various: LD, health psychology, adult mental health	Various approaches depending on psychologist	Not specified	Level 2	.75 (good)
Whitton, Small, Lyon, Barke, & Akiboh (2016)	Mixed methods within group, self-report pre-and post-questionnaires	*N*=89 (staff)	Secure forensic learning disability and Autism service	Regular MDT-based formulation meetings	Not specified	Level 2	.65 (adequate; qual) .85 (strong; quant)
Psychoanalytic/ attachment theory/Object relations							
Also see Berry et al. (2009)							
Also see Summers (2006)							

Note. * = study discussed more than once. MDT = multidisciplinary team. LD = learning disability

Main Findings

Quality of studies. All studies were of at least adequate quality, except for one mixed methods study where the quantitative aspect was of limited quality (Prior et al., 2013). The other quality ratings ranged from .5 (qualitative aspect of Prior et al., 2013) to 1 (Douglas & Benson, 2015). Stronger quantitative studies were characterised by clear objectives, appropriate study design, appropriate participant selection strategy and sample size, blinding of the intervention to staff and participants, using appropriate analyses, and asking if the results supported the conclusions. Stronger qualitative studies were characterised by clear objectives and appropriate study design, with connections to a theoretical framework, clearly described data collection and analyses, used verification procedures, and contained some reflexivity by the researcher. Overall, 53% (8/15) studies met the criteria for strong quality research, 26% (4/15) studies met the criteria for good quality research, 13% (2/15) met the criteria for adequate quality research and 8% (1 study; Prior et al., 2003) met the criteria of limited quality research for the quantitative aspect only.

Models of psychological consultation.

Cognitive/cognitive-behavioural. Seven studies used a cognitive or cognitive-behavioural consultation approach. The specific models were Beckian (Berry, Barrowclough, & Wearden, 2009; Berry, Haddock, Kellett, Roberts, Drake, & Barrowclough, 2015; Murphy, Osbourne, & Smith, 2013) or using the "5 areas" approach (Ingham, 2011). Craven-Staines, Dexter-Smith & Li (2010) used their self-devised Roseberry Park model, which originated from cognitive behavioural principles. Summers (2006), and Wainwright and Bergin (2010) did not state a specific cognitive behavioural model. Berry et al. (2009) and Summers (2006) also used CAT/attachment theory and object relations, respectively, alongside cognitive behavioural approaches.

Cognitive analytic therapy/consultancy. Two studies named cognitive analytic therapy (CAT) or cognitive analytic consultancy (CAC) as their approach. Kellett et al. (2014) evaluated the Carradice (2013) CAC model by delivering training based on cognitive analytic principles, followed by case consultation, CAT-based supervision and follow-up. Berry et al. (2009) used CAT as part of a mixed approach to their psychological consultation discussed above.

Consultee-driven consultation. Two studies named the consultee-centred model of consultation (Caplan, 1970; 1995) where particular attention is given to the consultees difficulties with the client so that they can work more effectively with that client and future clients. Dimaro, Moghaddam, and Kyte (2014) offered consultation to social workers in a looked-after children's setting. Evans, Law, Turner, Rogers, and Cohen (2011) offered consultation to staff working in a residential care setting for young people.

Graded sequence of stages of consultation. One mixed methods study (Prior et al., 2003) described grading the sequence of stages of the psychological consultation. This self-created model for a team of health visitors, graded consultation between stage 1 to 5. Initially health visitors could anonymously attend a group consultancy session to raise cases for discussion. If more input was required an individual consultation could be arranged, escalating to a more detailed planning meeting. In the final stages, a one-off meeting with the child and their family could be arranged, escalating to a formal referral to the child psychology department being be made.

Undefined model. Four studies did not specify a precise model. In Clark and Chuan's (2016) study, psychological therapists used case consultation and training, with probation officers working with offenders with personality disorder. Douglas and Benson (2015), described psychological consultation using a psychosocial forum in a

paediatric gastroenterology setting. The content of the forums focussed on psychosocial factors that influenced client care. Whitton, Small, Lyon, Barke, and Akiboh (2016) used non-specific team psychological formulations in a secure forensic intellectual difficulties and autism service. While Mattan and Isherwood (2009), used various non-specific consultation approaches depending on the psychologists who worked in different settings (e.g. intellectual difficulties, health psychology, and adult mental health).

Psychoanalytic/attachment/object relations. Two papers (Berry et al., 2009; Summers, 2006) mentioned using attachment theory and object relations theory, respectively, as a secondary model for their consultation.

Modes and methods of delivery. Psychological consultancy was delivered in a number of ways. Over half of the studies (*N*= 10) explicitly described using a psychological formulation to inform the consultation. Formulations were sometimes in the context of team meetings with (Berry et al., 2015; Craven-Staines et al., 2010; Douglas & Benson, 2015; Kellett et al., 2014; Murphy et al., 2013; Summers, 2006; Wainwright & Bergin, 2010; Whitton et al., 2016) or without (Berry et al., 2009) the MDT. One study used formulation with individual staff (Dimaro et al., 2014). Of the five studies that did not use formulation, they reported using general case discussion (Clark & Chuan, 2016; Prior et al., 2003), various (non-specific) approaches depending on the psychological therapist (e.g. Mattan & Isherwood, 2009), and two studies did not report how they delivered consultation (Evans et al., 2011; Ingham, 2011). Apart from meetings, other modes of psychological consultation included workshops (Ingham, 2011), training (Clark & Chuan, 2016; Kellett et al., 2014; Murphy et al, 2013), and a psychosocial forum (Douglas and Benson, 2015).

There was a large variation in the frequency and duration of consultations. Studies reported consultancy sessions running twice per week (Craven-Staines et al., 2010), weekly (Berry et al., 2015; Craven-Staines et al., 2010; Douglas & Benson, 2015; Prior et al., 2003), fortnightly (Summers, 2006), monthly (Clark & Chuan, 2016), or as required (Dimaro et a., 2014; Evans et al., 2011; Mattan & Isherwood, 2009). One workshop ran over two days (Ingham, 2011), and a training session operated over three days (Murphy et al., 2013). Three studies reported no frequency at all (Berry, 2009; Kellett et al., 2014; Wainwright & Bergin, 2010; Whitton et al., 2016). In terms of duration, consultancy sessions ran for one hour (Berry et al., 2015; Prior et al., 2003; Wainwright & Bergin, 2010), one and a half hours (Craven-Staines et al., 2010), three hours (Ingham, 2011), or as required (Dimaro et al., 2014; Evans et al., 2011; Mattan & Isherwood, 2009). Seven studies did not report any duration of sessions.

Outcomes of psychological consultation. Next, studies have been clustered by the key outcomes regardless of model. The three overarching themes are related to client outcomes, staff outcomes, and consultant factors. Results can be seen in Table 3. Inter-rater agreement on the convergence codes was $\kappa = .82$ (89% agreement), $p < .05$, suggesting a strong level of agreement between raters. Following discussion between raters, complete agreement was achieved on all nine convergence codes.

Table 3.

Synthesis of Qualitative and Quantitative Results According to Review Questions

Theme	Author/s (quality rating)	Measure/s	Results	Merged findings code*
Client outcomes				
Symptoms	1. Berry et al. (2015) (STRONG)	1. Clients completed the Positive and Negative Syndrome Scale; Global Assessment of Functioning Scale; Severe Behaviour schedule.	1. QUANT: No statistically significant differences in client functioning	Confirmatory: convergent and complementary
	2. Kellett et al. (2014) (STRONG – QUAL, STRONG - QUANT)	2. Staff completed Clinical Outcomes in Routine Evaluation Outcome Measure; Work and Social Adjustment Scale	2. QUANT: No statistically significant differences in psychological distress, disability or overall engagement in CAC or TAU groups.	
Problematic behaviour	1. Ingham (2011) (STRONG)	1. Staff idiosyncratic behavioural measure; specifically designed carer questionnaire measuring severity of challenging behaviour and impact of behaviour on self and others	1. QUANT: Reduction in challenging behaviour (e.g. physical aggression, shrieking, verbal aggression) post-workshops. Staff perceptions of behaviour fell post-workshops and impact on self and others fell post-workshop	Confirmatory: convergent and expansion
	2. Clark & Chuan (2016) (STRONG)	2. Recall to prison data and case management recording system	2. QUANT: Significant decrease in the mean rate of prison recalls following introduction of the intervention, and this effect was sustained over two years	
Engagement with service	1. Clark & Chuan (2016) (STRONG)	1. Recall to prison data and case management recording system	1. QUANT: Significantly reduced non-compliance with supervision	Discrepant
	2. Kellett et al. (2014) (STRONG – QUAL, STRONG - QUANT)	2. Staff completed Service Engagement Scale	2. QUANT: No significant reductions in overall engagement with assertive outreach team in cognitive analytic consultancy or treatment as usual groups of the study	

Table 3. (continued)

Synthesis of Qualitative and Quantitative Results According to Review Questions

Theme	Author/s (quality rating)	Measure/s	Results	Merged findings code*
Staff outcomes				
Understanding the client	1. Berry et al. (2009) (STRONG)	1. Staff completed Brief Illness Perception Questionnaire; Illness Perception Questionnaire for Schizophrenia	1. QUANT: Significant improvements in staff perceptions of service users' problems on all dimensions assessed (more helpful attitudes towards working with clients' post-intervention; staff rated clients as putting in more effort in coping, felt more positive about clients and more optimistic about clients' treatment outcomes).	Confirmatory: convergent and complementary
	2. Dimaro et al. (2014) (GOOD-QUAL, ADEQUATE-QUANT)	2. Staff questionnaire using attachment-trauma perspective of consultation	2. QUANT: Majority of respondents reported 'increased understanding of the child and/or problems', and 'provided consultee with new ideas, a better way to consider a situation or a theoretical understanding'	
	3. Evans et al. (2011) (GOOD)	3. Qualitative staff interviews	3. QUAL: Main theme of 'seeing the value of consultation' with subtheme of 'putting the dots together – making sense'	
	4. Kellett et al. (2014) (STRONG – QUAL, STRONG - QUANT)	4. Qualitative staff interviews	4. QUAL: Main theme of 'increased awareness'. Main theme of 'changes made to the clinical approach' with subtheme 'increased awareness of patient's perspective'	
	5. Murphy et al. (2013) (GOOD)	5. Qualitative staff interviews	5. QUAL: Theme 'mechanisms of benefit': staff reported formulation helped staff knowledge and understanding of clients	
	6. Summers (2006) (STRONG)	6. Qualitative staff interview	6. QUAL: Theme "it makes you understand the reasons why people are like they are"	
	7. Whitton et al. (2016) (ADEQUATE-QUAL, STRONG-QUANT)	7. Self-designed staff questionnaire including an open question	7. QUANT: Significant improvements in understanding the client's psychological issues post-consultation and why that client presents with their current problems	
	8. Craven-Staines et al. (2010) (STRONG)	8. Qualitative staff interview	8. QUAL: Theme 'increased understanding of the client'	
	9. Wainwright & Bergin (2010) (GOOD)	9. Qualitative staff interview	9. QUAL: how staff understand service users: Theme 'by making sense', 'in terms of non-linked descriptive information'.	

Table 3. (continued)

Synthesis of Qualitative and Quantitative Results According to Review Questions

Theme	Author/s (quality rating)	Measure/s	Results	Merged findings code*
Confidence and competence	1. Berry et al. (2009) (STRONG)	1. Staff completed Brief Illness Perception Questionnaire; Illness Perception Questionnaire for Schizophrenia	1. QUANT: Statistically significant improvements in staff confidence in working with their client	Discrepant
	2. Dimaro et al. (2014) (GOOD – QUAL, ADEQUATE- QUANT)	2. Staff questionnaire using attachment-trauma perspective of consultation	2. QUANT: No improvements in 'increased confidence in consultee's existing skills and/or ability to manage the situation' or 'changes to direct practice by using different skills/interventions or different ways of communicating'.	
	3. Douglas & Benson (2015) (STRONG)	3. Qualitative staff interviews	3. QUAL: Main theme of 'influence on clinical work' with subtheme of 'building confidence with difficult situations'	
	4. Evans et al. (2011) (GOOD)	4. Qualitative staff interviews	4. QUAL: Main theme of 'initiating consultation' with subtheme of 'doubts about what you know and how you perform' post-consultation. Main theme of 'seeing the value of consultation' with subtheme of 'I am doing alright - self-validation'	
	5. Prior et al. (2003) (ADEQUATE –QUAL, LIMITED-QUANT)	5. Health Visitor Questionnaire, Knowledge of Behavioural Principles as Applied to Children questionnaire	5. QUANT: Frequency comparisons reported a slight increase perceived competence. Frequency comparisons reported showed slight upward trend in most pre-and post-scores on the Knowledge of Behavioural Principles questionnaire	
	6. Whitton et al. (2016) (ADEQUATE-QUAL, STRONG-QUANT)	6. Self-designed staff questionnaires	6. QUANT: No significant difference in staff confidence post-consultation.	

Table 3. (continued)

Synthesis of Qualitative and Quantitative Results According to Review Questions

Theme	Author/s (quality rating)	Measure/s	Results	Merged findings code*
Satisfaction and wellbeing	1. Berry et al. (2015) (STRONG)	1. Staff completed General Health Questionnaire; Maslach Burnout Questionnaire	1. QUANT: No statistically significant improvements in general health or emotional exhaustion and personal accomplishment subscales of MBI. However, statistically significant improvements in depersonalisation post-intervention	Discrepant
	2. Murphy et al. (2013) (GOOD)	2. Qualitative staff interviews	2. QUAL: Theme 'the impact of psychology on feelings invoked by the workplace'	
	3. Summers (2006) (STRONG)	3. Qualitative staff interviews	3. QUAL: Theme 'dimensions of benefit': staff reported formulation helped improve their satisfaction	
	4. Prior et al. (2003) (ADEQUATE –QUAL, LIMITED-QUANT)	4. Session Evaluation Form	4. QUANT: Frequency scores indicated increasing reported satisfaction during the consultation period.	
Feelings towards the client	1. Whitton et al. (2016) (ADEQUATE-QUAL, STRONG-QUANT)	1. Self-designed staff questionnaires	1. QUANT: Statistically significant improvements in staff empathy towards the client and their problems, post-consultation. Frequency outcomes: most staff did not think that the formulation meetings made excuses for the client's behaviour. No significant differences in staff negative attitudes and feelings towards the client, post-consultation.	Confirmatory: convergent and expansion
	2. Wainwright & Bergin (2010) (GOOD)	2. Qualitative staff interviews	2. QUAL: staff relationships with service users: Themes 'factors that help empathy and tolerance' 'factors that damage empathy and tolerance'	

Table 3. (continued)

Synthesis of Qualitative and Quantitative Results According to Review Questions

Theme	Author/s (quality rating)	Measure/s	Results	Merged findings code*
Consultant factors				
Importance of visibility and accessibility	1. Douglas & Benson (2015) (STRONG)	1. Qualitative staff interviews	1. QUAL: Main theme 'influence on clinical work' with subthemes of 'using psychological expertise', and 'having a psychologist to treat psychological problems'	Confirmatory: convergent and complementary
	2. Evans et al. (2011) (GOOD)	2. Qualitative staff interviews	2. QUAL: Main theme 'building the consultative relationship' with the subtheme of 'availability and responsiveness of the consultant' important to create sense of safety	
	3. Mattan & Isherwood (2009) (GOOD)	3. Qualitative staff interviews	3. QUAL: Main theme 'interpersonal dynamics' with subtheme of 'availability of consultant'	
	4. Murphy et al. (2013) (GOOD)	4. Qualitative staff interviews	4. QUAL: Theme "It's here now. You can touch it now: The importance of visibility and accessibility"	
Prevents unnecessary interventions	1. Douglas & Benson (2015) (STRONG)	1. Qualitative staff interviews	1. QUAL: Main theme 'influence on clinical work' with subtheme of 'prevents unnecessary medical interventions'	Confirmatory: convergent and expansion
	2. Prior et al. (2003) (ADEQUATE- QUAL, LIMITED-QUANT)	2. Referral figures	2. QUANT: Consultation was never escalated beyond Stage 1 for all cases. None of the cases were referred to social services. No child protection issues arose during the study period. Reduced referrals to psychology department following consultation intervention. GP practises making fewer referrals and now only referring complex cases	

Note. *Merged findings codes: "Discrepant" = findings are contradictory; "confirmatory: convergent and expansion" = findings broadly agree and add depth; "confirmatory: convergent and complementary" = findings broadly agree and add breadth.

Client outcomes.

Symptoms. Two randomised controlled trials produced complementary findings reporting no statistically significant changes in client symptoms. Berry et al. (2015) reported no changes in longer-term client outcomes (e.g. symptoms, functioning, behaviour, on-going risk, changes in medication, and relapses) during the six months prior to- and during consultation. Kellett et al. (2014) also reported that no statistical differences in psychological distress occurred in either cognitive analytic consultancy (CAC) or treatment as usual (TAU) arms.

Problematic behaviour. Two studies reported expansive findings in relation to reduced problematic behaviour following consultation. Ingham (2011) found post-consultation reductions in the levels of challenging behaviour (e.g. verbal and physical aggression) and reduced risks of a client's placement breaking down. Clark and Chuan (2016) found a significant and useful decrease in mean rates of prison recalls following consultation, and this effect was sustained over two years.

Engagement with the service. Two studies reported discrepant findings in relation to clients' engagement with services. Clark and Chuan (2016) reported that failure to attend appointments with professionals was reduced by two-thirds as a consequence of case consultation and training. However, Kellett et al. (2014) found no significant differences in overall client engagement between CAC and TAU.

Staff outcomes.

Understanding the client. Nine studies reported expansive findings reporting improvements in staff understanding of clients' difficulties following consultation. Three studies used quantitative approaches. Berry et al. (2009) reported staff increased their understanding of clients' problems, felt clients made more effort in coping, felt more optimistic about treatment, and generally felt more positive towards clients.

Dimaro et al. (2014) reported respondents most frequently perceived that consultation had facilitated situational understanding of clients. Whitton et al. (2016) reported improved consistency amongst the MDT in understanding clients and their difficulties, staff/client dynamics (e.g. splitting), and staff reporting that consultations were insightful about clients' backgrounds. However, staff did not attribute psychological factors to understanding clients' problems.

Six studies reported improvements in staff understanding of clients' difficulties using qualitative methodology. Summers (2006) reported increased understanding through the formulation meetings. Murphy et al. (2013) found consultation generated new ways of thinking which helped staff develop more positive, supportive relationships with clients. Kellett et al. (2014) reported that consultation allowed staff to gain a deeper understanding of clients, think about clients in a different manner, and no longer felt stuck and in unhelpful patterns. Craven-Staines et al. (2010) reported that staff found formulation meetings useful because combining different team member's perspectives, helped to highlight blind spots about clients. Staff felt they got to know clients better, what made clients 'tick', and got a better idea about clients' backgrounds. Evans et al. (2011) reported that staff found linking theoretical concepts to the histories and backgrounds of clients enabled them to gain a deeper understanding of clients as individuals rather than just the challenging behaviours they were displaying. Wainwright and Bergin (2010) reported that formulation meetings helped some staff to make sense of clients, allowing them to take a deeper look at their histories. However, other staff continued to see clients as a series of diagnoses.

Confidence and competence. Six studies reported discrepant findings on staff confidence and competence as a result of psychological consultation. Of the studies which reported positive findings, Berry et al. (2009) found statistically significant post-

consultation improvements in staff confidence in their work with clients and Prior et al. (2003) reported a slight increase in perceived competence. Douglas and Benson (2015) reported staff felt consultation helped them to develop further skills in dealing with difficult situations. Evans et al. (2011) reported the consultant supported staff in their decision-making and monitored their progress, which helped staff feel validated and increased their confidence about themselves and their practice.

Of the studies which reported negative findings, Whitton et al. (2016) found no significant difference in post-consultation staff confidence. Dimaro et al. (2014) found very few staff reported improvements in post-consultation confidence in their skills and ability to manage difficult situations, or make changes to their practice by using different skills/interventions/alternative ways of communicating. Evans et al.'s (2011) found consultation allowed some staff to reflect negatively on confidence in their knowledge and skills. Participants reported feelings were due to a general lack of confidence rather than the consultation.

Satisfaction and wellbeing. Four studies reported discrepant findings in relation to staff satisfaction and wellbeing in their work. Berry et al. (2015) did not find any statistically significant reductions in staff stress. However, Summers (2006) reported improved staff satisfaction as a result of consultation (e.g. '…helps when the patient is demanding. It took away the sting…'). Murphy et al. (2013) captured various aspects of clinical work that can impact on staff work satisfaction and wellbeing such as feelings of frustration, burnout, and fear as a consequence of the job. Post consultation, staff reported improved job satisfaction. Active involvement in consultation contributed towards staff feelings of value and power, particularly for unqualified staff, often allowing staff to speak up in professional's meetings chaired by higher ranking staff. Prior et al. (2003) reported their participants were satisfied with the consultation

process.

Feelings towards the client. Two studies reported how psychological consultation affected staff feelings towards clients (particularly improved empathy), which generated expansive findings. Whitton et al. (2016) reported improvements in staff empathy towards clients' problems but no significant improvements in staff negative attitudes and feelings towards clients. Wainwright and Bergin (2010) reported empathy and tolerance towards clients was enhanced by staff understanding the client's problems, feeling they could move forward with the client's care, feeling able to help the client, and the client's story evoking some emotion in staff. Not being able to understand a client's presentation, behaviour that presented as challenging, not feeling able to help the client, and staff experiencing similar difficulties in their own life as the client, inhibited staff empathy and tolerance towards the client.

Consultant factors.

Importance of visibility and accessibility. Four qualitative studies reported complementary findings with regards to how accessibility of the consultant impacted on the success of the psychological consultation. Murphy et al. (2013) reported that pre-consultation, the consultant was viewed as a busy professional, who was difficult to access, and was a separate entity to the team. Staff were also not sure how psychological approaches could help them in their practice. However, once the consultant became more visible, participants were keen to think about how they might use psychological approaches in their practice, preferring more psychological consultation than they were receiving.

Douglas and Benson (2015) reported consultation was an efficient means of accessing psychological input, and found the ready availability of the consultant extremely helpful. The main benefits to clients were that they could receive earlier

psychological interventions and ensure the treatment addressed the problems faced, so clients could get better and be discharged more efficiently. Evans et al. (2011) reported that accessibility and availability of the consultant generated a sense of safety for staff. Staff felt frustrated when the consultant was not available, particularly when they were working to timeframes and needed the consultant's views to inform decisions. Mattan and Isherwood (2009) reported that how available, flexible and accommodating the consultant presented themselves, was important. The emotional availability of the consultant to tune into what consultees had to say was also important.

Prevents unnecessary interventions. Two studies reported expansive findings on how discussing cases in consultation sessions, prevented unnecessary interventions. Prior et al. (2003) demonstrated that none of their cases were escalated to social services or child protection for the duration of the study. There was also a reduction in referrals into their psychology-led consultancy service since the consultations began, with referrals for complex cases only. Douglas and Benson (2015) reported using consultation prevented unnecessary investigations, treatments, or access to other services (e.g. accident and emergency), ensuring a more cost-effective treatment in the long-term.

Discussion

This mixed methods review considered various aspects of psychological consultation at levels 1b and 2 of the Carradice and Bennett (2012) framework. Specifically, the review aimed to identify what models inform psychological consultancy, define the modes of delivery, assess the methodological quality of the literature, and consider outcomes for clients, staff, and psychological consultants.

Summary of Findings

Models of psychological consultation. A variety of psychological consultation models were identified, including cognitive behavioural, cognitive analytic, consultee-driven, graded sequence of stages, psychoanalytic, and undefined models. The number of studies under each model was small (range 1-5 studies), highlighting a limited evidence base. Cognitive behavioural consultation research was the most frequently conducted, followed by undefined models. Both the CBT and unspecified model studies were mainly of strong quality research. It is unsurprising there are more CBT-based consultation studies than any other model. CBT is one of the most extensively researched models of psychotherapy (Butler, Chapman, Forman, & Beck, 2006). CBT easily lends itself to consultation processes because it has gained considerable momentum for many disciplines in mental health care (Currid, Nikcevic, & Spada, 2011), so consultants can build on existing knowledge. It is worrying that some consultation approaches appear to be delivered in an a-theoretical manner. Four studies either did not use a model or failed to report what model was used. Theoretically informed consultation should be the norm (Onyett, 2007).

Modes of delivery. The results indicate that psychological consultants mostly used formulations in MDT-based team meetings to deliver consultation. Sharing psychological formulations with other disciplines is a common practice for psychological therapists (Division of Clinical Psychology, 2011; Skinner & Toogood, 2010). Psychological formulations can be widely shared during team meetings, reflective practice forums and ward rounds (Onyett, 2007) to a beneficial effect (e.g. Rowe & Nevin, 2013).

