A review of Indirect Psychological Input as evaluated by previous Service Evaluation Projects

Georgina Burnett

Commissioned by Dr Ciara Masterson

Prepared on the Leeds D.Clin.Psychol. Programme, 2020

Table of Contents

1. Introduction

The role of clinical psychology is ever changing, driven by political, economic and social pressures (Gale, 2018). The British Psychological Society New Ways of Working document (BPS, 2007) outlines the wider remit of the Clinical Psychologist (CP), encompassing a migration to leadership and development roles rather than solely offering direct therapeutic input. Aligned with this, BPS (2012) guidelines outline the importance of including indirect working into the job plans of CPs.

Indirect psychological input can take different forms. Four key types have previously been evaluated by Service Evaluation Projects (SEPs) and will be reviewed here.

1.1 Reflective Practice Groups

Reflective practice involves the clinician standing back from their practice, querying their decisions and considering theory-practice links (Hartley & Kennard, 2009). The Department of Health (DoH, 2002) outlined the importance of reflective practice for mental health teams, allowing them to consider the impact of working in challenging environments. Dickey, Truten, Gross, and Deitrick (2011) found that participants of Reflective Practice Groups (RPGs), staff members in a medical centre, reported an increase in resilience, team cohesion, and an increase in ability to deliver quality care as a result of attending. However, it is challenging to accurately assess RPG outcomes, like quality of care, as most are assessed through qualitative self-report.

1.2 Supervision Groups

Clinical supervision is "a formal process of professional support and learning, which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations" (DoH, 1998, p. 15). Supervision is suggested to stand apart from Consultation as in the latter there is a briefer relationship, which prevents the facilitator from witnessing the participant's growth (Charlton, 2010). Supervision groups (SGs) are often used in mental health settings and aim to enhance skill development and reduce stress (Buus, Delgado, Traynor, & Gonge, 2018). Arvidsson, Löfgren, and Fridlund

(2001) interviewed Danish psychiatric nurses 4 years after a 2-year SG finished. The themes identified included: job satisfaction, personal development, and gaining knowledge and competence. In support, Sheppard, Stacey, and Aubeeluck (2018) evaluated SGs for student nurses in the UK, the nurses remained in the same group for 2 years. The students cited some of the most valued aspects of the SG as its restorative function, its ability to increase self-awareness and the opportunity to learn from the facilitator. However, these results may not be mirrored outside of training programmes, where high turnover of qualified staff affects regular group attendance.

1.3 Formulation Meetings

Formulation meetings enable the team to consider the onset and maintenance of a service user's (SU's) concerns (e.g. Harrison, Sellers, & Blakeman, 2018). Team formulation capitalises on the experiences and skills of different team members, ensuring a shared understanding is developed (Hollingworth & Johnstone, 2014). This helps to guide interventions for the SU (e.g. Hood, Johnstone, & Christofides, 2013).

Harrison et al. (2018) found that team formulation meetings were valued by staff, increased empathy and understanding of SUs, and aided the development of knowledge. Among the barriers to these meetings were staff feeling that they do not hold enough knowledge about the SU and that their input will not matter.

1.4 Consultation Meetings

Consultation has been defined as an indirect form of problem solving between an expert and another person (or people) which allows concerns of the 'client' (e.g. the SU or team) to be addressed (Sheridan, Welch, & Orme, 1996). Blumenthal and Lavender (1997) found from a survey of community mental health team practitioners that consultancy was rated as the second most core role of the psychologist. Walsh, Ryan, and Flynn (2018) explored Dialectical Behaviour Therapy (DBT) clinicians' experiences of team consultations via interviews. Consultation meetings were thought to enhance motivation, provide learning opportunities and help with regulating emotions. However, generalising these findings may prove problematic as this form of consultation is based specifically on DBT protocols.

1.5 Rationale and Impact of Covid-19

Across these four types of indirect psychological input, there is acknowledgement of both the overlap and the nuances that distinguish between them. This SEP will explore these factors in more depth through an investigation of SEPs previously conducted on the University of Leeds Clinical Psychology Doctorate and will hope to provide recommendations for indirect working and guide future SEPs in this field.

Initially, this SEP was designed to evaluate the RPGs held in the Leeds and York Partnership Foundation Trust Forensic Service. This would have required ward staff to be interviewed and due to the pressures the pandemic placed on healthcare staff, this would not have been viable. The project then shifted to focus on reviewing previous SEPs looking at different types of indirect psychological input.

2. Aims

The main aim of this SEP was to review the impact of indirect psychological input investigated in past SEPs.

This incorporated the following research questions:

1. What are the common factors and differences in forms of indirect psychological input?
2. Is it possible to make general recommendations for indirect psychological input when working with staff from this review?
3. Is it possible to make general recommendations for future SEPs investigating indirect psychological input from this review?

3. Method

3.1 Design

This SEP takes the form of an adapted systematic review. A systematic review aims to deliver a summary of the primary research available to answer a research question (Clarke, 2011). Adhering to systematic review principles allows for a rigorous, transparent and replicable method. However, it is a resource-intensive process and can be affected by missing data or methodological diversity (Mallett, Hagen-Zanker, Slater, & Duvendack, 2012).

This review is termed 'adapted' as the search strategy was not systematic. A full search strategy using electronic databases was not employed because the focus here was the examination of other SEPs, rather than a wider literature review. However, other steps of the systematic review process were adhered to. Khan, Kunz, Kleijnen, and Antes (2003) outline the five steps: framing the research question, identifying relevant studies, undertaking a quality assessment of these studies, summarising the evidence and interpreting the findings.

3.2 Data Sources

One hundred and sixty seven SEPs were identified and accessed via the Leeds Clinical Psychology Doctorate extranet or by requesting archived SEPs from course staff.

3.3 Study Selection

The inclusion criteria for SEPs was as follows: the population was staff members participating in the group/meeting; the intervention was one of the four indirect forms of psychological input introduced above and the outcomes included qualitative and quantitative results, related to the impact/opinions of the input.

One hundred and fifty three of the 167 SEPs were eliminated based on titles and a brief review of the SEP as they were not relevant to the research aim. The remaining 14 SEPs were reviewed by reading the reports in full. This two-stage approach was in line with guidance from the Centre for Reviews and Dissemination (CRD, 2008). At this stage, three SEPs were omitted; two were methodologically dissimilar to the other included SEPs and one as the participants were input facilitators. This process is depicted in Figure 1.