Methodological rigour of the studies. Methodological rigour is important to increase the quality of consultation research because it minimises the biases inherent in

primary studies (Yang, Chang, & Chung, 2013). Findings from the present review, reported that nearly 70% of the included studies were of strong or good quality. Only three studies were of adequate or limited quality. Despite limitations to the quality assessment tool used (see below), these are positive findings for practitioners and policy makers who may wish to use these findings to influence their consultation practices.

Outcomes of psychological consultation. Studies measured many differing outcomes and used multiple methods. Here, themes which were generated by four or more studies are discussed further.

Psychological consultation improved staff understanding about clients. These finding are consistent with previous research which suggest that understanding clients is important to the practice role of caregiving (Finch, 2004). It can positively impact on how staff sensitively attend to client issues and improve interpersonal outcomes (Finch, 2004).

There was no consensus that psychological consultation made an impact on staff confidence and competence. Increasing staff confidence in managing complex clients can ensure the safety of both clients and staff (Martin & Daffern, 2006). When staff feel more confident in managing complex clients, they are more likely to respond in line with therapeutic considerations, rather than out of fear or anger (Thackrey, 1987). Furthermore, there was no consensus about whether psychological consultation made an impact on staff satisfaction and wellbeing in their work. Work related stress is associated with job satisfaction and can result in burnout if not managed effectively (Kalliath & Morris, 2002).

Studies agreed on the importance of visibility and accessibility of the consultant. These findings support the integration of psychological consultants into clinical teams (Onyett, 2007).

Strengths and Limitations of the Review

A major strength of the present review was that by triangulating findings from mixed methodological design studies, enabled the data to be compared and contrasted. This triangulation process minimised the risk of exaggerating the impact of psychological consultation, and provides more valid and reliable evaluation of the primary studies (Golafshani, 2003). Other strengths included the use of clearly focused a priori research aims and the use of a second rater to validate a sample of the quality ratings and the convergence codes.

Limitations exist to the Qualsyst scoring tool (Kmet et al., 2004), which does not assess the psychometric properties of outcome measures. Therefore, the quality and validity of the outcome measures used by studies included in this review were not assessed. However, despite this, nearly 70% of the included studies' quality scores ranged from good to strong, suggesting research practices were generally good. Future research may wish to use an additional quality tool that specifically evaluates outcome measures.

The review was limited to English language and published studies, which may have prevented relevant studies from being included. The included studies used small sample sizes, and reported very little theoretical clarity on the models of consultation used, limiting their internal validity. None of the studies published a protocol that they used to implement psychological consultation. This meant that adherence to, or competence in, the consultation model stated could not be assessed, further limiting their internal validity. Similarly, there are no known studies of process-outcome during consultation and future research needs to access and study the conversations that take place during consultation.

Clinical Implications

From a staff perspective, understanding clients is a critical component of any helping relationship (Shattell, McAllister, Hogan, & Thomas, 2006). From a client perspective, feeling understood helps to facilitate moving towards recovery (e.g. Stallard, Velleman, & Baldwin, 2001). Therefore, it is important that psychological consultants continue to encourage staff understanding of clients to influence recovery. This review has highlighted that sharing psychological understanding about clients is most often done by developing formulations with staff, which is advocated by the Division of Clinical Psychology (2011). More research is needed into how staff go about implementing the lessons learnt from consultation and how helping conversations change on the basis of increased awareness.

Compared to other disciplines in the MDT, psychological therapists are underrepresented, and therefore often considered a limited resource (Roe, Yanos, & Lysaker, 2006). Therefore, it is important for psychological therapists to better integrate into MDT's and offer indirect access to psychologically-informed care (Onyett, 2007). However, concerns exist about what type of training psychological therapists receive to become consultants (Meyer, Fink, & Carey, 1988), so consideration will need to be given to the competence and training of consultants. At present, psychological consultation is not part of core training during any clinical training. If clinical training courses (regardless of orientation) were to integrate formal psychological consultation training, they would also need to consider what consultation supervision competencies might entail.

Future Research

The findings highlight a paucity of research into psychological consultation at levels 1b and 2 of the Carradice and Bennett (2012) model. CBT-based consultation

remains the dominant model researched, but other models show promise and there appears to be absence of evidence rather than evidence of absence. Future research should seek to go beyond CBT in various health and social care contexts to generate options for clinical staff. However, if consultation fares anything like traditional one-to-one therapy, then the findings would be equivocal (Luborsky et al., 2002; Messer & Wampold, 2002). It is likely a dodo bird verdict is possible should the outcomes from psychological consultation processes be compared.

Four studies did not specify a model of psychological consultation, which prevents a more detailed examination of its effectiveness to take place. It would be helpful to build on this review by asking which model of consultation offers the best research evidence, in what circumstance. Similarly, future research should routinely report how much consultation was delivered and how frequent the meetings were. This would entail testing the potential dodo bird verdict by conducting head-to-head trials of differing consultation approaches, which have an adequate follow-up period, use bespoke outcome measures, and include measures of adherence to the model and consultant competence in delivering the model. Policy-makers and practitioners are encouraged to keep up to date with future reviews to inform their practice.

Conclusions

This mixed-method literature review hoped to inform practitioners and policy makers about the evidence for use of psychological consultation practices. Cognitive behavioural approaches were most often researched. Consultation was most often delivered via formulation meetings with the MDT. The quality of the studies varied from limited to strong. Psychological consultation can improve staff understanding about clients, which can positively impact on client care. Psychological therapists should remain visible and accessible to teams in order to offer indirect access to

psychologically-informed care. In summary, consultation offers the opportunity for the efficient use of scarce psychological resources and appears to benefit clients and staff in different ways. More work needs to be completed to specify theoretically distinct methods of action. This was the first review of its kind and can be built on as further controlled and high-quality research in this area is undertaken.

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Appendix A. QualSyst Quantitative Scoring Sheet

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Appendix A. (cont.)

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Appendix A. (cont.)

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Appendix B. QualSyst Qualitative Scoring Sheet

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Appendix B. (cont.)

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Appendix C. QualSyst Scoring Sheet

Author/s (date)	Quantitative														/28	Qualitative										/20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14		1	2	3	4	5	6	7	8	9	10	
Berry et al. (2009)	2	1	2	2	NA	NA	NA	2	2	2	2	2	2	2	27											
Berry et al. (2015)	2	2	2	2	1	2	NA	2	2	2	2	2	2	2	27											
Clark & Chuan (2016)*	2	2	1	2	NA	NA	NA	2	2	2	2	0	2	2	25											
2nd rater scores	2	2	1	2	NA	NA	NA	2	1	2	2	0	2	2	25											
Craven-Staines et al. (2010)																2	2	2	2	1	2	1	2	2	1	17
Dimaro et al. (2014)	2	2	1	NA	NA	NA	NA	1	1	2	0	0	2	2	21	2	2	2	2	1	2	2	0	2	0	15
Douglas & Benson (2015)																2	2	2	2	2	2	2	2	2	2	20
Evans et al. (2011)																2	2	2	2	1	2	2	0	2	0	15
Ingham (2011)	2	2	2	2	NA	NA	NA	2	2	1	NA	NA	2	2	27											
Kellett et al. (2014) *	2	2	2	2	2	NA	NA	2	1	2	2	2	2	2	27	2	2	2	2	2	2	2	0	2	0	16
2nd rater scores	2	2	2	2	2	NA	NA	2	1	2	2	1	2	2	25	2	2	2	2	2	2	2	0	2	0	16
Mattan & Isherwood (2009)																2	2	2	2	1	2	2	0	2	0	15
Murphy et al. (2013)																2	2	2	2	1	2	2	0	2	0	15
Prior et al. (2003)	2	2	1	0	NA	NA	NA	0	0	0	NA	NA	0	1	16	2	2	2	0	1	1	1	0	1	0	10
Summers (2006)*																2	2	2	1	2	2	2	0	2	1	16
2nd rater scores																2	2	2	1	2	2	2	0	2	2	15
Wainwright & Bergin (2010)																2	2	2	2	1	2	2	0	2	0	15
Whitton et al. (2016)	2	2	1	1	NA	NA	NA	1	2	2	2	NA	2	2	25	2	2	2	2	1	1	1	0	2	0	13

Note. Total sum calculated with following codes: 2=Yes; 1=Partial; 0=No; NA=not applicable/2 points. Total possible score for quantitative studies = 28; total possible score for qualitative studies = 20. To calculate final summary score: divide the total sum by the total possible sum. *=second rated studies

Part Two: Research Report

Cognitive Analytic Consultancy: A small *N* case series

Abstract

Objectives. Cognitive analytic consultancy (CAC) provides a useful way for psychological consultants to support complex clients and associated staff where traditional one-to-one therapy is not appropriate. This study aimed to index the effectiveness of CAC in a community mental health team and explore the possible mechanisms of change from staff and client perspectives.

Method. A small *N* case series (*N*=5) using an A-B design with six-week follow-up. A mixed methodology provided both quantitative and qualitative data. Outcome measures were collected across eight time points (measuring client distress and fragmentation; staff competence and burnout; and alliance between staff and clients). Change interview data collected after follow-up provided qualitative data regarding potential mechanisms of change. Outcomes were triangulated to assess convergence.

Results. Participants attended 100% of CAC sessions. All clients were above the clinical cut-offs for distress and fragmentation at screening and baselines were relatively stable. There were significant improvements in client fragmentation, staff competence and emotional exhaustion, and alliance from a client perspective. Potential mechanism of change included the therapists approach, using the sequential diagrammatic reformulation, and acknowledging that difficult processes helped recovery.

Conclusions. CAC appears effective in working with complex clients who might not be suitable for one-to-one therapy. Further clinical trials comparing CAC with other consultation approaches are now indicated.

Practitioner Points

- CAC can benefit clients that are struggling to make use of extant support from community teams
- CAC can benefit staff to manage emotional exhaustion that can result from working with complex clients
- The sequential diagrammatic reformulation, therapist approach, and acknowledging that CAC processes can be difficult at times does aid engagement.

Cautions

- Longer follow-up and service level measures of treatment success (e.g. frequency of crisis contacts) would be useful for future studies.
- Larger scale trials into CAC are warranted to establish its credibility in the psychological consultation literature.

Introduction

Community mental health team's (CMHT's) often provide care to clients who present with challenging and difficult to manage behaviours (Kerr, Dent-Brown & Parry, 2007; Onyett, Pillinger & Muijen, 1995) such as repeated self-harm, crises, and rejecting the help on offer (Dunn & Parry, 1997). When teams struggle to effectively manage such clients, this can lead to splits within teams and cycles of blame and anxiety-driven practice (Foster & Roberts, 1999). Professionals can be left feeling stressed, burnt-out with reduced morale (Ryle & Kerr, 2002), and with associated risks of high sickness, vacancy and turn-over rates (Evans et al., 2006). The resulting poor therapeutic alliances with clients can result in a 'double impact' as clients' have mental health problems plus the difficult interpersonal dynamics with the team to contend with (Howgego, Yellowlees, Owen, Meldrum & Dark, 2003). These difficulties in therapeutic alliances are not always acknowledged or addressed (Charman, 2004), so perpetuating the cycle. The community is a more open and chaotic environment than in-patient settings, leaving both clients and staff feeling uncontained (Foster & Roberts, 1999). Therefore, interventions that help staff and clients to break dysfunctional cycles are important and worthy of investigation.

Cognitive analytic consultancy (CAC; Carradice, 2013; Kerr, 1999) provides one such intervention. It is based on the principles of cognitive analytic therapy (CAT; Ryle & Kerr, 2002) and supports staff and clients to develop a deeper understanding of the processes playing out in their dysfunctional care relationships. CAC is particularly used for complex clients who are not suitable for, or might not benefit from, individual therapy (Carradice, 2013). CAC usefully locates the difficulties experienced as in the system, rather than in the client (Ryle & Kerr, 2002). CAC involves offering five consultancy sessions to the care dyad (the client and care professional; Carradice,

2013). The process involves creating a 'contextual' map (or sequential diagrammatic reformulation; SDR) of the key problematic relational patterns via reciprocal roles (RR) and reciprocal role procedures (RRP) for the client and team. CAC focusses on the 'here and now' roles and patterns that are often enacted in the therapeutic relationship between care coordinator and client (Mitzman, 2010). Alternative strategies for relating (i.e. exits) are then considered by both parties and added to the SDR. CAC is experienced as non-blaming and validating for the client and supportive and containing for the Care Coordinator (Parry, n.d.).

Despite a growing interest in CAT in the UK (Ryle, Kellett, Hepple, & Calvert, 2014), there is a paucity of research that considers the effectiveness of CAC in clinical practice (Calvert & Kellett, 2014). Much of what exists is restricted to providing CAC indirectly to teams (Dunn & Parry, 1997; Kerr, 1999) and focuses on the educative element to support teams in providing more informed care (Carradice, 2004; De Normanville & Kerr, 2003; Thompson et al., 2008). However, CAC is largely viewed as favourable by staff (Barnes, Bridges, & Freshwater, 2012; Styring, 2010). A small pilot clinical trial (Kellett, Wilbram, Davis, & Hardy, 2014), found that offering indirect CAC (involving a teaching component, team consultation, team-based supervision and follow-up) had no benefit on client outcomes, but did impact on organisational outcomes (i.e. team relationships and practices). Therefore, despite CAC being used in clinical practice, clinicians cannot be confident that the approach is effective or useful from a staff and client perspective.

Rationale for the Present Study

The present study evaluates CAC delivered using the Carradice (2013) framework from a staff and client perspective. Salkovskis (1995) describes a process of clinical development in the 'hour glass' model, which acknowledges that research into

relatively new areas should begin with small-scale research, often in the form of case studies. This level of research often has less stringent methodological criteria, is exploratory in nature and acknowledges the constraints on time and resources. These findings can then contribute towards research with more stringent methodological criteria via randomised controlled trials and finally resulting in large-scale service evaluations and clinical audits. The present study is located at the first level of the 'hour glass' model (Salkovskis, 1995).

Primary Aim

The present study had an overarching aim of measuring the effectiveness of CAC for clients with complex mental health difficulties and staff based in a community setting. This was operationalised through three study hypotheses:

1. CAC will reduce client distress and sense of fragmentation.
2. CAC will enable staff to feel more competent and less burnt out.
3. CAC will improve the alliance between clients and staff.

Secondary Aim

To explore possible mechanisms of change during CAC from client and staff perspectives.

Method

This study received Scientific Approval and Indemnity from the University of Sheffield Clinical Psychology Unit Research Sub-committee on 28th May 2015 (Appendix D). NHS ethical approval was received on 27th August 2015 (Research Ethics Committee reference: 15/YH/0336; Appendix E).

Design

A prospective small *N* mixed methods design (Davis, 2005) was used to evaluate the effectiveness of CAC. Case series are often employed to describe outcomes

of novel or evolving treatments through session-by-session analysis (Barlow & Herson, 1984). By introducing a replicable experimental procedure to a small number of participants, comparisons can be made within each case, between the cases and across the treatment effects for the entire sample. The information gained can be used to refine new techniques before they are studied in more advanced clinical trials (Kooistra, Dijkman, Einhorn & Bhandari, 2009). Small *N* design sample sizes are less than 30 and frequently less than 10 (Barnett et al., 2012).

The current case series used an A-B with follow-up design (Kazdin, 1973) in which clinical outcomes were collected over three phases: baseline, intervention and follow-up (Figure 2). Baseline data were collected over three time points (time point 1 to time point 3): the initial screening session (SS), a mid-week phone call (TC) and prior to session one (S1). This baseline phase tested for evidence of the stability of the symptoms for staff and clients, prior to CAC introduction. The treatment phase (CAC) comprised of four further time points (S2-S5). A follow-up session (FU) was conducted six weeks after CAC to evaluate durability of treatment effects over time.

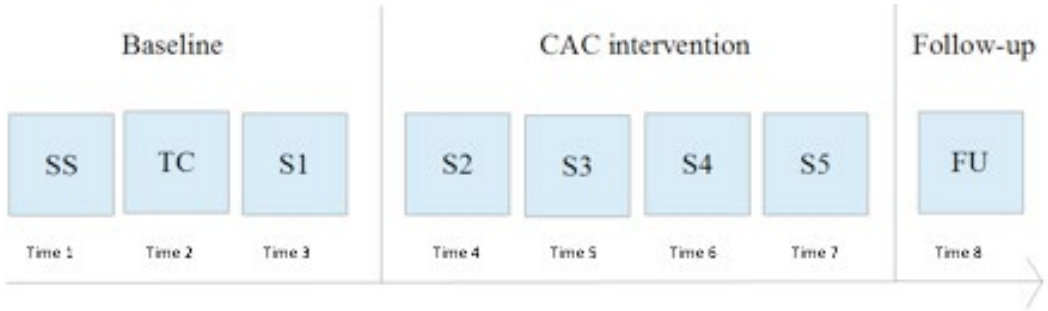


Figure 2. Data collection points throughout each phases of CAC

The qualitative interviews involved the researcher interviewing both clients and staff individually, two weeks after the follow-up session. The individual interview is an in-depth method of data collection and is a valuable method of gaining insight into people's perceptions, understandings and experiences of a given phenomenon (Ryan, Coughlan, & Cronin, 2009). Furthermore, semi-structured interviews enable the researcher to retain flexibility whilst allowing the participant to talk at length about their experience (Smith, Flowers & Larkin, 2009).

The mixed methodology was used to allow both a measure of effectiveness and exploration of the usefulness of CAC. Mixed methods complement each other by gaining different types of knowledge about what is being studied, addressing the weaknesses associated with each approach and by strengthening the findings and conclusions through triangulation (Yeasmin & Rahman, 2012). Pragmatism, a single paradigm stance, was taken (Creswell, 2014; Tashakkori & Teddlie, 2010), as it is often associated with small *N* research and mixed method studies (e.g. Harding, 2012). Greene and Hall (2010) suggest that pragmatism results in a solution focussed, action-oriented inquiry process, which is committed to democratic values and progress.

Procedure

Service details. The study was conducted in a NHS based Community Therapies Team in the North of England. This team provides care to individuals meeting criteria from clusters 4 (non-psychotic-severe) and 7 (enduring non-psychotic disorders-high disability; Department of Health, 2014). A clinical psychologist in the team delivered CAC under fortnightly supervision from a CAT psychotherapist and supervisor.

Recruitment Procedure. The CAC practitioner (who is also an integrated member of the team) initially informed team members about the study. A letter

describing the purpose of the study (see Appendix F) was given to all Care Coordinators. If staff agreed to take part in the study they were asked to sign a Consent Form (see Appendix G). Care Coordinators identified clients who met the inclusion criteria and gave them a letter describing the purpose of the study (see Appendix H for the Client Participant Information Sheet). If a client agreed to participate, they were asked to inform their Care Coordinator to organise a meeting between them both and the CAC practitioner for a screening session. If at this stage, the client continued to agree to take part in the study, they were asked to sign the Consent Form (see Appendix I), and their details were anonymised. Demographic Information Sheets were used to collect information about the client (see Appendix J) and Care Coordinator (see Appendix K) upon enrolment to the study.

Selection criteria. Staff were recruited based on the following inclusion criteria: (1) were currently working for the Community Therapies Team; (2) they found their work with a specific client difficult and knew them well; and (3) were able to provide fully informed consent. Staff were excluded if they did not work closely with the client. Clients were recruited based on the following inclusion criteria: (1) currently accessing the Community Therapies Team; (2) they were considered not suitable for therapy by their clinical team; (3) the team were experiencing difficulties working with the client; and (4) the client was able to provide fully informed voluntary consent. Clients were excluded if they: (1) could not speak, read or write English and could not provide fully informed consent; (2) were under any legal restrictions under the Mental Health Act (2007); (3) were under 18 years old; and (4) were currently floridly psychotic or manic (secondary diagnosis). The selection criteria were intentionally broad to capture typical community team populations in order to enhance external validity (Reiss & Judd, 2014).

Sample

Seven potential care dyads (client and their Care Coordinator) met eligibility criteria. One client was later discussed between the CAC practitioner and Care Coordinator and deemed inappropriate to progress to enrolment because they had other more pressing issues to address first. Another client was enrolled but was placed on hold after the screening session due to physical health concerns, and never subsequently returned. One staff member enrolled two clients onto the study. This resulted in five care dyads completing the study and can be seen in Figure 3.

Demographic data. Client and staff demographic data, collected at screening, are summarised in Table 4.

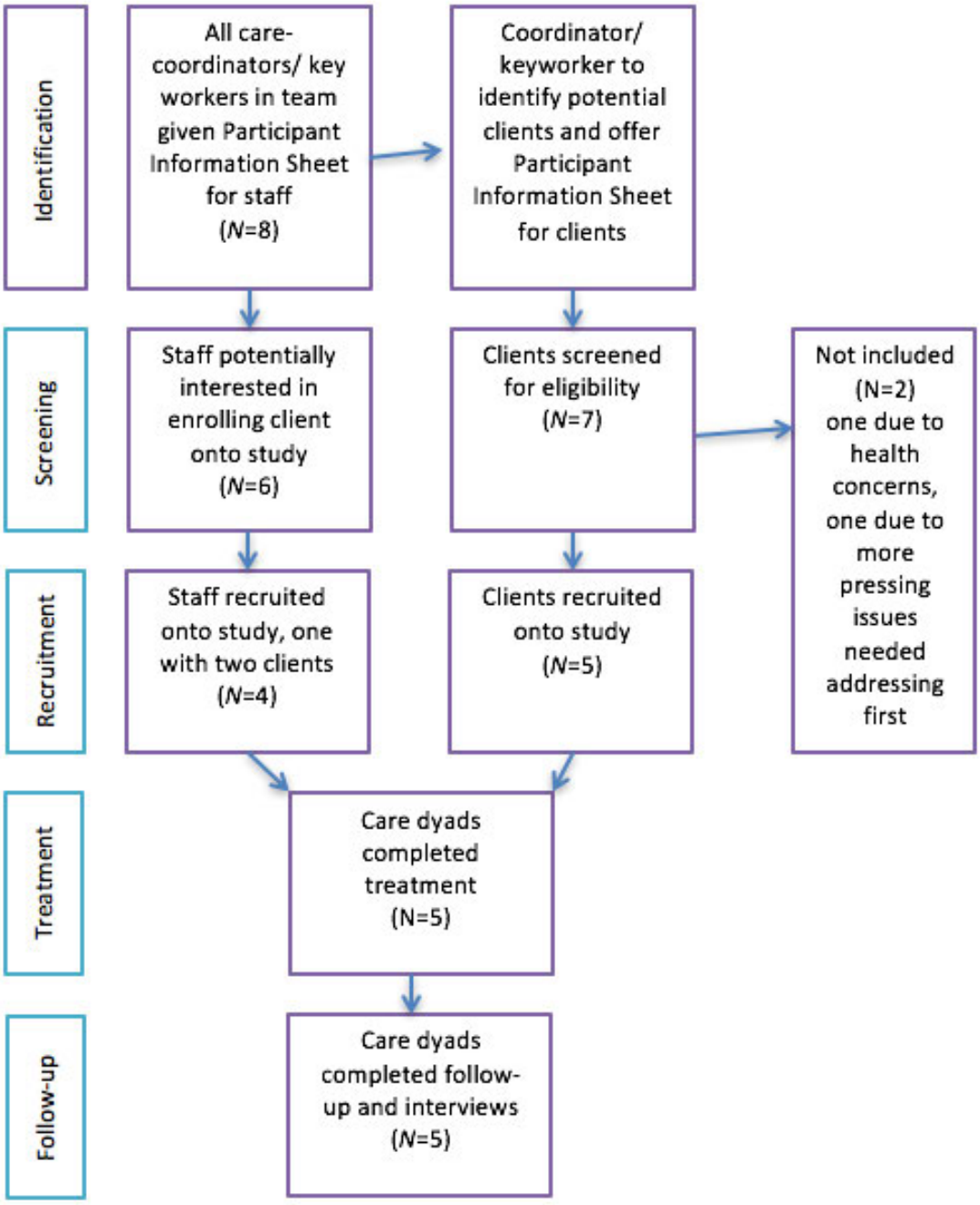


Figure 3. PRISMA diagram of the flow of participants

Table 4

Baseline (Screening) Demographic Characteristics of Clients and Staff

Care dyad	Client demographics								Staff demographics					
	Gender	Age	Marital status	Yrs. of education	Ethnicity	Meds (Yes/ No)	Diagnosis	Yrs. of diagnosis	Gender	Prof. backg round	Yrs. exp. in prof.	Yrs. as CC	Yrs. worked in team	Yrs. worked with client
1*	F	60	Married/ civil	16	WB	Yes	EUPD	1	F	OT	6	4	4	0.5
2	F	55	Divorced/ Sep.	13	WB	No	A, D, PC	7	F	OT	8.5	6	0.33	0.08
3	F	61	Married/ civil	13	WB	Yes	A, D	17	F	SW	10	10	5	2
4*	M	62	Widowed	11	WB	Yes	D	7	F	OT	6	4	4	0.08
5	M	47	Divorced/ Sep.	16	WB	Yes	A, D, AD	20	F	SW	0.5	0.5	0.5	0.16
Mean (SD)		57 (6.2)		13.8 (2.2)				10.4 (7.9)			6.2 (3.6)	4.9 (3.5)	2.8 (2.2)	0.6 (0.8)

Note. Education years calculation: attended school (even if no qualifications obtained) =11, completed college=13, completed university=16. Ethnicity: WB=White British. Diagnosis: D=Depression/Recurrent Depressive Disorder/Low Mood, A=Anxiety/Generalised Anxiety Disorder, AD=Adjustment Disorder, EUPD=Emotionally Unstable Personality Disorder, PC=Poor Coping, P=Psychotic features, OCD=Obsessive Compulsive Disorder (all reported by CC's). *The staff member in this dyad represented two clients. Professional Background: OT=Occupational Therapist, SW=Social Worker. CC=Care Coordinator.

Intervention

The intervention was the CAC five-session protocol (Carradice, 2013), which involved a three-way meeting (typically lasting an hour) between the care dyad and the CAC practitioner. The CAC practitioner also met with the Care Coordinator for up to half an hour before and after each three-way meeting, as per the protocol.

Carradice (2013) suggests using a screening session to discuss the structure of sessions and client goals, expectations; issues related to endings and process issues; and seeking informed consent. The five subsequent sessions covered; (1) using a 24-hour clock to learn about the client's typical day, with the aim of understanding the client's current coping style and giving and explaining the purpose of the psychotherapy file to the client, (2) using the psychotherapy file to aid self-reflection and build a picture of the client's patterns and triggers; considered the client's goals for care; and learn what the client's motivation to change were, (3) finish the psychotherapy file and define any risks, (4) the CAC practitioner explained the concept of RR's, identified the client's RR's and drew up a draft SDR, and (5) feedback about the map was sought; goals were clarified with plans for change and exits identified.

Treatment adherence. To ensure treatment fidelity, adherence was self-assessed against the session by session plan set out by Carradice (2013; see Appendix L) by the CAC practitioner and discussed in fortnightly supervision with a CAT psychotherapist and supervisor.

Outcome Measures

Nomothetic outcome measures were completed at each time point (8 data collection points in total spanning baseline (T1- T3), intervention (T4-T7) and follow-up (T8) for clients and staff, respectively.

Nomothetic outcome measures – Client

Primary outcome measure: Personality Structure Questionnaire (PSQ; Pollock, Broadbent, Clarke, Dorrian & Ryle, 2001). The PSQ (Appendix M) is a reliable and valid 8-item measure of identity disturbance and state shifting. The PSQ is the CAT outcome measure of choice (Pollock, et al., 2001). The measure consists of eight bipolar items and scores range from 8-40. This is the total clinical score. Higher scores indicate worse clinical symptoms. An alpha coefficient of 0.87 in a Borderline Personality Disorder population was achieved, with test-retest reliability indicating that the PSQ is stable across time (Pollock, et al., 2001). The PSQ has been subject to satisfactory cross-cultural validation and has a cut-off for Borderline Personality Disorder clients of 27 (Berrios, Kellett, Fiorani, & Poggiolo, 2016).

Clinical Outcomes in Routine Evaluation 10 (CORE-10; Barkham et al., 2013). The CORE-10 (Appendix N) is a 10-item version of the CORE Outcome Measure (CORE-OM). It consists of a 5-point Likert scale ranging from 0 (not at all) to 4 (most or all of the time), which gives a score between 0-40. This is the total clinical score. A score of 10 or below denotes a score within the non-clinical range. Above 11 is the lower boundary of the 'mild' clinical level, over 15 for the 'moderate' level, 20 for the 'moderate-to-severe' level and 25 or over marks the 'severe' level. CORE-10 is considered a satisfactory generic sessional assessment (Andrews, Twigg, Minami & Johnson, 2011). CORE-10 demonstrates very good internal consistency, is sensitive to change and also has good acceptability rates in terms of completion (Connell & Barkham, 2007).

Working Alliance Inventory - short (client) (WAI-Sc, Tracey & Kokotovik, 1989). The WAI-Sc (Appendix O) has 12 items where a higher score indicates a stronger perceived working alliance. It has three subscales: Goals, Tasks, and Bond.

Each subscale is scored on a 7-point Likert-type scale ranging from 1 (*never*) to 7 (*always*) and has four non-overlapping items. Total scores range between 12-84. Reliability estimates of the WAI scale scores appear to be robust (Hanson, Curry & Bandalos, 2002). Tracey and Kokotovic (1989) report an alpha coefficient for the WAI-Sc of .98. Discriminant validity has been found through its use in a large number of different populations across diverse levels of alliance (Raue, Castonguay & Goldfreid, 1993; Samstag, Batchelder, Muran, Safran, & Winston, 1998).

Nomothetic outcome measures - Staff

Working Alliance Inventory - short (therapist) (WAI-St; Tracey & Kokotovik, 1989). As with the client measure of alliance, the WAI-St (Appendix P) was used to assess the client in CAC. Tracey and Kokotovic (1989) report an alpha coefficient for the WAI-St of .95.

Abbreviated Maslach Burnout Inventory (MBI; Maslach, Jackson & Leiter, 1996). The MBI (see Appendix Q; only three sample items are able to be shared from the instrument due to copyright restrictions) is a 22-item measure of staff burnout. The MBI is designed to measure three aspects of burnout: emotional exhaustion (EE), depersonalisation (DP) and personal accomplishment (PA). Staff were asked to rate how burnt-out they felt specifically in relation to the client brought to CAC. For EE, scores under 16 indicate low EE, 17-26 suggests moderate EE and scores over 27 suggest high EE. For DP, scores under 6 are low DP, 7-12 moderate DP, and over 13 high DP. For PA, scores between 0-31 indicate low PA, 32-38 moderate PA, and scores over 39 indicate high PA. The subscales have good psychometric properties (Maslach & Jackson, 1981). The internal consistency of the MBI subscales is good (EE = 0.88, PA = 0.83) or acceptable (DP = 0.70; Pisanti, Lombardo, Lucidi, Violani, & Lazzari, 2012)

Perceived Competence Scale (PCS: Deci & Ryan, 1985). The PCS (Appendix R) uses four differently worded items (depending on the target behaviour) that reflect practitioners' sense of competence at carrying out a specific task or treatment. Questions were focal to staff competence regarding working with the CAC client. The four items are (a) confidence, (b) capability, (c) ability to achieve goals related to working with the client, and (d) how well the worker met the challenge. Participants are asked to respond to each statement using a 7-point response scale that ranges from 1 = not at all true to 7 = very true. A PCS total scale score is obtained by calculating the mean of the four items. The PCS has been used in previous studies (e.g. Williams, Freedman & Deci, 1998; Williams and Deci, 1996), with alphas all above 0.80.

Idiographic client measures.

Idiographic measures (Appendix S) were completed weekly from session four of the intervention phase, because this was the stage at which recognition started in the CAC. This provided three data points. Idiographic measures focussed on four areas: How did you feel about yourself? How did other people get on with you this week? How did you get on with other people this week? How did you get on with your care team this week? Under each heading, key RR's were collaboratively generated between the client and the CAC therapist. The client rated each item on a scale of 1-10 (e.g. accepting myself=1 to very critical =10). Higher scores indicated worse outcomes.

Idiographic staff measures.

Staff idiographic measures (Appendix T) focussed on the Care Coordinators view about the client's ability to recognise and revise their target problem procedures (TPP) for the preceding week. The staff member was asked whether the client had been able to recognise the problem and pattern on a scale of 1-10 (e.g. totally unaware = 1 to very aware = 10). They were also asked to rate the client's ability to revise the problem

and pattern on a scale of one to 10 (e.g. stuck = 1 to changing = 10). Care Coordinators rated on multiple TPP's. Higher scores indicated improvement for both recognition and revision.

Qualitative procedure

Individual, face-to-face semi-structured interviews using the Change Interview Schedule (Elliot & Rogers, 2008) were conducted to explore client and staff experience of CAC after follow-up (Appendix U contains the Change Interview Schedule for clients and Appendix V for staff). The schedule asks about the degree and origin of any change processes occurring as a result of therapy, in this case CAC. Interviews were tape recorded and transcribed verbatim by a University of Sheffield approved transcriber.

Analyses

In order to address the primary aim of the research, quantitative outcomes were analysed at individual and groups levels, measuring the effectiveness of CAC for clients and staff. To address the secondary aim related to exploring mechanisms of change during CAC, qualitative data were analysed separately, followed by sequential mixed model analyses on the whole data set. This process of analyses is supported by Creswell and Plano Clark (2007) and allows one type of data to be transformed into another, so results can be merged (Driscoll, Appiah-Yeboah, Salib, & Rupert, 2007).

Quantitative analyses: Individual level. Baseline attendance was described, and demographics and screening outcomes presented graphically. Baseline stability was calculated by using the mean of the baseline data, calculating 50% above and below the mean to obtain a range, then checking all scores fall within that range. Visual inspection of the graphs allowed reporting of any potential impact of the intervention or durability over follow-up. Individual clinical effectiveness of CAC was assessed by whether

clients made reliable and/or clinically significant change on the main outcome measure (PSQ), by comparing screening (T1) with the end of CAC (T7) and follow-up (T8). Reliable and clinically significant change can be used to categorise 'recovery' in practice-based evidence (Barkham, Hardy, & Mellor-Clark, 2010). The number of participants that clinically and/or reliably deteriorated on all measures was also reported.

To calculate the Reliable Change Index (RCI) the formula described by Jacobson and Truax (1991) was used (RCI= 1.96xSD√2√1-r; where SD is the standard deviation of the non-clinical sample and r is the test-re-test reliability correlation). The calculation provides a figure that, exceeded, represents reliable change. Clinically significant change (CSC) is represented by a participant moving from the clinical range of the measure through a clinical cut-off point, and into the non-clinical range of the measure. Jacobson and Truax (1991) also provide a formula that can be used to calculate the clinical cut-off point:

$$\frac{(\text{mean}_{clin} \times \text{SD}_{norm}) + (\text{mean}_{norm} \times \text{SD}_{clin})}{\text{SD}_{norm} + \text{SD}_{clin}}$$

Both these methods require normative data to be available, which was not available for the WAI-S (client or staff versions, and the PCS). The RCI's and cut/off points are summarised in Table 5.

Idiographic diaries. Firstly, each of the idiographic data variables were plotted into graphs, by client or staff, to allow visual comparison between CAC session four, five and follow-up. Overall mean idiographic scores for each client and staff were also reported. Finally, a group graph was reported on mean idiographic scores for both clients and staff.

Table 5

Reliable Change Index and Clinical Cut Off Scores by Measure

	Direction of scoring	Reliable Change Index	Clinical cut off	Source data
PSQ	Lower score indicates improvement	4.17	≥27	Berrios, Kellett, Fiorani, & Poggioli (2015)*
CORE-10	Lower score indicates improvement	6	≥11	Connell & Barkham (2007)*
WAI-Sc	Higher score indicates improvement	-	-	NA
WAI-St	Higher score indicates improvement	-	-	NA
PCS	Higher score indicates improvement	-	-	NA
MBI: EE	Lower score indicates improvement	14.85	≥18	Maslach, Jackson, & Leiter (1996)
MBI: DP	Lower score indicates improvement	9.76	≥7	Maslach, Jackson, & Leiter (1996)
MBI: PA	Higher score indicates improvement	12.19	≤32	Maslach, Jackson, & Leiter (1996)

Note. NA= no normative data available; *= figures not calculated using formulas as provided by this reference.

Quantitative analysis: Group level. To establish baseline stability at a group level, t-tests were conducted between T1 and T3 for all outcome measures. Effectiveness of CAC at a group level was analysed using mean phase outcome scores compared between different phases of the study. Group outcomes were presented graphically to illustrate and plot progress and trends over the study phases. Effect size calculations with 95% confidence intervals were calculated. Effect sizes were calculated between T1 and T7, and T1 and T8. Results were contextualised using Cohen's (1992) power primer; d≥ .20 is a 'small' effect, d≥.50 is a 'medium' effect, and d≥ .80 is a 'large' effect. The significance of change of all outcome measures was considered

between baseline and CAC, baseline and follow-up, and CAC and follow-up using the Wilcoxon signed-rank test (Wilcoxon, 1945) for paired samples.

Qualitative analyses. Transcripts were initially analysed using thematic analysis. This involved reading and rereading each transcript, then individually coding, and clustering codes according to themes and checked against the original transcripts (as described by Braun & Clarke, 2006). This was done for all clients and then the data compared with the themes emerging from the associated Care Coordinator. This iterative and inductive process provided more nuanced information (Thomas, 2003). Themes were supported by reporting the number of times participants made reference to an area and by extracts from the transcript to aid transparency in the generation of theme development. A randomly selected sample of 20% of the data was checked by a co-rater (a trainee clinical psychologist also using thematic analysis) to increase reliability of the themes (one client and one staff transcript). Interrater agreement was reported using Cohen's kappa (McHugh, 2012). Percent agreement figures were reported instead of confidence intervals because of the small numbers of items being rated (McHugh, 2012). The Trainee also kept a reflective journal to ensure transparency in the analytic process (based on the description by Ortlipp, 2008).

QUAL-quant and QUANT-qual analyses. The term quantitizing describes the process of transforming coded qualitative data into quantitative data and qualitizing to describe converting quantitative data to qualitative data (Driscoll et al., 2007; Tashakkori & Teddlie 2010). For the present research, the quantitative subgroups of 'recovered' and 'not recovered' clients were qualitized (named QUAL-quant) by further thematic analysis of the differences between the subgroups. A 40% sample of the data was checked by a co-rater (a trainee clinical psychologist) to ensure reliability of the themes (one non-recovered client and one recovered client transcript). Interrater

agreement was reported using Cohen's kappa (McHugh, 2012). The qualitative data was quantitized by reporting changes from the qualitative interviews (Likert scale questions) and analysing these using quantitative methods (named QUANT-qual) such as frequency of ratings.

Mixed methods synthesis. Triangulation of the quantitative, qualitative, QUANT-qual and QUAL-quant data was conducted using the Farmer, Robinson, Elliot and Eyles (2006) protocol. First, findings from the different data sources were sorted according to the research question. Second, a convergence code was applied. Where findings were confirmatory, themes were coded whether they broadly agreed and added depth (i.e. "confirmatory: convergent and expansion") or findings broadly agreed and added breadth (i.e. "confirmatory: convergent and complementary"). Some findings were discrepant, in that they contradicted each other. Third, the convergence codes were second rated by a blind rater (a trainee clinical psychologist) to increase their reliability. Interrater agreement was reported using Cohen's kappa (McHugh, 2012). Finally, a unified and broader (than a single methodology would allow) summary is established under the research questions. A visual summary of how synthesis of the data has been achieved can be seen in Figure 4.

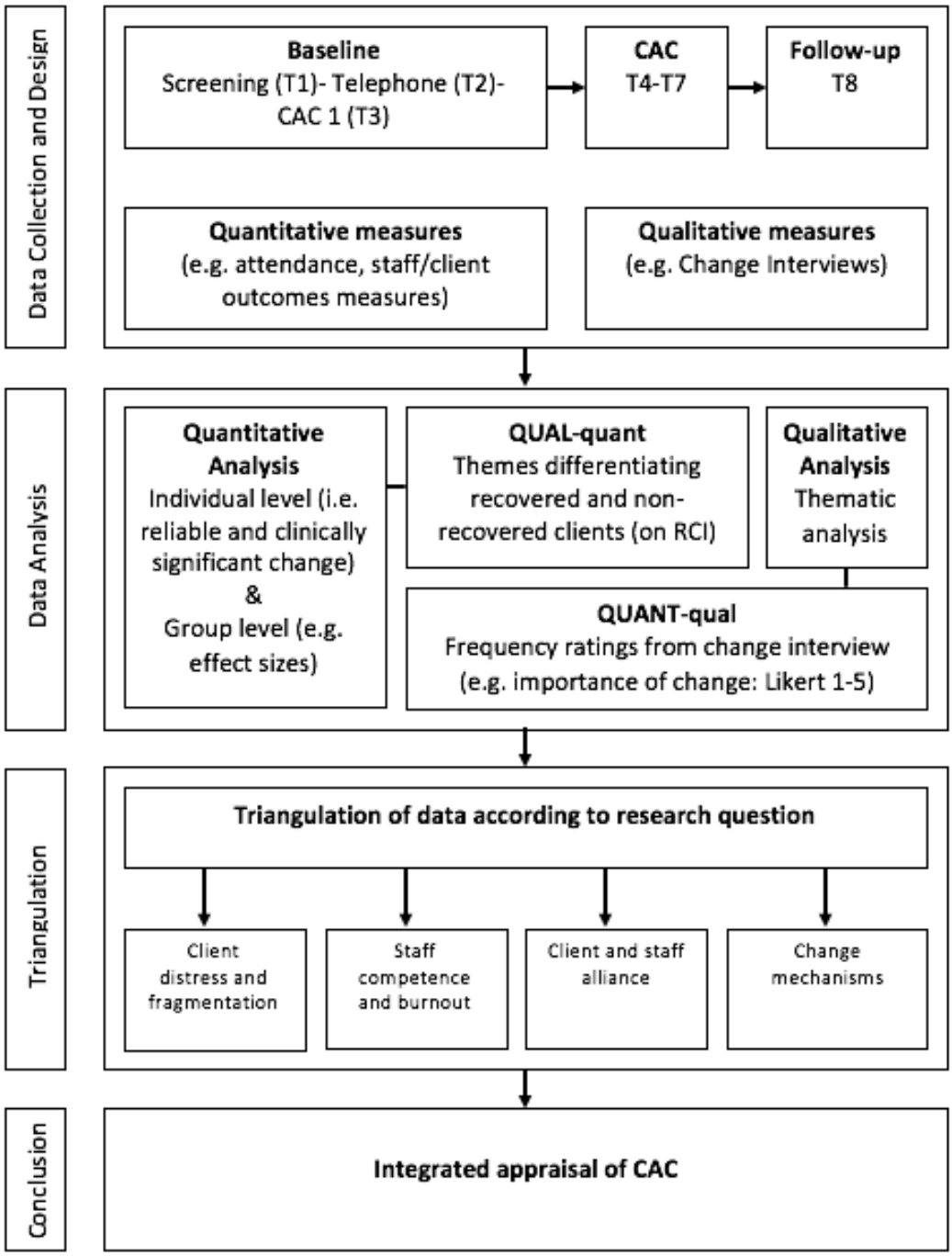


Figure 4. Visual summary of how the synthesis of the data was achieved

Ethical Considerations

Client and staff participants were informed that taking part in the research was voluntary and would not affect the service they received from the clinical psychology service in any way. Participants were advised that they could withdraw some or all of their data, without giving a reason, from the research at any point up to two weeks after the qualitative interview and that doing this would not affect their treatment. Confidentiality limits were explained, as were safe storage of data and the adverse incident procedure. The University of Sheffield and the local Trust monitored the research.

Results

Results are organised into five sections: quantitative (individual and group level), qualitative (client and staff experiences), QUANT-qual, QUAL-quant and the mixed methods synthesis.

Baseline Attendance and Outcome Measure Analysis

Five care dyads attended all sessions and so the attendance rate was 100%. Screening scores are summarised in Table 6. The screening CORE-10 mean score was 26.6 (SD=6.8), with all clients scoring above the clinical cut off and ranging from moderate to severe. The PSQ mean score was 34.6 (SD=3.9), with all clients scoring above the clinical cut off meeting the criteria for Borderline Personality Disorder. The WAI-Sc scores ranged from 64-81 (out of a possible 12-84) with a mean score of 71 (SD=6.3), which indicated reasonable to good alliance at screening.

The screening WAI-St scores ranged between 27-64 (M=51.2; SD=14.3) and the PCS scores ranged between 8-18 (out of 28; M=13.4; SD=3.9) suggesting low to moderate competence in working with that client. The MBI-EE scores ranged between 8-31 (M=17.6; SD=9.56), spanning a range of experience of low to high emotional

exhaustion. The mean MBI:EE score almost reached the clinical cut off (≥18), classified as moderate emotional exhaustion. The MBI-DP scores ranged between 0-7 (M=3.60; SD=3.21) categorised as low to low-moderate depersonalisation experienced by staff. The MBI-PA scores ranged between 15-35 (M=29.8; SD=8.41) categorised as an experience of low to moderate personal accomplishment. The mean MBI:PA score was below the clinical cut off (≤32), indicating low personal accomplishment.

Individual Level Outcomes

Each care dyad's total scores from screening (session 1) through to follow-up (session 8) are presented in Figures 5 – 9. Trend interpretation of client and staff outcomes can be seen in Table 7. All clients appear to have baseline stability on all measures except Client 1 on the CORE-10. All staff appear to have baseline stability except Staff 3, 4, and 5, all on the MBI:DP. Four out of five clients had a positive treatment outcome on at least one measure. Only one out of five staff (Staff 2) had positive treatment outcomes on one measure (MBI:EE). One client and one staff demonstrated modest gains at the follow-up phase.

The RCI and CSC change scores are presented in Table 8. Between the start of CAC and the end of CAC, Client 1 had recovered on the PSQ and CORE-10. Between the start of CAC and follow-up, Clients 1 and 5 had recovered on the PSQ and CORE-10. Between the end of CAC and follow-up Client 5 recovered on the PSQ.

No staff demonstrated reliable and clinical improvement on any measure. One staff participant no longer met the criteria for burnout (emotional exhaustion) by the end of treatment and follow-up. No staff participants showed reliable or clinical deterioration on any measure. Recovery analyses, according to outcome measure, are reported in Table 9.

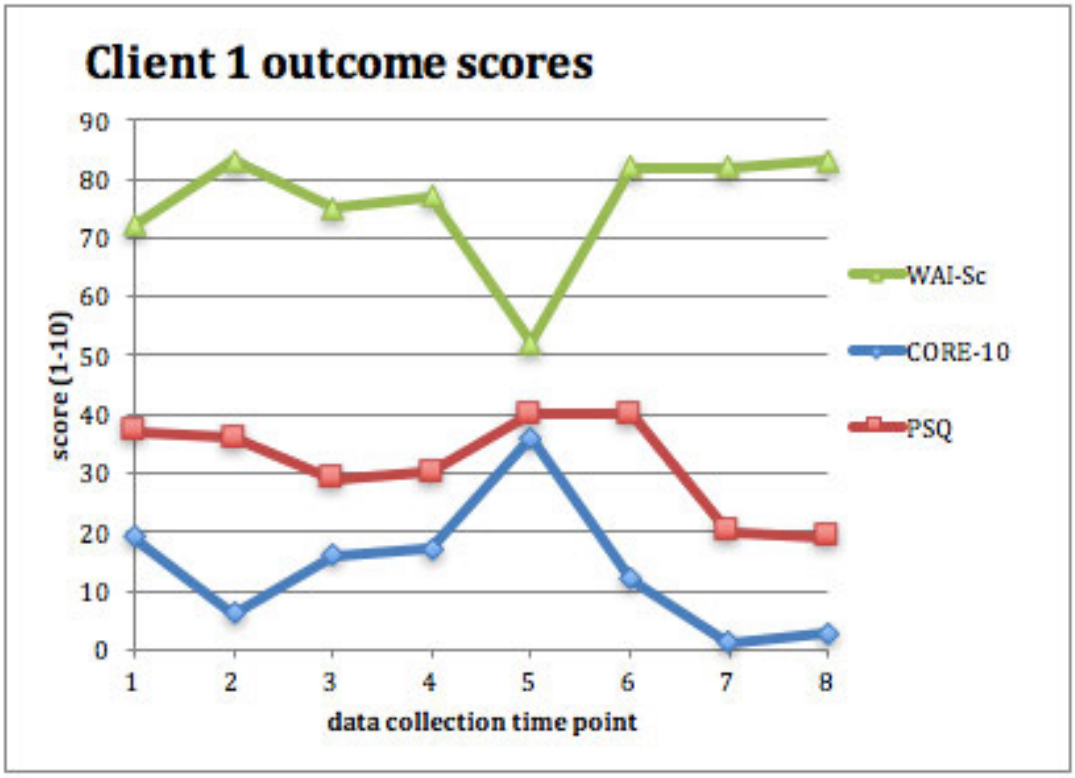
Idiographic client and staff graphs with individual scores and averages across items can be seen in Appendix W.

Table 6

Screening Outcome Measure Scores for Clients and Staff

Care dyad	Client measures			Staff measures				
	PSQ	CORE -10 (category)	WAI-Sc	WAI-St	PCS	MBI: EE (category)	MBI: DP (category)	MBI: PA (category)
1**	37*	19 (mod)*	72	57	18	13 (low)	2 (low)	31 (low)*
2	39*	28 (severe)*	69	27	8	31 (high)*	7 (mod)*	34 (mod)
3	30*	33 (severe)*	81	64	15	8 (low)	0 (low)	34 (mod)
4**	36*	33 (severe)*	64	51	11	12 (low)	2 (low)	15 (low)*
5	31*	20 (mod-severe)*	69	57	15	24 (mod)*	7 (mod)*	35 (mod)
Mean (SD)	34.6* (3.9)	26.6 (severe)* (6.8)	71 (6.3)	51.2 (14.3)	13.4 (3.9)	17.6 (mod) (9.6)	3.6 (low) (3.2)	29.8 (low)* (8.4)

Note. * = Above the clinical cut-off. ** = The staff member in this care dyad represented two clients.