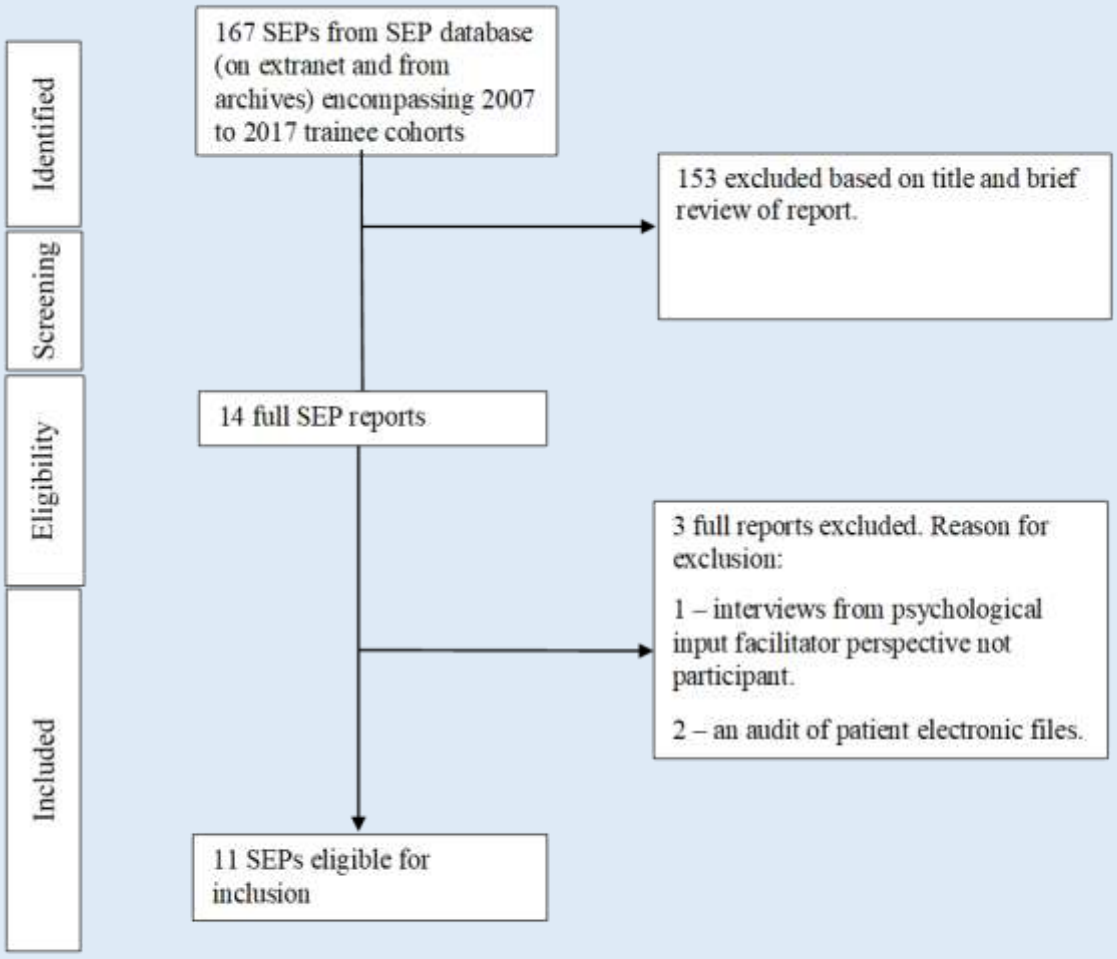


Figure 1. Flow chart of study selection process

3.4 Data Extraction

Data extraction allowed for a summary of each SEP to be provided. The data extraction table (an extract of which is found in Appendix A) was constructed using suggestions from the CRD (2008) and the researcher's supervision. Data was omitted if it was not related to the research aim.

3.5 Quality Assessment

Quality assessment ensures that reliable conclusions are made from robust enough studies (CRD, 2008). A number of quality assessment tools were considered for use,; Appendix B details the evaluation of these. Three tools were selected for piloting as they were deemed

to allow for a thorough yet practical evaluation. The three chosen were the Critical Appraisal Skills Programme (CASP, 2018), 'Appraising the quality of qualitative research' (Walsh & Downe, 2006) and the Mixed Methods Appraisal Tool (MMAT, Hong et al., 2018). The MMAT was agreed in supervision as the most appropriate choice, as it allowed for an assessment of the qualitative and quantitative components of the mixed methods SEPs.

The quality assessment was carried out by the main researcher, an extract for the decision making for quality ratings is shown in Appendix C and the Quality Assessment results are shown in Appendix D. The MMAT 'mixed methods' section was piloted for use with O'Neill's (2017) SEP. This SEP was randomly selected out of the five mixed methods SEPs using a random number generator. ~~and~~ Using this 'mixed methods' section was judged to not augment the quality assessment, so it was omitted from use. All SEPs were rated with the initial two 'screening questions' and the 'Qualitative' section of the MMAT. The five SEPs with a quantitative component were additionally rated with the 'Quantitative descriptive' section.

An independent rater, another trainee, reviewed 2 out of 11 SEPs using the MMAT. This number balanced the importance of a thorough quality assessment and the trainee's own demands. The SEPs to be double rated were chosen by random number generator. There was a 79% agreement between the ratings. For the four ratings not agreed upon, discussions were undertaken to reach an agreement.

There is also an acknowledgement that the SEPs have already been through a level of quality assessment when graded against the course marking criteria.

3.6 Data Synthesis and Analysis

Data synthesis allows results to be collated and summarised, whilst considering the report's quality and accounting for inconsistencies (CRD, 2008). The process of narrative synthesis informed the data synthesis of this review. This is a textual approach which allowed the relationships between SEPs to be analysed. This was used as it would have been inappropriate to use quantitative synthesis methods for these SEPs where inferential statistics were not calculated.

Narrative synthesis comprises of an initial synthesis of findings, consideration of the relationships between/within studies and an assessment of the robustness of the synthesis (CRD, 2008). It must be acknowledged here that the aim of this SEP was not to derive a theory of how the intervention works (the first stage of a typical narrative synthesis), but to understand the commonalities and differences between these types of indirect work. Appendix E details how this review adhered to the stages of narrative synthesis.

For the preliminary synthesis, thematic analysis (TA) was used (CRD, 2008). This was chosen as all the SEPs included produced qualitative data, and TA is not wedded to a particular theoretical orientation, suiting this SEP which required a more practical form of analysis.

The results sections of each SEP, along with appendices (where relevant to the results) were analysed using TA, as described in Braun and Clarke's (2006) six-stage process:

1. Familiarising oneself with the data, reading and re-reading transcripts and noting down initial thoughts.
2. Coding the data, labelling interesting features.
3. Searching for themes; considering how codes relate to each other to form overarching themes or subthemes.
4. Reviewing themes to ascertain whether they standalone or require combining with another.
5. Defining and naming themes.
6. Writing the report.

As a credibility check, the coding process and themes were discussed in supervision~~,~~; a photo of the coding process is shown in Appendix F. The next stage of the narrative synthesis involves considering the relationships between/within included studies~~,~~. CRD (2008) cites tools that can be used to aid this process, including among others: idea webbing, conceptual mapping and qualitative case descriptions. For this review, both maps (Figures 2, 3 and 4) and quotes (Tables 2, 3 and 4) have been used to aid the description of relationships.

Quantitative results from SEPs will be used to support qualitative results where available and relevant.

3.7 Ethical Considerations

As the SEP reports included had already been through an ethical review process, it was deemed that ethical approval was not necessary.

3.8 Alternative Design

A narrative review could have been conducted instead of this adapted systematic review. This brings together primary studies regarding a topic to provide a more descriptive account of the findings. Narrative reviews do not have a pre-determined research question or follow a specific protocol, quality assessment guidelines or search strategy, unlike a systematic review (e.g. Pae, 2015; Demiris, Oliver, & Washington, 2019). It is argued that narrative reviews can be less objective and more informal and descriptive (Miller, Bonas, & Dixon-Woods, 2007). As such, an adapted systematic review method was adopted to bring more rigour to the process (Mallett et al., 2012).

4. Results

4.1 Details of Included Studies

Table 1 provides a brief overview of the included SEPs.

Table 1.

Summary of Included Studies

Psychological Input Type	Study	Service Type	SEP Design	Participants (n)
RPGs	McAvoy (2011)	Forensic Inpatient service	Mixed Methods – questionnaire and free text responses	55
	O'Neill (2017)	Acute Liaison Psychiatry service	Mixed methods Questionnaire and interviews	13
	Smithson (2013)	Forensic Inpatient service	Qualitative – interviews	10
Formulation	Morton (2017)	Rehabilitation and Recovery service (inpatient care)	Qualitative – focus groups	18
	Wainwright (2010)	Acute Older Peoples Female ward	Mixed Methods – questionnaire and interviews	5
SGs	Charlton (2010)	Oncology service	Mixed Methods - questionnaire and interviews (quantitative data for Charlton (2010) and Gallagher (2010) was combined and only reported in Charlton (2010))	7
	Gallagher (2010)	Oncology service	Qualitative - interviews	6
	MacIntyre (2009)	Paediatric Specialities	Mixed Methods – questionnaire and interviews	13
Consultation	McMullan (2013)	Personality Disorder Pathway Development service	Qualitative - interviews and focus groups	12
	Norburn (2016)	Infant Mental Health service	Qualitative – interviews	9
	Wild (2011)	Learning Disability Community services	Qualitative - focus groups	10

4.2 Quality Assessment Outcome

Hong et al. (2018) discourage total MMAT scores from being used and instead suggest a detailed presentation of the ratings. A brief summary of notable points will be provided. Firstly, in McAvoy's (2011) SEP, the TA was performed on one free-text response question, which had a 60% response rate, and no credibility checks were performed. Morton (2017) merged facilitator and participant data and similarly, McMullan (2013) combined focus group data (of those attending consultations) with manager interviews (whose teams had ceased attending) meaning detail could have been lost in these results. Wainwright's (2010) findings were based on five participants and themes were only reported if they appeared more than twice, meaning themes may have been missed. Across the assessment of qualitative methods, there were issues with leading interview schedules or schedules designed with commissioners, which could introduce bias. For quantitative methods, there were common issues, with little detail given about the 'target population' or reasons for non-responders and the use of only descriptive statistics meaning that limited conclusions could be drawn. These quality assessment issues were held in mind when interpreting the findings and aided the final stage of narrative synthesis, assessing the robustness of the synthesis.

4.3 Themes

Three main themes, common across the different input types, were identified: opinions of the input, common factors (strengths) and common factors (challenges). SEP contributions to each theme are shown in Appendix G.

4.3.1 Theme: Opinions of the Input

Across the types of input, evaluative comments were made as depicted in Figure 2 and supported by quotes in Table 2.