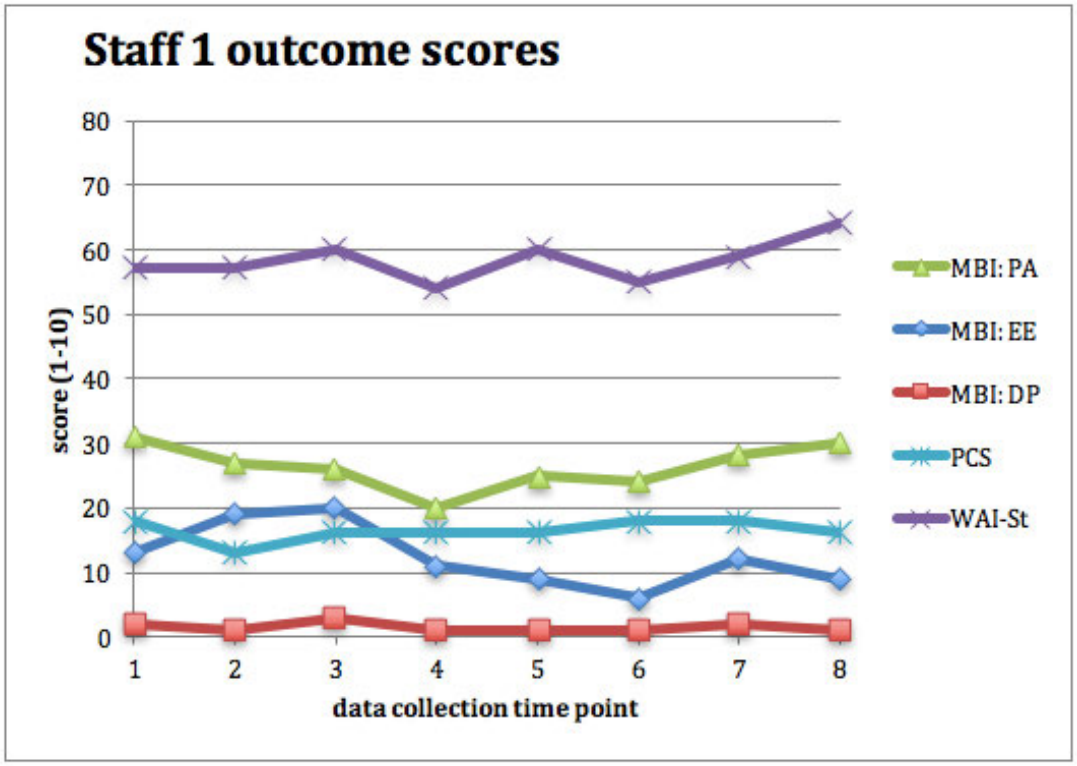
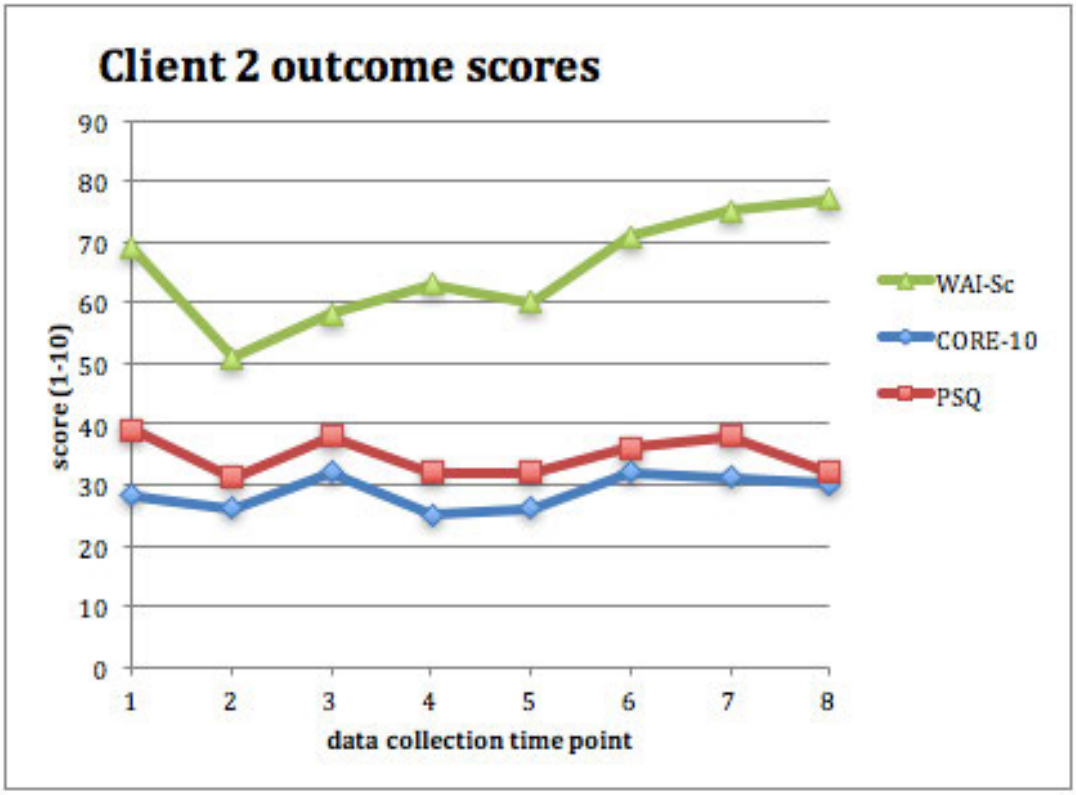


Figure 5. Outcomes for care dyad 1



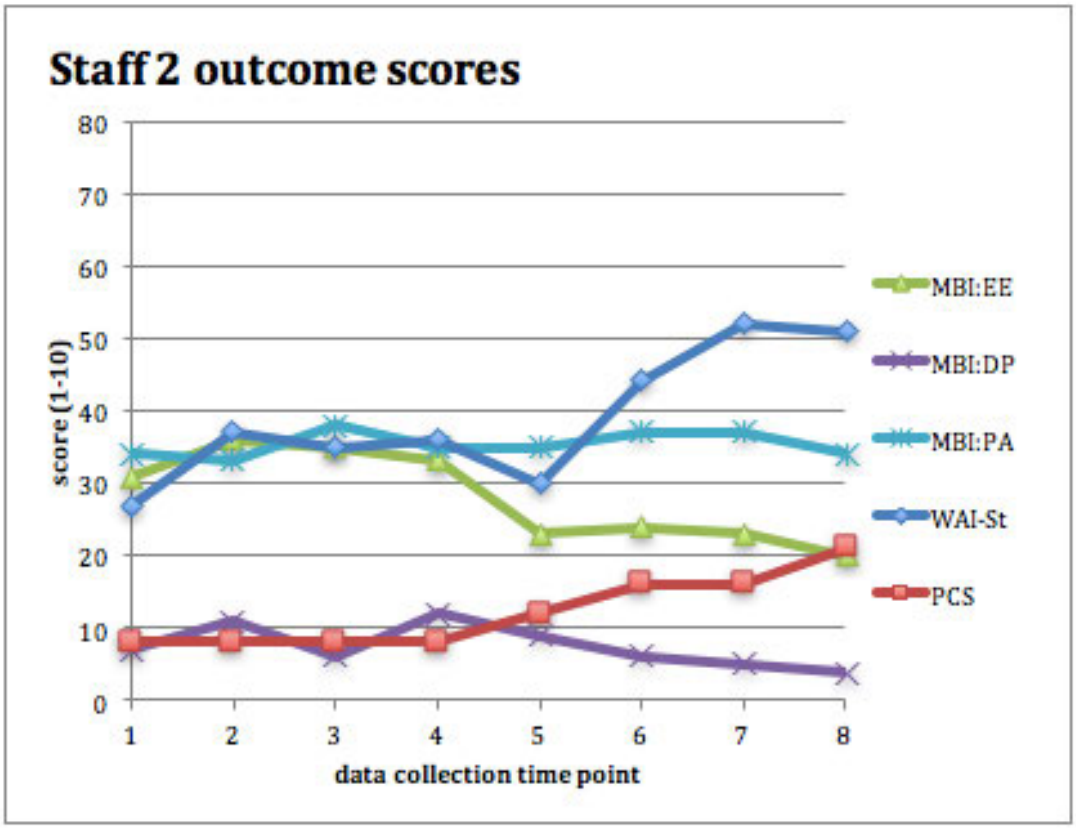
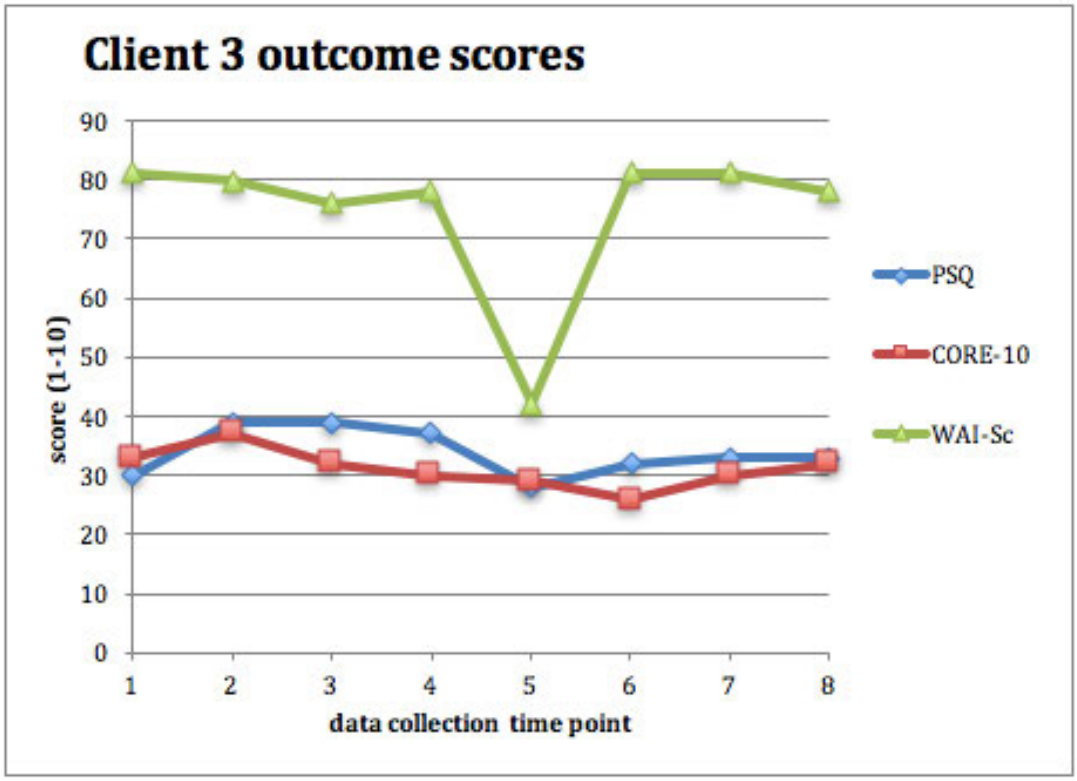


Figure 6. Outcomes for care dyad 2



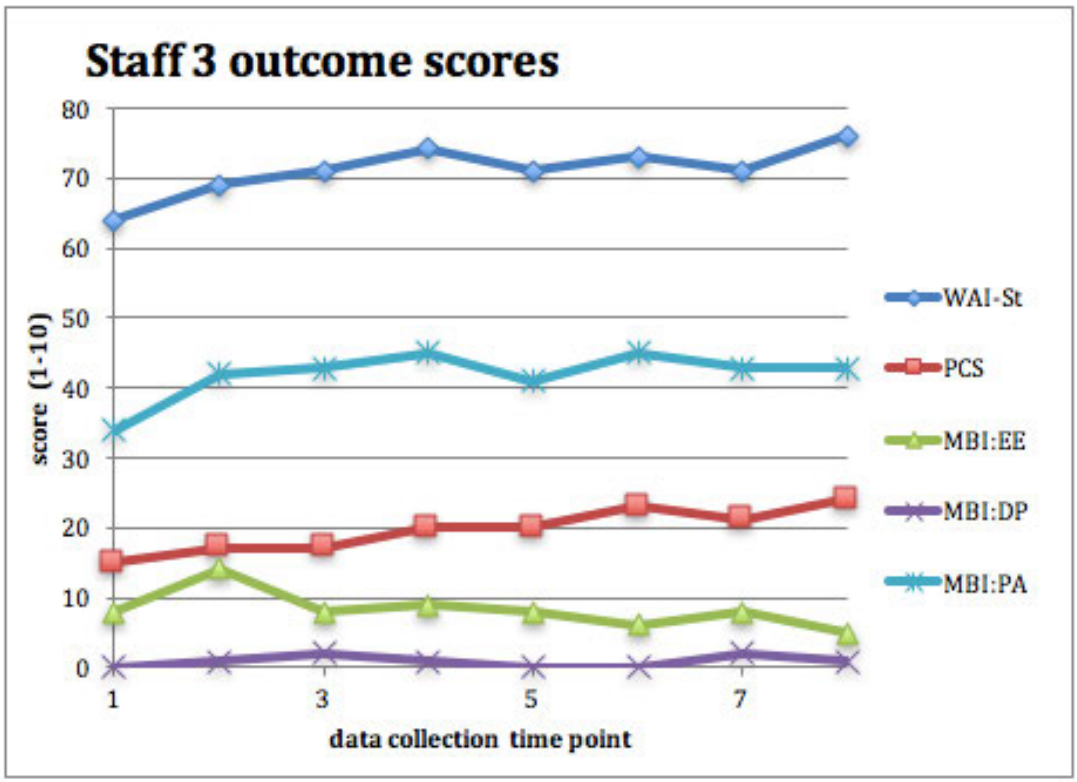
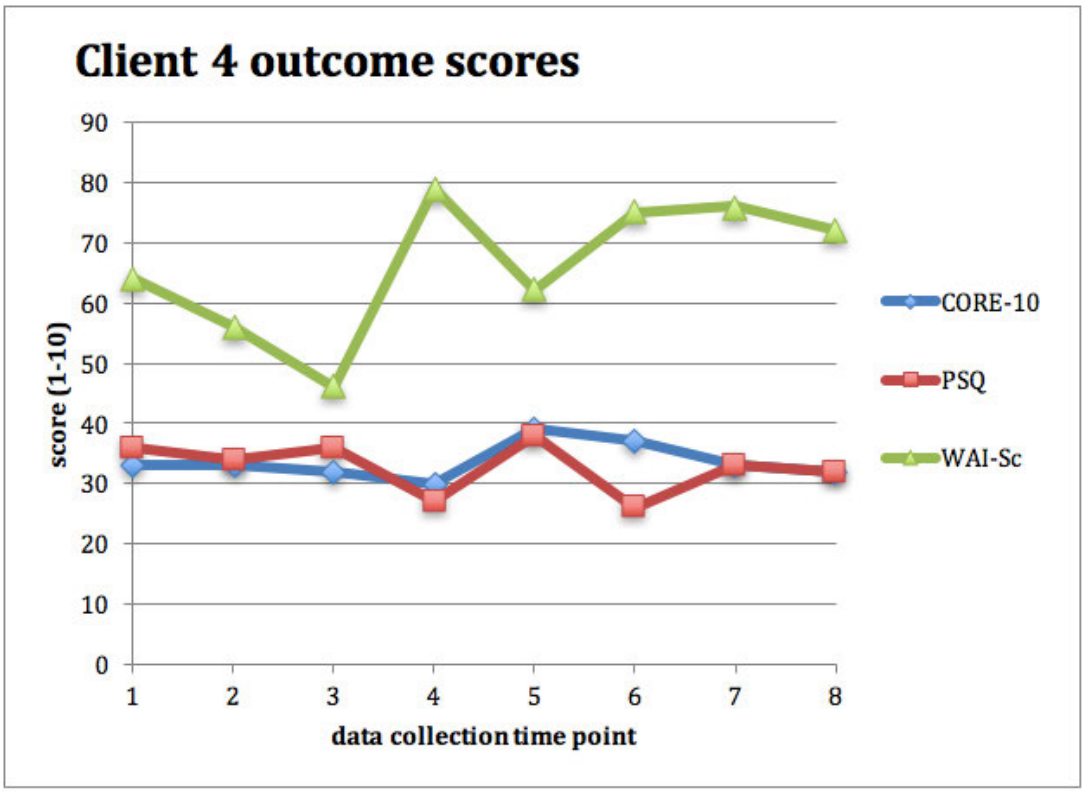


Figure 7. Outcomes for care dyad 3



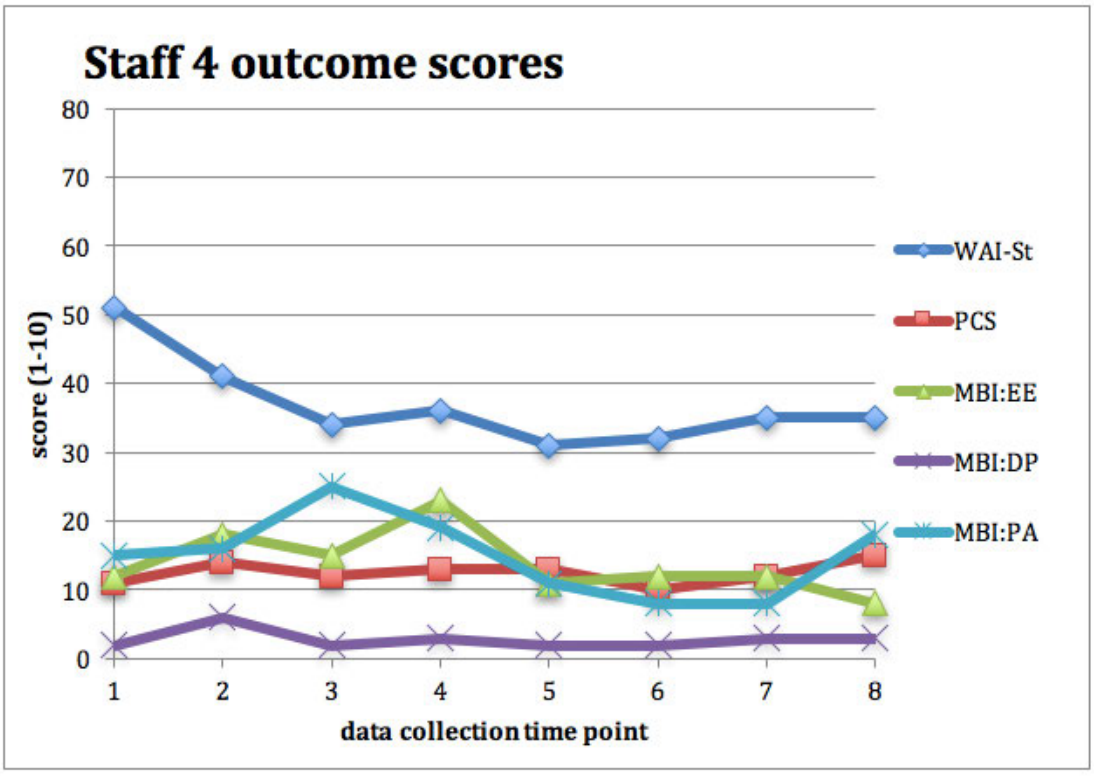


Figure 8. Outcomes for care dyad 4

Figure 9. Outcomes for care dyad 5

Table 7

Trend Interpretation of Client and Staff Outcome Graphs

Client/ staff	Measure	Baseline Stability*	Effect of CAC	Change over FU
Client 1	CORE-10	No	Effective	No further gains
	PSQ	Yes	Effective	No further gains
	WAI-Sc	Yes	No change	Stable
Staff 1	WAI-St	Yes	No change	Stable
	PCS	Yes	No change	Stable
	MBI:EE	Yes	No change	Stable
	MBI:DP	Yes	No change	Stable
	MBI:PA	Yes	No change	Stable
Client2	CORE-10	Yes	No change	Stable
	PSQ	Yes	No change	Stable
	WAI-Sc	Yes	Effective	No further gains
Staff 2	WAI-St	Yes	Effective	No further gains
	PCS	Yes	Effective	No further gains
	MBI:EE	Yes	Effective	Modest gains
	MBI:DP	Yes	No change	Stable
	MBI:PA	Yes	No change	Stable
Client3	CORE-10	Yes	No change	Stable
	PSQ	Yes	No change	Stable
	WAI-Sc	Yes	No change	Stable
Staff 3	WAI-St	Yes	No change	Stable
	PCS	Yes	No change	Stable
	MBI:EE	Yes	No change	Stable
	MBI:DP	No	No change	Stable
	MBI:PA	Yes	No change	Stable
Client4	CORE-10	Yes	Effective	No further gains
	PSQ	Yes	No change	Stable
	WAI-Sc	Yes	No change	Stable
Staff 4	WAI-St	Yes	No change	Stable
	PCS	Yes	No change	Stable
	MBI:EE	Yes	No change	Stable
	MBI:DP	No	No change	Stable
	MBI:PA	Yes	No change	Stable
Client 5	CORE-10	Yes	No change	Stable
	PSQ	Yes	No change	Modest gains
	WAI-Sc	Yes	No change	Modest gains
Staff 5	WAI-St	Yes	No change	Stable
	PCS	Yes	No change	Stable
	MBI:EE	Yes	No change	Stable
	MBI:DP	No	No change	Stable
	MBI:PA	Yes	No change	Stable

Note. *= Baseline stability assessed using mean of baseline data, calculating 50% above and 50% below mean to obtain a range, then checking all scores fall within that range.

Table 8

Reliable Change (RC) and Clinically Significant Change (CSC) of Participant Change Scores

		Outcome scores			Start of CAC to end of CAC		Start of CAC to follow-up		End of CAC to follow-up	
	Measure	SC	EOT	FU	RC	CSC	RC	CSC	RC	CSC
C1	CORE-10	19	1	3	↑	↑	↑	↑	No	No
	PSQ	37	20	19	↑	↑	↑	↑	No	No
	WAI-Sc	72	82	83	-	-	-	-	-	-
S1	WAI-St	57	59	64	-	-	-	-	-	-
	PCS	18	18	16	-	-	-	-	-	-
	MBI:EE	13	12	9	No	No	No	No	No	No
	MBI:DP	2	2	1	No	No	No	No	No	No
	MBI:PA	31	28	30	No	No	No	No	No	No
C2	CORE-10	28	31	30	No	No	No	No	No	No
	PSQ	39	38	32	No	No	↑	No	↑	No
	WAI-Sc	69	75	77	-	-	-	-	-	-
S2	WAI-St	27	52	51	-	-	-	-	-	-
	PCS	8	16	21	-	-	-	-	-	-
	MBI:EE	31	23	20	No	No	No	No	No	No
	MBI:DP	7	5	4	No	No	No	No	No	No
	MBI:PA	34	37	34	No	No	No	No	No	No
C3	CORE-10	33	30	32	No	No	No	No	No	No
	PSQ	30	33	33	No	No	No	No	No	No
	WAI-Sc	81	81	78	-	-	-	-	-	-
S3	WAI-St	64	71	76	-	-	-	-	-	-
	PCS	15	21	24	-	-	-	-	-	-
	MBI:EE	8	8	5	No	No	No	No	No	No
	MBI:DP	0	2	1	No	No	No	No	No	No
	MBI:PA	34	43	43	No	No	No	No	No	No
C4	CORE-10	33	33	32	No	No	No	No	No	No
	PSQ	36	33	32	No	No	No	No	No	No
	WAI-Sc	64	76	72	-	-	-	-	-	-
S4	WAI-St	51	35	35	-	-	-	-	-	-
	PCS	11	12	15	-	-	-	-	-	-
	MBI:EE	12	12	8	No	No	No	No	No	No
	MBI:DP	2	3	3	No	No	No	No	No	No
	MBI:PA	15	8	18	No	No	No	No	No	No
C5	CORE-10	20	17	11	No	No	↑	↑	No	↑
	PSQ	31	29	20	No	No	↑	↑	↑	↑
	WAI-Sc	69	71	79	-	-	-	-	-	-
S5	WAI-St	57	59	54	-	-	-	-	-	-
	PCS	15	20	20	-	-	-	-	-	-
	MBI:EE	24	16	12	No	↑	No	↑	No	No
	MBI:DP	7	4	3	No	No	No	No	No	No
	MBI:PA	35	36	36	No	No	No	No	No	No

Note. C = Client, S = Staff; higher scores on CORE-10, PSQ, MBI:EE and DP indicate deterioration; higher scores on both WAI-s, PCS and MBI:PA indicate improvement; T1=time point 1 (Screening session); T7=time point 7 (end of treatment); T8= time point 8 (follow-up); - = indicates not possible to calculate; ↓ = reliable deterioration; ↑ = reliable improvement; CORE-10: RCI significant if >6; PSQ: RCI significant if >4.17; MBI-EE: RCI significant if >14.85; MBI-DP: RCI significant if >9.76; MBI-PA: RCI significant if <12.19; CSC for CORE-10 (general psychological distress) if pre-score ≥11 and post score <11; CSC for PSQ if pre-score ≥27 and post-score <27; CSC for MBI-EE if pre-score ≥18.75 and post-score <18.75; CSC for MBI-DP if pre-score ≥7.04 and post-score <7.04; CSC for MBI-PA if pre-score <32.62 and post-score ≥32.62.

Table 9

Reliable and/or Clinical Improvement Count (N=5)

	Screening (T1) to termination (T7)			Screening (T1) to follow-up (T8)			Termination (T7) to follow-up (T8)		
Measure	RI	CSI	RCSI	RI	CSI	RCSI	RI	CSI	RCSI
CORE-10	1	1	1	2	2	2	0	1	0
PSQ	1	1	1	3	2	2	2	1	1
WAI-Sc	-	-	-	-	-	-	-	-	-
WAI-St	-	-	-	-	-	-	-	-	-
PCS	-	-	-	-	-	-	-	-	-
MBI:EE	0	1	0	0	1	0	0	0	0
MBI:DP	0	0	0	0	0	0	0	0	0
MBI:PA	0	0	0	0	0	0	0	0	0

Note. RI=Reliable improvement; CSI=clinically significant improvement; RCSI=reliable and clinically significant improvement.

Group Level Outcomes

Baseline stability. T–tests between time point 1 and time point 3 were conducted to establish baseline stability. There was no significant difference in baseline CORE-10 scores between T1 (M=26.6, SD=6.80) and T3 (M=26.6, SD=7.60); t(4)=0.00, p=1.0. There was no significant difference in baseline PSQ scores between T1 (M=34.6, SD=3.91) and T3 (M=33.4, SD=6.10); t(4)=0.406, p=0.706. There was no significant difference in baseline WAI-c scores between T1 (M=71.0, SD=6.28) and T3 (M=62.6, SD=12.76); t(4)=2.389, p=0.075. There was no significant difference in baseline WAI-t scores between T1 (M=51.2, SD=14.29) and T3 (M=51.0, SD=16.14); t(4)=0.044, p=0.967. There was no significant difference in baseline PCS scores between T1 (M=13.4, SD=3.91) and T3 (M=13.8, SD=3.77); t(4)=-0.59, p=0.587. There was no significant difference in baseline MBI:EE scores between T1 (M=17.6, SD=9.56) and T3 (M=18.0, SD=10.46); t(4)=-0.121, p=0.909. There was no significant difference in baseline MBI:DP scores between T1 (M=3.6, SD=3.20) and T3 (M=3.2, SD=1.64);

t(4)=0.389, p=0.717. There was no significant difference in baseline MBI:PA scores between T1 (M=29.8, SD=8.40) and T3 (M=34.0, SD=8.03); t(4)=-1.572, p=0.191. All measures were statistically not significant, suggesting baseline stability for all measures. This means that interpretation of group level intervention and follow-up data would be appropriate.

Group level treatment outcomes. Mean phase client and staff outcome scores according to measure, are represented in Figures 10 and 11. For clients, PSQ and CORE-10 mean scores remained largely stable throughout baseline, CAC and follow-up. The WAI-Sc mean scores modestly improved between baseline and end of treatment, remaining stable over follow-up. For the staff group, there were modest increases in the WAI-St and PCS mean scores between baseline and end of treatment, improving slightly at follow-up. Depersonalisation and personal accomplishment remained stable throughout CAC, while emotional exhaustion reduced between baseline and end of treatment, making further reductions over follow-up.

Change scores on the PSQ (z = -2.03, p = .042) indicated significant improvement in client fragmentation between baseline and CAC, and baseline and follow-up (z = -2.02, p = .043). Change scores on the WAI-Sc (z = 2.02, p = .043) indicated significant improvement in client alliance between CAC and follow-up. Change scores on the PCS (z = 2.02, p = .043) indicated significant improvement in staff competence between baseline and follow-up. Change scores on the MBI:EE between baseline and CAC (z = -2.02, p = .043), baseline and follow-up (z = -2.02, p = .043), and CAC and follow-up (z = -2.02, p = .043) all indicated significant improvement in staff emotional exhaustion. Statistical significance of change scores are presented in Table 10.

PSQ effect sizes were large between baseline and CAC (d = 1.46; 95% CI: 0.36, 2.56) and large between baseline and follow-up (d = 4.23; 95% CI: 3.21, 5.26). CORE-

10 effect size was deemed not effective between baseline and CAC (*d* = -0.09; 95% CI: -2.43, 2.25) but large between baseline and follow-up (*d* = 3.20; 95% CI: 2.22, 4.19). WAI-Sc effect size was deemed not effective between baseline and CAC (*d* = -0.11; 95% CI: -5.37, 5.16) and large at follow-up (*d* = -3.84; 95% CI: -6.19, -1.48). WAI-St effect sizes were large between baseline and CAC (*d* = 0.92; 95% CI: --0.03, 1.88) and large between baseline and follow-up (*d* = -10.34; 95% CI: -10.70, -9.98). Staff competence (PCS) effect sizes were large between baseline and CAC (*d* = -3.95; 95% CI: -4.37, -3.52) and between baseline and follow-up (*d* = -8.25; 95% CI: -8.76, -7.74). Staff emotional exhaustion (MBI:EE) effect sizes were large between baseline and CAC (*d* = 1.77; 95% CI: 0.02, 3.52) and large between baseline and follow-up (*d* = 4.19; 95% CI: 2.88, 5.49). Staff depersonalisation (MBI:DP) effect sizes were large between baseline and CAC (*d* = 1.06; 95% CI: 0.54, 1.59) and large between baseline and follow-up (*d* = 1.76; 95% CI: 1.22, 2.31). Staff personal accomplishment (MBI:PA) effect sizes were large between baseline and CAC (*d* = 0.92; 95% CI: -0.18, 2.02) and small between baseline and follow-up (d = 0.20; 95% CI: -1.09, 1.50). Group effect size estimates are summarised in Table 11.

Table 10

Group Level Significance of Changes Between Main Phases on All Outcome Measures (Wilcoxon Z scores)

Measure	Baseline-CAC	Baseline-Follow-up	CAC-Follow-up
CORE-10	-0.14	-1.48	-0.94
PSQ	-2.03*	-2.02*	-1.83
WAI-Sc	-0.14	-1.75	-2.02*
WAI-St	-0.14	-0.94	-1.75
PCS	-1.75	-2.02*	-1.76
MBI:EE	-2.02*	-2.02*	-2.02*
MBI:DP	-1.84	-1.83	-0.92
MBI:PA	-0.14	-0.41	-0.41

Note. Baseline = T1-T3 (mean), CAC = T4-T7 (mean), Follow-up = T8. *=p<.05

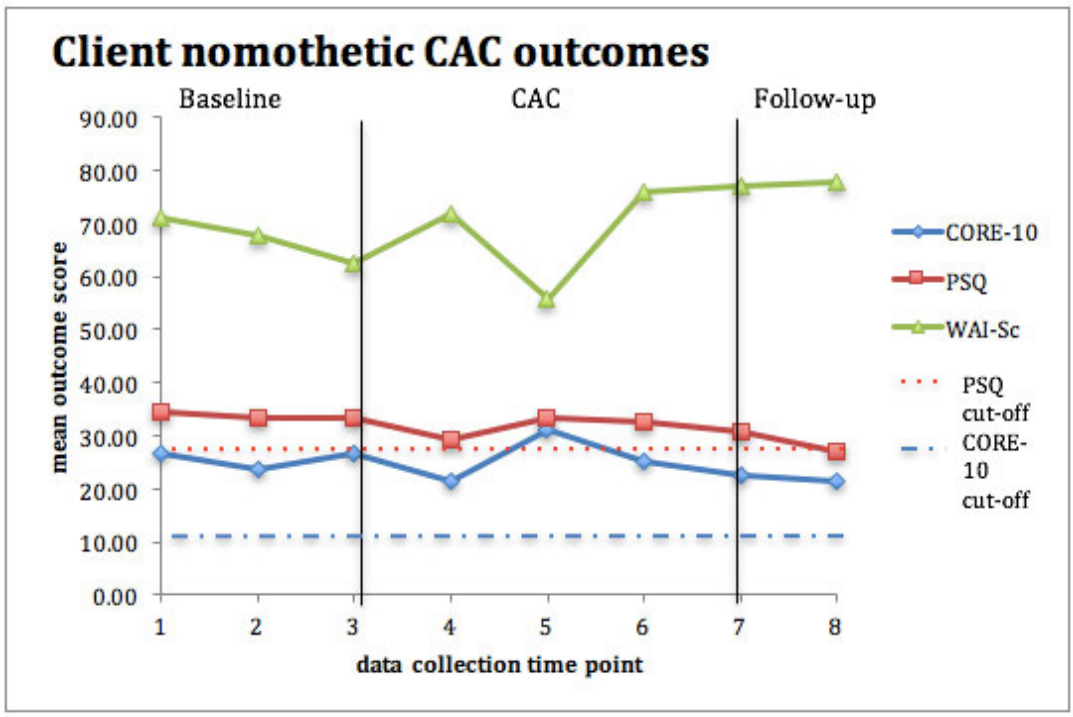


Figure 10. Client group outcome means by outcome measure

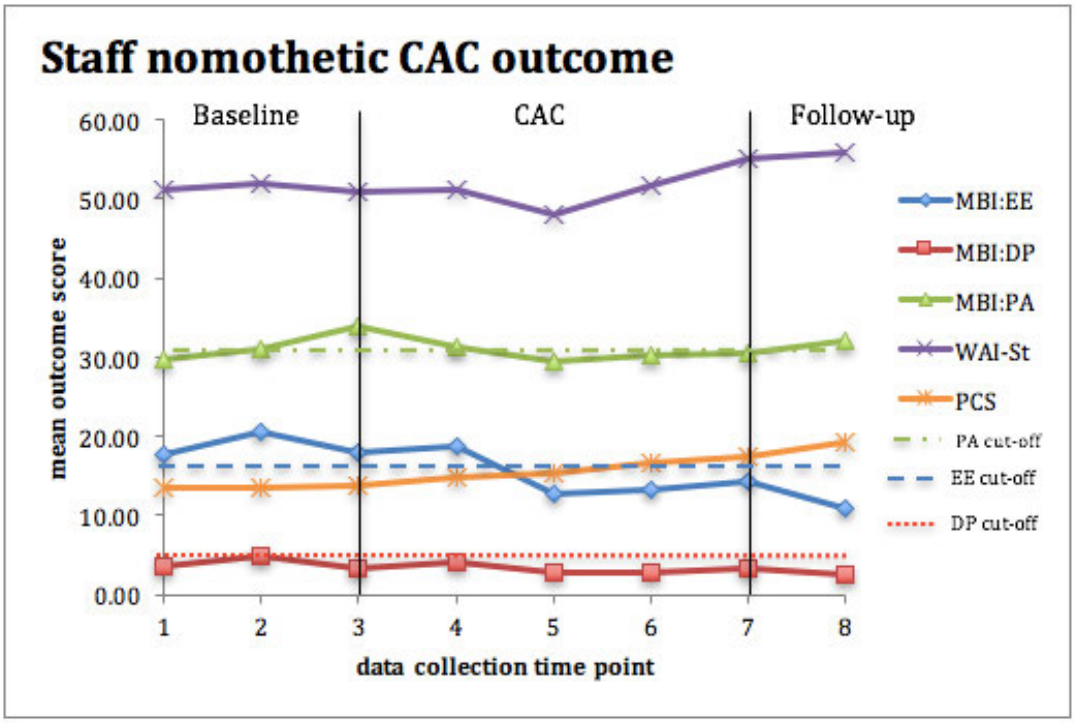


Figure 11. Staff outcome means by outcome measure

Table 11

Group Effect Size Estimates (d)

Measure	Baseline M (SD)	CAC M (SD)	Follow-up M	T1 – T7 Cohen's *d* (95% CI*)	Effect size Category**	T1-T8 Cohen's *d* (95% CI)	Effect size category**
CORE-10	25.60 (1.73)	25.00 (4.26)	21.60	-0.41 (-14.26, 5.86)	Small	-0.65 (-14.17, 4.17)	Medium
PSQ	33.80 (0.69)	31.50 (1.95)	27.20	-0.75 (-13.46, 5.46)	Medium	-1.35 (-17.12, 2.32)	Large
WAI-Sc	67.10 (4.23)	70.10 (9.79)	77.80	1.11 (-0.33,12.33)	Large	1.33 (-0.19, 13.79)	Large
WAI-St	51.40 (0.50)	51.50 (2.95)	56.00	0.29 (-14.19, 22.19)	Small	-0.32 (-14.02, 23.62)	Small
PCS	13.50 (0.20)	16.05 (1.17)	19.20	1.07 (-0.21, 8.21)	Large	1.52 (-1.19, 12.79)	Large
MBI:EE	18.73 (1.63)	14.70 (2.81)	10.80	-0.45 (-8.64, 1.84)	Small	-0.89 (-12.17, -1.43)	Large
MBI:DP	3.90 (0.90)	3.20 (0.57)	2.40	-0.18 (-2.97, 2.17)	-	-0.53 (-4.03, 1.63)	Medium
MBI:PA	31.60 (2.16)	30.35 (0.82)	32.20	-0.05 (-6.93, 8.13)	-	0.27 (-2.54, 7.34)	Small

Note. Baseline = time point 1 to time point 3; CAC = time point 4 to time point 7; follow-up = time point 8. CI = confidence interval.; M = mean; SD = standard deviation; * = Cohen *d* effect sizes calculated using the formula: (T7 mean – T1 mean)/average standard deviation, with positive treatment effects being reflected by a positive effect size, and vice versa. ** = effect size categories use Cohen's (1992) guidelines: d≥ .20 is a 'small' effect, d≥.50 is a 'medium' effect, and d≥ .80 is a 'large' effect.

Client Discharge Summary

Clients 1, 3, and 4 were all discharged from the service within one year of completing CAC. Client 2 was discharged but returned to the service for a discreet piece of work around benefits and was then discharged again. Client 5 remained in the service in psychiatric review only, due to medication issues that required monitoring whilst being reduced.

Qualitative Findings: Client Experience

Thematic analysis allowed five superordinate client themes to emerge from the qualitative client interviews. The number of times each client makes reference to a particular theme is shown in Table 12. Following second rating of one randomly selected client transcript (20%), inter-rater agreement was $\kappa = .73$ (83% agreement, McHugh, 2012), $p < .01$, suggesting a moderate level of agreement between raters, so no changes were made to the themes or coding template. Example client quotes are presented in Table 13.

Table 12

Themes Supported by Number of Times Reported by Clients

Theme	Client 1	Client 2	Client 3	Client 4	Client 5	Total no of statements
1. Doubts about CAC working	3	0	2	0	1	6
2. Areas of improvement. 2a. Optimism & confidence	3	0	2	2	1	8
2b. Insight	0	2	2	1	2	7
3.Change process. Map helpful to get insight and control	3	0	0	7	4	14
4. Process issues. CAC process hard but helpful	0	4	1	3	6	14
5. Model. More sessions would have been better	0	0	2	1	3	6

Table 13

Example Quotes from Client Themes

Theme/Subtheme	Client number: Quote
Theme 1: Doubts about CAC working	Client 5: *I sort of got a bit disillusioned half way through and not fully on board with the idea that this could probably help me.*
Theme 2: Areas of improvement 2a. Optimism & confidence	Client 3: *I've got more confidence and I can go out and I'm not feeling like everybody's looking at me and talking about me.*
2b. Insight	Client 2: *Well it's [CAC's] sort of making me think you know why I were doing things.*
Theme 3. Change process - Map helpful to get insight and control	Client 4: *Well if I'm starting to feel down, you know and err like I said if I, if I get myself tearful then I look at it [SDR] and I think well that's how I'm feeling at them moment so what made me feel like that, that so stop thinking of that, get into that one then you'll move into that one and then you can carry on.*
Theme 4. Process issues - CAC process hard but helpful	Client 3: *[CAC was] A bit hard at first, it were like taking a scab off you and you know all gunge coming out erm and then I couldn't shurrup (LAUGH)*
Theme 5. Model - More sessions would have been better	Client 5: *I think if they could increase the amount of time a bit more.*

Qualitative Findings: Staff Experience

Thematic analysis allowed five superordinate client themes to emerge from the qualitative staff interviews. The number of times each member of staff makes reference to a particular theme is represented in Table 14. Following second rating of one randomly selected staff transcript (20%), inter-rater agreement was $\kappa = .69$ (72% agreement), $p < .001$, suggesting a moderate level of agreement between raters, so no changes were made to the themes or coding template. Example staff quotes are presented in Table 15.

Table 14

Themes Supported by Number of Times Reported by Staff

Theme	Staff 1	Staff 2	Staff 3	Staff 4	Staff 5	Total no of statements
1.Before CAC 1a. Feeling stuck	5	1	5	1	0	12
1b. Interpersonal difficulties with client	9	3	0	8	1	21
2.Helpful aspects of CAC 2a. Using the SDR helped	12	7	7	7	7	40
3.Change processes 3a. Noticing change in the client	6	1	8	6	7	28
3b. Feeling more confident, optimistic, insightful and less anxious	7	7	1	5	4	24
3c. CAC process difficult	2	4	2	2	0	10
3d. Learning from the psychologist	7	7	0	4	3	21
4.The model 4a. Not speaking difficult but helpful	3	4	3	1	1	12
4b. Therapist approach	2	1	3	1	1	8
5.After CAC 5a. Worried about CAC finishing	16	0	4	1	0	21
5b. Outstanding work remains	1	4	6	1	1	13

Table 15

Example Quotes from Staff Themes

Theme/Subtheme	Client number: Quote
Theme 1. Before CAC Theme 1a. Feeling stuck	Staff 1: *it felt like I was a bit stuck and it felt like we were a bit stuck on where we were at and which is why I asked to do the five session CAT*
Theme 1b. Interpersonal difficulties with client.	Staff 4: *He's [client 4] somebody that made me feel incredibly uncomfortable, working with him made me feel very uncomfortable because of the comments that he made, erm and I didn't know how to address that with him either because he always caught me off hand.*
Theme 2. Helpful aspects of CAC 2a. Using the SDR helped	Staff 2: *The patterns which she's done at the end of the sessions erm its helped me to, to sort of work with (client 2) because I know what is happening now when (Client2) gets in a difficult situation, when she's feeling that she's in a corner she, she has these certain behaviours and I know now how to bring her, bring her back and stop her getting that far erm and talk to her and, and make her sort of see a different*
Theme 3. Change processes 3a. Noticing change in the client	Staff 5: *I feel that he's [Client 5's] more open, erm just, I think he'll, he's probably gonna be more open to suggestions about not sort of continuing with some of his behaviours in patterns with regards to alcohol and erm pain killers erm. I feel like there's probably not as much risk with him as what there were originally.*
3b. Feeling more confident, optimistic, insightful and less anxious	Staff 5: *Now, I feel a bit more confident in being able to really say what I'm thinking without offending him because its all there in black and white on the map erm and so he knows their his words basically from so when I can see him flipping I can try and prompt him and this isnt what you know you're doing it and how can we sort of stop it from sliding any further so that's been good.*
3c. CAC process difficult	Staff 1: *I think drawing out those things [SDR] and obviously you do the words, you know those words that sort of underpin everything cos you reached the bottom line haven't you but sort of have those words. I imagine that must be quite hard so I imagine it's not an easy process to sit there and two people and (Client 1) seemed to handle it incredibly well to be fair.*
3d. Learning from the psychologist	Staff 2: *It's been useful to look at erm someone else sort of talking to (Client 2) and sort of the way they talk to (Client 2) erm and sort of, watching (Therapist) for me was, was err was good for me cos it's given me some err some ways of talking to her*
Theme 4. The model 4a. Not speaking difficult but helpful	Staff 1: *So you're not allowed to say anything for five sessions so that's quite, that just quite a strange thing to just sit there erm but at the same time its really helpful because obviously you're observing erm then at the end I could sort of write questions down from sessions and [therapist] would spend ten/fifteen minutes with me and I'd say like, I'd get to pick up on things that had been said in sessions and we'd sort of get to look at that a little bit so that was then really helpful.*

QUAL-quant Findings

Three themes differentiated the experience of clients who met the criteria for recovery at the end of follow-up (n=2) compared to the clients that did not meet the criteria for recovery (n=3). The themes are shown in Table 16. Following second rating of 40% of the transcripts (one recovered client and one not recovered client) inter-rater agreement for the recovered client was κ= .72 (80% agreement), p <.01, suggesting a moderate level of agreement between raters, so no changes were made to the themes or coding template. For the non-recovered client, inter-rater agreement was κ= .74 (80% agreement), p <.001, suggesting a moderate level of agreement between raters, so no changes were made to the themes or coding template. Example quotes from non-recovered clients are presented in Table 17.

Table 16

Summary of Themes Differentiating Recovered and Non-Recovered Clients

Theme	Recovered (n = 2)	Non-recovered (n = 3)
	No. of statements	No. of statements
1. Positive perceived therapist characteristics	1	16
2. Areas of life that improved 2a. Behaviour change	5	13
2b. Improved exit/coping strategies	4	8
3. How CAC helped. 3a. To think differently	3	7
3b. Talking about the past	0	8

Note. Recovery has been defined as reliable and clinically significant improvement on the PSQ from baseline to the end of follow-up.

Table 17

Example Quotes from Non-Recovered Clients

Theme/Subtheme	Client number: Quote
Theme 1: Positive perceived therapist characteristics	Client 3: *[Therapist] were so nice about everything and so friendly how she came across and not erm not lecturing or judging or, it's been really nice and what she said made so much sense so I really liked her.*
Theme 2: Areas of life that improved Theme 2a. Behaviour change	Client 4: *When I've had something to eat just to put the dish in the sink and then keep doing that until all the dishes in the sink are not in the cupboard but I've stopped doing that now I've cleared me dishes and as I use one.*
Theme 2b. Improved exit/coping strategies	Client 3: *I used to hear these, hear these bloody horrible voices and they're a lot better, so I can cope with those, I heard this one in't shower and it was like "no, go away, I'm washing my hair, I'm not listening, come back later" which is what (Therapist and Staff 3), (Therapist) more than anybody said to try and do which is working.*
Theme 3: How CAC helped Theme 3a. To think differently	Client 4: *Well I'm a bit more thoughtful when I'm, when I'm starting to feel down and try to think of summat that's made me laugh or cheered me up during the day*
Theme 3b. Talking about the past	Client 3: *We talked about what happened in me past, especially with my mum it really did help.* [making her own links to historical past between her current critical voices and her mother who used to be critical of Client 3 when she was alive]

QUANT-Qual Findings

Clients. From the ratings at the end of the interview, related to types of, and numbers of changes experienced through CAC, clients reported a mean of 4.2 positive changes (SD = 1.92). Most frequently, participants considered themselves as 'very surprised' by the changes (modal rating = 5 out of 5; 1=very much expected, 5=very surprised; mean expectation of change = 4.29; SD = 0.72); thought change would have been 'very unlikely' without treatment (modal rating 1 out of 5; 1 = very unlikely, 5 = very likely; mean belief of change occurring without therapy = 1.1; SD = 0.30), and felt change was 'extremely important' (modal rating 5 out 5; 1 = not at all important, 5 = extremely important; mean importance of change = 4.86; SD = 0.36). The areas that clients reported frequently changing were: increased self-motivation and confidence (3 clients), increased self-awareness (2 clients) and improved relationships (2 clients).

Staff. At the end of the interview, staff rated how they felt they had changed and how their client had changed. Staff reported a mean of 4 positive changes (SD = 1.92) for themselves as a result of CAC. Most frequently, staff considered change as 'somewhat expected' (modal rating = 2 out of 5; 1=very much expected, 5=very surprised; mean expectation of change = 2.85; SD = 1.14); thought change would have been 'somewhat unlikely' without treatment (modal rating 2 out of 5; 1 = very unlikely, 5 = very likely; mean belief of change occurring without therapy = 2.05; SD = 0.94), and felt change was 'extremely important' (modal rating 5 out 5; 1 = not at all important, 5 = extremely important; mean importance of change = 4.75; SD = 0.44). The areas that staff reported in themselves as frequently changing were: increase in confidence of

working with that or other clients (4 staff), increased insight into working with that client (2 staff) and increased optimism of working with that client (2 staff).