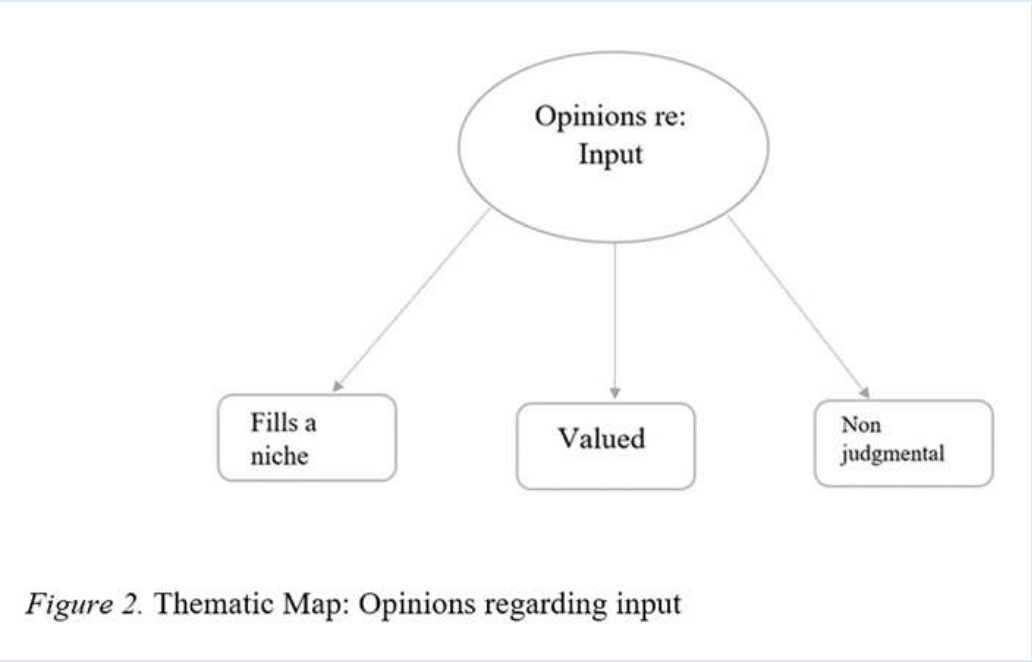


Figure 2. Thematic Map: Opinions regarding input

The forms of psychological input were perceived to be valued, non-judgmental and to offer something not available elsewhere.

Table 2.

Illustrative example quotations for Theme 1

Subtheme	**Illustrative example quotations**
Fills a niche	*"Taking support from the group and offering support to other people. That's the only real space we have to do that so it feels meaningful."* (O'Neill, 2017) *"formulation meetings fill a gap i.e. provides something that wasn't there before."* (Wainwright, 2010)
Valued	*"I think we're quite privileged to get it* [the supervision group] *really"* (MacIntyre, 2009) *"If reflective practice wasn't there… people wouldn't talk and nothing would improve, you'd get more sickness"* (Smithson, 2013)
Non-judgmental	*"it's the kind of meeting where it feels alright to say that"* (Morton, 2017) *"She [the consultant] was very welcoming friendly and you didn't feel that you were being spoken down to by her"* (Norburn, 2017)

These positive opinions were supported quantitatively by Wainwright (2010) where the average usefulness of the formulation meetings was rated as 5.8 (out of 7, meaning 'completely useful'). MacIntyre (2009) found that 11 out of 13 participants rated the SGs above the neutral point in terms of helpfulness, and further support was found using the Process-oriented Group Supervision Questionnaire (PGSQ, Arvidsson, Skärsäter, Baigi, & Fridlund, 2008). Charlton (2010) found a 5.93 out of 7 average rating for the helpfulness of SGs (7 meaning 'extremely helpful'). Participants were most likely to rate that they attend RPGs because they like them (McAvoy, 2011).

4.3.2 Theme: Common Factors (Strengths)

The strengths present across the input types outline the input's benefits as perceived by participants, shown in Figure 3, with supporting quotes in Table 3.

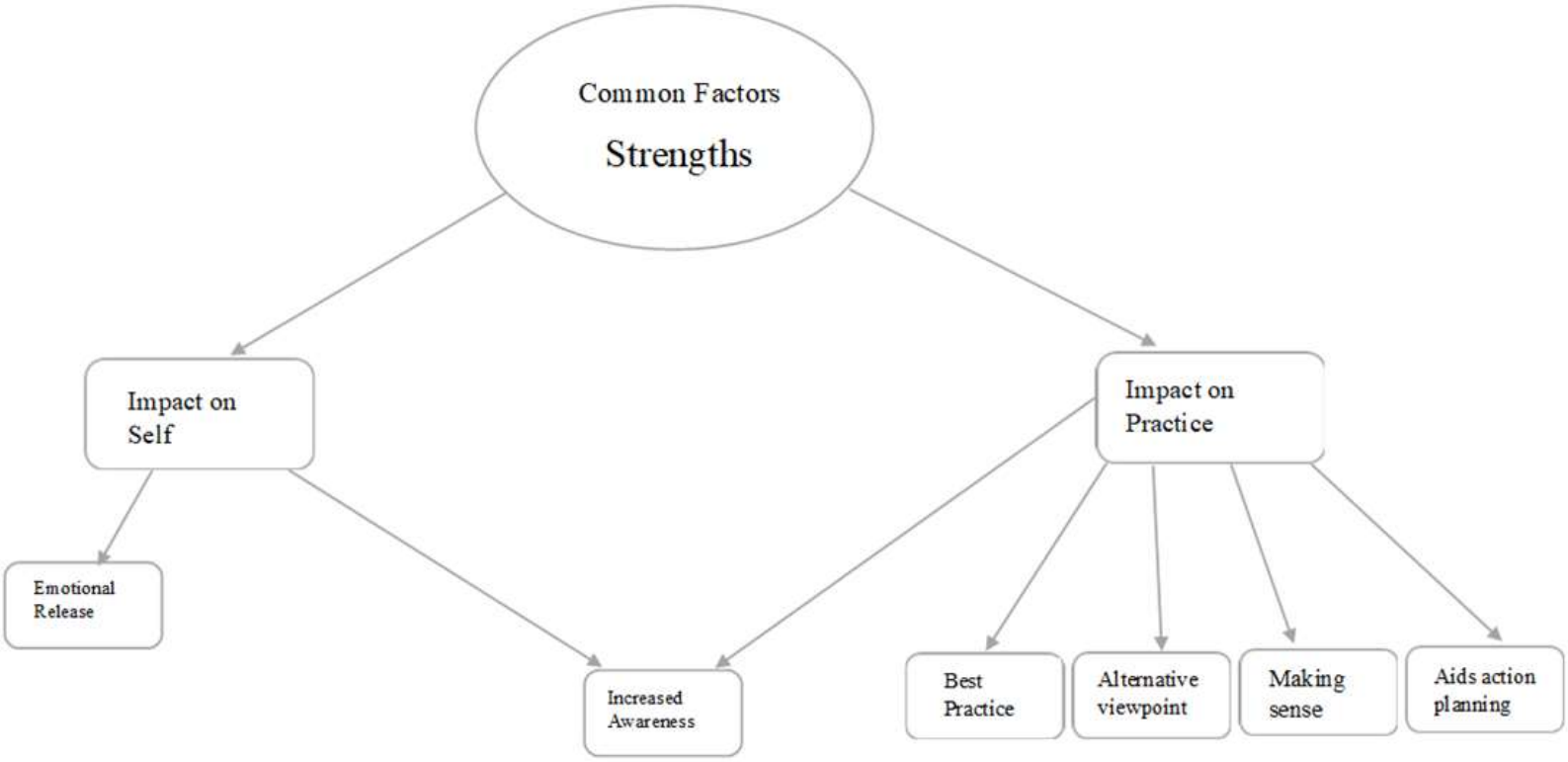


Figure 3. Thematic Map: Common Factors (Strengths)

Firstly, 'Impact on Self' encompasses the input's ability to provide a cathartic space and 'increased awareness' refers to the enhanced personal insight (regarding their own actions and interactions) participants developed.

Secondly, 'Impact on Practice' includes 'increased awareness' which refers to participants better understanding those around them. The input enabled participants to re-calibrate their practice to a high standard, to gain a different perspective and increased their ability to make sense of SUs and their working environment. Finally, the input assisted with suggestions for future action.

Table 3.