Staff reported a mean of 3.6 positive changes (SD = 1.52) for their clients as a result of CAC. Most frequently, staff considered themselves as 'somewhat surprised' (modal rating = 4 out of 5; 1=very much expected, 5=very surprised; mean expectation of change = 3.44; SD = 1.50) by the changes their clients made; thought change would have been 'very unlikely' without treatment (modal rating 1 out of 5; 1 = very unlikely, 5 = very likely; mean belief of change occurring without therapy = 1.61; SD = 0.78), and felt change was 'extremely important' (modal rating 5 out 5; 1 = not at all important, 5 = extremely important; mean importance of change = 4.44; SD = 0.78). The areas that staff reported their clients as frequently changing were: improved relationships (2 staff), improved control over clients' symptoms (3 staff) and clients' trying out new things that can help them (3 staff).

Triangulation of Mixed Methods Findings

The triangulation of the mixed methods findings according to the study aims are shown in Table 18. Following second rating of the convergence codes, inter-rater agreement was $\kappa = .60$ (67% agreement), $p < .05$, suggesting a moderate level of agreement between raters. After discussion between raters, complete agreement was achieved on all six codes.

Table 18

Triangulation of Mixed Methods Findings According to Research Question

Research question	Quantitative	Qualitative	QUAN-qual/ and QUAL-quan	Merged findings code*
Efficacy of CAC in reducing client distress and fragmentation	INDIVIDUAL LEVEL • 2 x clients showed reliable and clinical improvement on PSQ and CORE-10 between T1 and T7 GROUP LEVEL • Reduction in means for both PSQ and CORE-10 at follow-up • Clients remained above the clinical cut-offs for both the PSQ and CORE-10 (PSQ almost reached clinical cut-off by follow-up) • Significant change scores on PSQ between baseline and CAC (z = -2.02, p = .042), and baseline and follow-up (z = -2.02, p = .043) • Medium CORE-10 effect sizes at follow-up (d = -0.65) • Large PSQ effect sizes at follow-up (d = -1.35)	• Client Theme – 'Optimism and Confidence' improved with CAC for 4/5 clients • Client Theme – 'Insight' improved for 4/5 clients	• QUAL-quant client Theme – 'Behaviour change' (positive) for non-recovered clients • QUAL-quant client Theme – 'To think differently' (positive) for non-recovered clients • QUANT-qual: clients most frequently reported improvements in self-motivation and confidence, increased self-awareness • QUANT-qual staff reported most frequently that clients had improved symptom control	Discrepant

Table 18 (continued)

Triangulation of Mixed Methods Findings According to Research Question

Research question	Quantitative	Qualitative	QUAN-qual/ and QUAL-quan	Merged findings code*
Efficacy of CAC in improving staff competency and reducing burn-out	INDIVIDUAL LEVEL • No reliable or clinically significant change on PCS or MBI for any staff • One staff showed clinically significant change but not reliable change on MBI:EE (moved from above clinical cut-off to below) GROUP LEVEL • Significant change scores on the PCS between baseline and follow-up (z = -2.02, p = .043) • Large PCS effect sizes at follow-up (d = 1.52) • After session 4, group staff outcome scores on MBI:EE dropped from above the clinical cut-off to below the cut-off and remained there • Significant change scores in MBI:EE across all study phases (z = -2.02, p = .043) • Large MBI:EE effect sizes at follow-up (d = -0.89) • Medium MBI:DP effect size at follow-up (d = -0.53) • Small MBI:PA effect size at follow-up (d = 0.27)	• Staff Theme – 'Feeling stuck' before CAC for 4/5 staff • Staff Theme – 'Feeling more confident, optimistic, insightful and less anxious' for 5/5 staff	• QUANT-qual: staff most frequently reported improved confidence, optimism and insight into working with clients	Confirmatory: convergent and expansion

Table 18 (continued)

Triangulation of Mixed Methods Findings According to Research Question

Research question	Quantitative	Qualitative	QUAN-qual/ and QUAL-quan	Merged findings code*
Efficacy of CAC in improving staff and client alliance	INDIVIDUAL LEVEL • Care dyad 2 showed improvements in trend data on WAI-sc/t between baseline and end of CAC and made further gains at follow-up • Client 5 trend data suggested improvements in alliance between baseline and end of CAC GROUP LEVEL • Both staff and clients had a slight improvement in alliance over the duration of the study, both with a drop-in alliance at T5 • Significant change scores on WAI-Sc between CAC and follow-up (z = -2.02, p = .043) • Small WAI-St effect size at T7 (d = 0.29) BUT drop in staff alliance by follow-up (d = -0.32) • Large WAI-Sc effect size at follow-up (d = 1.33)	• Staff Theme – 'Interpersonal difficulties with client' before CAC for 4/5 staff	• QUANT-qual clients most frequently reported improvements in relationships with others (outside therapy) • QUANT-qual staff most frequently reported that clients had improvements in their relationships with others	Confirmatory: convergent and complementary

Table 18 (continued)

Triangulation of Mixed Methods Findings According to Research Question

Research question	Quantitative	Qualitative	QUAN-qual/ and QUAL-quan	Merged findings code*
Change mechanism: SDR/Map/exits	• None	• Staff Theme - 'Using the SDR helped' for 5/5 staff • Client Theme - 'Map helpful to gain insight and control' for 3/5 clients	• QUAL-quant client Theme – 'Improved exit/coping strategies' for non-recovered clients	Not codeable
Change mechanism: Difficult processes help recovery	• 4 out of 5 clients discharged from the service within one year of completing CAC	• Staff Theme– 'CAC process difficult' for 4/5 staff • Client Theme – 'CAC process hard but helpful' for 4/5 clients	• QUAL-quant client Theme – 'Talking about the past' helpful for non-recovered clients	Confirmatory: Convergent and expansion
Change mechanism: Therapist approach/ model factors	• 100% completed CAC (with some attendance issues)	• Staff Theme– 'Learning from the psychologist' for 4/5 staff (e.g. applying what they've observed the therapist do, with the current client and possibly future clients too) • Staff Theme– 'Not speaking difficult but helpful' for 5/5/ staff • Staff Theme – 'Therapist approach' mentioned by 5/5 staff (e.g. persistence and non-blaming) • Client Theme – 'Doubts about CAC working' for 3/5 clients • Client Theme – 'Model' more sessions would have been helpful for 3/5 clients • Staff Theme– 'Worried about CAC finishing' for 3/5 staff	• QUAL-quant client Theme – 'Positive perceived therapist characteristics' for non-recovered clients	Confirmatory: Convergent and expansion

Note. *Merged findings codes: "Discrepant" = findings are contradictory; "confirmatory: convergent and expansion" = findings broadly agree and add depth; "confirmatory: convergent and complementary" = findings broadly agree and add breadth; "Not codeable" = not enough data to reliably compare.

Discussion

Summary of Findings

This is the first case series of CAC (utilising a baseline period and follow-up) to assess the effectiveness of CAC, and qualitative interviewing and associated triangulation has attempted to explain how CAC works. In terms of effectiveness, this evidence suggests CAC is an effective intervention for both staff and clients in a CMHT. Client fragmentation benefited more than client distress, but clients remained above the clinical cut-offs throughout the study for both, indexing the degree of client complexity at intake. These findings challenge the Kellett et al. (2014) pilot trial results that found no change in client distress as a result of CAC. However, the qualitative findings were entirely more positive. CAC appears to be affecting the care system in that there were also statistically significant improvements in staff competence and emotional exhaustion, and the alliance from a client perspective (i.e. more competent staff creating better alliances). For staff, feeling able to share the emotionally demanding nature of client work with a consultant, may have resulted in a reduction in emotional exhaustion (Thompson, Kirk-Brown, & Brown, 2005).

All staff and most clients found the SDR helpful to affect change. Interestingly, more non-recovered clients reported improved exit and coping strategies as a result of CAC. Recovered clients certainly scored lower on measures of distress at screening than non-recovered clients. Perhaps, non-recovered clients were more complex, and benefitted from exit and coping strategies more than their recovered counterparts. The majority of clients found the CAC process hard but helpful to facilitate change. Staff demonstrated empathy for clients because they too thought going through CAC must have been difficult for clients but necessary to affect change. Both staff and clients found the therapist and/or the CAC framework important to affect change. The more a

client perceives positive therapist characteristics, the more sessions they will attend (Fiester, 1977; McNeill, May, & Lee, 1987; Olan, Deffenbacher, Guzman, Sharma, & Acuna, 2010), which can impact on outcomes (Steenbarger, 1994). There was a 100% completion rate, and this also reflects the general CAT evidence base of low dropout rates for CAT work (Calvert & Kellett, 2014).

Clinical Implications

Four out of five clients were discharged from the service within a year after completing CAC. Therefore, CAC shows health economic promise for working with adults with complex mental health difficulties in the community. Given that these clients were not considered suitable for direct therapy at that time, this is an important finding in relation to increasing psychological treatment options for clients (MIND, 2013). The brief nature of the consultation also presents implications for cost- and time-efficient delivery of CAC for adults with complex mental health difficulties. Otto, Pollack and Maki (2000) found that per-patient costs were substantially lower for empirically supported psychosocial treatments.

Statistically significant improvements in staff emotional exhaustion were observed during the course of CAC. Emotional exhaustion is regarded as the first step in the burnout process (Cordes & Dougherty, 1993; Lee & Ashforth, 1993), so it is critical to ensure staff are supported to manage their workload to reduce the associated risks of increased sickness and staff retention (Evans et al., 2006). The personal accomplishment subscale remained around the clinical cut-off point throughout CAC. Personal accomplishment is strongly related to lack of adequate resources (Lee & Ashforth, 1996; Bakker, Killmer, Siegriest, & Schaufeli, 2000) and has an impact for service leaders who wish to manage staff burnout through increasing a sense of accomplishment in working with clients (Huang, Wang & You, 2016). Findings suggest

that CAC can be effectively used to support staff competence and burnout whilst working with complex clients in a community mental health setting.

The present study has important clinical implications for practicing consultants. The mechanisms of change findings reveal continued support for developing a visual SDR in sessions ('mapping in the moment'; Potter, 2010) and not shying away from difficult conversations as both these processes appear to facilitate recovery. Therapists should continue to act as role models for staff and remain non-judgemental, friendly but persistent and firm to ensure low drop-out rates.

Theoretical Implications

One of the key differences of the Carradice (2013) protocol compared to other consultation models, is its use of the SDR. The SDR appears a containing feature of CAC from both client and staff perspectives, providing a visual aid to enable the care dyad to step back and disentangle itself from previously unhelpful or messy dynamics. CAC also advocates a therapist approach to locate difficulties in the system rather than the individual (Ryle & Kerr, 2002). Participants felt that the SDR, therapist approach, and acknowledging that difficult processes help recovery, contributed towards client recovery. This means that these factors can now be usefully added to the Carradice (2013) protocol.

Methodological Limitations and Future Research

This study had a small sample size and lacked randomisation. Future research might wish to use more robust methodological criteria, moving on from the first level of the 'hour glass' model (Salkovskis, 1995). Furthermore, future research could develop and use a CAC competency measure.

An important limitation of the study design was the length of time of follow-up. Due to CAC being a brief consultation approach (and not therapy), much of the changes

could be predicted to occur after completion of the consultation. As such, a six-week follow-up might not have observed participants' true changes. Future research might wish to adopt the follow-up practices of CAT therapists who typically offer four follow-up sessions spaced over six months (Ryle, 2004). Extending and formalising follow-up in this way, means that any difficulties the care dyad might be having in implementing CAC strategies can be problem-solved more regularly preventing too much drift from the approach. Extending follow-up could also manage staff and clients' anxiety about finishing CAC. Moreover, it might reduce re-referral rates or even loss of credibility of the approach if participants do not see positive outcomes straight away.

Service level measures of treatment success, such as frequency of contact with Care Coordinators (or other workers such as psychiatrists) between planned sessions were not measured in this study. Neither were crisis contact calls or admissions. Future research might wish to consider these as benchmarks for efficacy of CAC as they are objective measures that do not have the same level of risks associated with response bias as outcome measures. It would be important to establish a baseline level of contact, perhaps for the preceding six months prior to CAC and continue to monitor for at least six months after completion of CAC.

Whilst every effort was made to ask staff to complete measures taking into account only the presenting client, it would be difficult for staff separate out the impact of working with other clients on their caseloads. This means that measures of burnout and competence might have been impacted by general levels of burnout or competence related to other clients or their work more generally and vice versa. In addition, all qualitative findings were positive suggesting participants did not feel they could report the less positive aspects of CAC. Future research would need to consider how best to measure burnout, competence, and ensure balanced reporting.

Conclusions

This small case series has found CAC to be effective from both client and staff perspectives. From a client perspective, the consultation appeared to facilitate a degree of integration and from a staff perspective, workers were less emotional exhausted by their work. CAC is a systemic approach and the system appears to be affected by the intervention. Clearly, the approach is difficult to deliver, with consultants needing to be well trained in the model (Association for Cognitive Analytic Therapy, 2014) and also well supported via consultation supervision, as was the case here. CAT may be a useful approach for intervening at an organisational level and examples are starting to emerge of this wider systemic work (Shannon & Parry, 2017). This research has also shed light on the potential mechanisms of change of CAC and included the therapist's approach, using the SDR, and acknowledging difficult processes help recovery. This means that these factors can be now usefully added to the Carradice (2013) protocol. The SDR appears a containing feature of CAC from both client and staff perspectives – a visual aid to enable the care dyad to step back and disentangle itself from previously unhelpful or messy dynamics. Findings indicate further systematic research in this area, and head-to-head comparisons with other consultation approaches (e.g. Berry et al., 2015) appear indicated.

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Appendices

Appendix D. Scientific Approval from University of Sheffield

The University Of Sheffield.

DEPARTMENT OF PSYCHOLOGY.
CLINICAL PSYCHOLOGY UNIT.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinpsy@sheffield.ac.uk
Please address any correspondence to Ian Macdonald, Research Support Officer

28th May 2015

To: Research Governance Office

Dear Sir/Madam,

RE: Confirmation of Scientific Approval and indemnity of enclosed Research Project

Project title: Cognitive Analytic Consultancy: A small N case series
Investigators: Jeetender Ghag (DClin Psy Trainee, University of Sheffield); Dr. Stephen Kellett (Academic Supervisor, University of Sheffield).

I write to confirm that the enclosed proposal forms part of the educational requirements for the Doctoral Clinical Psychology Qualification (DClin Psy) run by the Clinical Psychology Unit, University of Sheffield.

Three independent reviewers appointed by the Clinical Psychology Unit Research Sub-committee have scientifically reviewed it.

I can confirm that all necessary amendments have been made to the satisfaction of the reviewers, who are now happy that the proposed study is of sound scientific quality. Consequently, the University will also indemnify it and would be happy to act as research sponsor once ethical approval has been gained.

Given the above, I would remind you that the Unit already has an agreement with your office to exempt this proposal from further scientific review. However, if you require any further information, please do not hesitate to contact me.

Yours sincerely

[redacted]

Dr. Andrew Thompson
Director of Research Training

Cc. Jeetender Ghag; Dr. Stephen Kellett

Appendix E. Ethical Approval from Research Ethical Committee

NHS
Health Research Authority
NRES Committee Yorkshire & The Humber - South Yorkshire
Unit 001
Jarrow Business Centre
Rolling Mill Road
Jarrow
Tyne and Wear
NE32 3DT

Telephone: 0191 428 3565

27 August 2015

Ms Jeetender Ghag
Clinical Psychology Unit
University of Sheffield
Sheffield
S10 2TN

Dear Ms Ghag

Study title:	**Cognitive Analytic Consultancy: A small N case series**
REC reference:	**15/YH/0336**
IRAS project ID:	**183554**

Thank you for your letter of 22 August 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Ms Gillian Mayer, nrescommittee.yorkandhumber-southyorks@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a **Favourable** ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

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

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

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

Guidance on applying for NHS permission for research is available in the Integrated

Appendix E. (cont.)

Research Application System or at http://www.rdforum.nhs.uk.

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

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

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

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

Ethical review of research sites

NHS sites

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

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering letter on headed paper [covering letter]	1.0	26 June 2015
GP/consultant information sheets or letters [Letter to GP]	1.0	03 July 2015
Interview schedules or topic guides for participants [Change Interview: Client]	1.0	03 July 2015
Interview schedules or topic guides for participants [Change Interview: Staff]	1.0	03 July 2015
Non-validated questionnaire [Ideographic Measure: Staff]	1.0	27 May 2015
Non-validated questionnaire [Ideographic Measure: Client]	1.0	27 May 2015
Other [Debrief Sheet]	1.0	27 May 2015
Other [Demographic Information Sheet: Care Coordinators]	1.0	27 May 2015
Other [Demographic Information sheet: Clients]	1.0	27 May 2015

Appendix E. (cont.)

Other [Adverse Incident Form]	1.0	27 May 2015
Other [Interventions Summary Sheet]	1.0	27 May 2015
Other [research contract]	1.0	27 May 2015
Other [letter to care coordinators]	1.0	27 May 2015
Other [costing form]	1.0	27 May 2015
Other [Care Coordinator Information Sheet]	1.0	13 August 2015
Other [Consent Form Care Coordinators]	1.0	13 August 2015
Other [REC decision response letter]	1.0	22 August 2015
Participant consent form [Consent form]	2.0	13 August 2015
Participant information sheet (PIS) [PIS]	2.0	13 August 2015
REC Application Form [REC_Form_03072015]		03 July 2015
Referee's report or other scientific critique report [Scientific approval letter]	1.0	28 May 2015
Research protocol or project proposal [research protocol]	2.0	13 August 2015
Summary CV for Chief Investigator (CI) [CI CV]	v 1.0	27 May 2015
Summary CV for supervisor (student research) [Stephen Kellett CV]	v.1	15 June 2015
Summary, synopsis or diagram (flowchart) of protocol in non-technical language [timetable of activities]	1.0	27 May 2015
Summary, synopsis or diagram (flowchart) of protocol in non-technical language [timetable of activities]	1.0	27 May 2015
Validated questionnaire [CORE-10]	1.0	27 May 2015
Validated questionnaire [Perceived Competence Scale]	1.0	27 May 2015
Validated questionnaire [CORE-10]	1.0	27 May 2015
Validated questionnaire [PSQ]	1.0	27 May 2015
Validated questionnaire [WAI-Client]	1.0	27 May 2015
Validated questionnaire [WAI-Therapist]	1.0	27 May 2015

Statement of compliance

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

After ethical review

Reporting requirements

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

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

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the

Appendix E. (cont.)

feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

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

15/YH/0336	Please quote this number on all correspondence

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

Yours sincerely
pp

Dr Ian Woollands
Chair

Email: nrescommittee.yorkandhumber-southyorks@nhs.net

Enclosures: 'After ethical review – guidance for researchers'

Copy to: *Ms Deborah McClean – R&D Dept, University of Sheffield*

Ms Rosie Jubb – R&D Dept, Sheffield NHS Foundation Trust

Appendix F. Letter to Care Coordinators

27.5.15 version 1.0

Rotherham Metropolitan Borough Council
Neighbourhoods & Adult Services

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

Community Therapies Team
Ferham Clinic
Kimberworth Road
ROTHERHAM
South Yorkshire
S61 1AJ
Tel: 01709 447280
Fax: 01709 322648

Letter to Care Co-ordinators

Dear [insert name of Care Co-ordinator],

Re: Cognitive Analytic Consultancy: A small *N* case series.

As a Trainee Clinical Psychologist, I am required to complete a thesis project. I am writing to you to ask if you would be willing to help with this project by identifying potential participants for the study. The study aims to explore whether Cognitive Analytic Consultancy is effective for service users and professionals. Cognitive Analytic Consultancy (CAC) involves a CAC practitioner, a mental health worker (usually the Care Coordinator) and a client working jointly to develop a map to understand the clients present difficulties, their patterns of coping and to support care planning. Currently, there is very little research available on CAC, therefore, participants input might contribute to knowledge in this area.

Who can take part?
When identifying potential participants please consider the following criteria:

Inclusion Criteria:

1. The client must be currently accessing the team.
2. You and/or your team must be experiencing some difficulties in working with the client.
3. The client must be considered not suitable for one-to-one or group psychological therapy.
4. The participant must be able to give fully informed consent.

Exclusion Criteria:

1. Those who do not speak, read or write English and cannot provide fully informed consent.
2. Anyone under any legal restrictions under the Mental Health Act (2007).
3. Anyone under the age of 18 years old.
4. Anyone who is floridly psychotic or manic.

Appendix F. (cont.)

27.5.15 version 1.0

What does the study involve?
CAC usually involves a clinical psychologist offering five to seven sessions of CAC to you and your client. This means that together, you would be working to understand what the current issues are for the client, and how they might have formed depending on their earlier life experiences. Some of the ways in which the client has learned to interact with others, might contribute to their current actions and difficulties. By understanding these patterns of interacting, it is hoped the CAC will support both you and the client to be able to move forwards in their care.

If you and your client decide to take part in the study, you will both complete outcome measures at the beginning of every session. This is to help us understand if the intervention has been effective in any way for you both. I will contact you by telephone one week after the very first session to complete the measures. The sessions should take between one and two hours to complete. After CAC has finished, I will conduct a one-to-one interview with you and the client to explore your experiences of CAC.

What will happen to the data?
The information collected during this study will be used to produce my Doctoral level thesis. All the information provided will be treated in confidence. This means that participants names will not be passed on to anyone else and the information will be used solely for the research or teaching purposes of the University of Sheffield. In terms of confidentiality, names and other identifying information will be changed. The only time my academic supervisor, the CAC practitioner or I would reveal anything to an appropriate authority would be if the participant divulges information that we feel could potentially put the participant or another person at risk of harm. This decision would only be taken following full consultation with my academic supervisor.

What next?
I have enclosed a Participant Information Sheet and Consent Form for you to have a look at which should answer any further questions you may have about this study. However, if you or any potential participants would like any further information please contact 0114 447280 and ask for Dr Katie Ackroyd (Clinical Psychologist) who will call you back as soon as possible.

If you feel that any of the service users you work with meet the participant inclusion/exclusion criteria (outlined above) then I would be grateful if you could pass on one of the enclosed Participant Information Sheets to the client.

Yours sincerely,

Jeetender Ghag

(Trainee Clinical Psychologist)

Appendix G. Staff Consent Form

13.8.15 Version 1.0

Rotherham Metropolitan Borough Council
Neighbourhoods & Adult Services

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

Community Therapies Team
Ferham Clinic
Kimberworth Road
ROTHERHAM
South Yorkshire
S61 1AJ
Tel: 01709 447280
Fax: 01709 322648

Consent Form (Care Coordinator)

Project Title: Cognitive Analytic Consultancy: A small *N* case series.
Trainee Clinical Psychologist: Jeetender Ghag
Project Supervisor: Dr Stephen Kellett
NHS Supervisor: Dr Katie Ackroyd

Please initial next to each statement and sign where indicated below:

☐ I confirm that I have read and understood the information sheet dated [insert date] ..... and understand what is expected of me. .....

☐ I understand that my participation is completely voluntary. .....

☐ I understand that I am free to withdraw from the study at any time before the consultancy sessions, stop the study at any time during consultancy sessions, and I am free to withdraw my data from the study at any time up to two weeks after the consultancy sessions without my medical care or legal rights being affected. Should I not wish to answer any particular question or questions, I am free to decline. .....

☐ I confirm that I have been given the opportunity to ask questions regarding the study, and if asked, the questions were answered to my full satisfaction. .....

☐ (If appropriate) I understand that the information held and maintained by the Health and Social Care Information Centre (or amend as appropriate)

Appendix G. (cont.)

13.8.15 Version 1.0

and other central UK NHS bodies may be used to help contact me or provide information about my health status. .....

☐ I agree to take part in the above research project. .....

Data Protection Act

I understand that data collected from me during this study will be stored on computer and that any computer files containing information about me will be made anonymous. I also understand that this consent form will be stored separately from any data that I provide.

I agree to the University of Sheffield recording and processing my data and that these data will be used for a Doctoral level thesis, and may be presented in other academic forums (e.g., academic journals, at conferences, or in teaching). I understand that my data will be used only for these purposes and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act. I understand that outside of my care team,the only other person that will know my real name will be the Cognitive Analytical Consultancy practitioner who will have access to my details.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

To be signed and dated in the presence of the participant

Copies (3: client, file and trainee)

Thank you for taking the time to consider this research.

Appendix H. Client Information Sheet

7.12.15 Version 3.0

Rotherham Metropolitan Borough Council
Neighbourhoods & Adult Services

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

Community Therapies Team
Ferham Clinic
Kimberworth Road
ROTHERHAM
South Yorkshire
S61 1AJ
Tel: 01709 447280
Fax: 01709 322648

Participant Information Sheet

Project title: Cognitive Analytic Consultancy: A small *N* case series.

Trainee Clinical Psychologist: Jeetender Ghag

Academic supervisor: Dr Stephen Kellett

NHS Supervisor: Dr Katie Ackroyd

Invitation to participate

You are being invited to take part in a research project. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. If by the end of reading this you decide not to take part in the research, you do not need to give a reason and the standard of care you receive from your mental health team will not be affected. Thank you for reading this.

What is the project about?

Cognitive Analytic Consultancy is one way that you and your Care Coordinator can understand your current difficulties. You and your Care Coordinator would work with a Clinical Psychologist to understand how your current issues might have formed depending on your earlier life experiences. Some of the ways in which you have learned to interact with others might have contributed to your current actions and difficulties. By understanding these patterns of interacting, it is hoped the Cognitive Analytic Consultancy will support both you and your Care Coordinator to be able to move forwards in your care.

The project aims to measure whether offering you and your Care Coordinator seven sessions of Cognitive Analytic Consultancy is effective for you both. The whole project will take between six and eight months from start to end. If you decide to take part, it will take approximately 18-22 weeks for the intervention from start to end.

Appendix H. (cont.)

What will I be asked to do?
The project involves both you and your Care Coordinator meeting with a Cognitive Analytic Consultancy practitioner up to seven times. The first six sessions will be completed once every fortnight and you will be offered a follow-up session six to ten weeks after your last session. You do not have to respond to a question if you do not wish. Each session should take no longer than hour. Throughout the study you will be asked to complete some questionnaires to see if the intervention is helping you. After the sessions have finished we will invite you to come for a one-to-one meeting to tell us about your experiences about the intervention.

What are the advantages and disadvantages of taking part?
Currently, there is very little research available on Cognitive Analytic Consultancy and whether it can help to improve the care that clients receive. Therefore, your participation may contribute to knowledge in this area. You can request a Summary Sheet with the results of the study once it has been completed if you wish.

We also anticipate that you and you Care Coordinator will possibly benefit from receiving Cognitive Analytic Consultancy. The benefits to you might be that you understand the reasons why you sometimes feel the way you do or that you can find alternative ways of dealing with things. The reason your Care Coordinator is there, is to help them to support you in a way that might be more helpful to you, which means that you might both benefit from taking part in the study.

There are no anticipated disadvantages to yourself, other than the time taken for you to be involved. Some people find talking about their problems difficult to do, and if this is the case for you, your Care Coordinator and the Cognitive Analytic Consultancy practitioner can support you with these feelings in the first instance.

How will my information be used?
The information collected during the study will be used to produce a Doctoral level thesis. The people who might read this in an official capacity are the researcher's academic supervisor, other members of the psychology staff and external examiners. Additionally, the information may be published in academic journals, presented at academic conferences, or used for teaching purposes. Although the information may be used for these purposes, you will not be identifiable in any way through these activities because your name and other identifying information will be changed.

Will my information be confidential/anonymous?
All the information you provide will be treated in confidence. This means that your name will not be passed on to anyone else and your information will be used solely for the research or teaching purposes of the University of Sheffield. In terms of confidentiality, your name, the name of the service and other identifying information will be changed to ensure that you are not identifiable in any way.

The only time that the Cognitive Analytic Consultancy practitioner would reveal anything to an appropriate authority would be if you divulge information that they feel could potentially put you or another person at risk of harm. This decision would only be taken following full consultation with the academic supervisor.

Appendix H. (cont.)

What happens if the project stops earlier than expected?
We do not anticipate that the project will stop early. However, if the project stops earlier than we expect then we will inform you of this. You can expect to continue with your Cognitive Analytic Consultancy to the end as has been described so there will be no consequence to you. However, all of your data related to the project will be safely and securely destroyed.

Can I change my mind?
Yes, you can stop taking part in the study at any time, either before the Cognitive Analytic Consultancy begins or at any time after the sessions have begun. You can also ask for part or all of your data to be destroyed for up to two weeks after the follow-up session. You can do this without any negative consequences and you do not need to provide a reason. If you would like to withdraw your data, please contact Jeetender Ghag directly (see below) with the pseudonym, you will be given at the end of the last session.

What if something goes wrong?
Please contact Jeetender Ghag on 0114 447280 and leave a message to be contacted back. This study is being sponsored and indemnified by the University of Sheffield. If you feel your concerns are not being dealt with, you can contact the University Secretary on 0114 2226649.

Who can I contact for further information?

Call Dr Dawn Bennnett on ..... About this research or for general information about research

and/or Jeetender Ghag on 0114 447280 about this research project

and/or Dr Katie Ackroyd on 0114 447280 about this research project.

What happens next?

If you feel that you would like to be involved in this study but would like more information before you agree, then you can speak to Dr Katie Ackroyd directly (see contact details above). Once you feel you have enough information and still wish to take part then you can let your Care Coordinator know, who will arrange for you both to meet the Cognitive Analytic Consultancy practitioner for an initial screening session, where you can ask any further questions you have. If, at this stage, you are still interested in taking part in the study, then you can sign a Consent Form to confirm this.

Please think carefully about whether or not you wish to take part in the study. Whether you decide to take part or not, will not affect the standard of care you receive from your community mental health team. If you decide you *do not* want to take part in the study you do not need to give a reason and do not need to do anything else. If you *do* wish to take part, please contact your Care Coordinator, ... (insert Care Coordinator name), by .....(insert date two weeks from receipt).

Thank you for considering participating.

Appendix I. Client Consent Form

13.8.15 Version 2.0

Rotherham Metropolitan Borough Council
Neighbourhoods & Adult Services

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

Community Therapies Team
Ferham Clinic
Kimberworth Road
ROTHERHAM
South Yorkshire
S61 1AJ
Tel: 01709 447280
Fax: 01709 322648

Consent Form (Client)

Project Title: Cognitive Analytic Consultancy: A small *N* case series.
Trainee Clinical Psychologist: Jeetender Ghag
Project Supervisor: Dr Stephen Kellett
NHS Supervisor: Dr Katie Ackroyd

Please initial next to each statement and sign where indicated below:

- ☐ I confirm that I have read and understood the information sheet dated [insert date] ..... and understand what is expected of me. .....
- ☐ I understand that my participation is completely voluntary. .....
- ☐ I understand that I am free to withdraw from the study at any time before the consultancy sessions, stop the study at any time during consultancy sessions, and I am free to withdraw my data from the study at any time up to two weeks after the consultancy sessions without my medical care or legal rights being affected. Should I not wish to answer any particular question or questions, I am free to decline. .....
- ☐ I confirm that I have been given the opportunity to ask questions regarding the study, and if asked, the questions were answered to my full satisfaction. .....
- ☐ (If appropriate) I understand that the information held and maintained by the Health and Social Care Information Centre (or amend as appropriate)

Appendix I. (cont.)

13.8.15 Version 2.0

and other central UK NHS bodies may be used to help contact me or provide information about my health status. .....

☐ I agree to take part in the above research project. .....

Data Protection Act

I understand that data collected from me during this study will be stored on computer and that any computer files containing information about me will be made anonymous. I also understand that this consent form will be stored separately from any data that I provide.

I agree to the University of Sheffield recording and processing my data and that these data will be used for a Doctoral level thesis, and may be presented in other academic forums (e.g., academic journals, at conferences, or in teaching). I understand that my data will be used only for these purposes and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act. I understand that outside of my care team, the only other person that will know my real name will be the Cognitive Analytical Consultancy practitioner who will have access to my details.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

To be signed and dated in the presence of the participant

Copies (3: client, file and trainee)

Thank you for taking the time to consider this research.

Appendix J. Client Demographic Sheet

27.5.15 Version 1.0

Rotherham Metropolitan Borough Council
Neighbourhoods & Adult Services

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

Community Therapies Team
Ferham Clinic
Kimberworth Road
ROTHERHAM
South Yorkshire
S61 1AJ
Tel: 01709 447280
Fax: 01709 322648

DEMOGRAPHIC INFORMATION SHEET (CLIENT)

Please complete this form, only answer those questions that you feel able to answer, all information you provide will remain completely confidential.

Date of birth .....

Gender (please tick the box that applies)

Male	☐
Female	☐

Marital status

Single	☐
Married/civil partnership	☐
Divorced/Separated	☐
Widowed	☐
Other	☐

Highest educational qualification

No formal qualifications	☐
O Levels/GSCE	☐
A Levels/Higher grade	☐
Undergraduate University	☐
Postgraduate University or above	☐

Appendix J. (cont.)

27.5.15 Version 1.0

How would you describe your ethnic Origin? (e.g. White British)

.....

.....

Do you take any medication? (Please list below)

.....

.....

.....

.....

What is your current diagnosis?

.....

.....

How long have you had this diagnosis?

.....

.....

Thank you for completing this form

For staff to complete

For confidentiality purposes: number allocated .....

Appendix K. Care Coordinator Demographic Sheet

27.5.15 Version 1.0

Rotherham Metropolitan Borough Council
Neighbourhoods & Adult Services

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

Community Therapies Team
Ferham Clinic
Kimberworth Road
ROTHERHAM
South Yorkshire
S61 1AJ
Tel: 01709 447280
Fax: 01709 322648

DEMOGRAPHIC INFORMATION SHEET (CARE COORDINATOR)

Please complete this form, only answer those questions that you feel able to answer, all information you provide will remain completely confidential.

Gender (please tick the box that applies)

Male ☐

Female ☐

Professional background (e.g. nurse, occupational therapist)

.....

.....

Please insert years and/or months:

1. How many years of experience do you have in your profession? .....
2. How long have you been a Care Coordinator?.....
3. How long have you worked in your current team?.....
4. How long have you worked with the client presented?.....

Thank you for completing this form

For staff to complete

For confidentiality purposes: number allocated.....

Appendix L. Intervention Summary Sheet

27.5.15 Version 1.0

INTERVENTION SUMMARY SHEET FOR CAC PRACTITIONER

Content and structure for meeting with Care Coordinator:

- Meet with the Care Coordinator for half an hour before and after each three-way meeting.
- Allow the Care Coordinator to discuss their difficulties and reactions when working with the client so that they can begin to understand the processes that are playing out between them and the client.
- Begin to think about a reformulation.
- Consider exits from the problematic patterns.

3-way sessions	Suggested content
Screening session	• Explain the model and what it involves • Explain that by the end there aims to be a map to help understand the repeating patterns that the client experiences and have a plan for the Care Coordinator and client to take forward • Identify any possible goals, if the client has any • Address expectations ensuring the focus is on realism and being clear about what can be achieved by the end and implications – patterns, map, ideas about what might help • Ending issues, deal with processes that arise • Answer questions and gain informed consent • Set the contract – number of sessions, the dates, what happens if someone is ill, DNA's
1	• Revisit issues above, ensure have informed consent • Looking for patterns/states using 24-hour clock exercise • Give a copy of the psychotherapy file and explain it
2	• Complete 24-hour clock • Psychotherapy file, presentation in session and examples from daily life • Goals for care plan, thoughts about change and motivation
3	• Complete psychotherapy file • Ensure clear understanding of the risks • Revisit goals (if needed)
4	• Explain the concept of reciprocal roles (RR) and suggest their unhelpful ones from the material from the sessions • Draw draft SDR (may be contextual)
5	• Feedback on map • Work together on identifying/clarifying goals, steps of change, exit list and plan • Clarify date for 3 month follow-up appointment
Follow-up session	• Explore any on-going issues that might be occurring between the care dyad • Revisit goals and exit plan • Ending

Adapted from Carradice (2013)

Appendix M. Personality Structure Questionnaire

(Pollock, Broadbent, Clarke, Dorrian, & Ryle, 2001)

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Appendix M. (cont.)

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Appendix N. Clinical Outcome in Routine Evaluation 10 (Barkham et al., 2013)

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Appendix O. Working Alliance Inventory – Short (Client: Tracey & Kokotrovic, 1989)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix O. (cont.)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix P. Working Alliance Inventory – Short (staff: Tracey & Kokotovik, 1989)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix P. (cont.)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix Q. Abbreviated Maslach Burnout Inventory (Maslach, Jackson, & Leitter, 1996)

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Appendix Q. (cont.)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix R. Perceived Competence Scale (Deci & Ryan, 1985)

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Appendix S. Idiographic Client Measures

27.5.15 Version 1.0

Monitoring how I have been getting on in the last 7 days

Todays Date .....

This form is to review the week prior to the meeting

HOW DID YOU FEEL ABOUT YOURSELF THIS WEEK?
Use your own words to describe the positive and negative extremes (e.g. accepting myself 1 to very critical 10) and then rate it on the scale below

Word = **Word =**
1 2 3 4 5 6 7 8 9 10

HOW DID OTHER PEOPLE GET ON WITH YOU THIS WEEK?
Use your own words to describe the positive and negative extremes (e.g. supportive of me 1 to very hostile 10) and then rate it on the scale below

Word = **Word =**
1 2 3 4 5 6 7 8 9 10

HOW DID YOU GET ON WITH OTHER PEOPLE THIS WEEK?
Use your own words to describe the positive and negative extremes (e.g. in harmony 1 to in conflict 10) and then rate it on the scale below

Word = **Word =**
1 2 3 4 5 6 7 8 9 10

HOW DID YOU GET ON WITH YOUR CARE TEAM THIS WEEK?
Use your own words to describe the positive and negative extremes (e.g. unhelpful 1 to helpful 10) and then rate it on the scale below

Word = **Word =**
1 2 3 4 5 6 7 8 9 10

27.5.15 Version 1.0

DIARY SHEET FOR STAFF
Please complete this prior to each appointment

DATE .....

Client ID .....

TAREGT PROBLEM:										
TARGET PROBLEM PROCEDURE:										
Rate the ability of the client to **recognise** the problem and pattern	1 totally unaware	2	3	4	5	6	7	8	9	10 very aware
Rate the ability of the client to **revise** the problem and pattern	1 stuck	2	3	4	5	6	7	8	9	10 changing

TAREGT PROBLEM:										
TARGET PROBLEM PROCEDURE:										
Rate the ability of the client to **recognise** the problem and pattern	1 totally unaware	2	3	4	5	6	7	8	9	10 very aware
Rate the ability of the client to **revise** the problem and pattern	1 stuck	2	3	4	5	6	7	8	9	10 changing

TAREGT PROBLEM:										
TARGET PROBLEM PROCEDURE:										
Rate the ability of the client to **recognise** the problem and pattern	1 totally unaware	2	3	4	5	6	7	8	9	10 very aware
Rate the ability of the client to **revise** the problem and pattern	1 stuck	2	3	4	5	6	7	8	9	10 changing

TAREGT PROBLEM:										
TARGET PROBLEM PROCEDURE:										
Rate the ability of the client to **recognise** the problem and pattern	1 totally unaware	2	3	4	5	6	7	8	9	10 very aware
Rate the ability of the client to **revise** the problem and pattern	1 stuck	2	3	4	5	6	7	8	9	10 changing

Appendix U. Change Interview Schedule – Client

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix U. (cont.)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix U. (cont.)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix U. (cont.)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix V. Change Interview Schedule – Staff

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix V. (cont.)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

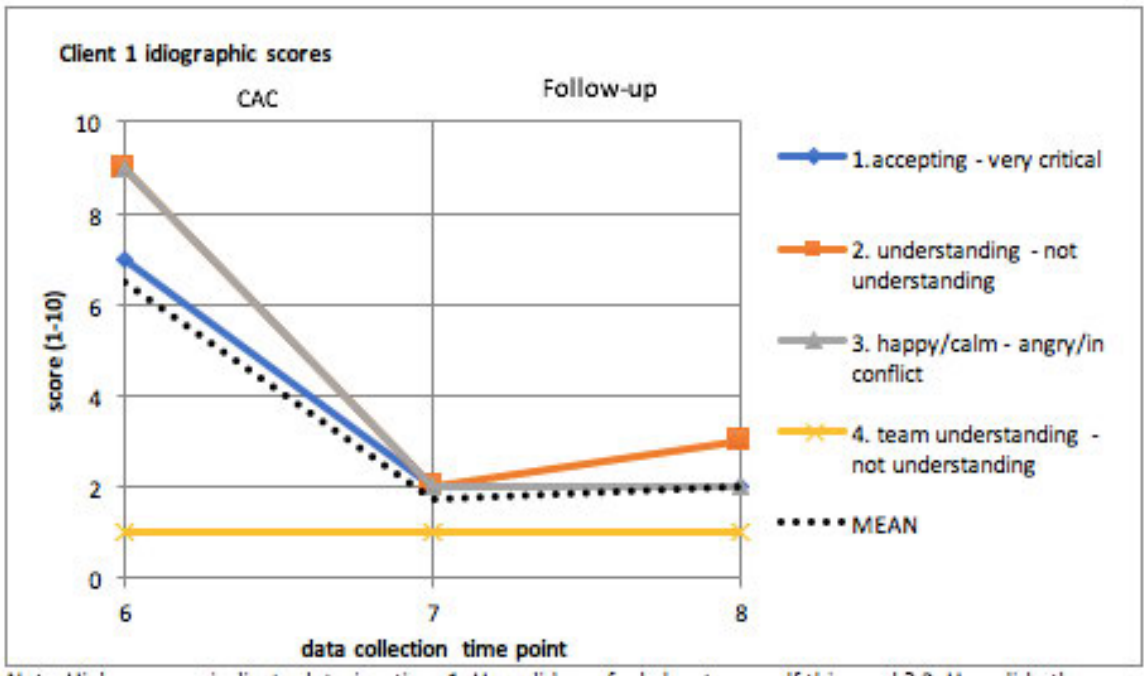
Appendix V. (cont.)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

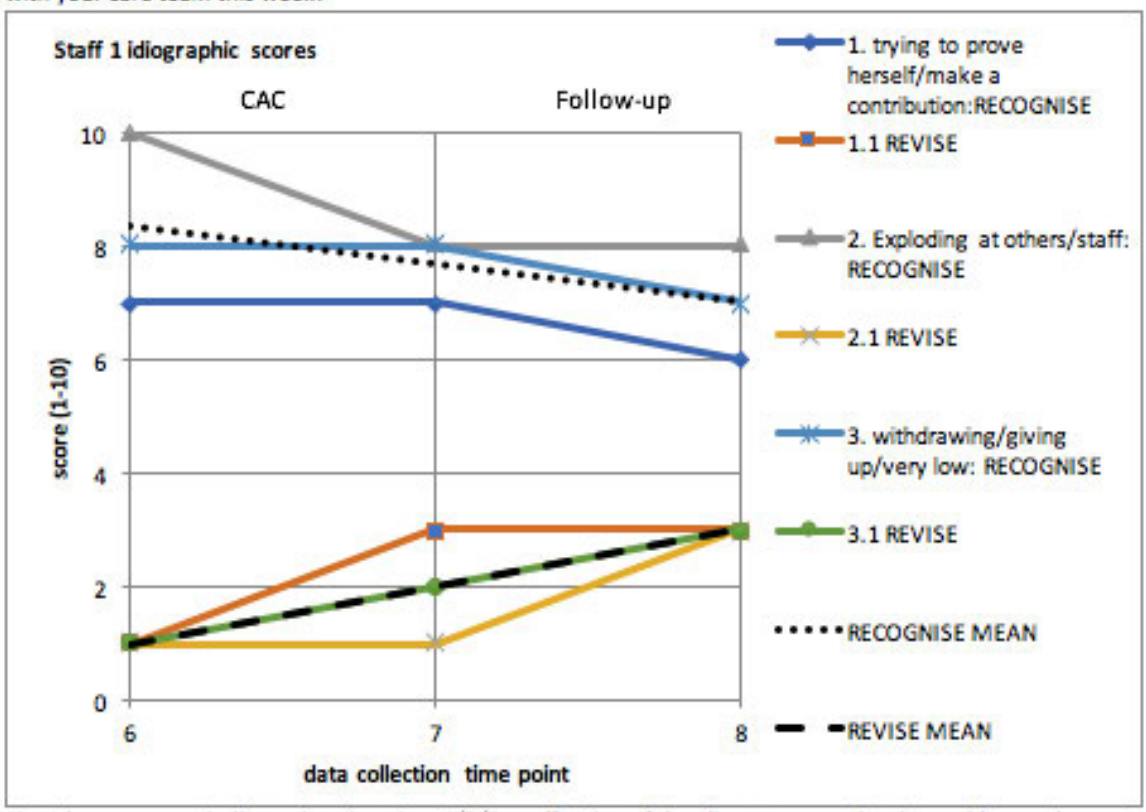
Appendix V. (cont.)

REMOVED DUE TO COPYRIGHT RESTRICTIONS

Appendix W. Idiographic Graphs

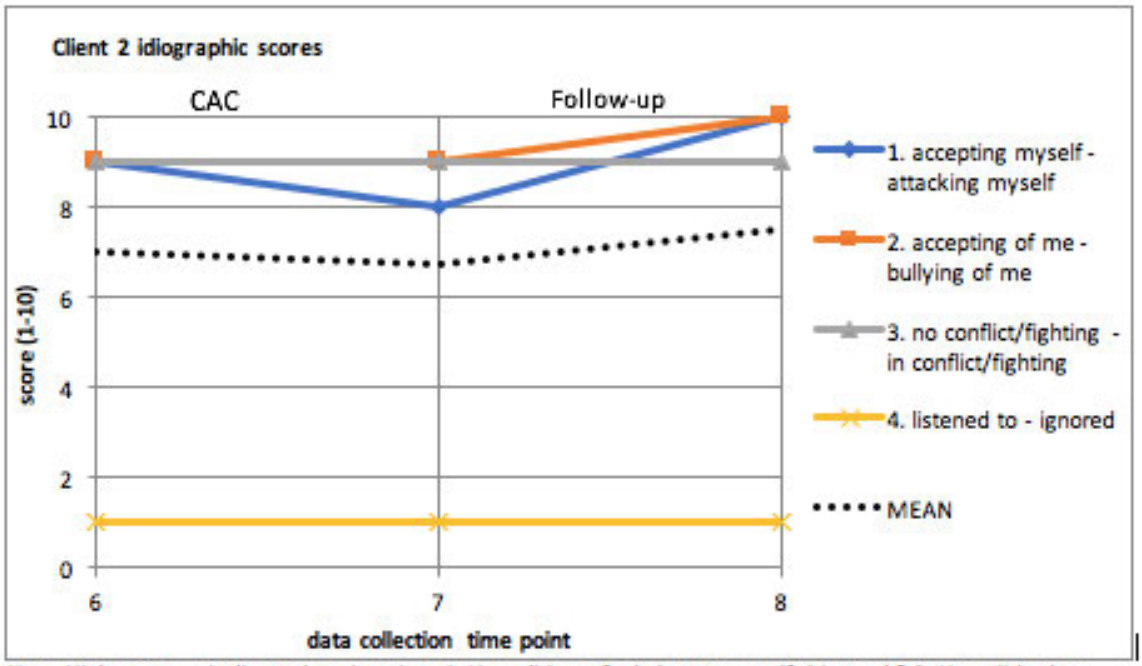


Note. Higher scores indicate deterioration. 1=How did you feel about yourself this week? 2=How did other people get on with you this week? 3=How did you get on with other people this week? 4=How did you get on with your care team this week?

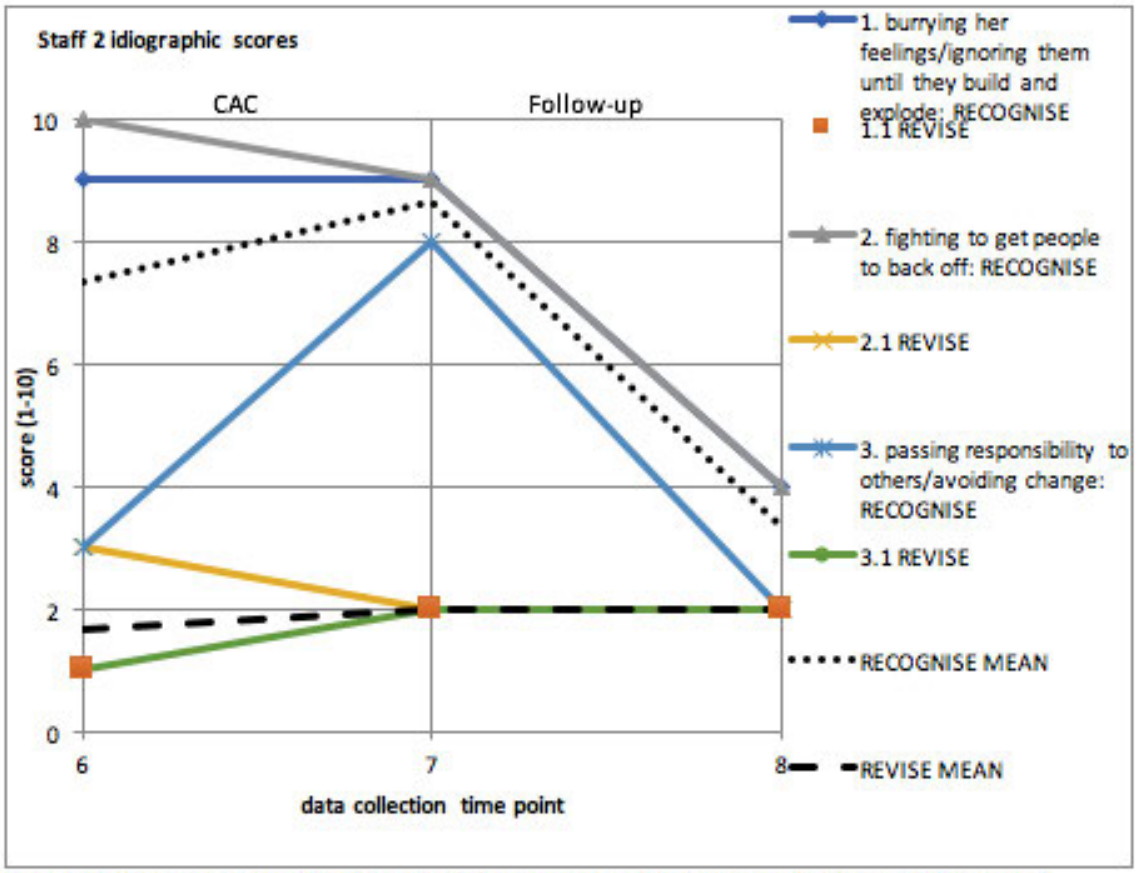


Note. Lower scores indicate deterioration. 1/2/3=staff rating of the client to recognize the problem and pattern from 1=totally unaware to 10=very aware. 1.1/2.1/3.1=staff rating of the client's ability to revise the problem and pattern from 1=stuck to 10=changing

Appendix W. (cont.)