Illustrative example quotations for Theme 2

Subtheme: Impact on Self	**Illustrative example quotations**
Emotional Release	*"You need to remain human in my job and I need an outlet for the way that I feel too."* (Charlton, 2010) *"it feels it's in the right environment and it feels a safe place to let off our loads, it's not like we're going to be judged or anything and its confidential."* (O'Neill, 2017)
Increased Awareness	*"people are more at ease questioning their own responses...less anxious about questioning their own interactions"* (Smithson, 2013). *"the group afforded for reflection and increased awareness of their own reactions, needs, and personal limitations."* (Gallagher, 2010)
Subtheme: Impact on Practice	
Increased Awareness	*"...more of an insight into my work environment."* (McAvoy, 2011) *"helped members to be aware of others that they work with and better understand their colleagues' professional roles and personal challenges"* (Gallagher, 2010)
Best Practice	*"...staff can see why the patient is here, who is doing what, and why everyone is having the same approach."* (Wainwright, 2010) *"valued the space to think about clients in more detail in sessions and felt that a 'better service' was offered as a result."* (Wild, 2011)

Alternative viewpoint	*"It's enlightening to hear other people's perspective on it which can help with either confirming your own views about it or give you the opportunity to think about it in a different way from someone else's perspective."* (O'Neill, 2017) *"when I was telling the group what problems I was facing…they made some very constructive points which really helped me helped me move things forward"* (MacIntyre, 2009)
Making Sense	*"*[consultation] *Gives us more understanding as to why they may kick off..."*(McMullan, 2013) *"It supports you in thinking 'oh yeah there's this history, that might explain why they do this'"* (Morton, 2017)
Aids Action Planning	*"social workers felt that they had a workable direction in which to intervene."* (Norburn, 2016) "[the group] *helps give you some direction if you're not sure where you want to go with somebody so yeah I think it helps improve my patient care."* (Charlton, 2010)

With regard to quantitative results for 'Impact on Self', O'Neill (2017) found a small increase in mean total scores for self-compassion pre-post RPG using the Self-Compassion Scale (Neff, 2003) and a small decrease in burnout using the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996). McAvoy (2011) found participants were most likely to agree that attending RPGs increased their insight into the feelings of their colleagues and themselves. However, they were least certain that attending groups improved their capacity to manage work stress. Charlton (2010) found moderate agreement ratings for SGs helping participants 'deal with emotional impact' and 'understanding the self'. Findings from MacIntyre's (2009) use of the PGSQ (Arvidsson et al., 2008) found a mean agreement rating of 5.39 (out of a maximum of 7 – indicating a strong agreement) supporting the statement 'the group supervision enhances self-knowledge' and 5.31 for 'my own experiences are illuminated at a deeper level.'

For 'Impact on Practice,' Charlton (2010) found moderate agreement with SGs aiding the participants to 'deal with challenges'. Wainwright (2010) found small increases in mean ratings pre-post formulation meetings for self and team psychological understanding, more

psychologically-informed care plans, and individuals feeling more empathic and tolerant towards SUs. On the PGSQ, MacIntyre (2009) found mean agreement ratings between 5.08 and 5.92 for the SG enhancing verbal ability, analytical ability, reflective ability and social competence.

4.3.3 Theme: Common Factors (Challenges)

The common challenges across the input types have been identified and are shown in Figure 4 and supporting quotes are shown in Table 4.

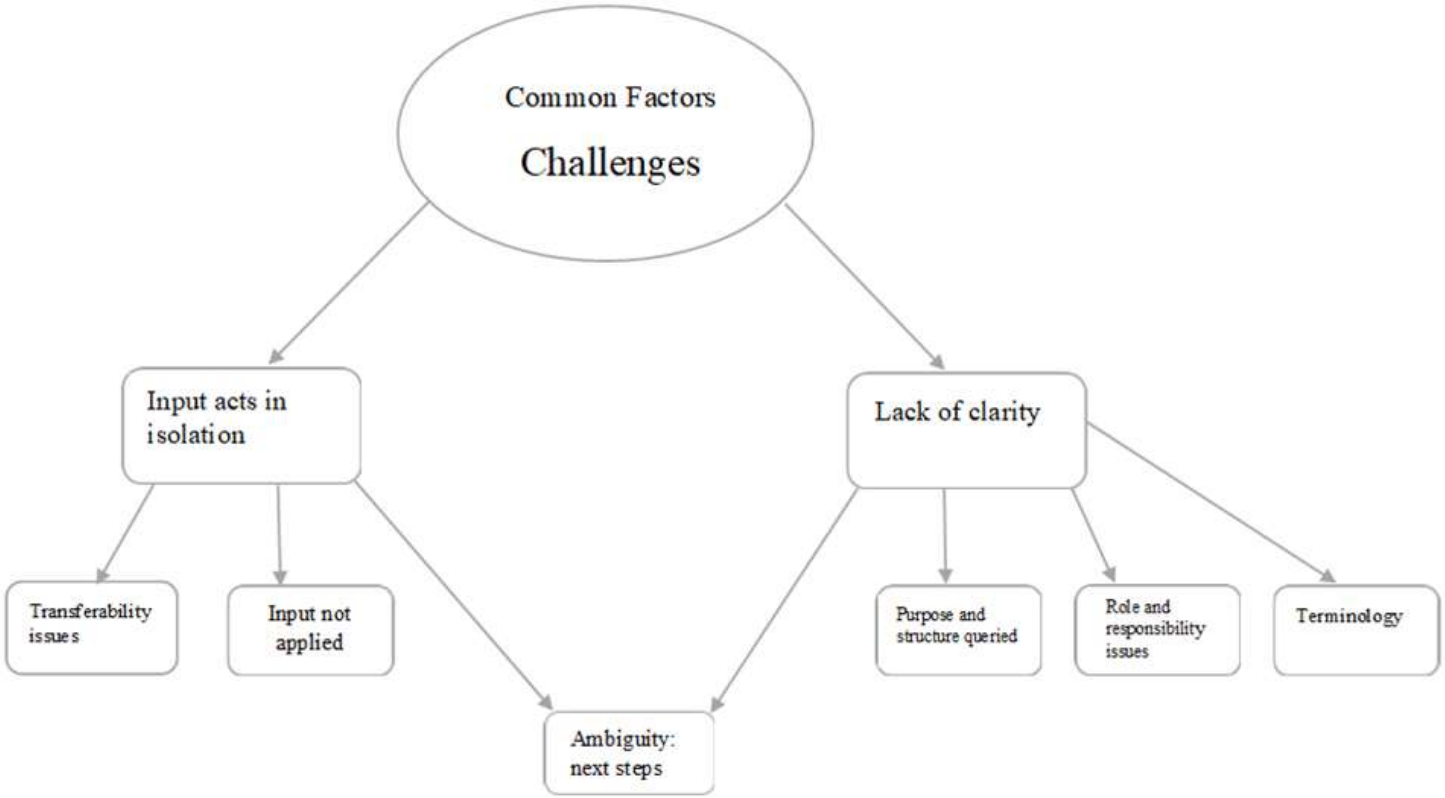


Figure 4. Thematic Map: Common Factors (Challenges)

‘Input acts in Isolation’ refers to concerns that there is no progression after the meeting/group. This includes ‘transferability issues’, meaning that the input suggestions were not feasible to implement. Another issue is that even when suggestions are feasible, they are not being applied. Finally, there was confusion about what the next steps were. Hence why this subtheme also exists under ‘Lack of Clarity’.

‘Lack of Clarity’ encompasses the uncertainty participants felt about the set up and purpose of the input and the terminology used. There was concern regarding roles and consequently who was responsible for carrying out certain actions or holding people to account.

Table 4.

Illustrative example quotations for Theme 3.

Subtheme: Input acts in Isolation	**Illustrative example quotations**
Transferability Issues	*“lack of resources’ to implement the suggestions made by the PDS”* (McMullan, 2013) *“Whilst ever they (IMHS) won’t provide a written report then the information is not admissible in court, so no in this respect it did not inform future practice”* (Norburn, 2016)
Input not Applied	*“…effort needs to be made to ensure that formulations are actually used.”* (Wainwright, 2010) *“it is hard for members to use the Psychology supervision when they feel that they are not properly supported in their work”* (Gallagher, 2010)
Ambiguity regarding next steps	*“In terms of embedding the formulation in everyday practice, participants felt “it is not specified how it’s used, it’s not clear”* (Morton, 2017) *“there were remaining difficulties after supervision… unsure about how these issues should be dealt with, especially when some need was identified in the supervision group”* (Charlton, 2010)
Subtheme: Lack of Clarity	

Purpose and Structure queried	*"if everyone had a clear idea about what our aims are and what we're hoping to achieve then maybe people wouldn't be reluctant…"* (Smithson, 2013) *"I'm not sure if the idea at the minute is just to give us a free floor to talk about anything because from my very limited experience that's what it seems like…"*(O'Neill, 2017)
Role and Responsibility Issues	*"I like it to be different - less hierarchical, having an agenda, both having equal feed into that and equal responsibility to stop and make a decision that's client focussed and we need to move on - more empowerment coming from nurses."* (Wild, 2011) *"Because it's facilitated by someone else you feel like it's their responsibility to say something if they feel that they need to pick something up, but maybe it should be more of a whole team thing but it feels harder as they are sort of leading it."* (Gallagher, 2010)
Terminology	*"puzzled by the need for psychologists to call consultancy 'consultancy' and wondering where the difference was between it and joint working."* (Wild, 2011) *"not having a thorough understanding about RPG"* (Smithson, 2013)

Quantitatively, for 'Input acts in isolation,' Wainwright (2010) found no change in mean ratings pre-post formulation meetings for shared understanding of a SU's concerns. This could support the qualitative results suggesting that the input is not translated outside of meetings. Additionally, Charlton (2010) noted that the statement which was agreed upon the least was that SGs changed practice.

4.3.4 Key differences between types of input

A number of key differences were identified. There appeared to be a divide between RPGs and SGs and Formulation and Consultation groups/meetings. Supporting quotes are found in Appendix H.

Firstly, themes related to interpersonal gains were identified in RPGs and SGs only. This included reciprocity, where participants felt the value of giving and receiving support, and a sense of community fostered through shared experiences. However, SGs and RPGs were most noticeably affected by the meeting composition, with participants identifying that the presence of 'higher-graded' staff affected what was brought to the meetings. Finally, qualitatively, for Consultation and Formulation meetings, there was a more positive direct impact on the SU reported, rather than just an increase in awareness and understanding.

Notably, Wild's (2011) SEP highlighted a more negative view of Consultation, particularly with reference to inconsistent instructions and feeling criticised.

"I think it's like school you know, I've talked to other team members as well, and you hand in something and it comes back with crosses and red pens!" (Wild, 2011)

Lastly, Formulation meetings did not provide the same sense of reassurance, validation or an increase in confidence which was noted in the themes of the other input types. There were also no concerns identified with participants feeling the meeting was dominated or that people were not contributing enough. Finally, no themes relating to important facilitator qualities were identified either.

5. Discussion

This SEP aimed to review the impact of indirect psychological input investigated in past SEPs. This encompassed a consideration of what the common factors and differences are between the input types, and whether general recommendations for indirect psychological input and future SEPs can be made from this review.

5.1 Common Factors

Common factors, held by all types of input, have been identified. This is in relation to both strengths and challenges, the latter of which has led to general recommendations for indirect input.

Overall, indirect psychological input was evaluated positively. A key exception to this was Wild's (2011) SEP. The more negative perspective here could be due to the SEP being conducted at the same time as the introduction of a new service pathway which caused unrest in the team. As the SEPs used in this review encompass only the views of people who agreed to take part in the project, this inherently may lead to more positive opinions being offered. Additionally, interview schedules were often designed with commissioners and asked positively-framed questions, as did questionnaires (e.g. McAvoy, 2011; MacIntyre, 2009), which could have introduced bias.

All input types showed strengths in positively affecting the self and clinical practice. This relates to Vygotsky's (1978) zone of proximal development (ZPD) which suggests that some skills could be challenging for an individual to develop alone but with appropriate guidance this can be achieved. Therefore, these forms of input could act as scaffolding (Wood, Bruner, & Ross, 1976), enabling participants to be supported through their ZPD, personally and professionally.

There initially appears to be a contradiction in subthemes 'aids action planning' and 'input acts in isolation'. It seems that while plans are made, they are unclear, not implemented or

not feasible. This is related to Kolb's (1976) learning cycle. It appears that when the event/experience/problem (the 'concrete experience') is brought to the meeting, the input helps staff through the middle stages: reflective observation (reviewing the experience) and abstract conceptualisation (using the experience as a learning opportunity). However, it seems that staff are stuck in these stages, unable to move into the active experimentation phase where plans are implemented. In turn, this could be explained by the theory of planned behaviour (TPB, Azjen, 1991). TPB suggests that behaviour is an outcome of attitude, subjective norms, perceived behavioural control and behavioural intentions. Behaviours are more likely to be enacted when the behaviour and its outcomes are evaluated favourably (the 'attitude'), when those around the individual approve of the behaviour ('subjective norms') and the individual perceives the behaviour as achievable to perform. If plans are successfully made in the meeting, but the individual/group feels unable to perform them or the individual or their colleagues have a negative view on said behaviour, it is unlikely to be enacted.

A criticism of the TPB suggests that it does not consider whether, regardless of intention, the resources are present for someone to enact the behaviour (LaMorte, 2019). Therefore, the individual/group may have the intention to enact plans but due to systemic problems in the distribution of time and resources, they are unable to act on these intentions. This forms a vicious cycle; if colleagues perceive that there is a pattern for plans to be abandoned, they are unlikely to believe in their ability to enact plans successfully so, yet again, the input acts in isolation.

Lack of clarity regarding purpose and structure, roles and responsibility and terminology were concerns spanning all input types. This reflects the overlap between types of input and issues over what label and interpretation the input is given. This overlap is clearly shown by Geach, Moghaddam, and De Boos (2018), who found descriptions of team formulation fell into three categories: a structured, consultation approach; a semi-structured RPG; and an unstructured informal interaction. They suggest that differences in interpreting and implementing 'formulation' create challenges when understanding outcomes and

recommendations. These ambiguities can lead to frustration in clinicians and lead to difficulties when setting up meetings (Cotton, 2001).

Both Wild (2011) and Cotton (2001) outline the power imbalances that can occur when input types are described with academic/professional language. This leads us to question who the label is for. Radcliffe (2000) argues that these terms move forms of input away from an accessible arena for common-sense thinking and merely exist to allow policy-makers a sense of security in their actions.

5.2 Key Differences

There was a marked distinction between RPGs/SGs and Formulation/Consultation meetings. RPGs/SGs held more themes related to interpersonal processes compared to Formulation/Consultation meetings. This could be due to the less task-focused nature of the former two approaches in contrast with the latter where there was often a specific problem to be addressed. This is supported by the fact that themes related to a more positive, direct impact on the SU were only identified in Consultation/Formulation meeting SEPs. Aligned with this, Johnston and Paley (2013) suggest a major difference between RPGs and Formulation meetings in that the latter focuses more on patient concerns from a management angle and the former focuses more on the interpersonal processes between patient and clinician.

This difference could be explained by Bordin (1979) who suggested three components to the working alliance: task, bond and goals. The bond relates to the relationship, in this case, between facilitator and receivers of the input or between input group members. The goals refer to what is hoped to be gained from the input and the tasks detail what actions are needed to reach the goals. The differences between these two sets of input types could be a result of different weightings ascribed to these components. The bond is perhaps more heavily weighted in RPGs/SGs, giving rise to themes related to interpersonal processes. This is in comparison to a higher weighting for tasks and goals in Formulation/Consultation meetings, resulting in more of a direct impact on the SU.

Additionally, RPGs/SGs were more affected by meeting composition, as when senior staff were present others did not speak as freely. This could be explained as the Consultation/Formulation meetings were set up with someone in a more 'expert' role leading the session. This provided a focus and perhaps allowed individuals to feel safer and more contained (e.g. Hartley & Kennard, 2009). However, in Wild's (2011) SEP, this expert role seemingly led participants to feel criticised. Yet without this, RPG/SG participants felt suspicious about motives for the meetings and felt 'monitored' by senior staff, which affected what they shared. However, it should also be held in mind that the lack of interpersonal gains and issues with group composition specifically in Consultation meetings could be explained by the fact that only McMullan's (2013) SEP was based on a group Consultation meeting.

Lastly, there were notable absences of themes for Formulation meetings. Whilst this could be a factor of Formulation meetings themselves, it could also be accounted for by methodological differences. For instance, Wainwright (2010) had a small sample size, themes were only reported if they appeared two or more times and notes were written in interviews rather than being recorded and transcribed, meaning other themes could have been missed. Also, the merged facilitator and participant data in Morton (2017) means detail may have been lost.

5.3 Limitations of the included SEPs

The majority of the SEPs with a quantitative component did not conduct pre-post analysis, therefore changes in quantitative results may be due to other factors rather than the input provided. SEPs included their commissioners in interview schedule construction and credibility checks which could also introduce bias. There was the problem of missing perspectives for both SUs and those not attending meetings/groups which means only a partial picture of these input types is formed. These limitations and the quality assessment process of this review allowed for general recommendations to be made to guide future SEPs conducted in this area.