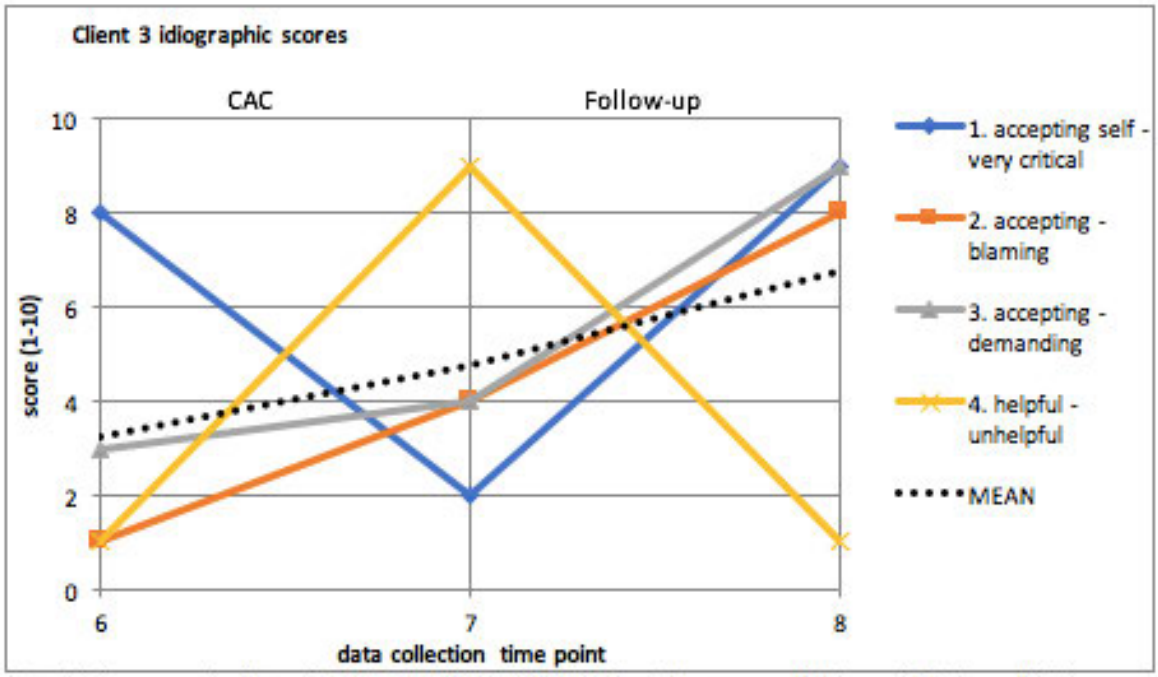


Note. Higher scores indicate deterioration. 1=How did you feel about yourself this week? 2=How did other people get on with you this week? 3=How did you get on with other people this week? 4=How did you get on with your care team this week?

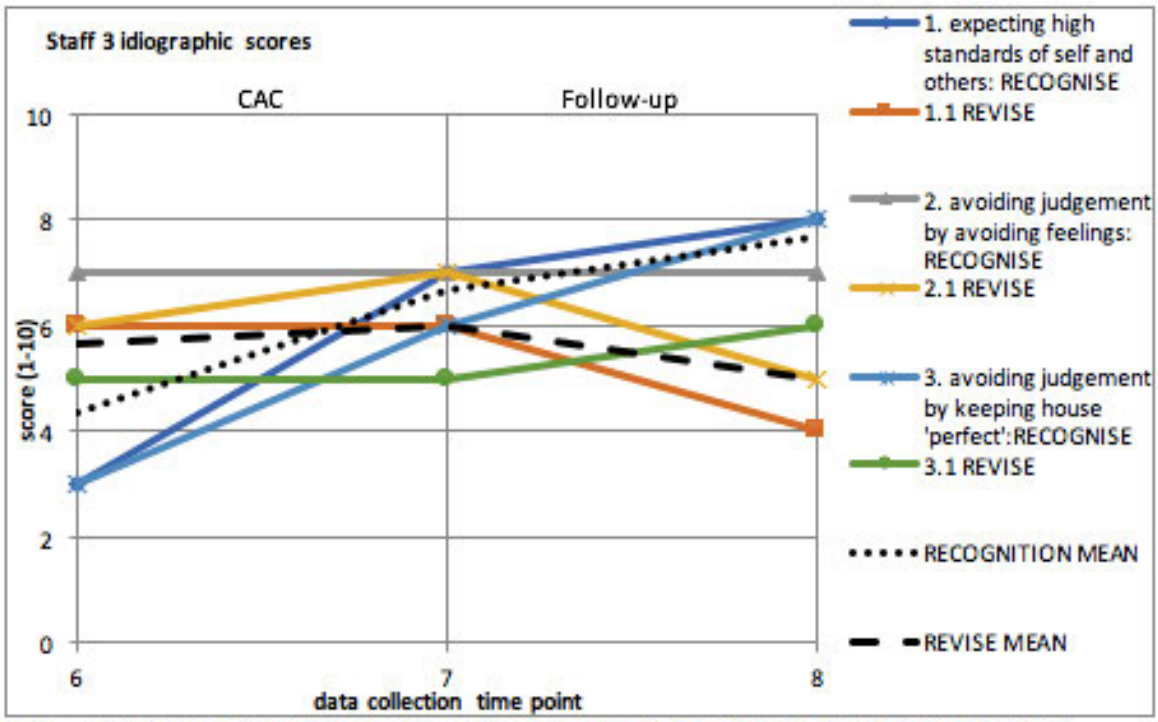


Note. Lower scores indicate deterioration. 1/2/3=staff rating of the client to recognize the problem and pattern from 1=totally unaware to 10=very aware. 1.1/2.1/3.1=staff rating of the client's ability to revise the problem and pattern from 1=stuck to 10=changing

Appendix W. (cont.)

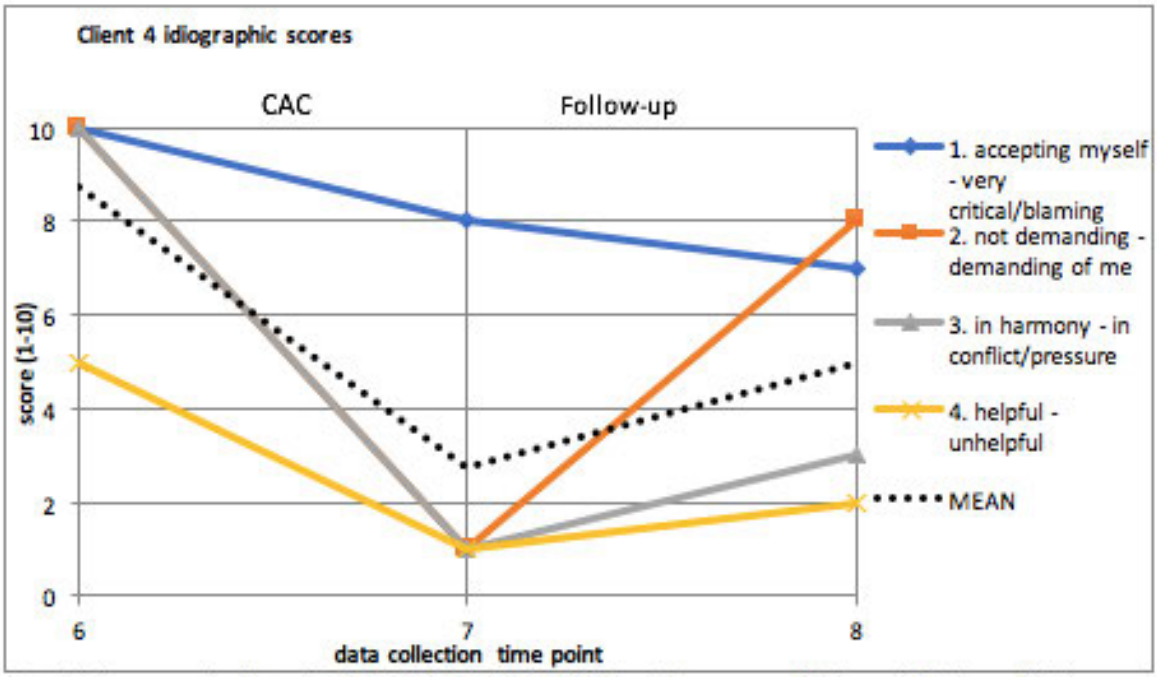


Note. Higher scores indicate deterioration. 1=How did you feel about yourself this week? 2=How did other people get on with you this week? 3=How did you get on with other people this week? 4=How did you get on with your care team this week?

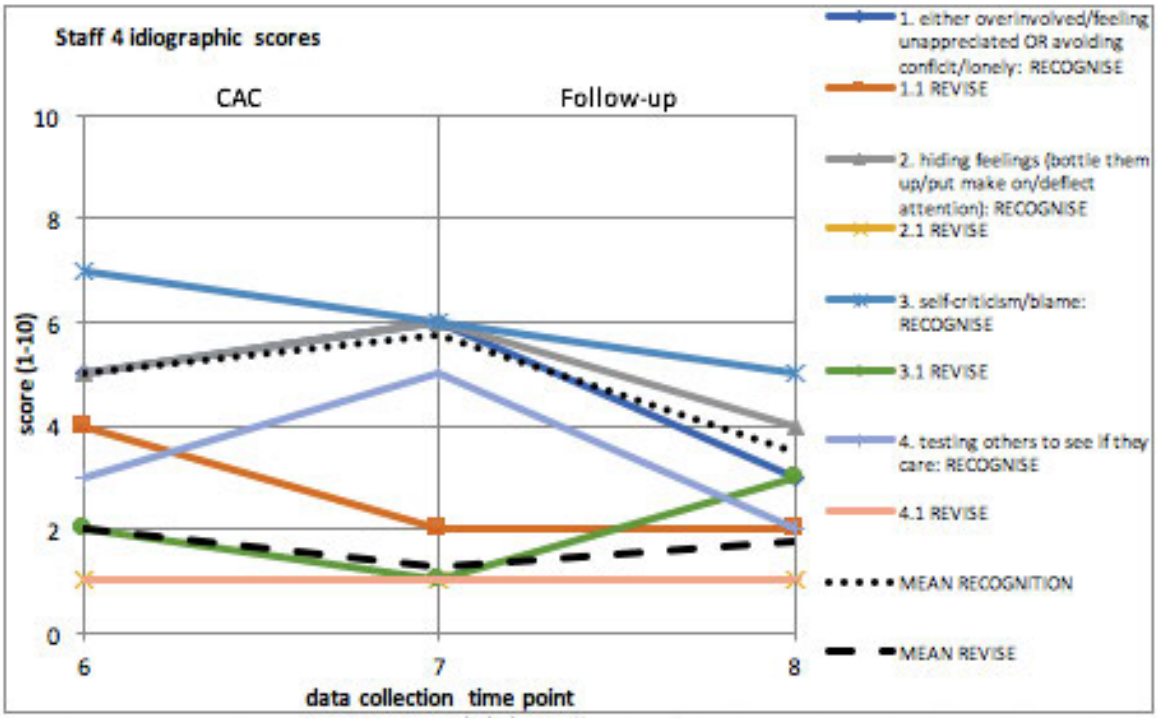


Note. Lower scores indicate deterioration. 1/2/3=staff rating of the client to recognize the problem and pattern from 1=totally unaware to 10=very aware. 1.1/2.1/3.1=staff rating of the client's ability to revise the problem and pattern from 1=stuck to 10=changing

Appendix W. (cont.)

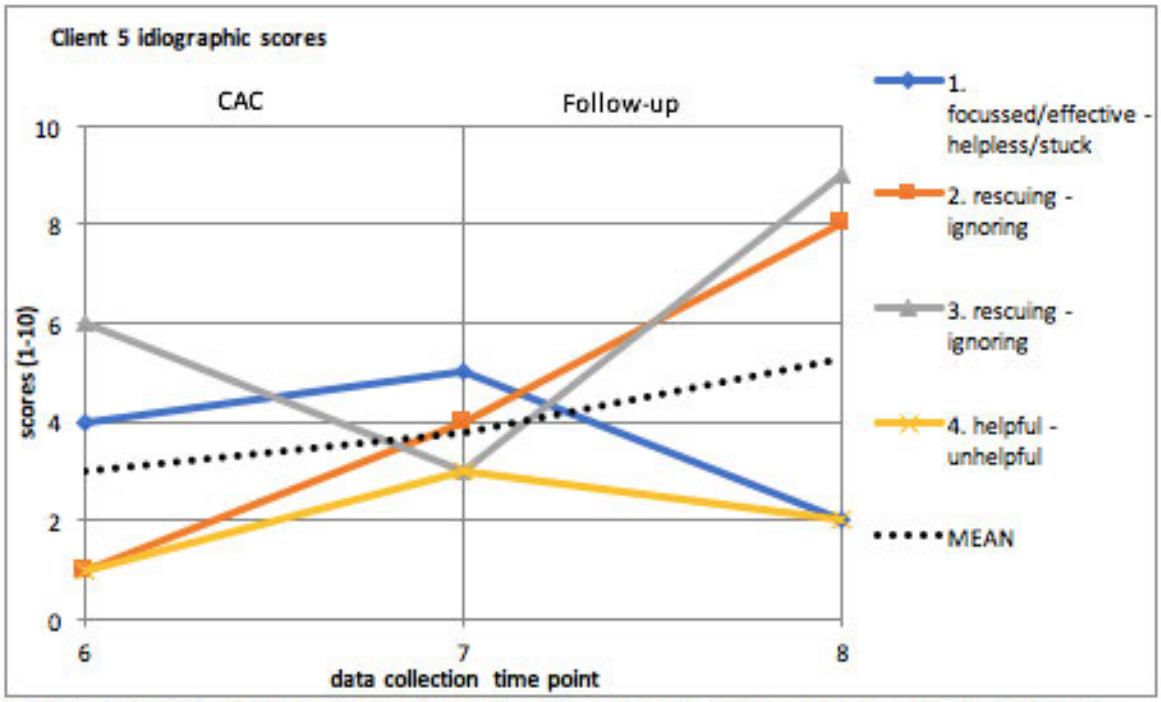


Note. Higher scores indicate deterioration. 1=How did you feel about yourself this week? 2=How did other people get on with you this week? 3=How did you get on with other people this week? 4=How did you get on with your care team this week?

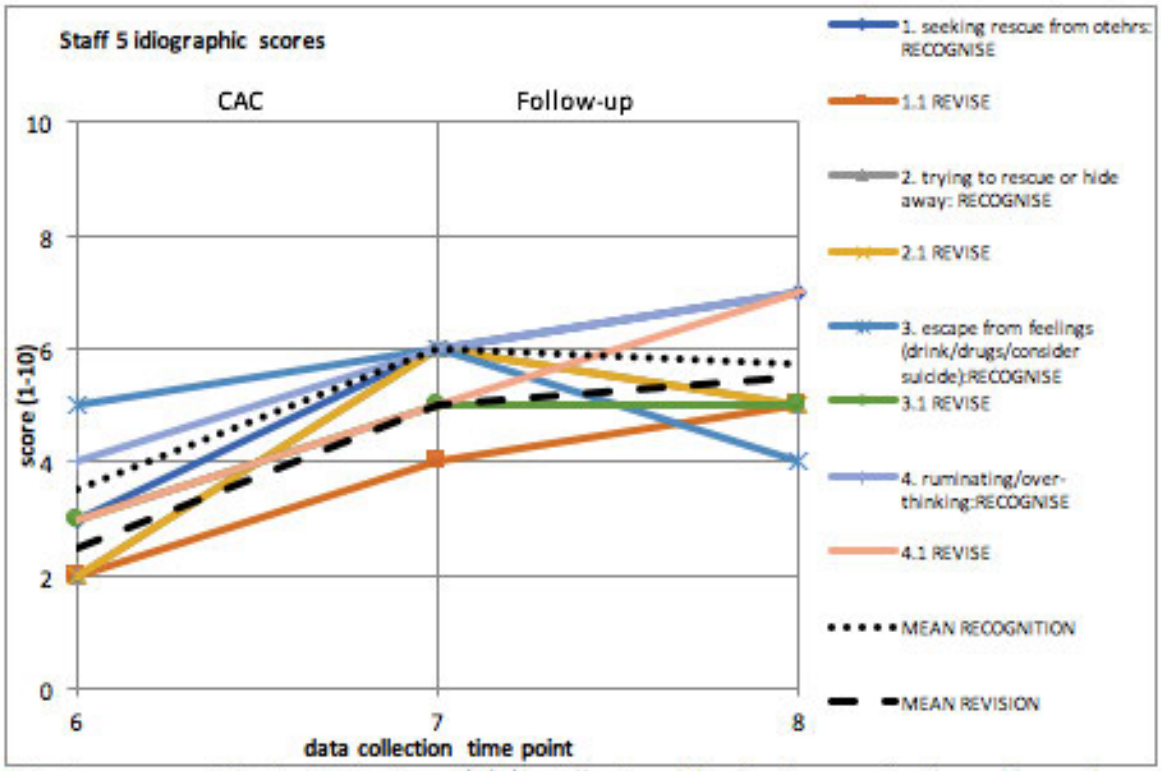


Note. Lower scores indicate deterioration. 1/2/3/4=staff rating of the client to recognize the problem and pattern from 1=totally unaware to 10=very aware. 1.1/2.1/3.1/4.1=staff rating of the client's ability to revise the problem and pattern from 1=stuck to 10=changing

Appendix W. (cont.)

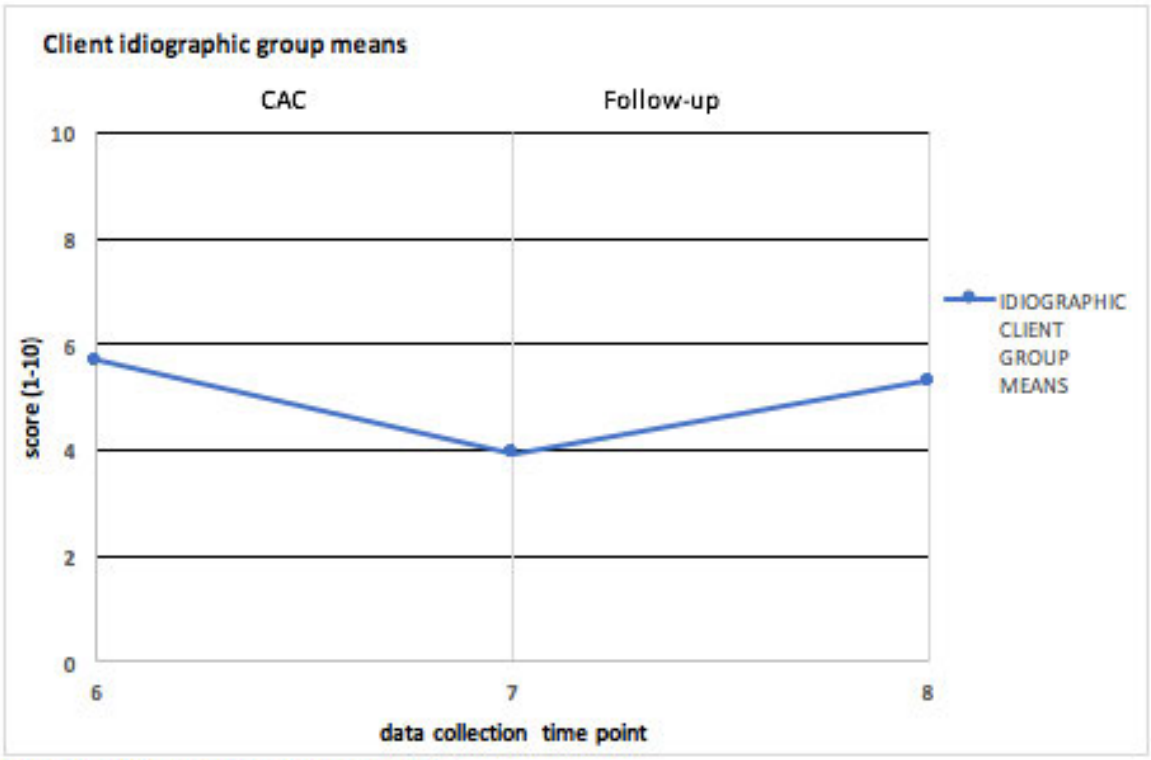


Note. Higher scores indicate deterioration. 1=How did you feel about yourself this week? 2=How did other people get on with you this week? 3=How did you get on with other people this week? 4=How did you get on with your care team this week?

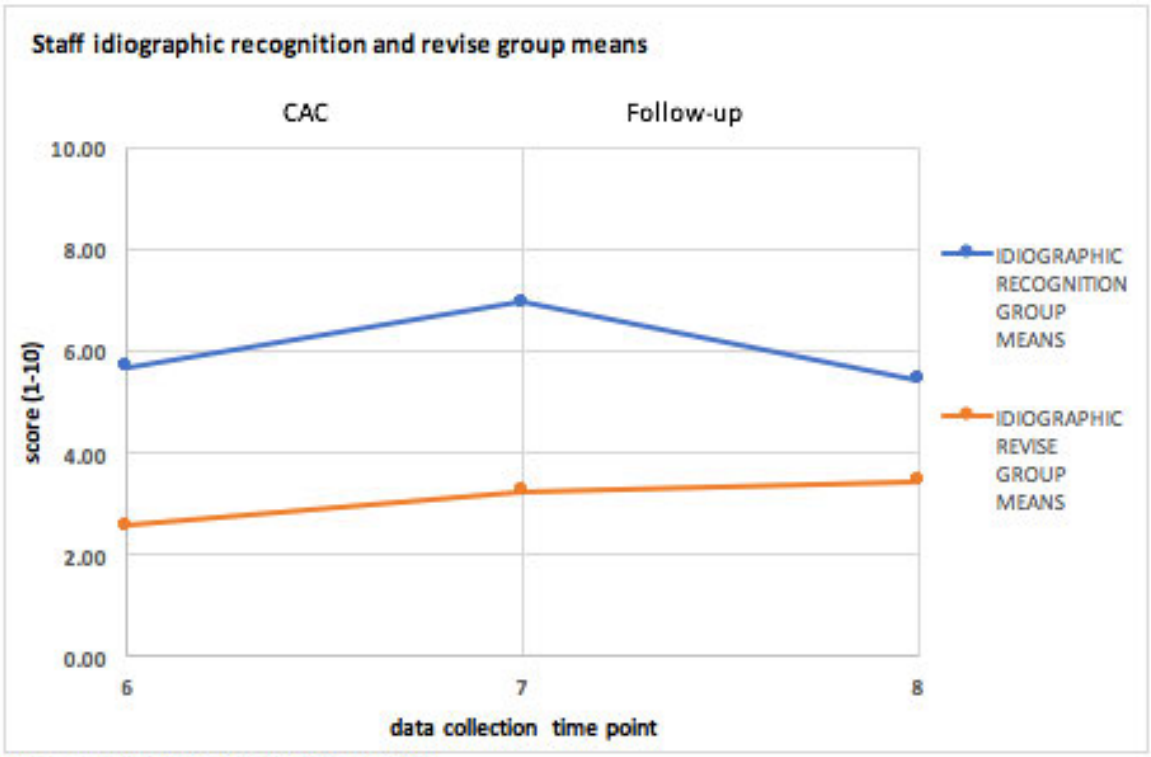


Note. Lower scores indicate deterioration. 1/2/3/4=staff rating of the client to recognize the problem and pattern from 1=totally unaware to 10=very aware. 1.1/2.1/3.1/4.1=staff rating of the client's ability to revise the problem and pattern from 1=stuck to 10=changing

Appendix W. (cont.)



Note. Higher scores indicate deterioration.



Note. Lower scores indicate deterioration.