5.4 Limitations of the review

Data source issues such as the lack of access to SEPs older than the 2007 cohort can be considered a limitation. Norburn (2016) and Wild's (2011) SEP's are the only two that are based on individual indirect psychological support. These could have been omitted and only group input reviewed but they were included as Consultation is a key role of a CP. The SEPs included came from a variety of different services which had run the input meetings for different amounts of time and frequencies, using facilitators with different theoretical backgrounds, all of which could have confounded the results.

For the quality assessment process, there were limitations of using the MMAT (Hong et al., 2018). At times, not all the questions were relevant, such as those relating to statistical analysis, as most SEPs employed descriptive statistics. If time were permitting, a SEP-specific quality appraisal tool could have been created. From a wider perspective, there is also the question of how appropriate it is to have a distinct quality assessment checklist for all types of qualitative research as methods are not as fixed as they present in checklists (Sandelowski, Voils, & Barroso, 2007) and qualitative research could be considered 'illuminating' regardless of quality (Sandelowski, 1993).

Additionally, the SEPs have a word limit, meaning that data analysed was 'thin.' As original data had already been transcribed, the authors' initial interpretations needed to be looked past, which was challenging to hold in mind. Resources permitting, it would have been more rigorous to have a peer reviewer for themes or double coding.

What also must be acknowledged is my own position when assessing the SEP quality. I am assessing the quality of peers and this may have affected how stringently I adhered to the criteria. Yet this review could have offered a more objective stance for the analysis as I am not under the same pressure as the original authors to present a favourable account to the commissioner.

6. Conclusion and Recommendations

In conclusion, this adapted systematic review explored the common strengths and challenges of different forms of indirect psychological input as well as considering the differences between them. Qualitative findings were moderately supported by quantitative results. Issues of report quality have been held in mind and tentative general recommendations for improving indirect working, regardless of input type, are suggested. There are clear commonalities arising from SEPs evaluating indirect psychological input. Therefore, recommendations are made to increase the value and quality of future SEPs in this area.

6.1 Recommendations for Indirect Psychological Input

- Improving the application of action plans by ensuring practical, clear plans are made, implemented and followed-up.
- Clarify terminology and labels used to describe the input.
- Foster a better understanding as to the aims and purpose of the input. This could take the form of pre-input preparation/training that outlines the input to new members and reviews aims as the meeting composition changes.
- Establish an agreement regarding the roles and responsibilities held in the meetings.

6.2 Recommendations for SEPs evaluating Indirect Psychological Input

- Consider non-attendee or SU views.
- Participants remarked on the psychological input affecting practice but this could be corroborated by quantitative means such as considering sickness/incident rates.
- Consider an external reviewer for credibility/quality checks.
- Consider an external party for interview schedule development.

6.3 Dissemination

This project was presented at the SEP Conference on 23rd October 2020. It will also be made available on the University of Leeds DClinPsych extranet website.

7. References

Ajzen, I. (1991). The theory of planned behavior. *Organizational behavior and human decision processes, 50*(2), 179-211.

Arvidsson, B., Löfgren, H., & Fridlund, B. (2001). Psychiatric nurses' conceptions of how a group supervision programme in nursing care influences their professional competence: a 4-year follow-up study. *Journal of Nursing Management, 9*(3), 161-171.

Arvidsson, B., Skärsäter, I., Baigi, A., & Fridlund, B. (2008). The development of a questionnaire for evaluating process-oriented group supervision during nursing education. *Nurse Education in Practice, 8*(2), 88-93.

Blumenthal, S., & Lavender, T. (1997). The role of clinical psychologists in community mental health teams. *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice, 4*(3), 192-200.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice, 16*(3), 252.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.

Buus, N., Delgado, C., Traynor, M., & Gonge, H. (2018). Resistance to group clinical supervision: A semistructured interview study of non-participating mental health nursing staff members. *International Journal of Mental Health Nursing, 27*(2), 783-793.

Critical Appraisal Skills Programme (2018). *CASP checklists. Critical Appraisal Skills Programme (CASP).* Oxford: CASP UK.

Centre for Reviews and Dissemination, (2008). *Systematic Reviews: CRD's Guidance for Undertaking Reviews in Health Care.* York: CRD, University of York.

Charlton, L. (2010). *An Evaluation of Clinical Psychology led Supervision Groups for Clinical Nurse Specialists working in Oncology*. Unpublished service evaluation project. University of Leeds, Leeds.

Clarke, J. (2011). What is a systematic review? *Evidence-based nursing, 14*(3), 64-64.

Cotton, A. H. (2001). Private thoughts in public spheres: issues in reflection and reflective practices in nursing. *Journal of Advanced Nursing, 36*(4), 512-519.

Demiris, G., Oliver, D., & Washington, K. (2019). Defining and Analyzing the Problem. *Behavioral Intervention Research in Hospice and Palliative Care*, 27-39.

Department of Health (1998). *A first class service - Quality in the new NHS*. London: Department of Health Publications.

Department of Health (2002). *Mental Health Policy Implementation Guide Adult Acute Inpatient Care Provision.* London: Department of Health Publications.

Dickey, L. A., Truten, J., Gross, L. M., & Deitrick, L. M. (2011). Promotion of staff resiliency and interdisciplinary team cohesion through two small-group narrative exchange models designed to facilitate patient-and family-centered care. *Journal of Communication in Healthcare, 4*(2), 126-138.

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

Gale, N. (2018, February 2). Taking our discipline and profession into the future [Web log message]. Retrieved from https://www.bps.org.uk/blogs/presidential-blog/taking-our-discipline-and-profession-future

Gallagher, B. (2010). *Evaluating Mixed Professional Supervision Groups in Oncology. Unpublished service evaluation project.* University of Leeds, Leeds.

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

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

Hartley, P., & Kennard, D. (2009). *Staff support groups in the helping professions: Principles, practice and pitfalls.* Hove, East Sussex: Routledge.

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

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., . . . O'Cathain, A. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018

for information professionals and researchers. *Education for Information, 34*(4), 285-291.

Hood, N., Johnstone, L., & Christofides, S. (2013). The hidden solution? Staff experiences, views and understanding of the use of psychological formulation in multi-disciplinary teams. *The Journal of Critical Psychology, Counselling and Psychotherapy, 13*(2).

Johnston, J., & Paley, G. (2013). Mirror mirror on the ward: who is the unfairest of them all? Reflections on reflective practice groups in acute psychiatric settings. *Psychoanalytic Psychotherapy, 27*(2), 170-186.

Khan, K. S., Kunz, R., Kleijnen, J., & Antes, G. (2003). Five steps to conducting a systematic review. *Journal of the royal society of medicine, 96*(3), 118-121.

Kolb, D. A. (1976). *Learning style inventory technical manual*. Boston, MA: McBer.

LaMorte, W.W. (2019). The Theory of Planned Behavior. Retrieved from: https://sphweb.bumc.bu.edu/otlt/mph-modules/sb/behavioralchangetheories/BehavioralChangeTheories3.html

Long, A. F., & Godfrey, M. (2004). An evaluation tool to assess the quality of qualitative research studies. *International Journal of Social Research Methodology*, *7*(2), 181-196.

MacIntyre, A. (2009). *An Evaluation of Supervision Groups Provided to Clinical Nurse Specialists Working with Families with Chronic Illness.* Unpublished service evaluation project. University of Leeds, Leeds.

Mallett, R., Hagen-Zanker, J., Slater, R., & Duvendack, M. (2012). The benefits and challenges of using systematic reviews in international development research. *Journal of development effectiveness, 4*(3), 445-455.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *MBI: Maslach burnout inventory*. Sunnyvale, CA: CPP, Incorporated.

McAvoy, P. (2011). *Reflective Practice Groups and Staff Well Being: A Service Evaluation Project.* Unpublished service evaluation project. University of Leeds, Leeds.

McMullan, E. (2013). *The impact of team consultation to criminal justice staff working with personality disordered offenders*. Unpublished service evaluation project. University of Leeds, Leeds.

Miller, T., Bonas, S., & Dixon-Woods, M. (2007). Qualitative research on breastfeeding in the UK: a narrative review and methodological reflection. *Evidence & Policy: A Journal of Research, Debate and Practice, 3*(2), 197-230.

Morton, C. (2017). *An evaluation of the implementation and impact of psychological formulation meetings in the Leeds Rehabilitation and Recovery service (R&R).* Unpublished service evaluation project. University of Leeds, Leeds.

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and identity, 2*(3), 223-250.

Norburn, M. (2016). *Making informed decisions: A service evaluation of Infant mental health consultation to children's Social workers in Leeds*. Unpublished service evaluation project. University of Leeds, Leeds.

O'Neill, L. (2017). *What are the experiences of Acute Liaison Psychiatry Service nurses attending a reflective practice group?* Unpublished service evaluation project. University of Leeds, Leeds.

Pae, C.-U. (2015). Why systematic review rather than narrative review? *Psychiatry investigation, 12*(3), 417.

Popay, J., Rogers, A., & Williams, G. (1998). Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research, 8*(3), 341-351.

Radcliffe, M. (2000). A super vision for practice. *Nursing times, 96*(4), 46.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research. *Advances in nursing science, 16*(2), 1-8.

Sandelowski, M., Voils, C. I., & Barroso, J. (2007). Comparability work and the management of difference in research synthesis studies. *Social science & medicine, 64*(1), 236-247.

Sheppard, F., Stacey, G., & Aubeeluck, A. (2018). The importance, impact and influence of group clinical supervision for graduate entry nursing students. *Nurse education in practice, 28*, 296-301.

Sheridan, S. M., Welch, M., & Orme, S. F. (1996). Is consultation effective? A review of outcome research. *Remedial and Special Education, 17*(6), 341-354.

Smithson, E. (2013). *Staff Perceptions of Reflective Practice Groups within a Forensic Mental Health Service*. Unpublished service evaluation project. University of Leeds, Leeds.

Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. (2003). *Quality in qualitative evaluation: a framework for assessing research evidence.* London: Cabinet Office.

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

The British Psychological Society (2012). *Guidelines on Activity for Clinical Psychologists: Relevant factors and the function and utility of job plans.* Leicester: The British Psychological Society.

Vygotsky, L. S. (1978). *Mind in society: The development of higher mental processes*. Cambridge, MA: Harvard University Press.

Wainwright, N. (2010). *An Evaluation of the Introduction of Psychological Formulation to an Acute Older People's Ward.* Unpublished service evaluation project. University of Leeds, Leeds.

Walsh, C., Ryan, P., & Flynn, D. (2018). Exploring dialectical behaviour therapy clinicians' experiences of team consultation meetings. *Borderline personality disorder and emotion dysregulation, 5*(1), 1-11.

Walsh, D., & Downe, S. (2006). Appraising the quality of qualitative research. *Midwifery, 22*(2), 108-119.

Wild, C. (2011). *An Evaluation of Consultation Offered by Community Psychology to Professionals within the Leeds Learning Disability Directorate*. Unpublished service evaluation project. University of Leeds, Leeds.

Wood, D., Bruner, J. S., & Ross, G. (1976). The role of tutoring in problem solving. *Journal of Child Psychology and Psychiatry, 17*(2), 89-100.

8. Appendices

Psychological Input Type	Study	Service Type	Features of psychological input	Aims	Design	Other Methodological Issues	Recruitment	Participants	Analysis	Qualitative Results **Key Themes** (subthemes)		Quantitative Results (if applicable)
										Strengths	**Challenges**	
Reflective Practice Groups	Smithson (2013)	Forensic inpatient service (same service as McAvoy, 2011)	RPG provision evaluated held for 18 months (RPGs held more infrequently in service since 2006) Developed in-house by the psychology team. All Ward staff welcome, each ward has its own RPG, facilitated by a psychologist from a different ward.	To identify the benefits of and barriers to using RPGs	Qualitative (semi-structured interviews, audio recorded)	Interview schedule developed with facilitator of RPGs, designed to capture areas of interest for the commissioners Interview length 20-45 minutes.	Study advertised at a team meeting and recruitment voluntary. Recruitment biased - only RPG attendees took part. One ward not represented as well as others.	n=10 (3 male), staff, all attendees of RPGs. Staff from 3 separate wards and a community rehab unit. Duration of time working on ward ranged from 4 months to 7 years. Number of RPGs attended ranged from 2 to greater than 20.	Thematic Analysis	Within individual experience: **Resilience/strength** – *5 participants*, (outlet for frustrations, space to talk, feeling valued), **Development** – *6 participants*, (self-awareness, clinical skills), **Safety** – *4 participants*, (non-judgemental space, confidence to speak out). Within group experience: **Safety –** *5 participants*, (togetherness), **Difference -** *5 participants*, (different perspectives), **Cohesion –** *6 participants*, (shared experience, understanding) Within organisation experience: **Safety –** *5 participants*, (consistency, relaxed environment),	Within individual experience: focus on sharing anger means there is no space to discuss anything else (n=1). Within group experience: **Safety** (Power) **Difference** (lack of change) **Cohesion** (disparity) Within organisation experience: **Safety** (fear of repercussion) **Ambivalence,** *8 participants*, (lack of understanding,	

											lack of change, undervalued activity).	

Appendix A: Data Extraction Table

Table 5.
Example Extract from the Data Extraction Table

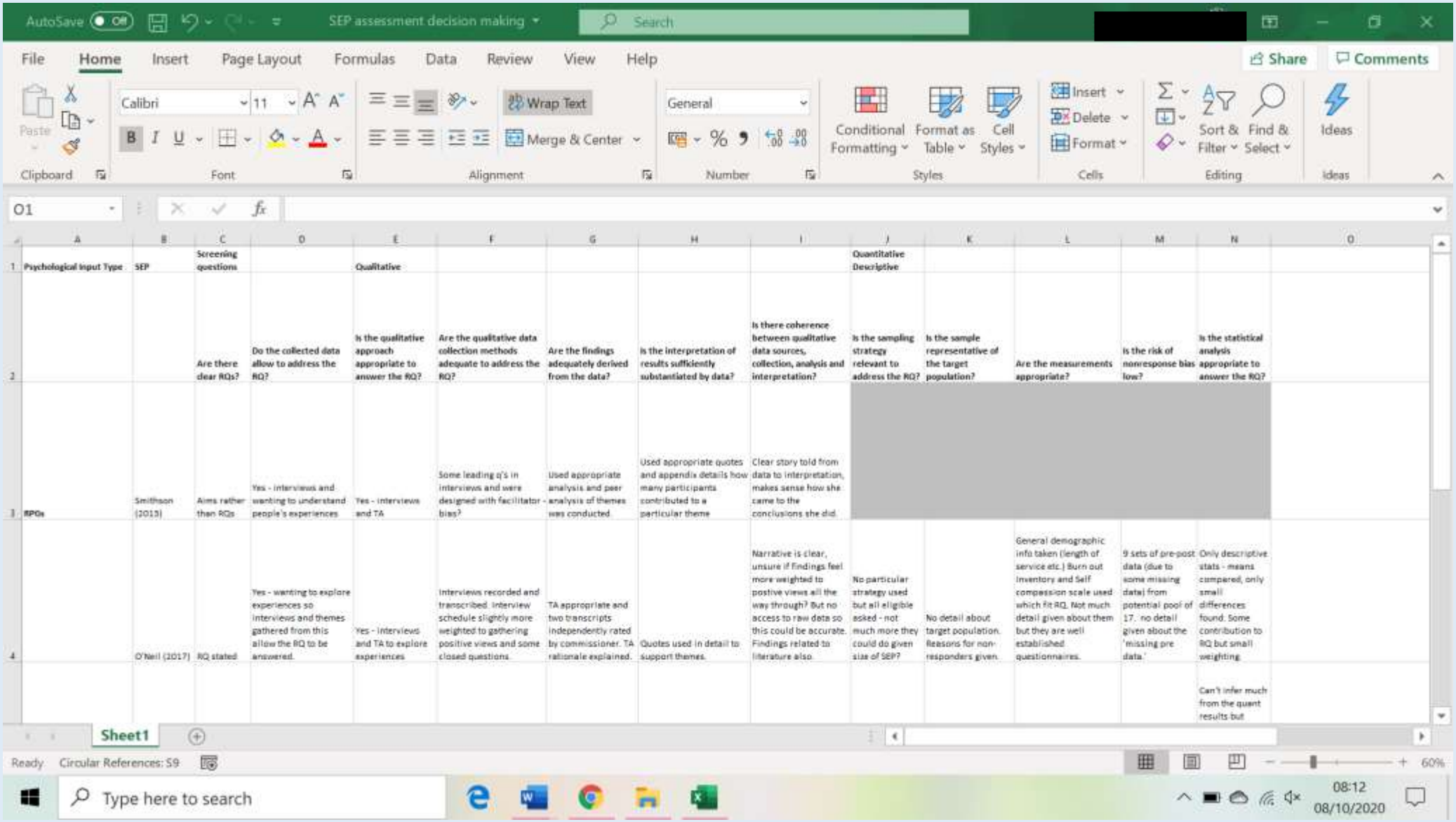
Appendix B: Appraisal of Quality Assessment Tools

Table 6.

Appraisal of Quality Assessment Tools

Quality Assessment Tool	Evaluation
An evaluation tool to assess the quality of qualitative research studies (Long & Godfrey, 2004)	Lengthy and detailed which may be inappropriate for a SEP. Less user friendly, does not give clear checklist points, more general questions.
Appraising the quality of qualitative research (Walsh & Downe, 2006)	12 essential criteria (some specific prompts could be omitted e.g. triangulation, as these are beyond scope of a SEP). To consider using.
Critical Appraisal Skills Programme (2018)	10 criteria User friendly, to consider using.
Mixed Methods Appraisal Tool (Hong et al., 2018)	Allows for an examination of qualitative and quantitative components. To consider using.
Quality in qualitative evaluation: a framework for assessing research evidence (Spencer, Ritchie, Lewis, & Dillon, 2003)	18 criteria, could be too long and in depth for a SEP (asks about corroborating evidence/wider inferences which could be beyond the scope for a SEP).
Rationale and standards for the systematic review of qualitative literature in health services research (Popay, Rogers & Williams, 1998)	Does not provide an actual checklist, more of a descriptive account of points regarding quality.
The problem of appraising qualitative research (Dixon-Woods, Shaw, Agarwal, & Smith, 2004)	Too few questions, may not give a thorough quality assessment of SEPs.

Appendix C: Screenshot of the Quality Assessment Decision Making Process



Psychological Input Type	SEP	Screening questions		Qualitative					Quantitative Descriptive				
		Are there clear RQs?	Do the collected data allow to address the RQ?	Is the qualitative approach appropriate to answer the RQ?	Are the qualitative data collection methods adequate to address the RQ?	Are the findings adequately derived from the data?	Is the interpretation of results sufficiently substantiated by data?	Is there coherence between qualitative data sources, collection, analysis and interpretation?	Is the sampling strategy relevant to address the RQ?	Is the sample representative of the target population?	Are the measurements appropriate?	Is the risk of nonresponse bias low?	Is the statistical analysis appropriate to answer the RQ?
RPOs	Smithson (2013)	Aims rather than RQs	Yes - interviews and wanting to understand people's experiences	Yes - interviews and TA	Some leading q's in interviews and were designed with facilitator - bias?	Used appropriate analysis and peer - analysis of themes was conducted	Used appropriate quotes and appendix details how many participants contributed to a particular theme	Clear story told from data to interpretation, makes sense how she came to the conclusions she did.					
	O'Neil (2017)	RQ stated	Yes - wanting to explore experiences so interviews and themes gathered from this allow the RQ to be answered.	Yes - interviews and TA to explore experiences	Interviews recorded and transcribed. Interview schedule slightly more weighted to gathering positive views and some closed questions.	TA appropriate and two transcripts independently rated by commissioner. TA rationale explained.	Quotes used in detail to support themes.	Narrative is clear, unsure if findings feel more weighted to postive views all the way through? But no access to raw data so this could be accurate. Findings related to literature also.	No particular strategy used but all eligible asked - not much more they could do given size of SEP?	No detail about target population. Reasons for non-responders given.	General demographic info taken (length of service etc.) Burn out inventory and Self compassion scale used which fit RQ. Not much detail given about them but they are well established questionnaires.	9 sets of pre-post data (due to some missing data) from potential pool of 17. no detail given about the 'missing pre data.'	Only descriptive stats - means compared, only small differences found. Some contribution to RQ but small weighting.
													Can't infer much from the quant results but

Appendix D: Mixed Methods Appraisal Tool Outcome

Table 7.

Mixed Methods Appraisal Tool Outcome (Hong et al., 2018)

Psychological Input Type	SEP	Screening questions		Qualitative					Quantitative Descriptive				
		Are there clear RQs?*	Do the collected data allow to address the RQ?	Is the qualitative approach appropriate to answer the RQ?	Are the qualitative data collection methods adequate to address the RQ?	Are the findings adequately derived from the data?	Is the interpretation of results sufficiently substantiated by data?	Is there coherence between qualitative data sources, collection, analysis and interpretation?	Is the sampling strategy relevant to address the RQ?	Is the sample representative of the target population?	Are the measurements appropriate?	Is the risk of nonresponse bias low?**	Is the statistical analysis appropriate to answer the RQ?
RPGs	McAvoy (2011)	+	+/-	+/-	+/-	+	+	+	+	+/-	+	n/a	+/-
	O'Neill (2017)	+	+	+	+/-	+	+	+	+	+/-	+	+/-	+/-
	Smithson (2013)	+	+	+	+/-	+	+	+					
Formulation	Morton (2017)	+	+	+	+/-	+/-	+	+					
	Wainwright (2010)	+	+	+/-	+/-	+/-	+/-	+/-	+	+/-	+/-	+	+/-
Supervision Groups	Charlton (2010)	+	+/-	+	+/-	+	+	+/-	+	+/-	+/-	n/a	+/-
	Gallagher (2010)	+	+	+	+/-	+	+	+					
	MacIntyre (2009)	+	+	+	+	+/-	+	+	+	+/-	+/-	n/a	+/-
Consultation	McMullan (2013)	+	+	+	+/-	+/-	+	+/-					
	Norburn (2016)	+	+	+	+	+	+	+					
	Wild (2011)	+	+	+	+/-	+	+	+					

"+" = yes, "-"= no, "+/-"= can't tell, RQ = research question, RPG = Reflective Practice Group

* Agreed in supervision that this can include any clear statement of research aims as this accounts for the reports being SEPs and not full scale research projects.

**Some SEPs are rated n/a as this criterion is related to attrition and missing data so only relevant to those SEPs with multiple time points.

Appendix E: Stages of Narrative Synthesis

Table 8.

The stages of narrative synthesis (as described in CRD, 2008)

Stage of Narrative Synthesis	**How this review adhered to the stage**
Developing a theory of how the intervention works, why and for whom	Not applicable as this SEP is not attempting to derive a theory.
Developing a preliminary synthesis of findings of included studies.	Braun and Clarke's (2006) Thematic Analysis process followed.
Exploring relationships within and between studies	Use of thematic maps, quotes and descriptions provided in Results and Discussion sections
Assessing the robustness of the synthesis	Quality Assessment procedure using MMAT (Hong et al., 2018) and including the use of an external coder and supervision

Appendix F: Photo of Coding Process

Appendix G: SEP Contributions to themes and subthemes
Table 9.

SEP contributions to themes and subthemes

SEP **RPGs**	**SEP Contributions to Themes**				
	Opinions re: input	Common Factors (Strengths)		Common Factors (Challenges)	
		Impact on Self	*Impact on Practice*	*Input acts in isolation*	*Lack of clarity*
McAvoy (2011)	✓	✓	✓		
O'Neill (2017)	✓	✓	✓	✓	✓
Smithson (2013)	✓	✓	✓	✓	✓
Formulation					
Morton (2017)	✓	✓	✓	✓	✓
Wainwright (2010)	✓		✓	✓	
Supervision Groups					
Charlton (2010)	✓	✓	✓	✓	
Gallagher (2010)	✓	✓	✓		✓
MacIntyre (2009)	✓	✓	✓		
Consultation					
McMullan (2013)		✓	✓	✓	✓
Norburn (2016)	✓	✓	✓		
Wild (2011)	✓		✓		✓

Appendix H: Illustrative example quotations for key differences

Table 10.

Illustrative example quotations for key differences between SGs and RPGs versus Consultation and Formulation

SEP Type	Sub-theme	Illustrative example quotations
RPGs and SGs	Reciprocity	*"Taking support from the group and offering support to other people."* (O'Neill, 2017) *"it feels positive when your able to give somebody that support that maybe last month they've given you."* (Charlton, 2010)
	Sense of Community	*"feelings of being part of a stronger team and maintaining a close bond with peers."* (Smithson, 2013) *"it was a place where good things were said about the team that maybe go unsaid too often and I think that did smooth out some of the issues and it was definitely a good place for it to be addressed"* (Gallagher, 2010)
	Meeting Composition	*"interactions between differing staff grades as being similar to the dynamics on the ward, namely that the lower grade staff tend not to speak out if senior nurses are present"* (Smithson, 2013) *"close networks affect what can be discussed"* (MacIntyre, 2009)
Consultation and Formulation	Direct impact on SU	*"She (mum) was able to make the right choices with the information that the IMHS gave me"* (Norburn, 2016) *"enhances their ability to engage with them [service user] therapeutically"* (Morton, 2017)